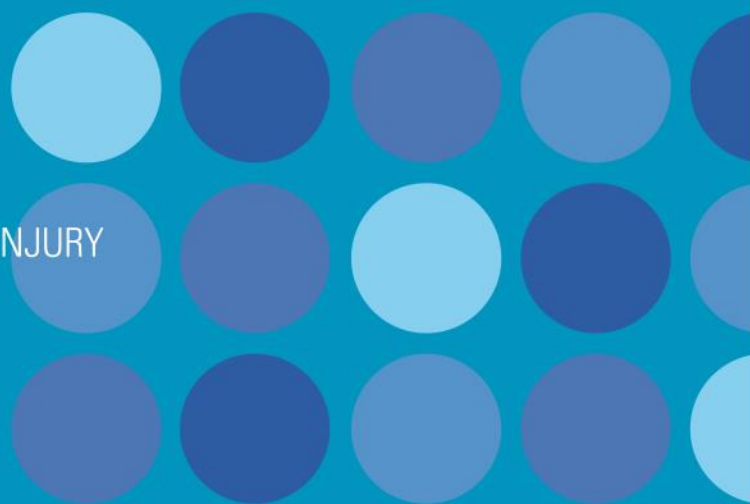


CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE



Annual Report 2019–2020



Government
of South Australia

GPO Box 1152
ADELAIDE SA 5001

T 08 8463 6451

F 08 8463 6444

E cdsirc@sa.gov.au

W www.cdsirc.sa.gov.au

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Letter of Transmission

Hon John Gardner MP
Minister for Education

Dear Minister

I submit to you for presentation to Parliament, the 2019–20 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

This report highlights the Committee's activities in fulfilling its statutory obligations.

In compliance with the *Public Sector Act 2009* and the *Public Finance and Audit Act 1987*, a further report concerning the management of human resources and financial issues of the Committee has been submitted as part of the Annual Report of the Department for Education for 2019–20.

Submitted on behalf of the Child Death and Serious Injury Review Committee by:



Meredith Dickson
Chair
Child Death and Serious Injury Review Committee
30 October 2020

Chair's Foreword

On behalf of the Child Death and Serious Injury Review Committee, I am pleased to present to Parliament, the Committee's 15th annual report. This report is provided under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

Nationally, and internationally, we have read expressions of concern about the impact of COVID-19 on vulnerable children and young people¹. In April, I wrote to the Ministers for Child Protection, Education, Health, and Human Services about this issue. Several cases of serious injury and death reviewed by the Committee, provided examples of the significant physical and emotional consequences that isolation from school and community can have on vulnerable children and young people. I shared the Committee's conclusion from these reviews that collaborative, active and assertive steps need to be taken by government agencies to prevent such tragedies.

I note that my colleagues – the Guardian for Children and Young People and the Commissioner for Children and Young People – have also raised issues about the impact that COVID-19 can have on children and young people².

With respect to the needs of the State's most vulnerable children and young people, a milestone was achieved with the publication of the inaugural report of the Commissioner for Aboriginal Children and Young People, and I congratulate Commissioner Lawrie on her work. The Committee is hopeful that in the coming year our government will take steps to establish the legislation and resources necessary to carry the work of the Commissioner into the future.

I share the Commissioner's concerns for the welfare of Aboriginal and Torres Strait Islander children and young people. A reading of this year's annual report confirms that, year after year, the death rate of these children and young people remains several times higher than those of their non-Aboriginal counterparts. This is an outcome that must be unacceptable to us all and requires urgent redress.

The Committee's report has changed this year as its access to certain information was compromised for several months while all agencies adjusted to the threat of COVID-19. Accordingly, the Committee has not been able to update its statistics regarding the

¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30757-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30757-1/fulltext)

² <https://www.cyp.com.au/wp-content/uploads/2020/06/Reflections-on-COVID-19-Web.pdf>
<http://www.gcyp.sa.gov.au/staying-connected-in-the-face-of-covid-19/>

causes of child deaths for 2019. This information will be released through a series of blog posts starting in the new year, allowing us to report up-to-date information in more interactive and dynamic ways.

The Committee continues to pursue effective ways to influence service systems and share the knowledge and understanding gained from its data analyses and review of child deaths. It is poised to begin working in ways that will provide a broader platform for using the information and expertise it has to influence system change, and to engage with other stakeholders.

The Committee extends its sympathy to all those families, friends and the communities who have lost a child. Our understanding of the heartache this loss causes is one of the factors that drives our work and I trust that this report will assist the efforts of those who work to keep children and young people safe.

Meredith Dickson

Chair

Child Death and Serious Injury Review Committee

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Glossary

ABS	Australian Bureau of Statistics
Act	<i>Children and Young People (Oversight and Advocacy Bodies) Act 2016</i>
ANZCDR & PG	Australian and New Zealand Child Death Review and Prevention Group
CALD	Culturally and Linguistically Diverse
CDSIRC	Child Death and Serious Injury Review Committee
CFARN	Child and Family Assessment and Referral Network
Child	In this report 'child' includes infants, children and young people from birth up to and including 17 years
DE	Department for Education
DCP	Department for Child Protection
DHS	Department of Human Services
ICD–10	International Classification of Disease (Version 10)
Infant	A child up to one year of age
POU	Pregnancy Outcome Unit, Wellbeing SA, SA Health
SEIFA	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
TAC	Team Around the Child

Acknowledgements

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR & PG)
- Births, Deaths and Marriages
- Department of Human Services which continues to provide technical advice and support for the Committee's database, and assistance with records management
- Department for Education for support with administrative, financial and human resource management
- Kidsafe SA
- National Centre for Health Information Research and Training, Queensland University of Technology, especially Ms Sue Walker, Director
- Pregnancy Outcome Unit, Wellbeing SA
- SA Health, Local Health Networks' staff and the staff of SA Pathology for their prompt responses to the Committee's requests for information
- SA Police for their diligent attention to collecting information about child deaths
- State Coroner and staff
- Chief Executives and senior officers from the Department for Child Protection, the Department for Education, the Department of Human Services, SA Health and SA Police for contributing to the Committee's understanding of service delivery within their departments.

Committee Members

Chair

Ms Meredith Dickson

Members

Dr Mike Ahern

Ms Melissa Bradley until 30 June 2020

Ms Angela Davis

Dr David Everett OAM

Dr Mark Fuller

Ms Dianne Gursansky

Ms Ann-Marie Hayes

Dr Deepa Jeyaseelan

Dr Margaret Kyrkou OAM

Mr William Thompson until 13 June 2020

Mr Philip Robinson PSM until 13 June 2020

Mr Kurt Towers from 18 February 2020

Executive Summary

This is the fifteenth annual report of the Child Death and Serious Injury Review Committee.

This report provides highlights of the Committee's data analyses and review of child deaths and serious injuries, notably:

- In 2019, the number of deaths of children and young people was the lowest recorded for fifteen years. Encouraging as this is, the Committee will await the 2020 statistics before considering reasons for this decrease.
- Analyses of child deaths in transport crashes point to the potential for tragic outcomes when children are unrestrained or not properly restrained.

Issues raised in reviews the Committee has undertaken in 2019–20, reflect its concerns for those children and young people who are most vulnerable. Issues include:

- The need for collaborative inter-agency practice to reduce the risk of death of infants born prematurely, or dying suddenly and unexpectedly, in vulnerable families.
- The impact of neglect on the quality and length of life of a young person with a chronic health condition.
- Safety and quality standards that should be in place when children and young people with disability are placed in the care of others.
- Placement of Aboriginal children and young people that ensures the protection of their safety and wellbeing.

These reviews have raised questions about the ways in which state and non-government agencies deliver services to children and young people, and have the potential to provide service agencies with some insight into preventing failures in their service systems.

Section One

1. Child Deaths South Australia 2005–2019

S37 – Functions of the Committee

- (1) The functions of the Committee are –
- a. to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future; and
 - b. to make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury; and
 - c. to maintain a database of child deaths and serious injuries and their circumstances and causes.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

1.1. Analysis and review of child deaths

The intent of the Committee is to improve the safety and wellbeing of children and young people in South Australia. It does this by collecting information about the circumstances and causes of all child deaths in South Australia, analysing and reviewing this information, making recommendations to relevant agencies, and monitoring the implementation of those recommendations. The Committee reviews specific cases of child death, and from time to time also reviews and analyses information about serious injuries.

1.2. Rates and patterns of death

Opportunities for prevention and intervention to improve the safety and wellbeing of children and young people can be identified through the systemic collection and analysis of information about child deaths. Section 37 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*³ identifies those deaths as eligible for review if: (a) the incident resulting in the child's death or serious injury occurred in the state; or (b) the child was, at the time of the death or serious injury, ordinarily resident in the state.

As required by the Act, the Committee maintains a database of child deaths and serious injuries, to which it continually adds information that informs its analyses about rates and patterns of child death in South Australia. Figure 1⁴ shows death rates for all children and young people who died in South Australia during the 15 years from 2005 to 2019, while Figure 2 shows death rates for children and young people who were usually resident in South Australia.

In 2019, the number of deaths of children and young people was the lowest recorded for 15 years. Much of this decrease is attributable to a smaller number of infant deaths (see Section 1.7).

During this 15 year period, the average yearly population of children and young people aged 0 to 17 was 356,149⁵.

³

[https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20\(OVERSIGHT%20AND%20ADVOCACY%20BODIES\)%20ACT%202016.aspx](https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(OVERSIGHT%20AND%20ADVOCACY%20BODIES)%20ACT%202016.aspx)

⁴ For each figure in Section One, there is a corresponding data table in Section 4.

⁵ For more information on how this number was calculated, see Section 3.1.3

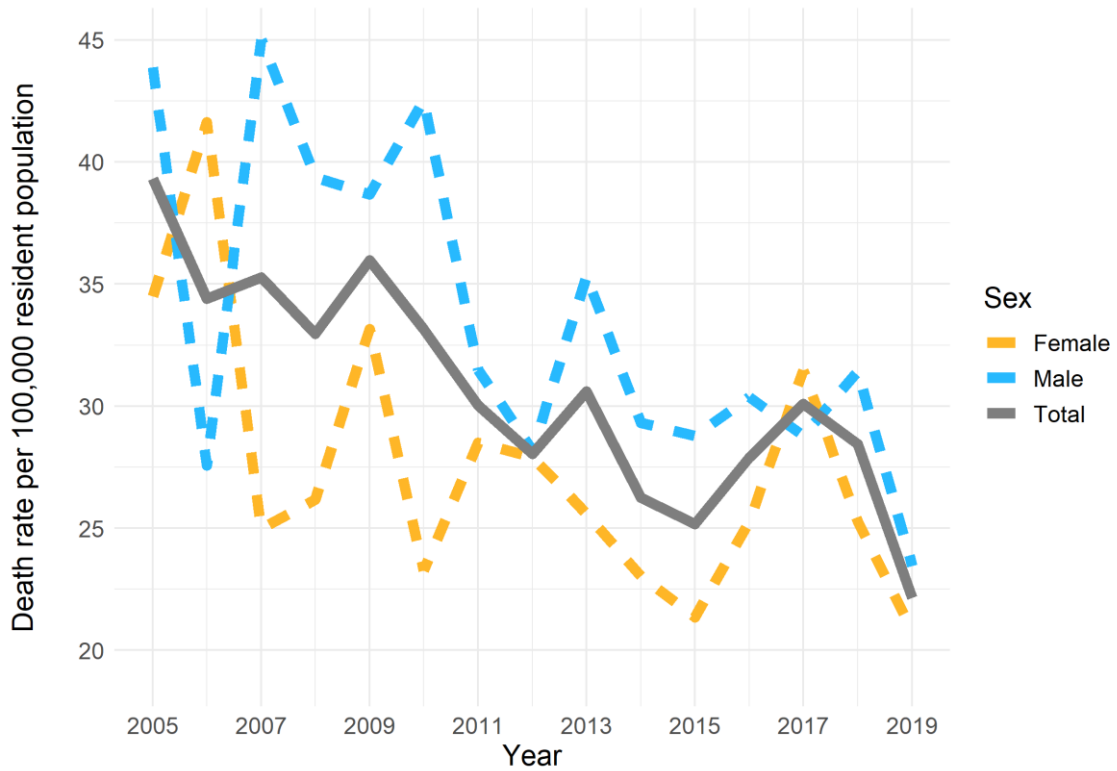


Figure 1: Death rate by year of death and sex for all children and young people, South Australia 2005–2019

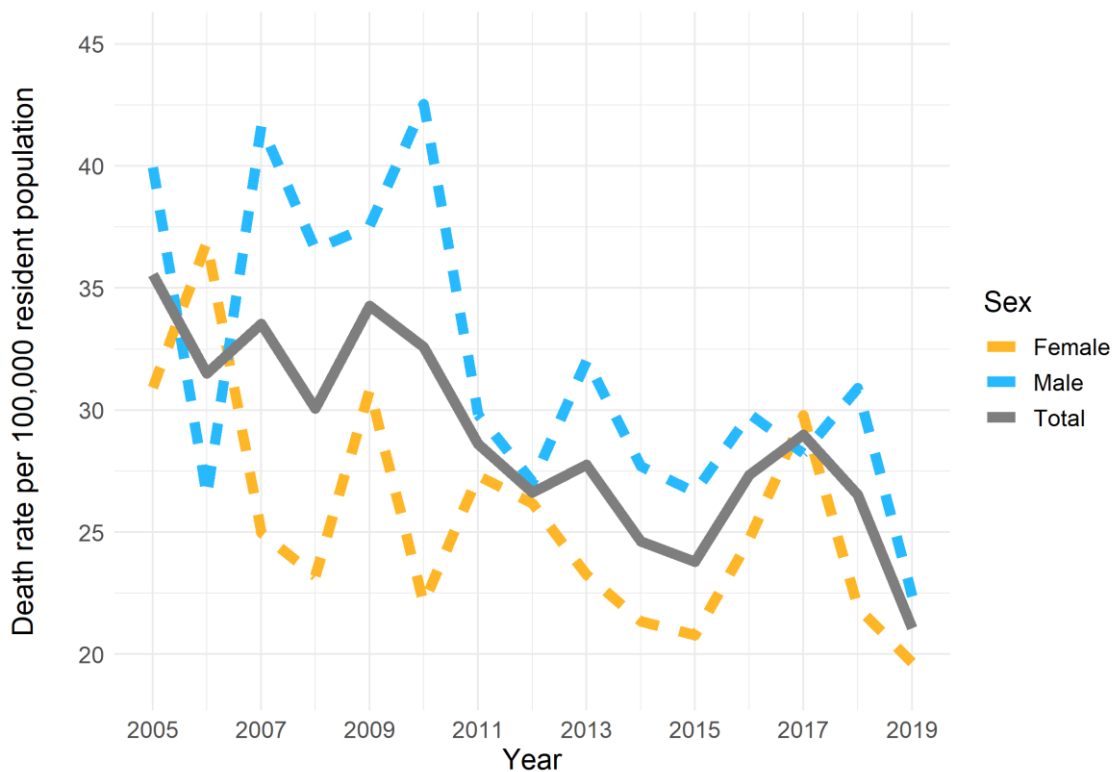


Figure 2: Death rate by year of death and sex for children and young people who were usually resident in South Australia, 2005–2019

1.2.1. Death rates by region

Important issues for service planning and delivery are highlighted when death rates and numbers of deaths are mapped against the South Australian Government's twelve administrative regions.

The highest *rate* of death for children and young people is associated with living in the Far North region of the state. In contrast, the greatest *number* of deaths is recorded in the Northern Adelaide region. Services should be planned and delivered to take into account regions where the rate of death is highest, and regions where the greatest number of deaths occur.

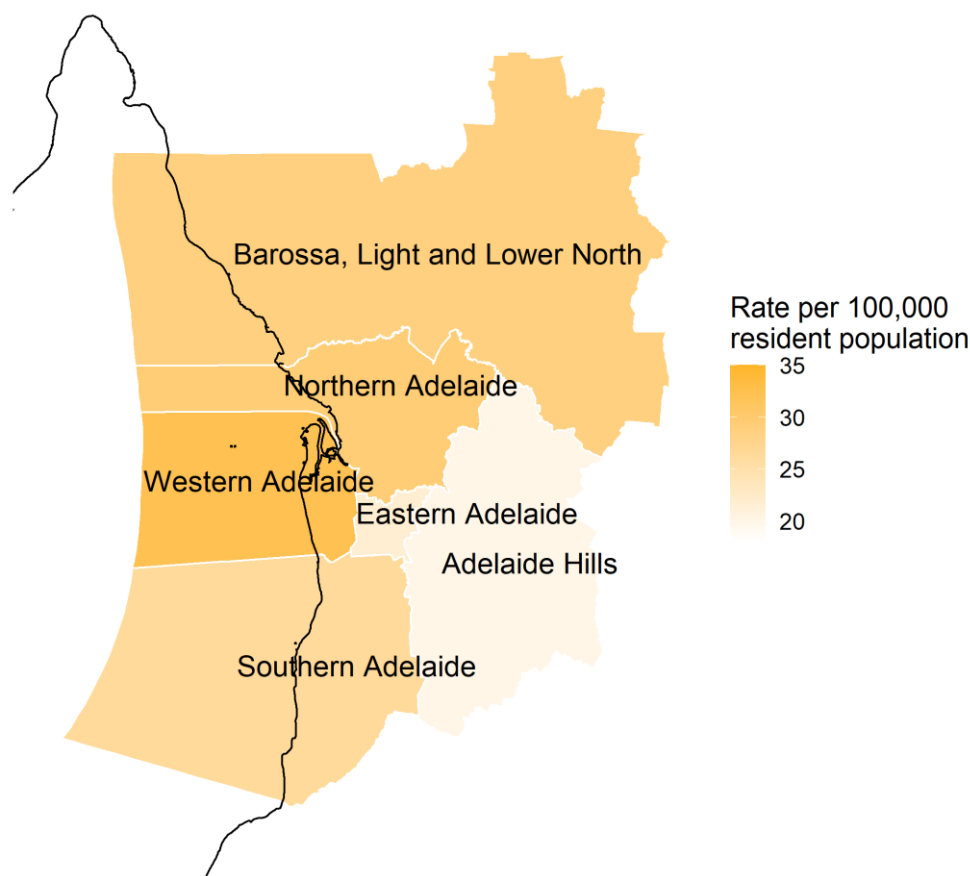


Figure 3: Death rate by metropolitan and inner rural regions for children and young people who were usually resident in South Australia, 2005–2019

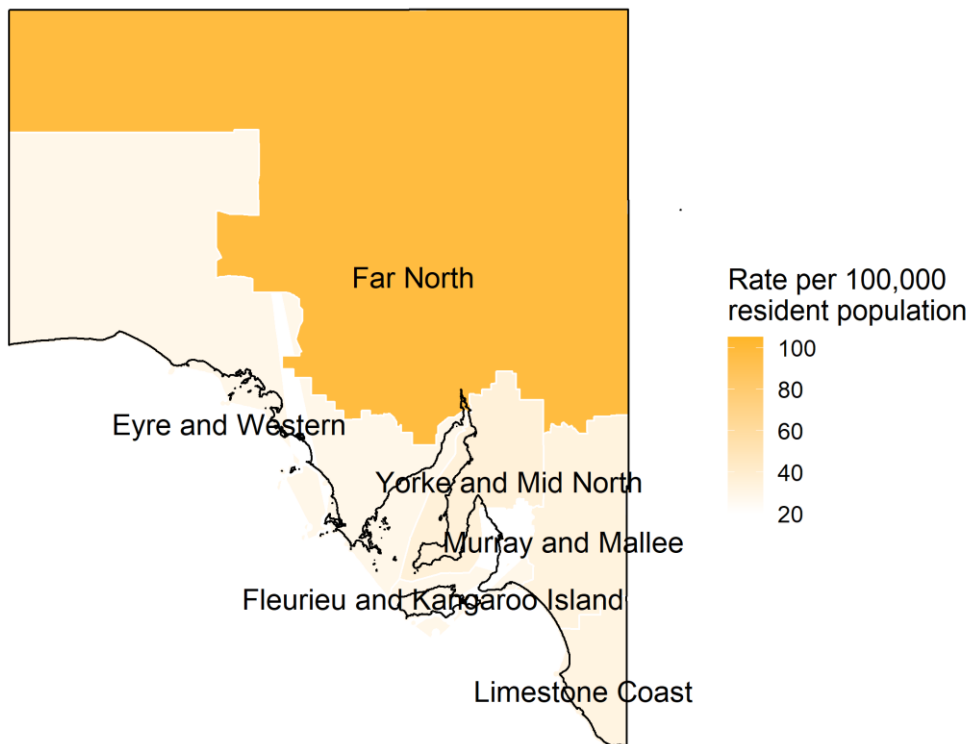


Figure 4: Death rate by outer rural regions for children and young people who were usually resident in South Australia, 2005–2019

1.2.2. Death rates of non-resident children and young people

Ninety-two (6%) of the 1633 children and young people who died in South Australia between 2005 and 2019, were usually resident in another state, territory, or country.

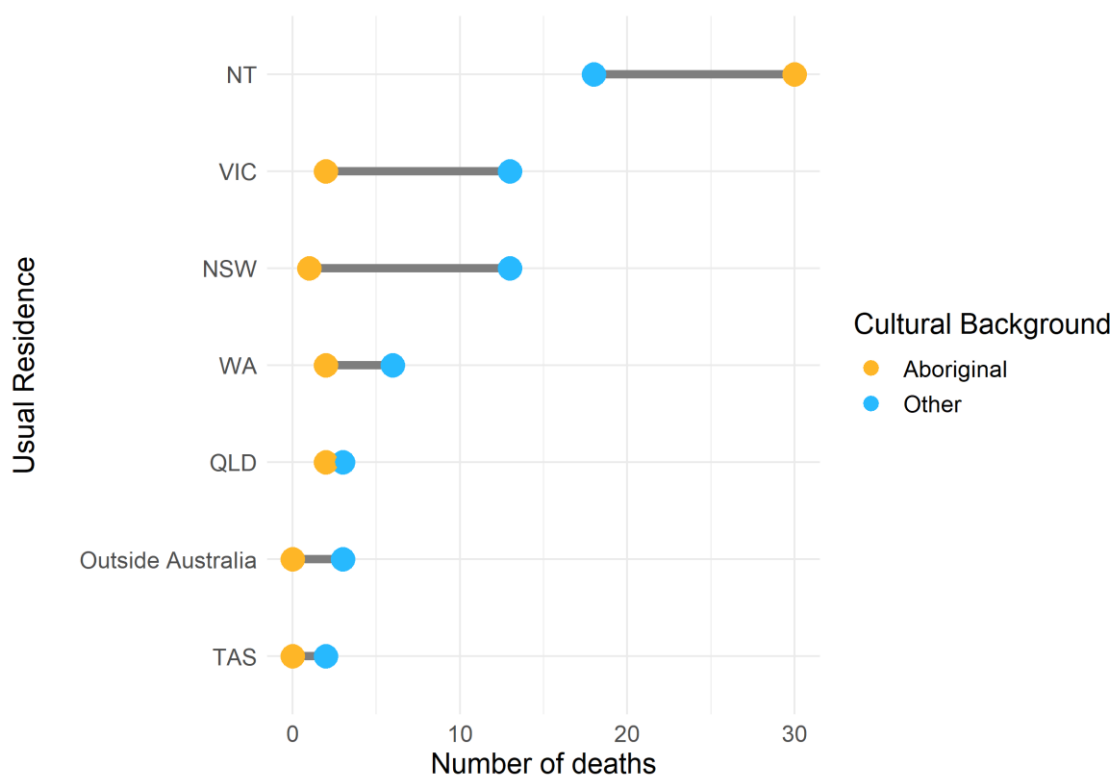


Figure 5: Number of deaths by state, territory or country of residence and cultural background, for children and young people not usually resident in South Australia, 2005–2019

Of the 98 non-resident children and young people who died in South Australia between 2005 and 2019, 48 were from the Northern Territory and thirty of these 48 were Aboriginal children and young people.

Many of the deaths occurring in South Australia reflect cross-border arrangements where seriously ill children and young people are brought to Adelaide for treatment of complex medical conditions associated with extreme prematurity, infant and childhood illness, and various external causes.

1.2.3. Death rates and socioeconomic disadvantage

More children and young people die in areas of South Australia where there are greater levels of socioeconomic disadvantage⁶. The relationship between child deaths and socioeconomic disadvantage is shown in Figure 6. Deaths of all children and young people between 2005 and 2019, resident and non-resident, were included in this analysis.

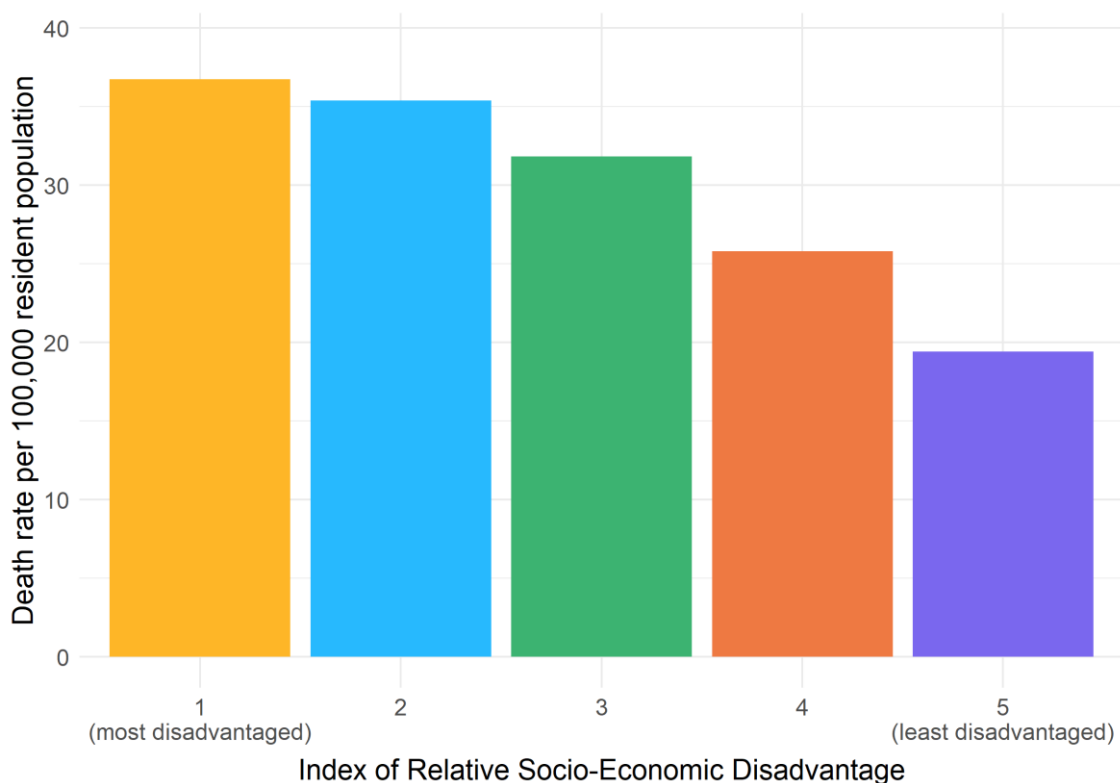


Figure 6: Death rate by Index of Relative Socio-Economic Disadvantage for all children and young people who died in South Australia, 2005–2019

⁶ For information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 3.1.3

1.3. Deaths of children and young people and the child protection system

The Committee continues to review deaths of children and young people where a child, young person, or their family has had contact with the Department for Child Protection (DCP)⁷, to monitor the implementation of recommendations associated with these reviews, and to analyse the number and causes of deaths.

In the 15 years from 2005 to 2019, 508 (31%) of the 1633 children and young people who died, or their families, had had contact with the child protection system in the three years prior to their deaths. Of these 508 children and young people, 244 (48%) lived in the state's most disadvantaged areas⁸.

1.3.1. Infant deaths and challenges for service delivery

In February 2020, the Committee presented information to a DCP workshop about high risk infants. The presentation provided information about the deaths of infants born prematurely, as well as the sudden unexpected deaths of infants. In all of these deaths, there had been a contemporary and/or past history of family contact with the child protection system. The Committee considers such contact to be a marker of vulnerability, and analysis of the circumstances of these deaths identified some consistent risk factors. Since that presentation, the Committee has continued to gather and analyse information about similar cases, focusing on the two-year period from 2017 to 2018.

During that two-year period, 128 infants died. The families of 30 of these infants had had contact with the child protection system. Forty percent (12 of 30) died suddenly and unexpectedly. The families of the other 98 infants had had no contact with the child protection system. Only 7% (7 of 98) of these infants had died suddenly and unexpectedly.

In the same two-year period, 76 infants were born prematurely (ie, before 37 weeks gestation) and died within 28 days of birth. Of these, 10 (13%) of the infants' families had had contact with the child protection system within the previous three years.

⁷ The child, young person, or a member of their family must have had some form of contact with DCP or its predecessors, within three years of the incident resulting in their death.

⁸ As represented by postcodes within the lowest relative disadvantage SEIFA quintile within South Australia. For more information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 3.1.4.

Six of these ten infants were born between 19 and 27 weeks gestation (ie, extreme prematurity), and eight of the ten died within 24 hours of their birth.

The risk factors common to these ten premature infants and the 12 infants who died suddenly and unexpectedly, all of whom had had contact with the child protection system, were:

- levels of socioeconomic disadvantage including residing in the state's most disadvantaged areas, single parent households, housing and financial insecurity, and unemployment
- the presence of family and domestic violence
- parents facing significant challenges including mental health problems, poor physical health, the use of alcohol and other drugs, and a history of childhood trauma
- previous notifications to child protection services – often about incidents of domestic violence and concerns for the wellbeing of children and young people in the household.

Also present in the deaths of seven infants who died suddenly and unexpectedly were unsafe sleeping risk factors including:

- no dedicated safe sleeping place for the infant – using parents' bed, sofas etc
- co-sleeping with parent(s) and siblings – often when parents were difficult to rouse
- breastfeeding in bed
- excess bedding, including adult size bedding, pillows
- smoking in the household
- face down/side sleeping position.

The risks to the health and wellbeing of all these infants were broad-ranging and did not necessarily arise directly from abuse and/or neglect. To mitigate these risks, all agencies providing services to infants and their families must be able to recognise vulnerability.

The challenges of working with vulnerable families are not unique to the South Australian context. A recent review of sudden unexpected infant death by the United

Kingdom Child Safeguarding Practice Review Panel identified a similar set of risk factors and challenges to service provision⁹.

The UK study emphasised the need for multi-agency action that could provide targeted support for vulnerable families, and tailoring messages about safe sleeping within the provision of broader support strategies that recognise the challenges faced by these families.

In South Australia, the development of the Child and Family Assessment and Referral Network (CFARN) model of care has the potential to provide services for vulnerable families, which might lead to early and sustained intervention, and ultimately to better outcomes for infants and their families. It is a model that lends itself well to the assertive provision of co-ordinated, multi-agency care and support during the antenatal period and throughout infancy. The multi-agency focus of the CFARN model also provides opportunity for adapting and integrating the UK study's 'prevent and protect' practice model for reducing the risk of sudden unexpected infant death.

A recent evaluation of CFARN services provided evidence that, in comparison to a group with similar family characteristics, a CFARN intervention group had fewer child protection investigations and care placements.

The Committee notes the intention to expand the reach of CFARNs into regional areas under the auspices of Child and Family Safety Networks. In the Committee's view, if the integrity of the CFARN model of care is to be maintained, there must be an accompanying level of funding and resources.

⁹ *The Child Safeguarding Practice Review Panel, Final Report (2020) Out or routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

1.4. Deaths of Aboriginal children and young people

During the period 2005 to 2019, Aboriginal children and young people constituted only 4% of the South Australian population of children and young people, but they accounted for 12% of child deaths. The rate of death for all Aboriginal children and young people who died in South Australia, was 83 deaths per 100,000. For Aboriginal children and young people who were usually resident in South Australia, the death rate was 67 deaths per 100,000 over the same period (Figure 7). This difference in rates reflects the number of children and young people with complex medical conditions who were retrieved from other states or territories for treatment in South Australian hospitals (see Section 1.2.2). The rate of death for non-Aboriginal children and young people was 28 deaths per 100,000. The rate of death for non-Aboriginal children and young people usually resident in South Australia was 27 deaths per 100,000¹⁰.

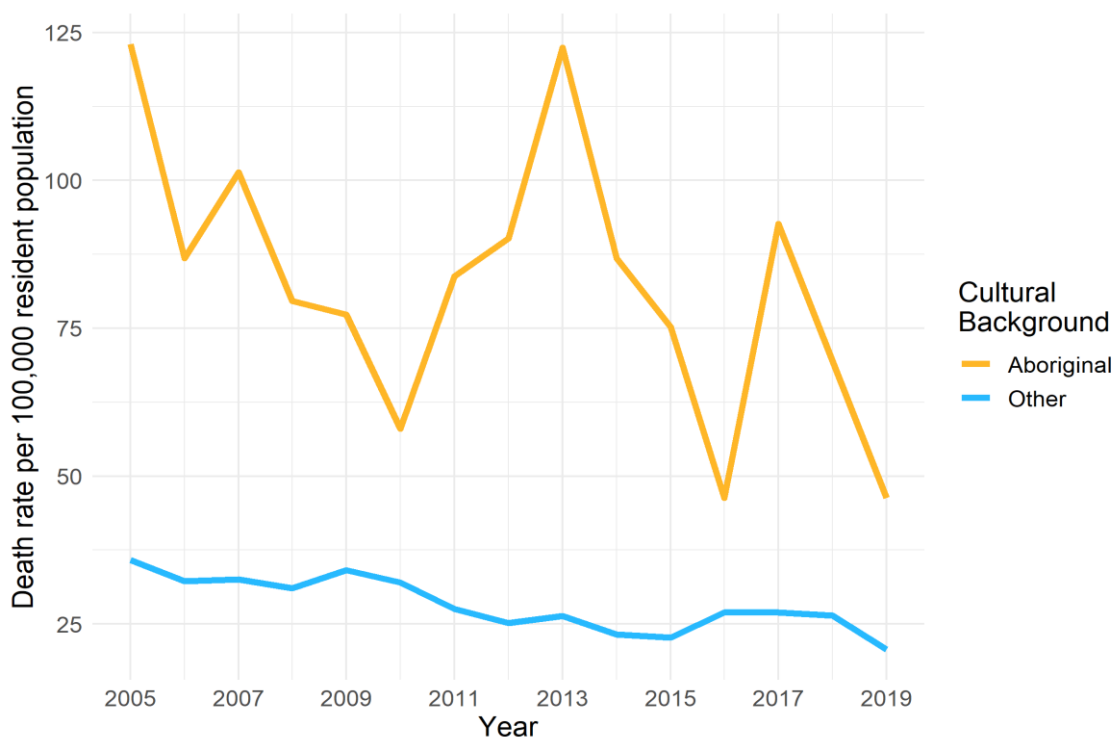


Figure 7: Death rate by cultural background for all children and young people, South Australia 2005–2019

¹⁰ For information about the estimated population of Aboriginal children in South Australia see Section 3.1.3.

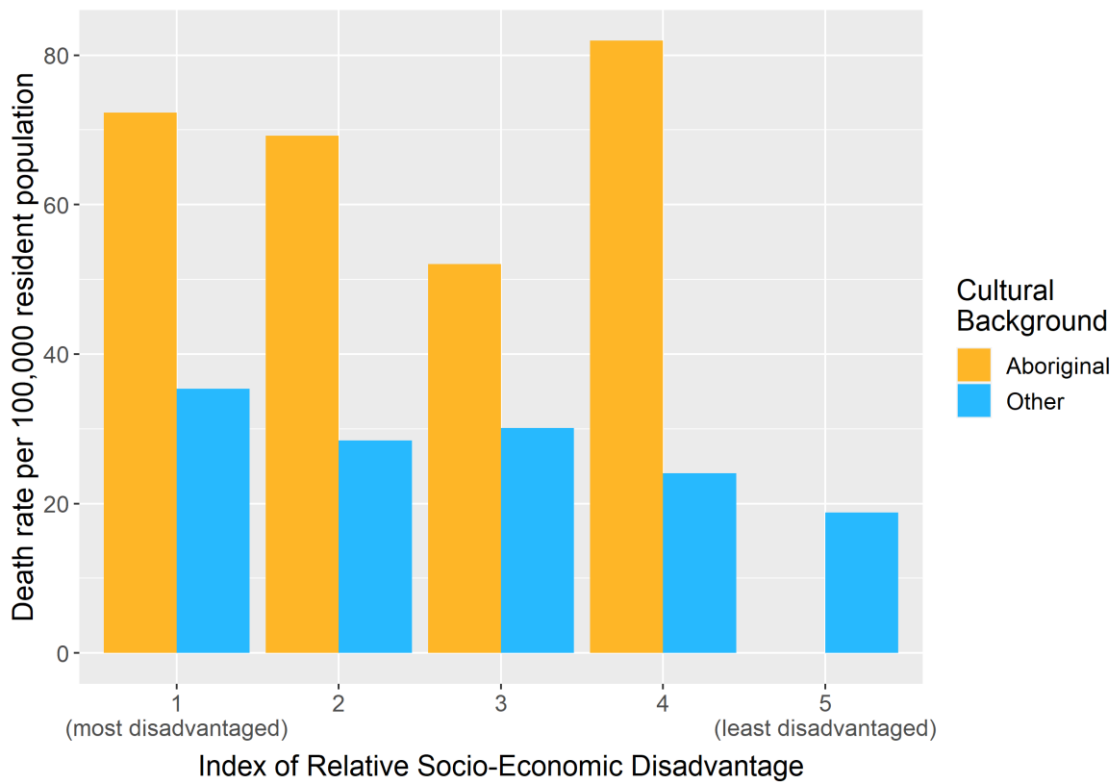


Figure 8: Death rate by cultural background and socioeconomic disadvantage, South Australia 2005–2019

Figure 8 shows the death rate for Aboriginal and non-Aboriginal children and young people in each Index of Relative Socio-Economic Disadvantage quintile. The death rate for Aboriginal children and young people is significantly greater than for their non-Aboriginal peers, regardless of the level of socioeconomic disadvantage they experience. For example, the death rate for Aboriginal children and young people living in the most disadvantaged areas is twice that of non-Aboriginal children and young people living in those same areas, and this discrepancy is similar in less disadvantaged areas. Note that the death rate for Aboriginal children and young people in the least disadvantaged areas has not been calculated because fewer than three deaths were recorded.

The factors contributing to the discrepancy in death rates within disadvantage levels are unclear. The Committee will await further data and explore this important issue in more depth in a future blog post.

1.4.1. Aboriginal children and young people – care by informal arrangement

A case that came to the Committee's attention was also the subject of a Coronial Inquest which concluded in 2019, meaning that the Committee could not undertake its own review until coronial findings had been made.

As the Coroner has made a comprehensive examination of the issues that resulted in this young girl's death, the Committee will not repeat this work. However, the Committee is concerned about issues mentioned in the files and Inquest, about which, no findings or recommendations were made.

This young Aboriginal girl went to non-Aboriginal carers by 'private arrangement', when only days old. The child protection system noted a long history of concerns for the carer regarding the often 9 to 12 Aboriginal children who resided with her – all of whom allegedly had some form of disability including intellectual disability, learning difficulties, behavioural problems or foetal alcohol syndrome. All of the children had been placed with the carer by private or informal arrangement.

After the death of the young girl's mother, and the subsequent death of her carer, she was placed into the care of her carer's daughter. The Finding of Inquest into the death of this young girl questioned the legal authority of her carer to transfer the care of the young girl to her daughter, and of her daughter to subsequently transfer the care of the girl to friends of the family – albeit with the knowledge of the child protection system.

The Committee has concerns about this issue and is aware that as far back as the 1980s, the child protection system was provided with legal advice that informal care arrangements were quite lawful. However, while legal, such arrangements provide no accountability for the welfare of the child, and possibly no establishment of legal guardianship.

In addition to the legality of this young girl's care arrangements, the Finding of Inquest queried:

- the child protection system's policies regarding children living in informal care arrangements
- the impact, if any, of the care arrangements on this young girl's cultural identity and her mental health status
- whether relevant Aboriginal organisations and the young girl's Aboriginal family members were consulted about changes to her informal care arrangements.

While acknowledging the significance of these matters, the Coroner noted that they were beyond the scope of a single inquest, particularly as many of these and related issues were considered by the Child Protection Systems Royal Commission 2014-2016.

The Committee has been unable to find any specific references to care by private or informal arrangement in the report of the Royal Commission, *The Life they Deserve*. Similarly, the *Children and Young People (Safety) Act 2017* is silent on the issue.

Under its legislation, the Committee is bound, in part, *‘to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future’*.

Accordingly, the Committee intends to examine the issue further. It has been a feature of several other cases that have come to the Committee’s attention.

In the interests of ensuring the rights and safety of children and young people, the Committee will consider, among other things:

- South Australia’s position on the issue of children and young people living under informal care arrangements
- the need for policy development on the issue
- the regulation of such arrangements
- the involvement of Aboriginal community-controlled organisations.

1.5. Deaths of children and young people with disability

Information about the deaths of all children and young people in South Australia is reviewed by the Committee to determine whether a child or young person's daily activities had been significantly limited by disability, and to explore connections between the disability and their subsequent death.

1.5.1. A review into the deaths of children and young people placed in the care of others

In the Committee's view, all children and young people, when placed in the care of others, are entitled to be kept safe and to have their needs understood and met. This entitlement should be the key consideration in all episodes of care, care arrangements or contracts for care arrangements. In its current review, the Committee chose five cases, both historical and contemporary, to illustrate the issues that can arise when children or young people with disability are placed in the care of a person(s) other than their parent and/or primary carer(s). The deaths of these five children may have been prevented if:

- the care needs of each child or young person had been fully disclosed, and adequately documented, so that the best possible decision could be made about the type and level of care they required
- the care needs of each child or young person had been placed before the needs of the system, the facility, the parents and/or the primary carers
- the needs of the system, the facility, the parents and/or the primary carers did not impede a decision that was in the best interests of the child or young person.

The Committee concluded that, to prevent such deaths from occurring, the quality and safety standards governing the practices of agencies who provide care for children with disabilities, must ensure that:

- Information required from parents reflects the most up-to-date knowledge about the child or young person, including the symptoms of their disability that require management – either medical or behavioural – and the signs that these symptoms might require some kind of intervention. It is important that this information is:

- written in a manner that is easy to understand and is readily available to care workers across various shifts
- continually updated and exchanged, and a review generated every three months or when there is a significant change to the child or young person's health status or behaviours.
- Assessment takes into account:
 - the child or young person's mental health and emotional needs, eg, will placement at a different facility cause this child or young person a level of anxiety that might increase the severity or frequency of certain medical or behavioural conditions?
 - will there be an increase in the frequency and severity of seizures, or of 'comfort' behaviours such as ingesting foreign substances in an unfamiliar environment? If so, then additional levels of supervision should be employed.
- A decision to provide care for a child or young person is based on a careful evaluation of their needs and the ability of a facility to accommodate those needs, in terms of the level of staffing, the experience and training of staff, the physical amenities of the facility, and the available equipment.
- The care provider accepts responsibility for ensuring the parent fully understands the level of care that will be provided to the child or young person, and will alert them to any matter, eg, staffing or equipment, that may pose risks to the child. Only then can parents and/or primary carers and care-providers make informed decisions about the provision of care.
- The child or young person is receiving the level and quality of care they require and:
 - the facility responsible for that care has an up-to-date, documented care plan which includes the levels of care the child will receive (including overnight care)
 - this plan is provided to, and signed by, the child or young person's parent and/or primary carer. Updated information or changes (eg, arising from a meeting between the parent and/or primary carer and care-provider(s)) must be noted in the plan, and agreed to and signed by the parent and/or primary carer and the facility.

The Committee is seeking to meet with state and national agencies which hold responsibilities for the safety and wellbeing of children and young people with disabilities, with the intention of discussing the best ways in which these recommendations can be incorporated into current quality and safety standards.

1.6. Deaths of children and young people from families with culturally and linguistically diverse backgrounds

The Committee has noted the deaths of children and young people in families with culturally and linguistically diverse (CALD) backgrounds. Cultural and linguistic diversity is interpreted by the Committee to include humanitarian migration status (refugee), migrant status, and a culturally or linguistically diverse background.

Families with a CALD background have knowledge, resilience and strengths that enable sound parenting. However, the experience of migration has been found to be stressful. It may include lack of social support, lack of contact with extended family, and linguistic difficulties¹¹. In addition, some families may also have had the experience of humanitarian migration. The Australian longitudinal study, *Building a New Life*, found that humanitarian migrants had experienced traumatic events including war, persecution, extreme living conditions, imprisonment or kidnapping, and natural disasters. Almost half of those people were at moderate or high risk of psychological distress¹².

A linkage analysis of neonatal deaths (deaths of infants up to 28 days of age) between 2005 and 2017, was conducted in 2019 with data obtained from Wellbeing SA's Pregnancy Outcome Unit (POU). The analysis showed that only 20% of the deaths identified by POU as occurring within families with a CALD background were identified as such on the Committee's database.

The Committee reviewed the deaths of 28 children and young people that occurred between 2014 and 2018, where the child or young person had been identified as living in a family with a culturally and linguistically diverse background. The Committee identified factors associated with migration, language and cultural diversity in the child or young person's circumstances of death (see Diagram 1).

The Committee will continue to incorporate information about CALD background in the information it collects about the circumstances of a child or young person's death.

¹¹ *The Parliament of the Commonwealth of Australia. Inquiry into migration and multiculturalism in Australia. Joint Standing Committee on Migration. March 2013 Canberra. Commonwealth of Australia.*

¹² *Jenkinson, R, Silbert, M, De Maio, J. Settlement experiences of recently arrived humanitarian migrants. 2016 Accessed on 21 June 2019 <https://aifs.gov.au/publications/settlement-experiences-recently-arrived-humanitarian-migrants>*

Is a family's CALD background an important factor in the circumstances of death or the care provided?

28 child deaths between 2014-2018

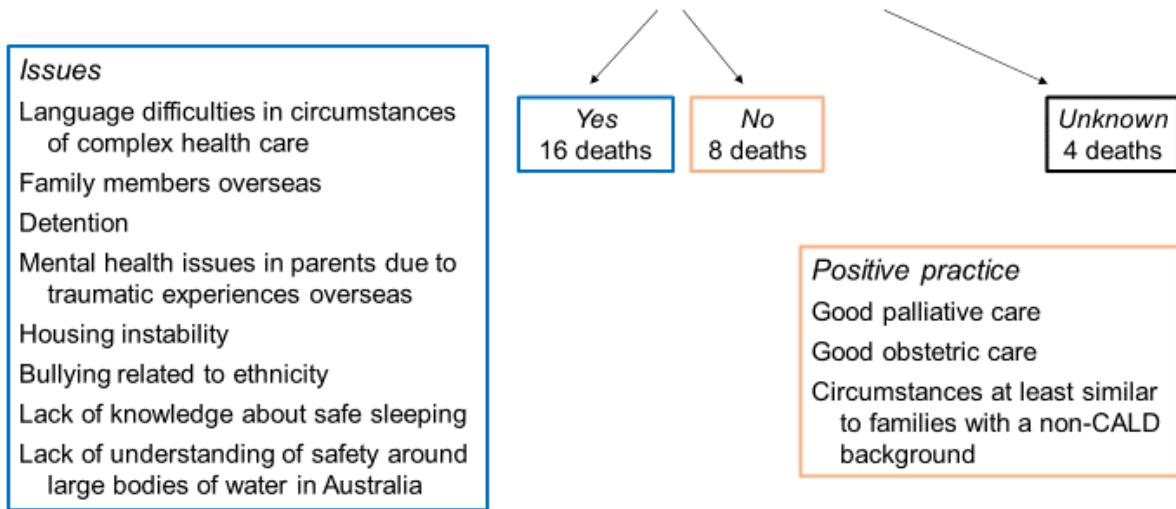


Diagram 1: Review of 28 deaths of children and young people in families with culturally and linguistically diverse backgrounds

1.7. Infant mortality

Of the 1633 children and young people who died in South Australia between 2005 and 2019, 925 (57%) were infants under one year of age.

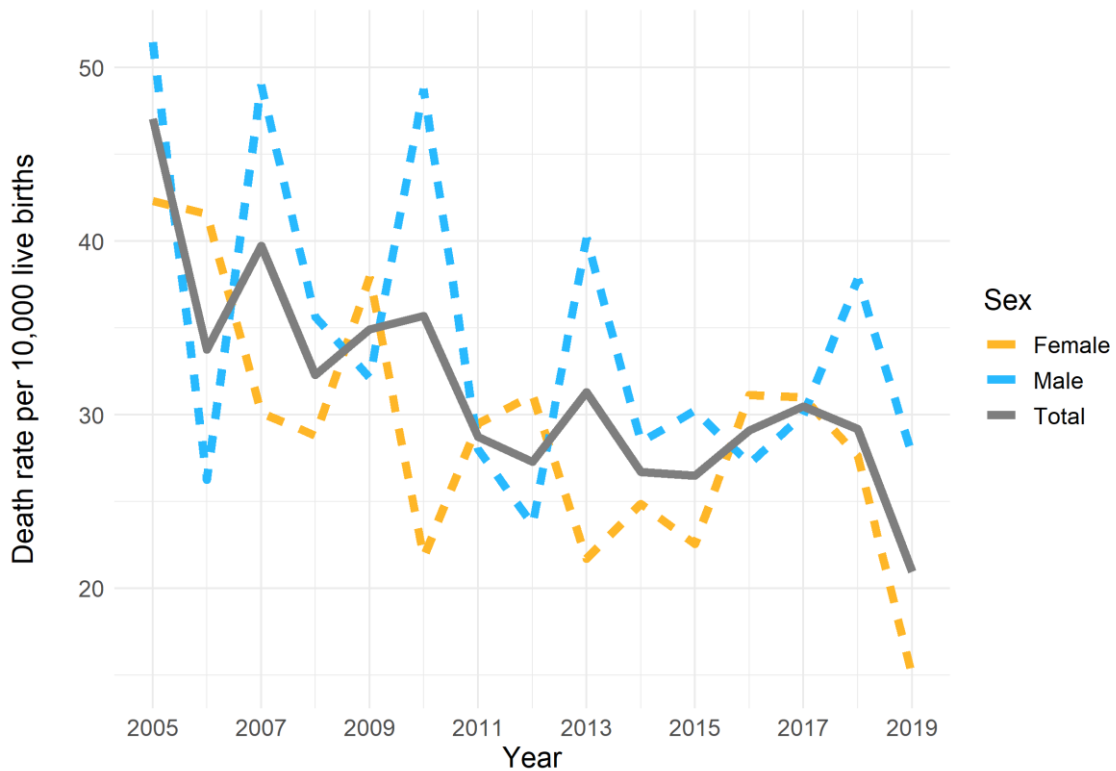


Figure 9: Death rate per 10,000 live births by year of death and sex, for infants, South Australia 2005–2019

In 2019, the Committee recorded the lowest number of infant deaths and the lowest infant death rate for the past 15 years. The Committee will await information about 2020 infant deaths before considering reasons for this decrease in numbers.

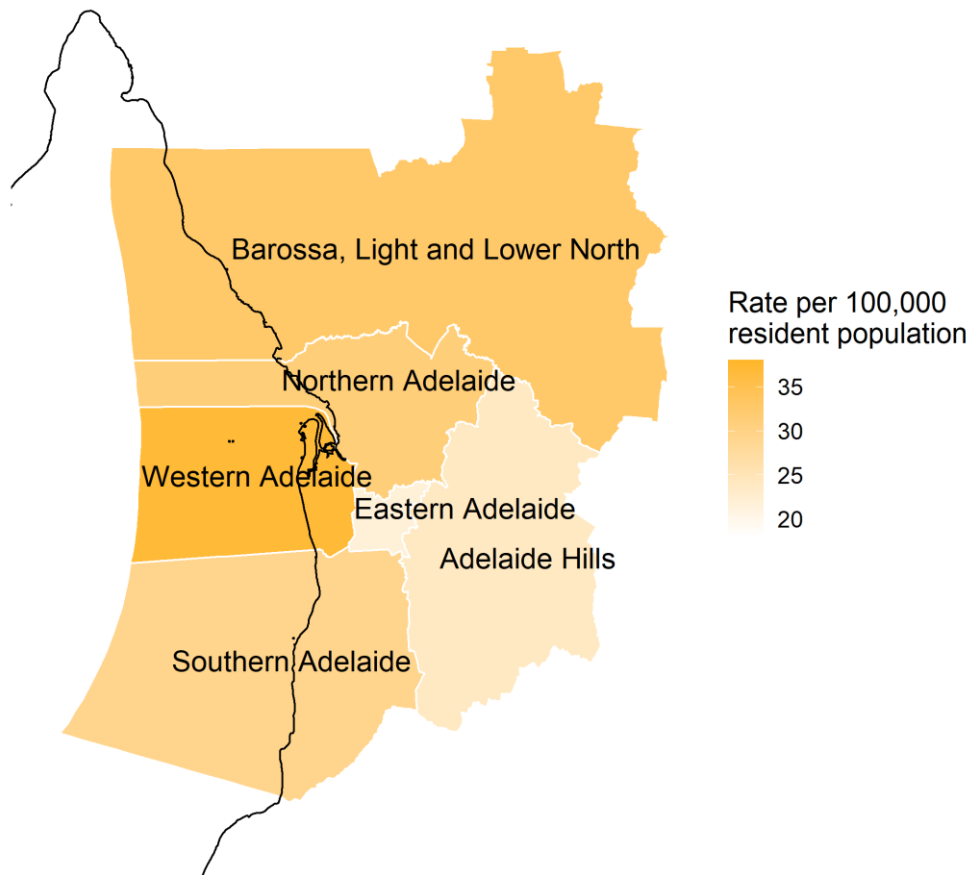


Figure 10: Death rate by metropolitan and inner rural regions for infants who were usually resident in South Australia, 2005–2019

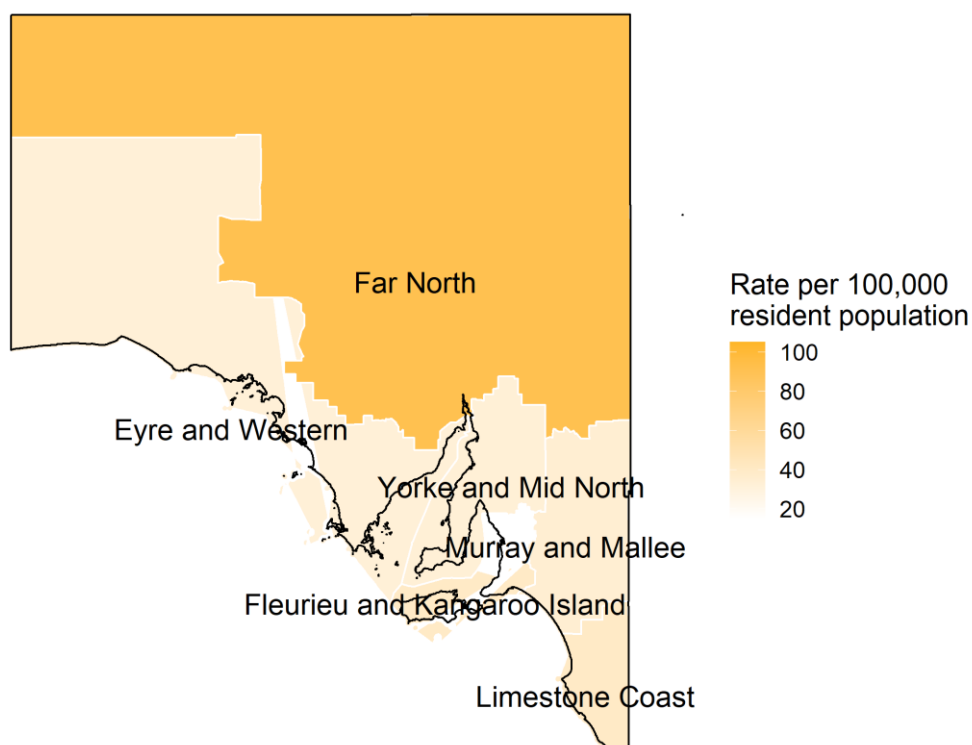


Figure 11: Death rate by outer rural regions for infants who were usually resident in South Australia, 2005–2019

Figure 11 shows that the highest death *rate* occurred in the Far North region. However, from the perspective of service delivery, it is important to note that the highest *number* of deaths occurred in the Northern Adelaide region.

1.8. Deaths from illness or disease

The deaths of children and young people from illness or disease consistently account for over half the total number of deaths in any year.

1.8.1. A review into the death of a young person with chronic illness in lifelong circumstances of neglect of her medical care

In determining medical neglect, Boos and Fortin (2014) state that: *‘Medical neglect occurs when children are harmed or placed at significant risk of harm by gaps in their medical care. This is most likely to occur and to be recognized when families lack resources, commonly due to poverty, and when medical demands are high, such as with complex, severe, and chronic illness’*¹³.

A young person with chronic illness, who was the subject of this review, died as a result of medical neglect, as defined above. She had been diagnosed early in life with a well known condition, which while life shortening, is more usually fatal in mid-life. Her life story exemplified what can happen when a service loses focus on a person who is at the heart of its business.

The young person experienced repeated admissions to hospital, ultimately spending almost 20% of her life in hospital. She also experienced educational neglect, being absent from school for over two thirds of each school year in the last five years of her life. The family’s circumstances included drug use, domestic violence, and multiple relocations of their household, which limited its ability to provide for her complex daily care needs.

Most service activity occurred in response to crises. Community-based support services actively promoted by SA Health and DCP were often not taken up by the family. Multiple notifications were made to DCP, but frequently no action was taken. The Committee commends individual service providers who made significant efforts to stay connected to the family for the young person’s health benefit. However, records show that her health only improved on extended admission to hospital.

¹³ Boos SC, Fortin K Medical Neglect. *Paediatr Ann.* 2014;43(11):e253-e259. Doi:10.3928/00904481-20141022-08.

Towards the end of her life, palliative care services worked to acknowledge her voice and views, enabling her to become an active participant in decisions about her life.

Previous reviews have documented the challenges for services in providing effective outcomes for children and young people who live with complex care needs in difficult family circumstances. All but one of the recommendations made in this review reflect recommendations made in earlier reviews.

The Committee will use the following recommendations as a basis for its proposed discussions with SA Health, the Department for Child Protection, the Department of Human Services (DHS) and the Department for Education (DE) regarding their responses to children and young people with lifelong complex care needs who live in difficult family circumstances.

Table 1: Recommendations relevant to the review of a young woman with a chronic illness

Recommendations
<p>Recommendation 1 – Parenting capacity assessment</p> <p>Parenting capacity assessments be undertaken where either health services or child protection services have significant concerns about the capacity of a family to manage a child’s complex care needs.</p>
<p>Recommendation 2 – Lifetime cost of care</p> <p>Service systems to work together to provide the most cost-effective care over the life course of the child, particularly where life-long disability and chronic health conditions are identified.</p>
<p>Recommendation 3 – Generalist medical leadership</p> <p>SA Health to examine the benefits of generalist medical leadership in medical care to children with complex chronic disease. Such generalist care would incorporate a holistic view of the child’s circumstances and interprofessional working relationships.</p>
<p>Recommendation 4 – Team Around the Child</p> <p>The Committee recommends:</p> <ul style="list-style-type: none"> - The adoption of a multi-agency ‘Team Around the Child’ (TAC) approach that ensures integrated service provision for children with complex needs which becomes the responsibility of all agencies working with each child and their family. - This approach is to be adopted for children with complex needs by DHS’ Child and Family Intensive Support System. DHS is to be responsible for the design and implementation of this system. - SA Health (including Child and Adolescent Mental Health Service and the Child Protection Service), DCP and DE, through their involvement in the co-design of the Child and Family Intensive Support System, to support the adoption of the TAC approach for children with complex needs. - Such a process is to: identify these children; assess their needs; determine which agency will lead the TAC approach; and agree clear roles and responsibilities for all agencies involved. The lead agency to be responsible for monitoring the effectiveness of the services being provided.

- The indicators of complex needs are to include: rates of absenteeism – including unexplained increases in the rate; involvement of the child/family with mental health services; involvement of the child protection system; and the child's physical, emotional and intellectual disabilities.

Recommendation 5 – Assertive case management

The DCP and DHS' Child and Family Intensive Support System must respond to cases of serious neglect with leadership of a long-term integrated service response. That is, they are to maintain an assertive case management function across all services involved with the child, and set time frames for:

- regular updates during the course of service provision
- notification of any failure to deliver services
- pro-active engagement by DCP or CFARNs to rectify aspects of service delivery that are not proving effective.

Recommendation 6 – The child's voice

Consultation with the child experiencing chronic illness is an essential element in planning for the care of each child or young person with complex care needs.

1.8.2. Chronic disease management in children and young people

In 2021, SA Health will release the Women's, Child and Youth Health Plan 2020–2030, which will provide policy direction for health services that will include the needs of families with children and young people who have long-term complex care requirements. The Committee will review the recommendations it makes for children and young people with long-term chronic disease and complex care needs in light of the new SA Health Plan.

1.8.3. Manner of death

Palliation, either planned or in response to an acute need, or withdrawal or withholding of life-sustaining treatment may be considered when life is limited in quantity, quality or the child is unable to benefit from continued life¹⁴. The decision to limit further treatment is made in the child or young person's best interests and, where possible, in consultation with family or caregivers.

¹⁴ Larcher, V., Craig, F., Bhogal, K., Wilkinson, D., Brierty J., Royal College of Paediatrics and Child Health, *Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice*. Arch. Dis. Child. 2015; 100 Suppl 2: s3-23.

Circumstances which might give rise to withdrawal of life-sustaining treatment were described by the United Kingdom Royal College of Paediatrics and Child Health (RCPCH)¹⁵ and included:

- brain stem death
- imminent death where further treatment is not effective in influencing physiological deterioration
- inevitable death where further treatment will not benefit the child
- where further treatment may prolong life but not provide significant benefit to quality of life
- where further treatment may cause pain and suffering greater than any benefit to the child
- where the child's condition causes pain and suffering that outweighs the benefit of lengthening life through treatment
- the child cannot derive benefit from a lengthened life
- informed competent refusal of treatment.

The Committee has a unique data collection comprising all deaths of children and young people between the age of 0 and 17 years in South Australia. It is well placed to document changes to the way in which the deaths of children and young people are managed.

Based on the RCPCH description of circumstances in which life-sustaining treatment might be withdrawn, the Committee developed a schema to categorise the manner of all child deaths in South Australia (See Diagram 2). Categories are:

- no opportunity to palliate
- a planned palliation approach is in place, or life-sustaining treatment is withheld
- treatment is initially active but redirected to palliative care after discussion with the family
- unknown manner of death.

¹⁵ *ibid*

In 2021, the Committee will discuss its findings with health professionals providing end-of-life care.

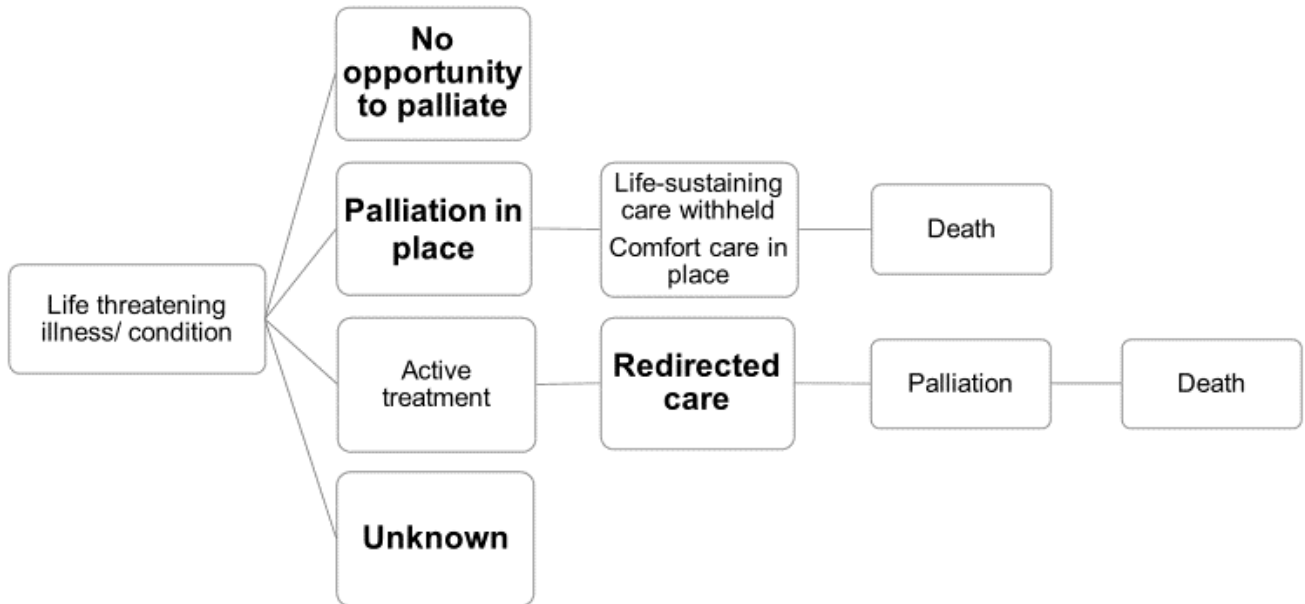


Diagram 2: Schema to categorise manner of death

1.9. Deaths from external causes

Deaths from external causes include those deaths that the Committee has classified as being transport-related, by suicide, due to drowning, a deliberate act by another person, fire-related, accidents (falls, suffocation and asphyxiation, poisoning), neglect, and medical misadventure.

1.9.1. Deaths of children aged 0 to 12 years who were passengers in transport crashes, 2005–2018

The risk of injury or death of a passenger in a vehicle collision is significantly reduced when that person is properly restrained. To safely use an adult seatbelt, a person must be at least 145 cm tall. Children who have not reached this height must use an appropriate-for-size child safety seat or booster seat to ensure that they are safely restrained.

Australian law requires that children aged up to 7 years be seated in an approved child safety seat when travelling in a vehicle. Children aged 7 years and over must be seated either in an approved child safety or booster seat, or use a seatbelt that is properly adjusted and fastened, depending on their size.

Unfortunately, some confusion may exist among parents regarding the appropriate time to transition their child to an adult seatbelt. Although the law suggests that a child may be able to transition safely at 7 years of age, most children cannot safely use an adult seatbelt until the ages of 10 to 12 years – indeed, by age 10, only around 10% of Australian children have reached a height of 145 cm.

In South Australia, between 2005 and 2018, 38 children aged 0 to 12 years died while passengers in a vehicle. Sixty-one percent (24) of these children were not appropriately restrained, including 9 children who were unrestrained.

Of these 24 children, almost half (11), were aged 8 to 12 years and seated in an adult seat despite being less than 145 cm tall (the tallest child was 140 cm).

Section Two

2. Committee matters

S30 – Continuation of Child Death and Serious Injury Review Committee

- (1) The Child Death and Serious Injury Review Committee established under the *Children’s Protection Act 1993* continues in existence.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

2.1. Legislation and purpose

The Child Death and Serious Injury Review Committee operates under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

The role of the Committee is to contribute to the prevention of death or serious injury of children and young people in South Australia.

The Committee reviews the circumstances and causes of death or serious injury to children and young people, and makes recommendations regarding changes to legislation, policies, procedures or practices of government and non-government agencies.

2.2. Committee matters 2019–2020

The Committee met on ten occasions in 2019–20. Three meetings in 2020 were by teleconference as the Committee adapted to COVID-19 meeting requirements.

In addition to attendance at these meetings, each member contributed their knowledge and expertise to regular meetings of one or more Special Interest Groups, including child protection, health, disability, suicide prevention, and Aboriginal children. In-depth reviews were undertaken by teams drawn from the Committee's membership. The members met as required to plan and complete each review. In 2020, some of these meetings were by teleconference or on virtual platforms. The average number of out-of-session meetings of Committee members was two per month.

The Committee continued its work in the following areas:

- the timely and accurate collection of information about the circumstances and causes of child deaths and serious injuries
- identifying cases for review, and undertaking reviews of deaths and serious injuries
- making recommendations to the Minister for Education regarding systemic changes that will contribute to the prevention of similar deaths or serious injuries
- monitoring the progress of the implementation of recommendations
- contributing to government and community knowledge and understanding of the causes of child deaths and serious injuries, and how to prevent them
- maintaining links with interstate and national bodies undertaking similar work.

2.3. Governance and support

The Minister for Education is responsible for the administration of the provisions governing the Committee. Financial and human resource management support is provided by the Department for Education.

The Committee was supported, in this reporting period, by:

Dr Sharyn Watts	Executive Officer (1.0FTE)
Ms Rosemary Byron-Scott	Senior Project Officer (0.6FTE)
Dr Owen Churches	Senior Statistician (1.0FTE) until 12 January 2020
Mr Jago Van Dam	Senior Statistician/Data analyst (1.0FTE) from 27 July 2020
Ms Una Sibly	Senior Project Officer (0.4FTE)
Ms Nikki Kearney	Administration and Information Officer (1.0FTE)

Review of the Act

In November 2019, the Minister for Education tabled in Parliament the independent review into the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

The Committee provided the Minister with its responses to the recommendations contained in that review in February 2020. The Committee supported recommendations that would enable it to broaden the reach of its prevention efforts by allowing discretionary powers to review the deaths of young people over the age of 18, to contribute to a national database of child deaths, and to enter into arrangements for the conduct of research based on the information it holds.

The Committee understands that the government will determine and advise the nature and timing of any response to the recommendations arising from the independent review, and will include consultation, where relevant.

2.4. The ANZCDR & PG

The Committee continues to support the work of the Australian and New Zealand Child Death Review and Prevention Group. The 2020 annual two-day meeting to be held in Sydney in April was cancelled.

2.5. Future directions

At its strategic planning meeting in September 2019, members recognised that the Committee could enhance its capacity to provide insight and opportunity for system change to service providers. To progress this goal, the members identified strategies for action in the following areas:

- maximising the Committee's capacity to create impact by utilising its strengths and expertise
- building mutually beneficial partnerships with service systems
- enhancing the Committee's ability to effect system change through the use of its data.

A Strategic Review Special Interest Group has met three times to progress the development of a strategic action plan based on these strategies.

Section Three



3. Methodology

3.1. Sources of information

3.1.1. Sources of information regarding a death

The *Children and Young People (Oversight and Advocacy Bodies) Act 2016* articulates the role and functions of the Committee, and empowers it to obtain information about a case of child death or serious injury from any person (whether or not the person is a state authority, or an officer or employee of a state authority). Using this power, the Committee receives information regarding the death of a child from a range of sources and uses this information in its determinations.

3.1.2. Sources of information regarding birth

The Committee receives the number of live births for each year from Wellbeing SA's Pregnancy Outcome Unit.

3.1.3. Sources of information regarding population estimates for children and young people in South Australia

The Committee acquires the publicly available number of children and young people resident across the dimensions of calendar year, single year of age, sex, cultural background, and postcode from the Australian Bureau of Statistics (ABS). The ABS provides this information, as well as the estimated resident population, in its five-yearly Census of Population and Housing.

For the purpose of this report, the population of children and young people resident in South Australia by calendar year, single year of age, sex, cultural background, and postcode is interpolated as follows: the counts across single year of age, sex, cultural background and postcode are taken from the census, and assigned to the calendar years as three years before each census to two years after the census. The multiplier needed to get from the census to the estimated resident population for each year is found and then applied to each of the 369,360 cells in the matrix calendar year (15 levels), age (18 levels), sex (2 levels), cultural background (2 levels), and postcode (342 levels). The multiplier is found by dividing the estimated resident population by the census count, and is performed separately for the Aboriginal and non-Aboriginal populations. Note that when re-aggregated, the adjusted count is the same as the estimate resident population.

3.1.4. Sources of information regarding SEIFA

Socio-Economic Indexes for Areas (SEIFA) is a product developed by the ABS that ranks areas in Australia according to relative socioeconomic advantage and disadvantage. The indexes are based on information from the five-yearly census.

For the purpose of this report, the Committee used the Index of Relative Socio-Economic Disadvantage (IRSD). The postcode of the usual residence of each child or young person who died was matched to the appropriate SEIFA/IRSD level extracted from the census nearest their year of death. Deciles were collapsed into quintiles: on this scale, quintile 1 includes areas with the greatest relative socioeconomic disadvantage and quintile 5 includes areas with the least relative socioeconomic disadvantage.

3.2. Committee classifications and definitions

3.2.1. Operational definition of death

The Committee receives information regarding the death of a child or young person in South Australia from three government sources: Births, Deaths and Marriages; the State Coroner's Court; and the Pregnancy Outcome Unit. The count of deaths in this annual report includes all cases received from these sources with the following exceptions:

- if the Committee understands from the information gathered that the case was a termination of pregnancy
- if the Committee understands that the death occurred after the birth of an infant, prior to 20 weeks gestation.

Where there is disagreement between the sources, the Committee reviews all of the available evidence to arrive at a conclusion.

3.2.2. Cultural background

To differentiate grouping, the ABS uses the categories of 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander', 'Not stated' and 'Non-Indigenous'. For the purpose of this report, the Committee collapses these categories into two groups: 'Aboriginal = 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander'; and 'Other' = 'Not stated' and 'Non-Indigenous'.

It is important to note that the Committee’s determination of the cultural background of a deceased child or young person uses multiple administrative sources, and is a different methodology than that used by the ABS which is based on the self-report of the person completing the census form. There are good reasons to think that these are different¹⁶.

3.2.3. Category of death

In many cases, the Committee has multiple sources of information available about children and young people, and is not limited to the causes of death recorded in post-mortem reports or death certificates. At the time of classifying a death, the Committee will consider all available information.

Table 2: Committee’s cause of death classification

Cause	Committee classification
Transport-related	Transport-related deaths include deaths resulting from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport.
Accidents	Accidents exclude deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, these deaths most commonly include accidental: suffocation, strangulation and choking, falls, and poisoning.
Suicide	<p>The Committee’s definition of suicide is: <i>Taking one’s own life, intending to do so.</i></p> <p>The Committee defines a death as suicide if, after a thorough review of all available evidence, it is satisfied that the young person killed him or herself, intending to take their own life.</p> <p>Since adopting this definition, three cases previously attributed to suicide have been reclassified as accidental deaths, resulting from misadventure.</p>
A deliberate act by another causing death	<p>Describes a range of deaths, including deaths from acts of violence, where a person, by whatever means, causes a child’s death by a deliberate act.</p> <p>While a person’s intent is obviously relevant to issues of criminal liability, for the Committee’s categorisation of deaths, this does not need to be considered.</p> <p>Similarly, there may be cases where the person who causes a child’s death does so as a result of mental illness, leading to a Court finding of mental incompetence. Such cases are also included in this category.</p> <p>It will not always be possible, on the basis of the available evidence, to be certain that a child’s death resulted from a deliberate act by another person. For instance, a child may have serious head injuries causing death, where it is not possible to say that the injuries were deliberately inflicted, as opposed to being caused by an accidental fall.</p> <p>In such cases, upon consideration of all the available evidence, the Committee will decide which is the most likely cause of death.</p>
Neglect	The Committee defines neglect as ‘a death resulting from an act of omission by the child’s carer(s)’ including:

¹⁶ Gialamas A, Pilkington R, Berry J, Scalzi D, Gibson O, Brown A, Lynch J. Identification of Aboriginal children using linked administrative data: Consequences for measuring inequalities Journal of Paediatrics and Child Health 52 (5), 534-540.

	<ul style="list-style-type: none"> • failure to provide for the child’s basic needs • abandonment • inadequate supervision, and • refusal or delay in provision of medical care. <p>This definition can account for both chronic neglect and single incidents of neglect, or a combination of both¹⁷.</p>
Health-system related	<p>These deaths have been classified as such by the Committee based on written records which may not necessarily be complete. The Committee places a death in this category based on consideration of preventable aspects in the circumstances of the death, and a focus on future prevention strategies rather than an investigation of the cause of death.</p>
Sudden unexpected infant death	<p>Sudden Unexpected Death in Infancy (SUDI) has been described as an ‘umbrella’ term that is used for all sudden unexpected deaths of infants.</p> <p>The definition of SUDI is based on the definition, proposed by Fleming et al. (2000)¹⁸, and includes infants from birth to 365 completed days of life whose deaths:</p> <p>Criterion 1: Were unexpected and unexplained at autopsy;</p> <p>Criterion 2: Occurred in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life-threatening;</p> <p>Criterion 3: Arose from a pre-existing condition that had not been previously recognised by health professionals; or</p> <p>Criterion 4: Resulted from any form of accident, trauma, or poisoning.</p>
Sudden infant death syndrome	<p>Sudden Infant Death Syndrome (SIDS) is a term used to describe the sudden and unexpected death of an infant, when the death occurs during sleep, and when the cause of death remains unexplained after a complete autopsy, review of the circumstances of death, and of the infant’s clinical history¹⁹.</p>

3.2.4. Disability

The definition used to determine inclusion as the death of a child or young person aged 1 to 17 years with disability is:

- the child or young person was over one year of age at the time of death
- the child or young person’s daily activities were limited due to their disability, illness, disease or health problem; and
- the child or young person’s daily activities were adversely affected for a period of six months or more.

Where the length of time during which the child or young person’s daily activities were adversely affected was unknown, the case was not included on the register. Cases where the child or young person had a chronic health condition (eg, asthma, epilepsy,

¹⁷ Lawrence R, & Irvine P. Redefining fatal child neglect. *Child Abuse and Prevention*, 21, 1-22.

¹⁸ Fleming P, Bacon C, Blair B, and Berry PJ. (2000) Sudden unexpected deaths in infancy, the CESDI studies 1993-1996. London: The Stationery Office.

¹⁹ Krous H, Beckwith J, Byard R, Rognum T, Bajanowsky T, Corey T, Gutz E, Hanzlik R, Keens T, and Mitchell E. (2004) Sudden infant death syndrome and Unclassified infant deaths: A definitional and diagnostic approach. *Paediatrics*, 114, 234–238.

diabetes) were only included on the register if other disabilities were present. Some children and young people have multiple types of disability, for example cerebral palsy and epilepsy. Multiple disabilities are recorded for each child or young person, where identified.

Table 3: Committee’s definition of disabilities

Disability	Committee definition
Neurodegenerative diseases, genetic disorders and birth defects	<p>This category included all instances of neurodegenerative diseases, genetic disorders and birth defects, including in-born errors of metabolism where the child’s health deteriorates over time.</p> <p>Children with many of these conditions are likely to die as a result of their disease, and they require significant care as their condition progresses.</p>
Cerebral palsy	<p>This category includes all cases of cerebral palsy, which is a term used to describe a group of non-progressive motor function disorders that arise because of damage to, or dysfunction of, the developing brain. This permanent condition can affect body movement, muscle control, muscle coordination, muscle tone, reflex, posture and balance. It may also cause visual, learning, hearing, speech and intellectual impairments, as well as epilepsy.</p>
Epilepsy	<p>Using the guidelines developed to identify disability, this category only included cases where the frequency and severity of the child’s epilepsy adversely affected their daily activities for a period of six months or more, or the child with epilepsy had associated disability.</p> <p>Epilepsy is a common disorder that is characterised by recurring seizures or sudden, uncontrolled surges in the normal electrical activity in all, or part of, the brain. While the Epilepsy Centre notes that epilepsy can mostly be controlled by taking medication and restricting daily living activities, epilepsy can be associated with sudden unexpected death.</p>
Heart and circulatory problems	<p>This category included all cases where a condition involving the heart or blood vessels was able to be identified, regardless of whether the condition resulted from an infection or from a birth defect.</p> <p>Children with conditions such as complex congenital heart defects or cardiomyopathy are, without life-saving surgery such as a heart transplant, at higher risk of dying as a result of their heart or circulatory problems.</p>
Intellectual disability	<p>This category included all cases where the available information suggested that the child had some form of intellectual disability. It was identified as a specific category because it is a developmental disorder, and people living with such disorders have significantly more difficulty than others in integrating new learning, understanding concepts and solving problems.</p>
Autism spectrum disorder	<p>Autism Spectrum Disorder is a lifelong developmental disability that affects, among other things, the way a child relates to his or her environment, and their interactions with other people. Where information was available indicating a diagnosis of ASD had been made, the child was placed in this category.</p>
Other types of disability	<p>This category accommodated all of the remaining disability types in children on the Disability Register. It incorporated cases where a child had conditions such as Epstein-Barr virus, systemic lupus, and community acquired pneumonia. It also included cases where the available information was too limited to confidently assign the case to a specified category.</p>
Cancer and ‘disabling medical conditions’	<p>The Disability team considered that the issues arising from these deaths were primarily about the medical management of these conditions rather than about issues arising from the disability caused by their impact on the child. These deaths will be reported as deaths from illness or disease.</p>

Infants with disability

There is a unique set of challenges associated with identifying disability in infants. A set of criteria has been developed by the Committee to identify the deaths of infants with a disability. Deaths are excluded from consideration if the underlying cause is: prematurity alone; prematurity and maternal factors; infection; haemorrhage; digestive or respiratory problems; cancer; heart disease, including myocarditis and cardiomyopathy; or, congenital malformations of major organs such as heart, kidney and liver.

Once these cases are excluded, the remaining deaths are then reviewed by the Disability Special Interest Group, and a decision made about inclusion in the Disability Register based on the available information. Multiple types of disability are not recorded for infants under one year of age.

3.2.5. Contact with the child protection system

To be included in this section of the report, the child, young person, or a member of their family must have had some form of contact with DCP or its predecessors within three years of the incident resulting in their death. The guardianship status of a child, young person, or their parent(s) is determined during this process, whether in South Australia or in another Australian state or territory.

3.3. Coding death using ICD-10

All deaths registered by the Committee are coded according to the International Classification of Diseases, Version 10 (2016) developed by the World Health Organization. This system is accepted as the world standard diagnostic classification system for all general mortality and morbidity classifications²⁰.

3.4. In-depth review process

Deaths screened by the Committee are assigned one of the following criteria:

- Eligible for review – a case will only be considered eligible for review under Section 37(2) of the Act, if the incident resulting in the death or serious injury

²⁰ <https://www.who.int/classifications/icd/icdonlineversions/en/>

occurred in the state; or the child or young person was, at the time of their death or serious injury, ordinarily resident in the state.

- Not for review – a case may not require in-depth review if the screening of information available at the time indicated that there are no systemic issues arising from the death. These cases are assigned a category of death, eg, illness or disease, SUDI, transport, deliberate acts etc, and the details are kept on the Committee’s database. They are included in the relevant annual report. They may be included in reviews in later years, where features from cases aggregated over a number of years suggest that there may be systemic issues that can be addressed.
- Pending further information – in some cases the Committee requests further information before making a decision regarding in-depth review.
- Pending completion of investigations – in accordance with Section 37(4) of the Act, the Committee must not undertake a review if there is a risk that the review would compromise an ongoing criminal investigation, and must wait until coronial investigations are complete.
- Awaiting assignment – in any reporting year, there are also cases ready for review but awaiting assignment to a ‘review team’. The number of cases pending investigation or review gradually decreases during any year as information is obtained, cases are finalised in the criminal and coronial systems, and the Committee makes a determination about further review.

3.5. Reporting requirements

Section 39 of the Act outlines the reporting responsibilities of the Committee. It requires the Committee to report periodically to the Minister for Education, and also to provide an annual report on the performance of its statutory functions for the preceding financial year. The Committee submits a report to the Minister for Education at the conclusion of each in-depth review. The report contains the Committee’s recommendations about systemic or legislative issues that may contribute to the prevention of similar deaths or serious injuries.

Section Four



4. Data tables

Data table 1: Death rate by year of death and sex for all children and young people, South Australia 2005–2019

Year	Sex	Number of deaths	Death rate per 100,000 resident population
2005	Female	58	34.5
2005	Male	78	43.88
2005	Total	136	39.32
2006	Female	70	41.63
2006	Male	49	27.57
2006	Total	119	34.41
2007	Female	42	24.98
2007	Male	80	45.01
2007	Total	122	35.27
2008	Female	44	26.17
2008	Male	70	39.38
2008	Total	114	32.96
2009	Female	57	33.14
2009	Male	70	38.67
2009	Total	127	35.98
2010	Female	40	23.26
2010	Male	77	42.54
2010	Total	117	33.14
2011	Female	49	28.49
2011	Male	57	31.49
2011	Total	106	30.03
2012	Female	48	27.91
2012	Male	51	28.17
2012	Total	99	28.05
2013	Female	44	25.59
2013	Male	64	35.35
2013	Total	108	30.59
2014	Female	41	23.04
2014	Male	55	29.31
2014	Total	96	26.26
2015	Female	38	21.35
2015	Male	54	28.77
2015	Total	92	25.16

Data table 1 continued

Year	Sex	Number of deaths	Death rate per 100,000 resident population
2016	Female	45	25.29
2016	Male	57	30.37
2016	Total	102	27.9
2017	Female	56	31.47
2017	Male	54	28.77
2017	Total	110	30.09
2018	Female	45	25.29
2018	Male	59	31.44
2018	Total	104	28.44
2019	Female	37	20.79
2019	Male	44	23.45
2019	Total	81	22.15

Data table 2: Death rate by year of death and sex for children and young people who were usually resident in South Australia, 2005–2019

Year	Sex	Number of deaths	Death rate per 100,000 resident population
2005	Female	52	30.93
2005	Male	71	39.95
2005	Total	123	35.56
2006	Female	62	36.88
2006	Male	47	26.44
2006	Total	109	31.51
2007	Female	42	24.98
2007	Male	74	41.63
2007	Total	116	33.54
2008	Female	39	23.2
2008	Male	65	36.57
2008	Total	104	30.07
2009	Female	53	30.82
2009	Male	68	37.56
2009	Total	121	34.28
2010	Female	38	22.1
2010	Male	77	42.54
2010	Total	115	32.58
2011	Female	47	27.33
2011	Male	54	29.83
2011	Total	101	28.61
2012	Female	45	26.17
2012	Male	49	27.07
2012	Total	94	26.63
2013	Female	40	23.26
2013	Male	58	32.04
2013	Total	98	27.76
2014	Female	38	21.35
2014	Male	52	27.71
2014	Total	90	24.62
2015	Female	37	20.79
2015	Male	50	26.64
2015	Total	87	23.8

Data table 2 continued

Year	Sex	Number of deaths	Death rate per 100,000 resident population
2016	Female	44	24.72
2016	Male	56	29.84
2016	Total	100	27.35
2017	Female	53	29.78
2017	Male	53	28.24
2017	Total	106	28.99
2018	Female	39	21.92
2018	Male	58	30.91
2018	Total	97	26.53
2019	Female	35	19.67
2019	Male	42	22.38
2019	Total	77	21.06

Data table 3: Death rate by metropolitan and inner rural regions for children and young people who were usually resident in South Australia, 2005–2019

Region	Number of deaths	Death rate per 100,000 resident population
Adelaide Hills	48	19.92
Barossa, Light and Lower North	65	28.67
Eastern Adelaide	113	21.71
Northern Adelaide	408	29.56
Southern Adelaide	290	26.34
Western Adelaide	200	32.3

Data table 4: Death rate by outer rural regions for children and young people who were usually resident in South Australia, 2005–2019

Region	Number of deaths	Death rate per 100,000 resident population
Eyre and Western	60	29.29
Far North	90	97.82
Fleurieu and Kangaroo Island	45	28.97
Limestone Coast	75	32.61
Murray and Mallee	81	33.69
Yorke and Mid North	79	35.63

Data table 5: Number of deaths by state, territory or country of residence and cultural background, for children and young people not usually resident in South Australia, 2005–2019

Usual residence	Aboriginal	Other
TAS	0	2
Outside Australia	0	3
QLD	2	3
WA	2	6
NSW	1	13
VIC	2	13
NT	30	18

Data table 6: Death rate by Relative Socio-Economic Disadvantage quintile for all children and young people, South Australia 2005–2019

Relative Socio-Economic Disadvantage	Death rate per 100,000 resident population
1	37.96
2	35.74
3	31.83
4	26.95
5	19.6

Data table 7: Death rate by cultural background for all children and young people, South Australia 2005–2019

Year	Cultural Background	Death rate per 100,000 resident population
2005	Aboriginal	123.07
2005	Other	35.84
2005	Total	39.32
2006	Aboriginal	86.87
2006	Other	32.22
2006	Total	34.41
2007	Aboriginal	101.35
2007	Other	32.52
2007	Total	35.27
2008	Aboriginal	79.63
2008	Other	31.02
2008	Total	32.96
2009	Aboriginal	77.31
2009	Other	34.08
2009	Total	35.98
2010	Aboriginal	57.99
2010	Other	32
2010	Total	33.14
2011	Aboriginal	83.76
2011	Other	27.56
2011	Total	30.03
2012	Aboriginal	90.2
2012	Other	25.19
2012	Total	28.05
2013	Aboriginal	122.41
2013	Other	26.37
2013	Total	30.59
2014	Aboriginal	86.83
2014	Other	23.25
2014	Total	26.26
2015	Aboriginal	75.26
2015	Other	22.68
2015	Total	25.16

Data table 7 continued

Year	Cultural Background	Death rate per 100,000 resident population
2016	Aboriginal	46.31
2016	Other	26.98
2016	Total	27.9
2017	Aboriginal	92.62
2017	Other	26.98
2017	Total	30.09
2018	Aboriginal	69.47
2018	Other	26.41
2018	Total	28.44
2019	Aboriginal	46.31
2019	Other	20.67
2019	Total	22.15

Data table 8: Death rate by cultural background and socioeconomic disadvantage, South Australia 2005–2019

Index of Relative Socio-Economic Disadvantage	Cultural Background	Number of deaths	Death rate per 100,000 resident population
1	Aboriginal	95	72.33
1	Other	436	35.39
2	Aboriginal	30	69.2
2	Other	255	28.42
3	Aboriginal	13	52.03
3	Other	267	30.08
4	Aboriginal	12	81.94
4	Other	259	24.06
5	Aboriginal	< 3	N/A
5	Other	199	18.83

Data table 9: Death rate per 10,000 live births by year of death and sex, for infants, South Australia 2005–2019

Year	Sex	Number of deaths	Number of births	Death rate per 10,000 live births
2005	Female	37	8744	42.31
2005	Male	48	9323	51.49
2005	Total	85	18067	47.05
2006	Female	38	9139	41.58
2006	Male	25	9521	26.26
2006	Total	63	18660	33.76
2007	Female	29	9629	30.12
2007	Male	49	9994	49.03
2007	Total	78	19623	39.75
2008	Female	28	9720	28.81
2008	Male	36	10099	35.65
2008	Total	64	19819	32.29
2009	Female	36	9487	37.95
2009	Male	33	10273	32.12
2009	Total	69	19760	34.92
2010	Female	21	9632	21.8
2010	Male	50	10251	48.78
2010	Total	71	19883	35.71
2011	Female	29	9834	29.49
2011	Male	29	10358	28
2011	Total	58	20192	28.72
2012	Female	31	9961	31.12
2012	Male	25	10566	23.66
2012	Total	56	20525	27.28
2013	Female	21	9678	21.7
2013	Male	42	10446	40.21
2013	Total	63	20124	31.31
2014	Female	25	10056	24.86
2014	Male	30	10548	28.44
2014	Total	55	20602	26.7
2015	Female	22	9754	22.55
2015	Male	31	10247	30.25
2015	Total	53	20001	26.5
2016	Female	30	9633	31.14
2016	Male	28	10300	27.18
2016	Total	58	19931	29.1
2017	Female	29	9359	30.99

Data table 9 continued

Year	Sex	Number of deaths	Number of births	Death rate per 10,000 live births
2017	Male	30	9997	30.01
2017	Total	59	19356	30.48
2018	Female	23	8326	27.62
2018	Male	33	8725	37.82
2018	Total	56	19199	29.17
2019	Female	14	9390	14.91
2019	Male	26	9390	27.69
2019	Total	40	19079	20.97

Data table 10: Death rate by metropolitan and inner rural regions for infants who were usually resident in South Australia, 2005–2019

Region	Number of deaths	Death rate per 100,000 resident population
Adelaide Hills	26	23.95
Barossa Light and Lower North	33	32.67
Eastern Adelaide	56	21.83
Northern Adelaide	241	31.16
Southern Adelaide	170	29.22
Western Adelaide	128	36.96

Data table 11: Death rate by outer rural regions for infants who were usually resident in South Australia, 2005–2019

Region	Number of deaths	Death rate per 100,000 resident population
Eyre and Western	33	32.75
Far North	47	91.31
Fleurieu and Kangaroo Island	27	40.06
Limestone Coast	45	40.12
Murray and Mallee	39	34.67
Yorke and Mid North	33	32.9

Data table 12: Populations of South Australian children and young people aged 0 to 17 years by year and cultural background from the original sources, and the populations used in this annual report, 2005–2019

Year	Cultural Background	ABS Census	ABS Estimate	CDSIRC Reporting
2005	Aboriginal	11584	13813	13813
2005	Other	330307	332060	332060
2005	Total	341891	345873	345873
2006	Aboriginal	11584	13813	13813
2006	Other	330307	332060	332060
2006	Total	341891	345873	345873
2007	Aboriginal	11584	13813	13813
2007	Other	330307	332060	332060
2007	Total	341891	345873	345873
2008	Aboriginal	11584	13813	13813
2008	Other	330307	332060	332060
2008	Total	341891	345873	345873
2009	Aboriginal	13016	15521	15521
2009	Other	335700	337481	337481
2009	Total	348716	353002	353002
2010	Aboriginal	13016	15521	15521
2010	Other	335700	337481	337481
2010	Total	348716	353002	353002
2011	Aboriginal	13016	15521	15521
2011	Other	335700	337481	337481
2011	Total	348716	353002	353002
2012	Aboriginal	13016	15521	15521
2012	Other	335700	337481	337481
2012	Total	348716	353002	353002
2013	Aboriginal	13016	15521	15521
2013	Other	335700	337481	337481
2013	Total	348716	353002	353002
2014	Aboriginal	14288	17274	17274
2014	Other	338485	348348	348348
2014	Total	352773	365622	365622
2015	Aboriginal	14288	17274	17274
2015	Other	338485	348348	348348
2015	Total	352773	365622	365622
2016	Aboriginal	14288	17274	17274
2016	Other	338485	348348	348348

Data table 12 continued

Year	Cultural Background	ABS Census	ABS Estimate	CDSIRC Reporting
2016	Total	352773	365622	365622
2017	Aboriginal	14288	17274	17274
2017	Other	338485	348348	348348
2017	Total	352773	365622	365622
2018	Aboriginal	14288	17274	17274
2018	Other	338485	348348	348348
2018	Total	352773	365622	365622
2019	Aboriginal	14288	17274	17274
2019	Other	338485	348348	348348
2019	Total	352773	365622	365622