CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2021–2022

Government
of South Australia

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Letter of transmission

Hon Blair Boyer MP
Minister for Education, Training and Skills

Dear Minister

I submit to you for presentation to Parliament the 2021–22 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 2021–22.

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

Ms Jane Abbey SC
Chair
Child Death and Serious Injury Review Committee
31 October 2022

Chair's foreword

I am pleased to present the Child Death and Serious Injury Review Committee's seventeenth Annual Report to Parliament.

In my first six months as Committee Chair, I have learnt that close review of the circumstances of a death can shine a light on the issues that should be addressed to strengthen the systems that keep children and young people safe and well. However, system change is not easy to achieve. The Committee continues to pursue as many avenues as possible to influence change that can contribute to better outcomes for children and young people.

Three issues of major importance have repeatedly come to my attention as the Committee reviews the circumstances of children's deaths:

- When the lives of children and young people are complex, service systems need to manage that complexity through collaborative effort and services that wrap around a child and their family.
- One-off interventions are not enough – children and young people need to be supported by systems with a long-term approach.
- Children and young people need to be 'seen and heard' when decisions are made about them.

The COVID-19 pandemic has brought new challenges to the lives of children and young people. In what ways this might be reflected in the causes or circumstances of child deaths is yet to be completely revealed, but the sharp decrease in death rates in 2019 and 2020, and the notable increase in 2021, suggest it is likely there will be lessons to be learned.

South Australia is a small state and the number of child deaths is proportionately small. The Committee is supporting conversations between states and territories that will lead to the development of a national child death data collection. Such a collection will provide unique opportunities to fully explore the factors that attend and impact upon the deaths of children and young people.

Thank you to the Aboriginal leaders and thinkers who came together to co-design the Terms of Reference for the establishment of the Oversight and Advocacy Authority for Aboriginal Children and Young People – CDSIRC, and who will now take the first steps towards developing a framework for the review of Aboriginal child deaths. I know the

work will be challenging but I believe it is essential to the work of the Committee and has the potential to make a substantial contribution to understanding and preventing Aboriginal child deaths.

I have been astounded by the amount of time and expertise members contribute to the Committee's work. There is no other body in the state that undertakes the kind of multi-disciplinary review achieved by this Committee, across vulnerable populations and in relation to many different issues including suicide, transport crashes, sudden unexpected infant deaths and chronic illness. I thank each of the Committee members for the diligence, enquiry and care that they have brought to the Committee's deliberations, especially noting the contribution of two out-going members – Ms Angela Davis and Ms Ann-Marie Hayes. I also thank the Committee's accomplished and hard-working Secretariat, without which the work of the Committee would not be possible.

On behalf of the Committee, I extend my condolences to the families and friends who have experienced the death of a child, and to the communities and professionals who have helped to care for them.

Ms Jane Abbey SC
Chair
Child Death and Serious Injury Review Committee

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Figures

Glossary

ACCC	Australian Competition and Consumer Commission
ABS	Australian Bureau of Statistics
Act	*Children and Young People (Oversight and Advocacy Bodies) Act 2016*
ANZCDRPG	Australian and New Zealand Child Death Review and Prevention Group
Average	Arithmetic mean
CDSIRC	Child Death and Serious Injury Review Committee
Child	In this report 'child' includes infants, children and young people from birth up to and including 17 years
Infant	A child under one year of age
Neonate	An infant up to and including 28 days of age
SEIFA	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)

Acknowledgements

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDRPG)
- Office of Births, Deaths and Marriages, Attorney General's Department
- Department of Human Services which provided 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
- SA Health, Local Health Networks' staff, the staff of SA Pathology and private practitioners 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 KC	until 26 July 2021
Ms Jane Abbey SC	from 24 February 2022

Members

These members served on the Committee during the financial year 1July 2021 to 30 June 2022.

Dr Mike Ahern

Dr Carmela Bastian

Ms Angela Davis

Dr David Everett OAM

Dr Mark Fuller

Ms Ann-Marie Hayes

Ms Kathy Moar

Dr Margaret Kyrkou OAM

Ms Karen McAuley

Mr Kurt Towers

Dr Mohammed Usman

Ms Kylie Walsh

Executive summary

This seventeenth annual report, presented to Parliament by the Child Death and Serious Injury Review Committee, provides a summary of the Committee's data analyses, reviews of child deaths, and activities undertaken to prevent the death or serious injury of children and young people.

In 2021, 104 children and young people died in South Australia. At the time of writing this annual report, information on causes of death for about one quarter of these child deaths was not available due to COVID-19-related delays in systems from which the Committee collects information. The Committee will publish a more detailed statistical report in 2023.

During the 2021–22 reporting period, the Committee continued to review child deaths in South Australia and to make and monitor recommendations for intervention and prevention on a range of issues, including:

- provision of specialist care to children and young people with poorly controlled, severe or unstable asthma
- development of effective across-agency responses to the critical medical care needs of children and young people
- the need for co-ordinated and collaborative service approaches to mitigate the risks of severe domestic squalor
- changes to standards for providers of education and training to young international students
- the oversight of informal placements of Aboriginal children and young people
- the management of child deaths and palliation.

Under the auspices of its strategic action plan, the Committee has continued to improve its knowledge and understanding of issues that impact children and young people, build its strategic alliances both within the state and nationally, and develop and implement an improved database and reporting system.

Section One

1. Child deaths South Australia 2005–2021

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. Monitoring and reviewing 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. Monitoring child deaths: 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 systematic collection and analysis of information about child deaths. Section 37 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*[1] 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 all child deaths and some serious injuries, to which it continually adds information that informs its analyses about rates and patterns of child death in South Australia.

1 https://www.legislation.sa.gov.au/

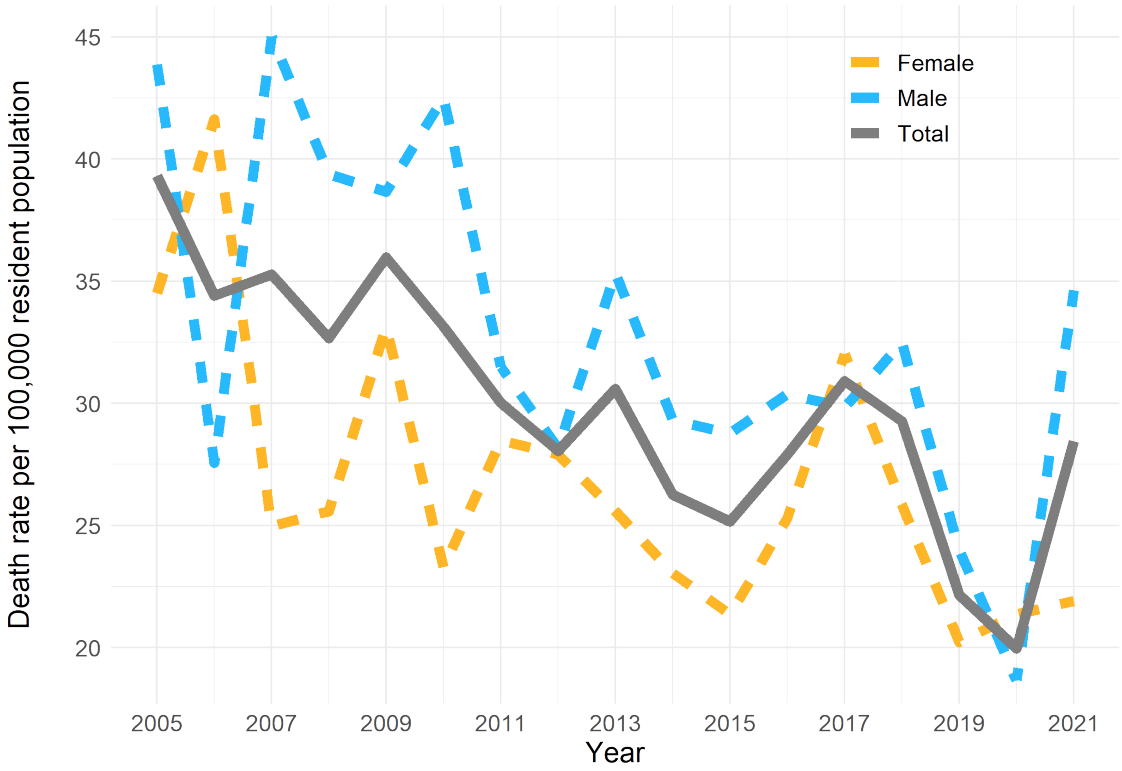

Figure 1: Death rate by year of death and sex for all children and young people, South Australia 2005–2021

Figure 1[2] shows death rates for all children and young people who died in South Australia during the 17 years from 2005 to 2021[3].

The Committee observed the lowest number of child deaths on record consecutively in 2019 (81 deaths) and 2020 (73 deaths). However, in 2021, 104 children and young people died in South Australia. This increase was seen particularly in males, a pattern that has also been observed in previous years.

At the time of writing, information on causes of death for about one quarter of the 2021 deaths was not available due to COVID-19-related delays in systems from which the Committee collects information. Consequently, it is not yet possible to identify potential causes of the increase in deaths in 2021. The Committee will publish a detailed statistical report in 2023, when this information is available.

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2 For each figure in Section One, there is corresponding data available on Data.SA
3 During this 17-year period, the average yearly population of children and young people aged 0 to 17 was 357,263. For more information on how this number was calculated, see Section 3.1.2.

1.2.1. Death rates by region

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

The highest *rate* of death for children and young people occurs 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 to take into account regions where the rate of death is highest, and regions where the greatest numbers of deaths occur.

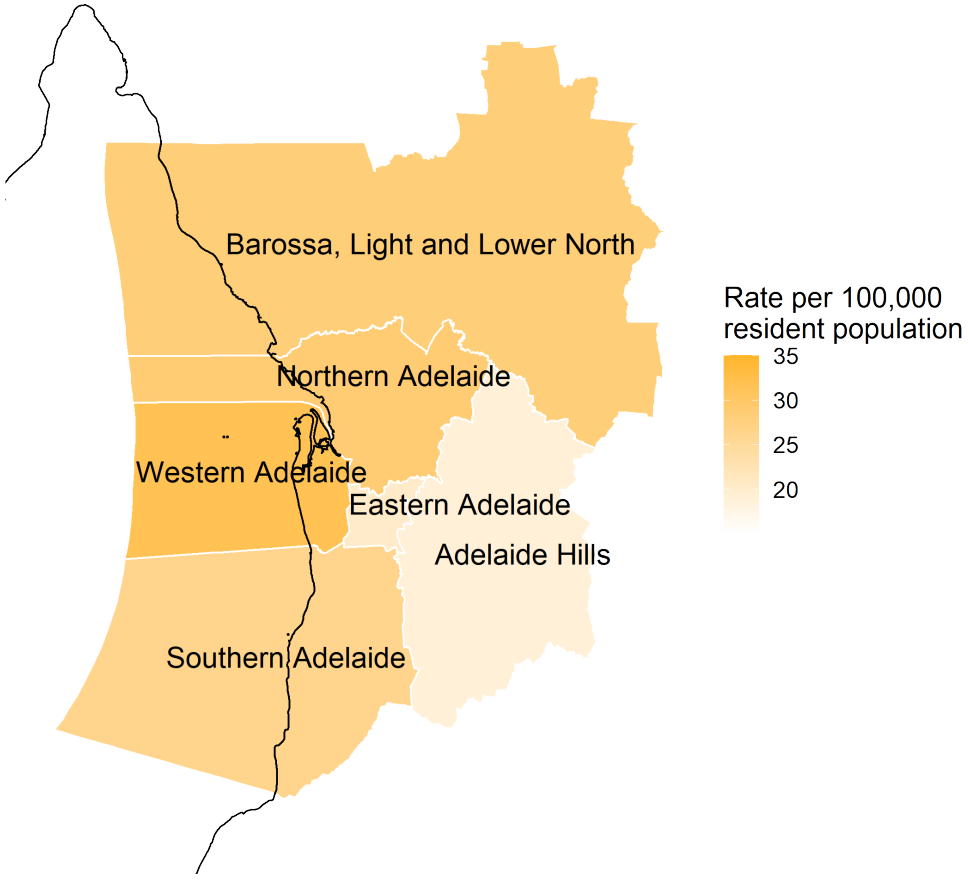

Figure 2: Death rate by metropolitan and inner rural regions for children and young people who were usually resident in South Australia, 2005–2021

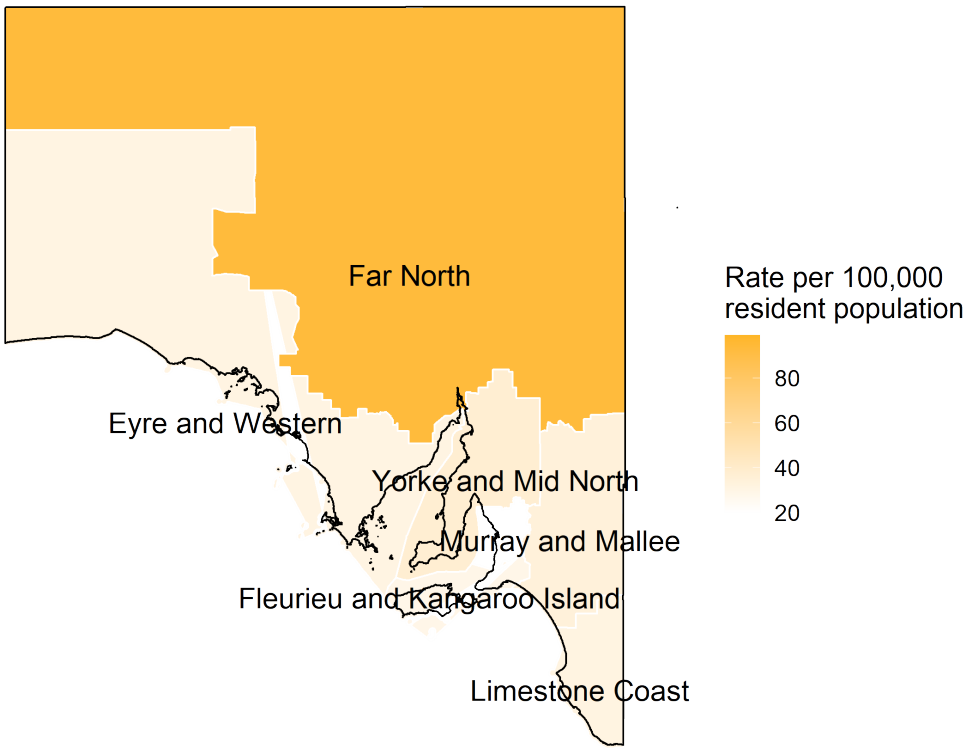

Figure 3: Death rate by outer rural regions for children and young people who were usually resident in South Australia, 2005–2021

1.2.2. Death rates and socioeconomic disadvantage

More children and young people die in areas of South Australia where there are greater levels of socioeconomic disadvantage[4]. The relationship between child deaths and socioeconomic disadvantage is shown in Figure 4. Deaths of all children and young people between 2005 and 2021, resident and non-resident, were included in this analysis.

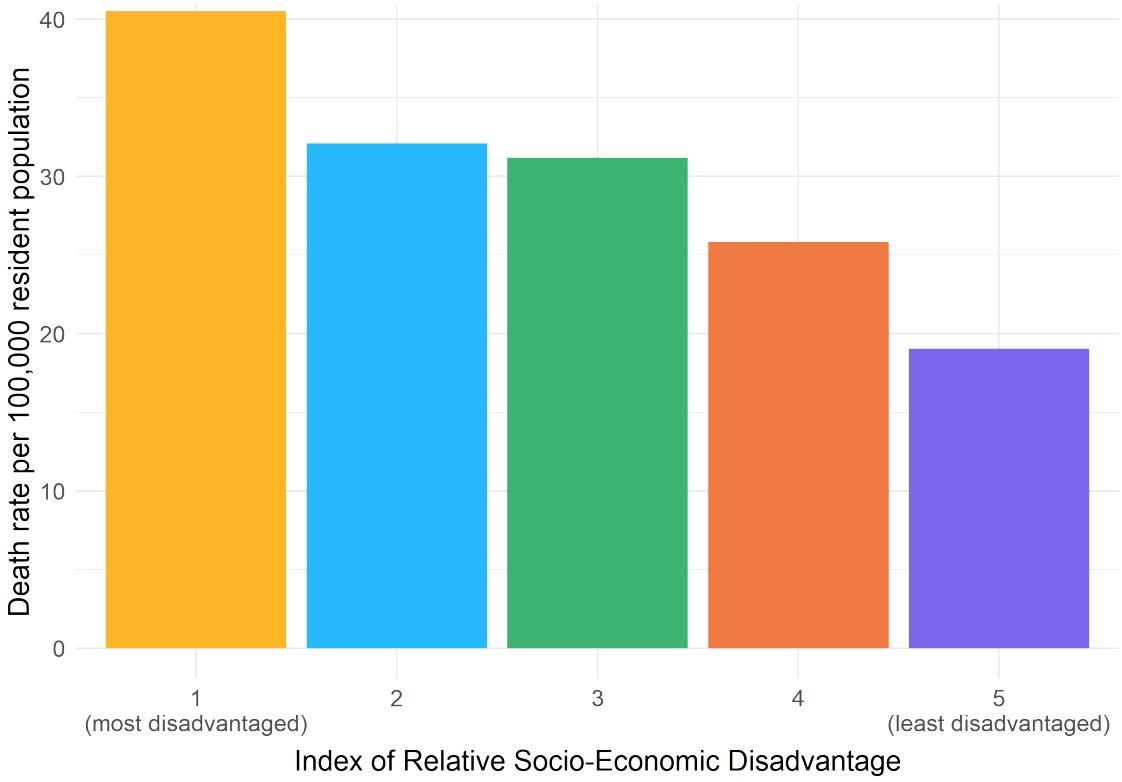

Figure 4: Death rate by Index of Relative Socio-Economic Disadvantage for all children and young people who died in South Australia, 2005–2021

1.2.3. Deaths of Aboriginal children and young people

During the period 2005 to 2021, Aboriginal children and young people constituted 4.5% 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 81 deaths per 100,000 (Figure 5). For Aboriginal children

[4] *For information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 3.1.4*

and young people who were usually resident in South Australia, the death rate was 66 deaths per 100,000 over the same period. 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. The rate of death for non-Aboriginal children and young people was 28 deaths per 100,000 (Figure 5). The rate of death for non-Aboriginal children and young people usually resident in South Australia was 27 deaths per 100,000[5].

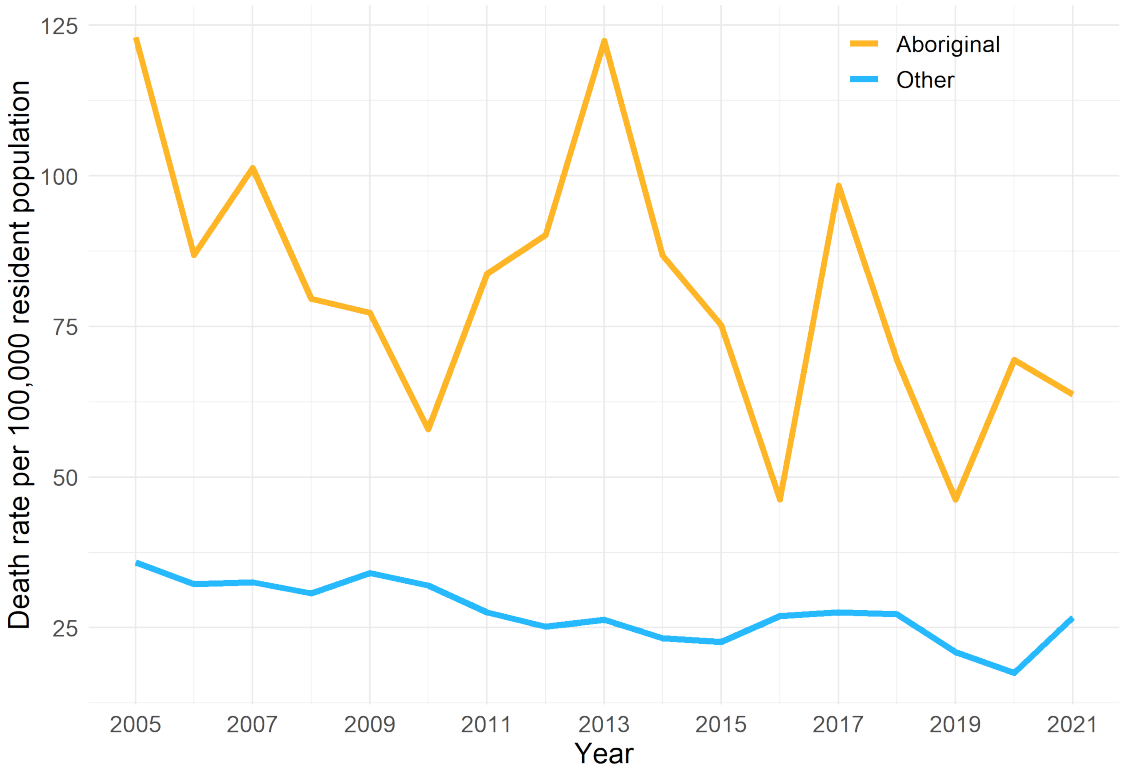

Figure 5: Death rate by cultural background for all children and young people, South Australia 2005–2021

1.2.4. Deaths from illness or disease and other causes

As explained in Section 1.2, it was not possible to produce updated statistics on deaths from illness, disease or other causes, or in other vulnerable groups of children and young people. These data will be shared in a statistical report when available.

[5] *For information about the estimated population of Aboriginal children in South Australia see Section 3.1.2.*

1.3. Opportunities for intervention and prevention: learning from child death review

The Committee has reviewed matters relevant to the safety and wellbeing of children and young people across a number of different issues and vulnerable populations. Snapshots of each area of review are provided here.

1.3.1. Neglect of critical medical care

'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 recognised when families lack capability, commonly due to poverty, and when medical demands are high, such as with complex, severe, and chronic illness'[6]. These illnesses, which are often life-limiting without treatment, typically require management by multiple sub-speciality medical units. When critical medical care is neglected, effective medical treatment must be provided promptly to prevent death.

Only a small number of children and young people each year experience neglect of their critical medical care. The Committee reviewed the deaths of four young people who died between 2018–2020 as a result of a serious disease and where neglect of critical medical care was identified in the circumstances of their deaths. Commonalities in the circumstances of their deaths included:

- challenges for sub-specialist medical systems in communicating the dangers of neglect of critical medical care and seeking assistance with child protection matters
- challenges for child protection systems in providing an effective response because of the medical complexity
- the unreasonable expectation that the young person could self-manage a complex and serious disease
- living in chaotic and/or neglectful situations or experiencing homelessness
- a history of concurrent mental health concerns in either the child, the family or both
- chronic absenteeism from school

[6] *Boos SC, Fortin K. Medical neglect.* Pediatr Ann. *2014;43(11):e253-e259. doi:10.3928/00904481-20141022-08*

- often a pattern of either more frequent hospital admission or presentation to the emergency department, or consistent non-attendance to medical appointments.

As a first step, the Committee drew the circumstances of death of children and young people experiencing neglect of their critical medical care to the attention of the Child Protection Reform Portfolio Management Board. At this meeting, the development of effective across-agency responses to neglect of critical medical care was discussed, including pathways to family support and broader access by medical staff to child protection expertise.

1.3.2. Severe domestic squalor

Squalor is a red flag for chronic neglect and cumulative harm, including serious injury and death. Children and young people should not be left to live in squalid conditions.

In a review of 13 child deaths, the Committee found that families living in squalor had contact with many different service systems including health, housing, child protection, education and police. These multiple contact points exemplify the complexities experienced by these children, young people and their families and highlight their need for co-ordinated and collaborative service approaches to assess and respond to the risk factors contributing to squalid living conditions.

The Committee raised these issues at a meeting convened by the Minister for Education, Training and Skills and attended by the ministers for Health and Wellbeing; Police, Emergency Services and Correctional Services; Child Protection; and Human Services. Discussed at the meeting were the roles each agency should play in addressing squalor and its impact on children and young people.

The Committee understands that this issue will be the subject of further discussion and action within these agencies.

1.3.3. Preventing deaths from asthma

In 2018, the Committee undertook a review of 14 deaths due to asthma to highlight areas for improvement in asthma management and prevention.

The Committee found that health services can improve the quality of their care to children and young people with asthma by:

- monitoring the medical follow-up by a paediatric respiratory specialist of all children discharged from high dependency or intensive care units

- monitoring the medical follow-up by a primary medical practitioner (general practitioner, paediatrician or paediatric respiratory specialist) of children and young people within 2–4 weeks of admission to hospital or presentation at an emergency department
- assertive follow-up of children and young people from vulnerable families who were admitted to hospital or presented to an emergency department with asthma.

Health services can assist children and young people to get the care they need by ensuring all those with poorly controlled, severe or unstable asthma are under the long-term care of a paediatric respiratory specialist. This may include the use of telehealth services in rural settings.

The SA Health Child and Adolescent Health Community of Practice (CAHCoP) has recommended the development of regional Paediatric Asthma Hubs. In 2022, CAHCoP held discussions with the SA Health Rural Support Service to ascertain the level of service needs for paediatric respiratory care and to propose that a co-designed service be established. Discussions about how to progress a partnerships-based care network and develop and deliver the model of care are ongoing.

1.3.4. The health and wellbeing of international students

Young international students face many challenges when they come to live and study in South Australia.

International students under 18 years old are legally children in South Australia and are entitled to the legislated protections that recognise all children and young people should be protected from harm.

The Committee has recommended changes to standards for providers of education and training to international students to ensure these standards are specific enough to protect and promote the health and wellbeing of these students.

The Committee's recommendations have been provided to the state government for consideration.

1.3.5. Informal placement of Aboriginal children and young people

There are many reasons why some Aboriginal children and young people may be moved informally to the care of people outside their immediate families. The suitability of these arrangements varies. Through its reviews, the Committee is familiar with the conditions under which some of these children and young people have lived – and died – trying to care for themselves without the conditions or maturity to do so.

Alongside the Commissioner for Aboriginal Children and Young People, the Committee has presented at several forums where it has raised the issue of how best to ensure the safety and wellbeing of children and young people in informal care arrangements. In the Committee's view, these arrangements need some degree of oversight, and this might best be provided by non-government Aboriginal organisations situated within the communities where these children and young people are living.

1.3.6. Manner and management of the deaths of children and young people

In 2019, the Committee asked the following question: Was every child offered management of their death where there was the opportunity for palliation?

The Committee developed a categorisation methodology for manner and management of death. In the cohort of children and young people who died between 2018 and 2020, 65% of deaths were managed either in a planned palliative manner or by offering redirection of active care to palliation. For 35% of deaths there was no opportunity to palliate. Based on this analysis, the Committee concluded that every child or young person was offered management of their death where there was an opportunity to do so.

The Committee presented these findings to the Australian and New Zealand Child Death Review Prevention Group in May 2022 and has discussed the findings with SA Health services caring for children and young people who are seriously ill. It was noted that the Women's and Children's Health Network Paediatric Intensive Care Unit has no dedicated social work resource to assist families with support when their child is seriously ill or with bereavement after their child has died.

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. The Committee's Strategic Action Plan 2021–22

The Committee developed a Strategic Action Plan with three priorities that guide and direct its work.

2.2.1. Understanding ourselves

The Committee will maintain its effectiveness by defining roles, responsibilities and expectations of all members.

The Committee met on eleven occasions in 2021–22. At each meeting the Committee considered 6-10 child deaths, including the circumstances of the death, the cause of the death, and if relevant the family's history of contact with the child protection system, with a view to identifying potential systemic issues that require further review by one of the Committee's Special Interest Groups.

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, culturally and linguistically diverse families, child safety, and Aboriginal children and young people. In-depth reviews were undertaken by teams drawn from the Committee's membership. The members met as required to plan and complete each review. The average number of out-of-session meetings of Committee members was two per month.

The Committee strives for continuous improvement of its knowledge and understanding of issues that impact children, young people and their families.

The Committee and its Special Interest Groups improved their knowledge of service provision issues that might impact children and young people through discussions with representatives from agencies providing services to children and young people, including:

- Post-care Services Design Project – Commissioning, Performance and Disability Directorate of the Department for Child Protection
- Child and Family Support System – Department of Human Services
- 'One in Four' reform program to support children and young people with functional needs in schools and preschools – Early Years and Child Development Division of the Department for Education
- structural and strategic reforms – Child and Adolescent Mental Health Services.

Establishment of the Oversight and Advocacy Authority for Aboriginal Children and Young People – CDSIRC

A co-design process with eight nominated Aboriginal thinkers and leaders has resulted in the drafting of a vision statement and Terms of Reference for the Oversight and Advocacy Authority for Aboriginal Children and Young People – CDSIRC. With Ministerial approval, appointments will be made as advisors to the Committee. Once established, this group will use Aboriginal cultural knowledge to guide and direct the review of Aboriginal child deaths in culturally appropriate ways.

2.2.2. Building strategic alliances

Through active engagement with service systems and strategic allies the Committee will seek to influence outcomes for children, young people and their families.

Ministerial engagement

Through regular meetings with the Chair and members, the Committee has maintained contact with the former Minister for Education and the current Minister for Education, Training and Skills. These meetings ensure that the Minister is apprised of the focus of the Committee's current and future work and the ways in which it is seeking to engage and influence service provision to children and young people.

Oversight and Advocacy Bodies

The Committee has been an active participant in three-monthly meetings of the five agencies established under the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*: the Commissioner for Children and Young People, the Commissioner for Aboriginal Children and Young People, the Guardian for Children and Young People and Training Centre Visitor, and the Child Development Council. These meetings provide the opportunity for each agency to share information and knowledge about the ways in which they are seeking to improve outcomes for children and young people.

Sudden unexpected infant deaths

Continuing its commitment to preventing the sudden unexpected deaths of infants, the Committee has supported the revision of the South Australian safe infant sleeping guidelines and standards. As part of the guidelines review working group, the Committee provided up-to-date data about the number and rates of sudden unexpected infant deaths in South Australia and provided feedback about the draft guidelines.

The guidelines and standards are critical to a state-wide, consistent and effective approach to the transmission of information to families about the best ways in which to safely sleep their infant.

On request from the Australian Competition and Consumer Commission (ACCC), the Committee has provided aggregated data to inform the ACCC's nation-wide consultation about proposed policy options to reduce the risk of injury and death associated with infant sleep products, including inclined sleep products, and household and folding cots.

Child restraints and transport-related deaths

Based on its analyses of the role of child restraints in transport-related deaths and of driveway runover deaths, the Committee provided a submission to the Department for Infrastructure and Transport in relation to *South Australia's Road Safety Strategy to 2031* (the Strategy). In its submission, the Committee questioned the reliability of the current age-based system governing the use of child restraints, which potentially leads to children being prematurely transitioned out of size-appropriate child seats.

The Committee also expressed concern about the lack of recognition of 'driveway runovers' in the Strategy. These deaths usually occur on private property and are not

included in road transport crash statistics, but are nevertheless transport-related deaths that can likely be reduced by improved road safety strategies.

In conjunction with Kidsafe SA, one of the Committee's key prevention partners, letters were sent to the Chief Executives of six public and private birthing hospitals in South Australia. The letter highlighted the need to ensure that all new parents receive child restraint information before and after the birth of their infant and recommended that each hospital embed information about Kidsafe's child restraint advice and support services into hospital discharge protocols.

2.2.3. Making data real and useful

The Committee is committed to using its data to build a better understanding of the contribution child death review can make to the safety and wellbeing of children.

In 2021–2022, the Committee's secretariat developed and implemented a new database and reporting system. This new system has features which will allow the Committee to work more effectively and efficiently, including:

- flexible design to meet the Committee's changing needs and data collections
- data validation and data quality controls
- automated data entry and data processing
- highly secure data storage.

Five-year data summary

In May 2022, the Committee published a five-year data summary on its website[7]. This analysis includes interactive figures and provides a contemporary summary of child deaths in South Australia, including the principal factors known to be associated with the risk of child death and with discrepancies in rates of child death between different parts of the population. This format takes important analyses that would previously be spread throughout an annual report and presents them together in a more digestible and accessible way. These data will be updated on a yearly basis.

[7] https://cdsirc.sa.gov.au/five-year-data-summary/

Trends in neonatal deaths

The Committee published a follow-up analysis[8] of its previous blog discussing an interesting trend in fewer neonatal deaths, particularly those associated with gestation, fetal growth, and complications of pregnancy. This phenomenon will be re-examined in 2023 and the Committee will share its findings on its website and in an upcoming data report.

Child deaths in families with a culturally or linguistically diverse background

Research suggests families with a culturally or linguistically diverse (CALD) background may experience multiple health conditions and barriers to accessing health care[9], which increase the risk of poor outcomes including death. The Committee has sought to better understand the experience of refugees and the impact of migration on the deaths of children by linking its register of child deaths with Births, Deaths and Marriages. The country of birth of both the deceased child and their parents has been linked with information about the death of the child. A first analysis of the impact of cultural and linguistic diversity will be available in 2023.

The Committee has also undertaken brief reviews of the deaths of several children and young people with a CALD family background to explore the influence their background had on the circumstances of their death. This will form the basis for future in-depth reviews of child deaths in families with a CALD background.

Work towards the Australian Child Death Data Collection

The Australian and New Zealand Child Death Review and Prevention Group (ANZCDRPG) aims to identify, address and reduce the number of infant, child and youth deaths by sharing information on issues in the review and reporting of child deaths, and to work collaboratively towards national and international reporting. In 2022, South Australia led discussions with ANZCDRPG about models of national data collection. ANZCDRPG agreed to establish a national data collection on child deaths at the Australian Institute of Health and Welfare (AIHW). Work continues in collaboration with the AIHW and the Queensland Family and Child Commission, the current convening jurisdiction for the ANZCDRPG.

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[8] https://cdsirc.sa.gov.au/a-continuing-trend-in-fewer-neonatal-deaths/
[9] *Khatri, RB and Assefa, Y. 2022 BMC Public Health, 22:880 Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges.* https://doi.org/10.1186/s12889-022-13256-z

Providing data to requesting jurisdictions

On request from the Northern Territory, the Australian Capital Territory and Victorian child death review teams, the Committee has provided de-identified information about the deaths of children in South Australia who were normally resident in another state. Sharing information between jurisdictions is an important way to foster collaboration between child death teams nationally.

2.3. Governance and support

The Minister for Education, Training and Skills 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:

Ms Rosemary Byron-Scott	Senior Project Officer (0.7FTE)
Ms Nikki Kearney	Administration and Information Officer (1.0FTE)
Ms Una Sibly	Senior Project Officer (0.4FTE; until 11 February 2022)
Dr Jago Van Dam	Senior Statistician/Data Analyst (1.0FTE)
Dr Sharyn Watts	Executive Officer (1.0FTE)

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 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 in its five-yearly Census of Population and Housing. The estimated resident population is also available on a yearly basis.

For the purposes 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 418,608 cells in the matrix calendar year (17 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 estimated resident population.

3.1.3. 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 lowest 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 Coroner's Court of South Australia; and Wellbeing SA's 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[10].

3.3. 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, Training and Skills, and 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, Training and Skills 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.

[10] *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.*