CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2022–2023

Government
of South Australia

GPO Box 1152
ADELAIDE SA 5001

T 08 8463 6451
E cdsirc@sa.gov.au
W www.cdsirc.sa.gov.au

ISSN 1833 - 9743

Letter of Transmission

Hon Blair Boyer MP
Minister for Education, Training and Skills

Dear Minister

I submit to you for presentation to Parliament, the 2022–23 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 2022–23.

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

Ms Jane Abbey KC
Chair
Child Death and Serious Injury Review Committee
27 October 2023

Chair's Foreword

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

This year the Committee has had a focus on monitoring the implementation of its recommendations in accordance with section 37(1)(b) of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016.* The Committee identified eighteen recent recommendations that required follow up to determine their status. The Committee acknowledges the work of those agencies that have recognised and accepted the need for change. The Committee is also interested to understand how agencies evaluate the effectiveness of their programs, policies and practices in improving the lives of children and young people, to ensure that this work is having a positive effect.

Thank you to the eight Aboriginal leaders who have formed the Committee's Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People (the Authority). As an advisory body to the Committee, the Authority was formed in 2022 to ensure that the review of Aboriginal child deaths and recommendations for system change are informed by Aboriginal voices and come from a place of cultural strength and knowledge. I would like to acknowledge the Authority's work to develop a framework for the review of Aboriginal child deaths. The Authority has provided a report to the Committee which is included as part of this Annual Report.

I thank each of the Committee members for the commitment, enquiry and care they have brought to the Committee's work. I especially want to note the significant contribution of an out-going member, Dr David Everett OAM, whose expertise and efforts to improve the safety of South Australia's children will be missed. I also want to thank the Committee's Secretariat, with special mention to Dr Sharyn Watts for her significant contribution as Executive Officer from 2005 until her retirement in 2023. Dr Watts has made an outstanding contribution to ensuring that children and young people in South Australia are seen and heard, and to the prevention of deaths.

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.

Contents

Figures

Glossary

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
Authority	Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People - CDSIRC
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
DE	Department for Education
DCP	Department for Child Protection
DHS	Department of Human Services
Infant	A child under one year of age
NDIS	National Disability Insurance Scheme
SEIFA	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SUDI	Sudden Unexpected Death in Infancy

Acknowledgements

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDRPG)
- Office of 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 Jane Abbey KC

Members

Dr Mike Ahern	
Dr Carmela Bastian	
Dr David Everett OAM	until 7 April 2023
Dr Mark Fuller	
Dr Margaret Kyrkou OAM	
Ms Kathy Moar	
Dr Rhiannon Pilkington	from 20 December 2022
Mr Kurt Towers	
Ms Catherine Turnbull	from 16 November 2022
Dr Deirdre White	from 16 November 2022

Executive Summary

This eighteenth 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 2022, 107 children and young people died in South Australia. At the time of writing this annual report, information on causes of death for about a quarter of these child deaths was not available to the Committee. The Committee will publish a more detailed statistical report in 2024.

During the 2022–23 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:

- recognition of the cumulative harm created by the longstanding neglect of the needs of vulnerable children
- expanding intensive family support services to better protect at-risk children and young people
- fundamentally changing the ways in which the needs of Aboriginal infants, children and young people, and their families, are conceptualised and met
- the need to develop an effective across-agency response to the neglect of critical medical care needs of children and young people.

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 its database and reporting system. The Committee has also provided project support to facilitate discussions between states and territories with the aim of developing a national child death data collection. The focus over the past twelve months has been on documenting each jurisdiction's legislation, governance and processes for data collection.

Section One

1. Special Report

Special Report: Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People.

1.1. Acknowledgements

The Oversight and Advocacy Authority for Aboriginal Infants, Children and Young people acknowledges its presence and work on Kaurna Land.

1.2. Background to the establishment of the Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People

Aboriginal infants, children and young people are disproportionately affected by child mortality rates. From 2005 to 2022, the death rate for Aboriginal infants, children and young people in South Australia (79.8 per 100,000) was nearly three times higher than for their non-Aboriginal peers (27.5 per 100,000). Systemic failures within society, including historical and ongoing injustices and racism, have contributed to the disproportionate number of Aboriginal child deaths.

The Committee's comprehensive reviews of Aboriginal child deaths have revealed that their lives can be impacted by numerous factors, such as failures in service delivery, parents traumatised by their own experiences, and intergenerational and complex trauma. Additionally, systemic factors that impact on Aboriginal and Torres Strait Islander communities not previously considered by the Committee include institutional racism, past government practices and policies that required Aboriginal cultural authority and oversight.

1.3. The Role of the Authority

To support the Committee in reviewing Aboriginal child deaths and identifying systemic changes that could contribute to their prevention in a culturally responsive and respectful manner, the Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People (the Authority) was established. In August 2022, with Ministerial approval, eight Aboriginal leaders and thinkers came together to form the Authority. The Authority provides expert advice to the Committee and envisions the creation of a culturally safe space for reviewing the deaths and serious injuries of Aboriginal infants, children and young people. It seeks to amplify the voices of Aboriginal infants, children and young people to bring about system disruption and change within the framework of truth-telling. Prior to the establishment of the Authority, the Committee had relied exclusively on one Aboriginal member to carry the

responsibility and the burden of leading the review of Aboriginal child deaths. The Committee's only Aboriginal member, Kurt Towers, brought this issue to the Committee's attention, pointing out that it was neither culturally safe nor appropriate.

1.4. Work completed to date by the Authority

The Authority met on five occasions in 2022–23. This is the first Aboriginal body known to have formed to review Aboriginal child deaths within Australia, and during this time, the Authority focussed on strengthening its governance. A framework for reviewing Aboriginal child deaths was drafted and used for the initial review of six deaths of Aboriginal infants, children and young people, and this work has informed and strengthened the governance practice framework of the Authority. The framework for assessing the social and emotional wellbeing of Aboriginal infants, children and young people aims to identify risk, service gaps, protective behaviours and Aboriginal strength-based factors for a standard set of domains relevant to a child's life based on the Model of Social and Emotional Wellbeing. This includes consideration of an infant, child or young person's connection to family and kinship, culture, Country, spirituality and ancestors, body and mind, and emotions.

The framework enables the Authority to ensure it identifies and considers all aspects of an Aboriginal child's life and the circumstances of their death, including from cultural, historical and political perspectives, and taking into account any relevant intergenerational history, identifying systemic issues and, most importantly, identifying the strengths of the family and community within the review to prevent future tragedies.

During the drafting of the framework it was noted some deaths should be reviewed in more detail, with more information to be obtained from agencies, non-government organisations and private practitioners if they have provided services to the child or family. From the initial review of six deaths, the Authority has posed recommendations including:

1. How can the Committee further draw out the truth of all deaths of Aboriginal children, whilst honouring the child and the strengths of the family and community?
2. The Authority is unable to access comprehensive information about deaths occurring within South Australia when children usually live interstate. Further work is needed to determine how child deaths will be reviewed when children are transferred interstate for their care.

3. How can the review of Aboriginal child deaths acknowledge the unique cultural circumstances and diversity?
4. The framework will not only report on the circumstances surrounding the deaths, it will also recommend strategies to prevent further deaths by identifying protective factors during reviews.

The Authority has also provided expert advice for the Committee's submission to the Inquiry by the Commissioner for Aboriginal Children and Young People into the application of the Aboriginal and Torres Strait Islander Child Placement Principle (Placement Principle) in the removal and placement of Aboriginal children in South Australia.

The Authority is comprised of eight Aboriginal leaders, but it is acknowledged that it does not reflect all Aboriginal people.

1.5. Acknowledgement of Cultural Authority

The Committee extends its gratitude to the Authority for its profound cultural expertise and the pivotal role it is playing in advising the Committee. The Authority's guidance is instrumental in enabling the Committee to strive towards uncovering the complete truth behind the mortality of Aboriginal infants, children and young people, as well as the previously overlooked strengths within affected families and communities.

Section Two

2. Child Deaths South Australia 2005–2022

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

2.1 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.

2.2 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 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.

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

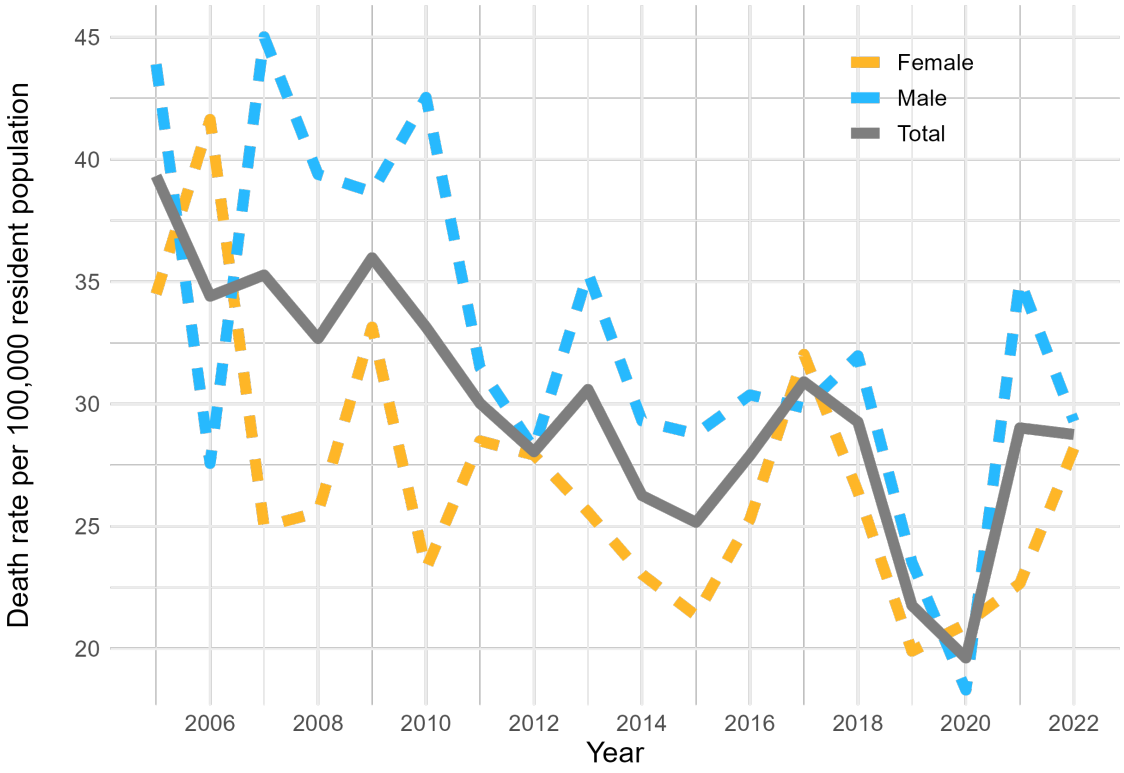

Figure 1: Death rate by year of death and sex for all children and young people, South Australia 2005–2022

Figure 1[2] shows death rates for all children and young people who died in South Australia during the 18 years from 2005 to 2022[3].

The Committee observed the lowest number of child deaths on record consecutively in 2019 (81 deaths) and 2020 (73 deaths). However, in 2021 there were 108 deaths and, in 2022, 107 children and young people died in South Australia.

The Committee is continuing to collect information on the deaths of children in 2022. It will publish a detailed statistical report when this information is available.

2 For each figure in Section Two, there is corresponding data available on Data.SA
3 During this 18 year period, the average yearly population of children and young people aged 0 to 17 was 359,172 For more information on how this number was calculated, see Section 4.1.2

2.2.1 Death rates by region

Important issues for service planning and delivery are highlighted when death rates (Figures 2 and 3) 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 (Figure 3). 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 number of deaths occur.

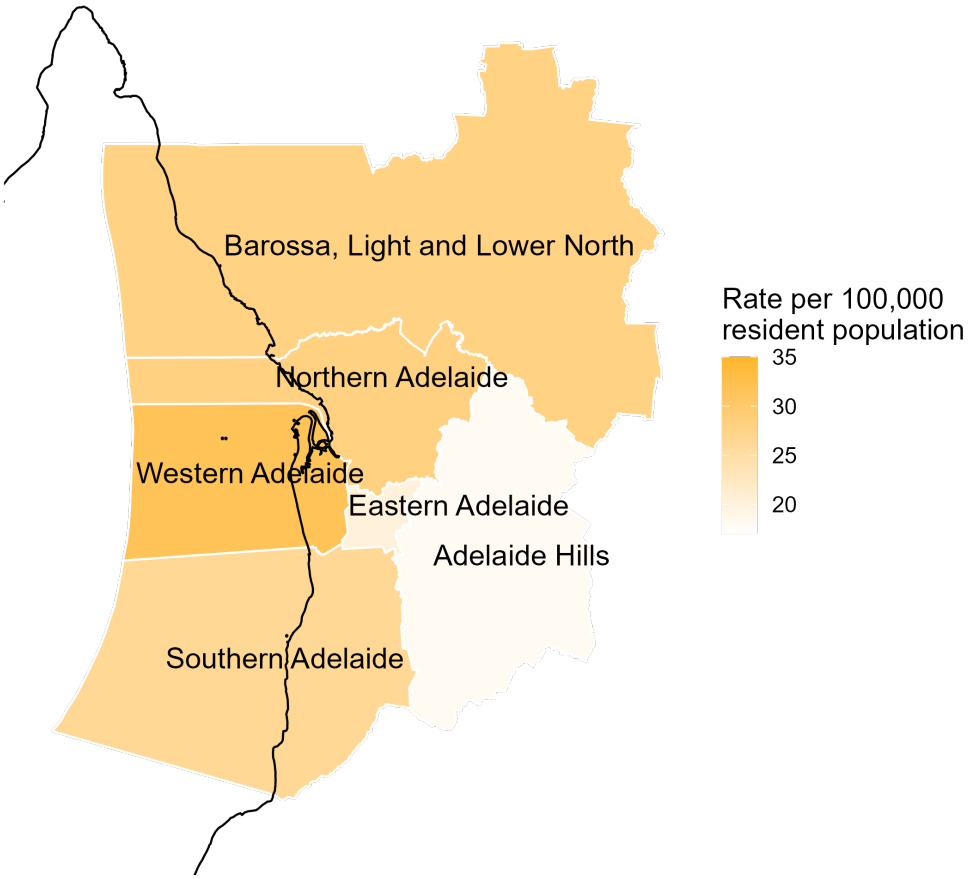

Figure 2: Death rate by metropolitan and inner rural regions for children and young people who were usually resident in South Australia, 2005–2022

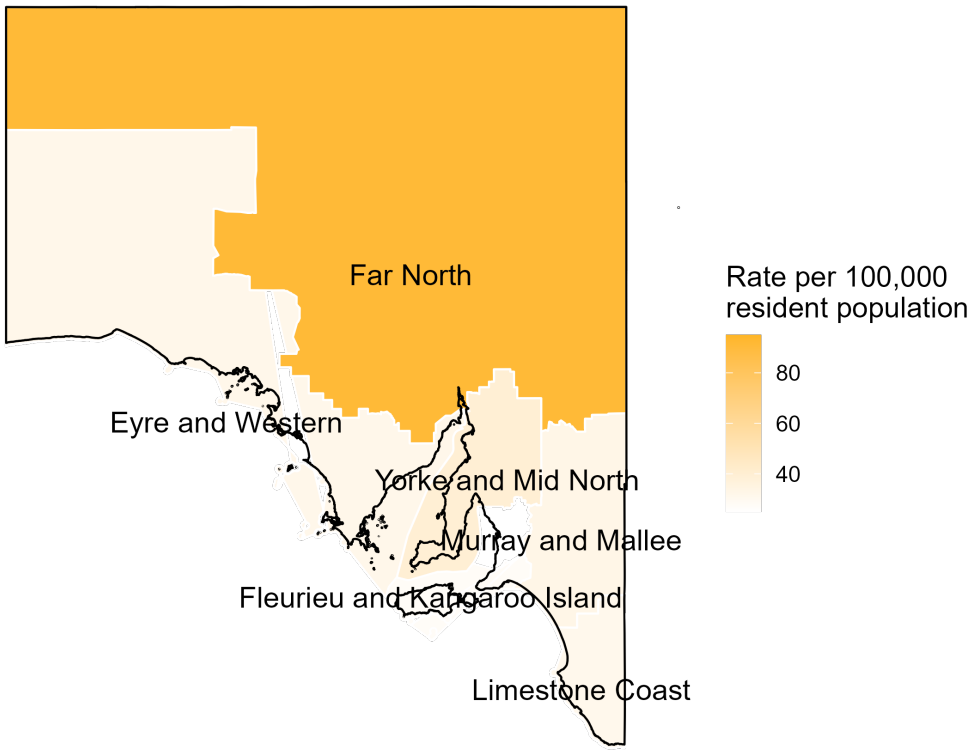

Figure 3: Death rate by outer rural regions for children and young people who were usually resident in South Australia, 2005–2022

2.2.2 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 2022, resident and non-resident, were included in this analysis.

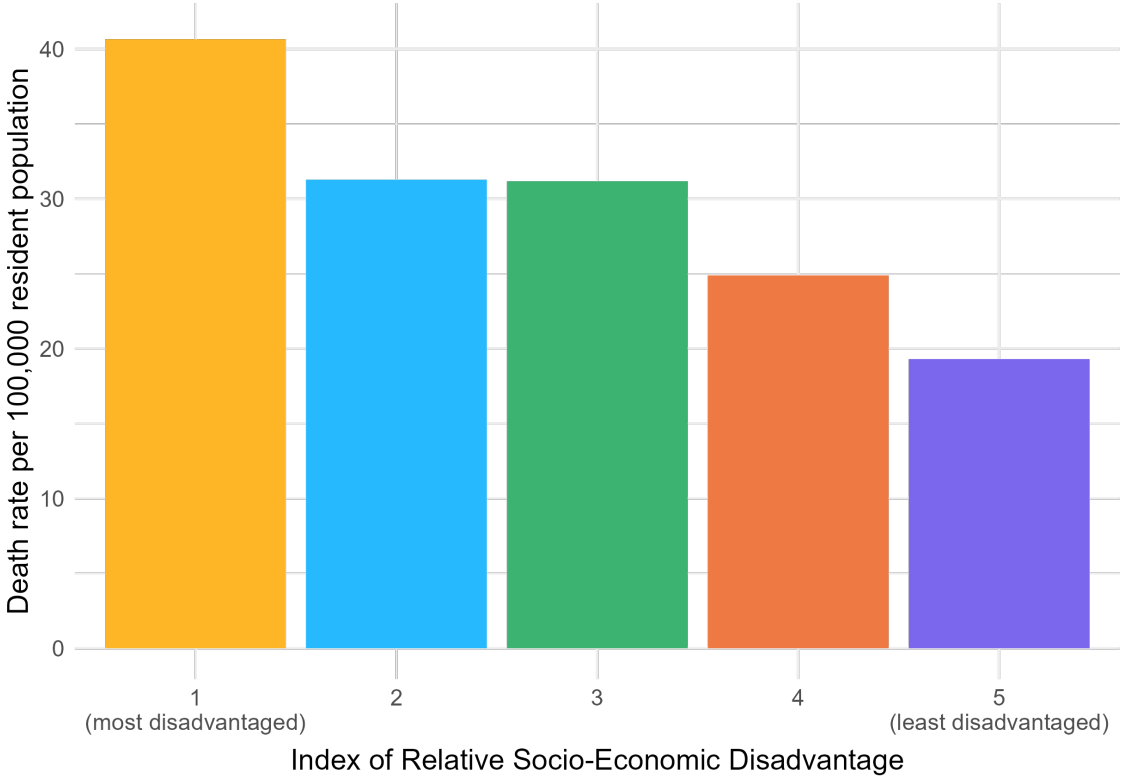

Figure 4: Death rate by Index of Relative Socio-Economic Disadvantage for all children and young people who died in South Australia, 2005–2022

[4] *For information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 4.1.3*

2.2.3. Deaths of Aboriginal children and young people

During the period 2005 to 2022, the rate of death for all Aboriginal children and young people who died in South Australia was 79.8 deaths per 100,000 population. For Aboriginal children and young people who were usually resident in South Australia, the death rate was 64.9 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 27.5 deaths per 100,000. The rate of death for non-Aboriginal children and young people usually resident in South Australia was 26.5 deaths per 100,000[5].

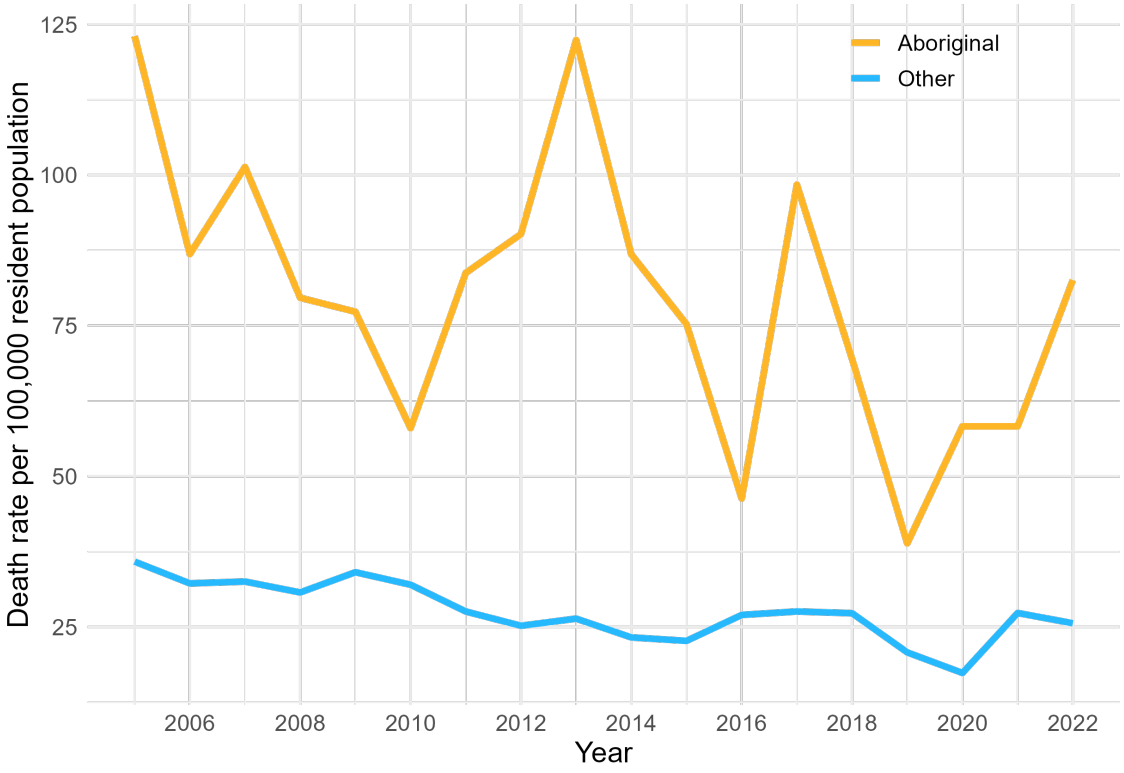

Figure 5: Death rate by cultural background for all children and young people, South Australia 2005–2022

[5] *For information about the estimated population of Aboriginal children in South Australia see Section 4.1.2.*

2.3 Opportunities for intervention and prevention: learning from child death review

The Child Death and Serious Injury Review Committee has reviewed matters relevant to the safety and wellbeing of children and young people across a number of different issues with the aim of identifying legislative or administrative changes that could prevent future child deaths.

2.3.1 Review of suicide deaths and suicide prevention

The Committee has been monitoring and reviewing suicide deaths of children and young people since 2005. Each potential suicide death is carefully reviewed to determine if a young person's death will be attributed to suicide. Review can include coronial reports and education, health, mental health and child protection records. The Committee has no power to interview family members, friends or those involved in the care of children and young people.

The Committee has determined that 74 young people – aged from 12 to 17 years – have suicided between 2005 and 2021. The Committee is continuing to collect information on the deaths of children in 2022 and will publish a detailed statistical report when more up-to-date information is available.

The Committee has reviewed 63 suicide deaths using life chart methodology[6]. Based on similarities in their life circumstances, each young person who suicided has been placed into one of four groups. Intervention and prevention strategies that are needed to address the issues in each of these groups have been identified.

Group 1

Seventeen (17) young people who suicided have been placed into this group. These young people faced long term challenges in their family circumstances, with learning, and with relationships. At the time of their deaths, they were disengaged from family, school and from their peers.

---

[6] *Fortune, S. Stewart, A, Yadav, K. and Hawton, K (2007) Suicide in adolescents: using life charts to understand the suicidal process. J Affect Disorders, 100, 199-210.*

Intervention and prevention strategies need to begin early in life for young people to foster positive engagement with home, school, community and other forms of support.

Group 2

Thirty-six (36) of the 63 suicides reviewed were placed into this group. Mental health challenges emerged later in childhood or during adolescence and included depression and anxiety, deliberate self-harm and/or suicide attempts. Seeking help from youth-oriented mental health services was common but engagement was often not maintained.

Youth-oriented mental health services with an emphasis on assertive outreach are needed by young people who experience anxiety, depression and other mental health issues that emerge in their teenage years.

Group 3

The life charts of this small group of seven young people showed positive engagement with family, learning and peers. There was little evidence of mental health issues, but they had each experienced difficulties in social, romantic or sexual relationships in the year/months proximal to their suicide.

Readily available support and information services are needed for young people who are facing a 'crisis' in relationships upon which they have placed great emotional value.

Group 4

The Committee does not have enough information about the three young people in Group 4 to determine common themes in their lives. More analysis may be possible in time should further cases be added to this group.

The Committee awaits the release of SA Health's Model of Care for Youth Mental Health Services in South Australia. The Committee continues to identify transition and continuity of care as key issues for young people, especially in the 15-17 year age group. The Committee has observed a high incidence of emerging serious mental health problems in this age group. It remains of great concern to the Committee that this age-related vulnerability coincides with a major service transition point from child and youth to adult mental health services.

2.3.2 Placement of Aboriginal children and young people in out-of-home care

The Committee has reviewed the deaths of sixteen Aboriginal children and young people who died while in the care of the state between 2005 and 2022. The Committee considered these deaths in relation to the Aboriginal and Torres Strait Islander Child Placement Principle, which provides a framework by which decisions for the placement of Aboriginal children and young people into state care can be made. The Committee acknowledges the significant contribution of the Oversight and Advocacy Authority for Infants, Children and Young People (the Authority) to this work. The Authority provided advice to the Committee for a submission on this issue to the Commissioner for Aboriginal Children and Young People's Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children in South Australia.

In the cases reviewed, there were often circumstances that made the application of the principle difficult. For example, placement choices for Aboriginal children and young people with a disability were limited because of the intensity or location of support the child required. In other cases when placements broke down the choices for the next placement became fewer and the application of the principle became harder to maintain or did not appear to be revisited. This sometimes led to young people self-placing and consideration given to the child protection service revoking the care order due to non-compliance. In other cases, connection to family and culture was limited to contact with family/parents and if that was not possible seemed limited by a lack of guidance for carers about what the child or young person needed.

Fundamental change is needed to the ways in which the needs of Aboriginal children and young people, and their families, are conceptualised and met. The Committee has recommended that culturally safe services should be delivered by trusted and culturally safe agencies located within communities and are resourced to act in ways that build on the strengths of Aboriginal culture and connection. Above all, there is a need to address systemic issues for Aboriginal people in South Australia to prevent Aboriginal children and young people entering state care in the first place.

2.3.3 A review into the death of a vulnerable child with complex health issues

In this review, the Committee found that a child who died as the result of a severe health condition had been particularly vulnerable due to lifelong health issues, intellectual disability and family circumstances. The Committee considered the child's life in retrospect which raised the issue of cumulative harm resulting from prolonged neglect of the child's care needs. The Committee has previously found that the number of notifications, as well as the complexity of a child's circumstances, inclusive of complex health needs, disability and family circumstances, are factors in cumulative harm. In the Committee's view, this requires an across agency response.

The Committee has recommended that an education program and tool kit of resources about cumulative harm be developed and adapted to the needs of the health, education, child protection and community service workforce. The Committee considers that mandatory reporters need a mechanism for escalating their concerns when they are ongoing and not being adequately addressed. In the Committee's view, a 3-6 month period of ineffective service delivery requires escalation to investigate the reasons and set new direction. These escalation pathways should be documented and communicated to service systems.

Where a vulnerable child has complex health needs and there are ongoing notifications about that child's safety, it is the Committee's view that intensive family support services should be available to the child's family. These services should be expanded to ensure that, where children are identified as being at risk of harm, their families can access services. South Australia has been noted to have a comparatively low level of family support services, spending less than four percent of its child protection budget on intensive family support services[7].

Complex care programs provided from within health services are also increasingly recognised as an efficient and effective response to providing health and social care to children with chronic illness who have experienced uncoordinated access to health,

[7] *Alexander, K. Trust in Culture. A review of child protection in South Australia. South Australian Government. November 2022. https://www.childprotection.sa.gov.au/documents/report/trust-in-culture-a-review-of-child-protection-in-sa-nov-2022.pdf Accessed 14 August 2023.*

disability and social service[8,9]. The Committee considers that a statewide paediatric complex care service with multi-disciplinary and family-centred care would benefit children in these circumstances. This is particularly the case where parents/caregivers do not have the capacity to coordinate and oversee the child's care themselves, even when receiving NDIS funding due to difficulty navigating complex systems. This service should also include embedded psychological services to support families and children.

The Committee intends to discuss these recommendations with SA Health, the Department for Child Protection, the Department for Education, Department of Human Services and National Disability Insurance Scheme.

2.3.4 Neglect of critical medical care

A small number of children and young people experience neglect of their critical medical care each year and need effective medical treatment provided promptly to prevent death. Neglect of critical medical care can occur when a child's medical demands are high, such as with complex, severe, and chronic illness, and families lack capability to provide the child's care, commonly due to poverty[10]. These illnesses are often life-limiting without treatment.

The Committee has continued to advocate for an effective across-agency response to the neglect of critical medical care. A rapid across-agency response to prevent these deaths is still to be identified.

2.3.5 Severe domestic squalor

In 2022, the Committee undertook a review of 13 child deaths involving severe domestic squalor. It found that families living in squalor need coordinated and

[8] *Strivastava R, Downie J, Hall h, Reynolds G. Costs of Children with Medical Complexity in Australian Public Hospitals. Journal of Paediatrics and Child Health, 2016; 52(5), 566-571. https://doi.org/10.1111/jpc.13152.*
[9] *D'Aprano a, Gibb S, Riess S, Cooper M, Mountford N, Meehan E. Important Components of a Programme for Children with Medical Complexity: An Australian Perspective. Child Care Health Dev. 2020; 46: 90-103. https://doi.org/10.1111/cch.12721.*
[10] *Boos SC, Fortin K. Medical neglect.* Pediatr Ann. *2014;43(11):e253-e259. doi:10.3928/00904481-20141022-08*

collaborative service approaches[11] to assess and respond to the risk factors contributing to squalid living conditions.

The Committee has received a response to this review from the Minister for Human Services. The Committee understands that the Department of Human Services is responding to several of the recommendations from the review led by Mr Malcolm Hyde AO APM into the deaths of two young children, of relevance to the issues raised in the Committee's review, including research into identifying and responding at an earlier stage to cases of neglect.

The Minister's response also identified that the South Australian Housing Authority uses a Risk Identification Tool to identify households at risk. The Committee subsequently met with the South Australian Housing Authority to better understand the Risk Identification Tool and how it is applied. The Committee commends this agency for its work to improve the safety of children living in high-risk households, including improved system and information sharing processes, regular family practice meetings, and asking about children aged five and under if they are not present during a home visit.

[11] *Interprofessional education collaborative. (2016). Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative,*

Section Three

3. 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

3.1 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.

3.2 The Committee's Strategic Action Plan

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

3.2.1 Understanding ourselves

The Committee met on eleven occasions in 2022–23. At each meeting, the Committee considered 8–10 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, multicultural 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 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:

- Child and Family Support Services – Department of Human Services
- Child Protection and Policy Unit – SA Health

- Student Support Services, Support and Inclusion Division – Department for Education
- Office of the Chief Psychiatrist – SA Health

3.2.2 Building strategic alliances

Oversight and Advocacy Bodies

The Committee has participated 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), the Child Development Council and the Child Death and Serious Injury Review Committee. 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

Between 2005–2021, 156 infants have died suddenly and unexpectedly in South Australia after being placed to sleep. The Committee is aware of the evidence base that supports the introduction of the Pēpi-Pod program to help prevent the sudden unexpected deaths of infants. To contribute to prevention efforts, the Committee has participated in Pēpi-Pod working group meetings with Kidsafe, health professionals and researchers seeking to progress this important initiative.

SA Consumer Product Advocacy Network

The Committee is a member of the South Australian Consumer Product Advocacy Network (SA CPAN). Chaired by Kidsafe SA, the group provides leadership to ensure both ongoing and emerging issues associated with unsafe products are identified and solutions to these issues explored. The group's goals include exploring solutions for unsafe products which have been identified and reducing the number and severity of injuries amongst children aged up to 15 years linked to consumer products.

Child and Family Support System

Through meetings with members, the Committee has increased its knowledge of the family support services provided through the Department of Human Services. The Committee recognises the challenges involved in raising a child with complex care

needs. The Committee recommended expanding family support services so that all vulnerable families caring for a child with complex health have access to intensive family support services where risks to the child's safety have been identified through child protection contact.

Purpose of public education

The Committee's reviews have demonstrated that some children and young people experience a high degree of vulnerability when living in complex family circumstances or with complex care issues that often require intensive support from schools.

The Committee participated in the Department for Education's consultation on the purpose of public education in South Australia and provided feedback on:

- integrating support services into schools, particularly for students experiencing disability, chronic disease management, mental health problems and socio-economic disadvantage
- prioritising collaborative models of integrated service provision such as the 'Team around the Child' approach[12]
- recognising the important role of teachers and school staff as a key influence in a child's developmental trajectory.

The Committee supports the new School Mental Health Service as an important contribution to improve the mental health of young people. In the Committee's view consideration should also be given to establishing an Education Health Liaison Officer role to support school staff who work with children who have complex health care needs.

[12] *Limbric, P, TAC for the 21st Century. Nine essays on Team Around the Child. Interconnections, Clifford, UK 2009.*

3.2.3 Making data real and useful

Child deaths in multicultural families

Research suggests families with a multicultural background may experience multiple health conditions and barriers to accessing health care[13], 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 Committee has developed a framework to explore cultural factors in the circumstances of the deaths of children with a multicultural background, to better understand the prevention of child death in multicultural communities.

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. The Queensland Family and Child Commission is the current convening jurisdiction for the ANZCDRPG.

In 2022, the Australian Institute of Health and Welfare (AIHW) assigned project management and data analysis resources to begin the process of developing the data collection, and South Australia provided a part-time project lead. The first round of discussions held in early 2023 between Australian jurisdictions and the AIHW provided comparative information about the enabling legislation, governance and processes for the collection of child death data in each jurisdiction. The national data collection aims to include risk factor information on particular types of child death, for example, the sudden unexpected deaths of infants. Work in 2023 aims to determine the minimum common data set in collaboration with each jurisdiction.

---

[13] *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*

3.3 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)
Mr Philip McNamara	Project Officer (0.6FTE) from 19 July 2022
Ms Carol Nightingale	Executive Officer (1.0FTE) from 18 January 2023
Dr Jago Van Dam	Senior Statistician (1.0FTE) until 17 March 2023
Dr Sharyn Watts	Executive Officer (1.0FTE) until 17 January 2023

Section Four

4. Methodology

4.1 Sources of information

4.1.1 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.

4.1.2 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. 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 445,824 cells in the matrix calendar year (18 levels), age (18 levels), sex (2 levels), cultural background (2 levels), and postcode (344 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.

4.1.3 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 least relative socioeconomic disadvantage.

4.2 Committee classifications and definitions

4.2.1 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 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.

4.2.2 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[14].

4.3 Reporting requirements

Section 39 of the Act outlines the reporting responsibilities of the Committee. It requires the Committee to report to the Minister for Education, Training and Skills as and when required by the Minister, and also to provide an annual report on the performance of its statutory functions for the preceding financial year. In addition to these mandatory reports, 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.

[14] *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.*