CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2023–2024

Government
of South Australia

Child Death and Serious Injury Review Committee
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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 2023–24 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to section 39(2) 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 2023–24.

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
31 October 2024

Chair's Foreword

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

This year, despite making up 5.2% of the child population in South Australia, 11.8% of child deaths were Aboriginal children. The death rate of Aboriginal children and young people in South Australia between 2011 and 2023 was over three times higher than for their non-Aboriginal peers. These numbers are concerning and signal an ongoing need to ensure the safety, wellbeing and positive life outcomes of Aboriginal children. This need is reflected in the recommendations of the Commissioner for Aboriginal Children and Young People in her 2023 Holding onto Our Future final report and in her response to the state government's draft Children and Young People (Safety and Support) Bill 2024. By taking measures to reduce the over-representation of Aboriginal children in the child protection system and by providing culturally appropriate support, more Aboriginal children can grow up safe and connected with family and culture.

In 2023, the Committee continued to review the deaths of Aboriginal children and young people using a framework to help identify and consider all aspects of a child's life and the circumstances of their death. This includes relevant intergenerational history, systemic issues and failures, and most importantly, the strengths of family and community to prevent future tragedies.

I want to thank each of the Committee members for their commitment, enquiry and care this year. I especially want to note the significant contribution of outgoing member, Dr Margaret Kyrkou OAM and her work serving the children and young people of South Australia living with disability. Dr Kyrkou established the Committee's information collection on disability, in which South Australia leads the country, and led the Committee's engagement with the disability service sector.

Likewise, I want to acknowledge Dr Mike Ahern, another outgoing member who sadly passed away in March 2024. Dr Ahern was a tireless contributor to the suicide prevention and child protection work of the Committee. His contribution will continue to be drawn upon, and his commitment to public service, humility, empathy and generosity will be remembered.

I also want to thank the Committee's Secretariat for its work, without which the work of the Committee could not be done.

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.

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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, Department for Education, 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	until 31 December 2023
Ms Mary Awata	from 21 January 2024
Dr Carmela Bastian	
Dr Mark Fuller	
Dr Margaret Kyrkou OAM	until 30 June 2024
Ms Kathy Moar	
Dr Rhiannon Pilkington	
Mr Kurt Towers	
Adj. Assoc. Prof. Catherine Turnbull	
Dr Deirdre White	

Executive Summary

This nineteenth 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.

The Committee was established in 2005 and has a total of 2,018 deaths recorded on the Child Death Registry. This annual report focuses on deaths for the period 2011 to 2023, which is a total of 1,285 records.

In 2023-24, 93 children and young people died in South Australia. Most of these deaths were a result of natural causes, with 14 deaths from causes other than natural which can include accidents, transport-related deaths, suicide and drowning. Drowning deaths remain a concern for the Committee, in particular for infants and children between 0 to 4 years of age and for children and young people from multicultural backgrounds. An overview of drowning deaths is included in section 2 of the report.

During 2023–24 the Committee continued to review child deaths in South Australia with the aim of identifying legislative or administrative changes that could prevent future deaths. A common theme arising in these reviews included the need for systems and service providers to work together to respond to the needs of families, especially those experiencing complex circumstances. This was particularly evident in the reviews of the deaths of Aboriginal infants, children and young people where coordinated service provision delivered in a culturally responsive way, that acknowledges and considers the voices and experiences of children and their families, may have resulted in different outcomes.

The Committee has continued to improve its knowledge and understanding of issues that impact children and young people, build strategic alliances both within South Australia and nationally, and contribute to discussions between states and territories with the aim of developing a national child death data collection.

Section One

1. Special Report by the Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People

We, the Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People (the Authority), are a group of eight Aboriginal leaders and thinkers that came together in August 2022 to analyse systems and processes in a culturally safe environment and in a way that doesn't restrict Aboriginal ways of understanding when reviewing the death of, or serious injury to, Aboriginal infants, children and young people. We are the first Aboriginal body known to have formed to review Aboriginal child deaths within Australia.

This report includes information about our establishment, our role and the important work we have undertaken in the past 12-months to review the deaths of infants, children and young people in South Australia.

Acknowledgement of Cultural Authority

The Committee extends its gratitude to the Authority for its profound cultural expertise, and cultural reflection and obligation in walking in two worlds. The Authority plays a pivotal role in advising the Committee. The Authority's guidance is instrumental in uncovering the truth behind the mortality of Aboriginal infants, children and young people, as well as highlighting the strengths and partnerships within affected families and local communities. The Committee acknowledges that there is a lot more work to do and is actively considering how best to strengthen the voices of Aboriginal and Torres Strait Islander people and the Authority's commitment to culturally responsive approaches that will reduce the disproportionately high rate of deaths among Aboriginal infants, children and young people.

The Committee also extends its gratitude to outgoing member, Luke Cantley, for his leadership and contribution to the work of the Authority over the past 2 years. Luke was an inaugural member of the Authority.

1.1 Acknowledgements

We acknowledge our presence and work on Kaurna Land.

We acknowledge that we do not reflect all Aboriginal people across Australia.

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. Between 2011 and 2023, the death rate for Aboriginal infants, children and young people in South Australia (8.14 per 10,000) was over three times higher than for their non-Aboriginal peers (2.47 per 10,000). Systemic failures within society, including historical and ongoing injustices and racism, have contributed to the disproportionate number of Aboriginal child deaths.

Prior to the establishment of the Authority in 2022, the Committee relied exclusively on one Aboriginal member to carry the responsibility and the burden of leading the review of the deaths of Aboriginal infants, children and young people. This issue was raised by the Committee's only Aboriginal member, Kurt Towers, highlighting that this arrangement was not culturally safe nor consistent with Aboriginal ways of knowing, being and doing. While the Committee's comprehensive reviews of Aboriginal child deaths revealed a range of factors that impacted on the lives of Aboriginal and Torres Strait Islander children, their families, and communities, the Committee understood the analysis of the deaths of Aboriginal infants, children and young people needed to be culturally responsive and culturally informed. This could only occur through the authority, oversight, knowledge and expertise of Aboriginal people.

In response, and with Ministerial approval, the Committee established the Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People (the Authority) in August 2022.

1.3 The Role of the Authority

Our role, as outlined in the Terms of Reference, is to provide expert advice to the Committee in creating a culturally safe space for the review of the death of, or serious injury to, Aboriginal infants, children and young people. We seek to do this in a culturally responsive and respectful way to amplify the voices of Aboriginal infants, children and young people and disrupt and challenge systems to change using a truth-telling environment. In 2023-24, we reviewed the Terms of Reference and developed a statement (below) that better reflects how we now approach this work - by advocating with authority and drawing on the resilience and strength of our culture:

Authority Role Statement

Our Cultural and Sacred Affirmation:

We vow to forge a future where no Aboriginal infant, child, or young person suffers premature death due to systemic or institutional barriers, or because of inadequate procedures and a lack of culturally safe and responsive support within service provision. Our commitment is unwavering: we will confront these challenges head-on, ensuring that every aspect of care and support is culturally relevant, responsive and considered broadly (every local community has different cultural obligations but has the same respectful protocols), and that systemic failures are rigorously addressed to prevent any further loss. Unified in our mission, drawing on the resilience and strength of our culture, we will advocate with authority, ensuring that the memory of each of these young losses remains illuminated, as we refuse to let the memory of our young ones fade into the shadows.

Our Cultural and Sacred Responsibilities and Obligations:

We, as a collective of Aboriginal people from South Australia, stand together in our sorrow and resolve as we gather to review the tragic, premature loss of Aboriginal infants, children, and young people in South Australia. Sorry Business for local communities can vary via ceremonies and/or funerals following the loss of our little ones and young people, which can profoundly impact us all. We are committed to honouring their lives with unwavering determination. Our resolute dedication drives us to uncover the factors behind each untimely passing and to scrutinize gaps and barriers in system and service provision that demand urgent improvement.

Our Cultural Approach:

Our Authority interrogates each premature loss through a strength-based approach, using the 'Social and Emotional Wellbeing Framework,' including its nine guiding principles that emphasize the holistic and whole-of-life definition held by Aboriginal and Torres Strait Islander peoples. This framework has been created in consultation with Aboriginal and Torres Strait Islander communities across Australia and is informed by cultural ways of knowing, being and doing; it recognises the importance of culture and history as important factors that inform and guide understandings of health and mental health for Aboriginal and Torres Strait Islander peoples. It encompasses expressions and experiences, determinants of health, connection to body and behaviours, mind and emotions, family and kinship, community, culture, Country, and Ancestors, as well as the structural determinants/factors of health. We are intentional with our disruption, our truth-telling advocacy for reforms across institutions, systems, and practices, guided by evidence-based, culturally sound solutions to prevent further premature losses within our families and communities.

1.4 The Authority's work in 2023-24

The Authority has been in operation since August 2022. In our second year, we continued to review the deaths of Aboriginal infants, children and young people using the 'Model of Social and Emotional Wellbeing' developed by Gee, Dudgeon, Schultz, Hart and Kelly in 2014[1] (cited in Commonwealth of Australia 2017[2]). This framework has been created in consultation with Aboriginal and Torres Strait Islander communities across Australia and is informed by cultural ways of knowing, being and doing; it recognises the importance of culture and history as important factors that inform and guide understandings of health and mental health for Aboriginal and Torres Strait Islander peoples. It has assisted us to assess, discuss and formulate recommendations, taking into consideration all aspects of an Aboriginal child's life and the circumstances of their death. This has included looking at cultural, historical and political perspectives and intergenerational history, identifying systemic issues and, most importantly, identifying the strengths of the family and community within the review to prevent future tragedies. We continue to consider other frameworks and additional domains to ensure the model for reviewing deaths is right for current and future members reviewing the tragic and premature loss of Aboriginal infants, children, and young people in South Australia.

Our initial reviews of deaths in 2023-24 continued to find gaps and barriers in system and service provision that demand urgent attention and improvement to prevent further premature losses within Aboriginal families and communities. We also reviewed several deaths of children where parents showed inherent protection of their children and found examples of some services that were more responsive to the needs of the child and family (see 1.6 below).

From these initial reviews of deaths, we have identified the following emerging themes for the Committee to consider in their recommendations in the coming year:

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[1] *Gee G, Dudgeon P, Schultz C, Hart A, and Kelly K, 'Social and Emotional Wellbeing and Mental Health: An Aboriginal Perspective'. Chapter 4, in Dudgeon P, Milroy M, and Walker R (eds.), Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition, Commonwealth of Australia, Canberra, 2014, p.55.*

[2] *Commonwealth of Australia 2017. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet.*

- Support systems, like NDIS and general practice, are often complex and can be biased to supporting people who know the system best or have the loudest voice. How do services ensure access to support is equitable and culturally safe for Aboriginal families and communities?
- The Authority has also reviewed several deaths involving children and young people with high care needs, with multiple services involved, where the parents were overwhelmed due to their own earlier personal journey and trauma related to having to work with practices that have never been or are not Aboriginal culturally informed. In these circumstances, how do support services ensure service provision is culturally informed, coordinated (with a lead agency) and delivered in a culturally responsive way (e.g. busy services taking the time to listen to what is happening in a patient's life and recognising the cultural authority of grandparents, aunties and uncles in supporting overwhelmed parents)?
- The Authority is interested in investigating the way that services report and record information about a child or young person, to ensure the child or young person's voice is at the centre of service delivery, and where case notes identify family strengths and obligations rather than starting with the risks and deficits in a child's life. It is also our experience that bias, judgement and racism are still present across many services, and we are interested in investigating ways service delivery can improve for better outcomes.
- The Authority is also interested in identifying protective measures for Aboriginal people working within predominantly non-Aboriginal workplaces (e.g. health and child protection), including: having to follow expectations that may conflict with cultural approaches, the expectations of Aboriginal workers to solve complex social issues, and the burden of trauma for individuals working in these areas. There are also times when families will request and prefer non-Aboriginal workers due to fear of negative judgements after the death of a child, and we are interested in knowing how services enable 'service of choice' for Aboriginal families.

Our meetings can be extremely challenging for our members who draw on their own lived experience when discussing the circumstances of the deaths of Aboriginal infants, children and young people. In 2023-24, an important initiative of the Committee and the Authority was the engagement of an Aboriginal psychologist to provide a culturally safe space for us to debrief after and between meetings. This initiative allows us to give our all during these difficult conversations.

1.5 An example of protective factors in a strength-based review

In 2023-24, we reviewed the death of an Aboriginal child with a life-limiting condition who died due to natural causes in a regional town in South Australia. When interrogating how this child died, we found that inherently strong protective factors were present in the child's family and community, and services were, at times, responsive to their needs.

Both parents had a difficult time in their childhood but were strong and supported their child from birth and throughout the child's illness and death. They worked closely with Aboriginal workers within regional health services and providers. Aboriginal health workers provided care and support to the child and supported the family to engage with services when needed. When the child's illness was diagnosed, the family and community made the child's life as comfortable and enjoyable as possible. During the palliative care stage of the child's life, an end-of-life plan was developed with the child, child's family and palliative care services, which enabled the child to die on Country with family.

There are many challenges for services in meeting the cultural needs of Aboriginal families and local communities and this can only be addressed by services working together and not in isolation. There is a lot more to do to de-colonise services and make them culturally safe and culturally informed for Aboriginal families and communities, and we will continue to highlight examples, like this one, of strength-based approaches that may prevent future tragedies or reduce the burden of trauma on Aboriginal families and communities.

Section Two

2. Child Deaths South Australia 2011-2023

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

Data Snapshot

Between 2011-2023 there were **1,285** **child deaths in South Australia**

53.8% **were Infants** (under 1 year)

913 were from **diseases and morbid conditions**

Aboriginal children were **5.2%** of the child population but made up **13.3%** of child deaths **8.2%** died from **diseases and morbid conditions**

913 were from natural causes

Deaths from non-natural causes:

- 94 transport-related deaths
- 91 undetermined
- 68 suicides
- 40 deaths by accident
- 28 drowning deaths
- 26 deliberate acts by another or neglect
- 11 SIDS
- 4 fire-related deaths

**There are 10 pending*

Transport-related deaths include pedestrian deaths, car and motorbike accidents, water transport, go-kart accidents and other off-road accidents.

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*[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.

[3] https://www.legislation.sa.gov.au/

Figure 1: Death rate by year of death and sex for all children and young people, South Australia 2011-2023

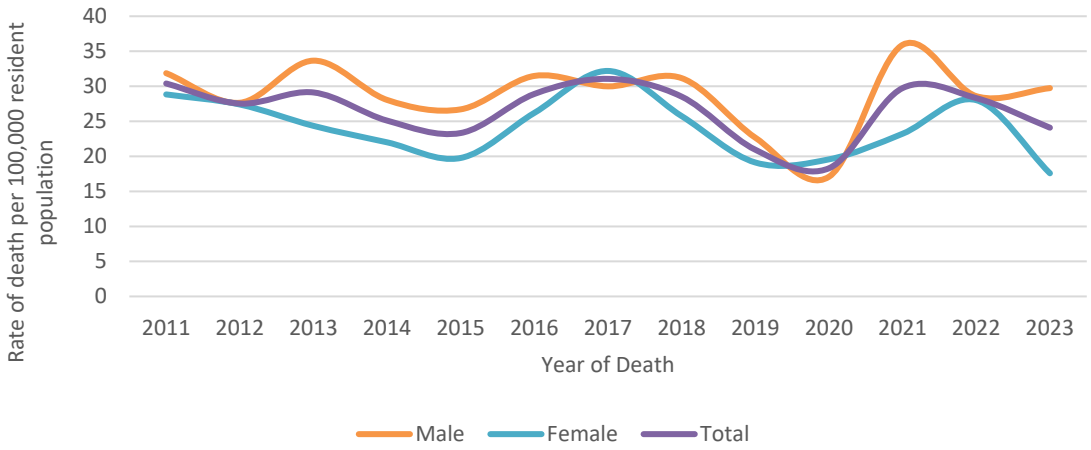


Figure 1[4] shows death rates for all children and young people who died in South Australia from 2011 to 2023.[5]

The Committee observed the lowest number of child deaths on record consecutively in 2019 (81 deaths) and 2020 (73 deaths). However, in 2023, 93 children and young people died in South Australia. The rate of deaths continues to be higher for males (29.74 per 100,00 resident children, n=59), than it does for females (17.58 per 100,000 resident children, n=34).

Where a child or young person identified as non-binary gender, they were included in the category relevant to their sex at birth. The Committee intends to further develop its data collection on gender.

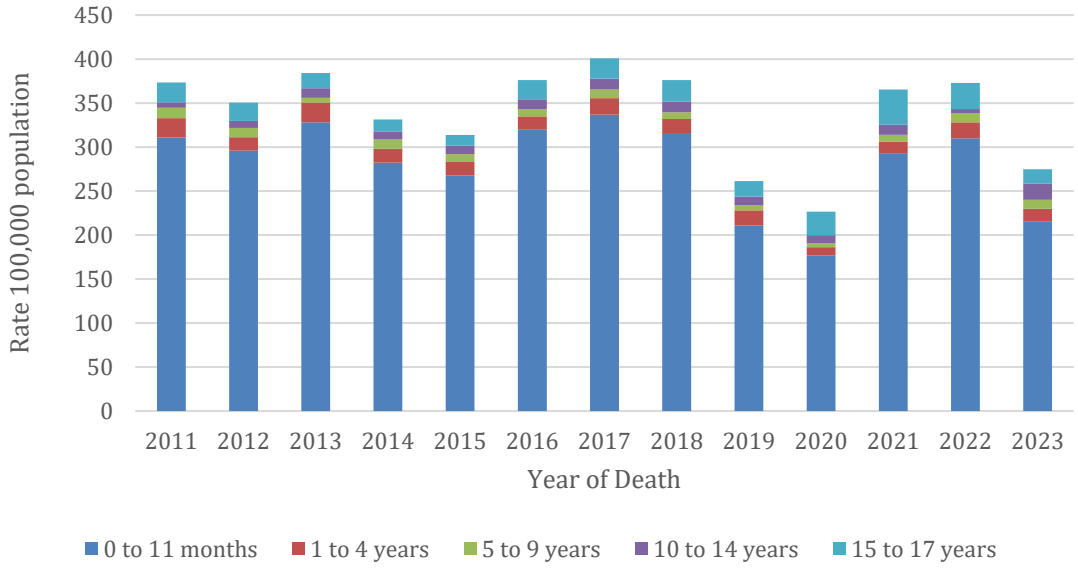
In the period 2011 to 2023, there were 109 child deaths of children who died in South Australia but their usual residence was outside of South Australia.

[4] For each figure in Section One, there is corresponding data available on Data.SA
[5] An estimated resident population of children and young people aged 0 to 17 has been used based on the Census for 2011, 2016 and 2021.

2.2.1 Death rates by age

Figure 2 shows the deaths of children and young people by age group. The largest proportion of deaths occurs in infants less than 28 days of age. According to the Australian Institute of Health and Welfare (AIHW) 2024 report[6], in 2021 the most common causes of neonatal death were related to spontaneous preterm labour or rupture of membranes, congenital anomaly, and antepartum haemorrhage.

Figure 2: Death rate by year of death and age for all children and young people, South Australia 2011–2023

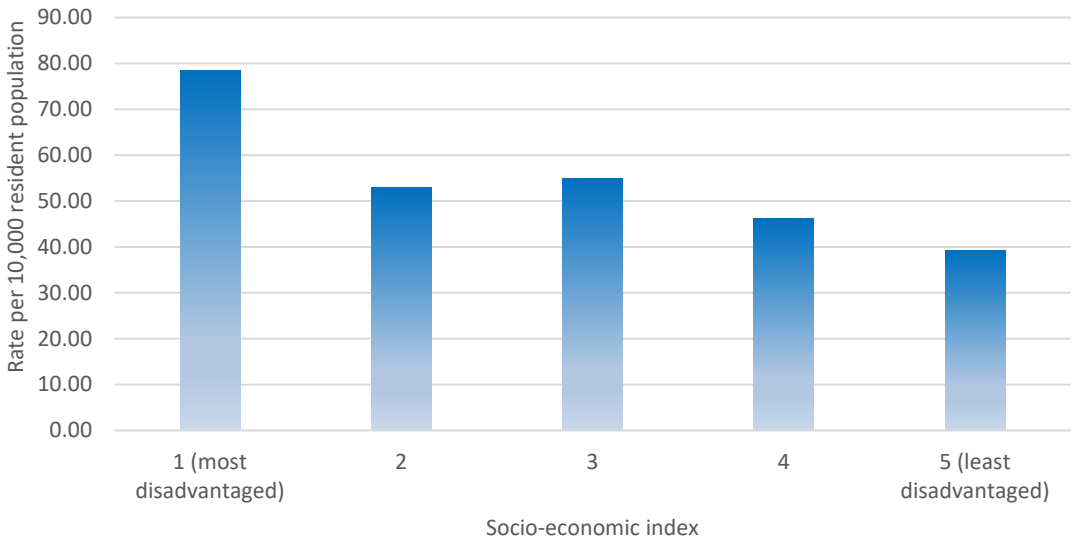


[6] *AIHW. (2024). Australia's mothers and babies. [online] Available at: https://www.aihw.gov.au/getmedia/bf03fda0-6d37-46f3-8ba6-9c3ebadc26f8/australia-s-mothers-and-babies.pdf?v=20240924161254&inline=true [Accessed 30 Oct. 2024].*

2.2.2 Death rates by socio-economic disadvantage

In the reporting period 2011 to 2023 the rate of deaths for children and young people was highest in areas of most disadvantage, in comparison to areas of least disadvantage where the rate of child death was 39.24 per 10,000 resident children (Figure 3). Most child deaths occurred in the northern metropolitan region of Adelaide accounting for 26.2% of child deaths, with the fewest in the Fleurieu and Kangaroo Island region at 2.7%.

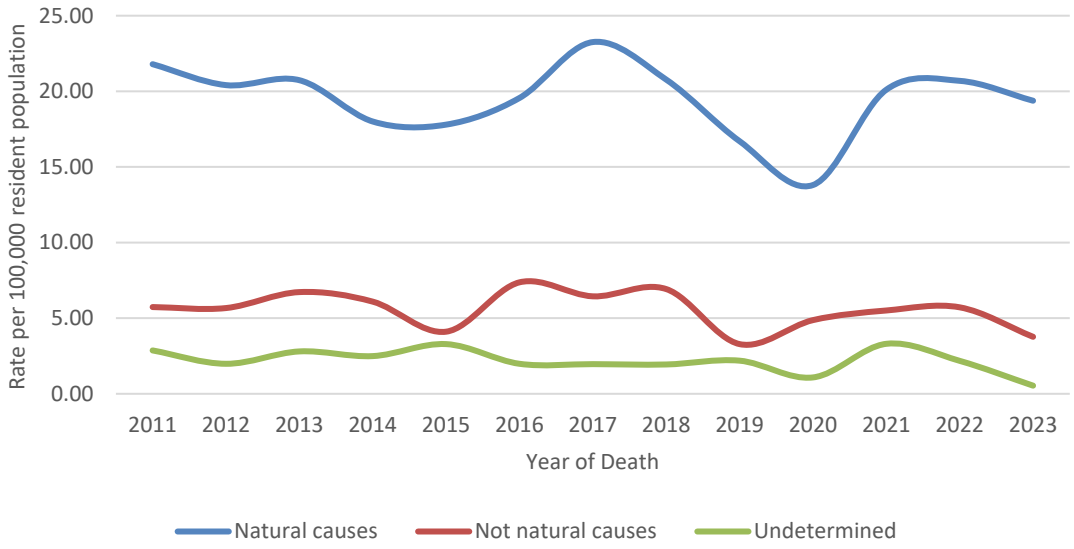
Figure 3: Death rate by socio-economic advantage and disadvantage for all children and young people, South Australia 2011–2023



2.2.3 Death rates by category of death

During the period 2011 to 2023 most deaths of children and young people were due to natural causes (Figure 4). For natural causes the rate of death for 2023 was 19.38 per 100,000 resident children (n=72), while in 2022 the rate of death was 20.69 per 100,000 resident children (n=76). The category ‘not natural causes’ includes death by accident, transport-related, fire-related, drowning, suicide, neglect and deliberate act by another. The rate of death for ‘not natural causes’ was 3.77 per 100,000 resident children for 2023 (n=14), and 5.72 per 100,000 resident children for 2022 (n=21). Death due to ‘undetermined’ causes is a category of death used by the Committee when a pathologist or the Coroner was not able to attribute a definite cause for a death.

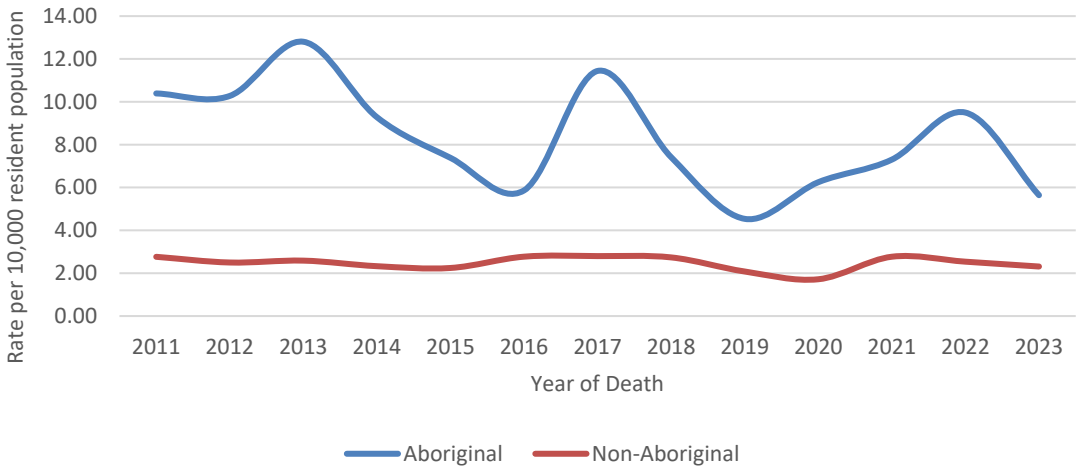
Figure 4: Death rate by category of death for all children and young people, South Australia 2011–2023



2.2.4 Deaths of Aboriginal children and young people

During the period 2011 to 2023 (Figure 5), the rate of death for all Aboriginal children and young people in South Australia was 8.14 deaths per 10,000 resident children. This rate also 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 2.47 deaths per 10,000.

Figure 5: Death rate for Aboriginal and Non-Aboriginal children and young people, South Australia 2011–2023



2.3 Comparison of SA data with other jurisdictions

The Queensland Family and Child Commission (QFCC) collects aggregate data from Australian states and territories to provide an Australian child death statistics report comparing the deaths of children by state/territory. With permission from the QFCC analyses have been repeated here.

The following analysis comprises the deaths of children from birth to 17 years of age during the period 1 January 2018 to 31 December 2021. Caution should be exercised when comparing rates between jurisdictions. Child deaths are rare events and variations in jurisdictional rates can be expected due to the small numbers involved (Australian child death statistics 2021, QFCC).

Figure 6 shows the mortality rates for all children and young people, aged 0-17 years, in each Australian state and territory from 2018 to 2021. Year to year changes should be interpreted with caution, especially for jurisdictions with smaller populations.

Figure 6: Death rate for all children by jurisdictions 2018 to 2021

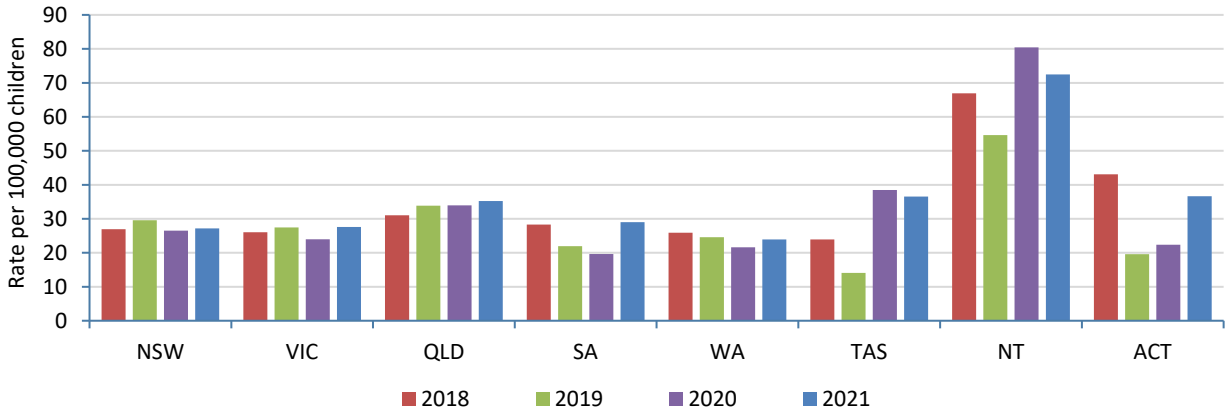
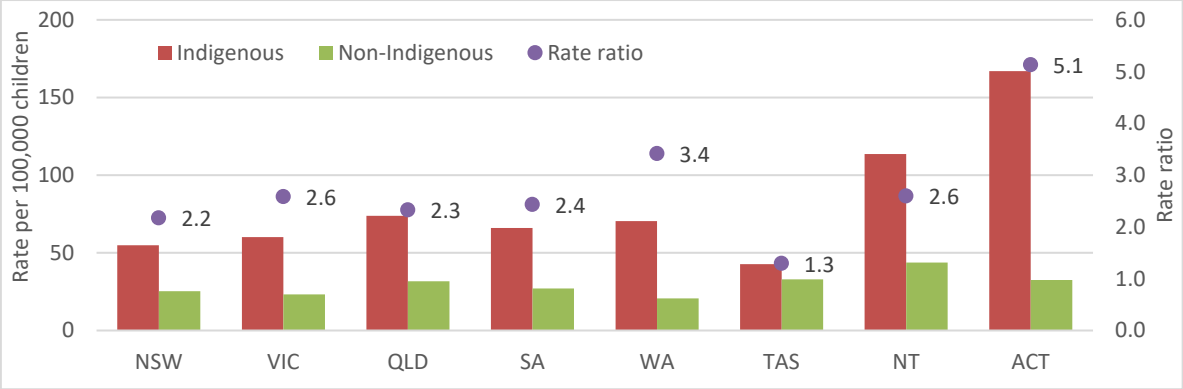


Figure 7 shows Aboriginal and non-Aboriginal child mortality rates in each jurisdiction. Aboriginal children were over-represented in child deaths in comparison to non-Aboriginal children, with the rate ratios ranging between 1.3 in Tasmania and 5.1 in the Australian Capital Territory.

Figure 7: Death rate for all children by Aboriginal status and jurisdictions 2021



2.4 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.

2.4.1 Review of drowning deaths

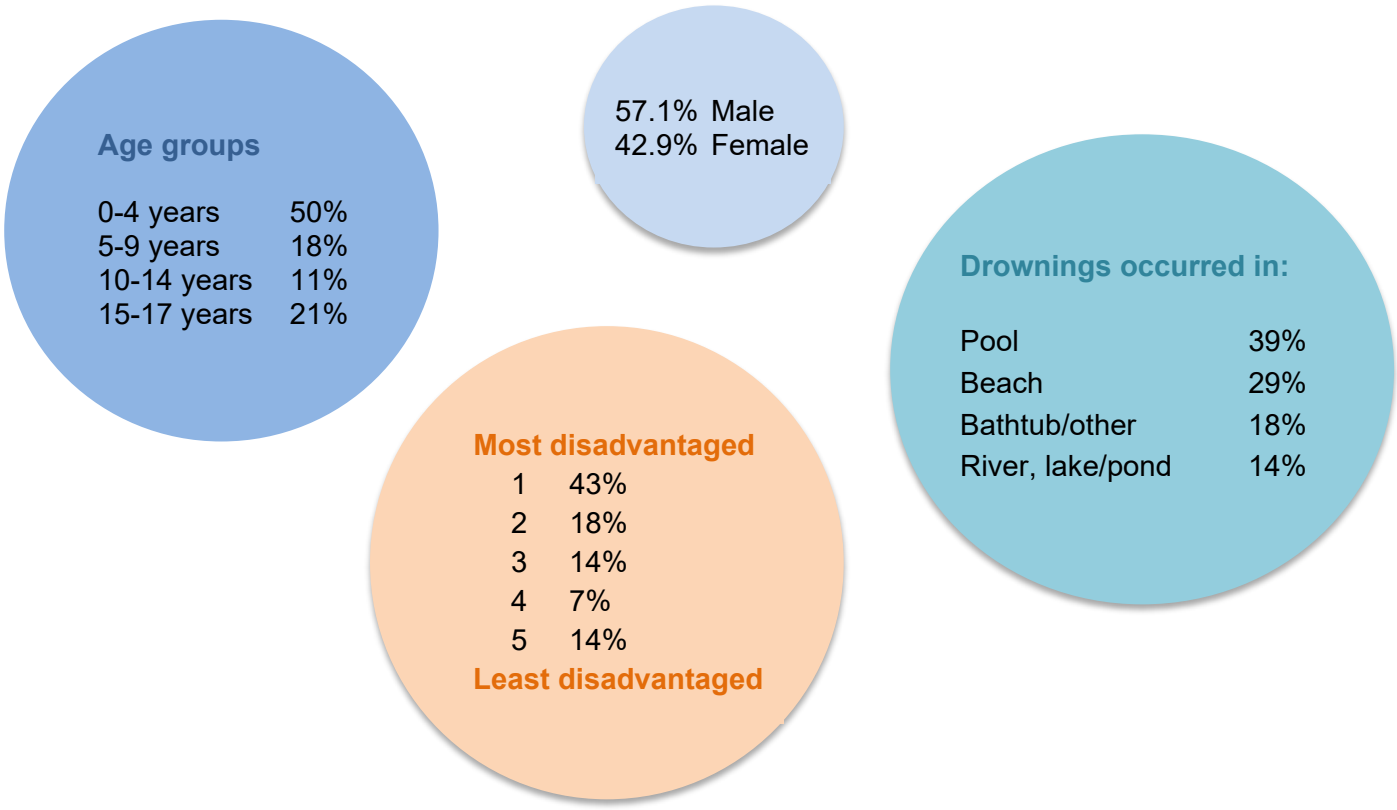
The Committee remains concerned about the deaths of children and young people due to drowning. For the reporting period 2011 to 2023, there were 28 children and young people who drowned (7.5 per 100,000 resident children). Since 2005 there have been a total of 46 drowning deaths of children and young people reported in South Australia. Fifty percent of those who drowned between 2011 and 2023 were in the 0 to 4 year age group, with the next highest proportion in the 15 to 17 year age group (21%). In both of these age groups, equal numbers were male and female, however overall there were more male deaths from drowning than female. The *National Drowning Report*

2023[7] published by Royal Life Saving Australia reports that there are more male deaths from drowning for all ages.

Of the 28 children and young people who drowned between 2011 and 2023, 42.9% were from the most disadvantaged areas compared to 14.3% from the least disadvantaged areas.

Drowning deaths occurred mostly in swimming pools (39.3%), with 28.6% drownings being at the beach. Half of the 28 drownings occurring in the period 2011 to 2023 were children and young people from a multicultural background, who were born overseas, or their parents were born overseas. The *National Drowning Report 2024*[8] (RLSA) reports an increase in Australia of drowning deaths involving people born overseas, highlighting that partnerships and collaboration among water safety organisations, swim program providers and multicultural agencies is important to drive community change and awareness.

Drowning deaths in South Australian children



[7] *Royal Life Saving Society – Australia (2023) National Drowning Report 2023, Sydney Australia.*
[8] *Royal Life Saving Society – Australia (2024) National Drowning Report 2024, Sydney Australia. https://doi.org/10.62977/85070*

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.

A review of the Committee's legislation identified opportunities to undertake reviews at an earlier stage, in some circumstances.

The Children and Young People (Oversight and Advocacy Bodies) (Child Death and Serious Injury Review Committee) Amendment Bill 2024 provides for the Committee to review a case of child death or serious injury where directed to by the Minister, in certain circumstances, even where it may be the subject of a Coronial inquest or inquiry or an ongoing criminal investigation. The Children and Young People (Oversight and Advocacy Bodies) (Child Death and Serious Injury Review Committee) Amendment Bill 2024 was passed in the Legislative Council on 23 September 2024.

3.2 The Committee's Strategic Action Plan

The Committee has 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 2023–24. At each meeting, the Committee considered 8 to 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
- Complex Support Needs Branch - National Disability Insurance Agency

3.2.2 Building strategic alliances

Ministerial engagement

In 2023 the Hon Blair Boyer, Minister for Education, Training and Skills led the presentation to the Early Intervention Cabinet Committee (EICC) of recommendations by the Committee. The recommendations presented have ongoing relevance and the potential to improve the safety of children and young people. The EICC chaired by the Deputy Premier, the Hon Susan Close MP aims to drive policy and reform programs to support vulnerable families and ensure people are supported from early childhood to succeed and participate.

Many of the Committee's recommendations focus on the challenges for services in providing effective outcomes for children and young people with complex lives. It is recognised that significant change is likely to require long-term commitment and investment. Continuous improvement is essential to achieving the best possible outcomes for children and young people. Final responses from across government about the progress with implementation of the Committee's recommendations will be compiled.

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 and reducing the number and severity of injuries amongst children aged up to 15 years linked to consumer products.

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 and resources and when medical demands are high, such as

with complex, severe, and chronic illness[9][10]. These illnesses are often life-limiting without treatment. 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 has recommended the development of an effective multi-agency service for the rapid identification and response to the neglect of expected critical medical care. The response should incorporate:

- An effective mechanism to identify infants, children and young people at risk.
- Rapid access to medical expertise regarding chronic health conditions that require prompt treatment
- Timely and effective escalation procedures to ensure all agencies are invested in and prioritise working collaboratively together with the parents/carers and their families/kin to maximise the infant, child or young person's access to medical care.
- An across government multiagency case review response at the executive level that can allocate an agency lead for the case, expedite responses and receive reports on progress and follow up by individual agencies who are working together collaboratively.

The Committee's submission to SA Health on the establishment of a separate policy on Medical Neglect of Children and Young People noted the importance of recognising the social factors in the child's life that contribute to an increased risk of neglect of medical care. The Committee will continue to monitor the effectiveness of action to prevent the deaths of children and young people experiencing medical neglect.

Paediatric Complex Care Services

The Committee reviewed the death of a child who lived with a complex health condition and intellectual disability in circumstances of vulnerability. In the Committee's view the family would have benefited from sustained assistance to manage complex, ongoing and increasing interactions across health, education, child protection and disability

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[9] *Boos SC, Fortin K, Medical neglect. Pediatr Ann. 2014;(11):e253-e259. Doi:10.3928/00904481-20141022-08*
[10] *SA Health. Medical neglect of children and young people. 24 June 2024. Government of South Australia https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/medical+neglect+of+children+and+young+people+policy*

services, including ongoing psychological support. The Committee recommended that SA Health consider establishing a statewide paediatric complex care service with team-based, multi-disciplinary and family-centred care for children experiencing complex health needs. This should include embedded psychological services.

Complex care programs are increasingly recognised as an efficient and effective response to providing health and social care to people with chronic illness who have experienced uncoordinated access to health, disability and social service. Complex care programs incorporate family-centred care, integrated interdisciplinary team approaches, relational care coordination, high quality communications, prioritise the lived experience of the child and family, and embed quality evaluation. Services are often close to home and responsive to changes in the intensity of the disease process experienced by the child and family. Complex care programs also build capacity within the family to self-manage the day-to-day challenges of complex and ongoing care[11]. In the Committee's view, the current paediatric complex care services located at Woman's and Children's Hospital should be funded to meet the need of families caring for children with complex and ongoing health conditions.

Other government agencies

During 2023-24 the Committee continued to maintain relationships through liaison officers of relevant government agencies to help inform reviews of child deaths and serious injuries. The agencies include South Australia Police, Department for Child Protection, SA Health and the Department for Human Services. In addition, regular meetings with officers from the National Disability Insurance Agency (NDIA) commenced in 2023 to gain an understanding of its policies and legislation.

3.2.3 Making data real and useful

Work towards the Australian National 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

[11] *Humowiecki M, Kuruna T, Sax R, Hawthorne M, Hamblin A, Turner S, Mate K, Sevin C, Cullen K. Blueprint for complex care: advancing the field of care for individuals with complex health and social needs. www.nationalcomplex.care/blueprint. December 2018.*

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 May 2022, the ANZCDRPG agreed to develop a national child death data collection at the Australian Institute of Health and Welfare (AIHW). The benefits of national reporting on child deaths will include raising awareness of the causes of child death in Australia and taking collaborative action to prevent child deaths. The child death data collection will also identify national trends and emerging patterns in child death.

There is currently no standard across Australian jurisdictions for the collection of information on child deaths. In November 2023 and August 2024, with leadership from South Australia, the first Data Advisory Committee meetings were held. Membership is comprised of representation from each state and territory child death review team, with observers and temporary members invited when their expertise is required. AIHW participated to provide advice on the development of the data collection. The Committee aims to advise the ANZCDRPG on the scope of and development of data items for inclusion in the national data collection for child deaths. It is envisaged that agreed data items will be developed in a format suitable for the Metadata Online Registry (METEOR) held at AIHW to form a national best endeavours data set for Australian child deaths.

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 (0.7 FTE)
Ms Nikki Kearney	Administration and Information Officer (1.0 FTE)
Ms Georgia Lefty	Senior Data Analyst (1.0 FTE) from 28 August 2023
Mr Philip McNamara	Project Officer (0.6 FTE)
Ms Carol Nightingale	Executive Officer (1.0 FTE) until 8 March 2024

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 statistical area (level 2) of the Australian Statistical Geography Standard (ASGS), has been calculated on the assumption of a linear growth of 1.16% over time.

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.[12]

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.

[12] *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.*

Appendix of Data Tables

Table 1: Death rate by year of death and sex for all children and young people, South Australia 2005-2023

Year	Sex	Number of deaths	Rate per 100,000 estimated resident population (0-17 years)
2005	Female	58	34.50
	Male	78	43.88
	Total	136	39.32
2006	Female	70	41.63
	Male	49	27.57
	Total	119	34.41
2007	Female	42	24.98
	Male	80	45.01
	Total	122	35.27
2008	Female	44	26.17
	Male	70	39.38
	Total	114	32.96
2009	Female	57	33.14
	Male	70	38.67
	Total	127	35.98
2010	Female	40	23.26
	Male	77	42.54
	Total	117	33.14
2011	Female	58	34.14
	Male	48	26.84
	Total	106	30.40
2012	Female	48	27.85
	Male	51	28.11
	Total	99	27.99
2013	Female	44	25.17
	Male	64	34.78
	Total	108	30.10

Year	Sex	Number of deaths	Rate per 100,000 estimated resident population (0-17 years)
2014	Female	46	25.93
	Male	50	26.77
	Total	96	26.36
2015	Female	38	21.10
	Male	54	28.49
	Total	92	24.89
2016	Female	45	26.21
	Male	57	31.48
	Total	102	28.91
2017	Female	57	32.72
	Male	56	30.48
	Total	113	31.57
2018	Female	47	26.59
	Male	60	32.18
	Total	107	29.46
2019	Female	36	20.06
	Male	45	23.78
	Total	81	21.97
2020	Female	38	20.86
	Male	35	18.22
	Total	73	19.50
2021	Female	41	23.23
	Male	67	35.92
	Total	108	29.75
2022	Female	51	28.46
	Male	55	29.05
	Total	106	28.76
2023	Female	34	18.69
	Male	59	30.69
	Total	93	24.85

Table 2: Death rate by year of death and Aboriginal / Non-Aboriginal for all children and young people, South Australia 2005-2023

Year	Background	Rate per 10,000 estimated resident population (0-17 years)
2005	Aboriginal	12.31
	Non-Aboriginal	3.58
	Total	3.93
2006	Aboriginal	8.69
	Non-Aboriginal	3.22
	Total	3.44
2007	Aboriginal	10.14
	Non-Aboriginal	3.25
	Total	3.53
2008	Aboriginal	7.96
	Non-Aboriginal	3.07
	Total	3.27
2009	Aboriginal	7.73
	Non-Aboriginal	3.41
	Total	3.60
2010	Aboriginal	5.80
	Non-Aboriginal	3.20
	Total	3.31
2011	Aboriginal	10.39
	Non-Aboriginal	2.77
	Total	3.04
2012	Aboriginal	10.27
	Non-Aboriginal	2.50
	Total	3.00
2013	Aboriginal	12.80
	Non-Aboriginal	2.59
	Total	3.01

Year	Background	Rate per 10,000 estimated resident population (0-17 years)
2014	Aboriginal	9.28
	Non-Aboriginal	2.33
	Total	2.64
2015	Aboriginal	7.38
	Non-Aboriginal	2.24
	Total	2.49
2016	Aboriginal	5.86
	Non-Aboriginal	2.77
	Total	2.89
2017	Aboriginal	11.44
	Non-Aboriginal	2.80
	Total	3.16
2018	Aboriginal	7.41
	Non-Aboriginal	2.74
	Total	2.95
2019	Aboriginal	4.54
	Non-Aboriginal	2.08
	Total	2.20
2020	Aboriginal	6.25
	Non-Aboriginal	1.72
	Total	1.95
2021	Aboriginal	7.30
	Non-Aboriginal	2.77
	Total	2.97
2022	Aboriginal	9.50
	Non-Aboriginal	2.54
	Total	2.88
2023	Aboriginal	5.64
	Non-Aboriginal	2.31
	Total	2.49

Table 3: Death rate by year of death and Category of death for all children and young people, South Australia 2005-2023

Year	Category of death	Number of deaths	Rate per 100,000 estimated resident population (0-17 years)
2005	Natural causes	92	26.60
	Not natural causes	38	10.99
	Undetermined	6	1.73
2006	Natural causes	71	20.53
	Not natural causes	41	11.85
	Undetermined	7	2.02
2007	Natural causes	81	23.42
	Not natural causes	30	8.67
	Undetermined	11	3.18
2008	Natural causes	78	22.55
	Not natural causes	27	7.81
	Undetermined	8	2.31
2009	Natural causes	88	24.93
	Not natural causes	28	7.93
	Undetermined	11	3.12
2010	Natural causes	79	22.38
	Not natural causes	25	7.08
	Undetermined	13	3.68
2011	Natural causes	76	21.79
	Not natural causes	20	5.74
	Undetermined	10	2.87
2012	Natural causes	72	20.41
	Not natural causes	20	5.67
	Undetermined	7	1.98
2013	Natural causes	74	20.74
	Not natural causes	24	6.73
	Undetermined	10	2.80

Year	Category of death	Number of deaths	Rate per 100,000 estimated resident population (0-17 years)
2014	Natural causes	65	18.00
	Not natural causes	22	6.09
	Undetermined	9	2.49
2015	Natural causes	65	17.80
	Not natural causes	15	4.11
	Undetermined	12	3.29
2016	Natural causes	69	19.56
	Not natural causes	26	7.37
	Undetermined	7	1.98
2017	Natural causes	83	23.26
	Not natural causes	23	6.44
	Undetermined	7	1.96
2018	Natural causes	75	20.77
	Not natural causes	25	6.92
	Undetermined	7	1.94
2019	Natural causes	61	16.70
	Not natural causes	12	3.29
	Undetermined	8	2.19
2020	Natural causes	51	13.80
	Not natural causes	18	4.87
	Undetermined	4	1.08
2021	Natural causes	73	20.11
	Not natural causes	20	5.51
	Undetermined	12	3.31
	Pending	3	0.83
2022	Natural causes	76	20.69
	Not natural causes	21	5.72
	Undetermined	8	2.18
	Pending	1	0.27

Year	Category of death	Number of deaths	Rate per 100,000 estimated resident population (0-17 years)
2023	Natural causes	72	19.38
	Not natural causes	14	3.77
	Undetermined	2	0.54
	Pending	5	1.35

Category of death for 'Not natural causes' includes: accident, transport-related, fire-related, drowning, suicide, neglect, deliberate act by another.

Pending refers to those that are waiting cause of death to be determined by the Coroner.