

Part I: Introduction and overview

Chapters 1–4

This section provides a historical overview of child death review in Australia, as well as the methodology employed for this report and an overview of child deaths in Queensland for both the 2004–05 and 2005–06 financial years.

Chapter 1

Child death review in Australia

“We usually know the cause of a child’s death, but we need to know the context of the death if we are to prevent it. Information about cause is often immediately available: the child was run over by a car; the young man shot himself; or the baby was beaten to death by her father. None of these causes tells us very much, yet the information needed to understand the context of these deaths often exists. It exists in a dozen different filing cabinets in a dozen different offices, but it is never brought together. The family general practitioner has information; the Children, Young Persons and Their Families Agency has information, the local church social service agency has information, the drug and alcohol services have information, the hospital has information, and the police have information – if it can be brought together we can start to understand the whole context”
(Bob Simcock, *New Zealand Child Mortality Review Board Bill, Second Reading, 28 April 1999*).

Key issues

- Most states and territories of Australia have implemented child death review mechanisms in various forms and stages of development. The Northern Territory and Tasmania are in the process of drafting legislation and advocating for the introduction of formal child death review systems.
- Child death review teams from all states and territories are convening to progress the development of a minimum dataset for reporting, to ensure comparable data across all jurisdictions.

The child death review movement

The past 30 years have seen increased attention directed to the phenomenon of child abuse and neglect, and child protection systems have been created and reformed in the wake of public and official concern (Reder & Duncan 2004:96).

While child death review teams initially started as a response to the need for a systematic review of child deaths where abuse or neglect was suspected, the overall concern with child protection has incorporated an increased interest in studying the patterns and trends of all child deaths and serious injuries. Consequently many teams have an expanded focus on all child deaths – both natural deaths and coronial cases such as suicide and deaths from accidental injury (Durfee, Gellert & Tilton-Durfee 1992:3175).

In accordance with this development, the prevention of child death from ‘external’ or ‘preventable’ causes¹⁴ has become the focus of much of the research in this area. Public health research has challenged the belief that injury-related deaths are typically the result of unpreventable ‘accidents’, contending that many injuries are not accidents or random, uncontrollable acts of fate, but rather that a significant number of injuries are predictable and preventable (Houk, Brown & Rosenberg 1987:576). Examples of public health initiatives in the area of child injury prevention include changes and improvements to mandatory pool fencing, standards for children’s nursery products and reductions in speed limits on suburban roads.

The child death review movement can be considered an integral part of the public health approach to child death and injury prevention.¹⁵ As outlined by Onwuachi-Saunders and colleagues (1999:276), this approach entails:

14 The Commission defines a preventable death as one which may have been avoided with reasonable medical, educational, social, legal or psychological intervention. These judgements are frequently made with the benefit of information unavailable at the time of death; therefore a finding of preventability does not imply that the circumstances leading to death were predictable. (Definition adapted from Durfee, Tilton-Durfee & West 2002).

15 Public health is defined as the “organised response by society to protect and promote health and to prevent illness, and implementing interventions, in the population as a whole, or population sub-groups”. Defined in this way, ‘public health’ encompasses research in the areas of public safety and injury prevention. Definition taken from ‘A Memorandum of Understanding: To establish a National Public Health Partnership for Australia’, 1997, and modified from that proposed in J. M. Last, *Public Health and Human Ecology* (Connecticut: Appleton and Lange, 1987).

... defining the issue through data collection or surveillance; analysing data to identify potential risk factors, enabling factors, and barriers; developing interventions based on the analysis; implementing interventions through community based programs; and using evaluation results to modify and re-evaluate original interventions.

The public health approach is reflected in the ultimate purpose of child death review: to integrate data collected from the investigation of child deaths and perform in-depth review and analysis to discover patterns, trends and risk factors in child death. This information can then be used to create informed policy and procedure aimed at preventing future child deaths (Bunting & Reid 2005:83; Durfee, Gellert & Tilton-Durfee 1992:3172; Elster & Alcalde 2003:303).

Systematic child death review can:

- assist in the accurate identification and uniform classification of causes of death, thereby decreasing their misclassification
- improve epidemiological understanding of causes of death and risk factors
- identify patterns and trends in child deaths
- identify gaps in service delivery and system weaknesses, and
- recommend programs, interventions and policy and/or legislative changes designed to prevent or decrease child morbidity and mortality (Elster & Alcalde 2003:304; Onwuachi-Saunders et al. 1999:279).

Child death review in Australia

Queensland

The impetus for the introduction of child death review functions in Queensland was provided by reports of two key government agencies that highlighted deficiencies in the Queensland child protection system. The Queensland Ombudsman's 2003 report *An investigation into the adequacy of the actions of certain government agencies in*

relation to the safety, wellbeing and care of the late baby Kate, who died aged 10 weeks (the Baby Kate Report) and the Crime and Misconduct Commission's 2004 report *Protecting Children: An inquiry into abuse of children in foster care* made wide-ranging recommendations of reform to the child protection system. These included the establishment of child death research functions within the Commission for Children and Young People and Child Guardian.¹⁶

The Commission's child death review functions commenced on 1 August 2004. Under Part 4A (Child Deaths) of the *Commission for Children and Young People and Child Guardian Act*, the Commission is responsible for:

- maintaining a register of the deaths of all children and young people in Queensland
- reviewing the causes and patterns of deaths of children and young people
- conducting broad research in relation to child deaths
- making recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child death, and
- preparing an annual report to Parliament and the public regarding child deaths.

These child death functions are undertaken by Commission employees. The team consults with expert advisers or convenes advisory committees as appropriate.¹⁷ Although reviewing all deaths, the Commission currently has a greater analytical focus on external causes of death and sudden unexpected deaths in infancy than on natural causes, as it is believed that the precipitating circumstances of external causes of death are more easily predicted, and thereby prevented.

The Commission's inaugural *Annual Report: Deaths of children and young people, Queensland, 2004–05* was released on 31 October 2005. This report provided a detailed discussion of the major external causes of child death: transport incidents, drowning, suicide, fire, fatal assault and accidental causes, as well as sudden unexpected deaths in infancy (SUDIs).

16 The Commission's *Annual Report: Deaths of children and young people, Queensland, 2004–05* provides a detailed overview of the impetus for the establishment of child death review functions in Queensland.

17 Part 5 (Advisory Committees) of the *Commission for Children and Young People and Child Guardian Act*.

The Commission is currently working on a number of specialised research projects dedicated to youth suicide, fatal assault and neglect, and rural deaths.

Child Death Case Review Committee

Recommendations arising from the CMC and Baby Kate reports also stipulated the necessity for both internal and external review of the involvement of the agency with statutory responsibility for child protection in all cases of the death of a child within the child protection system. As well as undertaking child death research, the Commission provides full secretariat support to the Child Death Case Review Committee (CDCRC), an independent committee established to increase accountability and improve effectiveness in decision-making in the child protection system.

Since 1 August 2004, the Queensland Department of Child Safety (DChS) has been required to conduct a review of its involvement with such cases where the child was known to the Department within 3 years before death.¹⁸

The CDCRC considers the adequacy of the review conducted by the DChS,¹⁹ and makes recommendations about:

- improving policies which impact on services to children in the child protection system
- improving relationships between the Department and other agencies involved with the children and their families, and
- taking disciplinary action against any departmental staff in relation to their involvement with a child.

The CDCRC is a multi-disciplinary committee made up of experts in paediatrics, child health and investigations. The Commissioner for Children and Young People and Child Guardian is the Chair and the Assistant Commissioner is also a member. The Commission provides full secretariat support to this body.

The *Child Death Case Review Committee Annual Report, 2004–05: Reviews of child deaths in the Queensland child protection population* was tabled in Parliament by the Premier in November 2005.²⁰

New South Wales²¹

The New South Wales (NSW) Child Death Review Team (CDRT) was established in 1995 under Chapter 7A of the *NSW Commission for Children and Young People Act 1998* as a result of reports indicating that the systematic collection of information regarding the circumstances of child deaths was necessary to inform policy and procedure in order to prevent future child deaths.

Under section 45N of the Act, the CDRT functions include:

- maintaining a register of all child deaths occurring in NSW
- classifying those deaths according to cause of death and other relevant factors such as demographics, and analysing the patterns and trends in child death which emerge
- undertaking research aimed at preventing or reducing the likelihood of child deaths
- making recommendations regarding legislation, policy and practice to help reduce child death, and
- identifying areas requiring further research by the team or other agencies or persons.

Meeting no less than four times per year, the team reports annually to Parliament. Additional research reports produced by the NSW CDRT have covered areas such as fatal assault and neglect, suicide and SUDI.

Although the legislation specifying the functions of child death review teams in both Queensland and New South Wales is notably similar, in contrast to Queensland's team, the NSW CDRT is a multi-disciplinary team composed of independent experts in the fields of paediatrics and child health, forensic pathology, mental health and child protection. State government agencies concerned with the safety and

18 Although the former Department of Families had a policy requiring the review of deaths of children in the child protection system, it is now a statutory requirement that the DChS conduct a review of its involvement in cases where a child is known to the Department within 3 years before death.

19 The DChS has 6 months from the time it learns of the child's death to provide the CDCRC with a report.

20 This report provided a detailed overview of the history, role and functions of the CDCRC.

21 The following information was kindly provided by Gillian Calvert, Convenor, New South Wales Child Death Review Team and New South Wales Commissioner for Children and Young People.

wellbeing of children are also represented, with nominees from departments including Community Services; Education and Training; NSW Health; Ageing, Disability and Home Care; NSW Police; Attorney-General; and the Office of the State Coroner.

Like Queensland, the NSW CDRT focuses on the analysis of external causes of death and sudden unexpected death in infancy.

New South Wales Ombudsman

The NSW Ombudsman is responsible for undertaking reviews of the deaths of children in care, as well as children who were known to the Department of Community Services (DoCS) within 3 years before their death. The NSW Ombudsman also reviews the deaths of children who are siblings of a child known to the DoCS, children who may have died from abuse or neglect, or in suspicious circumstances, and children in detention. The Ombudsman focuses largely on systemic issues, with individual deaths reviewed as necessary. The NSW Ombudsman reports annually to Parliament.

Victoria

Consultative Council on Obstetric and Paediatric Mortality and Morbidity²²

Victoria's Consultative Council on Obstetric and Paediatric Mortality and Morbidity (the Council) was established in 1962 under the *Health Act 1958* (Vic.) and reviews all maternal, perinatal and paediatric deaths in Victoria.²³ Its functions are:

- studying, researching and analysing the incidence and causes of maternal deaths, stillbirths and the deaths of children less than 18 years of age
- maintaining a perinatal data collection unit
- maintaining a register of congenital abnormalities
- providing information to be used in the instruction of medical and other healthcare

professionals in the fields of obstetrics and paediatrics

- conducting additional research as requested by the Minister, and
- publishing an annual report.

Annual reports of the Council on infant deaths have been produced since 1984, and on child deaths since 1985.

In contrast to child death research in Queensland and New South Wales, the Council's focus is primarily on the medical cause of death. Council reports discuss both natural and external causes of death, but detailed analysis of risk factors associated with child deaths that may have been preventable is not published.

Office of the Child Safety Commissioner²⁴

Before the establishment of a Child Safety Commissioner in Victoria, the Child Death Inquiry Unit of the Department of Human Services (DHS) prepared child death inquiry reports for those children known to the Department within 3 months of their death. The *Child Wellbeing and Safety Act 2005*, effective as at 1 June 2006, established the Office of the Child Safety Commissioner,²⁵ and granted this body the statutory responsibility for conducting child death inquiries.²⁶ The Inquiries and Review Unit undertakes this task, the object of which is to promote continuous improvement and innovation in policies and practices in relation to child protection and safety.

Victorian Child Death Review Committee

Performing a similar role to Queensland's CDCRC, the Victorian Child Death Review Committee (VCDRC), formed in 1995, reviews child death inquiry reports prepared by the Child Safety Commissioner for those children known to the Victorian Child Protection service within 3 months of their death. This independent multi-disciplinary committee, composed of health, welfare, police,

22 The following information was kindly provided by Rosemary Warren, Project Officer, Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Victoria.

23 The deaths of children from 0 to 17 years of age are reviewed, including stillbirths greater than 20 weeks gestation or greater than 400g. Previously only the deaths of children from 0 to 15 years of age were reported on. This was extended in 2004.

24 The following information was kindly provided by Kay Warn, Senior Program and Information Adviser, Office of the Child Safety Commissioner, Victoria.

25 Part 6 – Child Safety Commissioner.

26 Division 4 – Inquiries into Child Deaths.

legal and academic representatives, identifies common themes and patterns in child deaths. The Committee provides comment on service responses to children in the child protection system and develops recommendations based on child death inquiry findings. The Minister for Children/Minister for Community Services is then advised of the Committee's deliberations and any recommendations arising from their review. An annual report is also prepared by the VCDRC and tabled in Parliament. The VCDRC and its functions are not currently enshrined in legislation.

Western Australia²⁷

The two major government bodies responsible for the review of child deaths in Western Australia are the Child Death Review Committee (CDRC) and the Advisory Council on the Prevention of Deaths of Children and Young People (Advisory Council). Both were established in 2003 in response to a report on levels of child abuse in Indigenous communities.²⁸ The Perinatal and Infant Mortality Committee (PN&IMC) of Western Australia is a statutory committee under the *Health Act 1911*. It was established in 1978 and is covered by sections 336A, 340AK and 340AL of the *Health Act*. The PN&IMC was set up to audit perinatal and infant deaths and was aimed solely at increasing knowledge of medical science.

Advisory Council on the Prevention of Deaths of Children and Young People

The Advisory Council collects information relating to the deaths of children and young people aged 0–23 years who are born and die in Western Australia, for the purpose of identifying patterns and trends in child death and potential prevention initiatives.²⁹

The stated focus of Advisory Council reports is on 'preventable deaths, and the disparity between Aboriginal and non-Aboriginal infants, children and young people' (Freemantle, Stanley, Read & de Klerk 2004:xxiv). Both external and some natural causes (such as infections) are considered preventable by the Advisory Council and are discussed in detail.

27 The following information was kindly provided by Jane Freemantle, Telethon Institute for Child Health Research.

28 *Inquiry into Responses by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities* (the Gordon Report).

29 It is intended that the scope of the Advisory Council will be extended to include the deaths of all children whose deaths are registered in Western Australia, regardless of their place of birth.

30 The following information was kindly provided by Sharyn Watts, Executive Officer, Child Death and Serious Injury Review Committee, South Australia.

Additional functions of the Advisory Council include:

- identifying areas which would benefit from further research
- evaluating the efficacy of existing intervention strategies, and
- making recommendations targeting the prevention or reduction of child deaths.

Child Death Review Committee

Under section 22 of the *Community Services Act 1972*, the CDRC provides advice to the Minister for Community Development in cases where children have been known to the Department within 24 months before their death. In a similar fashion to the Queensland and Victorian systems, the CDRC reviews the operation of policies, procedures and organisational systems, including the internal reviews conducted by the Department. From this, 'best practice' and effective systems are identified.

Both the Advisory Council and the CDRC report annually. The inaugural CDRC report covered the 2002–03 reporting period, while the Advisory Council's *First Research Report: Patterns and trends in mortality of Western Australian infants, children and young people, 1980–2002* was released in May 2005. Although the Advisory Council has so far only analysed child deaths retrospectively, its first report recommended that it report annually on the patterns of child death in Western Australia.

South Australia³⁰

South Australia's Child Death and Serious Injury Review Committee (CDSIRC) was established as a result of the recommendations of *Our Best Investment: A state plan to protect and advance the interests of children* (the Layton Report), released in 2003. This was an extensive review of South Australia's child protection system, taking into consideration legislation, policies, practices and procedures of government and non-government child protection services. The CDSIRC has been provided for by funding from the South Australian Government's 'Keeping Them Safe' initiative, aimed at the reform of child protection services.

The CDSIRC's enabling legislation was proclaimed in February 2006 as part of certain amendments to the *Children's Protection Act 1993*. Thirteen committee members and a committee chair have been appointed. Experts in the fields of child forensics, psychology, advocacy, health and justice are represented.

The deaths and serious injury of children aged 0–17 years in South Australia are considered by the CDSIRC, with a view to identifying systems, policies, procedures, practices, legislation and/or information strategies that should be upgraded, modified or introduced to prevent death and serious injury to children in the future. Section 52S of the *Children's Protection Act* specifies two principal functions of the CDSIRC:

- to review cases in which children die or suffer serious injury, with a view to identifying legislative or administrative means of avoiding a recurrence of such cases in the future, and
- to make, and monitor the implementation of, recommendations for avoiding preventable child deaths or serious injury to a child.

Detailed reviews are to be conducted in cases where the death or injury was due to, or suspected of being due to, abuse or neglect, in addition to those cases where the incident may have been prevented by a systemic change or the child was in the custody of a government agency or detention facility.

Recommendations based on reviews will be provided to the Minister for Families and Communities and an annual report must be tabled in Parliament.

Australian Capital Territory³¹

The 2004 report *The Territory as Parent: Review of the safety of children in care in the ACT and of ACT child protection management* (the Vardon Report) made recommendations regarding the establishment of a child death review team. It was proposed that a Commission for Children and Young People be established, incorporating a child death review function.

On 23 March 2004, the Minister for Health announced that a Child Death Review Team would be established within ACT Health.³² The Team, which began operation in April 2004, classifies the deaths of children aged 0–17 years (excluding stillbirths) according to cause of death, and maintains this information, along with relevant demographics, in the Child Death Register. Aside from the maintenance of the Child Death Register, the Team's functions are to identify trends and patterns in child death and to make and monitor the implementation of 'recommendations to address systemic, social and environmental issues which impact on child and young persons' deaths'.³³

The Chief Health Officer chairs the Team, with membership which reflects a multi-disciplinary interagency approach to preventing and reducing the deaths of children and young people in the ACT. Members include experts in health care, research methodology, child development and child protection, and people who by nature of their experience or qualifications are likely to make a valuable contribution to the Team.

The first statistical report on the deaths of infants, children and young persons in the ACT for the period 1992 to 2003 (*Review of ACT Child Deaths*) has been compiled with guidance from the ACT Child Death Review Team.³⁴

The team is not currently provided for by any specific legislation, relying instead on the powers of the Chief Health Officer and his authority under the *Public Health Act 1997*, which allows investigation into matters of risk to public health. The *Public Advocate Act 2005*, the *Coroners Act 1997* and the *Children and Young People Act 1999* also lend support to the Team's functions.

Concerns have been raised about the location of the Child Death Review Team within ACT Health, particularly in regard to potential conflicts of interest where deaths have been the result of a health intervention or lack thereof. The Vardon Report has suggested that locating a child death review team

31 The following information was kindly provided by Meredith Whitten, Director, Advocacy Review and Quality, ACT Department of Disability, Housing and Community Services.

32 Before 2004, the ACT reviewed only deaths of children in the neonatal period, reportable deaths under the *Coroners Act 1997*, and deaths resulting from abuse.

33 Simon Corbell, Minister for Health and Minister for Planning, media release 'Child death review team to be established', 23 March 2004.

34 This report may be accessed at <http://www.health.act.gov.au>

within an independent agency such as the proposed Commission for Children and Young People is “a more suitable response” (Vardon 2004:117).

The ACT Government agreed in principle in its response to the *Territory as Parent* report that a child death review team or committee be established within the recommended Commission for Children and Young People, subject to further analysis to ensure that this function is appropriate once the role and capacity of the Commission have been established. As at 30 June 2006, the Child Death Review Team remains within ACT Health.

Northern Territory³⁵

The Northern Territory (NT) Government’s ‘Caring for Our Children’ reform agenda was introduced in August 2004 with the aim of reforming and replacing existing legislation (the *Community Welfare Act 1983*), policy and administrative processes concerned with child protection.

A draft *Care and Protection of Children and Young People Act 2005* has been prepared and, subject to government approval, will be introduced to Parliament in late 2006. The draft Act provides for the establishment of a Child Death Review and Prevention Committee, which it is currently proposed will consist of between 16 and 20 people, in addition to a Convenor, appointed by the Minister. Qualifications or expertise relevant to child protection are required, and at least 2 of the Committee members must be Aboriginal. The Deputy Coroner will also be a member of this Committee. The Committee will report annually to the Minister.

Tasmania³⁶

Tasmania’s Council of Obstetric and Paediatric Mortality and Morbidity (the Council) was established under the *Perinatal Registry Act 1994*. The Council collects, analyses and reports data on all child deaths in Tasmania. The focus of the Council has, to date, been medical. It makes recommendations aimed at improving policy and

practice, principally targeted at health professionals. It also provides information for education and instruction in medical theory and practice.

Section 6 of the Act stipulates the following functions of the Council:

- to investigate the circumstances surrounding the conditions that may have caused maternal and perinatal deaths in Tasmania, as well as the deaths of children aged 29 days to 17 years³⁷
- to investigate the circumstances surrounding congenital abnormalities in children, injuries, illness or defects suffered by pregnant women or viable foetuses at any time before or during childbirth, and
- to maintain a perinatal data collection for the purposes of researching and identifying trends in perinatal, maternal and paediatric health and providing information and education to health-care practitioners; a register of congenital abnormalities is also maintained.

Responsibility for fulfilling the Council’s functions in regards to paediatric deaths (29 days to 17 years of age) rests with the Paediatric Mortality and Morbidity Sub-Committee.³⁸ Paediatric deaths are classified by the Committee into a four-category system: conditions determined at birth; acquired conditions; sudden infant death syndrome; and injuries (Council of Obstetric and Paediatric Mortality and Morbidity 2005:22). Recommendations regarding systemic issues relating to paediatric deaths are made by the Committee.

This Committee currently comprises 5 medical specialists. The Tasmanian Commissioner for Children has also recently become a member of the Committee. The Council reports annually to the Secretary of the Department of Health and Human Services (DHHS).

Tasmania does not currently have a formal mechanism for reviewing the circumstances of individual child deaths outside forensic, medical or police investigations. Historically, ‘critical case

35 The following information was kindly provided by Dr Adam Tomison, Deputy Director – Reform, Family and Children’s Services, Northern Territory Department of Health and Community Services, 17 August 2006.

36 The following information was kindly provided by David Fanning, Commissioner for Children, Tasmania, 8 August 2006.

37 The Council previously reported on the deaths of children from 29 days to 14 years of age. After amendments to the *Perinatal Registry Act 1994* in September 2005, this was extended to 17 years of age.

38 Perinatal deaths (20 completed weeks of gestation to 28 completed days after birth) and injuries are reported on by the Perinatal Mortality and Morbidity Sub-Committee.

reviews' were undertaken by the former Child Protection Board (now disbanded) under the former *Child Protection Act 1974*. Critical case reviews were conducted if a child died as a result of abuse or neglect and where there had been previous departmental notification within the family. These reviews focused on systemic issues within the child protection system.

However, since the commencement of the *Children, Young Persons and Their Families Act 1997* in 2000, there has been no established and uniform practice for the review of child deaths by a dedicated child death review body.

Recently the Minister for Health and Human Services convened an inquiry into the death of a child who was previously known to Child Protection Services (in the DHHS). The review team was established under the auspices of the Paediatric Sub-Committee, under section 9 of the *Perinatal Registry Act 1997*. However, this was a one-off review intended as an interim measure in the absence of a permanent child death review body.

The Commissioner for Children, David Fanning, raised his concerns about the lack of a formal child death review mechanism with the Minister for Health and Human Services in June 2005. After this, the Minister formally requested the Commissioner for Children to provide advice regarding the need for a child death review process and options for establishing this process.

The Commissioner for Children is currently finalising the advice to the Minister and intends to publish it in September this year. The advice will propose various options, including a preferred option.

Child death review in New Zealand

The issue of establishing a child death review team was first raised in New Zealand by the Office of the Commissioner for Children in 1993. Subsequent proposals highlighted the importance of qualitative

data – information on the circumstances of death as collected by child death review teams enables thorough understanding of risk factors and preventability.

The Child and Youth Mortality Review Committee (CYMRC) was appointed by the Minister of Health in September 2001.³⁹ Membership consists of 10 people selected by the Minister of Health, including a representative from the Ministry of Health and from Child Youth and Family. The structure of the child death review system in New Zealand was adapted from that in place in Michigan, USA. Local committees (based on district health areas) are supported by a national committee overview, such that recommendations can be made at both a local and a national level⁴⁰ (Child and Youth Mortality Review Committee 2004:vii).

The CYMRC reviews the deaths of children and young people between the ages of 4 weeks and 24 years, aiming to reduce the numbers of deaths in this age group. The Committee functions to highlight systemic and social issues and make recommendations which can be used to improve policy and practice and contribute to further research. It meets 5 times per year, and its findings and progress are reported annually to the Minister of Health.

Office of the Commissioner for Children

The Office of the Commissioner for Children is responsible for monitoring the internal case reviews prepared by the Child Youth and Family Agency where a child was known to the Agency in the two years before death. These reviews focus on the case work and services provided by the child protection agency and do not investigate the death or its cause. Independent investigations into the death of a child may be conducted by the Office of the Commissioner in some circumstances (for example, *Final Report on the Investigation into the Death of Riri-O-Te-Rangi (James) Wakaruru*, June 2000; *Report of the Investigation into the Deaths of Saliel Jalessa Aplin and Olympia Marisa Aplin (also known as Jetson)*, November 2003).⁴¹

39 The appointment of this Committee is subject to sections 11, 12, 18 of the New Zealand *Public Health and Disability Act 2000* (Child and Youth Mortality Review Committee 2005).

40 2003 and 2004 were primarily 'pilot' years for the child death review processes in New Zealand. The CYMRC's Second Report to the Minister of Health (2005:16) reported on the evaluation of this pilot, which indicated that the CYMRC review processes were both feasible and useful. However, structural changes to the way in which these processes function may occur in the near future. The terms for the CYMRC are currently under review. There has also been insufficient funding for local review committees, with committees being established in only two or three local areas.

41 Under section 12(1)(a) of the *Children's Commissioner Act 2003*, the Commissioner can investigate any decisions or recommendations made, or any act done or omitted, in respect of any child (excluding the decisions of courts or tribunals).

Towards a nation-wide system

Australia and New Zealand Cause of Death Working Group

Representatives from the various child death review teams across Australia and New Zealand have recognised the public need to develop comparable interstate data on child deaths. As outlined above, the teams are at various stages of implementation and have varying legislative bases, functions, roles and reporting requirements through differing auspicing agencies.

In recognition of the need to develop nationally comparable data, nominated representatives from each of the child death teams convened in December 2005 to discuss the key issues involved in and problems surrounding the review and reporting of child deaths and to progress national collaboration.⁴² The key outcomes of the first meeting of Australian and New Zealand Child Death Review Teams included in-principle agreement that all Australian and New Zealand teams:

- use the ICD-10 or ICD-10-AM system of classification to code cause of death
- report on underlying cause of death, defined by the World Health Organisation as ‘the disease or injury which initiated the train of morbid events leading directly to death or the circumstances of the incident or violence which produced the fatal injury’
- work towards using an accredited mortality coder for classifying cause of death
- work towards a national minimum dataset, and
- develop and agree to a protocol that describes how deaths of children who usually reside in an Australian jurisdiction that differs from the state in which they died are reported.

In recognition of the need for the development of nationally comparable data, meeting participants also agreed in-principle to analyse and report on a number of core groups of death in detail. As a result, representatives from each of the child death review teams were nominated to form a working group to review the core groups of death on which all jurisdictions should report, and to progress agreement on minimum data reporting requirements. Since the initial meeting in December 2005, two working group teleconferences have been held. Work has progressed to develop in-principle agreement to report on the following by 2006–07:

- the amount and type of documentation available for coding and grouping cause of death
- the relevant qualifications and experience of the person(s) coding cause of death
- the rules used for coding cause of death
- the number of deaths for each ICD-10 (or ICD-10-AM) chapter (including diseases and morbid conditions and external causes of death), and
- detailed analysis⁴³ of SUDI; deaths due to diseases and morbid conditions, specifically perinatal conditions, congenital anomalies, neoplasms (cancers and tumours) and infections; transport incidents; drownings; suicide and suspected suicide; and fatal assault.

The working group also proposed that teams report on additional groups of death as appropriate and that teams should use their discretion in the reporting of cases where the ICD coding does not accurately reflect the circumstances of death.

It is recognised that the Cause of Death Working Group is in the early stages of development, but it is anticipated that this group will provide some useful direction in the bid to develop nationally comparable data and reporting.

42 Deaths can be grouped to simply report on the number of children who die of particular causes to enable rudimentary cross-jurisdictional analysis (as in the fourth point above). Deaths can also be grouped to report in more detail on factors including causes of death, demographics and the circumstances surrounding the death. Developing a consistent core group of deaths for all teams to analyse and report on in detail will enable teams to identify issues associated with and risk factors for child death and enable a comparison of these factors across jurisdictions. Details to be reported will depend on forthcoming agreement on the minimum dataset.

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