

Chapter 1: Historical overview of child death review

“The death of a child from a preventable cause is a tragic event...Prevention efforts require that the scope and complexity of the problem be understood (Christianson-Wood & Lothian Murray, 1999:5)”

Why review child deaths?

Child fatalities due to abuse and neglect have been the focus of research for the past several decades in the United States of America, Canada, New Zealand and Australia. The western world has held many public inquiries into fatal abuse and neglect as policy makers and the public have become increasingly sensitive to violence against children.

In the past thirty years, countless reports across many international jurisdictions have detailed the stories of children killed by adults expected to care for them and failed by agencies charged with statutory responsibility for protecting them. This concentrated attention has resulted in significant advances in understanding patterns of fatal and serious non-accidental injury of children and young people (Layton, 2003:18.2).

A growing interest in the causes of preventable child deaths and serious injuries has led to burgeoning research in public health¹ and legislative and policy changes.

Public health research has challenged the belief that injury-related deaths are typically the result of unpreventable ‘accidents’ and contends that many injuries are not accidents or random acts of fate; but are predictable and preventable (Houk, Brown & Rosenberg, 1987)².

Legislative changes to swimming pool fencing regulations, baby product and nursery furniture standards and the reduction of speed limits on suburban roads are salient examples of the substantial impact of the work of public health agencies and research bodies.

A child’s death creates considerable concern within any community. Historically, the responsibility for examining and preventing child fatalities has fallen on law enforcement and coronial, social service and public health systems working in isolation (Langstaff & Sleeper, 2001; Durfee, Gellert & Tilton-Durfee, 1992:3172). Consequently, uniform systems for the investigation of child deaths have been slow to develop, which has resulted in a lack of centralised or systematic collection and analysis of data on the morbidity and mortality of children and young people. In response to the escalating awareness of severe violence against children and the increasing attention given to the prevention of child fatalities and serious injuries, child death review teams and/or committees are being established throughout the western world.

Child death reviews are designed to integrate data collected from investigations, to discover patterns and trends in the causes of deaths and to propose action to prevent similar fatalities or serious injuries (Durfee, Gellert & Tilton-Durfee, 1992:3172; Elster & Alcalde, 2003:303).

Child death reviews offer a better understanding of risk factors and provide the foundation for informed public policy (Layton, 2003:18.3). More specifically, systematic child death reviews can:

- assist in the accurate identification and uniform classification of causes of death, thereby decreasing their misclassification
- lead to modifications of the causes of death listed on death certificates³
- 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, policy and/or legislative changes designed to prevent or decrease child morbidity and mortality. (Elster & Alcalde, 2003:304; Onwuachi-Saunders et al., 1999:279).

1 Public health is defined as the “organised response by society to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues problems and priorities and for designing and implementing interventions, is 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 a modification of that proposed in Last, JM. (1987) *Public Health and Human Ecology*, Connecticut: Appleton and Lange).

2 For example, research by the American Academy of Pediatrics has demonstrated that a substantial proportion of injury related infant and child deaths are preventable.

3 For example, as a result of the Queensland Ombudsman’s (2003) investigation into the adequacy of the actions of certain government agencies in relation to the safety wellbeing and care of the late baby Kate, the death certificate was amended from Sudden Infant Death Syndrome to ‘undetermined’.

Child death reviews in Australia

Queensland

Commission for Children and Young People and Child Guardian

The Commission's child death review function began on 1 August 2004. Under Part 4A – Child Deaths – of the *Commission for Children and Young People and Child Guardian Act 2000*, 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.

The child death functions performed by the Commission are essentially the same as the New South Wales (NSW) Child Death Review Team within the NSW Commission for Children and Young People (discussed further in this chapter). Aside from differences in legislated powers, the fundamental difference between the NSW and Queensland models is that in NSW, a multi-disciplinary team is responsible for reviewing deaths, while the Queensland team seeks assistance from expert advisors or convenes advisory committees as appropriate.

In addition to child death research, the Queensland 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 in each case where a child dies, who was known to the department in the

previous three years. The DChS has six months from the time it learns of the child's death to provide the CDCRC with a report. The CDCRC considers the DChS report 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
- whether disciplinary action should be taken 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 inaugural CDCRC Annual Report released to Parliament and the public on 31 October 2005 provides a detailed overview of the history, role and functions of the CDCRC.

Report of the Crime and Misconduct Commission

During 2003 a number of complaints and resulting media attention indicated that the foster care and child protection systems in Queensland, as administered by the former Department of Families (DOF), had failed many children. The Crime and Misconduct Commission (CMC) responded by undertaking two major misconduct investigations (Operations Zellow and Ghost) and an independent public inquiry. Evidence produced at the inquiry pointed to systemic failures by DOF over many years to prevent children in foster care from further abuse or neglect.

The implementation of the 110 recommendations from the CMC report, *Protecting Children: An Inquiry into Abuse of Children in Foster Care*, released in January 2004, led to extensive structural and organisational reforms to the child protection system in Queensland. This includes the creation of the new Department of Child Safety, which is exclusively focused on child protection.

Significantly, the CMC recommended that independent child death review mechanisms be established in Queensland. The recommended review system included:

- an internal review by the Department of Child Safety of any death of a child in the child safety system (Rec. 5.25)⁴
- monitoring of that review by an independent Child Death [Case] Review Committee, chaired by the Commissioner for Children and Young People (which was an endorsement of the recommendation of the Ombudsman’s Baby Kate report) (Rec. 5.27), and
- a child death research role for the Commission for Children and Young People, which includes maintaining a register of child deaths (Rec. 5.28).

The CMC also recommended that external accountability for child protection be strengthened through a new statutory position of Child Guardian within the Commission for Children and Young People. The Child Guardian’s sole responsibility is to monitor and investigate complaints against the Department of Child Safety or other service providers, conduct audits and monitor and review service providers. The Commission is now known as the Commission for Children and Young People and Child Guardian.

The passing of the *Child Safety Legislation Amendment Act 2004* in June 2004 amended legislation to implement the CMC’s recommendations and establish the above functions within the Commission .

Report of the Queensland Ombudsman

In October 2003 the Queensland Ombudsman tabled a report in Parliament, *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).

Baby Kate⁵ died in her cot while in the care of her intellectually impaired mother. The Queensland Police Service investigated the death and provided a report on the investigation to the Coroner who recommended that no inquest be held.

The Baby Kate investigation and subsequent report considered the adequacy of the actions taken by the former DOF and Queensland Health in relation to the care and wellbeing of baby Kate⁶.

Specifically, the report criticised DOF’s decisions to allow the mother and her partner to care for the baby and then to leave the baby in the care of her mother when the partner left the relationship.

The report highlighted systemic problems within DOF in the management of child protection cases and inadequacies in the internal review conducted by the department of its handling of baby Kate’s case.

DOF’s internal review found that no negligence by its staff had occurred in the management of the case. The Ombudsman considered DOF’s review inadequate and formed the view that DOF should have engaged a person external to the department to conduct the review under its child death review policy.

The Ombudsman argued that child death review processes are “an important safeguard and accountability mechanism in the child protection system, [as] ... effective child death review process[es] can identify significant deficiencies in practices and procedures and make recommendations to address those deficiencies and perhaps save the lives of other children”⁷.

The Baby Kate Report recommended, among other things, that an external body be established in Queensland to monitor and review the investigation of the deaths of all children known to DOF. Further, the Ombudsman recommended that the Commissioner for Children and Young People chair the body and that it should report annually to Parliament.

4 While DOF had a policy requiring the review of deaths of children in the child protection system, it is now a statutory requirement that DChS conduct a review of its involvement in cases where a child dies and was known to the department in the three years before the date of death. DChS has six months from the time it learns about the death to provide the Child Death Case Review Committee with a review of its involvement with the child.

5 The report uses pseudonyms for the baby, the mother and her partner. The report does not publicly identify the mother or her associates because the focus of the investigation is on the actions of the former Department of Families and Queensland Health, not the actions of the mother or her partner.

6 The report expressed no opinion about responsibility for baby Kate’s death and did not suggest that the systemic problems identified in the former Department of Families’ management of the case or the actions of individual Department of Families’ officers contributed to her death.

7 Queensland Ombudsman, http://www.ombudsman.qld.gov.au/news/media_release_27.asp, viewed 6 June 2005.

A nationwide system

There is currently no national approach to child death review and Australian states and territories do not collect comparable data on child deaths.

NSW, Queensland, Victoria and Western Australia are currently the only states which have some form of child death review committee and/or maintain a child death register to compile and analyse information.

South Australia, the Australian Capital Territory and the Northern Territory are in the process of establishing child death and/or serious injury review committees, including child death registers to examine the causes and circumstances of child deaths. The Office of the Commissioner for Children in Tasmania has been promoting the idea of a comprehensive child death review system since 2004.

As these systems expand, nationally comparable data will make it possible to develop a well informed understanding of how children die in Australia.

The following provides an overview of the status of child death review systems and processes within each Australian state and territory. This information is current as at 30 June 2005.

New South Wales

The first child death review team in Australia was established in NSW in 1993.

In 1990 a report by the Physical Abuse and Neglect of Children (PANOC) Committee identified the “lack of a central review in situations where a child suffers serious physical injury or dies”. The PANOC Committee recommended that the NSW Government establish an “independent review mechanism” to examine cases where children are injured or die and to recommend policy, procedural, practice and service changes (NSW Child Death Review Team, 2001:2).

As a result the Child Death Review Committee of the NSW Child Protection Council was established in 1993. The committee reviewed a sample of deaths of children (under 14 years) that occurred in NSW between 1989 and 1991, due to, or suspicious of, abuse or neglect. The committee’s principal objective was to “determine characteristics, causes and contributing factors [of deaths] and to assess

the effectiveness of existing policies and practices in dealing with them” (NSW Child Death Review Team, 2001:2).

In its report *Preventing Child Homicide*, the committee stated that very little systematic information was available about the deaths of children in NSW. It recommended that a legislated Child Death Review Committee be established with the aim of “learning from the facts surrounding the deaths of children, using the findings to educate workers and informing policy and procedure across all areas of work to prevent future child deaths” (NSW Child Death Review Team, 2001:2).

In 1995 the *Children (Care and Protection) Amendment Act 1995* establishing the NSW Child Death Review Team (CDRT) was passed with bipartisan support.

For its first three and a half years, the CDRT was administratively supported by the NSW Child Protection Council. When the Commission for Children and Young People was established, the Commissioner was appointed Convenor of the CDRT and the Commission became responsible for providing research, policy, secretariat and administrative support to the team.

The NSW CDRT is a multi-disciplinary team of experts in paediatrics and child health, forensic pathology, mental health and child protection. The team also includes nominees of state government agencies concerned with the safety and wellbeing of children including the Department of Community Services, the Police Service, the Department of Health, the Department of Education and Training, the Department of Attorney-General and the Office of State Coroner. The structure and composition of the NSW CDRT mirrors the multi-disciplinary, interagency response to child protection adopted in the US.

The NSW CDRT monitors trends in the deaths of children and young people (under 18 years) in NSW, maintains a register of deaths and makes recommendations to Parliament about policies and practices to be implemented by government, private agencies and the community. Each year the team reports on deaths of children in the reporting year and provides a detailed report on certain categories

of deaths. For example, the 1998–99 Annual Report included a case review study of 86 coronial cases which involved parental substance abuse.

Until recently the CDRT was particularly mandated to review child deaths from abuse and neglect, or those which occur in suspicious circumstances. However, in December 2002, the *Community Services (Complaints, Reviews and Monitoring) Act 1993* was amended and the former Community Services Commission was amalgamated with the NSW Ombudsman.

The NSW Ombudsman now reports on the deaths of certain children and young people under the age of 18 and those people with a disability who died in care. Specifically, under the new Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the deaths of the following children are reviewable:

- a child in care
- a child who was the subject of a report made under Part 2 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death
- a child whose death may be due to abuse or neglect or that occurs in suspicious circumstances
- a child who, at the time of death, was an inmate of a children's detention centre, a correctional centre or a lock-up, and
- a child who, at the time of death, was living in residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or in a residential centre for handicapped persons.

While Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act* is largely focused on systemic issues, the NSW Ombudsman also has the capacity and responsibility to review and, as necessary, inquire into the circumstances of individual deaths (NSW Ombudsman, 2004:7).

The NSW Ombudsman details its review of child deaths in an annual report. The inaugural report covering 2003–04 was released in December 2004.

While the NSW CDRT no longer reviews the deaths of children and young people that are subject to review by the Ombudsman, it continues to maintain the child death register and examine child deaths in NSW from all causes. The NSW CDRT also conducts broader research in relation to child deaths. Detailed research reports released to date cover the following areas:

- fatal assault and neglect
- suicide and risk-taking deaths, and
- sudden unexpected deaths in infancy.

Victoria⁸

In 1985 the then Victorian Department of Community Services assumed responsibility for investigating allegations of child maltreatment. At the same time, internal inquiry panels were established to investigate deaths and serious injuries of children and young people who had been the subject of child protection interventions⁹.

A ministerial inquiry process into the deaths of children and young people under the care of the department was established in February 1989. The inquiry was run by Mr Justice Fogarty or his nominee, with a second independent person and a departmental representative. The findings were made public via tabling in Parliament. At the same time, internal departmental inquiries continued into some cases. This dual process was in operation until 1993. A child death register was also established at this time.

Following a further review in 1994 it was decided to discontinue holding both ministerial and departmental inquiries as the panels were duplicating each other.

Inquiries had focused on deaths in serious circumstances, including intentional mistreatment and neglect. However, it became apparent that while such deaths required a special focus, there was also much to be learned through a broad examination of other types of child deaths.

8 The following information was kindly provided by Kay Warn, Child Death Inquiry Unit, Office of the Child Safety Commissioner, 15 June 2005.

9 The panels of inquiry were comprised of three people and while they were called 'internal panels', at least one panel member was external to the department.

One inquiry process was developed to review deaths and preparations began to establish an independent committee of expert professionals with a multidisciplinary focus to take a broader approach to reviewing deaths in the context of the child health and welfare systems.

The Victorian Child Death Review Committee (VCDRC) was established in 1995 to independently review child death inquiry reports prepared by the Department of Human Services (DHS) and advise the relevant Minister on issues in service delivery and patterns of causes of death that may require departmental attention.

An Auditor-General's report on Victoria's child protection system, including child death inquiries, led to further changes to the state's child death review processes, protocols and procedures throughout 1995 and 1996.

The VCDRC reviews the department's reports on deaths of children who were clients of child protection services at the time of death or within the previous three months. The inquiries establish the facts of the case and determine whether departmental standards, guidelines and protocols were followed. Professionals outside the DHS also undertake inquiries. The VCDRC considers all inquiries and reports to the relevant Minister. The VCDRC prepares an annual report that is tabled in Parliament.

The VCDRC is a multi-disciplinary committee comprised of members from health, welfare, police, legal and academic fields, appointed by the Minister for a period of three years.

In 2004 the VCDRC's terms of reference were revised to clarify its key functions. The current VCDRC terms of reference are to:

- review departmental inquiry reports of children and young people who died while current or recent clients of the Child Protection Service in Victoria and advise the Minister for Children and Minister for Community Services of the committee's deliberations
- identify particular groups of child deaths that may benefit from further investigation or research

- analyse and comment on any themes, trends or patterns that emerge from the review of inquiry reports
- comment on service and system responses to children and families arising from the review of inquiry reports and receive feedback on the implementation of service system reforms
- provide advice to the Minister for Children and Minister for Community Services on the child death inquiry process
- prepare an annual report for the Minister for Children and Minister for Community Services
- perform other functions in relation to child deaths as directed by the Minister for Children and Minister for Community Services.

In Victoria, child death inquiries are regarded as essential for public accountability within the statutory child protection system and an effective quality assurance strategy for creating a culture of ongoing monitoring and review.

In 2004 the Victorian Government announced some major changes to coordinate children's services under a new Minister for Children, a new Office for Children and the establishment of a Child Safety Commissioner.

In 2005 the Office of the Child Safety Commissioner for Victoria was established. The main roles of the Commissioner are to provide the Minister with advice and recommendations about children's safety issues and to ensure that the safety and protection of children is properly addressed. The Commissioner reports on his activities to the Victorian Parliament through the Minister. The Commissioner is responsible for child death inquiries and providing administrative support for the VCDRC.

Western Australia

The child death review process in Western Australia was established following the *Inquiry into Responses by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities* (known as the Gordon Inquiry), which released a report in July 2002. The Gordon Inquiry was commissioned by the Western Australian Government to provide advice on how to respond to endemic

levels of family violence and child sexual abuse in Aboriginal communities (Gordon et al., 2002).

Headed by Magistrate Sue Gordon, the report ran to more than 640 pages and made 197 findings and recommendations. One key recommendation was the appointment of an independent committee to probe child deaths.

In 2003 the government established two committees:

- the Child Death Review Committee (CDRC) to provide quality assurance mechanisms of particular departmental cases where a child has died, and
- the Advisory Council on the Prevention of Deaths of Children and Young People to examine trends for all child deaths with a view to implementing preventative strategies.

The CDRC was established under section 22 of the *Community Services Act 1972* to facilitate accountability in the Department of Community Development (DCD). The CDRC advises the Minister for Community Development and the Director-General regarding particular cases in which children or young people known to the department have died.

The CDRC reviews the operation of relevant DCD policies, procedures and organisational systems when a child dies within 24 months of contact with the department. The CDRC examines all records including client files and internal DCD reviews. The CDRC may also seek advice or opinion from DCD staff with professional knowledge of particular departmental policies and practices.

The CDRC has a responsibility to identify effective systems for department operations as well as any variance in practice which may have impacted on the provision of services by the DCD. The CDRC also identifies particular types of child deaths or related issues that may benefit from further investigation and research.

The CDRC reports to Parliament annually. Its inaugural annual report covering 2002–03 was tabled in September 2003.

The Advisory Council's terms of reference are to:

- review and analyse data, information and research relating to the causes of deaths of children and young people; identify patterns and trends relating to those deaths; and consider ways to prevention
- identify areas that would benefit from further research and consider linkages of data to better inform pathways to prevention
- evaluate the effectiveness of interventions designed to reduce or prevent deaths of children and young people and identify policies, programs and practices that are successful in reducing or preventing deaths
- formulate recommendations to be implemented by government, private organisations and the community for the prevention or reduction of deaths of children and young people, and
- undertake other functions relating to the promotion of the health, safety and wellbeing of children as the Minister may direct.

The council produces an annual report on the deaths of children in Western Australia, which examines ways to prevent deaths and enhance the wellbeing of children.

The council reports to the Minister for Community Development. Its inaugural annual report, *The First Research Report of the Advisory Council on the Prevention of Deaths of Children and Young People: Patterns and Trends in Mortality of Western Australian Infants, Children and Young People 1980–2002*, was tabled in Parliament in May 2005.

A key recommendation of the report was that the Western Australian Government ensures there is a comprehensive system of reviewing all deaths of infants, children and young people including:

- effective mechanisms for reviewing all such deaths within the State
- action taken when specific patterns of mortality are identified
- effective communication and collaboration exists between various agencies involved with the mortality review process, and

- the Ministerial Advisory Council for the Prevention of Deaths of Children and Young People reports annually on the trends and patterns of infant, child and youth mortality as part of the comprehensive State system for monitoring, reviewing and reporting on trends in mortality and identifying opportunities for preventative action.

South Australia¹⁰

The South Australian Government announced a comprehensive child protection review in March 2002, chaired by Robyn Layton QC. The most extensive review of child protection undertaken in South Australia's history, it assessed the legislation, policies and procedures of government and non-government child protection services.

The resulting report, *Our Best Investment: A State Plan for Advancing and Protecting the Interests of Children* (which became known as the Layton Report), was tabled in Parliament in March 2003. The report made 206 recommendations to improve the lives of children and young people. One of five major structural reforms recommended was the establishment of a Child Death and Serious Injury Review Committee (CDSIRC). The committee was funded from the government's 'Keeping Them Safe' reform program for child protection services and systems.

In 2004 the Minister for Families and Communities appointed the chair and 13 members to the CDSIRC. The membership includes experts in child forensics, psychology, advocacy, health and justice. The committee is assisted by a small secretariat located within the Department for Families and Communities.

The CDSIRC looks at the deaths and serious injuries of South Australian children aged from birth to 18 years. It identifies systems, policies, procedures, legislation and/or information strategies that should be upgraded, modified or introduced to prevent deaths and serious injuries.

The CDSIRC makes recommendations to the Minister based on reviews of individual cases of death or

serious injury to children as well as information from a comprehensive database of child deaths and serious injuries in South Australia.

The CDSIRC seeks to understand the circumstances surrounding the death or serious injury of a child and recommend strategies to prevent similar deaths or serious injuries.

The CDSIRC is currently operating under Cabinet Directions. These directions allow the committee to establish and maintain the database of all child deaths and serious injuries based on information obtained from government agencies.

The CDSIRC has met four times since the beginning of 2005 on a schedule of six-weekly meetings. A set of guiding principles have been adopted and members have approved the guidelines and processes for collection, storage and retrieval of highly confidential and sensitive information. The CDSIRC is continuing to consider processes for the review of deaths and serious injuries and the definition of serious injuries.

Legislation to enable the CDSIRC to begin reviews of individual child deaths or serious injuries and to obtain information from sources, contained in the *Children's Protection (Keeping them Safe) Amendment Bill 2005*, is currently before the Parliament of South Australia.

Under section 52S of the Bill, the CDSIRC will have two principal functions:

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

Section 52S requires the CDSIRC conduct detailed reviews of cases of child death or serious injury if the death or injury was due to, or suspicious of, abuse or neglect. The committee should also review cases in which it is believed the death or serious injury might have been prevented by systemic change, or

¹⁰ The following information was kindly provided by Dr Sharyn Watts, Executive Officer, Child Death and Serious Injury Review Committee, 19 July 2004.

the child was in custody or detention or in the care of a government agency at the time of death or injury. Deaths or injuries should also be reviewed if the case was referred to the CDSIRC by the State Coroner¹¹.

The purpose of a review is to:

- identify trends and patterns in cases of child deaths and serious injury
- review policies, practices and procedures designed to prevent cases of child death or serious injury, and
- provide an objective basis for the CDSIRC recommendations.

Australian Capital Territory

Despite attempts and recommendations prior to 2004, the Australian Capital Territory (ACT) has not had an overall mechanism for collecting and recording information about and reviewing child deaths (Vardon, 2004:111)¹².

The need for a child death review system has been debated since at least 1998, when a paper was prepared for the then Minister for Education and Community Services under the *Children's Services Act 1986*. A proposal for an ACT child death review team was developed by the Children's Services Council in consultation with the Chief Health Officer of the Department of Health and Community Care. A working group consisting of the Department of Health and Community Care, Department of Education and Community Services and the Community Advocates Office met in 2002 and asked the Chief Health Officer's Quality Unit to investigate the proposal to create a review team in the ACT (Hansard, 9 May 2002). Since 2003 an interdepartmental working group has been developing the proposal.

In January 2004 the Chief Minister announced that the Commissioner for Public Administration, Cheryl Vardon, would undertake a review of child protection management in the ACT, following revelations that the Department of Education, Youth and Family Services had failed to meet legislated reporting requirements.

The terms of reference for the review required an investigation into the failure of the department to fulfil statutory obligations under section 162 of the *Children and Young People Act 1999* and an audit of files relating to children and young people in care. The review team also looked at departmental practices and policies, governance and resources.

The subsequent report, *The Territory as Parent: Review of the Safety of Children in Care in the ACT and of ACT Child Protection Management* (known as the Vardon Report) released in May 2004, revealed widespread systemic and administrative problems and focused on four major areas of reform:

- accountability and governance frameworks
- workloads and staffing
- service and sector development, and
- early intervention.

Significantly, the Vardon Report recommended establishing a Commission for Children and Young People, with the Commissioner to chair a child death review team. The report concluded that the "formation of a child death review team with adequate resourcing is critical to determining why children die and developing a systems response to prevent future deaths" (Vardon, 2004:117).

On 23 March 2004 the Minister for Health announced that a child death review team would be established. The media release stated that the team would investigate the causes of deaths of children under age 18 in the ACT and would implement and monitor "recommendations to address systemic, social and environmental issues which impact on child and young persons' deaths."

The Vardon Report raised concerns that a conflict of interest could arise if the project remained the responsibility of ACT Health, particularly if a child died as a result of health intervention or lack of it. The report claimed that locating a review team within an independent agency such as the proposed Commission for Children and Young People was "a more suitable response" (Vardon, 2004:117).

11 The CDSIRC only conducts reviews if there is no risk that the review would compromise an ongoing criminal investigation of the case. There is a further requirement that a case not be reviewed unless a coronial inquiry has been completed, the State Coroner requests the CDSIRC to carry out the review or the State Coroner indicates that there is no present intention to carry out a coronial inquiry.

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

The ACT Government committed to respond positively to all of the Vardon Report's recommendations and implement further reforms including:

- committing to establishing an independent Commission for Children and Young People, and
- agreeing in principle that a child death review team or committee be established within the Commission for Children and Young People subject to further analysis once the role of the Commission has been established.

The Vardon Report Implementation Team, led by the Chief Executive of the Chief Minister's Department, will oversee the implementation of agreed recommendations. The team comprises a government steering committee, reference groups with government and non-government representatives and a small implementation unit.

In September 2004 the Vardon Implementation Team released a position paper for a proposed Commissioner for Children and Young People. The paper argued that in line with other jurisdictions, the child death review team should be located within an agency such as the Commission to guarantee independence and objectivity and should have a legislative basis.

As at 30 June 2005 the child death review team remains within ACT Health. The team's report is due to be released at the end of 2005.

Northern Territory

In August 2004 the Northern Territory (NT) Government introduced its 'Caring for our Children' reform agenda. The agenda has two key components aimed at better protecting children:

- new legislation to reform and replace the *Community Welfare Act 1983*, and
- reform of existing policy and administrative processes.

To implement its reform agenda, the Department of Health and Community Services commissioned new research and used existing studies and analysis on child abuse in Australia. A number of these reports were specific to the NT and several were specific to Aboriginal and Torres Strait Islander issues¹³.

The NT government has received bi-partisan support for its child protection reform agenda (Scrymgour, 2004:11).

Part 3.3 of the draft *Care and Protection of Children and Young People Act*, the new legislation to replace the current Act, is specifically directed at the prevention of child deaths.

Clause 211 provides for the establishment of a Child Death Committee. The committee is to consist of a convener and between 14 to 20 other members appointed by the Minister. There must be at least two Aboriginal members on the committee and the others must have expertise or experience relevant to the functions of the committee.

The main functions of the Child Death Committee, as outlined in clause 212, are to:

- make recommendations to the relevant Minister about the prevention of deaths of children
- conduct research or arrange the conduct of research
- establish and maintain the Child Death Register (clause 214), and
- contribute to a national register on the deaths of children.

The child deaths register will include non-personal information about the incidence of deaths of children; causes, patterns and trends of deaths; and other data concerning deaths.

The legislation will require that various individuals and statutory office holders, such as the Commissioner for Police, the Registrar of Births Deaths and Marriages, health practitioners and various service providers, provide information to the Child Death Committee.

The discussion draft of the proposed *Care and Protection of Children and Young People Act 2005* was tabled in the Legislative Assembly by the Minister for Family and Community Services during sittings of the Assembly in November 2004. The Department of Health and Community Services has since been consulting community groups on the draft legislation. The final legislation will be passed in mid to late 2005.

13 See for example, Tomison, A. (2004) *Current issues in child protection policy and practice: Informing the NT Department of Health and Community Services child protection review*, National Child Protection Clearing House, Australian Institute of Family Studies.

Tasmania

Tasmania does not have a formal mechanism for reviewing child deaths outside forensic, medical or police investigation. However, the Office of the Commissioner for Children has been promoting the introduction of a child death review system since at least 2004.

In April 2004 the Commissioner for Children released a memorandum of advice to the Minister for Health and Human Services detailing the need for a child death review system in Tasmania. The memorandum cited specific concerns, received by the Commissioner, that highlight problems in the current process for reviewing child deaths. Issues included:

- while coronial investigations examine the circumstances surrounding individual child deaths, they do not address systemic issues and questions about inter and intra agency policy and practices
- contact between agencies and child protection responsibilities need to be improved to ensure effective action can address emerging dangers to a child, and
- case practice reviews conducted by Child and Family Services were only mandatory if a child or young person died from possible abuse and neglect and there was current or recent (within the past twelve months) involvement by Child and Family Services.

The Commissioner also cited the following deficiencies in the critical case practice review system:

- the system is run by the Department of Health and Human Services and is not open to scrutiny by an external authority
- information about all child deaths is needed to inform policy decision making, but critical case practice reviews are not always mandatory, and
- the critical case practice review system focuses on individuals and does not allow for statistical analysis and ongoing research into trends relating to child deaths.

The memorandum also recommended establishing an adequately resourced and expert child death review system to help agencies learn from the deaths of children and reduce preventable tragedies.

“A child death review panel could help identify systems issues and also make recommendations for their solutions. The panel could also investigate trends and patterns related to child deaths in Tasmania. This could help agencies to better identify emerging dangers to a child and avoid similar tragedies in the future” (Patmalar Ambikapathy, Commissioner for Children Tasmania, April 2004).

As at 30 June 2005, the Office of the Commissioner for Children has not received a response to the issues raised¹⁴ from the Division of Children and Families.

Child death review in the United States

“Now that the teams have scrutinised all children’s deaths, we see clearly the number of children who have died needlessly, brutally, or in circumstances of gross neglect. Out of this wasteland, must come some meaning” (Rosenberg cited in United States Advisory Board on Child Abuse and Neglect, 1995:79).

The child death review movement began in the United States to address fatalities due to suspected child abuse and neglect¹⁵. Many teams have expanded this focus to address all coronial cases, including suicide, accidental deaths and natural deaths.

The first interagency child death review team in the US – comprised of criminal justice, health and social service professionals – was formed in Los Angeles County in 1978 under the auspices of the Inter-Agency Council on Child Abuse and Neglect (ICAN) and the direction of Dr Michael Durfee. Frustrated by the number of infants and children dying under vague and violent circumstances, the council hoped

14 Office of the Commissioner for Children, email correspondence received 30 March 2005.

15 In the United States, the concept of conducting reviews of individual deaths dates back over sixty years with maternal mortality reviews, conducted by state multidisciplinary teams, for the purpose of reducing pregnancy-related maternal mortality (Webster et al., 2003:59).

the combined effort of different agency perspectives could help identify child abuse cases that had been falling through the cracks (United States Advisory Board on Child Abuse and Neglect, 1995:77; Broderick, 2004).

Maltreatment is considered more difficult to conceal and less likely to be overlooked when professionals from various agencies share information regarding the child and family and the circumstances surrounding the death (Webster et al., 2003:58–59).

The team discovered many previously undetected abuse and neglect fatalities and, within the first five years of operation, the cause of death in seven deaths was reclassified from ‘natural or accidental’ to ‘death at the hands of another’ (Elster & Alcalde, 2003:303; Durfee, Gellert & Tilton-Durfee, 1992:3174).

The team made recommendations to improve the transparency and accountability of agencies with child health, safety and protection responsibilities; helped increase child homicide prosecutions; and promoted service improvements for high-risk families (Durfee, Gellert & Tilton-Durfee, 1992:3174). High-risk problems detected by child death reviews have included chronic family violence, pregnancies involving maternal substance abuse, failure-to-thrive infants and homes lacking basic child safety measures.

The review processes developed in Los Angeles County were progressively adopted across other parts of the country. By the late 1980s and early 1990s, the work of earlier teams, combined with increasing cooperation from public agencies, led to a rapid increase in the number of review teams in the US.

In 1991 the United States Department of Health and Human Services, *Healthy People 2000* objectives endorsed the need for child death review and recommended its extension to at least forty-five states (Webster et al., 2003:59; United States Department of Health and Human Services, 1991).

In 1992 a landmark study of Missouri child deaths published in the *Journal of Pediatrics*, brought child death reviews into the national spotlight by highlighting the extent of under-reporting maltreatment fatalities and the success of retrospective reviews in identifying these deaths. In 1992, eight states passed statutes for child death review teams (Elster & Alcalde, 2003:304; Durfee & Tilton-Durfee, 1995:378; Broderick, 2004).

The child death review movement in the United States was further fuelled by the ‘Adam Mann Documentary’ (1991) which reported the death of a five-year-old boy, fatally beaten by his stepfather and mother. While Adam Mann’s cause of death was listed as a broken skull, broken ribs and a split liver, the autopsy also revealed more than 100 injuries, as well as evidence that almost every bone in the child’s body had been broken at some stage during his life. Adam Mann’s story prompted Congress to request that the United States Advisory Board on Child Abuse and Neglect undertake research and make recommendations regarding “a national policy to reduce and ultimately prevent such fatalities”, as well as “changes needed to improve data collection about child abuse and neglect fatalities” (United States Advisory Board on Child Abuse and Neglect, 1995:xxiu).

The board embarked on a two and a half year national study which included public hearings across ten states, focus groups, evaluation of research and an extensive review of the findings of state and local multiagency child death review teams.

The 1995 release of *A Nation’s Shame: Fatal Child Abuse and Neglect in the United States* (known as the Nation’s Shame Report) highlighted the vast under-reporting and misclassification of child abuse and neglect deaths throughout the United States¹⁶. The Nation’s Shame Report (1995:xxiu) revealed that each year in the United States at least 2000 infants and young children were killed by those with primary responsibility for their care – an average of five per day.

16 The Nation’s Shame Report was the fifth Annual Report of the United States Advisory Board on Child Abuse and Neglect. It was written with the specific purpose of alerting Americans to the increasing problem of child maltreatment fatalities. A number of national databases were studied for this report in an attempt to provide accurate figures on the incidence of child abuse and neglect related deaths. However, no final analysis was possible due to the identification of chronic misclassification in these databases (Christianson-Wood & Lothian Murray, 1999:11).

The Nation's Shame Report concluded that child abuse and neglect fatalities and other serious injuries to children could not be significantly reduced without comprehensive information about the circumstances surrounding these incidents. It found that multi-agency child death review teams may "offer the greatest hope of finding the underlying nature and scope of fatalities from child abuse and neglect, as well as a means to prevent these tragic deaths" (Durfee & Tilton-Durfee, 1995:377).

The findings and recommendations of the report gave clear impetus for the expansion of child death review programs. By 1999, 47 states and the District of Columbia had established child death review teams. By 2000 all states had legislation for creating child death review teams (Elster & Alcalde, 2003:304). By 2005 all states except Idaho had some type of local or state review team in operation¹⁷.

Legislative basis for child death review in the United States

There is no uniform system for the review of infant and child deaths in the United States. While all states have some form of legal directive for the establishment of a child death review process, the approaches vary significantly.

Some statutes mandate child fatality review by state or local teams (or both); other statutes allow for the discretionary formation of child death review teams (Elster & Alcalde, 2003:304; Durfee, Tilton-Durfee & West, 2002:622). Some statutes identify case criteria and review requirements, while others are more broadly written, allowing state or local teams to establish their own criteria and requirements.

Expanded focus of United States teams

While child death review teams developed largely in response to the need for evaluation and case management of suspicious deaths, most teams have expanded to include all forms of preventable child deaths, including child suicides, accidents and deaths from natural and undetermined causes.

In 1992 the United States Maternal and Child Health Bureau convened the Committee on Early Childhood Health and Development to advise on child death reviews. While acknowledging the vital role of reviews in addressing fatalities related to abuse and neglect, it strongly encouraged child death review teams to take a preventative approach and consider deaths of all children and young people under the age of 19 (Covington & Rich, 2005:5).

More recently, the *Healthy People 2010* Initiative has made child death reviews a national priority¹⁸. The goals of this initiative include "continued improvements in child fatality review team systems", and extending state fatality reviews to focus on deaths from external causes of children aged 14 and under, with the "ultimate goal" being adequate resourcing to "extend review to all causes of death for all children eighteen years and under" (United States, Department of Health and Human Services, 2000). Since the launch of this initiative, all newly established child death review programs have been developed as public health models.

Child death review in Canada

Child death review teams or mechanisms currently exist in eight of the 13 Canadian provinces/territories¹⁹. The composition of the teams and their duties vary across jurisdictions (Durfee, Tilton-Durfee & West, 2002:620).

In recent years there have been widespread moves towards the establishment of multidisciplinary review teams in Canada as coroners, medical examiners, child advocates, police and child welfare professionals respond to increasing public demands for accountability and effectiveness in service delivery (Christianson-Wood & Lothian Murray, 1999:19).

In 1998 Canada embarked on the Child Mortality Analysis Project, a national project funded and led by Health Canada. The aims of the project were to review and analyse existing data collection procedures and techniques and to develop a model

17 Idaho does not have any form of child death review team after state funding was ceased three years ago (Theresa M. Covington, Director, The National Maternal and Child Health National Centre for Child Death Review, email correspondence, 4 May 2005).

18 *Healthy People 2010* is a comprehensive set of public health priorities and specific, measurable objectives for the United States to achieve over the first decade of this century.

19 British Columbia, Manitoba, New Brunswick, Northwest Territories, Nova Scotia, Ontario, Quebec and Saskatchewan all have some form of child death review team or committee.

for multidisciplinary child death review teams, including recommendations for child mortality data collection. The project's report *Child Death Reviews and Child Mortality Data Collection in Canada* highlighted the need for uniform coding and collection of child death data; mandated independent child death review teams; and called for a national database of information from reviews of child deaths (Christianson-Wood & Lothian Murray, 1999:45–46).

The Federal/Provincial/Territorial Working Group on Child Death Review was formed in May 1999 to provide advice and direction to the Child Death Review process in Canada.

In June 2000 the group developed guiding principles for child death reviews. According to these principles, each province and territory should create a multi-disciplinary team – including the chief coroner or medical examiner, experts in child welfare, child advocacy, law enforcement, paediatrics and forensic pathology and a member of the First Nation community – to review child deaths. Child death reviews should:

- be conducted by a review team external to and independent from the organisations and agencies subject to the review
- have statutory powers to ensure access to information
- have the authority to make recommendations and be able to monitor compliance with recommendations, and
- have the ability to make public reports.
- (Federal/Provincial/Territorial Working Group on Child Death Review, 2002; Saskatchewan Children's Advocate Office, 2005:12, 46).

Examples of child death review in Canada

Manitoba

Manitoba has Canada's oldest multidisciplinary child death review committee, formed in 1992. The Children's Inquest Review Committee is chaired by the Chief Medical Examiner²⁰ although it is not legislatively mandated.

Before each monthly committee meeting the Chief Medical Examiner briefly meets medical members of the committee to review all child deaths reported to the Office of the Chief Medical Examiner during the previous month and to identify cases for review.

Section 10 of the *Fatality Inquiries Act R.S.N.S. 1989* also provides that when a deceased child or the child's parent or guardian has received services from a Child and Family Service agency within one year before the death, a special investigator within the Office of the Chief Medical Examiner assesses the service provided by the agency. The Chief Medical Examiner then issues a confidential report to the Minister of Family Services and Housing. These reports usually contain an assessment of the agencies involved, address case management service providers and systemic issues and make recommendations regarding improvements²¹.

Ontario

The Paediatric Death Review Committee was formed in Ontario in 1991 to assist coroners with complex medical cases. The committee of paediatric experts developed a detailed protocol for the investigation of the deaths of children under the age of two.

Following six high-profile child deaths in Ontario, a Child Mortality Task Force was established to survey the cases of children who had died during 1994 and 1995 while receiving services from Children's Aid Societies (Ontario Child Mortality Task Force Final Report, 1997:4). The task force made more than 400 recommendations and initiated the implementation of a major child welfare reform agenda involving the introduction of a mandatory risk assessment model, amendments to child protection legislation and child death reviews (Christianson-Wood & Lothian Murray, 1999:30).

Examining child fatality review mechanisms in other jurisdictions, the Child Mortality Task Force found that the most effective vehicle for reviewing child deaths was a multidisciplinary committee, "comprised of members from a variety of disciplines,

20 The committee is comprised of approximately 10–12 members including the Chief Medical Examiner; Special Investigator; Head, Paediatric Pathology, Children's Hospital; Paediatric Representative from the College of Physicians and Surgeons of Manitoba; Head, Child and Family Services, Manitoba Family Services and Housing; the Children's Advocate, Police representatives and a representative from the Assembly of Manitoba Chiefs.

21 Much of the information on child death review processes in the Province Manitoba was provided to the Child Death Review Team in personal correspondence by Dr A. Thambirajah Balachandra, Chief Medical Examiner, Manitoba.

[that] had legislative authority to act and the ability to influence policy and practice” (Ontario Child Mortality Task Force, 1997:33).

In response to the recommendations of the task force, the Office of the Chief Coroner expanded the functions and membership of the Paediatric Death Review Committee in 1997. Specifically, the committee’s membership was enlarged to include representatives from child welfare, police and the Crown Attorney’s office. The authority of the committee was also broadened to review the deaths of all children with an open child protection services file at the time of their deaths. The committee’s findings are reported to the Children’s Aid Society, the Ministry of Community and Social Services/Ministry of Children and Youth Services and the Regional Coroner. (Ontario Paediatric Death Review Committee, 2004:1). The Paediatric Death Review Committee released its first report to the public in June 2004.

Saskatchewan

In Saskatchewan, a child death review policy was introduced 1992 and revised in March 2004. The Saskatchewan Children’s Advocate Office²² reviews the deaths of children and young people under the age of 18 when the child was receiving services from the Department of Community Resources and Employment (under the *Child and Family Services Act 1989–90* or the *Young Offenders Act 1990–91*) at the time of their death or in the six months preceding their death.

Since 2002, multidisciplinary review teams have assisted with the conduct of reviews. The teams advise on findings and recommendations; identify systemic issues; and propose strategies to prevent future child deaths, improve child-serving systems and promote public accountability. Teams include the chief coroner, physicians, educators, lawyers, former police officers, social workers and youth in care.

The Children’s Advocate Office also reviews other matters referred to the office, including all child deaths, in accordance with the *Ombudsman and Children’s Advocate Act*. When deaths are sudden and unexpected, the Chief Coroner also notifies the Children’s Advocate Office (Saskatchewan Children’s Advocate Office, 2005:7, 10–12).

In 1999, the Children’s Advocate Office called for the systematic examination of deaths of all children in Saskatchewan. The report, *A Summary of Child Deaths for the Year 1999*, recommended that “government develop a model to ensure all child deaths are reviewed by an ‘educated eye’ and that this model begin to be implemented by 1 January 2005.” As at March 2005, there remains no mechanism to review the deaths of all children. However, Saskatchewan Health has reported that it “will continue to work in partnership within other departments and agencies to more fully explore the operational, jurisdictional and legislative implications of an expanded child death review system; to consider the mandates and roles of the Chief Coroner’s Office and the Children’s Advocate Office in that respect; and to assess the extent to which the additional information obtained through an expanded review will contribute to the objective of reducing children’s deaths” (Saskatchewan Children’s Advocate Office, 2005:6).

British Columbia

In British Columbia, the Children’s Commission, created in 1996,²³ was responsible for reviewing child deaths. The Children’s Commission was notified and maintained a database of all children and young people who died under the age of nineteen. The Commission used a multidisciplinary consultative committee to review unexpected deaths and the deaths of children who were in care or who were known to the Ministry for Children and Families.

22 The Children’s Advocate is an officer of the Legislative Assembly of Saskatchewan and acts in accordance with *The Ombudsman and Children’s Advocate Act*. “The mandate of the Children’s Advocate is to promote the interests of and act as a voice for children when there are concerns about provincial government services” (Saskatchewan Children’s Advocate Office, 2005:9).

23 The Children’s Commission was created in response to the Gove Inquiry into Child Protection, an independent inquiry into the adequacy of the services, policies and practices of the British Columbia Ministry of Social Services as they related to the apparent neglect, abuse and death of Matthew John Vandreuil (Christianson-Wood & Lothian Murray, 1999:8). The recommendation was that the Children’s Commission’s mandate to review children’s deaths extend only to children and youth who were in the care of the province or who were receiving welfare services. When the Children’s Commission was set up, the proposed mandate was expanded to collecting information about the deaths of all children and investigating a child’s death when the Commission considered it “necessary to determining the adequacy of services to the child or to examine public health and policy matters” (Section 4(1)(a) *Children’s Commission Act*; Morley, 2001:32).

The child death reviews determined the adequacy of services provided to the child, determined whether any steps could have been taken to prevent the death and made recommendations to ministries and agencies to improve services and supports for children and youth (British Columbia Children’s Commission, 2000:8).

In February 2002 the Children’s Commission and the Office of the Child, Youth and Family Advocate were abolished and an Office for Children and Youth was established.

On 1 January 2003 the British Columbia Coroner’s Service assumed the former Commission’s child death review responsibilities. While the service was always required to investigate sudden, unnatural and unexpected deaths, the assumption of new responsibilities led to the introduction of three new functions:

- maintaining a database of all child deaths
- monitoring and identifying trends in the causes of child deaths, including a public reporting component, and
- establishing and maintaining a child death review team (British Columbia Coroners Service, 2004:5).

The Coroner reviews all sudden unexpected and unnatural deaths. The Child Death Review Team looks at trends or major issues highlighted by the Coroner, as well as individual deaths that require closer examination.

Agency interactions with all children receiving services within a year before their deaths is considered in all reviews (under the *Child, Family and Community Services Act RSBC 1996*). Recommendations designed to improve public safety and reduce child deaths in similar circumstances are made to government, community agencies and the public. Agency responses to recommendations are recorded and monitored²⁴ (British Columbia Coroners Service, 2004:6).

Child death review in the United Kingdom

The United Kingdom has a long history of reviewing child abuse fatalities. However, until recently reviews in the UK have followed a ‘public inquiry’ model. This approach differs significantly from the multidisciplinary review systems of the US and Canada.

The Monkton Inquiry into the death of Dennis O’Neill at the hands of his foster carers in 1945 was the first formal public child death inquiry held in the UK. In this case of extreme cruelty Dennis O’Neill was tortured, neglected and died in his foster home. The review found a lack of accountability from the agencies involved with the child, problems with interagency communication and information sharing and a failure of agencies to visit and talk to the child. The case sparked the Curtis Committee’s (1946) review of substitute family care, which led to the *Children Act 1948* (James, 1998:174)²⁵.

The high profile death of Maria Colwell in January 1973 again generated public concern about fatalities related to child abuse and neglect. Maria, aged seven, died after being starved and beaten by her stepfather, William Kepple. She had suffered brain damage, a fractured rib, black eyes, extensive external bruising and internal injuries. Maria had been fostered with her aunt and uncle because her mother could not cope with bringing up five children on her own. Five years later, Maria was returned to her mother. Although 50 officials, including social workers, health visitors, police and housing officers, visited Maria and the family, an inquiry by the Department of Health found that East Sussex county council had insufficient evidence to return the girl.

The public inquiry found a complete lack of coherent decision-making, information sharing and interagency communication and that no historical information was collated. Further, no adequate

24 The Coroners service has no statutory authority to order change or to ensure that its recommendations will be carried out. However, the British Columbia Coroners Service reports that it is “generally successful in having most of its recommendations considered and acted upon” (British Columbia Coroners Service, 2004:9).

25 The introduction of the *Children Act 1948* was a landmark in child welfare history as it “heralded a move away from the imperatives of the Poor Law and reflected a new understanding of the needs of children” (James, 1998:174).

assessments of the risks posed to Maria or her needs were carried out and there was a failure to involve the child, or place the child at the centre of decision-making (Department of Health and Social Security, 1974).

Since the Maria Colwell inquiry, more than 70 reports have been published about children who have died as a result of direct physical abuse and neglect, as well as abuse in residential and day care (Corby et al., 2001).

During the late 1970s and early 1980s a decline in deaths of infants older than one month was identified in the US, while England's and Wales' post neonatal mortality rate fell to 14th out of 16 OECD countries. This was principally due to a greater numbers of deaths attributed to sudden infant death syndrome and infection (Hobbs, Wynne & Gelletlie, 1995:329). The British Multicentre Study on Post Neonatal Mortality (Knowelden et al.,1985) recommended that infant deaths in Leeds be examined in detail. The Leeds Confidential Inquiry into Infant Death was established in 1987 to conduct a detailed review of all unexpected deaths of children aged between seven days and two years in Leeds.

A multidisciplinary team was formed with representatives from primary and secondary child health services, forensic and paediatric pathology and social services (Hobbs, Wynne & Gelletlie, 1995:330). Detailed medical, demographic and social information was used to examine the circumstances surrounding and risk factors contributing to child deaths, with a focus on future prevention (Hobbs, Wynne & Gelletlie, 1995: 330–331). The Leeds inquiry adopted the same multidisciplinary approach to child death review used in the United States and Canada.

The findings of the Colwell and Leeds inquiries led to major changes in the systems designed to protect children from abuse, including the establishment of local authority child protection units, Area Child Protection Committees and revisions to the *Children*

Act 1989. The Act was accompanied by a document titled *Working Together Under the Child Protection Act 1989*, which provided a national framework for agencies and professionals to work together to promote children's welfare and protect them from abuse and neglect. Importantly, it outlined procedures for reviewing cases in which a child had died from abuse or neglect²⁶.

Part 8 of the document requires the Local Area Child Protection Committee to conduct a review (known as a Part 8 Review) into a child's and family's involvement with agencies and professionals, when a child dies due to possible abuse or neglect²⁷. Reviews are designed to ensure the protection of siblings and to identify and improve procedures local professionals and agencies use to work together to safeguard children (Department of Health, Home Office & Department of Education, 1999:87). Since the introduction of the *Children Act 1989* more than 1,500 Part 8 Reviews have been carried out in the United Kingdom.

More recently, the public inquiry that followed the death of Victoria Climbié has led to the introduction of a widespread program of reforms to protect children from abuse and neglect, including the passing of the *Children Act 2004*. Victoria Climbié, aged eight, died in intensive care in February 2000 from hypothermia, malnutrition and physical abuse inflicted by her carers. Lord Laming described the management of the Climbié case as “a catalogue of administrative, managerial and professional failure by the services charged with her safety” (Speech by Lord Laming, 25 January 2003²⁸). Lord Laming's Inquiry Report made 108 recommendations to improve the transparency and accountability of child protection services in the UK (Laming, 2003).

The terms of reference set for the Climbié Inquiry were not restricted to understanding and evaluating the reasons for the failure of services to protect Victoria. The inquiry was also required to make recommendations on how safeguards for children might be strengthened to prevent other tragedies.

26 *Working Together Under the Child Protection Act 1989* prepared and issued jointly by the Home Office the Department of Health and the Department of Education.

27 A Part 8 Review should also be conducted in situations where “a child has suffered a potentially life-threatening injury through abuse or neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse and neglect and the case gives rise to concerns about the way in which local professionals and services work together to safeguard children” (Department of Health, Home Office & Department of Education, 1999:88).

28 A transcript of the speech can be accessed at: <http://www.victoria-climbié-inquiry.org.uk>.

The inquiry organised a series of seminars on the essential elements of good childcare practice and the processes designed to secure the safety and wellbeing of children (Laming, 2003:349). These seminars included considerable debate on the best way to learn from child deaths.

A key criticism of Part 8 Reviews was their exclusive focus on organisational issues. The Climbié Inquiry Report noted that “there are clear advantages in ensuring that every death or serious deliberate harm to a child known to social services is investigated, [as this would serve to] ensure that no cases were missed and would assist in the development of preventative strategies more generally” (Laming, 2003:359). In research publications released in the wake of the Victoria Climbié tragedy, the National Society for the Prevention of Cruelty to Children (NSPCC) has strongly agitated for the introduction of independent, multidisciplinary child death review teams to review all child deaths²⁹ (May-Chahal et al., 2004; National Society for the Prevention of Cruelty to Children, 2001).

Sections 13 to 16 of the new *Children Act 2004* require local authorities to establish Local Safeguarding Children Boards (LSCBs) as the statutory successors to Area Child Protection Committees³⁰. These boards will have investigatory, monitoring and review functions, and their core tasks include ensuring that lessons are learnt from every child death and providing families with appropriate support after a child dies.

Specifically, each LSCB will establish local screening teams to review child deaths and respond rapidly to unexpected deaths³¹. The Department for Education and Skills (DfES) is developing the LSCBs, to be introduced in April 2006. Once finalised, the operation of local screening teams will significantly

influence the way in which information concerning child deaths is collected and how deaths are reviewed in the UK (Confidential Enquiry into Maternal and Child Health, 2005:1–2).

The Confidential Enquiry into Maternal and Child Health (CEMACH) was launched in April 2003³². In early 2004, a new national child health inquiry program was developed, of which the Child Death Review Pilot Project comprises one aspect. The project will examine all deaths of children aged from 28 days to 18 years in a one year period in the south west and north east of England, Wales and Northern Ireland. Core data on all child deaths in these regions will be collected and detailed multidisciplinary reviews will be conducted on a subset of deaths to identify ways to prevent deaths. A protocol for the project is currently under development. According to the CEMACH, the outcomes of the project will “inform the future direction of national child mortality reviews” by local screening teams and the coronial service (Confidential Enquiry into Maternal and Child Health, 2005:2).

Child death review in New Zealand

*“Mortality reviews are for determining problems or failings with systems or processes and recommendations will not focus on individual actions. They are **not** courts of inquiry – not for name/blame/shame procedures”* (New Zealand Child and Youth Mortality Review Committee, 2004:3).

The New Zealand Office of the Commissioner for Children first began promoting a national child death review system in 1993. In January 1997 the Minister for Social Welfare encouraged the Commissioner to promote legislation to establish a Comprehensive National Child Mortality Review System and undertook to sponsor such legislation (O’Reilly et al., 1998:iv).

29 Not just those where a child known to local agencies has died from abuse and neglect.

30 Key local agencies will be required to participate in LSCBs as Board partners. The core Board partners prescribed the *Children Act 2004* are local authorities, National Health System bodies, the Police, local probation boards, the Connexions Service, local prisons, Young Offender Institutions, the Children and Family Court Advisory and Support Service (CAFCASS) and district councils, where relevant.

31 ‘Local screening teams’ is a working title only, which may change. The guidance relating to the functioning of these teams is still under development and has yet to be consulted on. Therefore it is not yet clear what mechanisms of review will be put in place, the extent to which they will be independent, whether there will be local variations in procedures, and when they will fully come into effect (because of the piloting phase).

32 CEMACH is a self governing body managed by its own board with members nominated by: the Royal College of Obstetricians & Gynaecologists; Royal College of Midwives; Royal College of Paediatrics and Child Health; Royal College of Pathologists; Royal College of Anaesthetists; Faculty of Public Health. CEMACH has been given section 60 approval under the *Health and Social Care Act 2001*. This Act enables the secretary of state to support and regulate the use of patient confidential information in the interests of patients or the wide public good.

Under the Commissioner's proposal, the 'National Comprehensive Mortality Review System' was to include:

- the collection and/or collation of standardised information on child deaths, mandated by empowering legislation
- a multidisciplinary review process, involving local/regional committees and a state/national overseeing body
- a comprehensive review all child deaths (from all causes), with a focus on preventability³³, and
- using findings to influence legislation, policy and practice (O'Reilly et al., 1998:17–22).

The Commissioner's proposal highlighted that while administrative data about the causes of child death is collected, qualitative information is also necessary to understand risk factors in preventable deaths.

After consultation with experts in child protection, child safety and child health issues,³⁴ the *Child Mortality Review Board Bill 1999* was introduced as a member's Bill to the New Zealand Federal Parliament in April 1999. In February 2001, after considerable debate, this Bill was discharged³⁵.

The Child and Youth Mortality Review Committee was established in 2002 as the first of several possible statutory committees that can be appointed under section 18 of the *New Zealand Public Health and Disability Act 2000*. The committee reviews and reports on the deaths of children and young people aged four weeks to 24 years, to help reduce preventable deaths. The Child and Youth Mortality Review Committee has adapted processes developed in Michigan, US. This involves a structure based on local mortality review committees, supported by national committee overview and national data support and analysis (Child and Youth Mortality Review Committee, 2004:vii).

The role of the committee is to highlight systemic and/or interagency issues, environmental issues and social issues affecting family behaviour that contributes to child deaths. The committee identifies factors contributing to deaths and provides expert recommendations to improve professional practice; inform education campaigns and policy and service development; reduce the number of deaths; and contribute to further research³⁶.

The Office of the Commissioner for Children also monitors case reviews by the Child Youth and Family Agency concerning its involvement in each case in which a child dies and was known to the agency in the two years before the 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. The agency notifies the Commissioner for Children of all deaths and provides a copy of the review report. The Commissioner considers the agency's child death review, comments on the resulting report and may request additional information or action. In some circumstances, the Office of the Commissioner for Children conducts its own investigations (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 Alpin (also known as Jetson)*, November 2003)³⁷. The Commissioner's monitoring and investigations are authorised by sections 12 and 13 of the *Children's Commissioner Act 2003* and are guided by the United Nations Convention on the Rights of the Child, which was ratified by New Zealand in 1993.

33 No consensus regarding age range was reached. It was suggested that a system including those cases under the age of 20 years would comply with both the relevant legislation and New Zealand's international obligations.

34 For example, the Auckland District Council of Social Services; the medical director of the Maori sudden infant death syndrome prevention team; the professor of paediatric surgery at Canterbury Health; SIDS Auckland; Health Waikato's senior paediatrician; the New Zealand Medical Association; the New Zealand Law Society.

35 The Labour-Alliance Government of the day opposed the Bill and the rationale for its discharge appears to be that the newly enacted *New Zealand Public Health and Disability Act 2000* included provisions for the establishment of appropriate child death review processes.

36 2003 and 2004 have primarily been 'pilot' years for the child death review processes in New Zealand and structural changes to the way in which these processes function may occur in the near future. The terms for the Child and Youth Mortality Review Committee are up currently under review. There has also been insufficient funding for local review committee's with committee's being established in only two-three local areas .

37 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).