

# Child Death Review: Achieving Outcomes that make a Difference

***Mary McAlorum***

***Commission for Children and Young People  
Victoria***



Commission *for* Children  
and Young People

*improving young lives*



# Child Death Inquiries: Achieving outcomes that make a difference

4<sup>th</sup> Australasian Conference on Child Death Inquiries and Reviews:  
6 November – Mary McAlorum

*Victorian children: seen and heard - safe and well*





# Our Legislation

The *Commission for Children and Young People Act 2012*, provides the legislative mandate of the Commission for Children and Young People (the Commission).

The functions of the Commission set out in the Act include:

- conducting inquiries into service provision or omission in regard to:
  - children who have died and were known to Child Protection at the time of their death or 12 months before their death
  - the safety and wellbeing of an individual or group of vulnerable children and young people
  - a community service, health service, human service, school or child protection services or youth justice services where there are persistent or recurring systemic concerns.



# CCYP Act 2012

## **31 Object of inquiries**

The object of an inquiry is to promote continuous improvement and innovation in policies and practices relating to child protection and the safety and wellbeing of—

- (a) vulnerable children and young persons; and
- (b) children and young persons generally.

## **34 Commission must conduct inquiry into death of child protection client**

- (1) The Commission must conduct an inquiry in relation to a child who has died and who was a child protection client—
  - (a) at the time of his or her death; or
  - (b) within 12 months before his or her death.
- (2) The inquiry must relate to the services provided, or omitted to be provided, to the child before his or her death.



# How child death inquiries are conducted

Department of Human Services notifies the Commission of the death of the child



Inquiries and Systemic Reform unit of the Commission conducts inquiry and prepares report





# How child death inquiries are conducted

The Commission Review Committee considers the report and may make recommendations

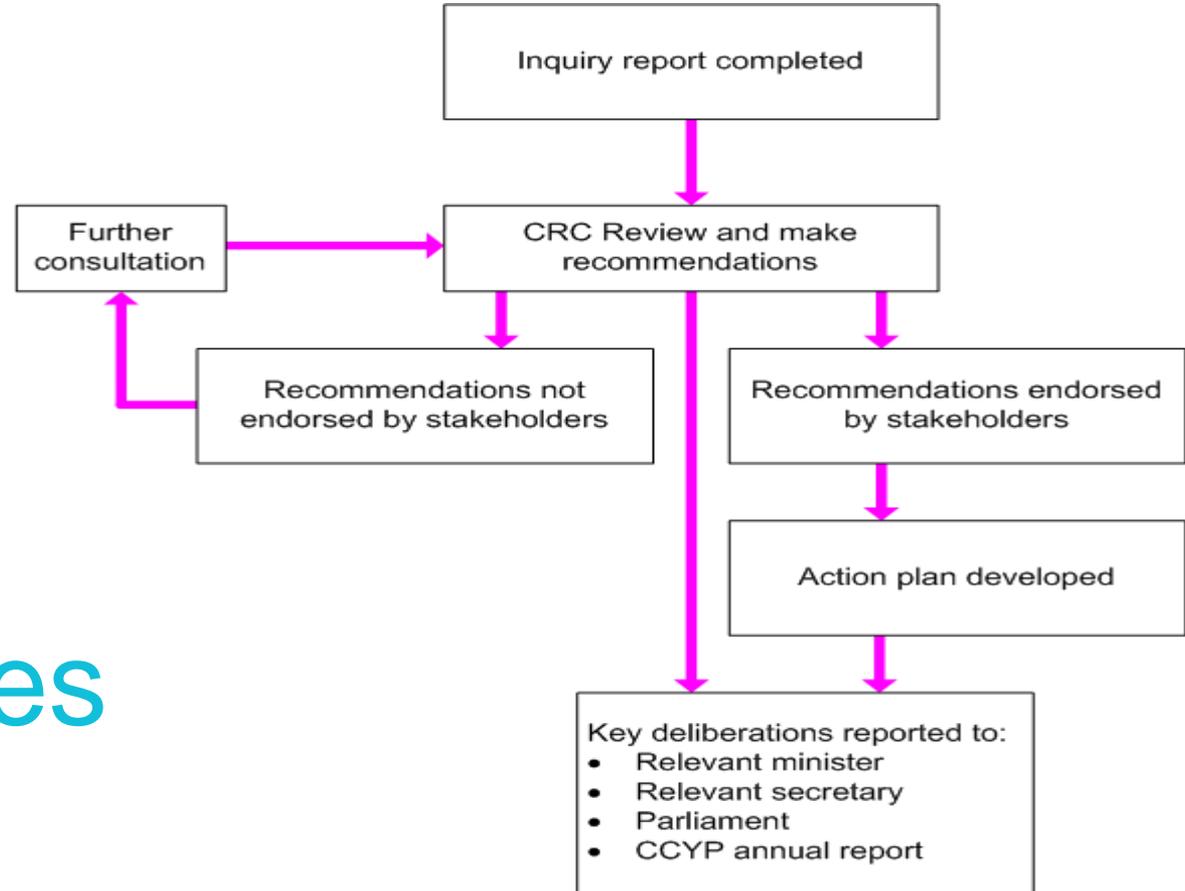


Final report provided to the Minister for Community Services, Secretary to the Department of Human Services and other relevant Ministers





# CRC Processes





# Inquiries and Systemic Reform

Mary McAlorum

Manager, Inquiries and Systemic Reform

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03-8601 5282

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# Child Death Review: Achieving Outcomes that make a Difference

***Steve Kinmond***

***Office of the New South Wales Ombudsman***

# Child Death Review: Achieving outcomes that make a difference

4<sup>th</sup> Australasian Conference on  
Child Death Inquiries and Reviews  
6 November 2014

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## Our jurisdiction

- All child deaths in NSW (around 500-600 per year)
  - A subset are 'reviewable' – this includes deaths due to abuse or neglect, or suspicious of abuse or neglect, and children in care (around 20-40 per year)
  - Oversight responsibilities regarding the child protection and disability services systems
-

# Tools that support our work

- We operate under secrecy provisions
  - Our work is not subject to FOI legislation
  - We are 'not compellable or competent' in any proceedings
  - Productive professional links with FACS; Police; Coroner; Health; Education etc.
  - We have direct access to the police, CS and NCIS databases
  - We have the legislative power to obtain the information we need (from public agencies; NGOs; private providers and citizens)
-

# Methodology

- Review officers complete reviews using information from multiple sources
  - In certain matters, we obtain expert advice, e.g. from medical practitioners, psychiatrists
  - Information from reviews is incorporated into an integrated database
  - The data is the basis for CDRT annual reports, biennial reviewable deaths reports and research reports, and informs our other systemic work
-

# Child Death Review Process

Notification of child death



Integrated death database



Initial review of available information on cause and circumstances:

- Police report to the Coroner
- Cause of death certified by medical practitioner
- Is the death a “reviewable” death? Abuse, neglect (or suspicious of ), or a child in care?
- Is there a child protection history?



Determine the level / type of review and records required:

- Police, Health, FACS, Education
- Private providers – GPs, psychologists, psychiatrists
- Other service providers – family support, early intervention
- Coronial and criminal outcomes

# Child Death Review Process

Detailed review completed by review officers



Certain natural causes      SUDI      Drowning      Transport      Suicide      Assault      Other external causes

Reviewable



International Classification of Diseases (Version 10) (ICD-10AM) coding



Further action as needed



Additional information from service providers about the death or other matters



Report to agency on issues arising from review (CS CRAMA) or Inquiry



Complaint or investigation of agency conduct (Ombudsman Act)



Final Coronial and Court proceedings



Child Death Review Team Annual Report  
Biennial Report of Reviewable Deaths  
Research  
Recommendations

# An integrated database

- The new integrated child and disability deaths database (Resolve v10) has been developed to hold information about all child and disability deaths under our jurisdiction
  - The database went live on 28 August this year and replaces three historical databases (and numerous spreadsheets)
-

# Key features and capabilities of the system include:

- Detailed information on circumstances/ cause of death
  - Detailed information about issues identified by review
  - Case specific data for all causes and reviewable types
  - Health and social factors for child, family and associated persons
  - Improved reporting capabilities will assist us to identify emerging trends and to track recommendations
-

**Case**

Number: DRS/2014/273 Reportable Jurisdiction: In jurisdiction Assigned To: Palmer, Amy OO Reg. Date: 2-Sep-2014 11:20 AM

File Type: Single - CDRT How Received: BDM Team: CSD - Information Analysis Team Case Due Date: 14-Oct-2014 11:20 AM

Deceased Person: Tester, Simone Case Status: Pending review Last Edit Date: 20-Oct-2014 11:54 AM Security Classification: For Official Use Only

**Deceased Person**

Tester, Simone

Date of Death: 1-Sep-2014 Gender: Female

Age (Yrs): 14 Age (Month): 6 Age (Day): 30

Usual residence State: NSW Death State: NSW

**Checking**

COPS checked:  NCIS checked:

KIDS checked:  Case effort: Standard

Was the deceased in care at the time of death? Yes

Type of care: Out of Home Care (child)

Evidence of recent child protection history?

Is Death Reviewable: No

Primary Reporting Category: Suicide

Secondary Reporting Category:

Sudden unexpected death? Non-SUD/SUDI

Broad underlying COD:

Coronial Case: To be referred to Coroner

**Further action taken (Read Only)**

Further action taken

- S11(e)
- 13AA
- S16/18
- S34L
- S39
- S43(3)
- S43/18
- Expert Advice
- Meeting with agency/s
- Refer case

**Related Matters / Actions**

Other OO action: Yes

Other agency review/action: Yes

**Summary of agencies involved**

Agencies involved

- Community Services

**Detail circumstances of death (F2 Full Screen Mode)**

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**Comments**

Comments	Created By	As At Date
NOT REVIEWABLE - Amy ...	Palmer, Amy	20-Oct-2014

**Case**  
 Number: DRS/2014/273 Reportable Jurisdiction: In jurisdiction Assigned To: Palmer, Amy OO Reg. Date: 2-Sep-2014 11:20 AM  
 File Type: Single - CDRT How Received: BDM Team: CSD - Information Analysis Team Case Due Date: 14-Oct-2014 11:20 AM  
 Deceased Person: Tester, Simone Case Status: Pending review Last Edit Date: 20-Oct-2014 04:51 PM Security Classification: For Official Use Only

**Cause of Death**  
 Autopsy Performed: No Objection to Autopsy: Yes  
 Toxicology Performed: No

**Coroner**  
 Coronial Case: To be referred to Coroner Referred by Ombo to Coroner: Yes  
 Coroner's Case Reference: JH783627 Coroner Manner of Death: Suicide  
 Coronial Process Status: Closed - inquest dispensed  
 Inquest dispensed date: 1-Oct-2014  
 Coronial recommendations made?

**Coronial Inquest Findings / Recommendations**

**Sources - Cause of Death**  
 Add Cause of Death

Source Type	Source Name	Comments
BDM		

**ICD Coding**  
 Coding Status: In progress  
 Ombo Coder Name: Savage, Kelly Last Updated: 20-Oct-2014  
 Ombo Case Classification Status: Interim

**Codes**

Level	Sub-Level	Type	Code	Description	Coder's Notes
1	a	Underlying cause	X60.1	Intent selfpoison anlgsc antip...	

**OO Finding consistent with Coroner finding**  
 OO Finding consistent with Coroner finding:

**Ombo Coder Comments**

**BDM Source (read only)**  
 BDM  
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**Latest Coroner & Other Sources (read only)**

Case Number:	DRS/2014/273	Reportable Jurisdiction:	In jurisdiction	Assigned To:	Palmer, Amy	OO Reg. Date:	2-Sep-2014	11:20 AM
File Type:	Single - CDRT	How Received:	BDM	Team:	CSD - Information Analysis Team	Case Due Date:	14-Oct-2014	11:20 AM
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**Suicide**

Main Suicide Other factors Conditions & Concerns Management and support (deceased) Management and support (associated persons)

**Main Suicide**  
Suicide type: Probable suicide  
Manner determined by Coroner: Undetermined intent  
Means of death / method / mechanism: Overdose

**Detail method or specify 'other'**  
Testing testing testing

**Deceased's personal history**

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Was supervision a factor? Yes  
Who located the body: Member of public  
Was suicide intent: Undetermined

**Detail evidence of intent or reasons why intent could not be determined**

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Case Number:	DRS/2014/273	Reportable Jurisdiction:	In jurisdiction	Assigned To:	Palmer, Amy	OO Reg. Date:	2-Sep-2014	11:20 AM
File Type:	Single - CDRT	How Received:	BDM	Team:	CSD - Information Analysis Team	Case Due Date:	14-Oct-2014	11:20 AM
Deceased Person:	Tester, Simone	Case Status:	Pending review	Last Edit Date:	20-Oct-2014	05:39 PM	Security Classification:	For Official Use Only

**Issues**

**Were any other factors relevant to this death?**  
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**Issues identified by NSW Ombudsman's Office**

Issue	Issue comment
Supervision	

**Comments on identification of issues**

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**Issues identified by other agencies**

Issue	Agency	Specify agency / other	Issue comment
Supervision	Community Services		

**Other Agency Issue**

Issue selected: Supervision

**Comments on identification of issues by other agencies**

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# Achieving outcomes that make a difference

## Relies on various processes:

- Getting the data right – what you collect, how you classify it, how you retrieve it
  - Bringing together the findings from child death reviews and from our broader work (child protection/other areas) to strengthen recommendations
  - Combining case studies and systemic review findings to highlight issues
  - Drawing on research and the work of external stakeholders
  - Developing strong stakeholder relationships
  - Ownership and leadership, good governance and monitoring arrangements
-

# Challenges

- Ensuring our work complements rather than conflicts with the activities of other agencies
  - Making the right call about when to report publicly on issues and recommendations arising from individual child deaths
  - Connecting with the work of other states and international bodies
  - Consistency in data
-

# ‘Must haves’ for recommendations

- Sound understanding of the business and core work of the agency/s, and the operational issues that affect frontline staff
  - Effective consultation with the agency/s and other relevant stakeholders
  - Consultation with experts
  - Involving agencies in the development of recommendations
-

# Recommendations should be **COMPACT**

**C**lear

**O**utcome focused

**M**easurable

**P**roportional

**A**chievable

**C**ertain

**T**argeted

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## How we track implementation of recommendations

- We require agencies to report back on their acceptance and compliance with recommendations by a set date
  - Periodically, we seek written updates from agencies
  - We meet with agencies to discuss the progress on specific recommendations and /or place them as a standing agenda item on regular meetings
  - Issues and outcomes register
-

- Ongoing liaison with stakeholders
  - Our annual and biennial reports include information about the progress that agencies have made in implementing recommendations
  - Recommendations are monitored until such time that we are satisfied any commitments made by an agency have been substantively met
-

## Contact details

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Deputy Ombudsman

Community and Disability Services Commissioner

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# Child Death Review: Achieving Outcomes that make a Difference

***Natarlie De Cinque***

***Office of the Western Australian Ombudsman***

# **Child Death Reviews – Achieving Outcomes that make a Difference**

## **4th Australasian Conference on Child Death Inquiries and Reviews**

Director, Reviews  
6 November 2014

# Today's presentation

- Background to child death reviews in Western Australia (**WA**)
- Role of the Western Australian Ombudsman
- Individual death reviews
- Own motion investigations
- Conclusion

# Background to child death reviews in WA

- 2002 Gordon Inquiry
- 2003 Child Death Review Committee
- 2007 Ford Report
- 30 June 2009 – Child Death Review jurisdiction commenced by the Ombudsman

# Role of the WA Ombudsman

The Ombudsman reviews child deaths that meet the criteria of an investigable death as provided by section 19A(3) of the *Parliamentary Commissioner Act 1971*:

- A child or child relative had wellbeing concerns or significant involvement with the Department for Child Protection and Family Support (**CPFS**) in the past two years up to the date of death; and
- A child or child relative has pending protection orders or is in the care of the CEO of CPFS.

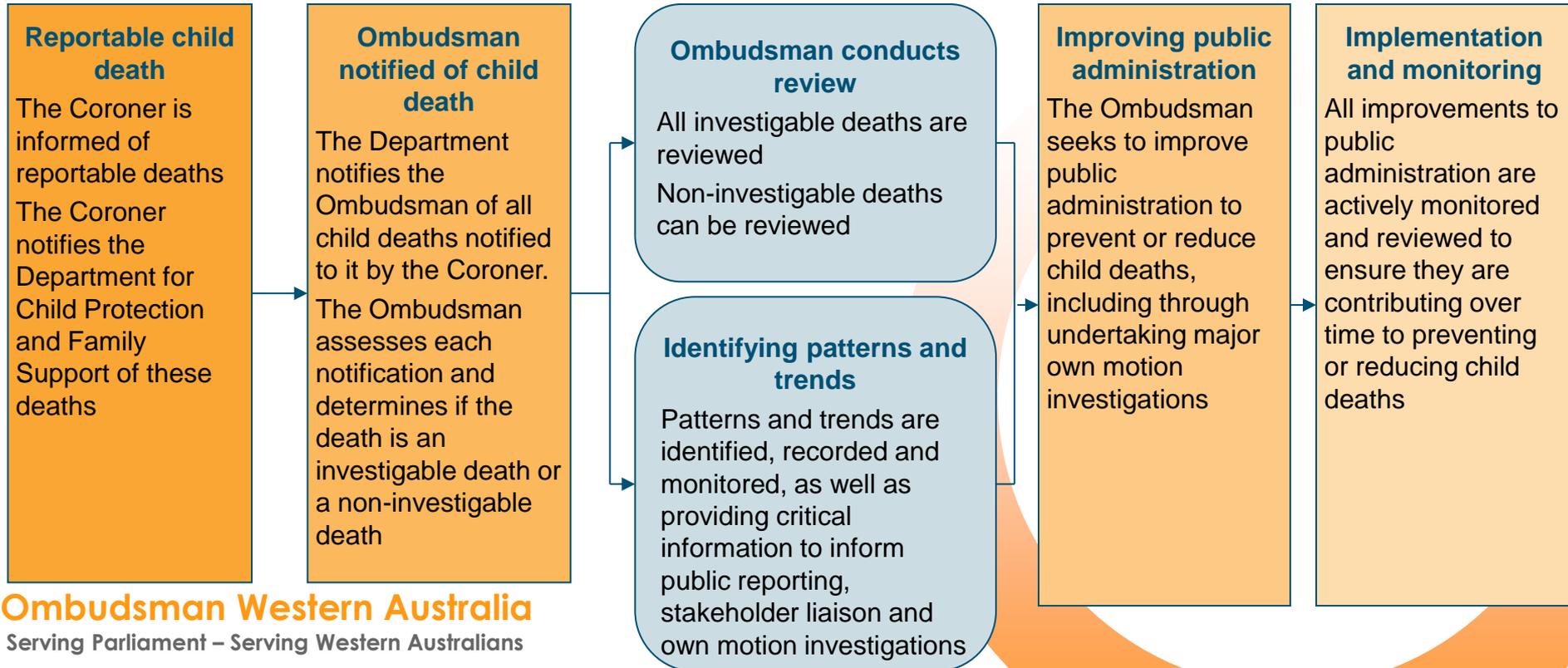
# Role of the WA Ombudsman

The Ombudsman:

- Reviews the circumstances in which and why deaths occur
- Identifies patterns and trends
- Makes recommendations to public authorities about ways to prevent or reduce child deaths

The WA Ombudsman achieves this through **individual child death reviews** and **own motion investigations**.

# Role of the WA Ombudsman – The Child Death Review process



# Role of the WA Ombudsman

## What we do not do

- Determine whether a crime has been committed; or
- Determine the cause of death.

# Individual Child Death Reviews

## Individual death reviews - Notification and Assessment

- Section 242A of the *Children and Community Services Act 2004* provides that CPFS is required to notify the WA Ombudsman of certain child deaths and provide background of CPFS involvement within 14 days of receiving the Coroner's notification of a child death.
- The Ombudsman assesses if the child death is investigable as identified by section 19A(3) of the *Parliamentary Commissioner Act 1971* or otherwise requires an investigation.

# Individual Child Death Reviews

- Examine decisions and actions of relevant public authorities in accordance with their legislative responsibilities
- Reviews identify compliance issues and potential gaps
- Usually a desktop process – review files/documentation and responses to practice questions
- Multi-agency reviews
- Consider the interagency communication and collaboration where applicable
- Focus on future prevention

# Individual Child Death Reviews

Outcomes can be achieved through:

- Voluntary actions by the agency
- Recommendations by the Ombudsman
- Monitoring implementation and effectiveness of recommendations
- Identification of patterns and trends
- Public reporting of the review function and our own motion investigations

# Individual Child Death Reviews

- In undertaking reviews we have all the powers provided under the *Parliamentary Commissioner Act 1971* and the *Royal Commissions Act 1968*.
- We are also bound to observe all of the relevant provisions of the *Parliamentary Commissioner Act 1971* including, for example, in relation to confidentiality of our reviews.

# Individual Child Death Reviews – Patterns and trends

- When child death notifications are finalised, all relevant issues are identified and recorded and, over time, indicate relevant patterns and trends in relation to the issues associated with child deaths.
- They also provide critical information for own motion investigations.

# Individual Child Death Reviews – Characteristics of children who have died

- Male children are over-represented for all age groups, particularly for children under the age of one;
- Aboriginal children are over-represented overall, and particularly in the under one age group and among those living in regional and remote locations.
- Children under two years and children aged between 13 and 17 are over-represented; and
- Children in regional locations are over-represented.

# Individual Child Death Reviews – Circumstances of Child Deaths

- The two main circumstances of death for the 453 child death notifications received in the five years from 30 June 2009 to 30 June 2014 are:
  - Sudden, unexpected deaths of infants; and
  - Motor vehicle accidents.

# Individual Child Death Reviews – Patterns and trends of children in particular age groups

- **Infants (0 – 1):** 91% of deaths were sudden, unexpected deaths and the majority occurred while the infant had been placed for sleep.
- This information led to the Ombudsman's 2012 own motion investigation into sleep related infant deaths.

# Individual Child Death Reviews – Patterns and trends of children in particular age groups

- **1 - 5 year olds:** illness or medical condition is the most common circumstance of death for this age group (27%), followed by motor vehicle accidents (24%) and drowning (19%).

# Individual Child Death Reviews – Patterns and trends of children in particular age groups

- **6 – 12 year olds:** motor vehicle accidents are the most common circumstance of death for this age group (37%), followed by illness or medical condition (29%) and drowning (12%)
- The Ombudsman's examination of reviews of deaths of children aged 6 to 12 years has identified the critical nature of certain core health and education needs. Where these children are in the CEO's care, inter-agency cooperation between CPFS, the Department of Health and the Department of Education in care planning is necessary to ensure the child's health and education needs are met
- This information led to the Ombudsman's 2011 own motion investigation into planning for children in care

# Individual Child Death Reviews – Patterns and trends of children in particular age groups

- **13 – 17 year olds:** suicide is the most common circumstance of death for this age group (39%), followed by motor vehicle accidents (29%) and illness or medical condition (14%).
- This information led to the Ombudsman's 2014 own motion investigation into suicide by young people.

# Own Motion Investigations

- Own motion investigations that arise out of child death reviews focus on the practices of agencies that interact with children and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

# Own Motion Investigations – Topic selection

Selection Criteria include:

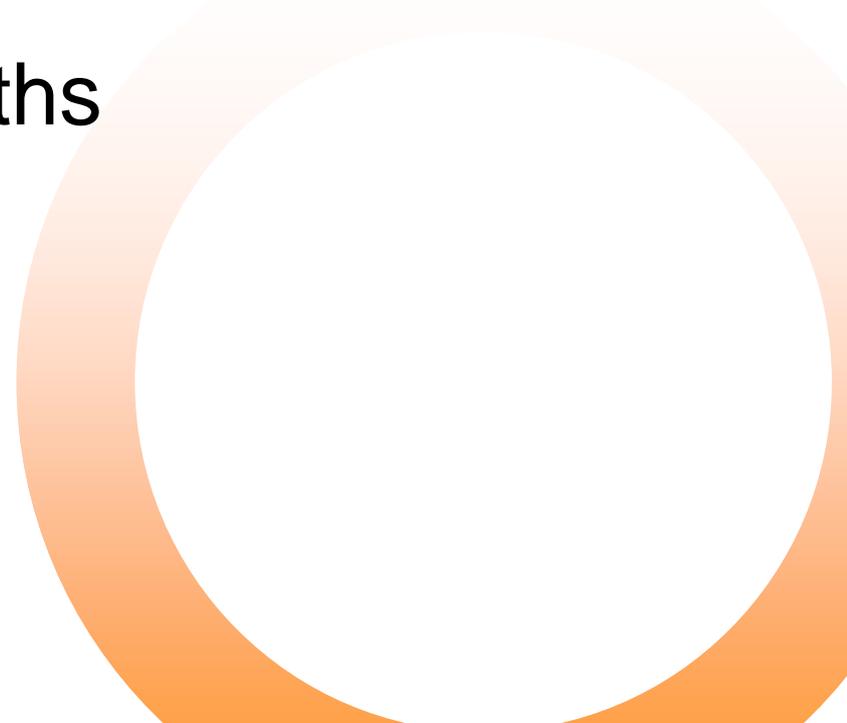
- The number and nature of child death reviews;
- The likely public interest in the identified issue of concern;
- The number of children likely to be affected;
- Whether reviews of the issue have been done recently or are in progress by the Office or other organisations;
- The potential for the Ombudsman's investigation to improve administration across public authorities; and
- Whether investigation of the chosen topic is the best and most efficient use of the Office's resources.

# Own Motion Investigations - Method

- Preliminary research and planning
- Consultation with agencies
- Draft findings and recommendations
- Report tabled in Parliament containing final findings and recommendations

# Own Motion Investigations – Completed

- Planning for children in care
- Sleep related infant deaths
- Youth suicide



# Own Motion Investigations - Current

- Deaths from drowning
- The implementation and effectiveness of Ombudsman recommendations arising from own motion investigations

# Conclusion

- Dual model – individual case reviews, and the identification of patterns and trends to inform own motion investigations.
- Focus on government agencies administration of their responsibilities and potential gaps, individually and collectively.
- Recommendations for improvements to public administration to prevent or reduce these deaths.



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**Ombudsman Western Australia**  
Serving Parliament – Serving Western Australians

# Child Death Review: Achieving Outcomes that make a Difference

***Dr Felicity Dumble***

***Child and Youth Mortality Review Committee  
New Zealand***

# **The Child and Youth Mortality Review Committee**

**Learning from the past to prevent avoidable loss in the future**



**4th Australasian Conference on Child Death Inquiries and Reviews**

**Dr Felicity Dumble, with contributions from Dr Nick Baker**

A long time ago in a city far, far away...





# Mortality Review in NZ

- CYMRC
- PMMRC
- POMRC
- FVDRC
- Suicide
- Hospital review

# CYMRC

- The Child & Youth Mortality Review Committee (CYMRC) was established under the NZ Public Health & Disability Act 2000
- The CYMRC is an independent committee reporting directly to the Health Quality & Safety Commission
- Aim = reduce preventable deaths through an interdisciplinary and interagency approach

# Local CYMR Groups

- Local groups function as regional extensions of the national committee
- 20 groups based in DHBs
  - Multidisciplinary and multi-sectorial
  - Network and linkages
  - Rapid local action
- A third of cases medical focus
- Collection of detailed local data and stories

# How do local groups work?

## The Waikato Group as an example...

- Established in 2005
- Police, CYF, St John, Plunket, Ministry of Education, Quality and Risk, paediatricians, Whakawhetu (formerly Māori SIDS), mental health services, child protection, local Iwi representative, Population Health, primary care, maternity care...
- Group meets once a month for 2 1/2 hours
- Reps bring information discussed openly in “no fault” context
- Recommendations are agreed and reported
- Representatives take ownership of relevant recommendations and report progress to the group

Pre - Death Events and Circumstances

Death

After Death Events



Understanding of Causal Pathway

Identifying Intervention points

Learning/ findings

Case specific / Population specific



Local Action

What

How

Who

Issues

Means

Context

Recommendations

Outcome

National Action





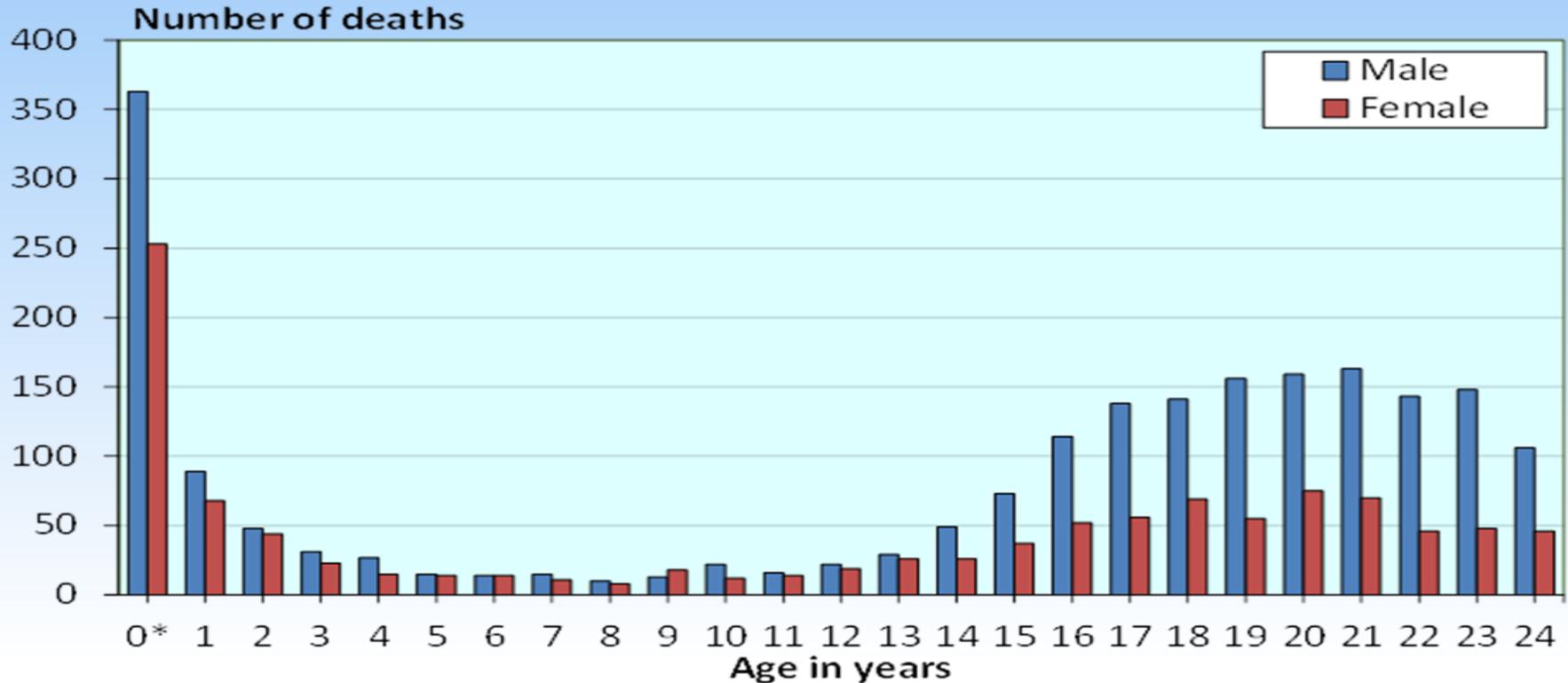
# CYMRC Data



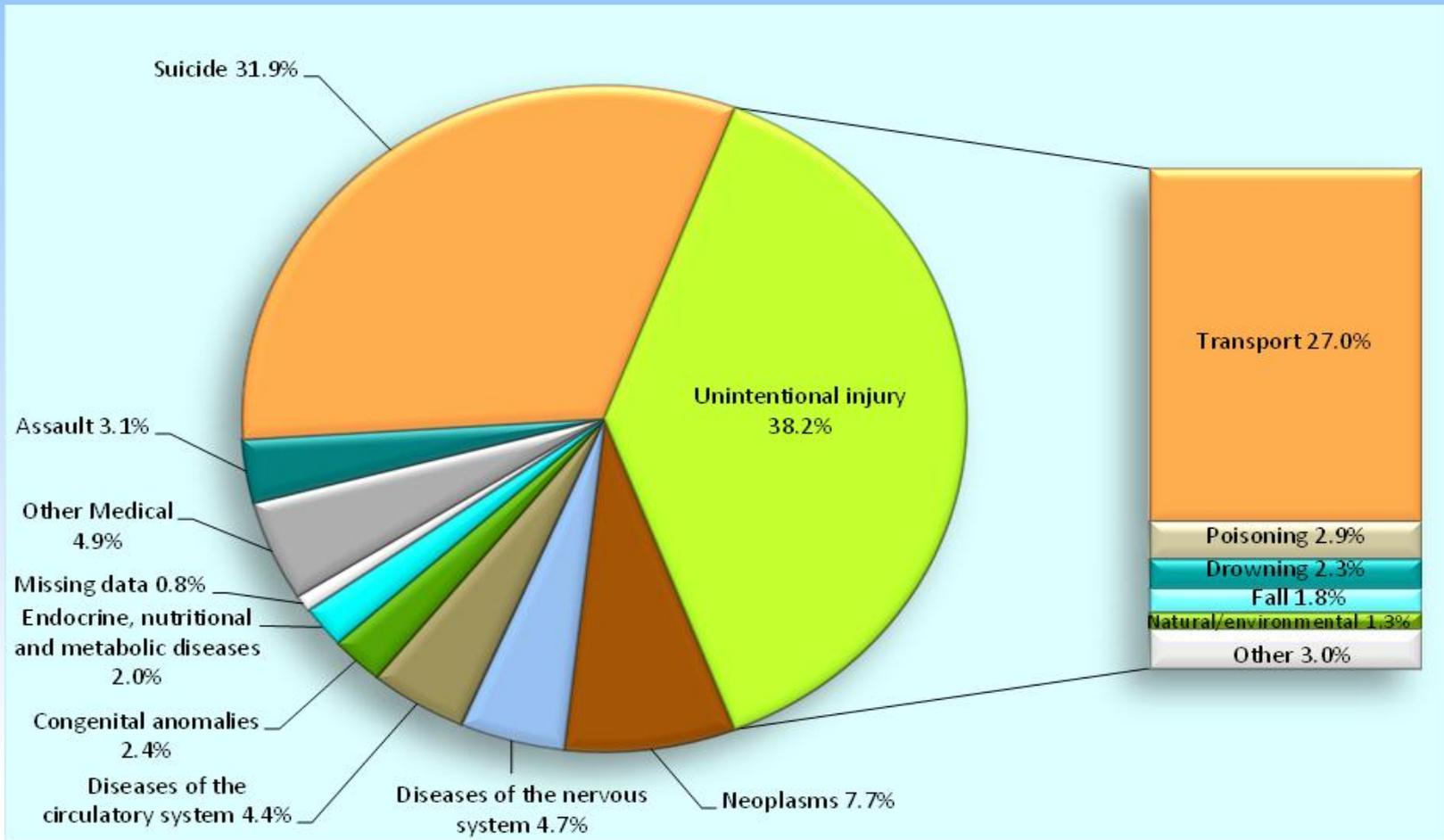
# Types of reports

- National data
  - National Data Overview 2007–2011
- DHB data – 2 versions
- Activities
- Special topic

# Mortality statistics 2008–2012 combined

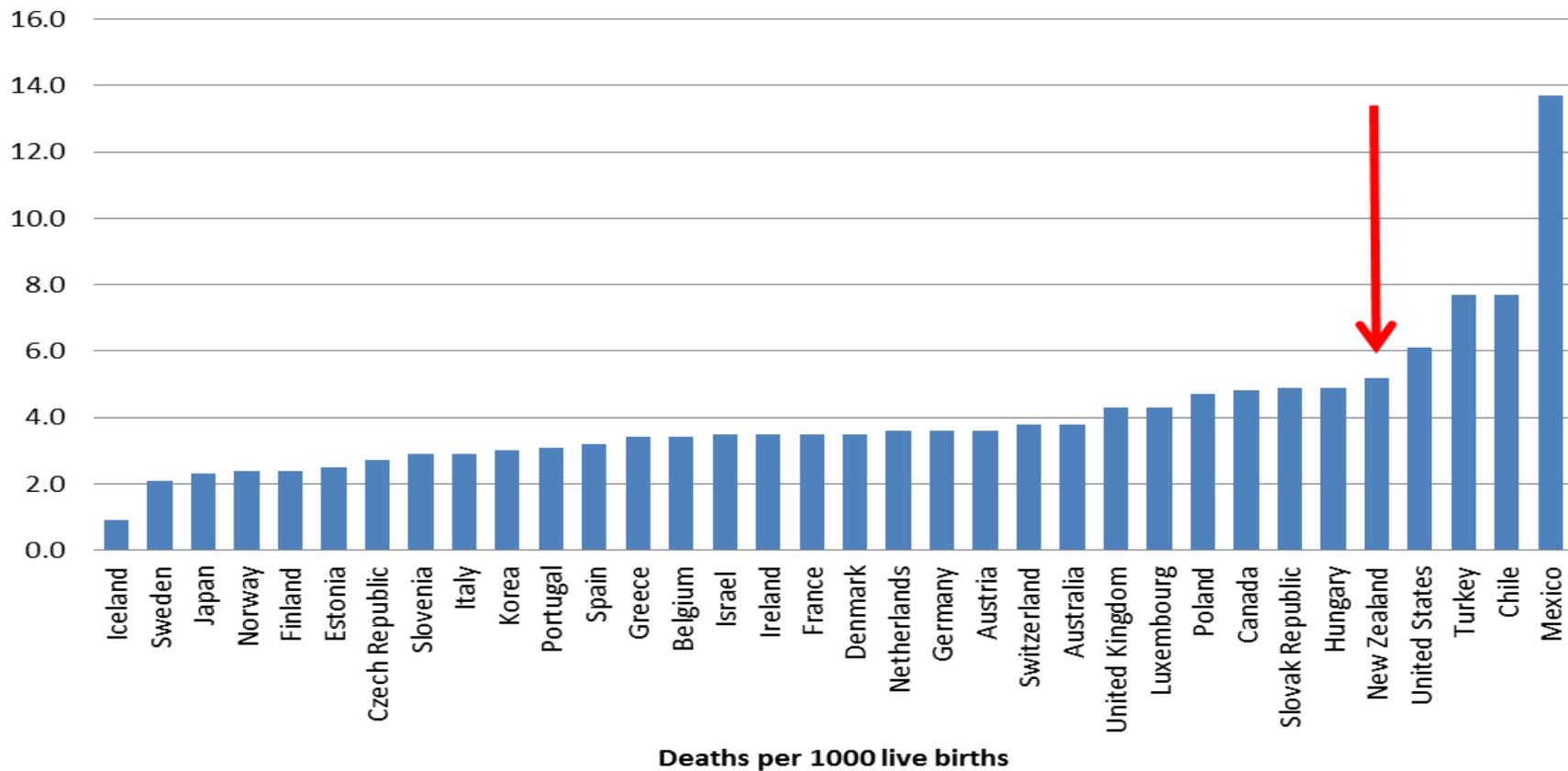


# Cause of mortality in 20–24-year-olds (%), by category of death, 2008–2012 combined (1004 deaths)

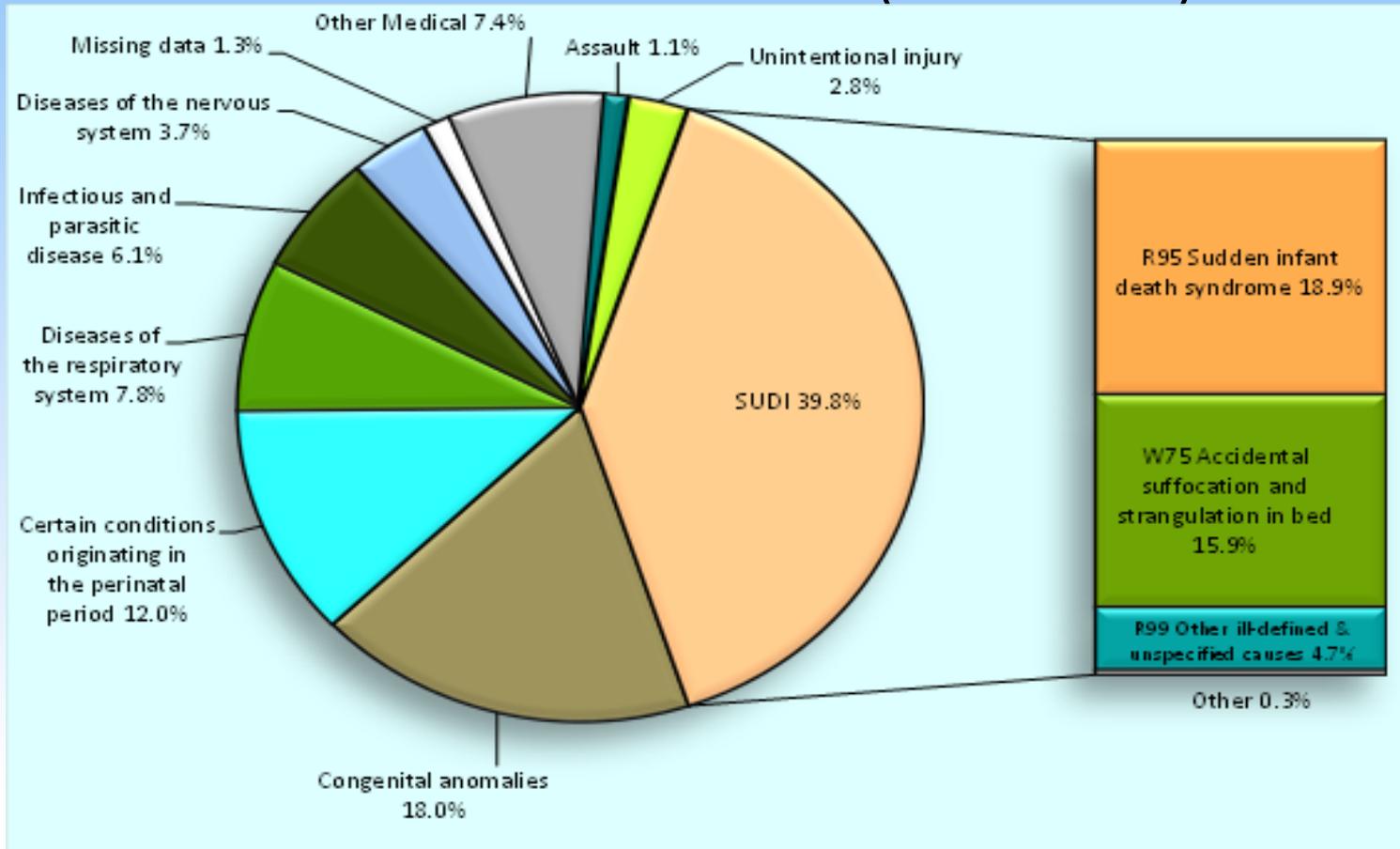


# Sudden Unexpected Death in Infancy

## Infant mortality for OECD nations 2011



# Causes of post-neonatal mortality (%), by category, 2008–2012 combined (618 deaths)



# Sudden Unexpected Death in Infancy

- Sixty Deaths Every Year
- Many preventable
- A public health emergency?!
  - Good news -- 3000 babies have not died since 1992
  - Disappeared off nation's radar?

*“Among the industrialized nations, New Zealand has the highest rate 1.1/1000”*

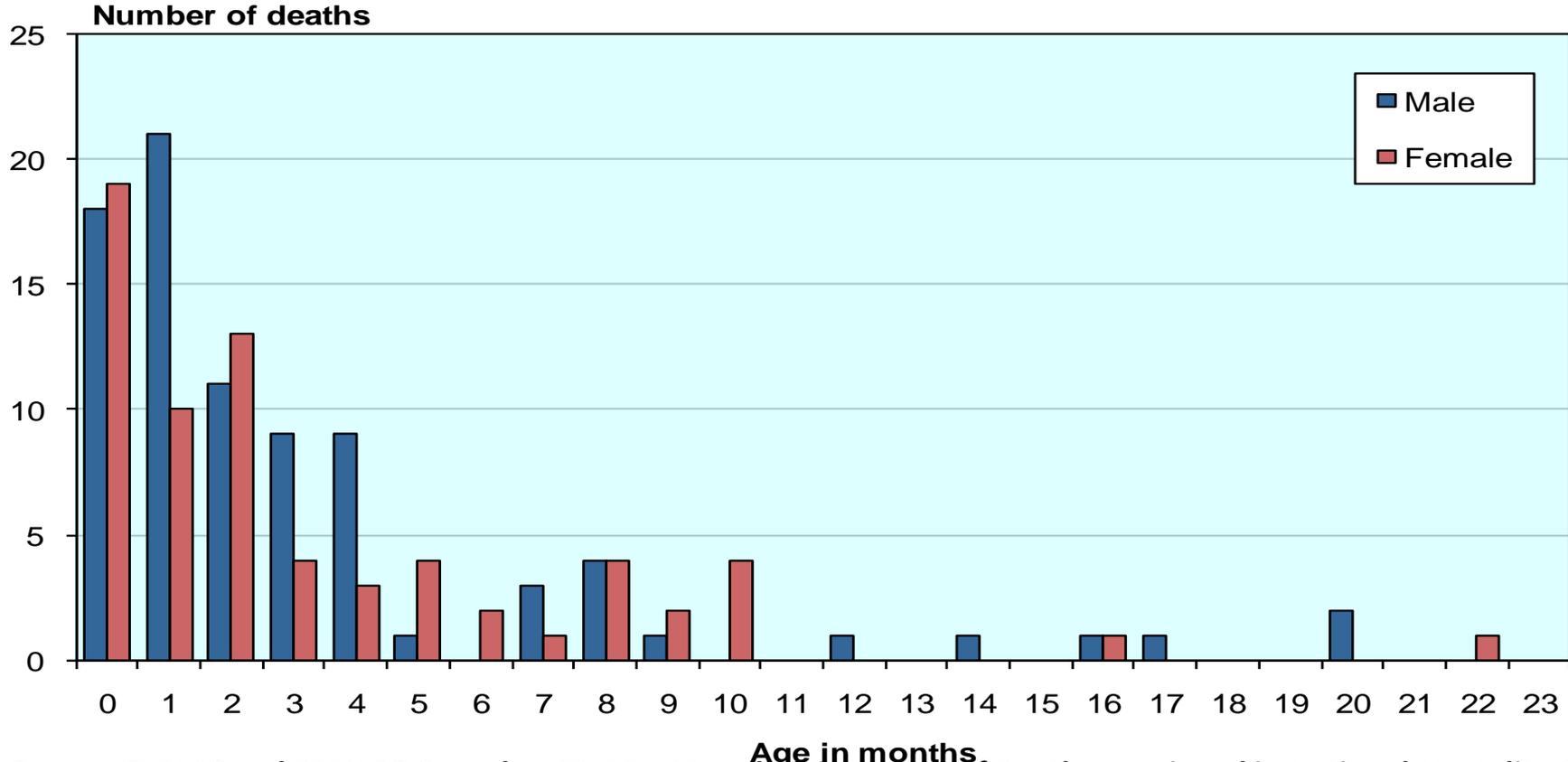
- *Maori 2.3, Pacific 1.3, Other 0.5 (per 1000)*

*Unintentional  
suffocation,  
foreign body  
inhalation and  
strangulation*

March 2013



# Accidental suffocation in place of sleep - 0 days to 23 mths NZ 2002-2009 (n=152)



Source: CYMRC and PMMRC Cases by ICD-10-AM Underlying Cause of Death as assigned in National Mortality Collection.

# Suffocation in Bed

- Entrapment/wedging
  - Soft surfaces, bedding poor fitting, bed/wall
  - Broken cots
  - Sofa, Pillows and Cushions
  - Domestic chaos
- Suffocation if shared sleep surface
  - Adult > sibling > mother while feeding
- Infants 20 times more likely to suffocate in adult bed than cot or bassinette
- Hazards away from home and make shift

# Consistent and Persistent Safe Sleep Practices

- Maori community driven solutions
  - **culturally appropriate, appealing, possible, easy**
- Safe sleep for infants reprioritised
  - **Model and support good practice at every opportunity**
    - Especially during health care – staff, training skills
    - Policy, audit, record keeping
  - **Antenatal preparation**
  - **Enable safe sleep – make doing the right thing easy**
    - “we did it with car seats”
    - Wahakura, Pepi-pods
  - **Whole of society priority**
    - Health curriculum in schools to great grand parents!
- Every baby needs a sober caregiver





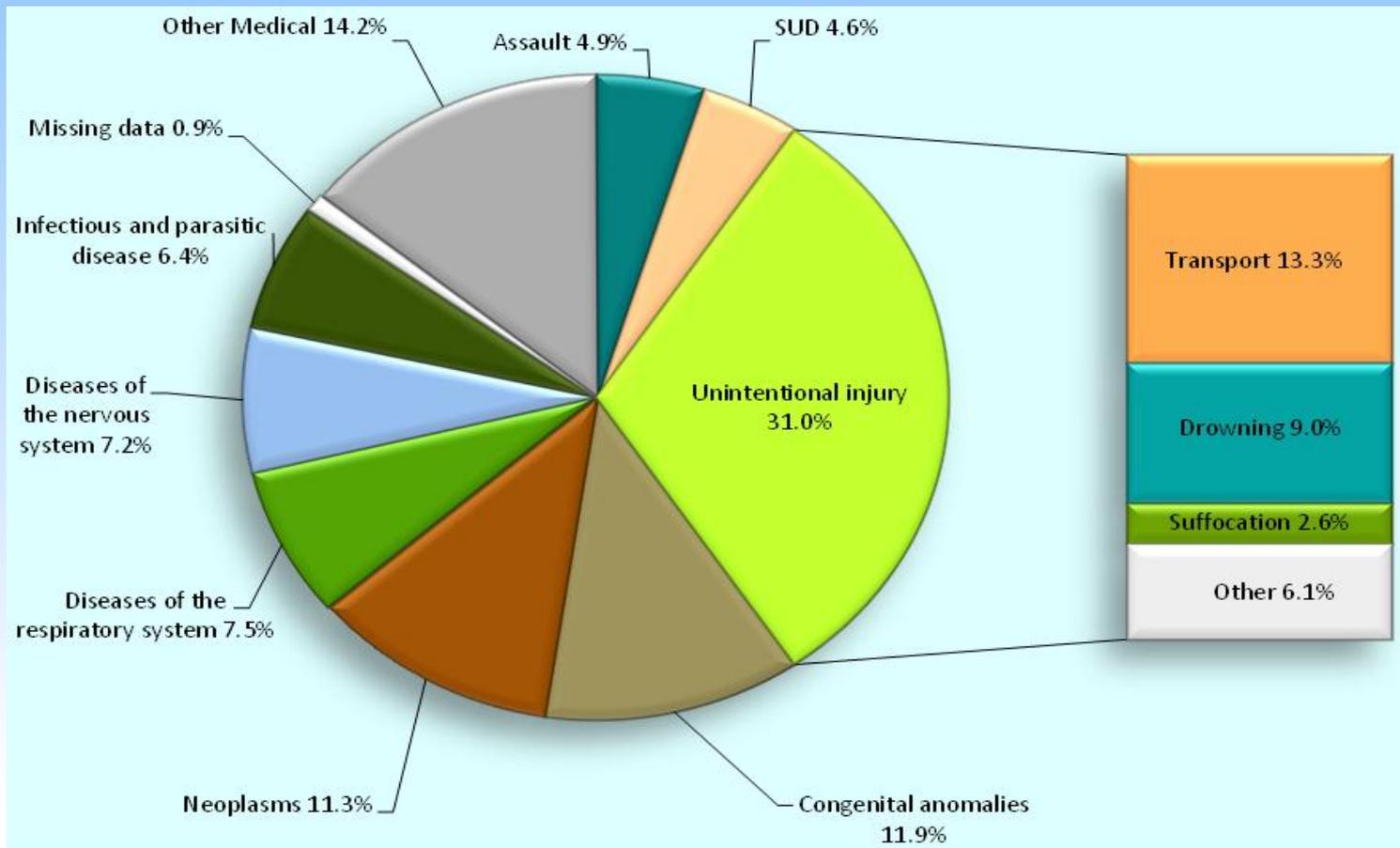
# Implementation

- Whakawhetu e-learning package founded on our information
- DHB policy formation – HQSC support letter influence
- Change for Our Children - DHB policy framework and audit
- Pepi-pod roll out, supported by safe sleep knowledge
- Coroners using the information
- Injury prevention workers engaged (eg, SafeKids and IPRU)
- Consumer affairs product safety information
- MOH redrafting education resources & setting targets
- Provider training systems
- MSD guidance to caregivers

# *Low speed run over mortality*

August 2011

# Cause of mortality in children aged 1–4 years (%), by category of death, 2008–2012 combined (345 deaths)



# Low speed run over

- Twenty seven cases over five years
  - under six years old
  - outside a vehicle
  - mostly in driveways
  - low speed (< 10 km/hr) moving vehicle
  - not always reviewed because they occurred on private property

No SIM



23:58

74%

Layers



orpheus place, papakura



Google earth

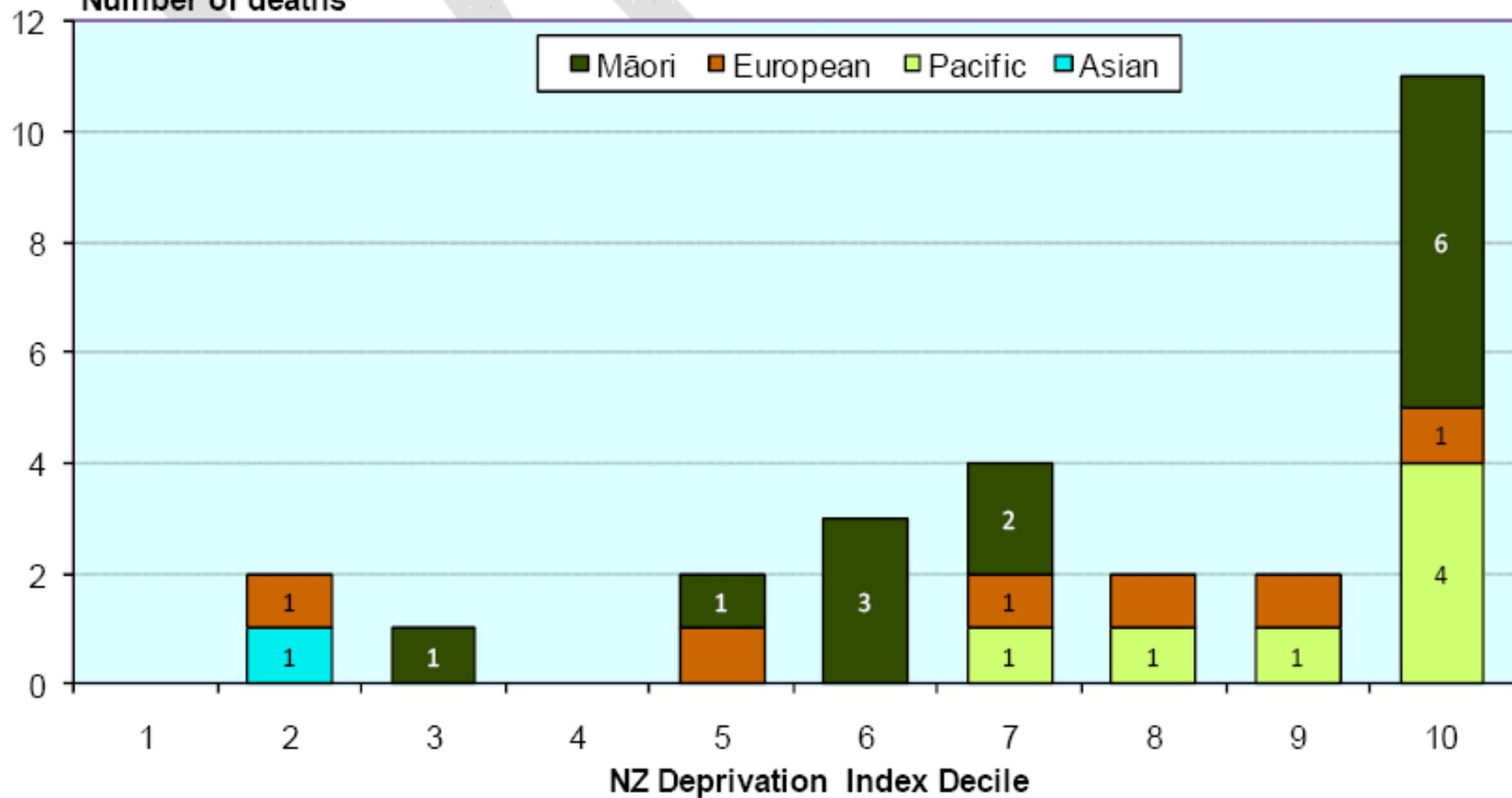


Orpheus Pl, Papakura, New Zealand

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# Number of deaths



# Activity of deceased

Activity of deceased	Number of deaths	Percentage of total known n=21 (%)
Passive play or wandering	11	52.4
Playing with other children	4	19.0
Transition from passenger to pedestrian	4	19.0
Unexpected sudden movement	2	9.5
Unknown	6	-
<b>Total</b>	<b>27</b>	<b>100.0</b>



- 13,000 houses with under fives assessed
- Housing NZ Checklist
- New Zealand takes out Leading innovation and Leading Asset Management trophies at Australasian Housing awards – *Oct 2013*

# Local initiatives

- Ownership of recommendations by Local agents
  - Pol 47a
  - Transport of deceased infants
  - Pool fencing audits

# The way forward

- Off Road report
- Maori caucus and report
- Pertussis burden of disease
- The vulnerable child, ACE
- Cross committee