

Our reference: ADM/1704P04

1 February 2013


The Hon Catherine Cusack MP
Chair
Committee on the Office of the Ombudsman,
Police Integrity Commission
and the Crime Commission
Parliament of NSW
Macquarie Street
SYDNEY NSW 2000

Dear Madam Chair

**18th General Meeting of the Committee and Second General Meeting with the Convenor
of the Child Death Review Team**

Please find attached answers to your Questions on Notice for the 18th General Meeting with
the NSW Ombudsman and the Second General Meeting with the Convenor of the Child Death
Review Team.

Yours sincerely



Bruce Barbour
Ombudsman

Enc.

Second general meeting with the Convenor of the Child Death Review Team

Answers to questions on notice

- 1. In your evidence to the Committee in June 2012 you explained that the software used to maintain the Child Deaths register was outdated and that you were developing a business case for supplementary funding to replace it. Can you provide an update on the progress of this project?**

We completed a business case, and have sought funding from Treasury to implement a new system. It should be noted that the problems are not only software related, but concern the entire data system; including the platform, data capture, and reporting capacity. Our work to inform the business case included a business and system analysis, development of data specifications and a review of options for a new system.

We took a three tiered approach to funding:

- In July 2012 we submitted a request for supplementary funding of \$160,000 in 2012-2013 and a further \$90,000 the following year to NSW Treasury. It is usually not the practice of NSW Treasury to provide supplementary funding however we thought that this project required immediate action. Our request was not successful
- In October 2012 we submitted a request for funding from the ICT reinvestment pool. Our request included a short form business case. In December 2012 we were advised by the NSW Treasury that our application was unsuccessful.
- In November 2012 we submitted a 'Parameter and Technical Adjustment Proposal' to NSW Treasury as part of our forward estimates submission. This proposal is still be considered by NSW Treasury as part of its overall 2013-2014 budget strategy. NSW Treasury has sought additional information from us, including some more detailed costing of various options. This information is to be submitted by early February 2013.

We have been disappointed by the response to our request for funding to date.

The need for a new data system is critical for the CDRT. We have been advised by our database consultant that further design amendments to the existing database should not be made unless absolutely necessary, and that the system is reaching its 'end of life' in terms of stability and maintainability. A copy of the consultant's project briefing is attached at annexure A for the Committee's information.

- 2. In your 2010 Annual Report you conducted a survey seeking feedback on the Report. In your evidence to the Committee in June 2012 you indicated that at the time you were in receipt of 15 responses. Can you brief the Committee about the findings of the survey?**

We received 18 responses to the survey. Generally, most thought that the 2010 report was useful and an improvement on previous reports, and that it contained about the right amount of detail. Positive comments largely related to depth and focus of analysis in the report; and improvements were indicated in trends analysis, more detailed focus to the analysis, and presentation of data. A copy of the survey questions is attached at Annexure B.

In more detail, the survey results identified:

Fourteen respondents (78%) answered 'Government' for their work organisation. Seven of the sixteen respondents (39%) who answered stated that their work sector was health-related. The others were Community Services, an inter-state Ombudsman's office, ADHC, Transport NSW (2) and one non-government organisation. All but one were NSW based, and one respondent did not answer.

Fifteen respondents (83%) stated that their interest was work related, one person stated personal interest and one did not answer.

Twelve respondents (67%) said that they were interested in the entire report, four stated only external cause deaths (assault, suicide, transport-2) and one perinatal deaths.

Fourteen respondents (87%) had received a copy, two stated 'personal contact', one had read a media report and one did not answer.

No respondents endorsed 'Safety' as an area in which they could use the report, four replied that they could use it in 'Research', four that they could use it in 'Policy Development' and five that it could be used to 'Improve service Delivery'. Three replied that their interest was for personal knowledge.

Sixteen out of eighteen respondents (89%) thought the report 'Quite useful' or 'Very useful'. Sixteen out of seventeen (88%) thought the report 'Very clearly written' or 'Quite clearly written'. Only one respondent found the report 'Not useful at all' and 'Not at all clearly written' and one did not answer. Of the eleven respondents who answered the 'Improved' question, two found it 'Much Improved', eight found it 'Quite improved' and one found it 'Not much improved'.

Thirteen out of eighteen thought the level of detail 'About right' with two 'Too little detail', one 'Too much detail' and one 'Far too much detail'.

Ten respondents gave positive comments about 'What the report does well'.

- Objective Assessment
- Identify patterns and trends in cause of death. Provide breakdown for Aboriginal children.
- Clearly outlines the causes of death and enough detail to see how they occurred. Great summary of take home messages to prevent future deaths.
- Clear examination of the issues and recommendations.
- Detailed analysis of causes of deaths.
- Sets forth clearly some of the risk factors for children and young people.
- Well presented.
- Differentiates causes of death in childhood.
- Relates the statistics in a comprehensive manner.
- Description of causes of death Over representation of Aboriginal and Torres Strait Islander population.

Six comments were made in 'What could be improved', but two of these were 'No comment' and 'Nothing identified':

- Improvements in presenting data that is dense are noted. Continuing that into the next report would be good.
- More analysis of background information in relation to trends in deaths may be helpful when considering how the information can inform practice.
- Sources of data and research methodology. It should be included in the table of contents.

- Prenatal and 1 month postnatal deaths should be analysed separately.
- Recommendations and how and where it is possible to prevent child death.

In the 'Other comments':

Transport extends to cars, trains, trams, buses, ferries, cycling and pedestrians and the Report could be extended to cover all modes. (*Note: the report does include all modes of transport*)

- Will be better when integrated with deaths due to neglect etc.
- Broad geographic areas for assault / neglect deaths.
- I could not locate anything to explain the sources of data and the methodology used. Maybe it is there, but I couldn't find it.
- Health should be involved with CS in doing reports on reviewable deaths
- Education and awareness information.

- 3. Your 2011 Annual Report notes that 32 children from NSW died outside the state during 2010 (p34). You also note that the Child Death Review Team is a member of the Australia and New Zealand Child Death Review and Prevention Group, which aims to identify trends and issues and achieve consistency in definition and approach between jurisdictions. Can you provide an update about the work of this Group?**

The Group meets annually, and has its next scheduled annual meeting on Monday, 25 February. Responsibility for convening the group recently moved from Queensland (Ms Elizabeth Fraser, Commissioner for Young People and Child Guardian) to Victoria (Professor Jeremy Oats, Chairman, Consultative Council on Obstetric and Paediatric Mortality and Morbidity).

The group is not a funded or resourced entity; it is a voluntary coalition of similar entities that have responsibility for child death review. Each state and territory – while having some form of child death review – differs in focus, jurisdiction and capacity. These factors limit the scope of work the group is able to undertake, in the absence of explicit support from both levels of government. Despite these limitations, the group is committed to working collaboratively to maximise the knowledge held in each jurisdiction, and to achieve national consistency in reporting.

The work of the Group has been recognised under the *National Framework for Protecting Australia's Children 2009–2020*; Outcome 4, Strategy 4.4 of the Framework identifies the need for enhanced national consistency and continuous improvement in child protection services. Actions listed under Strategy 4.4 include supporting the Group to '*develop more consistent data to help better understand the circumstances of child deaths and how these could be prevented.*'

Throughout 2011, and in the context of the Framework, the Group focused considerable effort on preparing a submission for Commonwealth funding for a 'preventable infant mortality' project. The aim of the project was to initiate a national data analysis and agenda in relation to infant mortality. Part of this work was to develop a working definition of 'potentially preventable' infant mortality, and to establish and analyse a national infant mortality data set.

The proposal for funding was unfortunately not supported by the Department of Families, Housing, Community Services and Indigenous Affairs.

The most recent work involving the Group was the preparation of national data on child deaths in 2011. This was prepared by the Queensland Commission for Children and Young People and Child Guardian, and published in that organisation's annual report of child deaths. A copy is attached at annexure C.

It is clearly desirable that there be national focus and response to risks and prevention strategies that are similar in all states and territories. While there is a strong commitment between states and territories, focused national work is likely to progress very slowly without national impetus.

- 4. The overrepresentation of children with a history of child protection notifications among child deaths is an issue of continuing concern. At the hearing in June 2012, you indicated that this would be a major focus of your work in 2013. Can you tell us what work you are planning to do in this area.**

The Team has commenced work on a project to analyse causes of death for children from families with a child protection history over a 10 year period. The analysis will identify any differences in causes of death for this group of children, compared with children whose families had no child protection history.

The purpose of the project is to identify any causes of death which are more common amongst these children, and if so, why this may be the case, and whether targeted prevention strategies are warranted. The project will consider all manner of deaths (natural, unintentional injury, intentional injury, suicide). Previous work undertaken by both the Ombudsman's office (2007) and the CDRT (2008) has indicated the need for further research in this area. For example, the Ombudsman's work identified children whose deaths were reviewable (over 90 per cent of which were children with a child protection history) were over 7 times more likely to die as a result of intentional causes of death than non-reviewable children, and over twice as likely to die as a result of unintentional causes of death.

The Team has contracted the Australian Institute of Health and Welfare to conduct the initial data analysis using ICD-10 classification of underlying causes of death and contributory causes of death of children. This work will include analysis of underlying and contributory cause by age, gender, indigenous status, remoteness and socioeconomic status. The analysis will also consider the rates and causes of death for children identified as Sudden and Unexpected Death in Infancy (SUDI) in the two groups.

CDRT staff in the Ombudsman's office are conducting complementary work on group reviews of children who have died, with a particular focus on looking at the frequency of reports about child protection concerns.

The project will be completed by October.

- 5. Aboriginal children are also significantly over-represented among child deaths? Do you have any specific projects planned in regard to Aboriginal issues?**

The over-representation of Aboriginal children in child deaths in NSW – and nationally – has been a consistent trend over the 16 years of the CDRT.

The Team has two Aboriginal representatives, and its work in general has given close regard to the deaths of Aboriginal children; for example, in the above mentioned project, Indigenous status is a specific point of analysis.

The Team does not have any specific projects planned that focus on Aboriginal issues. The Team has a scheduled planning day in March 2013, and this will consider the Team's future priorities and key areas of focus.

Work on child deaths within the Ombudsman's office is also informed by this office's broader work on Aboriginal issues. For example, this office recently completed a three-year audit of the Interagency Plan relating to child sexual assault in Aboriginal communities. This work has spanned a range of areas related to Aboriginal disadvantage, child protection, education and health. Since 2005, we have

tabled seven reports in the NSW Parliament specifically relating to Aboriginal issues, with the two most recent reports focused on Aboriginal children.

6. You have previously recommended that the Ministry of Health develop a social marketing campaign and new media resources for suicide prevention (p.117). Can you give us an update on the progress of this recommendation.

As noted in the section on monitoring recommendations of the *Annual Report 2011*, the Team recommended in its 2009 Annual Report that the NSW Government ‘consider the range of communication mediums used by children to inform peers of their intention to suicide.’ In the context of that recommendation, NSW Health advised that it was developing multimedia resources to target young people as part of the NSW Suicide Prevention Strategy.

In 2011, the Team requested a progress report. NSW Health subsequently advised that it was tendering a suicide prevention market research project that would identify and review new media and social media initiatives promoting suicide prevention for young people. The Team was advised that the market research project would inform the development of a communication strategy.

In 2012, the Team requested a further progress report. The Ministry of Health advised the team that ‘The market research project is currently on hold while another of the commitments in the Suicide Prevention Strategy (community guidelines for discussing suicide) is being finalised.

The Team has now made a further recommendation in its Annual Report 2011 that:

The Ministry of Health should progress the proposed development of a social marketing campaign and new media resources for suicide prevention in 2013 with specific inclusion of aims to:

- Develop multimedia and new media resources that target young people and provide support and information to those affected by suicide or suicide attempt
- Develop effective strategies to raise awareness among young people of suicide prevention, to promote help-seeking behaviour, and to challenge the stigma associated with suicide.

We do not have an update on the Ministry’s progress on this recommendation at this stage. Standard process for the Team is to seek a progress report from agencies closer to the time the next annual report is being prepared. We will seek specific information from the Ministry in April.

7. In your 2011 Annual Report (p. 85) you have recommended that the Centre for Road Safety should bring together key agencies to consider the need for targeted research and public awareness strategies to prevent low-speed vehicle run-over incidents. Is it your view that such research and awareness strategies are needed?

The Team’s view is that low speed run-over incidents are preventable, and that would indicate a need for a better understanding of why they occur, and for prevention messages that deliver the right information in the right way.

As the report notes, there are a number of strategies that may have a preventative impact on low speed vehicle run-overs; changes to vehicle design, modifications to housing and driveway design, and raising public awareness.

It is the Team’s view that the best approach to identifying exactly what is needed is to coordinate the expertise of agencies and groups in NSW that are actively concerned with, or active in, the prevention of childhood injury – both broadly and in a transport context. These groups are best placed to look

closely at what is being done now or is planned, both in NSW and nationally, and to identify where the gaps are in research and public awareness campaigns.

The Team also plans to release its second occasional paper on low speed vehicle run-overs soon. The paper will aim to provide prevention messages that link with existing prevention efforts.

- 8. In your Annual Report (p. 122) you note that the Child Death Review team has repeatedly recommended that the Motor Accidents Authority develop targeted strategies to reduce the number of driver deaths of children under 16 that occur in the context of recreational activities. In 2010 the Motor Accidents Authority advised that it had provided \$50,000 to the Commission for Children and Young People to appoint a project officer to commence this work. However, in your Annual Report you note that you have since been advised that this money was not paid and the recommendation had not been implemented. Can you explain what happened?**

Firstly, it should be noted that the recommendation was made in 2008 (*Trends and issues in child deaths 1996 – 2005*) and progress toward implementing it was monitored by the Commission for Children and Young People prior to the transfer of the CDRT to this office.

From our review of the information we have received from both agencies, and the relevant CDRT annual reports, it appears that the Motor Accidents Authority (MAA) determined it would progress the recommendation by providing \$50,000 funding to the Commission for Children and Young People (CCYP) in 2008. The CCYP in turn appears to have commenced a process to facilitate a ‘multi lateral agreement from relevant agencies to develop and implement a plan for reducing childhood injury’ from falls, off-road use of motor cycles and other vehicles, and safe socialising and transport options for young people. The CCYP appears to have undertaken a number of activities from 2008 to progress this work, including establishment of a reference group in April 2009 that met three times in 2009/10, research into models of injury prevention, and consultation with other states. However, this approach seems to have been overtaken by a different injury prevention initiative; the production of a surveillance report on childhood injury more generally. The Commission released this report in December 2012.

The Team expressed disappointment in its 2011 Annual Report because – notwithstanding the production of a surveillance report on childhood injury – there has been no substantive action on the recommendation to develop targeted strategies to reduce driver deaths of children occurring during recreational activities.

In regard to the funding, in February 2012, we sought advice from the CCYP about the current status of the Commission’s work in relation to prevention of childhood injury. We referred to the MAA’s funding of \$50,000. In response, the CCYP advised that:

The Commission has investigated this matter in liaison with the MAA and wishes to advise that the Commission’s financial records indicate that this grant was not received. An agreement existed between the Commission and the MAA to pay this amount, however the financial records of both organisations indicate that the grant was not paid.

The MAA subsequently advised us that it was intended that the 2008 recommendation be progressed by the MAA contributing to the payment of a project officer at the CCYP, and ‘...during 2010 and 2011 the MAA were advised by the CCYP that the work was progressing and that funds had been received. It was later discovered in 2012 that despite previous advice, CCYP had not invoiced the MAA.’

- 9. The Team's 2010 study on Sudden Unexpected Death in Infancy made a number of recommendations in relation to the Ministry of Health (p. 118) Can you provide an update about the progress in implementing these recommendations, from your perspective?**

At this stage, we have no additional information than that reported in the Annual Report 2011. The CDRT has formed a SUDI sub Committee that plans to oversee the Ministry's progress with all recommendations, including the recent recommendation that the Ministry review the purpose, terms of reference and membership of the NSW Sudden Infant Death Advisory Committee.

In our view, the Advisory Committee has the potential to provide the expertise, coordination and direction necessary for progressing positive work in this area.

Deloitte.



NSW Ombudsman

Project Briefing:

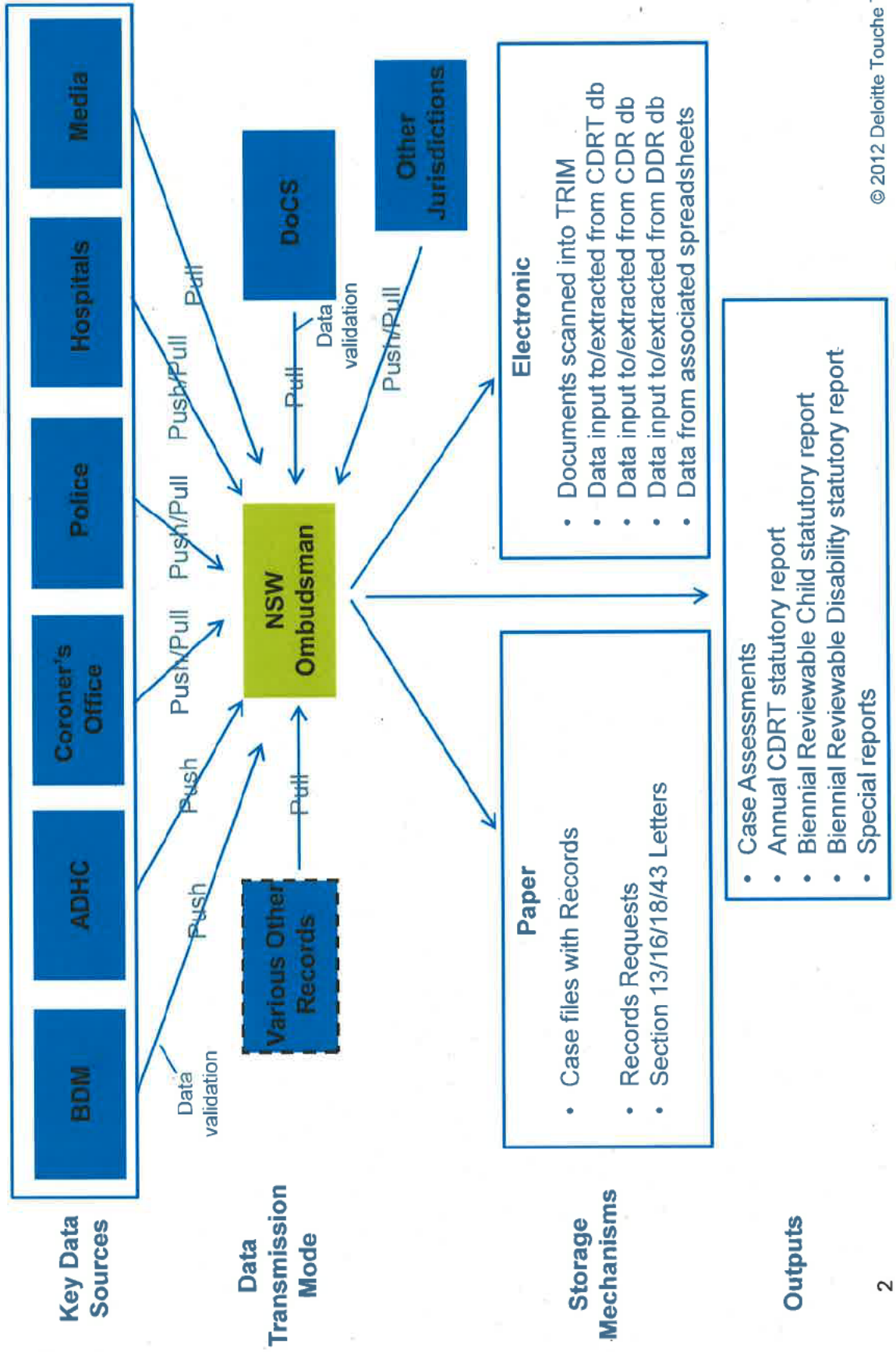
Toward an Improved System for Reviewable Deaths & CDRT Data

June 2012

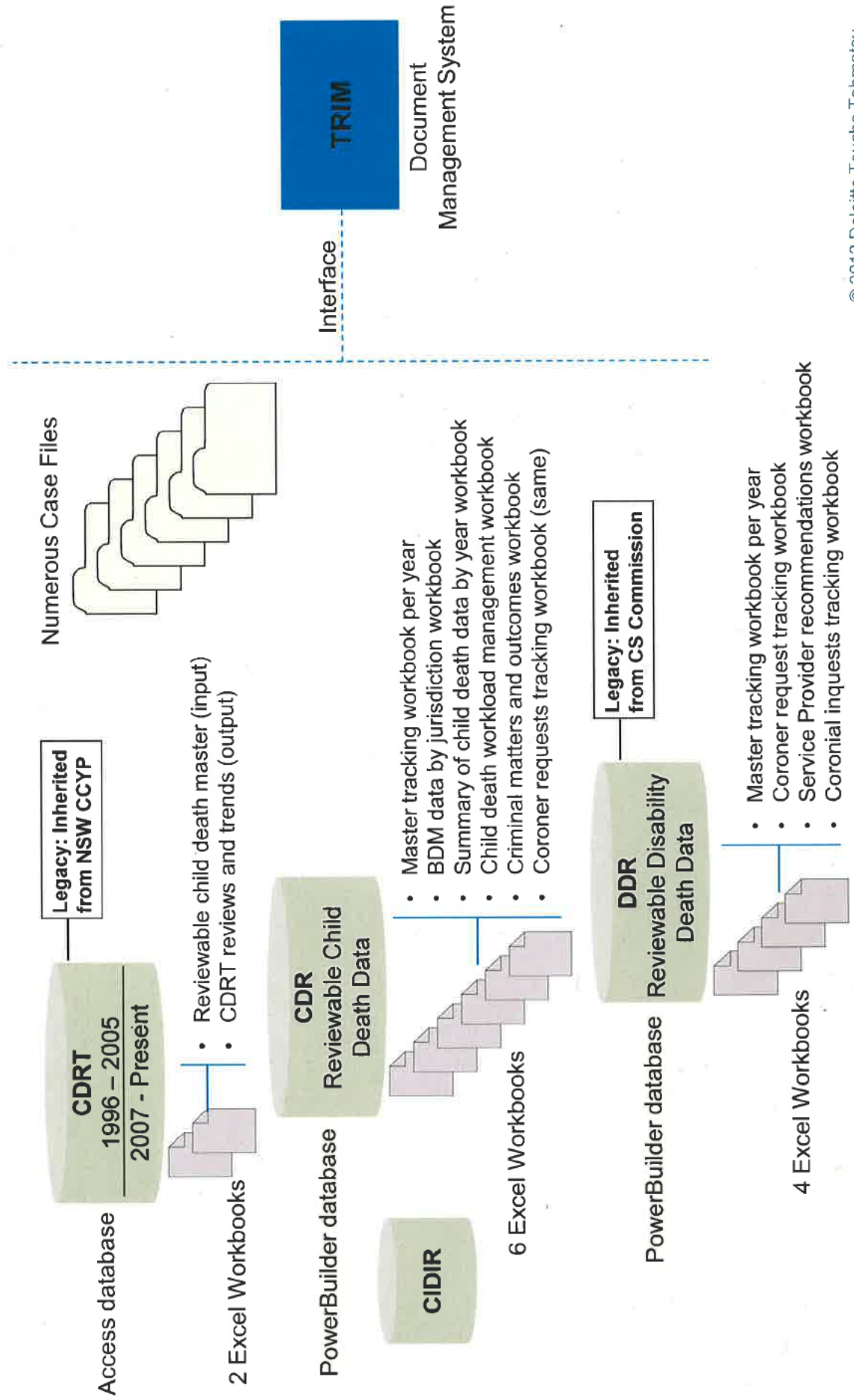
NSW Ombudsman initiated a business and system analysis project toward achieving the following objectives:

- Review and document business processes to identify opportunities for gaining efficiencies, eliminating duplication and leveraging automation
- Gather requirements to provide the foundation for an enhanced system supporting Reviewable Deaths and recently integrated Child Death Review Team (CDRT), including requirements for case data registration, analysis, review and reporting
- Determine new data structure for storing and managing Reviewable Deaths and CDRT data
- Identify options for enhancing (replacing) Reviewable Deaths and CDRT system

Information flow for Reviewable Deaths and CDRT data comprises multiple inputs and outputs



NSW Ombudsman currently uses a number of entities to register, analyse, review and report the Reviewable Deaths and CDRT data



NSW Ombudsman envisions an enhanced system that provides new benefits to help harness the power of the data

Drivers for Improvement

Present Challenge	Potential Future Gain
Separate, disconnected databases for storing and managing Reviewable Deaths and CDRT data	Single unified database for all data
Important case data stored outside of databases in various sources such as case files	Storage of as much case data as possible in single unified database
Mixed use of defined data values and lengthy narrative text	Use of defined values for as many data points as possible to support improved reporting
Limited reporting options	Augmented and ad-hoc reporting
Time intensive reporting largely dependent on submitting report generation requests to IT	Efficient report data extraction performed by business staff users
High degree of manual intervention	More automated processes and communication
Difficulty tracking status of cases	Case workload management to support timely case allocation and tracking
Lack of "What If?" analysis	Facilitation of decision-making and scenario analysis
Multiple user entry points given separate databases	Common user interface
Common user credential used by all staff accessing databases	Individual, secure usernames and passwords
Limited data version capability	Data storage, audit trail and archiving to support data integrity

Project team has followed a clear roadmap to help pave the way for a successful system project



Activities	Stage 1 Current State Assessment	Stage 2 Future Requirements	Stage 3 Business Case Development	Stage 4 Sourcing Strategy	Stage 5 Procurement Process
	<ul style="list-style-type: none"> • Conduct As-Is assessment • Identify key issues • Communicate key findings • Review and document business processes 	<ul style="list-style-type: none"> • Conduct To-Be assessment • Gather requirements • Consolidate list of requirements • Identify data needs 	<ul style="list-style-type: none"> • Consider options • Existing technology • New technology • Establish evaluation criteria • Establish risk assessment • Determine indicative costs • Identify benefits realisation • Outline system implementation timeline 	<ul style="list-style-type: none"> • Determine sourcing approach • Existing contract • EOI • RFP • RFT • Research potential providers • Establish evaluation criteria 	<ul style="list-style-type: none"> • Prepare and distribute procurement documents • Evaluate and make recommendation • Negotiate and finalise contract • Mobilise team • Develop project plan

Deliverable	Stage 1 Current State Assessment	Stage 2 Future Requirements	Stage 3 Business Case Development	Stage 4 Sourcing Strategy	Stage 5 Procurement Process
	Process Maps	Requirements Specification & Data Tables and Relationships Specification	Business Case	Sourcing Strategy	Contract & Project Plan

Project team started with identification of Guiding Principles






The Requirements and Design approach of a new system will:

- Be business-driven
- Be outcome-focused – provide data to help service providers deliver improved health outcomes
- Support smart and consistent capture of data by case
- Support efficient extraction of meaningful data
- Collect data that serves a purpose
- Work toward a single source of data
- Provide for ease of use
- Carefully manage scope
- Maintain flexibility for future requirements
- Achieve a solution that has long-term sustainability
- Take advantage of best practices

Thus far, the project has illuminated several key findings

- More manual intervention is involved than originally assumed such as hard-coding case file numbers into one database (CDRT) that were generated from another database (DDR)
- More duplicative processes occur than originally assumed such as entering reviewable disability death data in the DDR database as well as in various spreadsheets; entering child death data in the CDR and CDRT databases
- Some case data is collected that is not subsequently used for case assessment and/or reporting purposes
- Capture of potential 'systemic' issues sometimes occurs without defined process for discussion and confirmation of an issue as systemic
- Opportunity exists for common processes across all types of cases, including initial data capture, case classification, assessment data capture, case workload management, record request generation and tracking, case sign-off, and issue identification
- Opportunity exists for increased integration across reviewable and non-reviewable child death case work
- Opportunity exists for combining the different case assessment forms to avoid duplicate capture of data (e.g. child disability death; reviewable drowning child death)
- Data validation of disability death counts with ADHC should occur going forward as already occurs on an yearly basis with child death counts with BDM
- Possibility exists to input BDM data for all child death cases on a fortnightly basis – and one BDM input per case
- Potential exists for automated solutions for cumbersome activities such as sending, tracking and monitoring receipt of records requests; identifying and reviewing issues; reviewing history of service providers/agencies

There are a few options to consider for an enhanced system for Reviewable Deaths and CDRT

Assumptions	Improvement
<p>1. Use Resolve* System As-Is</p> <p>Fit Reviewable Deaths and CDRT data into existing Resolve database and user interface; employ existing (limited) reporting functionality</p>	
<p>2. Use Resolve System with New Reporting Solution</p> <p>Fit Reviewable Deaths and CDRT data into existing Resolve database and user interface; implement new reporting software which could be leveraged office-wide (e.g. Crystal Reports)</p>	
<p>3. Implement New System with Reporting Solution</p> <p>Build new system/database (separate from Resolve), including reporting software, to satisfy Reviewable Deaths and CDRT requirements</p>	
<p>4. Transfer Solution (Queensland CCYP)</p> <p>Wait for Queensland Commission for Children & Young People to implement new system in development; transfer solution (.NET) with appropriate customisation for NSW</p>	 or 

Note: All options assume use of TRIM, the existing document management system employed by NSW Ombudsman

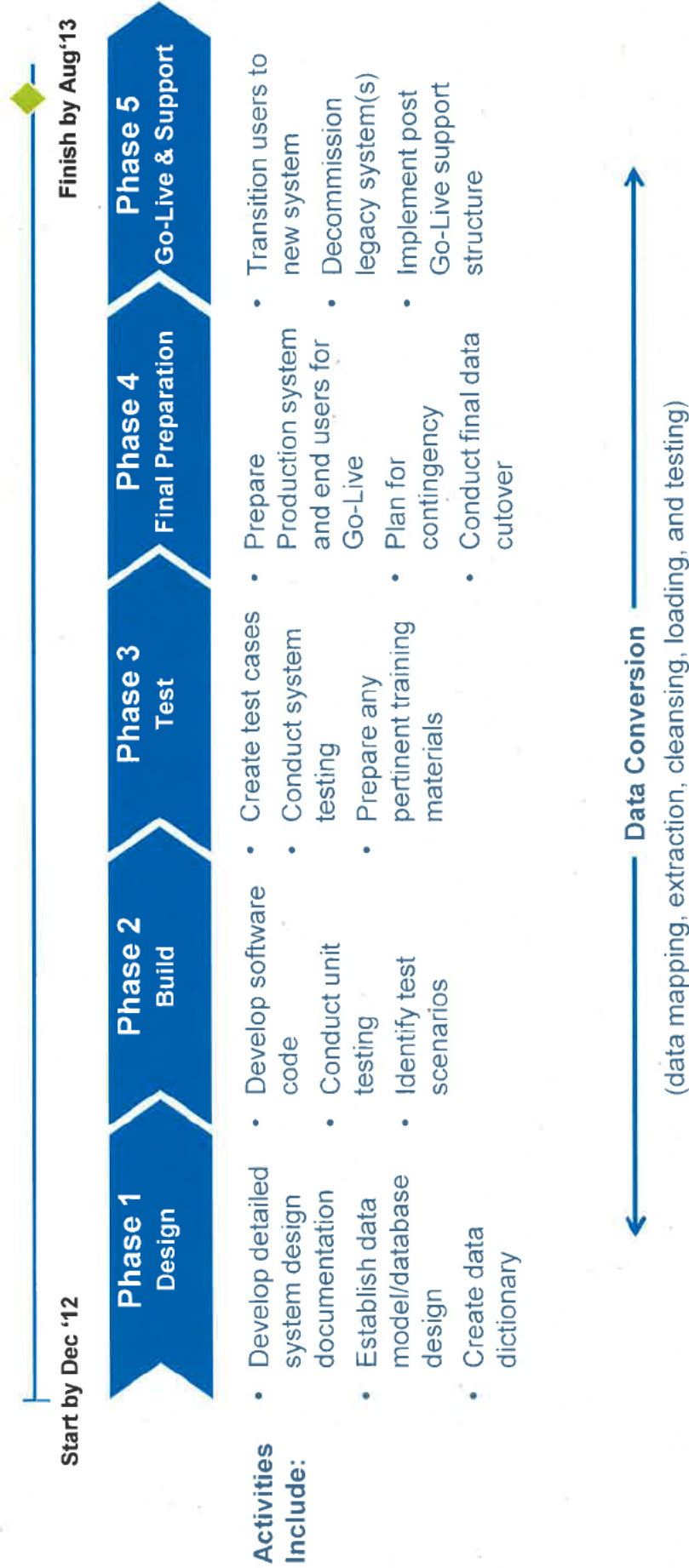
*Resolve is the office-wide system currently used by NSW Ombudsman to manage complaint, inquiry and investigation records. Microsoft SQL Server (relational database management) and Visual Basic are the supporting software.



Recommendation:
Implement new system with reporting solution (option 3)

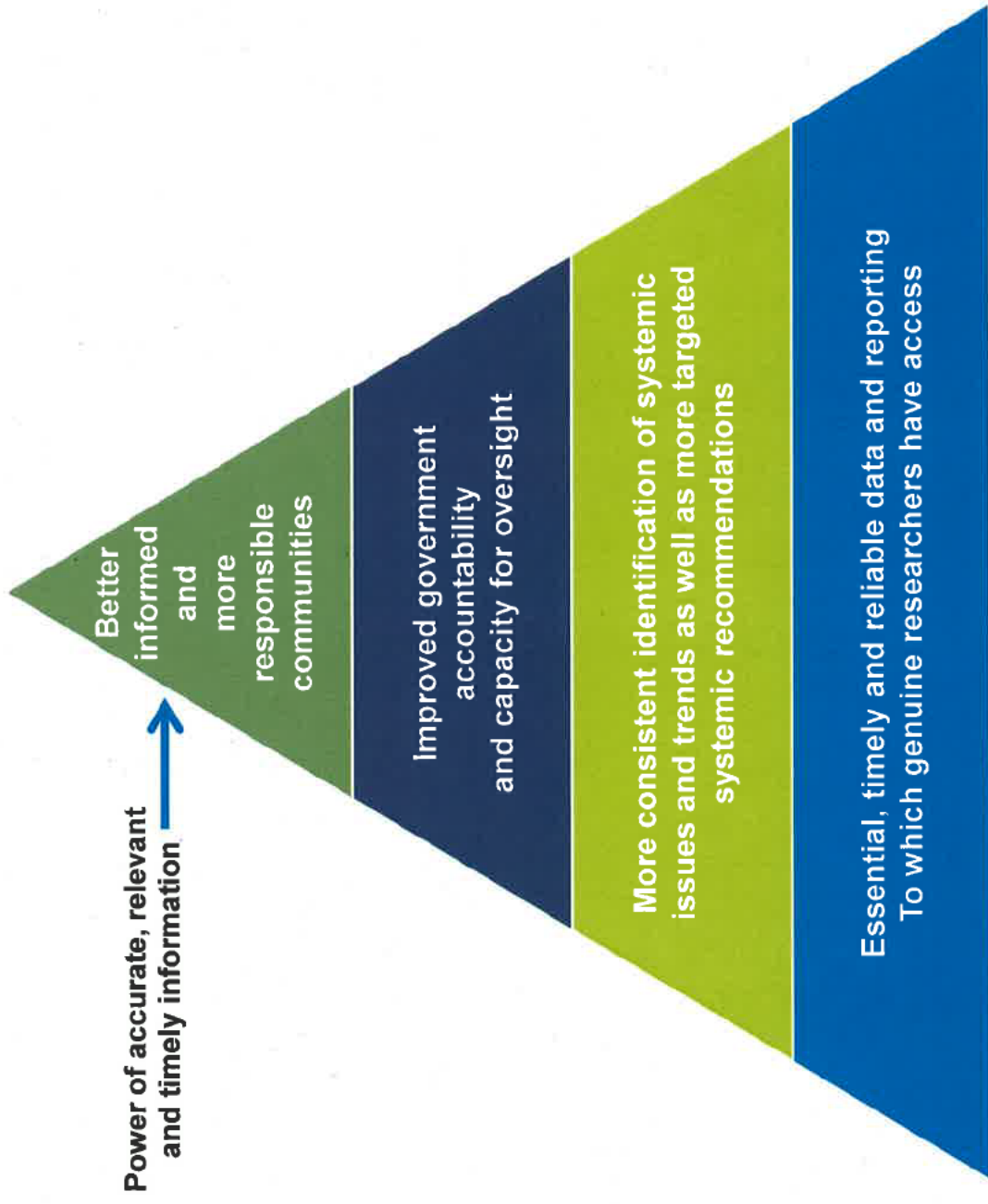
In terms of implementation of a new system, NSW Ombudsman should commence design by end of this year in order to fully complete before tabling CDRT annual report next year

With a business blueprint (requirements and processes) defined and data structure specified, Reviewable Deaths and CDRT are prepared for system design



Given current state of data and importance of historical records, data conversion activities are on an especially critical path for transitioning to a new system

What are the benefits of an enhanced Reviewable Deaths and CDRT system?



Annexure B[Exit this survey](#)**1. Name (optional)****2. Organisation (optional, if applicable)****3. Where are you based? (optional)**

- NSW
- Other Australian state/territory
- Other country

4. What is your interest in reading this report?

- Parent or carer of a child who died
- Relative or friend of a child who died
- Interested person
- Work-related
- School/university related

Other (please specify)

5. If your interest is work-related, what is the type of organisation?

- Government
- Peak body
- Other NGO
- University
- Private business

Other (please specify)

6. If your interest is work-related, what is the main sector in which you are active?

- Community welfare
- Child protection
- Health

- Law/justice
- Early childhood
- Education
- Housing
- Media

Other (please specify)

7. Is your interest in the report as a whole or in specific sections of the report?

- All

If only a part, which part?

8. How will you use the information in this report?

- Personal knowledge
- Research
- Media reporting
- Policy development
- Improve service delivery

Other (please specify)

9. How did you find out about this report?

- Received a copy
- Media report
- Personal contact

Other (please specify)

10. How useful is the report for you?

- Very useful
- Quite useful
- Not very useful
- Not useful at all

11. If you have previously read the CDRT Annual Report, is the difference this year in the style and content:

- Much improved
- Quite improved
- Not much improved
- Not at all improved

12. Do you think this report is clearly written?

- Very clearly written
- Quite clearly written
- Not so clearly written
- Not at all clearly written

13. How do you rate the level of detail?

- Far too much detail
- Too much detail
- About right
- Too little detail
- Far too little detail

14. What do you think the report does well?

15. What do you think could be improved?

16. Are there any issues or topics you would like to see covered in the report?

Done

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Chapter 10

Australian and New Zealand child death statistics: An interjurisdiction comparison, 2010 calendar year

National child death statistics

In recognition of the need to develop nationally comparable data and multi-jurisdiction prevention messages, agencies with child death review functions have convened the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG).

The stated aim of the ANZCDR&PG is to identify, address and potentially decrease the numbers of infant, child and youth deaths by sharing information on issues in the review and reporting of child deaths and to work collaboratively towards national and international reporting.

At present, child death review functions within agencies throughout Australia and New Zealand are at varying stages of implementation and have individual legislative bases, functions, roles and reporting requirements. The data prepared by these agencies currently differs in some respects, but meaningful comparison is still achievable.

The ANZCDR&PG is currently progressing a body of work to establish national benchmarks for risk factors associated with child deaths.

Previously, the Commission has used national mortality statistics compiled by the Australian Bureau of Statistics (ABS) and summarised by the Australian Institute of Health and Welfare (AIHW) to provide an overview of rates of child deaths from various causes across Australian jurisdictions. While this data, as published in previous reports, has been useful in establishing basic variances in child death rates between Australian states and territories, the detailed information held by agencies with child death review functions presents a significant opportunity, and will ultimately lead to an ability to compare and contrast risk factors and prevention efforts for different causes of death.

A number of the agencies within Australia, and for the first time, New Zealand are at a stage where it is possible to provide the Commission with a comparable level of child death data. The following overview represents the fourth occasion to bring together the data held by member jurisdictions of the ANZCDR&PG and draw meaningful comparisons. Currently, the jurisdictions with the capacity to share detailed child death data are Queensland, New South Wales, Victoria, South Australia, Tasmania and New Zealand. As other jurisdictions further develop their data collection and reporting capacity, it is hoped that this dataset will evolve to include child death data from all Australian states and territories.

The ANZCDR&PG is working collaboratively to collect and report consistently on common risk factors for certain categories of child death. As this dataset is under development, the comparative overview provided in the Commission's Child Death Annual Reports should include progressively more discussion of the prevalence of risk factors for death in each jurisdiction. The methodology used in compiling the data in this chapter is outlined in Appendix 10.1.

All causes of child deaths: 2010

Table 10.1: Number and rate of child deaths by age and jurisdiction, 2010

Age category	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
Under 1 year	322	531.1	367	391.5	73	374.8	35	565.4	307	442.9	334	524.1
1–4 years	39	16.0	68	18.3	14	18.0	5	19.2	51	18.3	64	25.8
5–9 years	28	9.8	35	8.0	7	7.5	4	13.0	43	13.3	19	6.6
10–14 years	30	10.3	43	9.7	8	8.1	7	21.1	28	8.5	45	15.2
15–17 years	64	35.4	78	28.3	17	27.1	10	48.3	48	22.9	83	43.8
Total	483	45.4	591	36.4	119	33.8	61	52.2	477	39.4	545	50.3

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

* Rates have not been calculated for numbers less than 4.

Notes: 1. Rates are calculated per 100,000 children and young people in each age category in each jurisdiction.

2. Total rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.

3. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.

4. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

Children in the under 1 year age category had the highest number of child deaths in all jurisdictions. In general, the rate of death in childhood usually decreases with age until the teen years, when it increases again. In all jurisdictions, numbers and rates of death are second highest in the 15–17 year age category.

Table 10.2 below shows the number and rate of child deaths in each jurisdiction by gender. Males experienced higher rates of death in all jurisdictions, at between 1.4 and 1.8 times the rate of females.

Table 10.2: Number and rate of child deaths by gender and jurisdiction, 2010

Gender	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
Female	195	37.7	225	28.5	42	24.4	24	42.6	190	32.2	211	39.9
Male	287	52.6	366	43.9	77	42.7	37	61.3	286	46.1	334	60.1

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

Notes: 1. Rates are calculated per 100,000 females and per 100,000 males aged 0–17 years in each jurisdiction.

2. One child death in Queensland and one child death in Victoria whose sex was unable to be determined.

3. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.

4. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

Diseases and morbid conditions

Deaths from diseases and morbid conditions are those deaths whose underlying cause is an infection, disease, congenital anomaly or other naturally-occurring condition.

As outlined in Table 10.3 below, deaths from diseases and morbid conditions were highest for infants under 1 year of age in all jurisdictions.

Table 10.3: Number and rate of child deaths from diseases and morbid conditions by age and jurisdiction, 2010

Age category	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
Under 1 year	269	443.7	319	340.3	58	297.8	28	452.3	272	392.4	226	354.6
1–4 years	21	8.6	44	11.8	7	9.0	4	15.4	28	10.1	41	16.5
5–9 years	22	7.7	23	5.2	5	5.4	4	13.0	30	9.3	15	5.2
10–14 years	19	6.5	34	7.6	5	5.0	3	*	13	3.9	20	6.8
15–17 years	24	13.3	29	10.5	5	8.0	2	*	21	10.0	16	8.4
Total	355	33.4	449	27.6	80	22.7	41	35.1	364	30.1	318	29.3

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

* Rates have not been calculated for numbers less than 4.

- Notes:
1. Rates are calculated per 100,000 children and young people in each age category in each jurisdiction.
 2. Total rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.
 3. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.
 4. The cause of 50 deaths in New Zealand, 15 deaths in New South Wales and one death in Tasmania are yet to be finalised and are not counted in Tables 10.3, 10.4 or 10.5. Hence the overall numbers and rates are subject to change.
 5. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

External causes

External cause deaths are those resulting from environmental events and circumstances causing injury, poisoning and other adverse effects. Table 10.4 illustrates the number and rate of child deaths from external causes across the six jurisdictions.

Deaths from external causes occurred at a higher rate in New Zealand than in any other jurisdiction (12.4 per 100,000). Tasmania had the next highest rate of death from external causes, at 10.3 per 100,000.

New Zealand had the greatest rate of transport deaths (4.9 per 100,000) followed by Tasmania (4.3 per 100,000).

Queensland recorded the highest rate of drowning deaths, followed by Victoria, whilst youth suicide was most prevalent in Queensland and Tasmania.

Table 10.4: Number and rate of child deaths from external causes by jurisdiction

Cause of death	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
Transport	30	2.8	34	2.1	13	3.7	5	4.3	22	1.8	53	4.9
Drowning	12	1.1	13	0.8	<4 ^a	*	1	*	12	1.0	10	0.9
Other non-intentional injury-related death	8	0.8	26	1.6	<4 ^a	*	2	*	14	1.2	48	4.4
Suicide	25	2.4	13	0.8	4	1.1	4	3.4	15	1.2	15	1.4
Fatal assault and neglect	6	0.6	13	0.8	<4 ^a	*	0	0.0	<10 ^b	*	8	0.7
Total	81	7.6	99	6.1	25	7.1	12	10.3	71	5.9	134	12.4

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

* Rates have not been calculated for numbers less than 4 or less than 10 for Victoria data.

^a Figure not specified where number of deaths is less than 4.

^b Figure not specified where number of deaths is less than 10.

Notes: 1. Classification of external cause deaths may differ from state to state. The methodology section in Appendix 10.1 provides further details.

2. Rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.

3. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.

4. The cause of 50 deaths in New Zealand, 15 deaths in New South Wales and one death in Tasmania are yet to be finalised and are not counted in Tables 10.3, 10.4 or 10.5. Hence the overall numbers and rates are subject to change.

5. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

Deaths from ill-defined and unknown causes of mortality

The deaths of children as a result of unknown or ill-defined causes of mortality, including Sudden Infant Death Syndrome (SIDS) are outlined in Table 10.5 below.

Unexplained deaths of infants

Of specific interest in the study of infant deaths are those certified as due to SIDS or where the cause of death cannot be determined. SIDS is defined as the sudden, unexpected death of an infant under 1 year of age, the cause of which remains unexplained after a thorough investigation (including review of the death scene, clinical history and complete autopsy). While SIDS is, essentially, an undetermined cause of death itself, infant deaths should be specifically certified as 'undetermined' when:

- natural disease processes were detected (insufficient to cause death but precluding a SIDS diagnosis)
- there are signs of significant stress
- non-accidental but non-lethal injuries were present, or
- toxicology screening detects non-prescribed but non-lethal drugs.

Tasmania recorded the highest rate of unexplained infant deaths (113.1 per 100,000 infants) followed by South Australia (71.9 per 100,000).

Undetermined deaths of children over the age of 1 year

Each year, the deaths of a number of children over the age of 1 are registered for whom a cause of death is unable to be determined. These deaths may occur in any age category, but are most often of children in the 1–4 year age category. The circumstances of these deaths often resemble those of infants, but are precluded from a diagnosis of SIDS as they are over the age of 1.

Table 10.5: Child deaths from SIDS and undetermined causes by age and jurisdiction, 2010

Age category	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
Under 1 year	43	70.9	24	25.6	14	71.9	7	113.1	30	43.3	37	58.1
1–4 years	3	*	3	*	0	0.0	0	0.0	<10 ^a	*	<3 ^b	*
5–9 years	0	0.0	0	0.0	0	0.0	0	0.0	<10 ^a	*	0	0.0
10–14 years	0	0.0	0	0.0	0	0.0	0	0.0	<10 ^a	*	<3 ^b	*
15–17 years	1	*	1	*	0	0.0	0	0.0	<10 ^a	*	4	2.1
1–17 years total	4	0.4	4	0.3	0	0.0	0	0	12	1.1	6	0.6
Total	47	4.4	28	1.7	14	4.0	7	6.0	42	3.5	43	4.0

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

* Rates have not been calculated for numbers less than 4, or less than 10 for Victoria data.

^a Figure not specified where number of deaths is less than 10.

^b Figure not specified where the number of deaths is less than 3.

Notes: 1. Classification of external cause deaths may differ from state to state. The methodology section in Appendix 10.1 provides further details.

2. Rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.

3. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.

4. The cause of 50 deaths in New Zealand, 15 deaths in New South Wales and one death in Tasmania are yet to be finalised and are not counted in Tables 10.3, 10.4 or 10.5. Hence the overall numbers and rates are subject to change.

5. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

Deaths of Indigenous children and young people

Table 10.6: Number and rate of Indigenous child deaths by jurisdiction, 2010¹

Year	QLD		NSW		SA		TAS		VIC		NZ	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000
2007	52	77.8	56	81.4	12	98.1	N/A	–	<10 ^a	54.4	225	86.8
2008	67	98.8	53	76.6	11	89.2	0	0.0	12	80.8	204	77.7
2009	64	93.1	32	45.9	11	88.4	0	0.0	<10 ^a	*	239	90.1
2010	62	88.9	60	85.3	8	63.7	0	0.0	<10 ^a	*	219	81.6

Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

* Rates have not been calculated for numbers less than 10 for Victoria data, with the exception of 2007.

^a Figure not specified where number of deaths is less than 10.

– Number of deaths not provided.

Notes: 1. Rates are calculated per 100,000 Indigenous children and young people aged 0–17 years in each jurisdiction

2. Victorian data in this table are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm.

3. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.

¹ Note that for Australian jurisdictions, *Indigenous children* refers to the Aboriginal and Torres Strait Islander population, whilst for New Zealand it refers to the Māori population.

It should be noted that some states experience difficulty with the collection of data regarding Aboriginal and Torres Strait Islander status. Challenges are also faced in obtaining accurate population data for Indigenous children and young people in Australia to enable the calculation of rates. Therefore, the rates presented in Table 10.6 should be interpreted with caution.

Rates of Aboriginal and Torres Strait Islander child deaths (Australia) and Māori child deaths (New Zealand) from 2007 to 2009 have also been included in Table 10.6. The Commission hopes to monitor long-term trends in Indigenous child mortality across Australia, in line with the Commonwealth Closing the Gap initiative, which aims to reduce disparity in mortality rates between Indigenous and non-Indigenous children. This initiative commenced in 2010, and it is hoped that improvements in the rate of Indigenous child mortality will be observed in future reports. Based on the available data, in 2010 Queensland had the highest rate of death for Aboriginal and Torres Strait Islander children and young people, followed by New South Wales. The New Zealand rate of deaths for Māori children was lower than the New South Wales and Queensland Aboriginal and Torres Strait Islander rates.

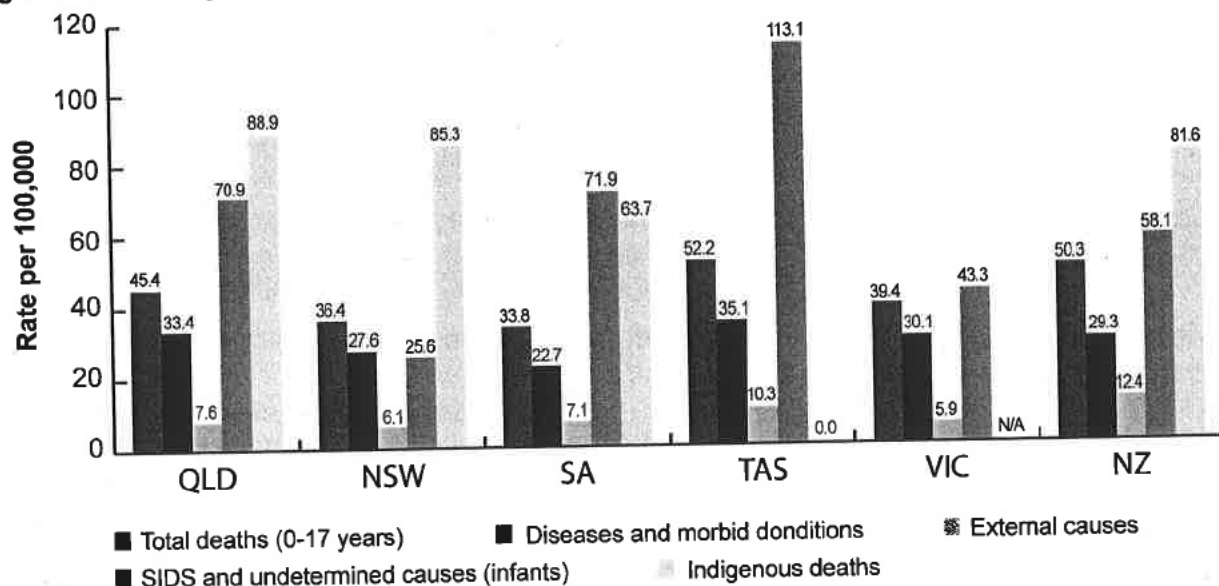
National child death statistics: findings and conclusions

The information presented above is a snapshot of child mortality in contributing Australian states and New Zealand in 2010. Analysis of statistics for 2010 has shown:

- Tasmania had the highest rate of child death overall, as well as the highest rate of death from suicide.
- New Zealand had the highest rate of death from transport and other non-intentional injury, and
- Queensland had the highest rate of death from drowning.

Selected findings are highlighted in Figure 10.1 below.


Figure 10.1: Interjurisdiction comparisons – selected findings, 2010



Data source: Australian and New Zealand Child Death Review and Prevention Group (2010)

Notes: 1. Victorian data in this figure are provisional and subject to change. Full data will be available from the upcoming Annual Report for the Year 2010. This will be available from www.health.vic.gov.au/ccopmm/index.htm

2. Note that caution must be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event, and hence have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates for 2010, and should not be used to infer the general probability of death for specific cohorts.



The comparison of child death data across jurisdictions as undertaken for the first time in the Child Death Annual Report 2008–09 represented a significant first step in the journey towards developing nationally comparable data. The Commission was pleased to be able to continue this initiative in 2011–12. This is the first year that data from New Zealand has been provided and it is hoped that future years will see the inclusion of data from other states and territories as the development of their child death review mechanisms progress.

Findings from this year have highlighted that, at a national level, further efforts need to be invested in addressing risk factors for sudden unexpected deaths in infancy, external cause deaths and factors and circumstances affecting life expectancy for Aboriginal and Torres Strait Islander children and young people.

While the findings of these early analyses have provided some direction for prevention activities, more meaningful conclusions and specific targeting of prevention initiatives will become more apparent through future analysis of data over multiple years. Long-term data analysis is imperative for the accurate identification of trends and patterns in child mortality. In addition, as the reporting capabilities of review mechanisms throughout Australia continue to develop, the analysis of social, situational and risk factor information is likely to become available to further inform prevention efforts.

The Commission greatly appreciates the efforts of the New South Wales Child Death Review Team, the South Australian Child Death and Serious Injury Review Committee, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity and the New Zealand Child and Youth Mortality Review Committee in contributing to this report, and looks forward to continued collaboration in an effort to reduce child mortality from preventable causes.