Government of South Australia

Child Death & Serious Injury Review Committee

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Hon Jennifer Rankine MP
Minister for Education and Child Development
Level 9, 31 Flinders St
Adelaide 5001

Dear Minister Rankine,

On 8 July 2014 I received a letter from the Premier indicating his intention to reform Boards and Committees.

On 14 August 2014 I received a letter from you, dated 8 August 2014, requesting a response from the Committee about this issue. You requested a reply by 15 August 2014 and I am writing to you to outline the reasons why the Committee says it should continue to function in its current form.

The Committee was established under the *Children's Protection Act 1993* in 2006. As you would be aware, the Committee can only be abolished by legislation.

In *Our best investment: A State plan to protect and advance the interests of children* Robyn Layton QC stated the following reason for the establishment of the Committee:

The Child Death and Serious Injury Review Committee provides the only effective whole-of-systems review mechanism across Government to monitor the adequacy of systems and services involved where a child has died or experienced serious injury, identify areas for improvement and use these findings to educate the community and inform policy and procedures across Government and non-Government sectors to prevent future deaths of or serious injury to children.

It is the Committee's view that the reasons for its continued existence are at least as valid today as where the reasons for its establishment.

The Committee considers the following points, in relation to its functions, worthy of mention:

- The current structure is cost effective – the Committee operates with a small budget. In 2013-14 sitting fees to members totalled less than $10,000. Committee members contribute an extraordinary amount of volunteer hours. The Secretariat staff is minimal (2.6 FTE). The total operational budget for the Committee and its Secretariat is attached.
- The current structure epitomizes what is recognized internationally as the 'gold standard' for death review committees – a multi-disciplinary team of experts who are highly skilled in the unique functions and processes that comprise death review.
- The current structure enables a high degree of objectivity to be brought to the review processes undertaken by the Committee.

- It is difficult to envisage any realistic alternative to carrying out the Committee's vital role. Undertaking death review, whether by consultancy or commission would not only be highly costly but would not bring to bear the accumulated knowledge and expertise the Committee has acquired over the years. Nor would it provide the independence of analysis or the multi-disciplinary expertise of a committee.

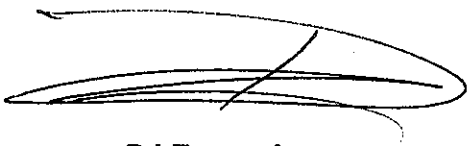
The Committee makes the following points about its work:

- No other body or agency in the State has the unique powers and functions of the Committee. Its oversight of systemic issues now extends into many areas pertaining to the safety and wellbeing of children and focusses on some of the State's most vulnerable populations.
- No other body undertakes individual or group reviews of the circumstances of certain deaths (eg. suicide, asthma, sudden unexpected infant deaths, deaths of children with disability) and addresses systemic issues in service provision that might prevent such deaths from happening again.
- No other body provides the community with a yearly report about the circumstances and causes of all child deaths in South Australia or comments so broadly on, and makes recommendations about improvements to child safety and wellbeing.
- Since its establishment the Committee has contributed to systemic change in many different areas including: safe sleeping for infants; swimming pool legislation; discharge processes for vulnerable infants; recognition, assessment and response to neglect, chronic truancy and homelessness; case management and, information sharing.
- The Committee monitors the implementation of its recommendations and reports each year to Parliament and the community on the progress made towards the systemic changes it has recommended.
- Both the Government and the Coroner have called upon the Committee to undertake in-depth reviews of cases that raised particular issues of concern for the community. Recognizing the impact the Committee's recommendation will have on the safety and wellbeing of children, in those cases the Government has accepted and undertaken to act upon these recommendations.

Every child death is a tragedy. The Committee feels strongly that, as a community we owe children and their families the time and effort necessary to think, learn and improve children's health and safety by considering death and serious injury events.

I am available to discuss the future of the Committee with you at any time.

Yours sincerely



DJ Eszenyi

Chair
Child Death and Serious Injury Review Committee

15 / 8 /2014