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Children's Institute,
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Learning Brief 54 April 2014

Introducing Child Death Review Teams in South Africa: learning from international models

Introduction

Violence against children is a pervasive global problem with deaths from child abuse viewed as the most extreme consequence. The World Health Organisation, using limited country data from low- and middle-income countries, estimates that 53 000 children were victims of homicide during 2005 (Pinheiro, 2006). Until recently, very little was known about child deaths in the context of violence in South Africa.

The first South African national child homicide study established that 1 018 children died due to homicide in 2009 at a rate of 5.5 per 100 000 children under 18 years (Mathews et al, 2013), compared to the global rate of 2.4 per 100 000 children (Pinheiro, 2006). The study also showed for the first time the relationship between child homicide and fatal child abuse in South Africa and estimates that just under half (44.6%) of child homicides were in the context of child abuse and neglect. Almost three quarters (74%) of fatal child abuse occurred in the 0 – 4-year age group, with most of these deaths occurring in the home (Mathews et al, 2013).

Under-ascertainment of fatal child abuse an international concern

Globally, underestimating the number of child abuse or child maltreatment related deaths has been shown in multiple settings with only a third of these deaths classified as homicide (Gilbert et al 2009). It is estimated that 13% of all injury deaths in children under-15 are due to child abuse and neglect (Pinheiro 2006). Studies from high-income settings have shown that fatal child abuse is poorly detected in vital statistics, and by child protection services and the police, resulting in a huge underestimate of fatal child abuse (Gilbert at al 2009). The poor identification rates

Child maltreatment vs child abuse and neglect

Internationally the concept child maltreatment is used to define acts of commission or omission by a parent or caregiver resulting in harm, potential harm or threat of harm to the child (Gilbert et al 2009). Maltreatment is broader than child abuse and neglect and encompasses physical abuse; sexual abuse; psychological or emotional abuse and neglect (WHO 2002). The concept child maltreatment is not widely used as South African legislation does not use the term "child maltreatment" but defines child abuse and neglect as follows:
The Children's Act No 38 of 2005 defines abuse in the context of physical injury as: "assaulting a child or inflicting any other form of deliberate injury to a child" and separately defines sexual abuse and neglect. Neglect is defined as "a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs" of the child and sexual abuse is defined as "sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted".

The Act makes it mandatory to only report deliberate neglect but does not provide a definition for deliberate neglect.

of child abuse deaths are proposed to be primarily due to difficulties in identifying such deaths, investigating and reporting of the deaths by police to child protection services, and a lack of standard definitions of child maltreatment (Schnitzer et al 2008). Deaths due to violence or severe physical abuse have been shown to be the most likely recognised child abuse death (Crume et al 2002), while deaths related to omission of care such as neglect – including abandonment or resulting from drowning, poisoning and fire injury – are more likely to go undetected (Crume et al 2002). In addition, deaths in infancy due to asphyxiation from smothering are easily misclassified as Sudden Infant Death Syndrome (SIDS), with 10% of SIDS deaths shown to be infanticide (Levene & Bacon 2004). Overall, the most common perpetrators of child abuse are parents, yet in child abuse deaths unrelated perpetrators are more commonly identified (Crume et al 2002).

Child maltreatment is a global problem

The United Nations World Report on Violence against children has shown that child maltreatment is a pervasive problem that mainly occurs within the family context and has serious long-term consequences (Pinheiro 2006). The family is conceptualised as the natural setting for the optimal growth and development of children and the United Nations Convention on the Rights of the Child requires the state to support the family. However, the nature and construction of families are changing globally due to urbanisation, placing pressure on families as traditional sources of support that are no longer available and children are left vulnerable as a result of migration and protracted periods of family separation (Krug et al 2002). The magnitude of child maltreatment is substantially underestimated and estimates are unreliable as protection services data, self-reports and community surveys are primarily used to determine prevalence and incidence of maltreatment (Gilbert et al 2009). Nevertheless child maltreatment contributes significantly to child mortality and morbidity and has lasting consequences with respect to mental health as well as on the social integration of both males and females (Gilbert et al 2009, Pinheiro 2006).

Preventing deaths from child abuse and neglect – child death reviews as an international approach

Child abuse fatalities caught public attention in the United States and United Kingdom in the 1970s through individual case reports and subsequent inquiries into these deaths highlighted failures in their child protection systems (Durfee, Durfee & West 2002; Douglas & Cunningham 2008; Sidebotham 2012). In response, the first child death review team was established in 1978 in one state in the United States, as a multi-disciplinary, multi-agency approach to determine if abuse was associated with the unexpected child death (Christian et al 2010). During the 1980s and '90s this approach spread across states in the United States with only one state not having a child death review team by 2012 (Vincent 2012).

Child death review teams were first established to review only suspected child abuse and neglect deaths but have expanded to review all child deaths in most states (Christian et al 2010). The United State Department of Health and Human Services endorsed the need for child death reviews and recommended its expansion to all states and a National Centre for Child Death Review was established in 2002 funded by the state (Webster et al 2003). Yet, the United States system still has challenges with no national standardised process to review child deaths.

England and Wales

England and Wales followed a model of public

Child death review teams

The main purpose of child death review teams is to conduct a comprehensive review of suspected child abuse deaths, all injury-related child deaths, or all child deaths. Child death reviews aim to better understand how and why children die, and to use those findings to prevent other deaths and improve the health, safety and well- being of all children in the country, state or territory. The child death review team consists of core representatives from law enforcement, child protective/social services, a paediatric nurse/paediatrician, forensic pathologist, and a prosecutor.

inquiry which differed significantly from the US multi-disciplinary approach. Child death reviews were only formally implemented in England and Wales in 2008 under their Children's Act of 2004 which mandates each local authority to establish a child death overview panel to review all child deaths from birth to 18 years who live in the area (Sidebotham 2011).

Northern Ireland

Northern Ireland introduced a case management review process in 2009. This is facilitated by a regional child protection committee comprising senior managers from child protection organisations, health, education and police, with a mandate to establish the facts of the case, improve inter-agency collaboration and use lessons learnt to work together to safeguard children (Daveney et al 2013). Cases reviewed are either known to a child protection service or child abuse is suspected.

Canada

The first multi-disciplinary child death review team was established in 1992 and has since expanded to all provinces and territories to investigate child deaths where a child was in care or known to a child protection agency (Vincent 2012). There is a lack of consistency in the composition of child death review teams and data collected, as well as variability of functions across the country. In some provinces they serve as watchdogs of government departments and in others they comprise multi-disciplinary teams either at the conclusion of a case or while a death are being investigated. Reviews are provincial, without common definitions therefore unable to provide a national picture of child deaths.

Australia

There is no uniform national approach to child death reviews as the child protection system is state and territory based with different legislative frameworks (Newton et al 2010). Nevertheless, child death review teams have been established in almost all states, with the exception of two (Frederick et al 2012).

New Zealand

The Child and Youth Mortality Review Committee (CYMRC) was only established in 2002 and is a statutory body established to review and report on all deaths of children and youth aged 28 days to 25 years (Vincent 2012). The committee collects standardised data from district health boards on every child and youth death in New Zealand and is the most comprehensive system.

Introducing Child Death Review Teams in South Africa

Until recently, little was known about child deaths in the context of violence in South Africa. The first national child homicide study by the Medical Research Council (MRC) established South Africa has a child homicide rate more than double the global rate (Mathews et al 2012). This study also found that just under half (44.6%) of child homicides are due to child abuse and neglect.

Table 1: Summary of International institutionalisation

Country	Review mechanism	Scope of review	Legislated
Australia	Each state/territory differs	Variation across states; some only child abuse deaths and all child deaths	No
New Zealand	National co-ordinated system	All child and youth deaths from 28 days to 25 years	Yes
United States	All states have a child death review system, no standardised process	Variation across states; some only child abuse deaths and all child deaths	Variation across states
Canada	Each province/territory differs	Child deaths known to a child protection agency	Variation across provinces
United Kingdom	National co-ordinated system	All child deaths	Yes

Almost three quarters (74%) of fatal child abuse occurred in the 0-4 year age group with most of these deaths occurring in the home.

The main purpose of promoting the introduction of child death review teams in South Africa is so that a comprehensive review is automatically done of all injury-related child deaths. As an abuse prevention mechanism, child death reviews aim to better understand how and why children die, and to use those findings to prevent other deaths and improve the health, safety and well- being of all children in the country. This is currently not the case and many cases fall through the cracks with the safety of remaining children also compromised. The South African pilot is being delivered at two sites in South Africa; one at the Salt River mortuary in Cape Town, Western Cape and the second at Phoenix mortuary, in the KwaZulu-Natal province. Both of the pilot sites fall under the respective provincial Departments of Health. Designed along international models, the core team consists of representatives from law enforcement, child protective/social services, a paediatric nurse/paediatrician, forensic pathologist, and a prosecutor. This team will be reviewing all suspicious death at the facilities during 2014. It is planned to share the research results to all relevant parties mid-year, 2015.

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