

BOOK REVIEW

Preventing Child Deaths: Learning From Review

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Reviewed by Professor Thea Brown,

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Preventing Child Deaths: Learning From Review is a new book published this year and authored by Sharon Vincent, a UK academic and Reader in Social Welfare at the University of Wolverhampton, England. The book addresses the grave topic of child deaths and their review by child death review committees, which the author believes can play a significant role in preventing these tragedies. It is the fourth book in the series, *Protecting Children and Young People*, published by Dunedin Academic Press, which is headquartered in Scotland.

Sharon Vincent has previously published *Learning from Child Deaths and Serious Abuse in Scotland* in 2010 and in this latest book she has extended the research in her initial book to describe in considerable and precise detail the diversity of child death review mechanisms that exist in her selection of international locations, namely New Zealand and the various states in Australia in Chapter One, the provinces of Canada and the numerous states in USA in Chapter Two, and in England and Wales in Chapter Three. The book then provides a cross country comparison of child death review processes in Chapter Four.

The author depicts child death review committees as an emerging child welfare and child health phenomena, originating in the USA in the 1970s, but now spreading internationally. The aim of these committees is to document unexpected child deaths, to explore them, both at an individual case level and in aggregate, and gain knowledge from these reviews for health and social policy development and for professional practice. In her Introduction, Vincent explains the purpose of the book and her view that these deaths are preventable and that child death reviews can reduce them, by saying

.... Child Death Reviews can help prevent deaths... Children rarely die but when they do it is extremely tragic and we have a responsibility to families and communities to find out why they died. CDR [Child Death Review] ... enables us to do this (p. ix)

Much of the book is devoted to describing the various child death review (or child fatality review) mechanisms in the countries she has selected. This information is exhaustive and has not been compiled elsewhere. The compilation

shows a bewildering array of different structures pursuing somewhat different goals in a variety of ways. Although Vincent has set up a common framework for the analysis of these structures they vary so much, even within the one country—as is the case in Australia where they are state based. This can make it difficult to get a sense of them and an overall picture of their strengths and weaknesses. Some of them focus just on the deaths of children currently or recently in the care of child protection services; some extend further to children up to the age of 18, and even to 25, who have died in unexpected circumstances or to children who have died in any circumstance. Obviously there is some overlap between these committees, specialised child protection committees, and health and hospital committees. Some involve the families of the victims and some do not, some involve relevant agencies and some do not. Some are legislatively based; some are not; some are linked to government departments and some are not.

By presenting these details the author shows the types of child deaths that occur in these countries, the broad categories of causes and the relative proportions of types and causes. She tends to focus on the most common types of deaths and on deaths through child abuse.

In the second half of the book she moves to a more analytical perspective and considers the efficacy of these structures. She gives a number of case examples in Chapter Six that illustrate where the CDRs have contributed to reductions in child deaths, particularly in the public health area. At the same time, she raises a number of issues that she suggests weaken the efficacy of these structures. First is poor funding as a limitation of their work, second is not having a legislative mandate to support their work, third is the fragmentation of some of these structures, fourth is the narrow membership of some committees resulting in the relevant stakeholders being unable to be brought together for coordinated action, fifth is an absence of regular research of all deaths or of groups of deaths being undertaken by the review structures, and sixth is an inability to make recommendations and/or to move recommendations into service reforms. However, while pointing to these problems, Vincent sees these structures evolving further and improving over time.

Vincent is careful not to argue that any country is managing these structures better than any other, although a sneaking admiration for New Zealand creeps through at times. She sees each locality needing to develop its own approach. For us in Australia her work raises questions as to what we see as best for us and how we might achieve this. Her work suggests that each of our state and/or territories' review mechanism is so different from the others that we are unable to present a national picture of the incidence of child deaths let alone review them. Moreover, the review structures in each state are often multiple and overlapping, confusing what is important for us to know at a state level. We are, according to her framework, somewhere between the child welfare and the child health models of child death reviews (pp. 91–92), but without having a commitment to move in one particular direction, although she sees the child health model as being the more informative. We have no national approach, despite having a national child protection framework.

This issue has emerged recently within the Australia's own literature (Brown & Tyson, 2012; Newton, Frederick, & Wilson et al., 2010). We are recognising that we collect a lot of data about children, but it is held in different (often state based) databases that should be integrated. However, because there are a number of different ones in each state or territory, they are difficult to put together within the state let alone across the nation (Schlonsky, 2012). An example of the weakness of our current review structures in Australia can be seen in the research that this writer is undertaking together with colleagues at Monash and other agencies in Melbourne and Canberra that is culminating in an interna-

tional conference, *Addressing Filicide: the First International Conference*, in Prato, Italy in late May. None of the various child death review structures in Australia has highlighted this problem, although the deaths of children through filicide in Victoria occurring outside the child protection services exceed those occurring within the service. The current death review mechanisms have missed this issue entirely.

The book is an important contribution to the literature on child health, child protection and child deaths; it is unique in its international analysis of child death review committees and their role in overcoming child deaths. Its topic area is growing in significance and the book is one of the few policy guides available. It is relevant to all university based disciplines in the child health and welfare area and to all the policy staff and professional practitioners in these areas. It will challenge readers by raising many complex issues for consideration and it will also lead them to a great deal of reflection and debate.

References

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