

Protecting Victoria's Vulnerable Children Inquiry

Submission from the Victorian Child Death Review Committee

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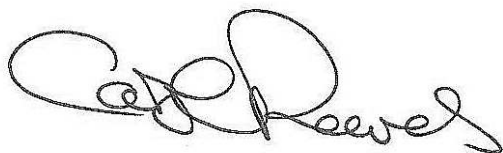
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A handwritten signature in black ink, appearing to read 'Carol Reeves', with a stylized, cursive script.

Carol Reeves
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Victorian Child Death Review Committee

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Introduction

- Since 1995, the Victorian Child Death Review Committee (VCDRC) has operated as an oversight mechanism of Victoria's Child Protection system, specifically in relation to the examination and public reporting of deaths of children known to the Child Protection system.
- This submission relates to Term of Reference 8 concerning oversight and transparency processes and sets out:
 - **Background to Victoria's current model of child death review**
 - **Victoria's child death review system**
 - Consultative Council on Obstetric and Paediatric Mortality and Morbidity
 - Office of the Child Safety Commissioner child death inquiries
 - VCDRC
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 - New South Wales
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 - **Impact of CDIs and VCDRC reviews on Victoria's Child Protection program**
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Background to Victoria's current model of child death review

- An internal departmental [currently known as Department of Human Services (DHS)] process for examining practice in relation to deaths of children known to Child Protection began in 1985.
- In November 1995 the VCDRC was established as a multidisciplinary Ministerial advisory committee to function as an external review mechanism independent from the department which was responsible for both the delivery of statutory Child Protection services as well as the examination of deaths of children known to that service.
- In 2005 the Office of the Child Safety Commissioner (OCSC) was established as a business unit of DHS. The *Child Wellbeing and Safety Act (CWSA) 2005* was enacted and set out the role and mandate of the Child Safety Commissioner (CSC) with Division 4 of the Act setting out the specific functions and powers regarding undertaking child death inquiries (CDIs) in relation to children known to Child Protection.
- The Act established a statutory responsibility for undertaking CDIs and located this in the OCSC within DHS but at arm's length from the program area responsible for the operation of Child Protection services.
- The VCDRC continued receiving and reviewing CDI reports, but from 2005 these were conducted and provided by the OCSC.
- Since its establishment in 1995, the VCDRC has retained its original function as an independent second tier of review of CDI reports prepared under different organisational arrangements within DHS, provided advice to the Minister regarding each CDI, identified themes and issues common across reviewed cases and prepared an annual report for the Minister which has been tabled in parliament since 1995.

Victoria's child death review system

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

- The broadest approach to examining child deaths in Victoria is undertaken by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), a statutory body established in 1962 under the *Health Act 1958*. It is an advisory body to the Minister for Health on maternal, perinatal and paediatric deaths.
- CCOPMM reviews all maternal, perinatal and paediatric deaths in Victoria in order to consider the clinical features of each case and to assess preventability – it has a public health surveillance, reporting and research role into all deaths of children aged less than 18 years of age (including still births >20 weeks gestation or >400 gms).
- The chair and members of CCOPMM are appointed on advice from government by the Governor in Council under provisions of the *Public Health and Wellbeing Act 2008*.
- The Council consists of 12 members appointed according to specific criteria in the Act reflecting the required experience and expertise and has four sub-committees which review deaths of specific cohorts: the Maternal Mortality Committee; the Stillbirth Committee; the Neonatal Mortality Committee; and the Infant and Child Mortality Committee. There is also a Births Defects Subcommittee that reports to the Council but this committee does not involve the review of deaths.
- CCOPMM has produced annual reports containing information on infant and child deaths from 1984. Until 2004 CCOPMM reported on child deaths 0-<15 years only; this was extended to <18 years in 2004 and the 2005 annual report was the first containing data on 15-17 year olds.
- CCOPMM can request information from health service providers for the purpose of performing its functions but does not have the power to compel provision of information.

The Office of the Child Safety Commissioner child death inquiries

- Victoria has a two-tier system of examining the specific subpopulation of all child deaths – deaths of children known to Child Protection.
- The first level of review is undertaken by the OCSC which conducts a CDI in relation to the death of each child which falls within the legislative definition of 'known to Child Protection'.
- Until legislative changes in 2009, the cases which were eligible or in scope for a child death inquiry were children who were clients of Child Protection at the time of their death or within three months of their death. This was a narrow eligibility compared to other Australian jurisdictions.
- In August 2009 the *Children Legislation Amendment Act 2009* expanded the scope to include deaths occurring within 12 months of case closure.
- This expanded legislative scope applied from 2007 and consequently additional child deaths that were in scope from 2007, 2008 and 2009 were identified. Reported data relating to these years was adjusted and CDIs were initiated.
- With the transfer of the child death function to the OCSC, the statutory purpose of CDIs was defined as 'to promote continuous improvement and innovations in policies and practices relating to child protection and safety' (s33 (2) CWSA 2005).

- Whilst being directed to the goal of continuous improvement the legislation also requires CDIs to address 'the services provided, or omitted to be provided, to the child before death' (s33 (3) CWSA 2005).
- Children known to Child Protection at the time of their death or within 12 months of their death includes deaths from all causes and is not restricted to those deaths from external causes which might be interpreted as adverse outcomes for the Child Protection system.
- This means that the Victorian child death review system is not adverse outcome driven as all deaths known to Child Protection, which fall within the timeframe scope, require CDIs to be undertaken regardless of the cause of death. The trigger for a CDI is not the death of a child known to Child Protection in problematic circumstances but rather the involvement of Child Protection no matter how minimal or extensive.
- The effect of this more inclusive approach is that CDIs provide a window into routine practice and service delivery. The process of CDIs is more akin to an audit of case practice and service provision as there is not a presumption that there are 'serious case reviews' in which practice deficiencies have occurred.
- There is no legislative timeframe regarding the completion of CDIs by the OCSC but practice has been for CDIs to be completed within 12 months of notification of the death.
- CDIs are conducted by an OCSC practice reviewer or by a contracted 'case analyst' or jointly for more complex CDIs. An Aboriginal consultant is appointed to provide a cultural understanding and perspective in CDIs that involve the deaths of Aboriginal children.
- The process of undertaking each CDI involves accessing Child Protection electronic and paper files and those of other relevant services, interviewing Child Protection staff (which may include frontline practitioners, supervisors/team leaders, senior regional managers and central program staff) as well as relevant staff from other participating services.
- The CWSA provides for the OCSC to access information held by DHS or Child Protection as well as defined 'health and human services'. The Act also provides protections for health and welfare practitioners who provide information to a CDI process.
- The practice of the OCSC is to advise parents of deceased children of the conduct of a CDI and invite participation although such participation rarely eventuates.
- The CDI report including 'findings' is finalised by the OCSC after the penultimate report is made available to DHS and relevant sections of the report to other services which participated in the CDI process.
- Each CDI report together with other relevant documents (including departmental briefings and Coronial documents) are provided by the OCSC to the VCDRC.

Victorian Child Death Review Committee

- The VCDRC is a Ministerial advisory committee that undertakes independent, multidisciplinary review of CDIs conducted by the OCSC.
- The role and operations of the VCDRC relating to child deaths does not have a specific statutory basis although it is established as a Ministerial advisory committee pursuant to s6(2) CWSA.
- The VCDRC membership is drawn from welfare, health, Aboriginal, police, legal and academic fields representing the many professional groupings

involved in the broad Child Protection system, and its operation models the interdisciplinary collaboration that is required in practice with vulnerable children and families.

- The chair of the VCDRC is a Cabinet appointment and members are appointed by the Minister for Community Services. Members are appointed based on experience and expertise and, whilst they do not represent their services, the membership of the committee seeks to draw on the perspectives of the various service sectors.
- The VCDRC's terms of reference are:
 1. To review the deaths of all children and young people who were clients of the Victorian Child Protection service at the time of their death or within twelve months of their death and advise the Minister for Community Services of the committee's deliberations.
 2. To identify particular groups of child deaths that may benefit from further investigation or research.
 3. To analyse and comment on any themes, trends or patterns that emerge from the review of inquiry reports.
 4. To comment on service and system responses to children and families arising from the review of inquiry reports and receive feedback on the implementation of service system reforms.
 5. To provide advice to the Minister for Community Services on the child death inquiry process.
 6. To prepare an annual report for the Minister for Community Services.
 7. To perform other functions in relation to child deaths as directed by the Minister for Community Services.
- The VCDRC undertakes its review role consistent with the purpose espoused in the CWSA of 'promoting continuous improvement' thereby providing coherence between the two tiers of Victoria's child death review system undertaken by the OCSC and the VCDRC.
- The VCDRC meets on a monthly basis to consider finalised CDIs prepared by the OCSC. The committee does not itself have any investigative role and undertakes its second tier review on the papers of the CDI report and other available documentation. The capacity of the VCDRC to perform its role is dependent upon the quality of first level inquiries.
- When considering individual CDIs, the VCDRC seeks to understand how the particular case evolved and to identify themes and threshold issues. The committee provides written advice to the Minister concerning each CDI including commenting on the report's findings, discerning learnings from the material and formulating recommendations.
- Over time, review of CDIs enables the committee to build up some understanding of how the Child Protection system operates in general although this is dependent upon the sample of cases reviewed. In this way, CDIs and VCDRC reviews provide a window into how policies, practice guidance and standards are translated into practice and whether the intended goals of such policies, practice guidance and standards are being achieved.
- Any comments regarding practice deficiencies that the VCDRC makes are directed toward understanding the performance of the service system and as criticisms of individual efforts and competencies.
- When the VCDRC considers that more research is required into an identified theme or issue common across cases before well-defined and sufficiently

informed recommendations can be made, it can request that the OCSC undertake a group analysis. A group analysis process allows for a more comprehensive examination of issues arising from a particular group of deaths. Since the inception of the VCDRC, the following group analyses have been initiated: *Effective responses to chronic neglect* (2006); *Tackling SIDS - a community responsibility* (2005); *Children with complex medical needs and a limited life expectancy* (2004); *Protective issues for newborn siblings of children previously taken into care* (2002); *Who's holding the baby? Improving the intersectoral relationship between maternity and child protection services - an analysis of child protection infant deaths* (2000).

- The OCSC at the request of the VCDRC is currently undertaking a group analysis, *Responding to the co-existence of family violence, parental substance use and parental mental illness: an integrated multi-service system response to the wellbeing and protection of vulnerable children*.
- Whilst there is no statutory requirement for the VCDRC to prepare an annual report for tabling in parliament, this has been the practice since its inception in accordance with the Terms of Reference. The VCDRC annual report is the means by which data relating to the number of deaths of children known to Child Protection becomes publicly available. This has resulted in the VCDRC's work becoming part of accountability and transparency processes concerning the state's Child Protection program.
- Media reporting regarding data contained in the VCDRC annual reports has focussed on the number of deaths, generally not distinguished between deaths due to natural and external causes and wrongly inferred that deficient Child Protection practice was associated with all deaths (see Attachment 1).
- The nature of the media reporting of the VCDRC annual report makes it more challenging for identified practice and service delivery issues to be effectively communicated to Child Protection and other service staff. In order to improve dissemination of learnings, the VCDRC has published *Information for Practitioners* brochures in the 2009 and 2010 reporting periods (see Attachments 2a and 2b).

Different models of child death review

- Child death review mechanisms have increasingly become a component of both quality assurance/continuous improvement and accountability processes relating to Child Protection.
- While child death review processes now exist within most national and international jurisdictions, the approaches vary considerably reflecting the differing welfare, legal and cultural contexts within which they exist. There has also been evolution and change over time in many jurisdictions concerning how child deaths are examined and organisational arrangements supporting this.
- In most jurisdictions there is a layered approach to the examination of child deaths. Coronial processes are a common feature although the deaths captured within this system vary due to different legislative provisions.
- The main dimensions of the various models relate to:
 - whether the public health and more narrow Child Protection death review processes are separate or integrated
 - definition of which child deaths are within the cohort to be examined – focussed on deaths due to abuse and/or neglect or broader
 - timeframe eligibility of cases in scope
 - whether the focus of examination is exclusively on Child Protection or also includes the broader service system
 - whether the detailed case review is done within the responsible department or externally
 - whether there is multidisciplinary input or oversight
 - whether the stated objective of the process is learning or prevention
 - allocation of responsibility
 - the quality of information systems that outcomes are captured within
 - the arrangements for publication and dissemination of findings and/or learnings.

New South Wales

- New South Wales (NSW) has a two-tier child death review system with each body operating independently of the other - there is no interconnection between the two tiers with one providing oversight of the other - they are separate but complementary.
- Changes to NSW's child death review system most recently occurred as a result of the *Special Commission of Inquiry into Child Protection Services in NSW* which recommended changes to the respective roles of involved bodies as well as streamlining processes. Previous duplication in the reviews undertaken by the Department of Community Services (DOCS) and the Ombudsman was resolved and the function previously undertaken by the Commissioner for Children and Young People was relocated to the Ombudsman.
- The first tier of review is undertaken internally by the Department of Community Services' Child Death and Critical Reports (CDCR) Unit which is located within the broader Investigations and Review Branch, that is, at arm's length from the program area responsible for child protection services but within the same department.

- The CDCR Unit reviews the deaths of children or young people who died, or the siblings of children or young people who died, who were known to Community Services having been the subject of a report in the three years prior to death.
- The CDCR can also conduct reviews into critical incidents that do not involve a death.
- The CDCR must complete child death reviews within six months of the CDCR being notified of the death.
- Depending on the scoping of involved issues, CDCR reviews may be limited to a desk-top review or when more wide-ranging inquiries are considered necessary this is supplemented by interviews with Community Services staff.
- CDCR child death reviews are internal reviews, subject to departmental policies and focussed on internal learning purposes. They seek to support practice improvement and agency accountability. Any recommendations are made only about the Department of Community Services and the CDCR is responsible within the organisation for monitoring the implementation of recommendations.
- A copy of each endorsed CDCR child death review report is forwarded to the NSW Ombudsman.
- The second tier of NSW's child death review system is undertaken by the Ombudsman. Since July 2009 the NSW Ombudsman has no longer reviewed the deaths of children 'known to Community Services' but continues to review 'reportable' deaths which are those that may have been the result of abuse or neglect, or occurred in suspicious circumstances, children in care or detention/correctional centres or children in disability care services.
- The NSW Ombudsman can formulate recommendations regarding policies and practices to be implemented by government and service providers for the prevention or reduction of 'reviewable' deaths.
- The NSW Ombudsman tables a report in parliament every two years regarding 'reviewable' deaths.
- Since November 2009, the NSW Ombudsman is now also responsible for the Child Death Review Team (CDRT) which was previously a function of the Commissioner for Children and Young People. The CDRT undertakes the public health/epidemiology function of reviewing the deaths of all children in NSW from birth to 17 years. The CDRT was established in 1996 to prevent or reduce the number of child deaths in NSW.
- The CDRT is now convened by the Ombudsman with the Commissioner for Children and Young People as a member. The CDRT is a multidisciplinary team reflecting a multidisciplinary and interagency response to promoting the safety of children. It oversees the work of a research team which have to date produced seven special reports: *Fatal assault of children and young people* (2002); *Suicide and risk-taking deaths of children and young people* (2003); *Fatal assault and neglect of children and young people* (2003); *Sudden unexpected deaths in infancy and the New South Wales experience* (2005); *Trends in the fatal assault of children in New South Wales: 1996-2005* (2008); *Trends in child deaths in New South Wales 1996-2005* (2008); *A preliminary investigation of neonatal SUDI in NSW 1996-2008: opportunities for prevention* (2010).

Queensland

- Queensland has a three tier system of child death review.

- The first tier is undertaken by the Department of Communities (Child Safety Services) which, since 1 August 2004, has had responsibility to undertake reviews of deaths of children known to the department. Individual case reviews are undertaken by this department's Case Review Unit which is located within a broader Complaints and Review section within the Office of the Director-General, that is, at arm's length from the program area responsible for Child Protection services but within the same department.
- Such reviews must be undertaken in relation to the deaths of children known to the Child Protection system in the three years before the death.
- Reviews must be completed within six months of the department becoming aware of the death.
- Depending upon scoping of involved issues, reviews are conducted as either a Limited Review or a Detailed Review.
- Before being forwarded to the second tier external review mechanisms, these case review reports are considered and finalised by the department's internal Systems and Practice Review Committee.
- The second tier of Queensland's child death review system is undertaken by the Commissioner for Children and Young People and Child Guardian. The Commissioner convenes and chairs the Child Death Case Review Committee, which is a multidisciplinary committee established under the auspices of the Commission to increase the accountability of the Child Protection system.
- The Child Death Case Review Committee receives for consideration the departmental review report and all the material collected in the preparation of that report (both from within and external to the department). The committee can require the department to provide a supplementary report if the initial report is considered insufficient or incomplete.
- The committee assesses the department's report against a set of review criteria and provides advice back to the department within three months of receiving the review report.
- The committee can make recommendations to the department about informing policies which impact on services to children in the Child Protection system; improving relationships between the department and other agencies involved with children and their families; and whether disciplinary action should be taken against any departmental staff in relation to their involvement with a child.
- The third tier of Queensland's child death review system is also undertaken by the Commissioner for Children and Young People and Child Guardian as this independent, statutory authority is also responsible for the public health/epidemiology function of registering and reporting on all deaths of children and young people in the state; to review the causes and patterns of such deaths; to make recommendations to help reduce the likelihood of child deaths; and to prepare an annual report to parliament. Deaths of children known to the Child Protection system are a subset of this broader responsibility undertaken by the Commissioner.

South Australia

- South Australia (SA) has a two-tier child death review system with each body operating independently of the other – there is no interconnection between the two tiers with one providing oversight of the other – they are separate but complementary.
- The Department of Families and Communities (Families SA) has an internal departmental review mechanism which examines both death and serious

injury of a child known to any Families SA program area within three years of the death or serious injury.

- Internal case reviews are undertaken by the Adverse Events Review Team which is located within the Practice Development Directorate of Families SA, that is, at arm's length from the program area responsible for service delivery but within the same department.
- There is no legislative requirement for such reviews. The departmental policy basis for such reviews was established in 2004.
- Policy expectation is that reviews be completed within six-nine months of reviews being referred, but this can depend on whether a review is undertaken as a single case review or a group analysis of similar cases.
- The focus of such reviews is to examine the quality and nature of Families SA service delivery to children and their families at a practice level and systems level – including its interface with other services.
- The review report contains findings but not recommendations.
- All review reports are submitted to the internal Adverse Events Committee (comprised of senior Families SA staff) which can accept, reject or amend the findings as well as make recommendations regarding any area of Families SA practice and systems.
- Any recommendations are forwarded to the Families SA Executive for consideration and if accepted, implementation is monitored by the Executive.
- All Adverse Events Review reports and Adverse Events Committee deliberations are available to the other body involved in SA's child death review system – the Child Death and Serious Injury Review Committee (CDSIRC) – upon request.
- The CDSIRC is a statutory body established in February 2006 to review the deaths and serious injuries of all children aged 0-17 years (excluding still births).
- The CDSIRC undertakes the broad public health surveillance and prevention function as well as having the responsibility to review a specialised subset of cases: where there are indications of abuse or neglect; where the child or a member of the child's family has been the subject of a child protection notification in the past three years; where the child was under the guardianship of the Minister or was in the care of a government agency; where the committee considers the circumstances suggest that systemic changes could be made to prevent similar deaths or serious injuries.
- The CDSIRC is not required to review all deaths and serious injury in depth but exercises discretion regarding which to examine closely. Committee members, with the assistance of the secretariat, undertake the in-depth reviews.
- The CDSIRC aims to identify systems, policies, procedures, practices, legislation and/or information strategies that should be introduced, upgraded or modified to prevent deaths and serious injuries.
- The committee is required to report annually to the Minister for Families and Communities who must table the committee's annual report in parliament.

Western Australia

- Western Australia (WA) has a single tier external review system of deaths known to Child Protection.

- WA does not have a public health review mechanism that examines all child deaths following the Advisory Council on the Prevention of Deaths of Children and Young People, which was established in 2003, ceasing operation in 2008.
- The *Ford Report 2007*, into the former Department of Community Development which was responsible for the state's Child Protection program, recommended that the child death functions relating to children known to Child Protection be transferred to the Office of the Ombudsman. This transfer occurred in 2008.
- The function was transferred from the Child Death Review Committee which was independent from the department and established to provide an external quality assurance mechanism for the Child Protection program. The Committee was not able to fulfil its function because it was responsible for undertaking reviews, could only access files of the department and could not interview staff.
- A Child Death Review Team led by an Assistant Ombudsman has been established in the WA Ombudsman's office.
- An 'investigable death' is defined as the death of a child known to the Department of Child Protection in a number of specified ways (including a sibling of the deceased child being known) within a two-year period before the date of death.
- There is no statutory timeframe for the completion of a child death investigation.
- The purpose of the review function is to identify any patterns or trends in relation to 'investigable deaths' and to make recommendations to any state department about ways to prevent or reduce investigable deaths.
- There is discretion about the level of review conducted based upon screening of whether there are issues which warrant examination and whether the department has initiated a review which acknowledges errors and includes a plan to address identified issues.
- The WA Ombudsman has all the powers of a Royal Commission but these have not been used to date in relation to the child death review jurisdiction.

Tasmania

- Tasmania has a population-wide child death review mechanism – the Council of Obstetric and Paediatric Mortality and Morbidity which was established under the *Perinatal Registry Act 1994*.
- To perform its functions in relation to paediatric mortality, the Council established the Paediatric Mortality and Morbidity Sub-Committee which reports on the deaths of children aged 29 days to 17 years and makes recommendations regarding systemic issues. The Council consists of five medical practitioners but, more recently, was expanded to include the Children's Commissioner, a person experienced in the Child Protection area, a paediatrician and the Deputy Secretary of Health and Human Services. The Council and Sub-Committee report to the Secretary of the Department of Health and Services annually.
- The Tasmanian process for reviewing deaths of children known to Child Protection is currently under review and development. There may be amendments made to the *Children, Young Persons and their Families Act 1997* to enable reviews to be undertaken under new provisions and with altered organisational arrangements.

Northern Territory

- The Northern Territory (NT) has a population-wide child death review mechanism but no specific mechanism in relation to the deaths of children known to Child Protection – although some of these deaths may fall within the scope of the Children’s Commissioner statutory investigative complaints framework.
- The *Care and Protection of Children Act 2007* contained provisions relating to the Prevention of Child Deaths which began in May 2008. These provisions were aimed at the prevention and reduction of child deaths through maintaining a database on child deaths, conducting research and the development of appropriate policies aimed at reducing and preventing child deaths, diseases and accidents in the NT.
- A child death under this Act refers to the death of a child who usually resides in the NT regardless of whether the death occurred in the NT.
- The Act defines a child as a person less than 18 years of age or a person apparently less than 18 years of age if the person’s age cannot be proved.

England's child death review system

- Much of the literature relating to issues associated with unintended impacts of child death inquiry processes together with the learnings derived from these processes relates to the English system.
- England's current inquiry processes into child deaths relate exclusively to child deaths resulting from abuse.
- England's Child Protection system is currently undergoing comprehensive review instigated by the then newly elected government in June 2010 and so the system is entering a process of transition including possible changes to the approach to child death reviews.
- Reviews of child deaths from abuse are undertaken through what are termed Serious Case Reviews (SCRs) and sometimes referred to as Part 8 Reviews. SCRs are also conducted when a child has sustained serious harm not resulting in death.
- SCRs are local inquiries into the death or serious injury of a child where abuse or neglect are known or suspected. They are carried out under the auspices of Local Safeguarding Children's Boards (LSCBs) with the purpose of lessons being learnt in the local service network context.
- The introduction of these local processes was a deliberate policy shift away from large scale public inquiries into child deaths that occurred largely in the 1980s. These inquiries generally had major impacts on the overall service system on the presumption that these single cases occurring within local contexts demonstrated a more general problem across the entire system.
- With the introduction of the SCR local process there were still exceptional cases in which the government ordered a public inquiry. However, SCRs introduced a systemic process for local level review and learning.
- SCRs are themselves multi-faceted usually incorporating Individual Management Reviews (IMRs) undertaken by each service involved to examine its own performance in relation to involvement with the child and family and its effectiveness in working with other services. Another component of the SCR is an Overview Report which brings together and analyses information from all the IMRs undertaken in relation to the death or serious injury of a child. This requires the development of an Integrated Chronology of the involvement of all services and an understanding of what each was doing relative to each other. The ability to produce a quality Overview Report is highly dependent upon the quality of IMRs. The final stage of each SCR is the preparation of an Executive Summary Report which is made publicly available, usually on the LSCB website.
- Beyond this local learning and accountability process the government commissioned a national biennial analysis of all SCRs undertaken over the preceding two years to draw out themes and trends so that learnings could inform national policy and practice. Five such biennial analyses of SCRs have occurred and been published to convey the key messages for practice that have emerged from these macro analyses.
- In June 2010, the Minister for Children and Families when announcing that the government had commissioned an independent review into Child Protection to be undertaken by Professor Eileen Munro also announced that all chairs of LSCBs and directors of Local Authority Children's Services had been directed to publish from that date all SCR Overview Reports and Executive Summaries. The Minister announced that the presumption should be that these reports be published – anonymised and without identifying details – unless there was compelling reason relating to the welfare of any children directly concerned in

the case for this not to happen. This represented a re-casting of the balance to be struck between transparency and openness and the protection and welfare of children.

Victorian child death data

Figure 1 Trends in deaths from all causes 0-17 years (ABS)

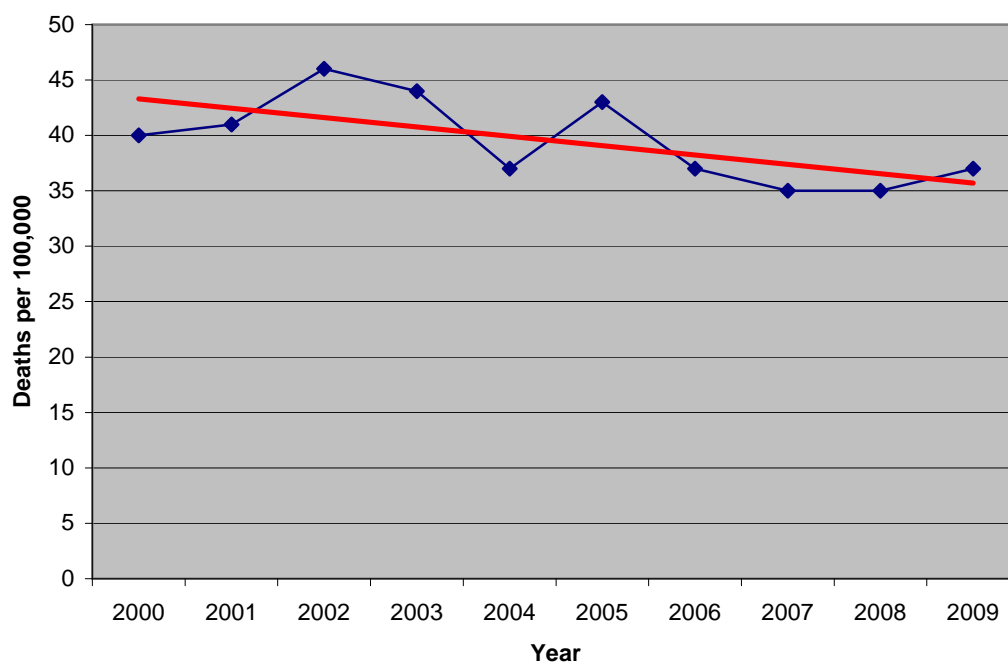


Table 1 Trends in deaths from all causes 0-17 years (ABS)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Deaths per 100,000	40	41	46	44	37	43	37	35	35	37
Actual deaths	467	484	519	501	492	495	435	424	427	455

- The overall death rate for children and young people aged 0-17 years is falling.
- Between 2000 and 2009 the rate declined from 40 deaths per 100,000 (467 deaths) to 37 deaths per 100,000 (455 deaths).

Figure 2 Deaths aged 0-17 years: All Victorian deaths (CCOPMM)/Deaths where child 'known to Child Protection' (VCDRC)

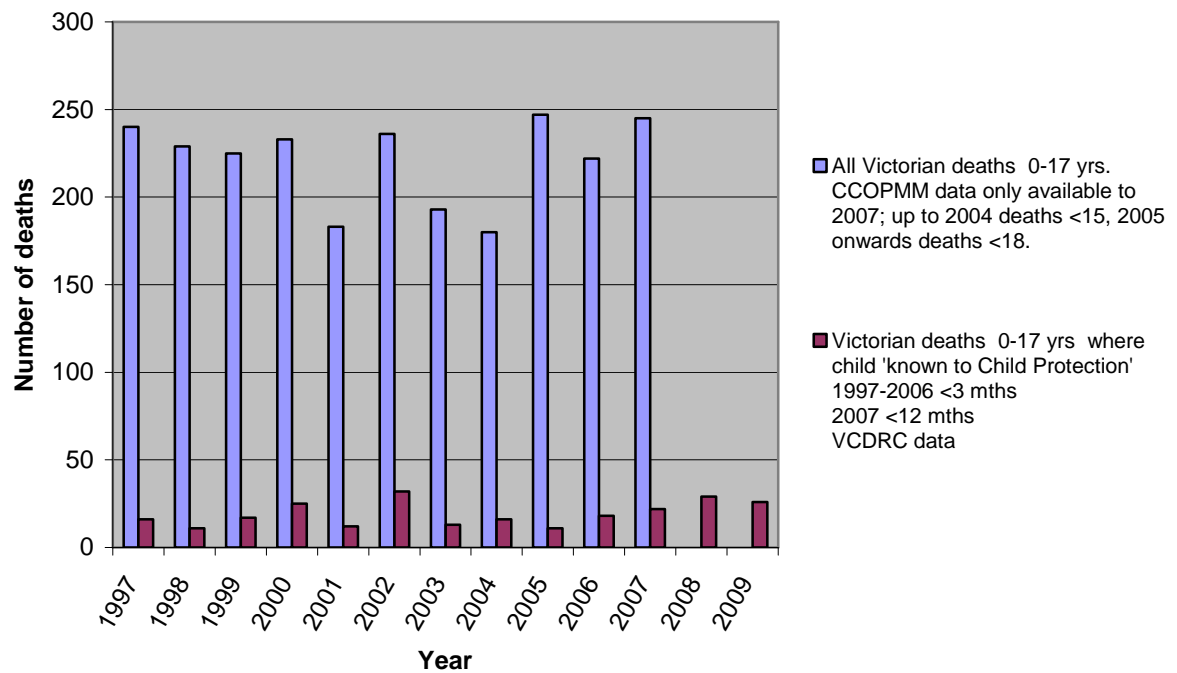


Table 2 Deaths aged 0-17 years: All Victorian deaths (CCOPMM)/Deaths where child 'known to Child Protection' (VCDRC)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Victorian deaths 0-17 yrs ¹	240	229	225	233	183	236	193	180	247	222	245	n/a	n/a
Victorian deaths 0-17 yrs where child 'known to Child Protection' ²	16	11	17	25	12	32	13	16	11	18	22	29	26

Figure 3 Deaths from intentional trauma (CCOPMM)/Deaths from non-accidental trauma where 'child known to Child Protection' aged 0-17 years (VCDRC)

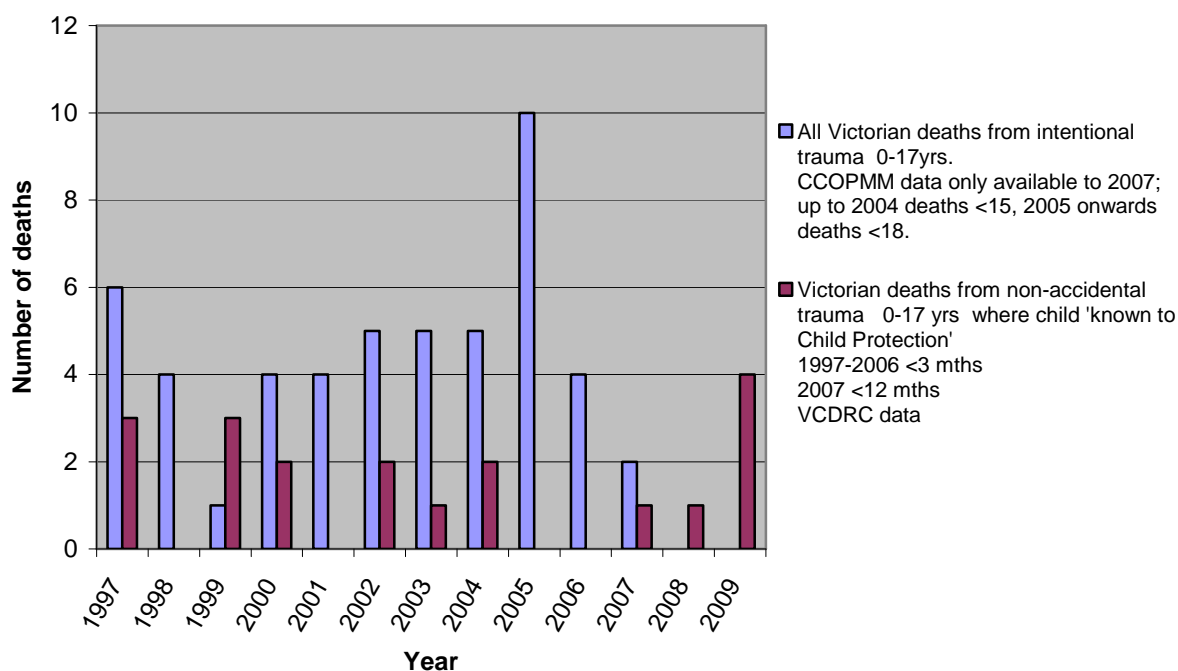


Table 3 Deaths from intentional trauma (CCOPMM)/Deaths from non-accidental trauma where 'child known to Child Protection' aged 0-17 years (VCDRC)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Victorian deaths from intentional trauma 0-17 yrs ¹	6	4	1	4	4	5	5	5	10	4	2	n/a	n/a
Victorian deaths from non-accidental trauma 0-17 yrs where child 'known to Child Protection' ²	3	0	3 ³	2	0	2	1	2	0	0	1	1	4

Figure 4 Deaths from suicide (CCOPMM)/Deaths from suicide where child 'known to Child Protection' aged 0-17 years (VCDRC)

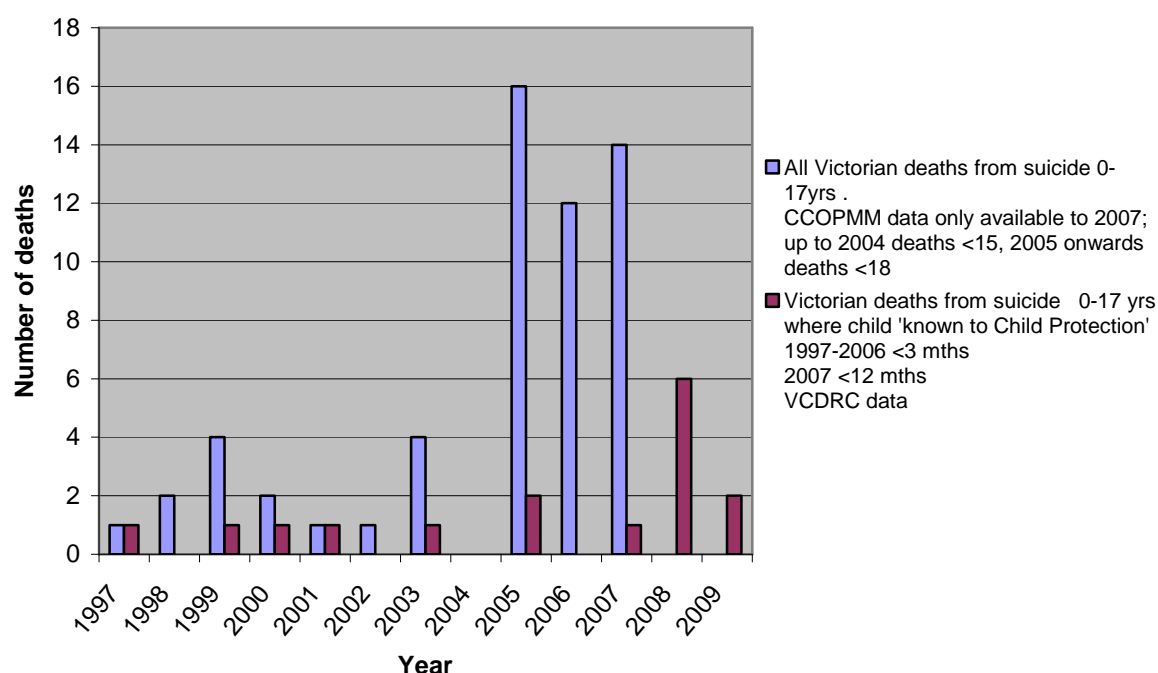


Table 4 Deaths from suicide (CCOPMM)/Deaths from suicide where child 'known to Child Protection' aged 0-17 years (VCDRC)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Victorian deaths from suicide 0-17 yrs ¹	1	2	4	2	1	1	4	0	16	12	14	n/a	n/a
Victorian deaths from suicide 0-17 yrs where child 'known to Child Protection' ²	1	0	1	1	1	0	1	0	2	0	1	6	2

Figure 5 Deaths from suicide and intentional trauma (CCOPMM)/ Deaths from suicide and non-accidental trauma where child 'known to Child Protection' aged 0-17 years (VCDRC)

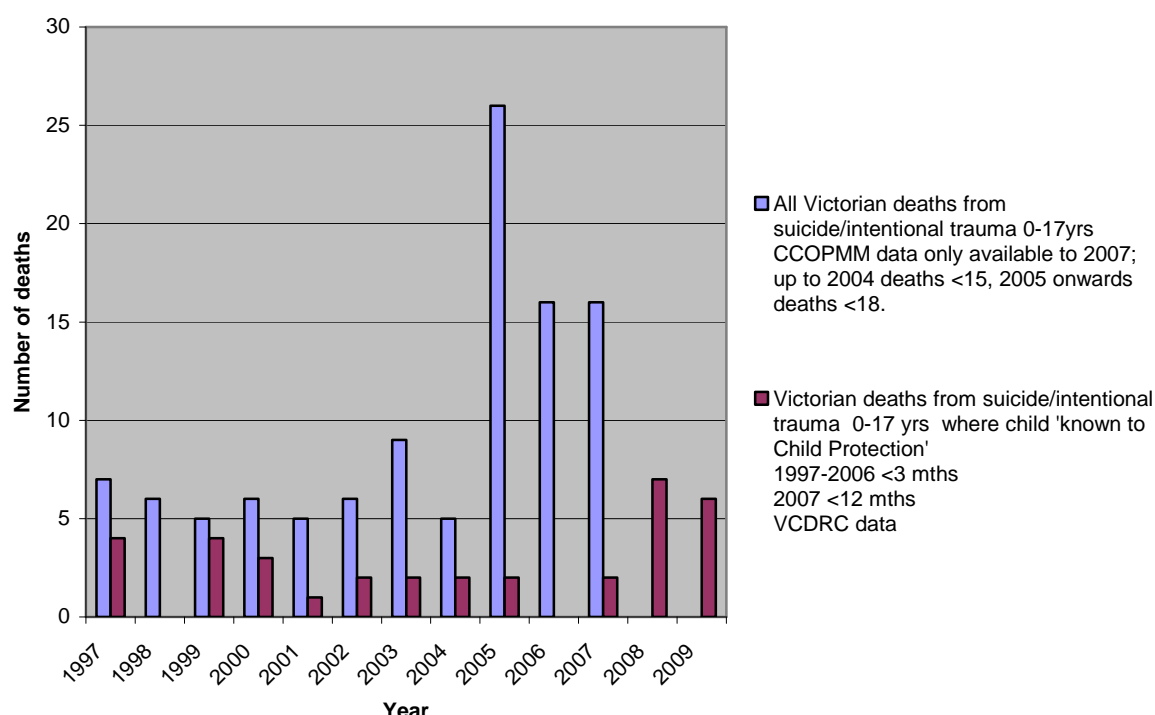


Table 5 Deaths from suicide and intentional trauma (CCOPMM)/ Deaths from suicide and non-accidental trauma where child 'known to Child Protection' aged 0-17 years (VCDRC)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Victorian deaths from suicide and intentional trauma 0-17 yrs ¹	7	6	5	6	5	6	9	5	26	16	16	n/a	n/a
Victorian deaths from suicide and non-accidental trauma 0-17 yrs where child 'known to Child Protection' ²	4	0	4	3	1	2	2	2	2	0	2	7	6

¹ The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) 2010, *Annual Report for the Year 2007*, Victorian Government Department of Health, Melbourne Victoria.

CCOPMM data available to 2007 only.

Shows post-neonatal infant and child deaths (28 days to 14 years) from 1997 to 2004, and post-neonatal infant, child and adolescent deaths (28 days to 17 years) from 2005 to 2007.

² Shows deaths of all children aged 0 to 17 years where the child is known to Child Protection. 1997 – 2006 ≤ 3 months; 2007 onwards ≤ 12 months.

- ³ Of these three deaths: one was aged 17 years - CCOPMM data up to 2004 reports only on post-neonatal infant and child deaths from 28 days to 14 years. One death occurred interstate – CCOPMM reports only on deaths of children who were residents in Victoria *and* who died in Victoria.

Common practice and service delivery issues identified by the VCDRC

The following summarises the consistent themes identified by the VCDRC.

- **Case finding:**

- opportunities exist for earlier reporting to Child Protection particularly in relation to Unborn Child Reports
- unborn child reports should initiate early planning; the dual pathway of Child Protection and ChildFIRST remains a 'work in progress' and needs sustained attention to embed into practice effectively
- the role of the Community Based Child Protection Worker is pivotal to achieving the policy objective of this dual pathway initiative
- ChildFIRST services must have the capacity to undertake assessments and undertake work with vulnerable families and not operate primarily as a referral mechanism.

- **Assessment- information gathering and analysis:**

- assessments are compromised if insufficient information is collected
- assessment requires a systematic process of gathering information
- information is not being routinely sought from important universal services – doctors, maternal and child health nurses and schools – and specialist adult services – family violence services, drug and alcohol services and mental health services
- organising, analysing and weighing the significance of information is a necessary component of undertaking assessments and requires thinking and analytical skills
- sufficient direct contact with families and children is necessary to undertaking an effective assessment in order to make direct observations and to collect family and individual histories
- assessments need to address not just immediate parenting issues but also the capacity for parents to change and sustain those changes necessary for the protection and welfare of their child/ren
- assessment and responding more effectively to cumulative harm has not to date been fully realised.

- **Working together:**

- the need for Child Protection to take a leadership role whilst also working collaboratively with a wide range of other services
- effective communication is fundamental to working together
- the need for child focused and adult focused services to work more closely together particularly in relation to the increasing prevalence of the co-occurrence of family violence, mental health issues and substance use within families
- communication should be two-way – other services need to understand Child Protection assessments and the basis of these if they are to be able to contribute to safety plans and monitor risk to vulnerable children
- the need to re-invigorate case conferencing as a basic mechanism for working together

- Child Protection and its service partners need to put a higher value on reciprocal communication and constructive challenge of divergent assessments in order to build shared understandings as the basis of working together
 - Child Protection case closure should not occur without clear agreement about the roles and responsibilities of other service in relation to protective issues
 - Care teams should be built around high risk young people which share responsibility for planning and decision making and accept that each service will not be making unilateral decisions regarding withdrawing from service provision without reference to the Care Team.
- **Operating environment:**
 - resource constraints adversely impact on practice and service provision in cases but good work can also take place in resource-constrained environments due to the efforts of individual practitioners who demonstrate persistence despite numerous organisational constraints
 - the importance of supervision processes facilitating reflective and critical thinking
 - the importance of quality assurance processes relating to high risk infants and adolescents and the need for input from these specialist roles to be privileged in decision-making
 - frequent poverty of options in relation to care arrangements, particularly for adolescents
 - the urgent need to improve the availability of a range of culturally relevant services to Aboriginal children and their families.

Recommendations made by the VCDRC

- The VCDRC has made a total of 84 recommendations in the period 2005-10.
- These recommendations are attached and have been categorised in relation to two dimensions – *Aspects of Practice* and *Service Sectors* (see Attachment 3).
- Prior to 2005, CDI reports included recommendations which the VCDRC commented on in its deliberations but did not itself produce any recommendations.
- In the reporting period 2005-06, a change in practice occurred through agreement with the OCSC, which was then newly formed and had responsibility for undertaking CDIs, and the VCDRC. These changes resulted in CDIs producing findings and the VCDRC determining if these should be translated to formal recommendations for change.
- Recommendations made by the VCDRC may result from individual CDIs; common themes/issues which have been noted across cases and over time; or a group analysis of a particular cohort of cases for which the VCDRC has requested the OCSC to undertake additional examination of issues.
- The VCDRC's approach to making recommendations has evolved over time. In order to avoid a platform of potentially conflicting recommendations, agreement was reached between the OCSC and the VCDRC that CDIs would contain findings but not recommendations.
- Whilst seeing recommendations for change as important product of the committee's work, the VCDRC has adopted a judicious approach to making recommendations for change and does not do this in relation to all CDIs considered.
- The committee considers that the value of its work is found as much in its comments on individual CDIs and the patterns it identifies across cases as in the specific recommendations for change it makes. The insights that the VCDRC provides along with the recommendations it makes are important inputs into service development activities of DHS and its quality assurance and continuous improvement processes.
- When making recommendations, the VCDRC generally avoids a reductionist approach which drives proceduralism within Child Protection but seeks to point to issues which require attention. Specifying precisely how identified problems should be resolved is seen as the responsibility of DHS rather than the committee.

Impact of child death inquiries and VCDRC reviews on Victoria's Child Protection program

DHS has identified the following impacts relating to learnings obtained from CDIs and VCDRC reviews:

- Child Protection *Every child every chance* reform strategy:
 - new legislation refocuses on neglect issues and cumulative harm, stability and developmental needs
 - Family Services Strategic Framework - development with input from the Chronic Neglect group analysis
 - Best Interests case practice model focuses on assessment areas of information gathering, analysis, decisions and actions.
- Legislation allows reports on unborn children
- Practice Guidance:
 - Working with children and families with complex medical needs
 - Babies, children, young people at risk of harm: Best practice framework for acute health care
- Practice Instructions:
 - Multiple reports to Child Protection intake
 - Admission and discharge of children from hospital
- Learning and development strategies:
 - supports *Every child every chance* reforms
 - joint training across all community sectors
 - Child Protection leadership training initiative
- Child Protection strategic priorities 2007-2008 included:
 - mental health, drugs and alcohol – strengthen early intervention, prevention and access to treatment
 - pursuit of workforce strategies
- Child Protection operating model and workforce strategy:
 - review of operating model: functions, structures, roles
 - workforce: stabilisation, sustainability, capacity.

Looking ahead

- The VCDRC considers that there is value in maintaining a multidisciplinary committee as part of the child death review system although organisational arrangements may change.
- The establishment of an independent Children's Commissioner clearly provides opportunities for change to organisational arrangements concerning the VCDRC.
- A multidisciplinary review committee which considers individual CDI reports could be convened and chaired by the Children's Commissioner. Alternatively, a multidisciplinary committee could retain the status of a Ministerial Advisory Committee and be chaired by the Children's Commissioner.
- Opportunities for a closer structural relationship between the epidemiological population-wide function of CCOPMM and the body that considers deaths of children known to Child Protection could also be considered. Whilst it is important not to lose the value of examining deaths of children known to Child Protection to discern case practice and service delivery learnings for this specialist subpopulation cohort, there would also be value in having a broader understanding on a total population basis of mortality and morbidity issues. Other jurisdictions which combine the population-wide and subpopulation child death review functions have produced data that reveals that children known to Child Protection have higher death rates from all external causes.
- Government policy is to broaden the scope of CDIs to include reviewing the circumstances of children who die as a result of abuse or neglect regardless of whether these children were known to Child Protection. The VCDRC has advocated this change as important both from a learning perspective and to strengthen the credibility and integrity of the child death review system.
- Regardless of changed organisational arrangements which might occur, the VCDRC supports the continued evolution of the CDI process in order to derive maximum value from the investment of resources into this function.
- The OCSC initiated a review of the CDI process in 2008 and the VCDRC supports the following directions for change:
 - a differential approach to CDIs so that the investment of resources in reviews is concomitant with the extent of issues to be explored
 - a flexible approach to the level of review required so that more intensive review can occur if issues are more extensive or complex than initially identified
 - a process that promotes greater engagement with and valuing of CDIs by practitioners
 - broader attention of CDIs beyond Child Protection to other involved services and how the broad service system operates
 - assistance in building a reflective practice culture by adjustments to the process of CDIs
 - replacement of an investigative CDI mindset with an approach that is reflective, inclusive and transparent - the process should not be about getting answers to predetermined questions but giving participants the opportunity to tell their story of how the case unfolded and factors which impacted on practice and service delivery
 - importance of establishing not just what happened but also 'why' – if practice deficiencies are identified, it is equally important for the CDI to explore the factors which contributed to this

- a move towards the use of integrated chronologies which are not limited to a chronology of Child Protection actions but also include the involvement and actions of other services so that an overall understanding of what all services were doing relative to each other is portrayed
- a move towards CDIs engaging not just with individual practitioners and services but also with service networks when particular CDIs warrant this - and with input from service networks to the CDI and feedback to service networks
- faster timeframes for completion of CDIs and review processes so that advice regarding findings to participants, services and networks can be timely and therefore more meaningful
- importance of an information management system which captures patterns, trends and CDI findings over time and is comparable with information systems relating to other auditing processes so that child death insights can contribute to broader quality assurance efforts.

Attachments

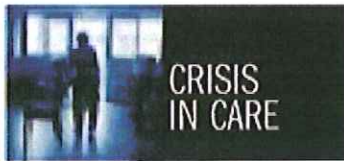
Attachment 1	Media articles relating to VCDRC Annual Reports
Attachment 2a	Information for Practitioners 2009
Attachment 2b	Information for Practitioners 2010
Attachment 3	VCDRC recommendations 2005-10



Age
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Frequency: MTWTFSS-

Seven Victorian child deaths 'preventable' System 'underestimates risk'

By **RICHARD WILLINGHAM**



THE deaths last year of 26 children known to Victoria's child protection authorities has highlighted staff shortages, inadequate training and poor assessment practices, a report has found.

The annual report by the Child Death Review Committee on deaths of children known to be in protection last year was tabled in Parliament yesterday. It is the third report in a year to be critical of Victoria's child welfare agencies.

Four of the 26 deaths last year were the result of non-accidental trauma, two were suicides, one was from substance abuse, eight were attributed to acquired or congenital illness, two to accidents, one to SIDS and one is unknown. The other seven are still under investigation.

"Overall the case reviews paint a picture of the corrosive effect of chronic staffing shortages and workload pressures," the report said.

There are 1598 cases that do not have an independent, long-term worker. These children are managed by a senior member within a welfare region.

The report said child protection did not work cohesively

with other welfare bodies and more information sharing was needed to protect children.

Case assessment also came under fire in the report.

The chief executive of the Australian Childhood Foundation, Joe Tucci, said at least seven deaths could have been preventable.

"Overall, the child protection system underestimates risk to children in Victoria," Dr Tucci said. "It minimises the impact of violence and neglect on children. I think it does that because it is oriented too much to a family support model."

He said there needed to be more emphasis on the child rather than the parent.

Opposition community services spokeswoman Mary Wooldridge said a Coalition government would set up a judicial inquiry to understand the complexity of child welfare. It would also appoint an independent children's commissioner.

She said a new culture of support need to be fostered in the Department of Human Services to help retain staff.

For the first time the scope of deaths of children investigated was increased. The report

investigated children who died within 12 months of having been in child protection; previously it had been three months.

Child safety commissioner Bernie Geary said he welcomed the government's expansion to 12 months.

"It means the government are fair dinkum in their acknowledgment of that fact that we need to be as thorough as we can in looking at these children's deaths and how the services have impacted on them," Mr Geary said.

Ms Wooldridge said the new criteria skewed the data and that on a like-for-like comparison 2009 had the most deaths for children known to child protection since 2002 when there were 32.

Community Services Minister Lisa Neville said the government had made big changes with an investment of more than \$300 million in the past two budgets.

"Since October last year we have recruited over 400 new child-protection workers to the system that has filled all the vacancies and filled the additional position we have funded," Ms Neville said.

Almost 30 children dead under protection

July 29, 2010 - 2:14PM

Twenty-six children died last year while under the watch of Victorian child protection, a new report shows.

Four deaths were the result of non-accidental trauma, two were suicides, one was the result of substance abuse and seven are still under investigation.

Of the remainder, eight were attributed to acquired/congenital illness, two to accidents, one to SIDS and one is unknown.

The Victorian Child Death Review Committee investigates deaths of minors known to child protection.

In its annual report, tabled in State Parliament today, the committee noted there had been 26 child deaths in 2009.

Of the 16 deaths it reviewed between April 2009 and March this year, 11 involved children aged under three.

Fifteen of the children were in the care of their families when they died, while one was in out-of-home care.

Parental substance abuse and domestic violence were risk factors in 62 per cent of cases, and family mental illness and homelessness presented in almost half of the deaths.

The report criticised child protection workers for not adequately assessing child risk and gathering information on family history.

"When responding to possible physical abuse, assessment and decision making are time critical and must clarify issues regarding the safety of the child as the most urgent priority," the report said.

"In such circumstances, child protection practitioners must be confident to use the authority vested in their role and to act decisively."

It said safety must be given greater weight in making decisions about the child's welfare, warning that failure to do so "can have immediate and life-threatening outcomes for children".

AAP

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Australian
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Child deaths reveal services at fault

MILANDA ROUT
VICTORIAN POLITICAL
REPORTER

MORE than half of the 26 children who died while under the watch of child protection authorities in Victoria last year had parents with known histories of substance abuse and violence.

The latest Victorian Child Death Review Committee report paints a grim assessment of an overworked, understaffed government department that is failing to properly assess the risks some children face while at home.

It found that of the 16 deaths from April last year to March this year, 44 per cent of the victims had "extensive child protection involvement", and up to 14 protective intervention orders had been filed on the families.

A further four children were on Children's Court orders — including three teenagers who committed suicide.

Fifteen of the children were in the care of their families when they died, while one was in out-of-home care.

The report, tabled in state parliament yesterday, found there were problems with "assessment" of risks done by the caseworkers at the Department of Human Services.

"Many child-death inquiries identify that insufficient information is collected on which to reasonably base an assessment," the committee said.

"There is not enough direct contact by Child Protection with families. Significantly, there is often even less contact with the child or children who are the subjects of the reported concerns."

The committee also noted the department had an inexperienced workforce that was pushed to the limit.

"The case reviews paint a picture of the corrosive effect of chronic staffing shortages and workload pressures," the report says.

Opposition community services spokeswoman Mary Wooldridge said the report showed Victoria had a "corroding child protection system", where services are chronically understaffed and under pressure.

"This is the third report in nine months that shows John Brumby and his government do not care about vulnerable children who... are being re-traumatised, neglected and in some cases dying," she said.

Community Services Minister Lisa Neville said all the committee's recommendations had been accepted and would be implemented.



MX (Melbourne)

29/07/2010

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26 kids died on watch

Twenty-six children died last year while under the watch of Victorian child protection services, a shocking new report shows.

Parental substance abuse and domestic violence were risk factors in 62 per cent of cases, and family mental illness and homelessness presented in almost half of the deaths.

Four deaths were the result of non-accidental trauma, two were suicides, one was the result of substance abuse and seven are still under investigation.

Of the remainder, eight were attributed to acquired/congenital illness, two to accidents, one to sudden infant death syndrome and one is unknown.

The Victorian Child Death Review Committee investigates deaths of minors known to child protection.

In its annual report, tabled in State Parliament today, it noted there had been 26 child deaths in 2009.

Of the 16 deaths it reviewed

between April 2009 and March this year, 11 involved children aged under three.

Fifteen of the children were in the care of their families when they died, while one was in out-of-home care.

The report criticised child protection workers for not adequately assessing risk and gathering information on family history.

"When responding to possible physical abuse, assessment and decision making are time-critical and must clarify issues regarding the safety of the child as the most urgent priority," it said.

"In such circumstances, child protection practitioners must be confident to use the authority vested in their role and to act decisively."

It said that safety must be given greater weight in making decisions about the child's welfare, warning that failure to do so "can have immediate and life-threatening outcomes for children".



Report: failures caused death **Children neglected**

KERRI-ANN HOBBS

VICTORIAN children in care died because workers failed to identify the risks they faced, a damning report released yesterday stated.

Child-protection workers also did not gather enough information on family history, according to the report by the Victorian Child Death Review Committee.

The report highlighted the failure of Victoria's child-protection system to keep children safe and other agencies to help families, according to Opposition Community Services spokeswoman Mary Wooldridge.

But Community Services Minister Lisa Neville defended her department's handling of children in care, saying millions was being spent to make kids safe.

"The safety of all Victorian children remains our priority and our ongoing investment and reform will continue - that is why this year alone we are investing close to \$300 million in protecting and supporting children who are no

longer able to live with their parents," Ms Neville said.

"We are providing specialist training to all carers, improving the standard of reporting and analysis of incidents, and expanding placement options for out-of-home care, to provide greater flexibility and more variety of accommodation, so that children are matched with the option that best suits their needs."

The investigation found child protection workers had not

ORDERED full assessments of each case and reacted to fragments of information;

ASSESSED families' backgrounds and histories properly;

CHECKED if parents were able to fully care for their children;

VERIFIED claims made by parents about their children, and

WORKED with other agencies to treat the children's complex needs.

Ms Wooldridge said the report was the third by the Government in nine months that highlighted that children known to the system

were being re-traumatised, neglected and dying.

"Instead of being helped and protected, this report shows that vulnerable children are further neglected by the Brumby Government's corroding child-protection system where services are chronically under-staffed and under pressure," she said.

The VCDRC, which investigates deaths of minors known to child protection, revealed 26 children died last year while under the watch of Victorian child protection.

Four deaths were the result of non-accidental trauma, two were suicides, one was the result of substance abuse and seven are still under investigation.

Of the remainder, eight were attributed to acquired/congenital illness, two to accidents, one to SIDS and one is unknown.

Of the 16 deaths it reviewed between April 2009 and March this year, 11 involved children aged under three.



Children dying in care

State service fails

VICTORIA

By CATHERINE BEST

CHILD protection services have again been lashed for failing to protect Victoria's most vulnerable children following a review of 16 deaths on the state's watch.

An annual report by the Victorian Child Death Review Committee shows 16 children known to protective services died in the 12 months to March 2010.

Three died of non accidental trauma and four committed suicide.

Five died from illness and four from sudden infant death syndrome.

Eleven of the children were aged under three, including infants aged one month and six months and a two-year-old toddler, all of whom died from non-accidental injuries.

Domestic violence and

substance use was a factor in most cases, while there were also high rates of parental mental illness and homelessness.

The report blamed staffing shortfalls and an inexperienced workforce for compromised care.

"Overall the case reviews paint a picture of the corrosive effect of chronic staffing shortages and workload pressures," the report said.

It highlighted a breakdown in information gathering and sharing between agencies and failures in building a historical profile of problem families.

Too often direct contact between child protection workers and clients was insufficient and relied on "announced visits".

In 2009, 26 children known to state protective services died.

AAP



Protection of children poor

DEATHS REPORT BLAMES STAFF SHORTAGES, INEXPERIENCE

MELBOURNE: Child protection services have again been lashed for failing to protect Victoria's most vulnerable children.

This follows a review of 16 deaths on the state's watch.

An annual report by the Victorian Child Death Review Committee shows 16 children known to protective services died in the 12 months to March 2010.

Three died of non-accidental trauma and four committed suicide.

Five died from illness

and four from sudden infant death syndrome.

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and relied on "announced visits".

The report said safety must be given greater weight in making decisions about a child's welfare, warning that failure to do so "can have immediate and life-threatening outcomes for children".

"When responding to possible physical abuse, assessment and decision-making are time-critical and must clarify issues regarding the safety of the child as the most urgent priority," the report said.

Herald Sun, Friday 26 June 2009

16 children die in state's care

Stephen McMahon

PARENTAL drug abuse was the No. 1 factor contributing to the deaths of 16 children under state protection last year.

Fourteen of the children who died had one or more parents using drugs and alcohol. Most came from violent homes.

A report tabled in Parliament yesterday showed four of the dead children were indigenous.

The vast majority of the children came from families with extensive histories of parental drug abuse, family violence and mental illness.

In 2007, the death toll was 15 children; the previous year, it was 18.

Nine of the 16 dead were younger than nine months; most deaths occurred in families with "multiple and complex parental risk factors".

Five of the six teenagers who died were female and the deaths were as a result of suicide or drugs.

The Victorian Child Death Review Committee found that in two infant deaths the protection ser-

vices failed to respond early enough to "chronic abuse and neglect".

The report blames overstretched resources and a high turnover of child protection staff for not nipping many of the problems in the bud.

"Parental substance use (86 per cent) presented as the most prevalent risk factor in the cases, followed by family violence (79 per cent) and parental mental illness (57 per cent)," VCDRC chairwoman Carol Reeves said.

Opposition spokeswoman Mary Wooldridge said the report was an indictment of a crisis-driven child protection system and a workforce stretched to breaking point; 25 per cent of staff leave each year.

Minister for Community Services Lisa Neville said the reform of the system was continuing.

"Every death is a tragedy and my heart goes out to any Victorian family affected by the death of a child," she said.

The Australian Friday 26 June 2009 Staff slammed on child deaths

Ewin Hannan

CHILD protection workers have been criticised over their handling of the cases of four babies who died after being born into violent, substance-abusing families with extensive child protection histories.

An investigation of child deaths in Victoria has found the handling of the four infant cases was "episodic", despite the babies being at chronic risk from family violence and drug and alcohol use in the home.

Necessary follow-up action before the death of one baby did not occur. Staff shortages were blamed for the inaction.

Child protection workers were also slammed for failing to respond earlier to the chronic abuse

and neglect of two teenage girls who died despite being subject to multiple notifications to the child protection service in Victoria and other states.

Repeated decisions were made by authorities either not to intervene or to limit their response in what the inquiry declared to be a "tragic series of missed opportunities".

Child protection authorities in Victoria received a record 41,934 notifications last year, but investigated 11,687. An estimated 6752 were substantiated, with child protection workers now servicing a record 38,763 clients.

A report by the Victorian Child Death Review Committee, tabled in state parliament yesterday, found the four babies died as a result of acquired or congenital

illnesses in households where "family violence and substance use were equally present as consistent risk factors".

The four dead babies were the youngest of their siblings, all of whom had child protection histories, including some who were subject to Children's Court orders.

"All four cases involved chronic risk and cumulative harm, but to the extent that assessment activity occurred it was episodic and lacked assertiveness and decisiveness," the committee found.

"Three of these infants had not been classified as high-risk infants prior to their death and it is not clear whether this status had been ascribed to the fourth case."



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Shame of 11 babies dying in state care

Geraldine Mitchell

ELEVEN babies died while under state child protection last year, a report has found.

Many of the babies who died were born prematurely.

One was drug-dependent and another was suspected of having fetal alcohol syndrome.

Another four children — aged between four and 17 — who were under state protection also died last year.

The report, tabled in Parliament yesterday, found the children came from families with histories of violence, drug abuse and mental illness.

It blamed a lack of co-

ordination between child protection officers and the children's parents for failing to provide better care.

The Victorian Child Death Review Committee recommended a new multi-service system to help child protection officers support parents.

Chairwoman Carol Reeves said an increase in mental illness, family violence and drug abuse affecting parents meant "a strong partnership approach across a range of services" was needed.

She said the committee found a limited understanding

by protection workers of some families complex problems.

"In one case, child protection accepted the mother's assurance that the violence was an isolated incident and that these issues were being addressed without following up and consulting with local police and relevant services."

In another case child protection workers failed to see the link between drugs and alcohol and family violence.

"Joint planning and improved communication procedures would have brought together the necessary range of

services to share specialist knowledge and allow a more comprehensive assessment of parenting capacity," she said.

"Without a comprehensive assessment, cases can be closed without a fully informed understanding of risk," Ms Reeves said.

Child protection officers had active cases with 11 of the 15 children when they died, the report found.

It was closing one case when the child died.



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Authorities under fire in child deaths probe

Ewin Hannan

CHILD protection authorities in Victoria prematurely closed cases, failed to follow up evidence of family violence, and did not make the connection between drug and alcohol abuse and domestic violence.

A review into the deaths of children known to child protection services found authorities closed cases before ensuring the parents of at-risk children had access to the necessary health and support services.

Fifteen children who had been existing or recent clients of child protection died last year, down from 18 deaths the previous year. Eleven were infants, including seven who were less than six months of age.

Examining 16 deaths between April last year and March this year, the Victorian Child Death Review Committee found six were born prematurely, two had symptoms of fetal alcohol syndrome and one was born drug-dependent.

Family violence was a factor in

12 deaths, parental substance abuse was a factor in 10 and mental illness in nine.

Of the 16 cases, child protection had ceased involvement in five cases before their deaths, and was in the process of closing another case at the time of death.

The committee found some instances of "premature case closure" in which parents were not linked up with support services. It said there was limited understanding of the issues faced by families experiencing violence and substance abuse.

Child protection workers, in some cases, were unable to obtain the necessary medical information about a child from a hospital. In eight cases, children were discharged from hospital without formalised planning involving child protection and health services.

The committee also criticised recent law changes that led to it being prevented from investigating a further three child deaths.

The Brumby Government said last night it had moved to address the issue.

THE AUSTRALIAN
FRIDAY MAY 25 2007

Kids died after case book was closed

Natasha Robinson

SIX chronically neglected children died after Victorian authorities prematurely closed their case files, abandoning the vulnerable children to carers who repeatedly failed to access support services.

The case files were closed despite child protection authorities receiving an average of eight notifications for four of the chronically neglected children, the Victorian Child Death Review Committee found in its annual report tabled in state parliament yesterday.

The report found that, of a total of 37,991 notifications to child protection authorities, only 11,526 investigations were launched and 7367 cases substantiated.

Eighteen children known to authorities died last year, the report found, and six of those children had had their cases recently closed.

Nine of the child deaths last year were due to illness and congenital conditions, four were from accidents, one was from Sudden Infant Death Syndrome and four have yet to be assessed by the coroner.

But the figure may represent just a fraction of the total deaths because legislation limits the number of cases that are reviewed in the watchdog's annual report.

All children who were clients of child protection authorities at the time of their death are placed on the state's Child Death Register for inquiry and review.

Of those whose files are closed by the Department of Human Services' child protection service, only those who died within three months are investigated.

The Australian Childhood Foundation's chief executive, Joe Tucci, attacked the Victorian Government yesterday for being more concerned with "limiting liability" for its department rather than ensuring children were protected.

"It is a fundamentally flawed system that really only is there to protect the department from

criticism rather than getting to the bottom of how the system is functioning in any particular year," Dr Tucci said.

The Child Death Review Committee's chairwoman, Lisa Ward, told *The Australian* yesterday there had been a push from within the committee for the three-month time frame to be abolished.

"Certainly the committee has discussed the issue of the time frame," Ms Ward said. "The committee would endorse a 12-month time frame."

A push last year from child welfare workers for a national approach to recording and analysing child deaths has not been realised.

In addition to analysing deaths last year, the watchdog reviewed 13 deaths that occurred over a three-year period.

Of the 13, six vulnerable children were left unmonitored after "incorrect assumptions" from child protection workers that families were in the hands of other support services.

Most of the families had been subject to multiple notifications, and the department had failed to take into account their non-attendance at appointments with support services.

Ms Ward called for greater co-operation between agencies yesterday to ensure children did not slip through the net.

"It's not enough for a family to be indicating that they will get some help before the case is closed," Ms Ward said. "Child protection and other services need to work with the family to make sure that they are getting that help."

The watchdog made 22 recommendations in its report, including calling for greater co-ordination between disability and health services and child protection services.

The watchdog also demanded that the DHS establish clear standards to justify why the cases of families that had been the subject of multiple notifications should be closed.

THE AGE • FRIDAY, MAY 25, 2007
theage.com.au

Child death cases closed down 'early'

A REVIEW of deaths among children known to Victorian child protection authorities has found that almost half of the cases were closed prematurely.

The Victorian Child Death Review Committee, which examined 13 deaths between 2004-06, found that six had their cases closed early.

It also found that 18 children known to authorities died last year, up from 11 the previous year.

Problems with case closures were most common in situations involving chronic neglect, while half of the 18 children died of illness.

The review found Child Protection should "ensure that community agencies are properly engaged" before cases are closed.

A Government spokeswoman said new child protection laws required "a much stronger response to chronic neglect". Opposition community services spokeswoman Andrea Coote said the most alarming part of the increase in deaths was the number of children under the age of one.

DAVID ROOD

18 die while on welfare watch

Child deaths shock

EIGHTEEN vulnerable children died last year under the watch of Child Protection Services, most of them less than a year old.

A report to State Parliament into the deaths — and 13 more between 2004 and 2006 — found six cases were closed too soon and 10 were plagued by communication failures between Child Protection and other welfare groups.

Most of the deaths happened while the children were in the care of drug addicted, violent, mentally ill or intellectually disabled parents.

The annual Child Death Review Committee report re-

Emily Power

vealed last year four children died from unknown causes, four from accidents, one of sudden infant death syndrome, and nine from natural causes.

The youngest was just eight days old; the eldest was 12 years old.

Seven were girls and 11 were boys. They were from rural and metropolitan areas. One was an Aboriginal child.

Eleven of the neglected children did not survive until their first birthday. All died while being monitored by Children Protection or within three months of their files being closed.

The report said the handling of some cases was "still some way from the ideal scenario in which the protection of children is genuinely seen as a shared community responsibility".

Committee chairwoman Lisa Ward, an adviser to the Department of Human Services and Correctional Services, said none of the deaths was directly caused by their parents.

Joe Tucci, CEO of the Australian Childhood Foundation, said children at risk of harm in the family home were often left in the guardianship of unfit parents.

"It is the most dangerous cocktail of risk factors for children," Mr Tucci said.

"There is pressure to close cases and move on to the next one.

"It is the worst scenario possible when Child Protection has been involved in a case and the child has still died even though the system has put in the resources required and we didn't get the outcome we wanted."

A snapshot of Victoria's most fragile lives over the past four years shows:

TWO of the children were sexually abused.

THREE had learning problems and did not go to school regularly.

A REFUGEE boy did not attend school for two years

before his death at 15. The report said he was socially isolated and went unnoticed by community members who could have helped him.

TWO of the children were being looked after by parents with an intellectual disability. SIX of the cases were closed prematurely.

IN 10 of the cases, welfare and community agencies assumed Child Protection was responsible for the child's wellbeing.

Ms Ward said the causes of death for some of the children who died last year were still unknown.

"From the information we have at the moment, four of the cases from last year are

from reasons we don't know yet — but none of the children died from deliberate means," Ms Ward said.

She said school and welfare groups working with parents with violence and drug problems should take a greater role in monitoring child welfare.

"Many of the families had lots of complex problems and were dealing with lots of services at the same time.

"Those services are well placed to reach out and help children."

A spokeswoman for Community Services Minister Gavin Jennings said new child safety legislation would improve responses to repeat cases of chronic neglect.

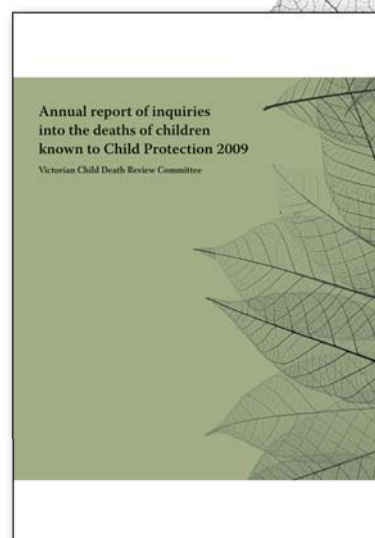
Victorian Child Death Review Committee Annual Report 2009

Information for Practitioners

The Victorian Child Death Review Committee (VCDRC) is an independent, multidisciplinary ministerial advisory body that reviews the deaths of children and young people who were clients of the Victorian Child Protection service at the time of their death or within 12 months of their death.

The VCDRC prepares an annual report that is tabled in Parliament as part of a continuing commitment to a transparent and accountable response to deaths within the Child Protection population.

The 2009 annual report provides: (1) information about the deaths of children known to Child Protection that occurred in 2008; (2) historical information regarding the deaths of children known to Child Protection from 1996, when the first VCDRC annual report was produced, to 2008 and; (3) information regarding the child death inquiries reviewed by the VCDRC in the 2008–09 reporting period and the themes and issues relating to case practice and service provision that resulted from this qualitative analysis of child death inquiries. This information focuses on the themes and issues which are of importance to practitioners.



“The purpose of child death inquiries is to promote learning.”

“The process of child death inquiries is essentially an audit of case practice and service provision triggered by each child death regardless of the cause of death.”

“Child death inquiries provide a window into routine practice.”

Themes and issues in 2008-09

Responding to adolescents with high risk behaviours

Two of the 14 child deaths reviewed in this reporting period related to young adolescent women who died from external causes – one drug related and the other as the result of suicide.

Responding effectively to adolescents with high risk behaviours presents distinctive challenges for Child Protection. High risk adolescents invariably have high needs and have been termed 'hard to help young people' (Brandon et al. 2008). Studies (Brandon et al. 2008, Rutter 1979) have identified that most 'hard to help' adolescents have had a long history of involvement with welfare agencies including Child Protection, often including periods in state care. These studies have found the life of 'hard to help young people' to be characterised by:

- a history of rejection and loss usually associated with severe maltreatment over many years
- parents or carers with their own history of abuse and rejection
- parents or carers with their own history of substance use and mental health difficulties;

and that by adolescence:

- most are typically harming themselves, neglecting themselves and are involved with alcohol and substance use
- most are difficult to contain in placement and are involved in high risk activity
- most are disengaged from mainstream educational settings.

These characteristics underscore the challenge that such young people represent and the imperative to shape practice and interventions in such a way that there is an effective practice and service system response to the special needs of this client group.

These two cases were consistent with these profiles. Both had extensive histories of Child Protection involvement, as did a number of siblings. Both were on Children's Court orders which transferred custody to the state.

Importance of intervening early

Both young women were the subjects of multiple notifications to Child Protection services in Victoria and other states. Despite the number of notifications and the severe and chronic issues identified, there were repeated decisions across a number of jurisdictions to either not

intervene or to limit the duration and intensity of the response. This pattern emerged in the context of Child Protection systems that were not responsive to cumulative harm. This failure to respond earlier to the chronic abuse and neglect in these young women's lives represented a tragic series of missed opportunities. By adolescence this meant that both young women had experienced extreme trauma and were dealing with that trauma by repeatedly exposing themselves to further risk.

Both Child Protection and other services intervening earlier in a purposeful and assertive way improves the capacity to intervene effectively in the lives of young people and the capacity to ameliorate the effects of trauma.

Importance of a therapeutic response

Given the level of trauma that these young women had experienced, there was a need for an overall therapeutic response to suffuse all practice interventions. While crisis planning is necessary in response to high risk behaviours, it is also imperative to seek to actively address the underlying trauma which is the root cause of the high risk behaviours. This requires balancing containment strategies with therapeutic engagement. Successful outcomes are impacted by neither dimension dominating but being part of an overall balanced intervention strategy.

A therapeutic response to such 'hard to help young people' is not just about discrete therapeutic specialist services, although these are vital components of the service response needed, particularly individually tailored residential programs with a therapeutic focus. A therapeutically-focused or supported placement was not available to either of these young women.

The use by all practitioners of a trauma informed case work perspective when interpreting the meaning of information related to the developmental histories and risk taking behaviours of high risk adolescents should underpin an overall therapeutic response. Such a perspective, together with relationship-based practice aimed at engaging the young person and assisting their own understanding of the trauma they have experienced, is a prerequisite to effecting change in their lives.

Importance of partnership between services and a care team approach

Adopting a care team approach is contingent on strong partnership between services.

The formation of effective care teams comprising Child Protection and staff from the range of involved services is essential to ensure agreement about ongoing assessment

processes and the direction of collaborative intervention. When attempting to deal with the challenges that adolescents with high risk behaviours present to the service system, it is imperative that a well coordinated service plan is based on a comprehensive assessment resulting in a clear, albeit evolving, case formulation and case plan. Care teams provide a mechanism for the implementation of coordinated service plans.

As service plans must strike a balance between short-term risk management and containment goals with longer-term therapeutic intervention and engagement goals, care teams provide the necessary vehicle for service providers to continually negotiate and monitor how this balance is being struck.

The committee considered that while there were episodes of sound practice in the case work with these two young women, there was insufficient sustained and coordinated effort within a purposeful plan of action agreed across all involved services.

Assessment issues

Undertaking adequate assessments of risk, need, parenting capacity and family functioning has been a consistent theme identified by the committee over reporting periods.

The committee considered important to highlight the following specific issues which were seen to impede effective assessments occurring.

Interpretation of meaning

Assessment requires the systematic collection and analysis of relevant information.

Some assessments are compromised because the necessary information is not gathered and highly relevant information is not considered. The committee also continues to note that assessments are often compromised because, while a plethora of information has been gathered, there is insufficient analysis about what this information means. Regardless of whether enough information is gathered, cases are often characterised by inadequate analysis of available information. The meaning of information must be explicitly interpreted to enable the formulation of an assessment upon which a case plan to guide action can be based.

It is important for practitioners to appreciate that disparate pieces of information are not sufficient to inform decision making and guide action. It is necessary to integrate and synthesise all relevant information into an assessment.

Analysis gives meaning to the information in terms of understanding the level of risk and produces hypotheses about how to intervene most effectively. Not considering the meaning of information can result in important patterns of behaviour not being recognised.

The resulting case formulations and action plans need to be evolving and verified or adapted against new information and its meaning as this emerges over time. Dramatic changes to the direction of case plans have been observed to be reactions to fragments of information and often indicate that a full assessment has not occurred in the first instance.

Importance of family histories

A comprehensive assessment must incorporate an understanding of family background and parental histories.

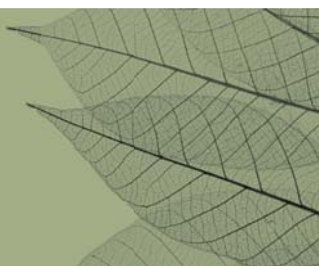
When practitioners are faced on a daily basis with responding to many immediate events/crises within families and the sustained high risk behaviours of adolescents, there can be scepticism as to the benefit of thorough assessment of background factors. However, without understanding of background histories, intervention, particularly in complex cases, will become captive to reacting to symptoms rather than seeking to address the factors that underlie the problem and drive the crisis-ridden nature of many cases.

It is always crucial that assessment of family background and developmental histories of family members occur so that there can be analysis and interpretation of the meaning of this relative to the presenting issues. This enables clearer hypothesis about what intervention strategies are likely to be successful and what incentives exist to promote engagement with the child and family members.

Understanding family histories and the key influences on parents' own development is essential to undertaking a comprehensive assessment. Gaining this understanding is also a key way of engaging people by discussing their life history with them. This approach has the dual advantage of both building a relationship with individuals by demonstrating an interest in their lives, as well as providing insight and understanding of the factors that impact on parenting capacity.

Significance of understanding cognitive ability

The committee noted that when undertaking assessments of parenting capacity there can be insufficient attention paid to understanding the cognitive ability of parents and what this can mean for the ability of parents to undertake the everyday functions of parenting. This can be particularly important in relation to a parent's capacity to perform



the daily care needs of young infants. Intervention plans directed at supporting parents to care for their children should take account of the parents' cognitive ability to learn parenting skills. The committee noted that the assessment of parenting capacity sometimes focuses unduly on the attitude and motivation of the parent without sufficient attention given to whether cognitive abilities suggest that the necessary changes can be made.

Verifying information

The committee again noted instances when Child Protection relied upon parental claims and assertions without checking the veracity of such information provided by the parents from other sources. Of particular concern to the committee are instances when critical decisions about case direction and case closure have been made solely or virtually on the basis of information obtained from parents. While it is recognised that some parents are reluctant to engage with services, which means it is not always easy to obtain information that confirms or disputes the accounts of parents, it is nonetheless necessary to always attempt to seek out independent sources of information. In particular, Child Protection practitioners should not take at face value information provided by parents which refutes serious issues relating to the safety and wellbeing of children without obtaining corroborating information from other sources that can be reasonably considered as reliable.

The committee considers that it is important for Child Protection practitioners to appreciate that a proper assessment cannot be based solely on self-reported information by parents regardless of how cooperative or apparently cooperative the parents appear to be.

Working collaboratively

Working collaboratively with other service providers is a necessary and core part of undertaking comprehensive assessments. While Child Protection has a leadership role in ensuring that an assessment is undertaken, this cannot be done without engaging the interagency and interprofessional network.

Failures in interagency communication, information sharing and collaboration regarding the implementation of service plans continue to be seen in the cases reviewed. Effective communication between practitioners is not just about complying with procedures that require information to be sought from others and shared; it must be based on a mindset that values the contribution of others (Reder & Duncan, 2003). Without such a mindset, while contact with others occurs, meaningful exchange does not take place.

A communication mindset results in purposeful and meaningful interaction rather than fragmented and superficial information sharing. Communication is not just about transferring information but about doing this in such a way that it is received and understood by the recipient. Working collaboratively is as much about a mindset as it is about procedural expectations that require information to be shared and services to be coordinated.

There is still some distance between policy that clearly recognises the importance of achieving a multidisciplinary and interagency perspective and the reality of some practice as revealed by child death inquiries.

Responding to vulnerable infants

Nine of the 14 child deaths reviewed related to infants nine months or younger.

Children with complex medical needs

The VCDRC identified specific challenges that relate to the case management of children with complex medical needs. In five infant death cases, Child Protection intervention occurred within a context of emerging diagnosis and uncertain prognosis, which changed into a scenario of limited life expectancy and the provision of palliative care. Particularly during the period when the prognosis is unclear, the task of Child Protection in assessing parenting capacity requires great sensitivity but continued focus on the risk for the child.

Deaths from unexpected natural causes

The VCDRC found that in four infant death cases (two SIDS deaths, one unascertained (co-sleeping) and one accidental death associated with sleeping arrangements), all four deaths occurred in families with multiple and complex parental risk factors and extensive Child Protection histories. Child Protection assessment of all four cases was found to be episodic and lacked assertiveness and decisiveness despite issues of chronic risk and cumulative harm.

Victoria's child death inquiry and review system: FAQs

Why is it important to examine the deaths of children known to Child Protection?

Child death inquiries and reviews are a component of quality assurance and continuous improvement processes and now exist, in differing forms, in most national and international jurisdictions. In Victoria, the *Child Wellbeing and Safety Act 2005* contains provisions requiring the conduct of child death inquiries.

What is the purpose of examining the deaths of children known to Child Protection?

The purpose of child death inquiries is to promote learning. Learning is central to service system improvement. The ability to identify learnings is not restricted to cases in which children have died but this is an important cohort to examine.

Which child deaths are the subject of child death inquiries and reviews?

The *Child Wellbeing and Safety Act 2005* requires the Office of the Child Safety Commissioner to initiate a child death inquiry in relation to the deaths of all children and young people known to Child Protection at the time of their death or within 12 months of their death.

Why are deaths due to illness and disease the subject of child death inquiries and reviews?

The Victorian approach to child deaths is not adverse event driven — it is not limited to only those deaths of children known to Child Protection whose deaths are due to abuse and neglect. Child death inquiries do not focus on practice relative to the circumstances of the death. The focus is more holistic on whether case practice and service provision responded capably to the needs of the case. The process of child death inquiries is essentially an audit of case practice and service provision triggered by each child death.

How can child death inquiries be critical of practice in cases in which children have died from natural causes?

Child death inquiries do not set out to investigate the factors leading to the child's death but rather to look at

practice and service provision against required practice standards and best practice principles. Identification of learnings from all cases examined does not in any way infer that deficits in practice were associated with the deaths or that the deaths were preventable. Child death inquiries provide an evidence base to identify issues associated with routine practice regardless of the cause of death.

What is the benefit of examining all child deaths regardless of the cause of death?

By looking at all child deaths rather than just those resulting from abuse and/or neglect, it is possible to build knowledge and understanding of how services routinely operate and, in turn, to identify patterns associated with either enhancing or hindering effective practice and service provision.

How does the child death review system operate?

Victoria has a multi level system of examining deaths of children known to Child Protection. Department of Human Services processes require critical incident reports and briefings in relation to all child deaths. This provides the opportunity for timely local reflection. When a current or recent client of Child Protection dies, the Department of Human Services notifies the Office of the Child Safety Commissioner and provides comprehensive documentation about the death of each child, including critical incident reports and briefings. This marks the beginning of the next level of examination of each child's death.

The Office of the Child Safety Commissioner commences the child death inquiry upon receiving notification of a child death. Child Protection practitioners and involved service providers are invited to participate and the focus is on the use of a reflective learning approach. The inquiry does not set out to identify factors contributing to the death or to determine culpability — these are roles for the Coroner and Victoria Police.

As the purpose is to promote learning, the focus in child death inquiries is on best practice. When problems with case practice and service provision are revealed, these are not criticisms of individual practitioners but are identified as areas for systemic service improvements.

“When problems with case practice and service provision are revealed, these are not criticisms of individual practitioners but are identified as areas for systemic service improvements.”

“Practitioners with direct case involvement are encouraged to participate.”

Should I participate in a child death inquiry?

The child death inquiry process relies on the participation of relevant staff within Child Protection and community service agencies. A distinguishing feature of Victoria's child death inquiry process is that it is not limited to examination of case records but recognises the importance of hearing directly from service providers. Records alone can only ever provide a partial understanding whereas participation enables reviewers to build a picture of how things looked at the time to those involved, including an understanding of contextual issues which may have impacted on practice and service provision. For this reason practitioners with direct case involvement are encouraged to participate.

A recent review of the child death inquiry process has resulted in the Office of the Child Safety Commissioner adopting a strengthened reflective learning approach. This will mean that participants are given the opportunity to firstly tell the story of their involvement and factors which they consider influenced the way the case developed, unstructured by the reviewer. After participants have had this opportunity to provide their own account, the case reviewer will then seek clarification of any matters that are considered pertinent to undertaking an analysis of the case. This will ensure that learnings are grounded in a real understanding of the drivers of practice and service provision.

What role does the VCDRC play?

The final child death inquiry report is forwarded to the VCDRC along with key Department of Human Service material as well as coronial documentation. The VCDRC provides an independent multidisciplinary review of all child death inquiries prepared by the Office of the Child Safety Commissioner. The VCDRC is a review body; it does not undertake or initiate any investigative role in compiling information relating to child deaths. The VCDRC considers each child death inquiry report and provides advice to the Minister for Community Services about its findings in relation to each case as well as across cases. Whilst there are instances of important learnings being identified in significant individual cases, the committee focuses strongly on identifying trends across cases.

The VCDRC's focus is not exclusively on the practice and service provision of Child Protection. The role played by the broader service system is also considered. This is in line with the new legislative environment and the associated policy and practice reforms relating to both Child Protection and the broader child and family service sector.

The VCDRC makes recommendations which become inputs into ongoing service development activities. If the identified themes and patterns require greater elaboration before key learnings can be well enough discerned, the VCDRC can request that the Child Safety Commissioner initiate a Group Analysis of a particular cohort of cases. Currently, such a Group Analysis entitled '*Responding to the co-existence of family violence, parental substance use and mental illness*' is taking place and is scheduled to be completed by March 2010.

“Identification of learnings... does not in any way infer that deficits in practice were associated with the deaths or that the deaths were preventable.”

Current members of the VCDRC

Ms Carol Reeves, Chairperson, Human Services Consultant

Senior Sergeant Dagmar Andersen, Victoria Police

Dr Neil Coventry, Director Child and Adolescent Mental Health Service, Austin Health

Dr Peter Eastaugh, Consultant Paediatrician

Ms Jill Gallagher, CEO, Victorian Aboriginal Community Controlled Health Organisation

Mr John Leatherland, Human Services Consultant

Ms Robyn Miller, Principal Child Protection Practitioner, Department of Human Services

Ms Lucy Raponi, Barrister at Law

Ms Paresa Antoniadis Spanos, Coroner, State Coroner's Office

Mr Bill Stronach, Alcohol and Drug Services Consultant

Ms Sandie de Wolf AM, CEO, Berry Street

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Victorian Child Death Review Committee Annual Report 2010

Information for Practitioners

The Victorian Child Death Review Committee (VCDRC) is a multidisciplinary ministerial advisory body that reviews the deaths of children and young people who were clients of the Victorian Child Protection service at the time of their death or within twelve months of death.

A window into routine practice

Victoria has a two level system of examining deaths of children known to Child Protection. *The Child Wellbeing and Safety Act 2005* requires the Child Safety Commissioner to conduct child death inquiries. Each child death inquiry is subsequently considered by the VCDRC. As a second level review mechanism, the VCDRC considers the issues relating to each case and, importantly, seeks to identify learnings across cases.

The purpose of child death inquiries and review by the VCDRC is to promote learning. Learning is central to service system improvement. Of course, the ability to identify learnings is not restricted to cases in which children have died but this is an important cohort to examine.

Processes to review child deaths of children known to Child Protection are now common across national and international jurisdictions but vary in both structure and focus. Victoria's approach to examining deaths of children known to Child Protection is not limited to deaths which seem to raise questions about service system performance. All deaths, regardless of cause of death, within the timeframe parameters are examined.

By looking at all deaths within the specified timeframe, knowledge of how services routinely operate is developed and promotes understanding of patterns of practice actually occurring.

Child death inquiries and reviews undertaken by the VCDRC do not focus on practice relative to the circumstances of the death – these are roles for the Coroner and Victoria Police. The focus is more holistic on whether case practice and service provision responded capably to the requirements of the case. Child death inquiries are essentially an audit of case practice and service provision triggered by each child death. Identification of learnings does not in any way infer that deficits in practice were associated with the deaths or that the deaths were preventable. When problems with case practice are revealed these are not criticisms of individual practitioners but are identified as areas for service system improvement. Recommendations made by the VCDRC become important inputs into ongoing service development and continuous improvement activities.



Children Legislation Amendment Act 2009

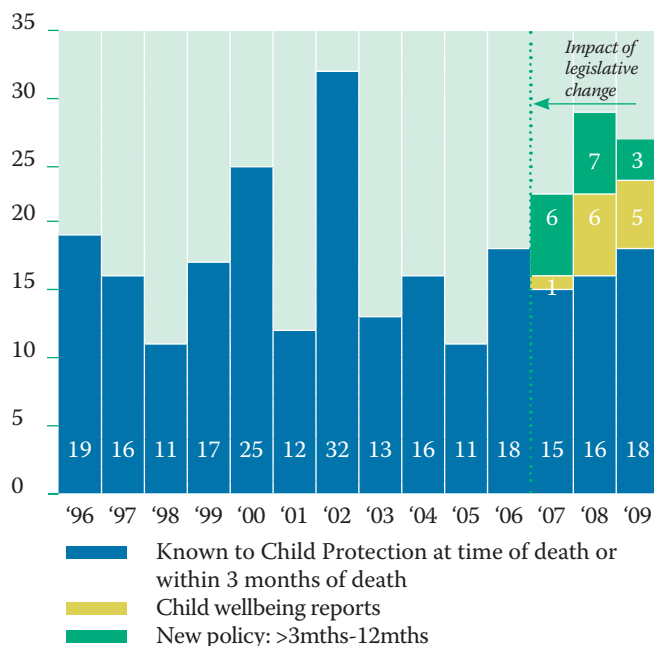
During this reporting period, in August 2009, the *Children Legislation Amendment Act 2009* was enacted. This Act amended the *Child Wellbeing and Safety Act 2005* in relation to those child deaths that fall within scope, or are eligible, for a child death inquiry.

The definition of 'Child Protection client' in the *Child Wellbeing and Safety Act 2005* has now been amended to include children who are the subject of wellbeing reports as well as those who are the subject of protective intervention reports.

The *Child Wellbeing and Safety Act 2005* has also been amended to require child death inquiries to be conducted in respect of all children who were Child Protection clients at the time of their death or within twelve months of death – an increase from the three month timeframe under the previous arrangements.

This extension of the eligibility timeframe increases the ability to identify learnings and strengthens accountability and transparency in relation to deaths of children who are the subject of reports to Child Protection.

Deaths of children known to Child Protection 1996–2009



The figure above shows all deaths of children known to Child Protection over the 15 year period that the child death review process has been operating. The child deaths now in scope as a result of the *Children Legislation Amendment Act 2009* are highlighted in the years 2007, 2008 and 2009.

The number of deaths fluctuates each year without any meaningful trend in the numbers. The child death review process looks beyond the numbers and endeavours to build a qualitative understanding of the case work and service system issues revealed by the cases.

Themes and issues in 2009-2010

The key contribution made by the VCDRC to the review of child deaths known to Child Protection is to identify common themes and emerging trends across the group of cases that have been the subject of child death inquiries.

While each child death inquiry identifies factors significant in each case, the review function of the VCDRC ensures that collective learning across cases is identified and used to inform ongoing system improvements.

In this reporting period, the Office of the Child Safety Commissioner presented the VCDRC with 16 child death inquiries for consideration.

The VCDRC conducts qualitative analysis of the case practice and service provision issues in each of the cases it reviews.

The VCDRC's capacity to undertake such qualitative analysis derives from the multidisciplinary expertise of its members. Twenty-seven recommendations were formulated by the VCDRC during this reporting period.

The themes and issues identified by the VCDRC and presented in this report should not be interpreted as related to the cause of death of these children but rather represent reflections on practice.

Many of these themes and issues have been noted not just in relation to Child Protection practice but also in relation to a range of other service providers involved with service provision to vulnerable families and children.

The following themes and issues have been prioritised for presentation in 2010:

Assessment

- Assessment as a pivotal task
- Gathering information
- Thinking and reasoning
- Attributing significance

Responding to adolescents with high risk behaviour

- Importance of the young person's 'voice'
- Responding to suicide risk
- Care teams with shared responsibility for 'hard to help' young people

Partnership

- Leadership alongside working together
- Constructive challenge

Impact of the practice environment

Assessment

Assessment: assessment as a pivotal task

Undertaking assessments of risk, need, parenting capacity and family functioning is integral to the process of Child Protection intervention.

Despite the ubiquitous nature of assessment as a central task in Child Protection practice, basic problems associated with undertaking assessments persist. The fact that this issue is consistently identified does not lessen its significance but rather speaks to the importance of strengthening this fundamental component of practice.

Assessment is central to Child Protection practice. In particular, accurate risk assessment is critical to ensure the immediate safety of children and underpins the longer term work with the child and the family.

Accurate assessment is vital to inform service planning to address the underlying causal factors within the family which are compromising care and safety. Accordingly, achieving quality outcomes for children is very dependent on the capacity of Child Protection to undertake competent assessments and make decisions based upon such assessments.

Undertaking assessments is not just bound up with individual worker competencies but also with the organisational context which provides the guidance and prescriptions for how this core responsibility is to be enacted. Individual practitioners undertake assessment activity within the context of organisational requirements and processes.

This means that the task of assessment is not just a clinical matter for the front-line practitioner but also involves organisational factors that either hinder or support the service system's capacity to consistently and accurately undertake assessments.

The VCDRC is also cognisant of the broader context of Child Protection work. By its very nature, Child Protection work involves uncertainty, ambiguity and fallibility (Munro 2008). Child Protection practitioners have to make complex judgments and difficult decisions in conditions of limited knowledge, time pressures, high emotions and conflicting values (Munro 2008).

When seen in this broader context, it becomes clear that assessment and associated decision making while simple in concept is more complex in practice.

Furthermore, even when comprehensive, accurate assessments are undertaken, risk assessments are fallible as circumstances within families are constantly changing and the ability to predict the future, even on past behaviours, is limited.

Assessments can only ever be understood as probabilities rather than certainties; as interpretations rather than as absolutes; and never definitive without need for up-dating and review.

Notwithstanding these varied contextual factors, it is important to strive to improve practice relating to undertaking assessments and associated decision making.

The committee has noted the following specific issues.

Assessment: gathering information

The first step in undertaking an assessment is to gather relevant information.

Many child death inquiries identify that insufficient information is collected on which to reasonably base an assessment. Assessment requires that sufficient information relevant to the issues being considered is systematically collected.

An important factor behind this lack of sufficient information being collected can be that there is not enough direct contact by Child Protection with families. Significantly, there is often

even less contact with the child or children who are the subjects of the reported concerns.

The committee has previously noted the relative marginalisation of children in the assessment process compared to parents when there is little direct contact with them or observation of them. Without sufficient contact with the family, including the children, it is not possible to collect information relevant for an assessment and make systematic observations of individual parent functioning, parent-child interaction and family functioning.

Another practice that can compromise the integrity of assessments is relying unduly on pre-arranged times for direct contact with families. Some parents, possibly those where the risk issues for the child are most severe, will not want Child Protection to witness their usual functioning.

Practitioners need to remain mindful of the possibility of both nominal compliance and disguised compliance by parents with Child Protection intervention. It is vital that contact with the family is sufficient and of a nature that leads to a genuine understanding of the child/ren's situation. It is therefore prudent not to rely on announced visits and vital to incorporate unannounced contact with the family as an important means of testing the veracity of parental claims.

Adequate assessments also require the integration of historical and contemporary information. It is essential that the parents' social histories are understood as this sheds light on current parenting capacity. While historical information about parental histories is often already known through previous periods of intervention, knowing the history and injecting it into a current assessment are two different things.

Another important part of conducting an assessment is gathering information from other service providers. Too often there is only partial information collected from a limited number of service providers and information is superficial rather than really reflecting the depth of knowledge that other service providers can hold.

It is not possible to develop a full, coherent and integrated assessment without both sufficient direct contact and a purposeful, thorough approach to collecting and processing the meaning of information with other services. The cases reviewed have again suggested that there needs to be a wider and more thorough engagement of other services during the assessment process.

The committee has also noted that, despite a paucity of assessment activity, there is often a belief that an assessment has occurred. At times it seems that initial assessments that occur at intake are being conflated with comprehensive assessments needed to understand risk and need.

Child Protection systems must undertake limited assessment at the point of intake in order to determine whether the eligibility threshold has been met and, if so, the priority of subsequent Child Protection intervention. These assessments can become quite extensive as eligibility and priority setting becomes an important function in managing the total workload. Consequently, when cases are allocated, there can be a reasonable amount of information already on file but this does not constitute an assessment of risk or need. It is important that these initial intake assessments should

not produce a mindset that predetermines and substitutes for an assessment.

The committee has noted that how a case is initially defined at intake can unduly determine the mindset which is adopted and narrow both the process and focus of assessment. Views can be too quickly formed and then too slowly changed if assessments are not informed by wide information gathering. Powerful assumptions based on limited intake information too often shape practice in the absence of proper assessments.

Assessment: thinking and reasoning

As well as insufficient information being collected, problems with undertaking assessments are also noted to be associated with a failure to integrate and understand the information that had been gathered.

Many assessments amounted to little more than the accumulation and presentation of disparate facts and pieces of information.

Organising, analysing and weighing information is what turns the raw material of information into an assessment that enables a case formulation to be developed, informs decision making and underpins service planning and delivery.

Turning usually dense, descriptive, historical and contemporary information into an assessment requires thinking and analytical reasoning. Child Protection work makes heavy demands on thinking and reasoning skills (Munro 2008) as the interactive effects of vulnerability and risk, resilience and protective factors must all be taken into account.

For the worker there is a journey of thinking between beginning to collect information and being able to incrementally analyse and give meaning to the collated information. The resulting assessment then summarises, integrates and synthesises the breadth and depth of information which has been gathered (Brandon et al 2008).

Assessment: attributing significance

The attribution of relative significance or weighting accorded to information is crucial and needs to take into account whether the case involves immediate safety issues or cumulative harm issues. In cases involving both, safety issues must be accorded greater weighting, particularly if injuries are present, because these can have immediate and life threatening outcomes for children.

Whilst 'cumulative harm' has entered the lexicon of Child Protection, responding effectively to cumulative harm is still in the process of being fully translated into practice. When weighing information as part of undertaking an assessment, small improvements in the care of the child should not be over-emphasised at the expense of focusing on the capacity of parents to sustain adequate care in accordance with community standards over time.

When assessing possible neglect, Child Protection should be satisfied that there is evidence of care rather than just an absence of apparent neglect. Assessment needs to encompass the impact of neglect upon both the child's immediate wellbeing and their longer term developmental outcomes.

Ensuring the immediate safety of children who are endangered must be a priority for any Child Protection system. When responding to possible physical abuse, particularly involving young children and when injuries that may be of non-accidental origin are present, assessment and decision making are time critical and must clarify issues regarding the safety of the child as the most urgent priority. Assessment action to clarify the immediate safety of the child should not be concluded and the child should not be left with or returned to the parent/carer without establishing a reasonable basis for being satisfied that the injuries are not non-accidental in origin.

This cannot be established without a medical examination of the child by a doctor skilled in undertaking such clinical examinations. If parents/carers are not willing to comply with a requirement for the child to be medically examined, the *Children, Youth and Families Act 2005* enables Child Protection practitioners to apply to the Children's Court for a Temporary Assessment Order. In such circumstances, Child Protection practitioners must be confident to use the authority vested in their role and to act decisively.

Responding to adolescents with high risk behaviours

Children who experience neglect and abuse in their early lives often play out the impact of this trauma in their adolescent years through challenging behaviours which invariably expose them to further risk.

Improving the service response to such young people is closely linked to the service system's capacity to recognise and respond to cumulative harm. Earlier intervention represents the best chance of being able to lessen the impact of trauma associated with neglect and abuse. Notwithstanding the importance of responding as early as possible, it will remain necessary to have service responses to adolescents with trauma-related high risk behaviours.

In seeking to strengthen practice the committee draws attention to the following issues:

Adolescents with high risk behaviours: importance of the young person's 'voice'

Many adolescents exhibiting high risk behaviours are difficult to engage. Such young people have been termed 'hard to help' (Brandon et al, 2008) resulting from their traumatised backgrounds and reflecting the difficulties practitioners have in working with them and services have in responding to their service needs.

Paradoxically, because 'hard to help' young people are challenging to engage and often do not seek out services, there is a danger that intervention can become parent-focused and the young person disappears from view. Attempts to build relationships with such young people need to be concerted and sustained.

Intensity of effort to attempt to reach out to high risk young people should increase in response to their escalating difficulties or increasing isolation. If they can be engaged, these young people can enlarge the practitioners' understanding of their situation and strategies that may be effective in safeguarding them.

Alongside attempting to directly engage with 'hard to help' young people, it is imperative that practitioners develop an understanding of them through a developmental history. This is key to understanding the underlying cause of their trauma and gives them a voice even in the absence of being able to successfully directly engage with them.

Adolescents with high risk behaviours: responding to suicide risk

Four of the cases reviewed concerned young people whose deaths were due to suicide.

Whilst it is not possible to contend that these deaths were preventable, the VCDRC considered that there were many opportunities for practice to have been stronger and that potentially the trajectory of these young people's lives may have been different.

The risk of suicide was recognised to varying degrees in these cases and effort went into trying to understand and respond to the risk.

The VCDRC is cognisant that working with adolescents with high risk behaviours requires practitioners to tolerate a high level of concern which can potentially make it difficult to identify when risk escalates to the point that containment should take precedence over engagement. It is inherently difficult to make judgments about what is sufficiently prudent practice at any point of time when working with chronically challenging young people. Successful outcomes depend on careful use of both engagement and containment strategies with neither dimension dominating but being part of an overall balanced intervention strategy. The use of Secure Welfare Services is an important component of a balanced approach.

Working with 'hard to help' young people who may at times be at risk of suicide requires high level knowledge and skills, including being attuned to indicators of suicide risk. The nature of adolescent suicide risk is that it is highly volatile due to the high level of impulsivity associated with adolescence as a developmental stage.

Sustained depressed mood is not a characteristic indicator for risk of adolescent suicide. Depression is not typically manifested in the same way for adolescents as for adults. Adolescents in general are more likely to present as labile with mood and behaviour fluctuations together with irritability rather than sustained depressed mood. Many high risk adolescents, indeed many adolescents generally, can present with such volatility contributing to the difficulty in identifying those at heightened risk of suicide.

It is essential for Child Protection practitioners together with other service providers working with vulnerable young people to have good knowledge of the signs and symptoms of depression in young people. It is important that all practitioners are astute to characteristics of 'depressive equivalence' in young people and mindful of heightened risk when these characteristics co-exist with behaviours indicative of underlying despair together with substance use. When these factors are present, a final stressor in a chronically vulnerable young person's life can result in heightened risk of suicide, particularly in view of the more generalised impulsivity of adolescents.

The vulnerability further increases when there is no supportive network around the young person who can be either isolated from or in conflict with all around them. Protective factors can be engagement with school, peer relationships and positive relationships with a family member, carer or worker. The final stressor can be very hard to identify other than through retrospective analysis but a disruption or loss of a key relationship should not be underestimated. Many young people tell others of their thoughts and feelings about suicide which must always be taken seriously, as well as the significance of previous suicide attempts.

Adolescents with high risk behaviours: partnership care teams with shared responsibility for 'hard to help' young people

Strategies for effectively engaging, understanding and supporting high risk adolescents are beyond the scope of individual services, including Child Protection.

The VCDRC identified the need to consider a different service model that goes beyond Child Protection being solely responsible for managing risk and orchestrating services to a model that enables collective sharing of responsibility and risk management. These cases, like many others involving high risk adolescents, required the joined up effort of mental health services and drug and alcohol services alongside Child Protection as a core minimum service provider group.

However, achieving sustained involvement of these essential service types operating on the basis of an agreed understanding of risk and management of this risk appears difficult to currently attain.

A different service model may be better able to achieve sustained service provision from all essential services.

Partnership

Partnership: leadership alongside working together

Child Protection carries the statutory responsibility to safeguard children. However, it is also increasingly recognised that while Child Protection has the primary responsibility for the protection of children, this can only be effectively undertaken through a partnership approach with other service providers. The importance of working together is broadly agreed but issues concerning how to go about translating this into practice remain.

Case reviews provide examples of Child Protection not being sufficiently proactive within the service network in its leadership role to ensure that child-focused assessments and service plans are developed in conjunction with other services. While Child Protection clearly has a leadership role that it cannot abrogate, it needs to give attention to the important role played by other services and lead a partnership approach.

Too often, Child Protection seeks information from other services about the child and family but does not share information with other services, even when expecting these other services to work with the family to ameliorate risk and monitor the welfare and safety of the child. Some of this reluctance to share information relates to anxieties about compliance with privacy requirements, suggesting that clearer guidance may be needed to support information exchange. In addition, cases reviewed illustrate that Child Protection does not always systematically engage with other services

before it withdraws, often leaving confusion about roles and responsibilities regarding protective issues.

Child Protection has a leadership responsibility to engage with other services during the assessment phase so that all relevant information can be ascertained and shared across services. Planning for case closure also requires Child Protection to take a leadership role to ensure that there is a clear and shared service plan across the services that will continue to have an active role in the case.

Child Protection practice must encompass both the leadership role that its statutory responsibility enshrines, while at the same time working collaboratively with service partners.

Partnership: constructive challenge

Case reviews have revealed that at times Child Protection enacts its leadership role in such a way that does not provide sufficient opportunity for all relevant information and alternative views to be heard.

There is enormous potential for varying views as different service providers involved in the same case can place differing emphasis on the same factor, resulting in divergent assessments.

The process of exploring such divergent views provides an opportunity to build a shared understanding to underpin case management. It is important that there is a culture that supports open discussion of what information is considered relevant and the process of reasoning that leads to different views.

The culture between Child Protection and its service partners should place higher value on forthright communication and constructive challenge.

Impact of practice environment

The majority of cases reviewed in this reporting period identified that practice had been adversely impacted by contextual factors. System capacity issues relating to workload relative to workforce, staffing vacancies, inexperienced workforce and a paucity of service options, particularly placement options, were all identified by child death inquiries as compromising the delivery of quality services.

On the other hand, the committee noted examples of positive practice and service delivery even within constrained operating environments which suggests that, while resourcing is an overarching factor, it is not the only dimension to high quality practice and service delivery. However, overall the case reviews paint a picture of the corrosive effect of chronic staffing shortages and workload pressures.

References:

Brandon M, Belderson P, Warren, C, Howe D, Gardner R, Dodsworth J and Black J. 2008 *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-2005* Department for Children Schools and Families. University of East Anglia.

Munro E. 2008 *Effective Child Protection* second edition, Sage London

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Ms Lucy Raponi, Barrister at Law

VCDRC recommendations 2005-2010

The VCDRC has made a total of 84 recommendations in the period 2005-2010:

- 83 recommendations have been endorsed or endorsed in principle by the Department of Human Services or the Child Safety Commissioner. One recommendation (no. 63) made in 2006 has not been endorsed.
- These 84 recommendations include 21 recommendations from the *Tackling SIDS – a community responsibility* (2005) group analysis and 17 recommendations from the *Effective responses to chronic neglect* (2006) group analysis.
- Recommendations made in the VCDRC 2010-11 reporting period have not been included in this list.
- The recommendations have been categorised in relation to two dimensions – *Aspects of Practice* and *Service Sector*.

	Recommendation numbers
Aspects of Practice	
– Partnership/Working together	2,3,7,15,16,19,26,30,32,36,37,38,41,43,44,49,55,60,61,62,63,76,77,78,80
– Safe sleeping	8,35,39,64,65,66,67,68,69,70,71,72,74,75,76,77,78,79,82,83,84
– Assessment/Information gathering	5,24,27,28,40,46,47,49,55,56,57,58,70,71,79,83
– Neglect	49,50,51,52,53,54,55,56,57,58,59,60,62
– High Risk Adolescents	14,15,16,21,22,26
– High Risk Infants	1,2,9,73
– Cultural consultation/consideration	22,45,59,84
Service Sector	
– Health/Hospitals	2,3,4,33,34,36,37,38,44,64,65,66,69,78,80,81
– Legal/Court	50,51,52,74,75
– Maternal & child health	56,78,79,83
– Mental health	23,41,42,82
– Disability	38,43
– Youth Justice	26
Other	
A recommendation may contain more than one 'other' theme.	6,10,11,12,13,17,18,19,20,24,25,29,30,31,35,39,42,48,57,58,62,67,68,69,70

No.	All VCDRC Recommendations 2005-2010
1	That the Department of Human Services Child Protection, Placement and Family Services Branch review the operational guidelines regarding unborn child reports and the high risk infant program in light of the issues in this case.
2	That the Department of Human Services Rural and Regional Health and Aged Care Services ensure hospital discharge planning processes for high risk infants are in place and that the need for communication and collaboration with Child Protection is a requirement of hospital systems.
3	That the Department of Human Services examine the issues identified in this case in relation to the interface between the Hospital and Child Protection and ensure that the necessary remedial action is taken.
4	That the Department of Human Services Child Protection, Placement and Family Services Branch ensure that a practice standard requires any instance of parents not complying with seeking medical attention where this has been determined as necessary by a health professional to be promptly escalated for attention of senior management to determine the appropriate action to ensure that the child receives such medical review.
5	That the Department of Human Services Child Protection, Placement and Family Services Branch ensure that practice guidelines relating to infants draw attention to the need to incorporate an understanding of feeding regimes and associated weight history into assessment of the adequacy of care.
6	That the Department of Human Services Child Protection, Placement and Family Services Branch ensure that the importance of contemporaneous note taking is reflected in relevant training, program guidelines and procedures.
7	That program standards specify that in cases where Child Protection has an expectation that services will be involved to provide support to the parent/s and monitor the safety and wellbeing of children, that case closure is contingent on Child Protection establishing a service network which includes identifying the lead service with responsibility for coordinating case management, clarifying respective roles and responsibilities of services within the network and communication processes to ensure that information is effectively shared.
8	That Department of Human Services guidelines for safe sleeping education explicitly address how to respond to situations where it is known that families may move between various households.
9	That the Department of Human Services Principal Child Protection Practitioner in consultation with the region examine the region's performance to identify actions required to strengthen the regional Child Protection program's capacity to respond effectively to high risk infants.

No.	All VCDRC Recommendations 2005-2010
10	That in instances of statutory clients themselves becoming parents, planning for the safety and wellbeing of these children should be initiated by an unborn child report and all program standards should apply.
11	That the Department of Human Services Child Protection and Family Services Branch ensure that program standards and guidelines provide for additional quality assurance monitoring in instances of statutory clients on either Guardianship to Secretary Orders and Custody to Secretary Orders themselves becoming parents.
12	That the Department of Human Services, Child Protection program standards and guidelines include a concise list that identifies the practical changes resulting from the new Act (<i>Children, Youth and Families Act 2005</i>) when responding to cumulative harm which make explicit the steps of effective intervention.
13	That the Department of Human Services, Child Protection, Placement and Family Services Branch provide guidance about management and quality assurance processes that are required when operating environments are sub optimal due to staffing shortages.
14	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure consistent state-wide quality assurance processes to support an effective response to high risk adolescents.
15	That the Department of Human Services, Child Protection, Placement and Family Services Branch, consider the state-wide development of regional multidisciplinary advisory panels to support an effective response to high risk adolescents.
16	That the Department of Human Services, Child Protection, Placement and Family Services Branch consider the development of a service model of specialist service care teams (comprising Child Protection, Drug and Alcohol services and Child and Adolescent Mental Health Services) which share governance responsibility for case management of complex cases involving high risk adolescents.
17	That the Department of Human Services, Child Protection, Placement and Family Services Branch reviews all program guidance relating to physical abuse to ensure that clear and concise information about minimum requirements for effective intervention is available to staff.
18	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensures that there is a mandatory Practice Standard requiring medical examinations being obtained for all cases concerning alleged physical abuse of young children where there are injuries present at the time of intervention; and not undertaking this course of action requiring approval by a specified level of senior management.
19	That the Department of Human Services, Child Protection, Placement and Family Services Branch consider ways of promoting a culture of constructive challenge between services responsible for contributing to the protection of children including promoting

No.	All VCDRC Recommendations 2005-2010
	an understanding of how complaints regarding Child Protection can be made.
20	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure that practice standards support all young people known to Child Protection being engaged with educational services.
21	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure that high risk adolescent processes identify all young people whose case management requires additional quality assurance monitoring and is not limited to cases receiving additional specialist resourcing.
22	That the Department of Human Services, Child Protection, Placement and family Services branch examine whether Aboriginal high risk adolescents receive sufficient access to Intensive Case Management Services and whether there is need for a specialist ICMS Aboriginal service response.
23	That the Department of Human Services, Child Protection, Placement and Family Services branch undertake a review of training materials used to promote an understanding of suicide risk in adolescents.
24	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure that program standards incorporate that assessment of cases concerning 'hard to help' young people incorporate an understanding of the family environment through the eyes of the young person and the necessity of having sufficient contact with the young person to give effect to their 'separate voice'.
25	That the Department of Human Services, Child Protection, Placement and Family Services Branch promote the key message of the importance of direct contact with young people, particularly 'hard to help' adolescents, and building relationships from a trauma informed perspective as a central means of achieving positive outcomes.
26	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure that there is effective joint planning and shared responsibility across Child Protection and Youth Justice in relation to joint complex clients and that the general high risk adolescent quality assurance processes apply to this client group.
27	That the Department of Human Services, Child Protection, Placement and Family Services Branch ensure that practice guidelines and program standards draw attention to the need to weigh information according to its relevance and, specifically, when undertaking assessments of parenting capacity, time limited observations of parenting in controlled environments such as hospitals are an insufficient basis to inform judgements especially when the concerns relate to chronic risk and cumulative harm.
28	That the Department of Human Services, Child and Family Services Branch ensure that all children placed in state care on Guardianship and Custody to Secretary Orders receive a comprehensive paediatric and developmental assessment to inform

No.	All VCDRC Recommendations 2005-2010
	care planning.
29	That the Department of Human Services, Child and Family Services Branch establish a quality assurance process in relation to negotiation of Custody to Secretary Orders in preference to Guardianship Orders to ensure that outcomes sought from the Children's Court are in the best interests of the child.
30	That the Department of Human Services, Child Protection and Family Services Branch program standards ensure that a care team approach be adopted to manage young people in kinship care.
31	That the Department of Human Services, Child Protection and Family Services Branch ensure access to therapeutic residential placements that bridge the current dichotomy between community placements and Secure Welfare Services be available.
32	That the Department of Human Services, Child Protection and Family Services Branch further examine why an effective care team was not appropriately established early in this case and identify learnings regarding the effective establishment and operation of care teams.
33	That the Department of Human Services, Child Protection and Family Services Branch include on the Child Protection training calendar sessions aimed at increasing understanding within the Child Protection workforce of the structure and processes of the medical profession and system.
34	That the Department of Human Services, Child Protection and Family Services Branch consider the merit of providing access for Child Protection workers to independent specialist medical expertise and identify options for enabling this.
35	That the Office of the Child Safety Commissioner examine SIDS education material used by Child Protection workers as to whether care information is conveyed to the functionally illiterate and those with limited literacy skills.
36	That the Office of the Child Safety Commissioner develop a process for reviewers undertaking child death inquiries to have access to independent expert medical advice to assist as necessary the analysis of cases involving complex medical issues and interaction between the medical and Child Protection systems.
37	That the current Victorian Child Protection System Operating Model Review consider the establishment of a specialist liaison function within each regional management structure to facilitate and improve communication and joint work between the Child Protection program and hospitals.
38	That the revision of the 1993 protocol take into account the group analysis <i>Children with complex medical needs</i> (2004) and incorporates an alert process to Department of Human Services senior regional management when children with complex medical needs are known to both Disability Services and Child Protection to ensure cooperation across these programs and

No.	All VCDRC Recommendations 2005-2010
	identify opportunities for improved outcomes for these children
39	That the Victorian Child Safety Commissioner, through the SIDS Working Group, which comprises several service systems including Child Protection, consider the merits of Child Protection workers promoting practical alternative sleeping arrangements when appropriate bedding is not immediately available.
40	That the Child Safety Commissioner identify mechanisms to enable the Victorian Child Protection service to gather information regarding multiple child deaths in a single family, where these occur in other Australian jurisdictions.
41	That the Department of Human Services Office for Children in collaboration with the Mental Health Services Branch, clarify roles and responsibilities for case planning in respect of joint clients who are inpatients of mental health facilities. This should occur in the context of broader protocol development between the two services that builds on the Working Together strategy and describes collaborative arrangements at both the programmatic and local levels.
42	That the Department of Human Services Office for Children continue to develop an enhanced range of services for young people experiencing significant trauma and emotional disturbance. These should comprise home based and medium term residential care services, therapeutic services and intensive case management support. They should be well integrated with other service system components, in particular, secure welfare and mental health inpatient services for children and young people.
43	That the Department of Human Services Office for Children progress the development of a revised protocol between Child Protection and Disability Services as a priority.
44	That the Department of Human Services Office for Children progress the development of a protocol with Acute Health Services incorporating procedures for achieving role clarity and developing medical treatment plans for children with complex medical needs.
45	That the Victorian Child Safety Commissioner liaise with the Department of Employment, Education and Training (DEET) to highlight the need to proactively monitor school attendance and provide culturally relevant outreach and support services to children of refugee families.
46	That the Department of Human Services Child Protection and Family Services Branch utilise the current review of the Victorian Risk Framework to incorporate key concepts and theories referenced in the group analysis report and summarised in the proposed Best Practice Principles, including a developmentally sensitive assessment of the cumulative impact of poor attachment and past trauma.
47	That the Department of Human Services Child Protection and Family Services Branch develop a special assessment guide as an attachment to the revised Victorian Risk Framework that incorporates the accumulation of harms as a determinant of severity of

No.	All VCDRC Recommendations 2005-2010
	harm and encourages the assessment of safety over the longer term, not just in the immediate assessment period.
48	That the Department of Human Services Child Protection and Family Services Branch establish a state wide standard requiring special consultation and endorsement to close cases at Intake where multiple past notifications have been received in a short period of time. This standard would require child protection professionals to justify why protective investigation should not occur in these circumstances.
49	<p>That the Department of Human Services Child Protection and Family Services Branch develop comprehensive practice guidance and supporting decision-making tools for workers in both child protection and community service organisations that reflects the proposed Best Practice Principles regarding chronic neglect and describes optimum approaches to:</p> <ul style="list-style-type: none"> • ameliorating and redressing harms to children arising from chronic neglect • assessing and responding to a lack of change within the family using a goal directed approach and formal periodic reviews of progress taken • maintaining a persistent, sustainable approach to practice in which case reviews, case conferences and supervision are used to change case direction and strategy as required • referring to secondary support services in a proactive, supportive manner that acknowledges the family history of participation with services and ensures meaningful engagement has occurred prior to case closure.
50	<p>That the Department of Human Services Child Protection and Family Services Branch develop specific practice guidance and practical, experiential training regarding:</p> <ul style="list-style-type: none"> • the relative merits of proceeding with court intervention in matters of chronic neglect • the presentation of evidence to the court regarding the deleterious impacts of exposure to chronic neglect that highlights specific vulnerability factors for the child and draws on current research and/or expert witnesses.
51	That, in the context of implementing the <i>Children, Youth and Families Act, 2005</i> , the Department of Human Services Office for Children liaise with the Department of Justice and the President of the Children's Court to ensure that Children's Court Magistrates receive training regarding child development, trauma and attachment theory, and the deleterious impact of exposure to chronic neglect.
52	That, in the context of implementing the <i>Children, Youth and Families Act, 2005</i> , the Department of Human Services Legal Services, develop a strategy for briefing in-house counsel on optimum approaches to presenting evidence regarding cumulative harm in cases of chronic neglect.
53	That the Department of Human Services Child Protection Professional Development Unit develop and deliver a new module on chronic neglect incorporating key concepts and theories referenced in the Group Analysis and summarised in the proposed Best Practice Principles, including the developmental impact of neglect; trauma and attachment theory; pluralist thinking and contingency planning.

No.	All VCDRC Recommendations 2005-2010
54	That the Department of Human Services Child Protection Professional Development Unit re-orient content in the Beginning Practice and the supervisory practice training modules to reflect key concepts referenced in the group analysis and summarised in the proposed Best Practice Principles.
55	That the Department of Human Services Child Protection Professional Development Unit and Children's Welfare Association of Victoria (CWAV) utilise the planned joint training strategy for child protection, family services and placement support services to introduce new risk assessment frameworks and practice guidelines regarding cumulative harm and chronic neglect.
56	That the Department of Human Services Office for Children liaise with key stakeholders to ensure that training is provided to maternal and child health nurses regarding the deleterious impacts of chronic neglect, opportunities for early intervention, and the impact of maternal exposure to family violence, substance use and other risk factors in the antenatal period.
57	That the proposed Best Practice Principles and the broader findings and practice implications identified in the Neglect group analysis be used to shape the practice framework for community-based intake.
58	That the proposed Best Practice Principles be used as a basis for framing the assessment, case management and data collection tools used by both the child protection and community-based intake services.
59	Following discussion with the Victorian Child Care Agency, other Indigenous service providers and the Indigenous Initiatives Program within Department of Human Services, that the analysis in the literature review providing a cultural perspective of neglect in Aboriginal communities be used to guide the development of frameworks and training for child protection, community-based intake and family services staff regarding responses to neglect of children in Aboriginal communities.
60	That the Child Safety Commissioner convene a forum of representatives of the primary care, maternal and child health, specialist children's, disability, education, mental health, drug and alcohol, child protection services to consider the report of the group analysis and identify opportunities for cooperative action to intervene early to prevent and ameliorate the impacts of chronic neglect.
61	That the Department of Human Services Office for Children emphasise the importance of partnerships with universal services in the development of frameworks for community-based intake and reinforce the need for family services to intervene early to prevent and redress the impact of harm.
62	That the Department of Human Services Office for Children give particular consideration to the support and development of flexible, universal services in rural areas so that these services can work in partnership with child protection and family services and actively contribute to the prevention and amelioration of chronic neglect.

No.	All VCDRC Recommendations 2005-2010
63	That cross-jurisdictional issues are presented at the next national meeting of Interstate Liaison Officers and their implications for future protocol development are discussed and actioned.
64	The Department of Human Services ensure funded health providers be made aware of the importance of their health promotion work with all new parents to ensure each cohort of parents with new infants is aware of the child care practices to reduce the risks of SIDS and fatal infant sleeping accidents.
65	The Department of Human Services ensure that, in particular, funded health providers are made aware of the significantly higher risk of SIDS among socially vulnerable families and the importance of effective practice to reduce the risk of SIDS and fatal infant sleeping accidents.
66	The Department of Human Services liaise with public health authorities to support research to monitor parent and health professional practices and awareness of infant sleeping risk factors (similar to studies undertaken in New South Wales (Jeffery 2003), Queensland (Young 2003) and Victoria (Ford 1997; 2000)).
67	The Child Death Inquiry Unit seek routine access to the event scene investigation report together with the autopsy report.
68	The Department of Human Services liaise with the State Coroner to discuss the absence of event scene investigation data in some cases of possible SIDS where there are initial suspicions about the cause of death.
69	The child death inquiry reviewers, when conducting inquiries into the death of an infant less than two years of age, routinely include a section in the report systematically detailing infant safety interventions undertaken by Child Protection and allied health services and including infant sleeping safety and factors related to risk reduction.
70	<p>The Department of Human Services Child Protection and Family Services Branch enhance current Child Protection practice policies and guidelines to:</p> <ul style="list-style-type: none"> • ensure Child Protection workers sight the infant, as well as the infant's sleeping environment, when conducting home visits • ensure protective workers record a description of the infant's sleeping arrangement and sleeping environment as well as any interventions taken by the Child Protection worker with regard to infant safe sleeping • ensure the SIDS risk reduction training reinforces the importance of protective workers recording their assessment and intervention regarding infant safe sleeping.
71	The Department of Human Services Child Protection and Family Services Branch take forward the suggestion that the next version of CRIS incorporate a drop-down box and prompt relating to the safety of the sleeping environment for infants and young children. It would be mandatory to complete this drop-down box before moving on to the next protective phase in CRIS.
72	The Department of Human Services Child Protection Training Unit ensure infant safe sleeping practice is included in the revised

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	Beginning Practice handbook.
73	The Department of Human Services Child Protection and Family Services Branch reinforce the importance of the practice instructions, practice enhancements for high risk infants, which advise protective workers in their initial and ongoing consultation with the specialist infant protective worker in cases where the infant is under two years of age.
74	The Department of Human Services Child Protection and Family Services Branch develop training for departmental legal and court officers on SIDS risk reduction and infant safe sleeping as it relates to their work in the Children's Court.
75	The Judicial College of Victoria liaise with magistrates who primarily preside in Children's Court matters in order to provide a briefing about SIDS risk reduction and infant safe sleeping practices, particularly as it relates to Child Protection.
76	The Department of Human Services Child Protection and Family Services Branch liaise with SIDS and Kids to develop an emergency response guideline for Child Protection following the sudden and unexpected death of an infant who is known to Child Protection and that this guideline be included in the SIDS and Kids emergency responders manual.
77	The Mental Health Branch, Disability Services Division, Drugs Policy and Services Branch and the Housing and Community Building Division (Office of Housing) of the Department of Human Services take a proactive approach in ensuring funded services include infant safe sleeping advice in their work with families and babies.
78	<p>The Department of Human Services' Rural and Regional Health and Aged Care Services Division, in conjunction with stakeholders, undertake activities to raise health professionals' awareness of the special aspects of health promotion to the families with infants who are at high risk of SIDS and fatal infant sleeping accidents. The program could readily involve:</p> <ul style="list-style-type: none"> • research to establish client understanding of infant health and risk and how these parents source their information and so on • research determining the antenatal service use by these clients • sharing existing health promotion skills and knowledge between services, in-service education for health professionals, and the development of relevant educational resource materials to promote infant health and wellbeing in this population • approaches to ensure the universal incorporation of SIDS risk reduction and infant safe sleeping in the routine work of the antenatal, midwifery and domiciliary services • addressing with health professionals, in conjunction with SIDS and Kids health in-service training activity, the special issues of health promotion to high risk families to remove the possibility of exclusion of these families from information and support to reduce the risk of sudden infant death • encouraging implementation of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity recommendations for general practitioners to incorporate SIDS risk reduction and infant safe sleeping recommendations into general practice in antenatal shared care arrangements.
79	The Department of Human Services' Metropolitan Health and Aged Care Services Division advise health services providing

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	<p>maternity services (including postnatal and special care nurseries, postnatal wards and neonatal intensive care units) to:</p> <ul style="list-style-type: none"> • familiarise themselves with SIDS and Kids infant safe sleeping practices • model infant safe sleeping with babies in the hospital • include routine assessment of the safety of the infant sleeping environment in discharge plans in addition to other risk assessment • have antenatal and postnatal domiciliary services make routine discussion of SIDS risk reduction with families • encourage midwives and domiciliary midwives to sight the infant sleeping arrangements during their postnatal home visits to families.
80	The Child Protection and Family Services Branch in conjunction with the Metropolitan Health and Aged Care Services Division develop stronger working relationships between Child Protection and birth hospitals to ensure birth information is available for high risk families and there is better coordination at the time of discharge.
81	The Child Protection and Family Services Branch consider familiarising Child Protection workers with signs of serious illness (such as those described in the 'baby check' system) within the context of general training about early childhood development.
82	The Chief Psychiatrist, Mental Health Branch, consider providing information across all program areas to raise mental health clinicians' awareness of infant safe sleeping and SIDS risk reduction strategies.
83	The Department of Human Services Early Years Services Branch encourage maternal and child health nurses to sight the infant sleeping arrangements during their home visit to families.
84	SIDS and Kids and the Victorian Aboriginal Community Controlled Health Organisation arrange a consultation with the Elders of the Aboriginal community and the community and Aboriginal maternity health workers about reducing the risk of SIDS and fatal infant sleeping accidents.