

ANNUAL REPORT OF INQUIRIES INTO
CHILD DEATHS:
PROTECTION AND CARE 2000



Victorian Child Death Review Committee

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INTO CHILD DEATHS:
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EXECUTIVE SUMMARY

Summary of Findings

During 1999, seventeen deaths occurred. Of these, the breakdown by cause is as follows:

- Two were from acquired illness
- Two were from accidental death
- One was drug related
- Two were from Sudden Infant Death Syndrome
- One was from suicide/self harm/high risk behaviour
- One was from non-accidental trauma
- Eight were from causes not known.

Five of these deaths related to clients who were only notified to the protective service system in the context of the event that directly resulted in their deaths.

The Committee considered eleven cases. Of these, nine were through the Child Death Case Practice Review, and two through Child Death Case Analyses.

In four cases the Committee recommended that the matter be referred for further analysis in line with the enhanced and revised procedures.

Emerging Themes

The Committee considered eleven cases from which seven themes were distilled. These were:

- Sudden Infant Death Syndrome
- Protective intervention and response
- Client placement issues
- Continuity of case/support worker
- Engagement with the education system
- Mothers: victims and perpetrators of abuse
- Inexperienced workers.

Achievements

The major achievements arising from the Committee's 1999 Annual Report were:

- Further refinement to the Child Death Inquiry process. During 1999 the Committee met with the reviewers of two cases to discuss the process and issues confronting those charged with conducting the review phase. Both believed that

the standardisation of the process had led to an expansion of the independent and critical overview of deaths within the system.

- The establishment of a systematic process for regular communication with Protection and Care Branch. This allowed the Committee to move towards being a more active, objective and vocal partner that improves the timeliness of debate on issues arising from findings on deaths within the system.
- The distribution to all protective workers of a Practice Bulletin highlighting issues and themes raised in the Committee's 1999 Annual Report.
- The finalisation of the Department's Building Professional Practice Strategy. Projects arising at least in part from this work are:
 - The Competency Based Recruitment Project
 - Behavioural Competencies and Staff Development Project
 - Team Leader Development Project
 - Training and Education Project.
- The implementation of the Victorian Risk Framework.
- Committee linkages with:
 - Professional colleges of learning
 - Consultative Council on Obstetric and Paediatric Mortality and Morbidity
 - State Coroner
 - Working Together management team.
- In partnership with the Department, a second Australasian Forum into child death procedures was held in Perth on 16 October 1999.

Continuing Work

The Committee will continue to work in the following areas:

- Policy on medical treatment for Department of Human Services (Protective Services) Clients.
- SIDS/Health Sector Analysis Project.
- Education system issues.
- Innovative support networks for mobile and at risk clients.
- Innovative placement options for high risk adolescents.

Public Perceptions

When this Committee first met in May 1996 the media, in particular, the daily newspapers were full of criticism with regard to deaths within the protective service system and the way in which the Department of Human Services was handling its responsibilities for investigating them.

Some four years on it is pleasing to report that public debate on the very same issue is less often characterised by emotive headlines. Rather, reporting is being made more often with an acute understanding of the complex issues that confront those workers responsible for protecting the children and young people of this State.

This change has been helped by the commitment of the Department to address earlier criticism through the establishment of this Committee, and by giving a public undertaking with regard to timelines for the completion of inquiries into the deaths of those involved with the Child Protection system.

The VCDRC still acts as an independent advisory Committee reviewing all deaths within the protective system, providing advice to the Minister on themes and issues noted during the review of these reports and documents. This Annual Report contains just this information.

SECTION 1

Introduction

The Review of the Ministerial Inquiry Process into Child Deaths 1991 recommended:

...an Annual Report be prepared that provides a concise overview of the cases reviewed and lists the recommendations and the manner in which they have been implemented. This Report should be circulated to panel members, regions and professionals working in Child Protection and family welfare. (Recommendation 16)

The Annual Report of Inquiries into Child Deaths: Protection and Care is presented in the Autumn Session of Parliament and contains details on all deaths which occurred in the previous calendar year.

The tabling of the Annual Report is seen as a continuing commitment on the part of the Department of Human Services to have timely and accountable systems in place to address these tragedies.

SECTION 2

Demography

The estimated number of persons aged between 0-17 years in Victoria is 1,125,493. (Source: Australian Bureau of Statistics Child Resident Population 1995.)

In 1999 the Department of Human Services, Child Protection program received 35,902 notifications of alleged child abuse.

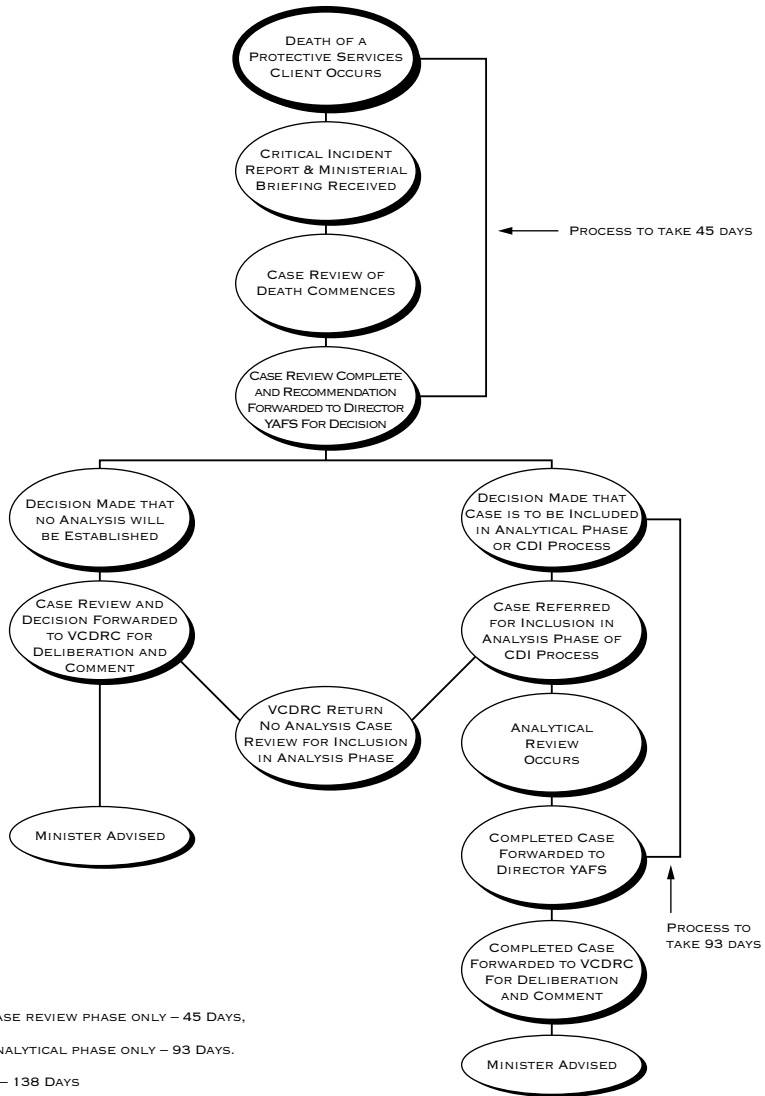
TABLE 1 PROTECTIVE NOTIFICATIONS BY OUTCOME, 1996-1999

YEAR	NOTIFICATIONS	INVESTIGATIONS	SUBSTANTIATIONS	NUMBER OF DEATHS*
1996	30,483	13,964	6,844	15
1997	32,309	14,666	7,268	11
1998	34,330	14,483	7,424	9
1999	35,902	13,125	6,128	15

*Death figures do not include those children and young people who died as a result of an acquired illness. For details of this group please refer to Appendix 9.

SECTION 3

Figure 1 The Child Death Inquiry Flow Chart



TIMELINE FOR CASE REVIEW PHASE ONLY – 45 DAYS,

TIMELINE FOR ANALYTICAL PHASE ONLY – 93 DAYS.

TOTAL TIMELINE – 138 DAYS

SECTION 4

The Victorian Child Death Review Committee: Terms of Reference

- Review investigative reports of all deaths of children who have died while they were current clients or, within three months of case closure, of Child Protection, Services and advise on any specific issues which the Committee believes need, addressing.
- Advise the Minister of the implications of findings in given cases where necessary.
- Describe trends and patterns of child deaths.
- Analyse and comment on any themes which may be emerging through the inquiry process.
- Identify the prevalence of risk factors which existed in the population of children who had died, and recommend further investigations into particular groups as appropriate.
- Evaluate service and system responses to children and families who are considered to be at high risk and offer recommendations for improvement of responses.
- Prepare an annual report for the Minister for Community Services.
- Provide advice to the Minister for Community Services on the Child Death Inquiry process.

SECTION 5

Overview of Work Done by the Victorian Child Death Review Committee in 1999

The Committee provides expert independent advice to the Minister on measures that will minimise the risk of child deaths and contribute to a more broadly targeted strategy aimed at reducing the unacceptably high rates of abuse and neglect in the community.

During 1999, the Committee continued its key role of reviewing reports relating to the deaths of children and young people involved with this State's Child Protection system, as well as considering a number of key aspects which affect the safety of Victorian children. Some of these are listed in the report as 'work in progress'. The results of other Committee initiatives affect practice in the field.

5.1 Child Death Inquiry Reports - Developments 1999

The revised and enhanced CDI process, as outlined in the VCDRC's 1999 Annual Report, was trialled by the Committee. This trial revealed a number of elements that needed modification.

To address these needs the Committee met with senior Child Death Inquiry (CDI) Unit management to discuss the findings and to continue to move the process forward to achieve the desired standard for all concerned.

This discourse resulted in further refinements to the Review Tier. These included an agreement that the Committee meet with the reviewers of two cases to discuss the process and issues confronting those charged with conducting the review phase. The outcome from these talks proved useful with both parties agreeing that the standardisation of processes had led to reduced anxiety in the field. Standardisation had also had the effect of maintaining, and in fact expanding, the independent and critical overview of deaths within the system.

While only two cases recommended for the Analysis Tier have been seen by the Committee, members commented that recommendations in these cases have still addressed case specific issues, rather than reflecting broader system issues, which is the desire of both the VCDRC and the Department.

The Committee will continue to monitor the outcomes from all cases referred for analysis and will work with the CDI Unit, if appropriate, on this matter.

During 1999 the VCDRC recommended that further group analysis be undertaken relating to five cases where the deaths were categorised as Sudden Infant Death Syndrome and in cases where concerns were raised regarding the role of hospitals in allowing discharge when an infant is in an apparent risk situation.

This work will cover SIDS deaths from 1996 until present and will be undertaken by appropriately skilled professionals with extensive experience in the protective and broader health systems.

It is anticipated that this report will be available in mid-2000. Details will be contained in the VCDRC's 2001 Annual Report.

5.2 Partnership with Protection and Care Branch

Section 6.9 of the *1999 Annual Report of Inquiries into Child Deaths: Protection and Care* indicated that the Committee felt the need to establish an appropriate partnership with the key service provider in the Department. Accordingly, the VCDRC undertook to:

...establish a systematic process for regular communication with Protection and Care Branch aimed at establishing a more active involvement with the development and monitoring of new program initiatives.

The Committee accepts that some may see the relationship as 'too close', complete with the inherent criticism that the VCDRC will be seen to lose its independence. Members, however, took the contrary view, and saw this as an opportunity for a synthesis to occur that sees the Committee move from an overseer role, to an active, objective and vocal partner. No longer could the VCDRC merely be viewed as standing back from the field, critical of practice via issues and themes raised in the Annual Report. The result of the initiative clearly facilitates much greater opportunity for timely and mature debate on the at times thorny and emotive issues that surround child deaths within the protective system.

Senior Protection and Care Branch staff attended three meetings in 1999 with presentations being made on the following initiatives.

5.2.1 Practice Bulletin: VCDRC Findings and Implications for Practice

This bulletin focused attention on issues identified in the 1999 Annual Report and emphasised the need for staff to learn from the highlighted themes and issues. The bulletin recognised the importance of conveying these themes and issues to staff who actually work with clients on a daily basis. It also encouraged a creative approach to making use of the Report and its findings.

The Practice Bulletin also discussed other issues, including:

- Risk assessments, including at case closure.
- Sudden Infant Death Syndrome (SIDS) issues.
- Clients with serious illness.
- Abuse by mothers.
- Streetwise adolescents.
- Structural issues, including education and training; management and support of staff; morale; and staff retention and recruitment.
- The culture of optimism.
- Links with Drug and Alcohol and Mental Health services.

5.2.2 Building Professional Practice (BPPS): A Child Protection Human Resource Strategy

In 1998 Child Protection Services commenced a Labour Market Analysis (LMA) in response to a number of significant factors, including:

- The rapid growth and change in the nature of the Child Protection workforce since 1985.
- Criticisms of the Department's operations contained in a number of reviews.
- Issues raised by industrial action undertaken by the Child Protection workforce in 1996.

In March 1998, the Hay Group undertook the initial consultancy for the LMA to identify key skills and competencies for Child Protection workers. In November 1998, a forum of key stakeholders reviewed the LMA's initial findings and identified key projects for implementation. Four projects have been consolidated under the broad title of Building Professional Practice: A Child Protection Human Resource Strategy (BPPS). The BPPS identified four key objectives:

- To develop strategies to address recruitment and retention difficulties.
- To raise the professional standing and profile of work within Child Protection.

- To establish a skilled, capable and competent work force.
- To develop human resource strategies that incorporate best practice.

The projects arising from this work are:

1. The **Competency Based Recruitment Project** which is based on the premise that, through the use of behavioural competencies, there is increased ability to recruit Child Protection workers with the potential to become outstanding practitioners. The use of competency based recruitment was implemented in April 1999, by Price Waterhouse, in conjunction with the Branch and Regional staff.
2. The **Behavioural Competencies and Staff Development Project** recognises the importance of ongoing staff development and effective performance management and the role that behavioural competencies can play in this. Training will be specifically targeted to enhance work performance and increase personal development and workplace satisfaction.
3. The **Team Leader Development Project** seeks to strengthen and enhance the leadership and staff development capabilities of the Child Protection Team Leader through appropriate training programs and assistance in developing management and leadership skills.
4. The **Training and Education Project** aims to develop an integrated education and training strategy for Child Protection services, including a review of current pre-employment training, links with the tertiary sector, and the exploration of post graduate training courses.

The 1999 Annual Report also detailed a further Committee initiative:

A quality improvement initiative aimed at developing best practice among key protective service managers.

While this initiative has not progressed as rapidly as the Committee would have wished, it is pleasing to report that discussions are continuing with all parties committed to achieving a mutually satisfactory resolution.

5.3 Victorian Risk Framework (VRF)

Since it first met in May 1996 the Committee has strongly believed that:

...a comprehensive assessment linked to a detailed social and family assessment is the cornerstone of a successful Child Protection system. (Annual Report of Inquiries into Child Deaths: Protection and Care 1997, page 35.)

In September 1999, the Protection and Care Branch presented the Victorian Risk Framework to the members.

Development of the VRF commenced in June 1996, with the aim of establishing a standardised approach to risk assessment for use within Child Protection services.

While the Branch considered different models from Australia and overseas, no single instrument was seen to have the versatility in content or application to relate to clients of all ages and problem types, and across all phases of protective service involvement. The VRF can best be described as a guided professional judgment model, with 'risk assessment' described as 'the degree of harm and the probability of the believed harm continuing versus safety being achieved'.

The methodology employed throughout the VRF's development has been one of 'practice research'. This method examines how experienced practitioners use theory and research to describe and drive practice. Where there is tension between the theory and the practice, alternate interpretations are generated, which are again tested for usefulness in practice.

Features which underpin the VRF include:

- A guide to the key activities of information gathering, analysis and judgment.
- That it seeks to adapt requirements of the risk assessment process across the different phases of protective services action and recording/accountability requirements.
- That it provides access to comprehensive knowledge to promote thorough and informed assessment of risk as well as the assessment of health, welfare and development needs where appropriate.

The framework provides protective workers with assessment tools to guide information gathering, risk analysis and risk judgments and provides for risk

assessment summaries to be completed at strategic decision making points to ensure transparency of decision making.

Statewide implementation commenced in November 1998, with an extensive training strategy for all Child Protection workers, supervisors and managers completed by the end of 1999.

Ongoing work will now centre on refining the VRF in response to Child Protection workers' needs. There will also be further training for non-government agencies and professionals in the theory and use of the VRF. Effective implementation will require the ongoing dynamism of critical reflection and involving Child Protection practitioners, sound research, other professionals and the broader community.

While the Committee appreciates the work of all involved with this particular development and await feedback on the framework from the field, it was concerned to learn that the Victorian Risk Framework does not have, as part of its format, an integrated evaluation mechanism. It is the view of members that such a major program initiative — one that clearly has such a crucial impact on the field — should be readily subject to a critical and comprehensive evaluation process.

5.4 Committee Linkages

5.4.1 Education and Training Initiatives with Professional Colleges of Learning

The impact of the views and information provided by the health professional in the management of a Child Protection case cannot be understated. For some years now this Committee has noted, at times with concern, an inconsistency in the provision of just such information to protective workers.

In 1998, and again in 1999, discussions were held with the Chair of the Committee of Presidents of Medical Colleges where the Committee's concerns were outlined. It is pleasing to report that as a result of this discourse a proposition was put to the Department via the Director, Community Care Division (formerly Youth and Family Services), for funding to cover the development of a training module covering dilemmas facing the profession on Child Protection issues.

The Committee has offered to assist either directly in the development, or by being on a Committee of Management charged with the responsibility for overseeing the initiative.

The VCDRC felt that the project and funding could be carried out on a local or Australia-wide basis. It is our understanding that the matter is on the agenda for discussion with the Director's interstate colleagues.

5.4.2 Linkages with Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)

The CCOPMM considers the deaths of all Victorian children and young people up to fifteen years of age. In effect their mandate results in many of the clients reviewed under CDI Terms of Reference and considered by the VCDRC being seen by the CCOPMM, but no formal exchange of information or debate occurs.

It has long been felt by this Committee that a closer and more formal relationship between both this Committee and the Consultative Council would be of benefit for Victorian families and their children.

The *1999 Annual Report on Inquiries into Child Deaths: Protection and Care* indicated that the Chair of this Committee had met with relevant CCOPMM staff with the view of establishing just such a relationship.

While little real progress has been made during the past twelve months it is this Committee's view that the climate is appropriate for such a move to occur. We accept that structural changes need to be addressed, since the CCOPMM reports to the Minister for Health and has its role in legislation, while the VCDRC reports to the Minister for Community Services and is not supported in any legislation.

The first step is a commitment from the Department which will allow for formal discussions to commence. It is hoped that over the next year such an undertaking will be forthcoming.

5.4.3 Linkages with the State Coroner

The Committee was advised that the State Coroner was to review 25 adolescent drug deaths incorporating their social and medical histories.

Given the VCDRC expertise with regard to this matter, a letter was sent to the State Coroner, Mr Johnstone indicating our willingness to become involved if required and/or appropriate.

5.5 Working Together Strategy (WTS)

Section 5.8 (Dual Clients) of the 1999 Annual Report detailed complexities faced by those working with young people who were subject to protective orders as well as a Juvenile Justice Court Order, and those who also required the support and service of Drug and Alcohol and/or Mental Health services.

In recognition of just such issues the Department launched the Working Together Strategy in May 1998.

In conjunction with this development this Committee requested that an analysis of sixteen adolescent drug related deaths, reviewed by the VCDRC since May 1996, 'where intersectoral problems were noted be undertaken'. (This analysis was contained as Appendix 11 in the 1999 Annual Report.)

Findings from this work were forwarded to those involved with the WTS for action.

The WTS team provided the Committee with a response on its activities as they relate to our ambit of interest in accordance with agreed timelines.

It is important that the Committee continue to be fully briefed on all WTS Regional developments and initiatives. Accordingly, the VCDRC has written to the Department requesting that a formal process to achieve such data is put in place.

It is also pleasing to report that the Department has responded appropriately with formal meetings and linkages now in place.

5.6 Workshops and Conferences

In partnership with the Department, the VCDRC held a second Australasian forum into child death procedures in Perth on 16 October 1999.

Professor Jan Carter represented the Committee at the workshop. She also attended the seventh Australasian Conference on Child Abuse and Neglect, where a presentation was made by the Child Death Inquiry Unit on the Analysis of Adolescent Child Protection Deaths 1994-1998.

Feedback from Professor Carter would indicate that while Victoria has had its share of problems with regard to Child Protection, it is well ahead of other states in the crucial areas of accountability and service delivery.

SECTION 6

Cases Considered 1999

The VCDRC held eleven regular meetings during 1999.

A total of eleven cases were considered during 1999. This figure includes two cases, shown in the 1999 Annual Report as 'referred back to the Department for analysis'.

Appendix 3 contains data on all Child Death Inquiry reports presented to the Committee for review during the 1999 Calendar Year. Appendix 4 contains information on all deaths that occurred in Calendar Year 1999.

6.1 Client Deaths

The VCDRC has set in place specific guidelines to assist in ascertaining deaths of children and young people known to Protective Services.

The Committee's initial Terms of Reference have been amended to indicate that a 'recent client' is one who died within three months of case closure by Child Protection Services. Due to the Committee considering cases where death occurred prior to 1996, previous reports provided details on deaths from 1989 onwards. As this backlog situation has now been rectified, data on deaths in this and future reports will commence from 1996.

It should also be noted that changes to the Category of Death information were made in the 1998 Annual Report. This was done to reflect more accurately the cause of death and to enhance the VCDRC's linkages to the CCOPMM.

The Committee recognising the need to more appropriately reflect the number of deaths of clients subject to protective intervention and investigation has separated the group of children and young people who died as a result of an acquired illness. The VCDRC have previously defined this to include ' a child and/or young person suffering from serious and life threatening medical condition that has as part of its prognosis a severely shortened life expectancy'. Details with regard to these clients are contained in Appendix 9.

The following data is contained in the appendices:

Appendix 1 The Victorian Child Death Review Committee

Appendix 2 Child Death Inquiry Panels

- Appendix 3 Cases Considered by the VCDRC in 1999
- Appendix 4 Deaths in 1999 Calendar Year
- Appendix 5 Deaths Per Calendar Year 1996-1999
- Appendix 6 Deaths Per Calendar Year by Gender 1996-1999
- Appendix 7 Deaths by Age 1996-1999
- Appendix 8 Deaths by Category of Death 1996-1999
- Appendix 9 Deaths of Children and Young People With an Acquired Illness 1996-1999
- Appendix 10 Part A: Cause of Death by Age at Time of Death 1996-1999
- Appendix 10 Part B: Cause of Death by Age at Time of Death 1996-1999
- Appendix 11 Cause of Death by Gender 1996-1999

6.1.1 Details of Cases Reviewed 1999

TABLE 2 DETAILS OF CASES REVIEWED 1999

CASE TYPE	NUMBER OF DEATHS
YEAR OF DEATH	
1998	2
1999	9
INQUIRY STATUS	
CASE PRACTICE REVIEW	9
ANALYSIS	2
GENDER	
MALE	8
FEMALE	3
CAUSE OF DEATH	
SUDDEN INFANT DEATH SYNDROME	2
ACQUIRED ILLNESS	3
ACCIDENTAL DEATH	2
NON-ACCIDENTAL TRAUMA	1
DRUG RELATED	2
HIGH RISK BEHAVIOUR/SELF HARM/SUICIDE	1

6.1.2 Deaths for Calendar Year 1999

TABLE 3 DEATHS FOR CALENDAR YEAR 1999

CASE TYPE	NUMBER OF DEATHS
TOTAL NUMBER OF DEATHS	17
GENDER	
FEMALE	5
MALE	12
CAUSES OF DEATH	
ACQUIRED ILLNESS	2
ACCIDENTAL DEATH	2
DRUG RELATED	1
SUDDEN INFANT DEATH SYNDROME	2
SUICIDE/SELF HARM/HIGH RISK BEHAVIOUR	1
NON-ACCIDENTAL TRAUMA	1
CAUSE NOT KNOWN	8
1999 DEATHS REVIEWED BY VCDRC	
(CASE PRACTICE REVIEW)	9
1999 DEATHS PENDING VCDRC REVIEW	
(CASE PRACTICE REVIEW)	8

The Committee found that in the main reports presented for review were of a high quality and addressed the practice issues in an uncompromising manner.

SECTION 7

Themes and Issues

Over the past year the Committee continued a practice, which commenced during 1998, of informing the Minister of concerns noted during review. Members believe that utilising such a system ensures that a more proactive and timely response can occur from senior management to the field. This view, we believe, is supported by the release of the Protection and Care Practice Bulletin in June 1999 (See Part 5.2).

The Committee considered eleven cases from which seven key themes were distilled. Like other years, a number are familiar. However, unlike other years, not all are reason for concern. The Committee was pleased to note improved understanding and response from the field in cases where death was categorised as Sudden Infant Death Syndrome (SIDS). Clearly, initiatives are making an impact.

The key themes are:

- Sudden Infant Death Syndrome
- Protective intervention and response
- Client placement issues
- Continuity of case/support worker
- Engagement with the education system
- Mothers: victims and perpetrators of abuse
- Inexperienced workers.

7.1 Sudden Infant Death Syndrome

It is pleasing to report that Child Death Case Practice Reviews considered by the VCDRC this year have shown that protective workers now have an improved recognition and understanding of risk factors associated with SIDS.

The presence of SIDS factors within the Child Protection population pose particular issues and challenges. The Committee understands all too well that while the reason for SIDS still remains a mystery, deaths among the infant population will occur. However, education has seen the number of deaths fall dramatically. The Committee's *1997 Annual Report* contained the following comment:

The Committee considers that unless a greater understanding is achieved about issues relating to the incidence of SIDS in families likely to be involved with the Child Protection system, then the incidence of SIDS among this already vulnerable group will continue to be of concern.

The VCDRC, along with the Department of Human Services and the Sudden Infant Death Research Foundation (SIDRF), have been keen advocates for better fieldwork training on this particular topic. It is therefore most pleasing to be able to report that, since mid-1998, the Child Protection and Juvenile Justice Branch (previously Protection and Care Branch), through the Child Protection Training and Development Unit, and in conjunction with SIDRF, have provided sixteen central and regional training sessions targeting Specialist Infant Protective Workers (SIPW), team leaders, managers and case workers.

In two of the three cases considered, review material clearly demonstrated that workers involved had an awareness of the published risk factors and articulated these to the parents.

Correspondence to the Minister acknowledged the Committee's recognition of this good work.

7.2 Protective Intervention and Response

Section 87(a), (b) and (c) of the *Children and Young Persons Act 1989* states:

...the Court as far as practicable—

- (a) must have regard to the need to give the widest possible protection and assistance to the family as the fundamental group unit of society and, accordingly, must ensure that intervention into family life should be to a minimum extent that is necessary to secure the protection of the child; and*
- (b) must have regard to the need to strengthen and preserve the relationship between the child and the child's family; and*
- (c) must have regard to the desirability of allowing the child to live at home...*

While the VCDRC has no particular argument with the philosophy inherent in the Act, Child Death Case Practice Reviews seen this year again reflect that in many instances, protective intervention unfortunately comes too late in the client's life.

The VCDRC has commented on this in previous years, and indeed Professor Whelan in his report *Adolescents in the Care of Protective Services* (contained in the *Annual Report of Inquiries into Child Deaths: Protection and Care 1997*) stated:

It is unrealistic to expect that, given the grossly dysfunctional backgrounds of these young people, a brief period of time (compared to the years of chaos prior to the coming in contact with Protective Services) in care would turn around the damage done.

Unlike the comments from Professor Whelan, the concerns raised by cases seen in 1999 were not that contact with protective services came 'too late', but rather that early notifications appeared to be lost opportunities.

In three cases, members agreed that the closure of an earlier notification appeared in hindsight to be clearly inappropriate. The basis for this view is that the escalation of identified behaviour problems and family issues finally led to formal Departmental intervention.

7.3 Client Placement Issues

7.3.1 Postnatal Care

Reviews relating to the deaths of young infants has highlighted the need for appropriate residential/support options for young mothers whose lifestyle has the demonstrated potential to put the life and safety of their baby at risk.

In two cases nursing mothers were discharged from a hospital to clearly inappropriate home environments.

CaseA4/99 - Deaths in 1999 Calendar Year

A mother and baby were released from hospital to share a one bedroom flat with five other adults including a known sex offender.

Case A5/99 - Deaths in 1999 Calendar Year

A mother and young infant went back into a relationship characterised by violence and drug abuse. This resulted in the infant being placed by the mother, but with the protective worker's approval, in an ad hoc arrangement with a neighbour. No police check on these carers was undertaken.

Both cases highlighted the need for not only appropriate safe placement and support options, but also for the broader health network (in this case hospitals) to assess the home environment, so far as may be possible, when treating and preparing to discharge at risk mothers and infants.

The Committee has acknowledged this has been a problem in the past and is optimistic that the SIDS/Health Sector Analysis Project (see Part 8.1) will go part of the way in identifying possible solutions.

7.3.2 Adolescents

Much has been written about placement options for this particular group of clients.

Child Death Case Practice Reviews and Analysis Reports overseen by the Committee this year again highlighted serious deficits in the availability of appropriate accommodation for high risk young people.

It would seem, from evidence contained in these documents, that what is available is clearly unable to contain, support and work with those young people at the most difficult end of the care spectrum.

The Committee accepts that those most difficult and at risk should not be subject to the lock-up facilities of the past, but believe that their needs should be met in such a way that offers them safety and nurturing in a setting that is both emotionally and physical secure.

7.4 Continuity of Case/Support Worker

The quality of the relationship between worker and client is paramount in the delivery of adolescent services. Progress will only occur if the young person believes they will benefit from the interaction and feel safe and supported in the relationship. (Analysis of Adolescent Child Protection Client Deaths 1994 - 1998 contained in the Annual Report of Inquiries into Child Deaths: Protection and Care 1999, page 73).

Reports considered by the Committee during 1999 again highlighted that this important aspect of protective work is often undermined by staff changes within work units and funding shifts to community support agencies.

The Committee believes that the timing is right for this particular aspect to receive more serious consideration. Accordingly, during 2000 the VCDRC will give careful consideration to a number of possible options and provide the Minister with comment and advice.

7.5 Engagement with the Education System

CaseAA - Annual Report of Inquiries into Child Deaths: Protection and Care 1997

Peter was sent to boarding school at an early age, but was asked to leave after incidents involving theft and property damage. After leaving, Peter's schooling was intermittent at best and generally he did not attend. Peter's grandmother tried a number of strategies to re-enroll Peter in school. When these failed she attempted to seek alternatives for keeping Peter occupied.

Both the 1998 and 1999 Annual Reports of this Committee highlighted a number of crucial concerns confronting the most marginalised of society; namely high risk adolescents involved with this State's protective and juvenile correction systems.

Case A2 - Annual Report of Inquiries into Child Deaths: Protection and Care 1997

On his first Probation Order the HPO stated that Steve was attending school and he was motivated and popular. His offences had been minor and mainly related to family issues. By the time of his second Probation Order the HPO stated Steve had become unmotivated, argumentative and aggressive.

Last year's report commented at length on the establishment of the Central Advisory Group as part of the School Focused Youth Service (SFYS). The aim of this group was to address many of the concerns noted by the VCDRC in earlier reports.

The Committee felt that reports considered during 1999 were unlikely to indicate that such initiatives had made any significant changes to school exclusion and attendance. In effect they reaffirmed that these problems are still endemic among high risk young people within the education system. Exclusion only increases their marginalisation, limiting even further their chances for the future. School structures and discipline policies do not sit well with young people who:

- May have drug and alcohol problems
- For most of their lives have been rebelling against rules
- Live or have lived in unstructured and chaotic family environments for much of their life.

Case A8/1998 - Annual Report of Inquiries into Child Deaths: Protection and Care 1999

The Panel thought there were a number of issues about Robert's interaction with the education system. Robert had 16 primary school moves and at least three secondary schools, as the family and/or Robert were constantly moving. It was noted that there appeared to be no system to assist Robert in managing these changes. Given the history of his mobility it was not surprising that Robert was not able to effectively manage secondary school.

The Committee believe that unless some radical consideration is given to ways of including this group of young people in the education system quickly, then we, as a society, will have destined these already severely marginalised young people to face the future with little hope for either employment or fulfilling life opportunities.

7.6 Mothers: Victims and Perpetrators of Abuse

The importance of protective workers knowing and understanding a family's history cannot be overemphasised. The personal history of the parents clearly has relevance for their parenting style. Knowledge about previous episodes of child abuse involving the family can be obtained from the Client and Service Information System (CASIS), however, information relating to the parent/s experiences as a child is not so readily accessible. This can only be obtained via a complete social history taken during the assessment of risk.

International research has shown that mothers who were subjected to abuse are more likely to also abuse their own children. In eight cases considered by the VCDRC during the past two years the mother of the deceased had suffered abuse as a child and/or spousal abuse.

In one tragic case the deceased was, in fact, the fourth generation to have been subject to the care/control or intervention by the Department.

Parenting is a relationship between the parents and the child, and it is a relationship which responds to fluctuations brought about by emotional, physical, and financial pressures affecting the particular family unit. How the parent copes with these pressures depends, to a large degree, on their own experiences as a child. If these experiences are characterised by abuse, neglect and substance use, then, as research highlights, it is more likely that their children will suffer similarly.

Healthy families, in all senses of the word, are more likely to cope with these pressures.

Parenting programs aimed at breaking the tragic cycle are needed. All too often, the parent, as a victim, is only known after they have been viewed by society as a perpetrator.

Parenting programs should acknowledge the added level of guilt and disappointment these parents carry when their children's safety is questioned.

7.7 Inexperienced Workers

The Committee noted that in a number of cases considered during 1999 questions with regard to the relative experience of the protective workers were raised by those charged with the responsibility for conducting the review. Accordingly, the VCDRC has included this issue in this Report. However the Committee feels that such a view is hard to quantify and believes that such criticism has the opportunity to be addressed via the upcoming quality improvement initiative.

SECTION 8

VCDRC Work for 2000

8.1 SIDS/Health Sector Analysis Project

The interface between protective services and the wider health sector has been one that has caused concern for this Committee dating back to 1996.

Since it first met in May 1996, five cases have revealed that young mothers, whose lifestyle could clearly be viewed as high risk, have been discharged from hospital without due consideration to supports being in place for the crucial postnatal period.

Accordingly, the VCDRC wrote to the Department of Human Services requesting that an analysis be undertaken to consider the issues, with the aim of actively bringing about recognition and change.

The Terms of Reference for this project are:

- To examine whether case management decisions and actions of the Department of Human Services and other agencies were adequate and appropriate in providing a service to the client. (This should be considered in the context of the *Children and Young Persons Act 1989*, established practice knowledge and professional wisdom).

It was also the Committee's recommendation that this work should focus on the intersectoral relationship between maternity services and protective services as they relate to young mothers.

It is anticipated that this project will be completed in mid-2000. Details of the findings and action outcomes will be included in the 2001 Annual Report.

8.2 Education System Issues

The importance of education in determining life opportunities for young people is accepted as paramount. School connectedness, ensuring continuing educational opportunities for high risk young people, is critical in assisting in their support and development. Yet all too often the review reports tell of multiple school placements and exclusion.

Amid increasing concern about the negative effects of institutionalisation, residential facilities with educational facilities attached were phased out. Clearly many of these

children's homes were outdated in terms of aims, design and staffing models, and were not in line with the directions that the field was taking. Members of this Committee have, on reflection, commented that some of the most difficult at risk young people may have benefitted from a residential option that also had, as part of its program, educational facilities and options.

The VCDRC strongly believe that it is necessary to stop this seemingly endless cycle of school rejection and exclusion and accordingly will consider this issue as a priority during 2000.

8.3 Mobile Adolescent Support Workers

The quality of the relationship between worker and client is paramount in the delivery of adolescent services. Progress will only occur if the young person believes he or she will benefit from the interaction and feel safe and supported in the relationship.' (Analysis of Adolescent Child Protection Client Deaths 1994-1998 contained in the Annual Report of Inquiries into Child Deaths: Protection and Care 1999, page 73.)

The Committee's 1998 Annual Report contained the following quote from the 1993 British publication Beyond Blame, a study of thirty-five child death reports:

In approximately one-third of the cases, a centrally involved professional was unavailable for some reason at a critical phase of the case.

These comments reflect and support review findings about instances where a crisis was able to be demonstrably linked to a change of worker, or removal of a support service. This may have occurred due to staff movements, changes to funding arrangements, or the movement of the client between Departmental regions.

Whatever the reason, the change ultimately provided for a negative outcome for the young person involved.

Members believe that a new approach needs to be considered - one that ensures that young people feel safe to engage with workers and service providers responsible for their support and well-being. The VCDRC believes that support providers should develop a system response specifically designed to follow and provide consistent support for those high risk young people, considered, by virtue of their history, to be mobile and at great risk.

The VCDRC will continue to consider this issue over the coming year.

8.4 Innovations in Placements for High Risk Adolescents

Committee deliberations have again disclosed that quality placement options for those at the greatest risk to themselves and the community are at best hard to access and at worst scarce.

Many residential placement options appear unable to contain or hold the young person, and experience shows that when residential security is problematic, so too are education and emotional/physical supports. With such deficits in the life of these vulnerable young people it is easy to see why protective intervention is so often viewed as a failure.

It is the Committee's aim to revisit and consider a number of innovative residential options over the next twelve months and convey, in due course, its views on these to the Minister.

8.5 Policy on Medical Treatment for Department of Human Services (Protective Services) Clients

This policy has been a regular item in both the 1998 and 1999 Annual Reports. Over the last twelve months the subcommittee has continued to consider the existing guidelines, research international literature and rulings on the topic.

During 2000 these findings, along with a recommendation from the VCDRC, will be forwarded to the Department for comment and action.

SECTION 9

Conclusion

When this Committee first met in May 1996 the media, in particular, the daily newspapers were full of criticism with regard to deaths within the protective service system and the way in which the Department of Human Services was handling its responsibilities for investigating them.

Some four years on it is pleasing to report that public debate on the very same issue is less often characterised by emotive headlines. Rather, reporting is being made more often with an acute understanding of the complex issues that confront those workers responsible for protecting the children and young people of this State.

This change has been helped by the commitment of the Department to address earlier criticism through the establishment of this Committee, and by giving a public undertaking with regard to timelines for the completion of inquiries into the deaths of those involved with the Child Protection system.

The VCDRC still acts as an independent advisory Committee reviewing all deaths within the protective system, providing advice to the Minister on themes and issues noted during the review of these reports and documents. This Annual Report contains just this information.

However, the Committee strongly believe that to advance the debate further the relationship between the VCDRC and the Department had to change into one that while still retaining this overseer role, expanded into a proactive, yet independent, partnership. For this reason the changes detailed in Part 5.2 have been put in place.

In 1996 fifteen clients of protective services died. In 1999 the total was again fifteen.

Many interested parties, including those on this Committee, would like to see the number of deaths reduced to zero, but this is unfortunately unrealistic. Those who become involved with the protective service system are the most vulnerable in our society. The impact of poor education, leading to poor life opportunities, when combined with the growing use of drugs, ultimately increases the risks to this already disenfranchised group. Deaths will continue to occur. What we, in partnership with Government, can do, is to continue to raise the issues, advocate on behalf of the client as well as those responsible for their care, and aim to maintain a quality service geared to meet their needs.

APPENDIX 1

The Victorian Child Death Review Committee Membership

The membership of the Victorian Child Death Review Committee is:

Professor Glenn Bowes MBBS (Hons), PhD, FRACP (Chair)
Executive Director (Medical)
Women's and Children's Health Care Network

Ms Pam White BA (Hons)
Director
Eastern Metropolitan Region
Department of Human Services

Ms Jan Norton, BA
General Manager,
Public Health and Development
Department of Human Services

Superintendent Frank Byrne
Region 2 Crime
Geelong Police HQ

Professor Jan Carter, MPhil, MSc (Econ), BA, Dip Soc Stud
Director, Deakin Human Services Australia
Deakin University

Mr Greg Levine, LLB, Dip Crim
Senior Magistrate
Sunshine Magistrates Court

Ms Diana O'Neil, BA, Dip Soc Stud
Director, Quality Assurance and Training
St Luke's Anglicare

Ms Margaret Coady, BA, BEd, Dip Educ, M Ed
Senior Lecturer, Early Childhood Studies Unit
Faculty of Education
University of Melbourne

Dr Tony Weldon, MBBS, FRACP
Consultant Paediatrician
Clinical Director of Paediatrics
Peninsula Health Care Network

Mr Francis Zemljak, LLB, BA
Partner
McKean and Park

Mr Warren Kelly, BA
Committee Executive Officer

Membership Changes

One change to Committee membership occurred in 1999. Mr Brian Joyce served from 1996 to 1999.

Accordingly, appreciation is extended to Mr Joyce for his commitment and work during the formative years of the VCDRC and we wish him well for the future.

Structure and Background

The Victorian Child Death Review Committee met for the first time in May 1996 and released its initial Interim Report in November, 1996, with its initial Annual Report being tabled in Parliament in May 1997.

The Victorian Child Death Review Committee (VCDRC) views the protective services system client deaths within a broad context. Its aim is to provide a multi-disciplinary focus on child death reports and to identify ways in which preventative and early intervention practices could improve the health and welfare of children at risk. It also provides advice and comment on any practice issues and themes which may emerge from the child death inquiry process.

The Committee meets on a monthly basis and holds special planning days as required.

APPENDIX 2

Child Death Inquiry Panels

The Minister for Community Services (previously Youth and Community Services) directed that inquiries be made into the deaths of children and young people subject to statutory orders, notification or investigation by Victoria's Child Protection system.

In April 1998, the then Minister for Youth and Community Services endorsed a revised and enhanced three-tiered Child Death Inquiry model that became operational in October 1998. This model ensures that each death, irrespective of whether concerns with regard to procedural issues are evident, is now the subject of a Child Death Case Practice Review. The process ensures a standardised independent review takes place in all cases and is designed to define good practice and assist the Committee in meeting the Terms of Reference (particularly, number six: 'Evaluate service and system responses to children and families who are considered to be at high risk and offer recommendations for improvement of responses').

The deaths of all children and young persons involved with Child Protection services are also subject to investigation by the State Coroner in accordance with the *Coroner's Act*.

Procedures for the review of child deaths were opened to further independent scrutiny in 1995 through the establishment of the Victorian Child Death Review Committee (VCDRC), chaired by Professor Glenn Bowes, Executive Director(Medical), Women's and Children's Health Care Network.

Child Death Inquiry Panel: Terms of Reference

Terms of Reference for Inquiries were approved by the Minister in 1998, and incorporated in the revised and enhanced review process from October 1998.

Child Death Case Practice Review Tier

- To establish the facts of the Protective Services involvement.
- To ascertain whether Departmental procedures, standards, guidelines and protocols were followed in the management of the case.

Analysis Tier

- To examine whether case management decisions and actions of the Department of Human Services and other agencies were adequate and appropriate in

providing a service to the client. (This should be considered in the context of the *Children and Young Persons Act 1989*, established practice knowledge and professional wisdom.)

Overview Tier

- To provide advice to the Minister on any issues which require attention by the Department.

The Terms of Reference in no way limit the VCDRC's right, when considering a Case Practice Review or Analysis Report, to comment, modify or add to the terms of reference, given the specific circumstances of the client's death. The Committee can also refer the document back to the Director, Community Care Division, requesting that additional work be undertaken to address unresolved issues.

Child Death Inquiries: Staff Participation

The input, in the inquiry process, of regional staff and non-government service providers who have worked or been involved with the client and their family remains an essential element in ensuring the effective examination of issues that may have impacted on the case. Unlike judicial inquiries, a Child Death Inquiry has no legal mandate to subpoena documents or to compel staff and other key people to be involved in the Inquiry. It is pleasing to report that cooperation in the process remains high.

In recognition of the potential for a high level of anxiety to be experienced by staff involved in a case where a child or young person dies the Department ensures that these workers are provided with a preliminary briefing regarding the purposes of the inquiry. People meeting with the panel may also bring support staff with them to interviews. Debriefing for staff affected by the client's death, and subsequent inquiry procedure is arranged as required.

Child Death Inquiries: Confidentiality and the Child Death Inquiry Report

Confidentiality of the people involved with the case is maintained. To protect the identity of the client, family members, other persons and services, fictitious names are used in the production of any analysis report associated with the death of a client.

Inquiry reports and other documentation, provided to the Victorian Child Death Review Committee panel members to assist with the review are returned to the Child Death Inquiry Unit upon the completion of these deliberations.

APPENDIX 3

Cases Considered by the VCDRC in 1999

NAME	AGE AT DEATH	DATE OF DEATH	GENDER	CAUSE OF DEATH	REVIEW/ ANALYSIS
A8/98	16 YEARS, 8 MONTHS	18.6.98	MALE	DRUG RELATED	ANALYSIS
A10/98	15 YEARS, 6 MONTHS	2.10.98	FEMALE	ACQUIRED ILLNESS	ANALYSIS
A2/99	17 YEARS, 3 MONTHS	26.2.99	FEMALE	DRUG RELATED	REVIEW
A3/99	14 YEARS, 7 MONTHS	11.3.99	MALE	ACQUIRED ILLNESS	REVIEW
A4/99	3 MONTHS	4.4.99	MALE	SIDS	REVIEW*
A5/99	6 MONTHS	18.4.99	MALE	SIDS	REVIEW
A6/99	4 YEARS, 4 MONTHS	30.5.99	MALE	ACQUIRED ILLNESS	REVIEW
A7/99	14 YEARS, 5 MONTHS	30.5.99	MALE	SUICIDE/SELF-HARM	REVIEW**
A8/99	9 MONTHS	13.7.99	FEMALE	ACCIDENT	REVIEW
A9/99	2 YEARS, 7 MONTHS	15.7.99	MALE	NON-ACCIDENTAL TRAUMA	REVIEW**
A12/99	7 MONTHS	1.9.99	MALE	ACCIDENT	REVIEW**

* Case was referred for group analysis. See SIDS Health Sector Analysis Project.

** After considering the review documentation the VCDRC felt that a number of key issues required further consideration. Accordingly, the matter was referred back to the Department for analysis.

APPENDIX 4

Deaths in 1999 Calendar Year

NAME	AGE AT DEATH	DATE OF DEATH	GENDER	CAUSE OF DEATH	REVIEW/ ANALYSIS
A/1/99	1 year, 3 months	6.2.99	Male	##	Pending
A/2/99	17 YEARS, 7 MONTHS	26.2.99	FEMALE	DRUG RELATED	REVIEW
A/3/99	14 YEARS, 7 MONTHS	11.3.99	MALE	ACQUIRED ILLNESS	REVIEW
A/4/99	3 MONTHS	4.4.99	MALE	SIDS	REVIEW*
A/5/99	6 MONTHS	18.4.99	MALE	SIDS	REVIEW
A/6/99	4 YEARS, 4 MONTHS	30.5.99	MALE	ACQUIRED ILLNESS	REVIEW
A/7/99	14 YEARS, 5 MONTHS	30.5.99	MALE	SUICIDE/SELF- HARM/HIGH RISK	REVIEW**
A/8/99	9 MONTHS	13.7.99	FEMALE	ACCIDENT	REVIEW
A/9/99	2 YEARS, 7 MONTHS	15.7.99	MALE	NON-ACCIDENTAL TRAUMA	REVIEW**
A/10/99	2 MONTHS	3.8.99	MALE	##	PENDING
A/11/99	1 YEAR	17.8.99	MALE	##	PENDING
A/12/99	7 MONTHS	1.9.99	MALE	ACCIDENT	REVIEW**
A/13/99	2 WEEKS	1.10.99	MALE	##	PENDING
A/14/99	2 YEARS, 1 MONTH	10.10.99	FEMALE	##	PENDING
A/15/99	18 YEARS	18.19.99	FEMALE	##	PENDING
A/16/99	10 YEARS, 3 MONTHS	29.10.99	FEMALE	##	PENDING
A/17/99	7 YEARS, 5 MONTHS	7.12.99	MALE	##	PENDING

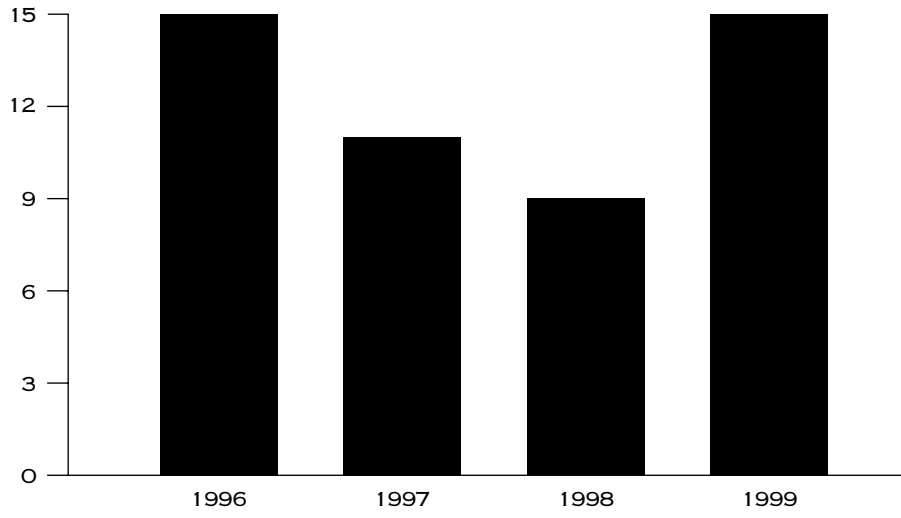
* Case was referred for group analysis. See SIDS Health Sector Analysis Project.

** After considering the review documentation the VCDRC felt that a number of key issues required further consideration. Accordingly, the matter was referred back to the Department for analysis.

Categorisation regarding cause of death pending VCDRC review of the case.

APPENDIX 5

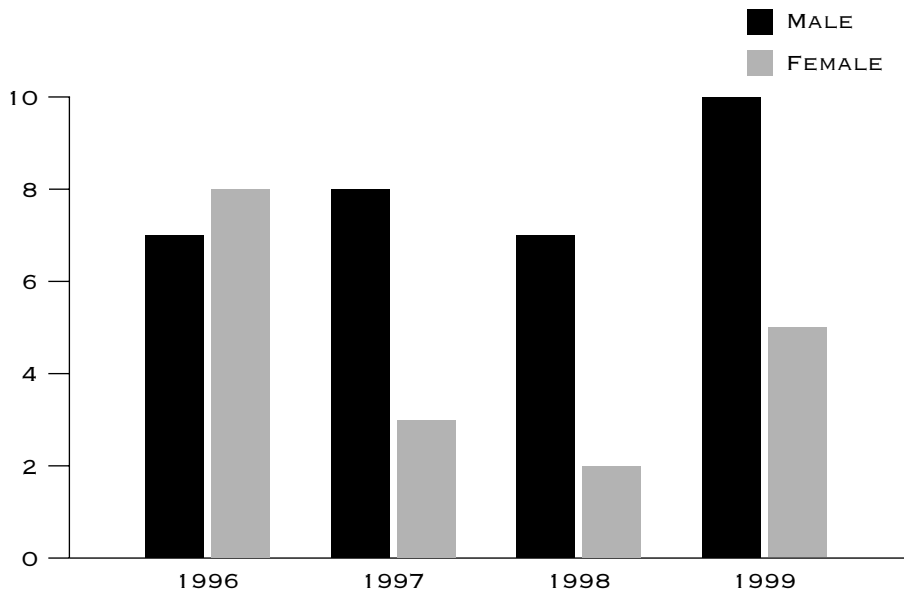
Deaths Per Calendar Year 1996-1999



Appendix 9 provides details of children and young people who have died as a result of an acquired illness.

APPENDIX 6

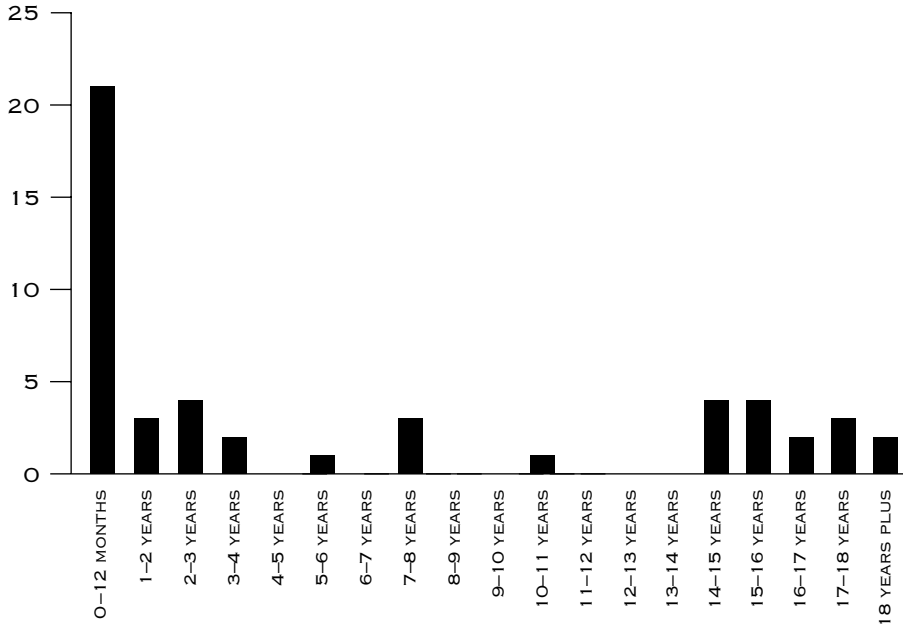
Deaths Per Calendar Year by Gender 1996-1999



Appendix 9 provides details of children and young people who have died as a result of an acquired illness.

APPENDIX 7

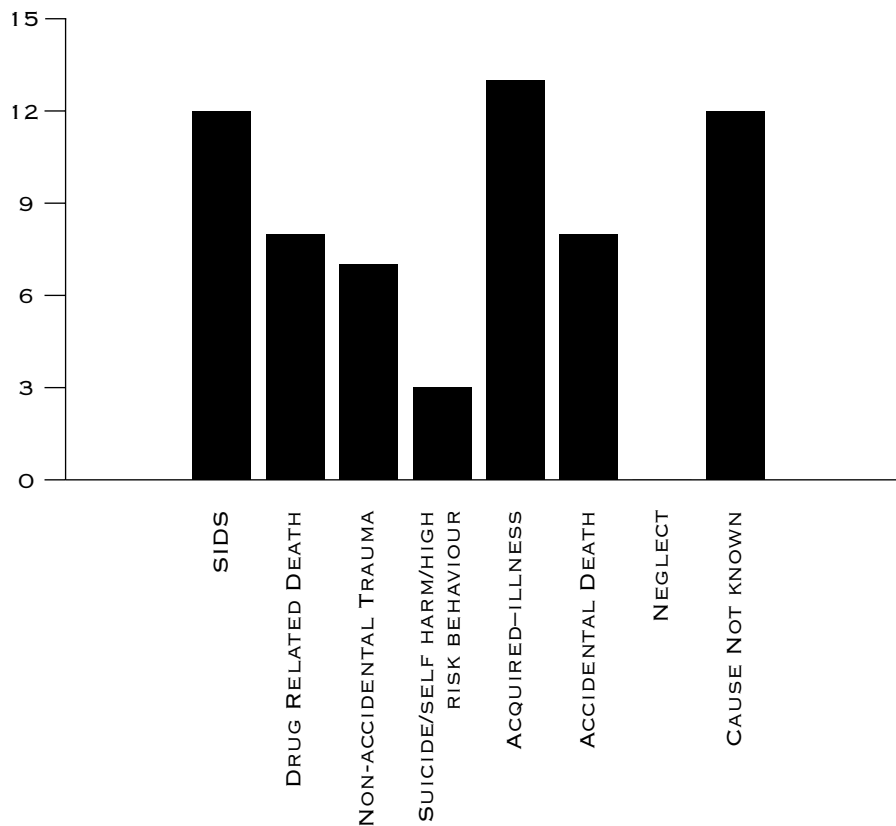
Deaths by Age 1996-1999



Appendix 9 provides details of children and young people who have died as a result of an acquired illness.

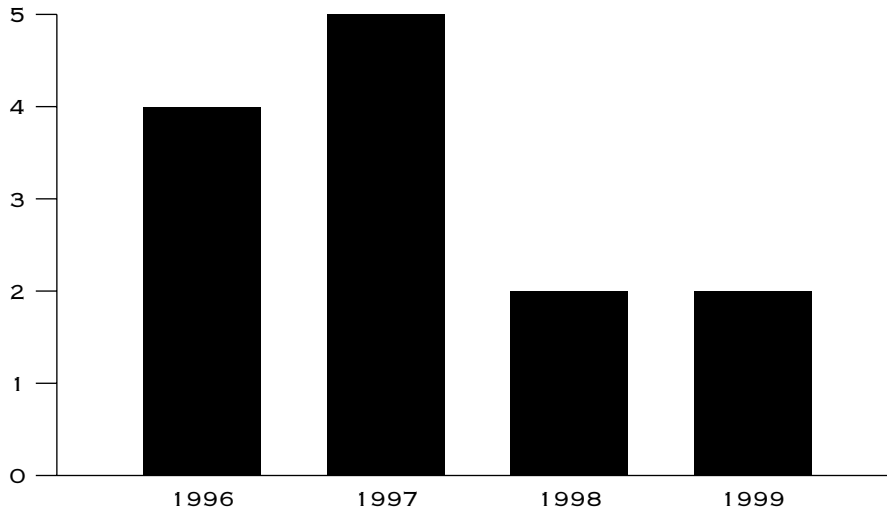
APPENDIX 8

Deaths by Category of Death 1996-1999



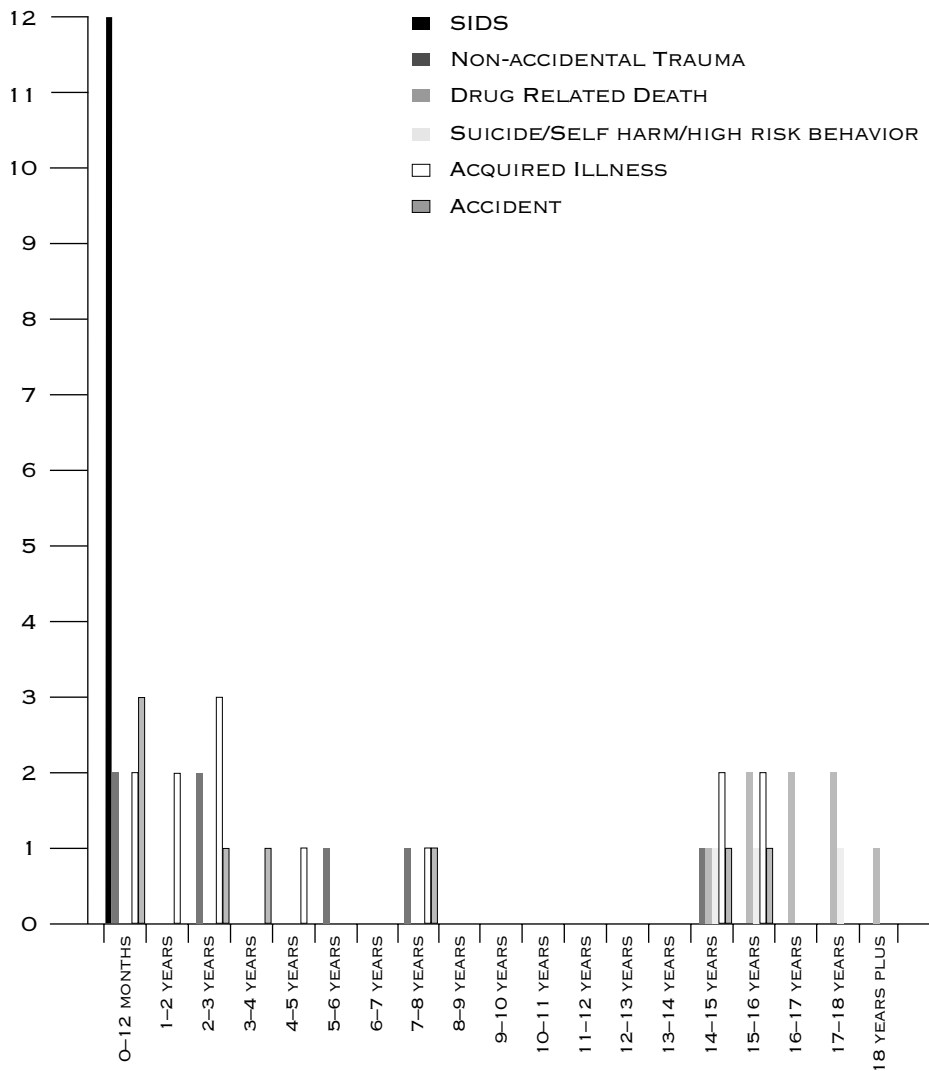
APPENDIX 9

Deaths of Children and Young People With an Acquired Illness 1996-1999



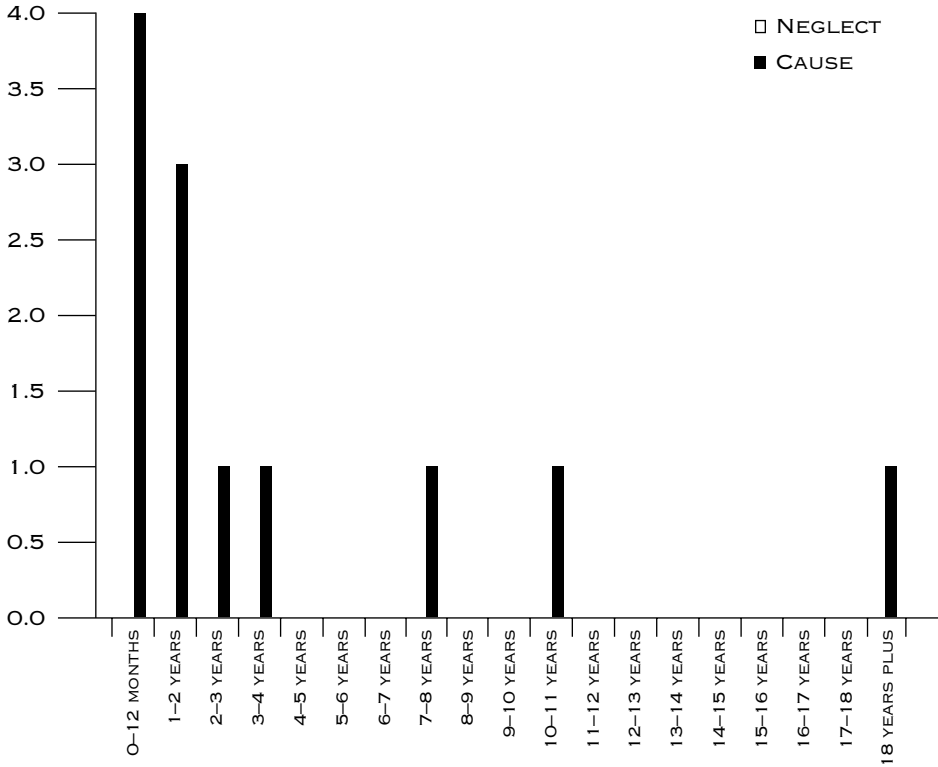
APPENDIX 10

Part A: Cause of Death by Age at Time of Death 1996-1999



APPENDIX 10

Part B: Cause of Death by Age at Time of Death 1996-1999



APPENDIX 11

Cause of Death by Gender 1996-1999

