



Annual Report
of Inquiries into
Child Deaths

Child Protection 2005

Victorian Child Death Review Committee



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Chairperson's foreword

This is the tenth Annual Report of the Victorian Child Death Review Committee (VCDRC), which reports on the deaths of children who are current or recent clients of the state's Child Protection service.

The VCDRC provides a multidisciplinary, external review of child death inquiries conducted by the Department of Human Services. The aim of this review is to analyse common themes and comment on service and system responses to vulnerable children and families as part of an ongoing, reflective learning process. The VCDRC does not express an opinion about the cause of death of a child subject to review nor does it determine culpability. Responsibility for these matters rests with the State Coroner and Victoria Police.

Because the VCDRC considers the deaths of all children known to Child Protection, it is well placed to identify emerging trends and patterns and make recommendations as required. Inevitably, a number of common themes emerge. Most of these have been acknowledged in previous annual reports of the VCDRC, many are the subject of wider debate among child protection experts and some represent the most persistent challenges facing services for vulnerable children and families the world over.

In this period, the committee found examples of excellent case practice as well as cases where risk assessment, case planning and interagency collaboration could have been improved. The committee also noted the ongoing challenge of providing culturally sensitive services to Aboriginal children and families. These issues are explored in some detail in this year's report.

As in previous years, most of the child deaths within the current reporting period are due to acquired illness and disease or accidents.

The death of each child is tragic and distressing for all involved. On behalf of the VCDRC, I extend my sympathy to the families and friends of all these children and to the professionals who provided support and assistance.

I take this opportunity to acknowledge the enormous contribution of Dr Judith Gibbs who retired as Chair of the VCDRC in June 2004 after a three year term. Dr Gibbs brought an extraordinary insight and knowledge of child protection practice to the committee and worked tirelessly to ensure that the committee's deliberations remained relevant, accessible and meaningful to practitioners involved in direct service delivery. Her contribution is appreciated by all committee members.

I would like to thank my colleagues on the VCDRC for their knowledge and expertise and the professional respect they bring to the multidisciplinary review process.

I hope that the information in this report will make a constructive contribution to Victorian services for vulnerable children and families.

A handwritten signature in black ink, appearing to read 'Lisa Ward', with a long horizontal stroke extending to the left.

Lisa Ward
Chairperson
Victorian Child Death Review Committee
May 2005

Acknowledgements

Many people have assisted, both directly and indirectly, with the preparation of this report.

Professionals who are involved with a child who dies participate voluntarily in the inquiry process that follows. This can be a painful and difficult process. The willingness of individuals and agencies to take part in a reflective learning exercise following the death of child is highly commendable.

Individuals both internal and external to the Department of Human Services are appointed to lead the sensitive and complex child death inquiry process. Their professionalism and skill is gratefully acknowledged.

The staff of the Child Death Inquiry Unit in the Department of Human Services oversee the conduct of child death inquiries and provide the Victorian Child Death Review Committee (VCDRC) with essential data and support services. Kay Warn, former Executive Officer to the VCDRC, has continued to play a vital role in the preparation of this report and her efforts are much appreciated.

Tatiana Zachariak has managed the Department of Human Services Child Death Inquiry Unit since its inception in the mid 1990s. The transfer of the Unit to the new Office of the Commissioner for Child Safety heralds a change in this arrangement. Ms Zachariak's contribution to the child death inquiry and review process over many years is gratefully acknowledged.

The Department of Human Services Victoria funds the printing and distribution costs of this publication.

Finally, the VCDRC is supported by a part time Executive Officer, Loula Dounias, who has been instrumental in the production of this report. Her commitment and dedication to the committee are much appreciated.

Contents

Chairperson's foreword	iii
Acknowledgements	v
Executive summary	ix
1. Introduction	1
2. Child death inquiry processes and the Victorian Child Death Review Committee	3
2.1 Overview of entities involved when a child dies in Victoria	3
2.2 Department of Human Services child death inquiry process	5
2.3 Victorian Child Death Review Committee	9
3. Child deaths occurring in 2004	13
4. Child death inquiries reviewed in 2004–05	27
4.1 Child and family characteristics	27
4.2 Themes and issues	32
5. Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy—Report summary	43
5.1 Purpose of the group analysis	43
5.2 Overview of the group analysis	43
5.3 Themes and issues	45
5.4 Conclusion	49
5.5 Recommendations of the group analysis	50
5.6 VCDRC response to the group analysis	52
6. The year in review, the year ahead	55
6.1 The year in review	55
6.2 The year ahead	58
Glossary and abbreviations	61
References	65

Executive summary

The Victorian Child Death Review Committee (VCDRC), an independent, multidisciplinary ministerial advisory body, has prepared the *Annual Report of Inquiries into Child Deaths: Child Protection 2005*. This annual report is tabled in Parliament as part of a continuing commitment to a transparent and accountable response to deaths within the Child Protection population.

The annual report serves two related, but distinct functions. Firstly, it provides quantitative and demographic data regarding the deaths of children known to Child Protection that occurred in 2004. Secondly, it provides qualitative analysis of child death inquiries reviewed by the VCDRC in the reporting period between April 2004 and March 2005.

This year, the annual report also presents the findings of the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy* (November, 2004).

1. Overview of deaths of children known to Child Protection in 2004

A total of 16 children who were known to Child Protection died in 2004, five for reasons unknown or yet to be determined, four from acquired illness, three from accidents, two from SIDS and two from drug/substance related activities. Three of these 16 children had little or no involvement with Child Protection prior to their deaths.

In 2004, almost one third of child deaths involved infants under six months old, consistent with previous patterns in the age distribution of child deaths.

There were no deaths of Aboriginal children known to Child Protection in 2004.

2. Overview of child death inquiries reviewed in 2004–05

The VCDRC reviewed 18 child deaths between April 2004 and March 2005. These deaths occurred over a three-year period: nine were from 2002, six were from 2003 and three were from 2004.

Five of these deaths involved children who had an Aboriginal family background.

Of the 18 cases reviewed, six died from acquired illness or disease, five died for reasons unknown or yet to be determined, three from accidents, two from SIDS, one from drug/substance related activities and one from non-accidental trauma.

The majority of children came from single parent families with the biological mother as the sole carer. A high number of parents had complex, multiple needs, including substance abuse, mental illness and/or intellectual disability. Family violence and transience were common.

3. Themes and issues

Based on a rigorous qualitative analysis of child death inquiries reviewed in 2004–05, the VCDRC has identified a number of key themes, including risk assessment, case planning, integrated service provision and culturally sensitive practice with Aboriginal families. In this period, the committee found examples of excellent case practice as well as cases where the quality of assessment, case planning and interagency collaboration could have been improved.

Many of the themes and issues raised in this annual report have been the subject of systematic, extensive reform undertaken by the Department of Human Services, in consultation with its community partners, in the past year.

Risk assessment

Inadequate risk assessment was a feature in most of the child death inquiries reviewed by the VCDRC. Concerns about risk assessment have been repeatedly expressed in all of the recent VCDRC annual reports.

Features of inadequate risk assessment identified in this period include: lack of thorough risk assessment, over-reliance on other service providers to assess protective risk, not taking into account previous reports, failing to assess longer term needs, underestimating the degree of risk and failing to reassess the child's safety given new information.

In more than half of the child death inquiries reviewed in this period, the VCDRC noted that an episodic approach to risk assessment was taken in which each notification was considered in isolation from previous ones, failing to recognise the cumulative nature of significant risk factors.

The VCDRC was concerned to note that many children were not assessed as 'high risk infants' or 'high risk adolescents', despite the coexistence of significant risk factors.

Case planning

Case planning issues were identified in the majority of cases reviewed. These issues included inadequate participation of family members and relevant professionals in planning, poor documentation of decisions and case plan outcomes and inadequate monitoring and review of the case plan.

The VCDRC noted that insufficient information gathering and analysis in the early stages of protective intervention can undermine subsequent planning efforts.

Integrated service provision and shared responsibility

In this reporting period, the VCDRC was encouraged to note examples of good inter-agency collaboration, including proactive information sharing, timely case conferencing and shared decision making.

However, difficulties with coordination and collaboration between service providers were noted in a large number of cases reviewed. These difficulties included a lack of consultation and communication between agencies, lack of case conferencing, inadequate definition of a lead or coordinating agent, poor documentation of task responsibilities and lack of understanding of roles and responsibilities, especially at case closure.

Difficulties with coordination and collaboration between service providers were noted in all five cases that involved Aboriginal children. While some of these reflect the broader challenges in achieving collaborative practice identified above, others relate specifically to the interface between Child Protection and Aboriginal support services in rural Victoria.

Comprehensive protocols and partnership arrangements have been established in recognition of the importance of collaboration between Aboriginal and non-Aboriginal services. In recent times, these have been supplemented with targeted relationship building activities aimed at establishing a shared practice framework between services with a stake in the safety and wellbeing of Aboriginal children.

Culturally sensitive practice

In all of the five deaths reviewed involving Aboriginal children, the VCDRC found that case practice could have been more culturally sensitive. In two of the five cases there was a failure to recognise the child's Aboriginality, one of which had a significant impact on the child's identity and psychological wellbeing.

Other cases involved multiple Child Protection involvements, complex family relationships, patterns of trauma, loss and unresolved grief spanning several generations that impacted heavily on the quality of parenting available. These factors were not consistently acknowledged in the risk assessment process. It is vital that the historical and social context of Aboriginal communities is factored into all aspects of protective intervention.

The VCDRC welcomes a number of recent initiatives that recognise the importance of these themes, including the Aboriginal Child Specialist Advice and Support Service (ACSASS) and the Department of Human Services *Indigenous Recruitment and Career Development Strategy, 2002–2005*, that forms part of the whole of government's Wur-cum-burra Indigenous employment strategy.

Timeliness of child death inquiries

Throughout 2004–05, the VCDRC has expressed its concern regarding the lack of timeliness in the child death inquiry process. Delays in finalising reviews undermine the relevance and credibility of the child death review process and place unnecessary stress on all parties involved. The committee looks forward to a more expeditious inquiry process in the year ahead.

Exemplary case practice

From time to time, the VCDRC reviews cases where, even though the ultimate outcome was the tragic death of a child, the involvement of all services involved was exemplary.

In this reporting period, the committee highlights one such case as testament to the capacity of the system to respond in a comprehensive, coordinated and timely manner to support a family with multiple, complex needs. The case demonstrated comprehensive information gathering and risk assessment, good collaboration between key professionals, timely use of case conferences and appropriate use of specialist infant and parenting services.

A final word

The VCDRC operates with the benefit of hindsight that is not available to practitioners. However, without reflection and retrospection the opportunity for improvement is lost. The committee hopes that its reflections on cases reviewed in 2004–05 make a constructive contribution to services for vulnerable children and families.

4. Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy

In this reporting period, the VCDRC considered a group analysis examining children with complex medical needs and a prognosis of limited life expectancy. The report made 15 recommendations aimed at improving practice and service provision to this extremely vulnerable group of children.

The VCDRC welcomed the high level of analysis reflected in this report and distilled several key themes considered critical in protecting children with complex medical needs and/or a limited life expectancy. These included:

- the need to assess the capacity of parents to perform complex and repetitive medical procedures in the home environment
- the value of a comprehensive assessment that balances specialist medical advice with an assessment of overall parenting capacity
- the need to ensure siblings are given adequate focus and attention in assessment and case planning
- the need for effective communication and collaboration between child protection, disability services and medical services
- the importance of long term case planning, despite a prognosis of limited life expectancy, that addresses quality of life issues alongside immediate risk
- the need to provide coordinated and intensive family supports early, to enable children to remain in the care of their parents, and offer planned, long term care alternatives where this is not possible.

The report underscores the fact that improved responses to children with complex medical needs and/or a prognosis of limited life expectancy are contingent upon a range of human services; responsibility does not lie exclusively with Child Protection. While the VCDRC is aware of many initiatives that have been undertaken in recent times to improve the interface between the child protection, disability and health service systems, this vital work must continue.

The VCDRC identified a number of key priorities for action arising from the group analysis. These include the development of an enhancement to the Victorian Risk Framework that addresses specific issues for this group of children, and development of some best practice principles that tackle long term planning and quality of life issues.

5. The year in review and the year ahead

In the past year, the Department of Human Services has initiated an ambitious legislative and policy reform agenda aimed at promoting a shared responsibility for children's health safety and repositioning Child Protection within a well resourced and supported family and children's services system. The VCDRC applauds these developments. Committee members have actively participated in the reform process to date and look forward to further involvement in the year ahead.

Significant structural changes have occurred, including the appointment of a Minister for Children, the establishment of an Office for Children within the department, and the creation of Victoria's first Child Safety Commissioner. The new Child Safety Commissioner will oversee the Child Death Inquiry Unit and support the VCDRC in the year ahead.

The VCDRC will continue to monitor system reforms that address threshold issues arising from the child death review process. In the coming year, the committee will take particular note of initiatives impacting on risk assessment as well as Departmental responses to the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy*.

The VCDRC will continue to build on its relationship with the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) to enable better understanding of how deaths within the Child Protection population compare with deaths in the wider population of Victorian children.

Finally, in the coming year the VCDRC will work collaboratively with the new Office for Children to identify formal, periodic opportunities to communicate its findings and influence policy, procedure and practice in Child Protection and related services.

1. Introduction

This report has been prepared by the Victorian Child Death Review Committee (VCDRC), an independent, multidisciplinary ministerial advisory body. It is tabled in Parliament as part of a continuing commitment to a transparent and accountable response to deaths within the Child Protection population.

The annual report serves two related, but distinct functions.

First, it provides quantitative and demographic data regarding the deaths of children known to Child Protection that occurred in 2004.

Second, it provides qualitative analysis of child death inquiries reviewed by the VCDRC between April 2004 and March 2005. Most of these inquiries relate to deaths that actually occurred in 2002 and 2003. The aim of this analysis is to identify common themes, issues and opportunities for learning that will influence future policy, procedures and practice within Child Protection and related service systems.

From time to time, the Minister for Children, the Executive Director, Office for Children or the VCDRC asks the Child Death Inquiry Unit to undertake a group analysis into a cluster of child deaths that share specific characteristics to enable more thorough exploration of the issues arising. This annual report presents the findings of the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy* (November 2004) and discusses its implications for service delivery to this small group of Child Protection clients.

The 2005 annual report is structured as follows:

Section 2 provides an overview of processes that apply when a child dies in Victoria and explains the Department of Human Services child death inquiry process and the composition, role and function of the VCDRC.

Section 3 provides quantitative and demographic data regarding the deaths of children known to Child Protection that occurred in 2004. These deaths are placed in a historical context, using additional data relating to the deaths of children known to Child Protection between 1996–2004. Information regarding age, gender, Aboriginal status, category of death and protective status is provided.

Section 4 provides a qualitative analysis of child death inquiries reviewed by the VCDRC in this reporting period. The discussion includes a description of both child and family characteristics and an analysis of practice and policy themes arising.

Section 5 presents the findings of the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy* and identifies areas for action.

Section 6 discusses other work of the VCDRC in the reporting period and describes the committee's focus and priorities in the coming year.

2. Child death inquiry processes and the Victorian Child Death Review Committee

2.1 Overview of entities involved when a child dies in Victoria

A number of official bodies are involved when a child dies in Victoria. Each plays a distinct and specialised role.

Registrar of Births and Deaths

When a child dies, a medical practitioner must certify the cause of death. A funeral director is then engaged to make necessary arrangements. Both the medical practitioner and funeral director are required to inform the Registrar of Births, Deaths and Marriages of the death. The information they provide on standard forms enables the Registrar to officially register the death.

Coroner

If the medical practitioner who examines the child is unable to determine the cause of death or the death is otherwise a 'reportable' death under the *Coroners Act 1985*, the death must be referred to the State Coroner. Reportable deaths include those that are unexpected, unnatural or violent and those that occur while the individual is in state care.

The Coroner investigating a death is required to find, where possible, the identity of the deceased person, how the death occurred, the cause of death and the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1996*. The Coroner's office is assisted in its investigative function by Victoria Police.

Victorian Institute of Forensic Medicine

When investigating a death, the Coroner will often request an autopsy or other medical review to assist in determining the cause of death. The Victorian Institute of Forensic Medicine (VIFM) provides specialist medical and scientific services to the Coroner, Police and government agencies. The VIFM has specially trained paediatric forensic pathologists who may perform autopsies in respect of children.

Department of Human Services

Whenever a child death is under investigation by the Coroner, the Department of Human Services is notified to determine whether the child was known to Child Protection services. Similarly, when Child Protection services are notified of the death of a client, contact is made with the Coroner's office to ensure that all parties are aware of Child Protection's involvement with the child.

When a current or recent client of Child Protection dies, this individual is entered on the Department of Human Services Child Death Register and an inquiry is commenced in accordance with the processes described in section 2.2 below.

Victorian Child Death Review Committee

The Victorian Child Death Review Committee (VCDRC) is a multidisciplinary ministerial advisory committee that reviews child death inquiries prepared by the department's Child Death Inquiry Unit. The VCDRC examines the deaths of all children and young people who are clients of Child Protection at the time of, or within three months of, their death. The VCDRC provides expert advice to the Minister for Children and Minister for Community Services on policy, procedural and practice issues arising from these inquiries. Further details of the VCDRC's operation are provided in section 2.3 below.

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) is a statutory body established under the *Health Act 1958*. It has a public health surveillance, reporting and research role in relation to all child deaths that occur in Victoria. When a child dies, the medical practitioner who certifies the death prepares a report to the CCOPMM that includes a range of demographic and descriptive data. These inform the CCOPMM's comprehensive annual report on perinatal, infant and child deaths in Victoria.

Recent legislative changes have extended the remit of the CCOPMM from children aged 0–14 years to children aged 0–17 years.

Identifying multiple sibling deaths

In the past year, new arrangements have been introduced to enable authorities to identify and investigate the deaths of multiple children in the one family. When a child death is notified to the Registrar of Births Deaths and Marriages, the Registrar is now required to conduct a search for any previous child deaths within the family and notify the State Coroner accordingly. The Registrar is also required to advise the Coroner of any living siblings. A new category of reviewable death has been created under the *Coroner's Act 1985* providing the Coroner with clear jurisdiction to investigate any case involving a second or subsequent child death within the one family.

2.2 Department of Human Services child death inquiry process

Establishing a child death inquiry

All children who are clients of Child Protection at the time of, or three months prior to, their death are recorded on the Child Death Register held in the department's Child Death Inquiry Unit.

Regional documentation regarding the death, including incident reports, ministerial briefings and a comprehensive Department of Human Services regional report undertaken approximately 10 days after the death, are provided to the Child Death Inquiry Unit. The receipt of these documents marks the beginning of the child death inquiry process.

An external professional is usually appointed to conduct the inquiry. Senior departmental officers may also be appointed to undertake inquiries, provided they work in a region or program branch independent from that in which the death occurred. Executive officers within the Child Death Inquiry Unit provide research, analysis and administrative support to the inquiry process.

At the completion of the child death inquiry, these documents are provided to the VCDRC for consideration.

Conducting a child death inquiry

Individual child death inquiries are designed to establish the facts of the Child Protection case; ascertain whether established departmental procedures, standards, guidelines and protocols were followed in the management of a case; and examine whether the case management decisions and actions of the department and other agencies were adequate and appropriate in providing a service to the client.

The child death inquiry process is embedded in a reflective practice approach, where all participants have an opportunity to think about 'why' and 'how' decisions were taken and the context in which practice took place. The entire case history is revisited. The inquiries do not set out to investigate the factors leading to a child's death or to determine culpability; this role is properly the role of police and the Coroner. The aim of the process is to distil key learning that will influence future policy and practice approaches.

Individual child death inquiries are conducted and reported in a standardised format. Risk assessment, case planning, record management, service collaboration and regional contextual issues are examined in each case. This ensures that every death is subject to consistent and rigorous review.

The confidentiality of client, family members and other persons and services involved with the case is maintained, consistent with departmental privacy and confidentiality principles and relevant government legislation.

The child death inquiry process relies on the voluntary participation of relevant workers within the department and community agencies, as well as families and carers of the deceased child. Revisiting the death of a child or young person is an emotional experience for all those involved. The Child Death Inquiry Unit briefs participants on the inquiry process and ensures that debriefing and support services are made available to participants as required.

Child death inquiry reports

Child death inquiry reports include findings arising from the investigation process and/or recommendations for further action. The draft report is forwarded to the region where the death occurred and to relevant Department of Human Services program branches for comment. Recommendations arising from the inquiry process take into account any regional action taken in response to the death and statewide program development relevant to the issues in the case.

The final inquiry report is forwarded to the VCDRC along with coronial documentation, where this is available. The VCDRC reviews each child death inquiry and advises the Minister for Children of its deliberations in each case. The VCDRC provides a multidisciplinary focus on inquiry findings and identifies emerging themes and patterns across all child deaths that may require a systemic response.

The final child death inquiry report and VCDRC comments are forwarded to the region where the death occurred and relevant department program branches, which in turn provide the Child Death Inquiry Unit with a work plan to address recommendations arising. The Child Death Inquiry Unit monitors implementation of these work plans over time.

Paper reviews

In some cases, a child is first notified to Child Protection at the time of their death or in the context of the event that leads to their death, meaning that Child Protection has little, if any, involvement in the child's life.

In these cases, the Child Death Inquiry Unit has traditionally forwarded any key regional documentation regarding the child to the VCDRC for review, rather than initiate the full inquiry process described above. These have been referred to as paper reviews.

The VCDRC has not found this to be a particularly satisfactory or productive exercise, as there is rarely sufficient information available to enable the committee to make meaningful comment. In essence, if Child Protection has not been involved and has no history with the child, there is little within the VCDRC's terms of reference to review. From January 2005, the VCDRC will no longer consider the deaths of children who are notified at the time of the incident that led to their death, if they have no previous involvement with Child Protection. However, such deaths will continue to be included on the department's Child Death Register and in the reporting of total child deaths each year.

Group analysis of child deaths

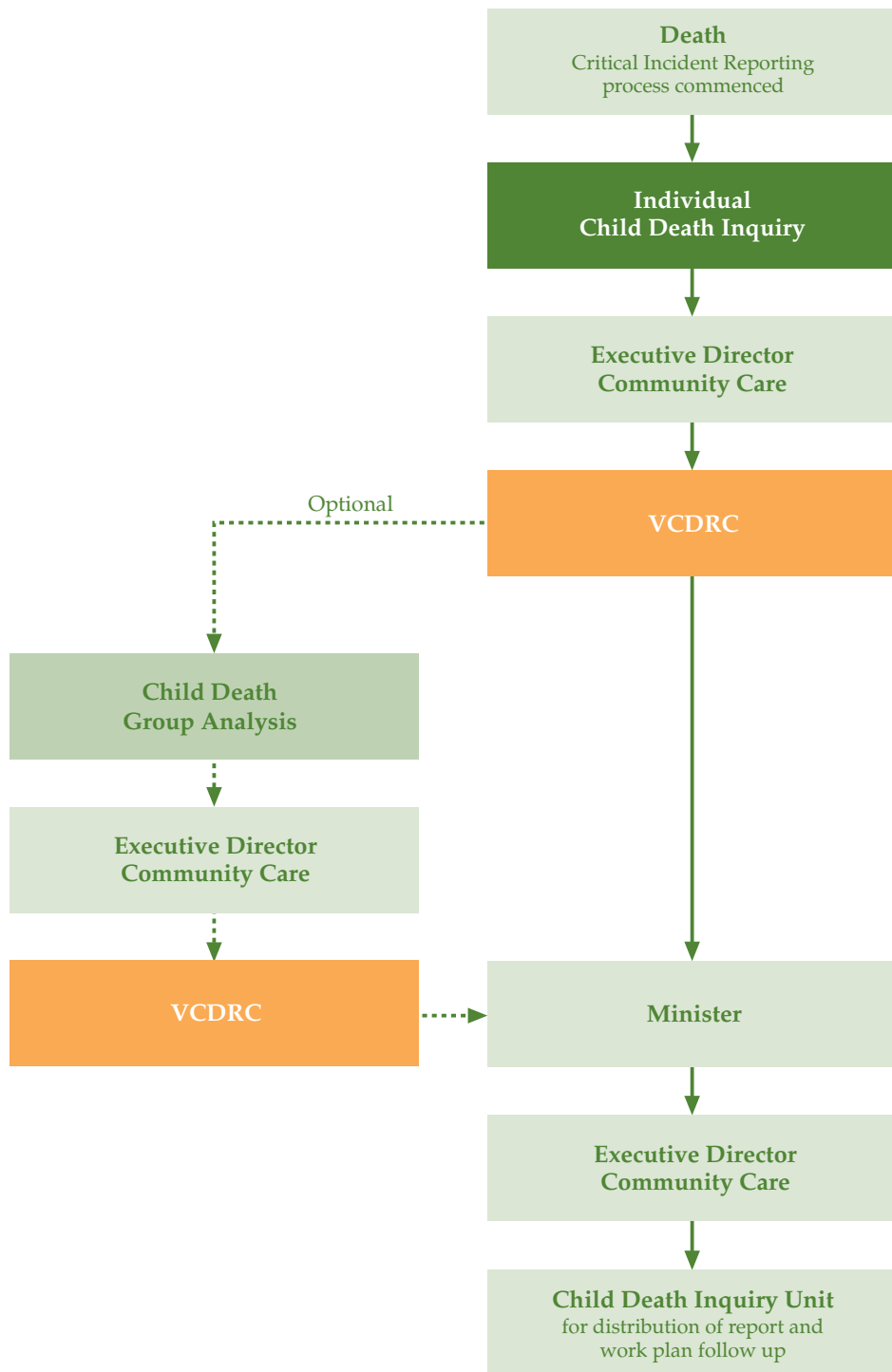
The Minister for Children, the Executive Director Office for Children or the VCDRC may, at its discretion, ask the Child Death Inquiry Unit to initiate an analysis of a group of child deaths that share similar characteristics. The decision to conduct a group analysis is made by the Executive Director, Office for Children.

The group analysis process allows for more comprehensive examination of the issues arising from a particular group of deaths, within the context of current research and practice knowledge. It provides for the identification of best practice principles, as well as current gaps or deficits in service provision.

Group analyses are usually conducted by a review panel of up to three participants, including one or two eminent professionals external to the department and one senior departmental officer.

This year, the VCDRC considered the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy* (November 2004). A summary of findings and actions arising is included in Section 5 of this annual report.

Figure 2.1: Department of Human Services child death inquiry model for the 2004–05 reporting period*



* The Department of Human Services child death inquiry model will be modified in the next reporting period to reflect the new organisational arrangements described in Section 6.

2.3 Victorian Child Death Review Committee

The VCDRC provides a multidisciplinary, external review of child death inquiries prepared by the Department of Human Services. The committee provides expert advice to the Minister for Children and Minister for Community Services on policy, procedural and practice issues arising from these inquiries.

Significantly, the VCDRC is the only point in the process that provides detailed analysis of the deaths of all children known to Child Protection. As such, the committee is in a unique position to identify emerging trends and patterns across all deaths and recommend action as required.

The VCDRC's membership is drawn from the health, welfare, police, legal and academic fields, mirroring the many professional groups involved in Victoria's Child Protection system. As such, the committee is well placed to consider the relationships between different systems that impact on vulnerable children and families and model forms of collaborative practice that are known to be essential with high risk families.

Terms of reference of the VCDRC

In 2004, the VCDRC's terms of reference were revised to clarify key functions and accommodate the changes to paper reviews discussed in Section 1.2. The current VCDRC terms of reference are to:

1. Review departmental inquiry reports of children and young people who died while current⁽¹⁾ or recent⁽²⁾ clients of the Child Protection Service in Victoria and advise the Minister for Children and Minister for Community Services of the committee's deliberations.
2. Identify particular groups of child deaths that may benefit from further investigation or research.
3. Analyse and comment on any themes, trends or patterns, which emerge from the review of inquiry reports.
4. 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. Provide advice to the Minister for Children and Minister for Community Services on the child death inquiry process.
6. Prepare an annual report for the Minister for Children and Minister for Community Services.
7. Perform other functions in relation to child deaths as directed by the Minister for Children and Minister for Community Services.

⁽¹⁾ The current or recent client definition does not include children and young people who are notified at the time of the incident that led to their death, if they have not previously been involved with the Child Protection Service in Victoria.

⁽²⁾ Recent means deaths that have occurred within three months of case closure.

Current VCDRC membership

Ms Lisa Ward

Chair

Human Services Consultant

Member of the Ministerial Advisory

Committee on Women's Correctional
Services

Ms Marg Stewart

Community Elder and Chairperson of
the Board of Directors, Victorian
Aboriginal Child Care Agency

Mr Laurie Harkin

Regional Director

Department of Human Services
Southern Metropolitan Region

Dr John McNamara

Consultant Paediatric Physician
(Retired)

Royal Children's Hospital

Member of the Medical Practitioner
Board of Victoria

Ms Robyn Miller

Human Services Consultant

Senior Clinician Bouverie

(Study Leave)

PHD Candidate (Robin Clark

Memorial Scholarship)

Ms Margaret Wagstaff

Human Services Consultant

Member of the Adult, Community and
Further Education Board and

Director of the Bendigo Health Group
Board

Ms Paresa Antoniadis Spanos

Magistrate

Melbourne Magistrates' Court
Victoria

Ms Luisa Bazzani

Barrister at Law

Clerk Holmes

Owen Dixon Chambers
Victoria

Detective Inspector Rod Jouning

Sunshine Police Complex

Victoria Police

Mr Paul McDonald

Director

Drugs Policy and Services

Department of Human Services

Retired members

Dr Judith Gibbs

Chair

Lecturer

School of Social Work and Social Policy La Trobe University

Mr Paul Grant

Deputy Chief Magistrate

Melbourne Magistrates' Court

Mr Francis Zemljak

Accredited Specialist in Family Law and Sessional Member, Victorian Civil and Administrative Tribunal

Dr Sharon Goldfeld

Senior Child Health Policy Advisor

Public Health Group

Department of Human Services

Membership changes

Since the last annual report, Dr Judith Gibbs has retired as Chair of the VCDRC, having completed her tenure on the committee. Dr Gibbs made an outstanding contribution to the child death review process and to services for vulnerable children and families more generally. Her participation has been highly valued.

This year Mr Paul Grant, Mr Francis Zemljak and Dr Sharon Goldfeld also completed their term of appointment on the VCDRC. The committee would like to acknowledge the significant work carried out by all three members and express its appreciation for their dedication and professionalism.

The VCDRC has been pleased to enlist the support of three new members: Ms Paresa Spanos, Magistrate; Ms Luisa Bazzani, Barrister at Law; and Mr Paul McDonald, Director, Drug Policy and Services, Department of Human Services. The new members bring significant relevant knowledge and skill from their respective professions and backgrounds.

Executive support

In the past year, the committee welcomed Ms Loula Dounias to the role of Executive Officer. Members would like to thank the previous incumbent, Ms Kay Warn, for her significant contribution to the VCDRC's administration.

3. Child deaths occurring in 2004

Overview of deaths of children known to Child Protection in 2004

The number of deaths of children and young people known to Child Protection can vary considerably year by year. For instance, in 2001 there were 12 deaths, in 2002 there were 32 deaths and in 2003 there were 12 deaths. The VCDRC has been monitoring child deaths in the Child Protection population for nine years and has not observed any meaningful trends in the number of deaths that occur each year.

Annual variation in the number of deaths underscores the importance of looking beyond numbers, to client and family characteristics and practice issues, as a means of informing future responses to vulnerable children and families.

In 2004, 16 children died who were known to Child Protection. Thirteen of these deaths are the subject of current child death inquiries. Three of the children who died in 2004 had little or no involvement with Child Protection prior to their deaths. These cases are subject to a paper review in accordance with the process described in Section 2.2.

The child death data presented in sections 3 and 4 of this report has been provided by the Department of Human Services.

Table 3.1 Deaths of children known to Child Protection in 2004 (N=16)

Age at death	Region	Type of Inquiry
<i>Involvement with Child Protection</i>		
10 years	Rural	Child death inquiry
12 years	Metropolitan	Child death inquiry
5 months	Metropolitan	Child death inquiry
17 years	Rural	Child death inquiry
16 years	Metropolitan	Child death inquiry
1 year	Rural	Child death inquiry
13 years	Rural	Child death inquiry
2 months	Rural	Child death inquiry
1 month	Rural	Child death inquiry
1 month	Rural	Child death inquiry
13 years	Metropolitan	Child death inquiry
3 years	Rural	Child death inquiry
1 year	Metropolitan	Child death inquiry
Sub total: 13 deaths		
<i>Little or no involvement</i>		
3 months	Metropolitan	Child death paper review
3 years	Metropolitan	Child death paper review
11 months	Rural	Child death paper review
Sub total: 3 deaths		

Estimates by the Department of Infrastructure indicate that the population of children (0–17 years) in Victoria in 2004 is 1,118,268. In 2004, the number of notifications to the Victorian Child Protection service was 37,873. Therefore, approximately 34 notifications are received per 1,000 of the 0–17 year-old population in Victoria.

The total death rate of children notified to Child Protection in 2004 was 0.42 deaths per 1,000 notifications. Australian Bureau of Statistics most current data on children's deaths reveals that 501 Victorian children (0–17 years) died in 2003. The death rate of all children in Victoria in 2003 was 0.44 per 1,000 of the population (0–17 years).

Table 3.2 shows the number of notifications, investigations, substantiations and total number of deaths known to Child Protection from 1996–2004. This period is used as the first VCDRC Annual Report was tabled in Parliament in 1996.

Table 3.2 Notifications, investigations, substantiations and deaths known to Child Protection by calendar year 1996–2004

Year	Notifications	Investigations	Substantiations	Total deaths	Little/no involvement**	Death rate***
1996	30,483	13,964	6,844	19	1	0.62
1997	32,309	14,666	7,268	16	1	0.49
1998	34,330	14,483	7,424	11	1	0.32
1999	35,902	13,125	6,128	17	3	0.47
2000	36,249	12,797	7,328	25	3	0.68
2001	38,153	13,192	7,743	12	–	0.31
2002	37,926	13,245	7,825	32	5	0.84
2003	37,562	12,481	7,216	12	3	0.31
2004	37,873	12,424	7,474*	16	3	0.42

* The number of substantiations is not yet finalised for 2004. Number is correct as at January 2005

** This column shows the numbers of deaths where there had been little or no involvement with Child Protection prior to the death. It is a sub-set of the total number of deaths.

*** Rate of deaths per 1,000 notifications received.

Age and gender of children who died in 2004

Of the children who died in 2004, almost two thirds (63 per cent) were infants between 0–3 years of age. In 2004, there were equal numbers of male and female deaths.

Table 3.3 Age and gender of children who died in 2004 (N=16)

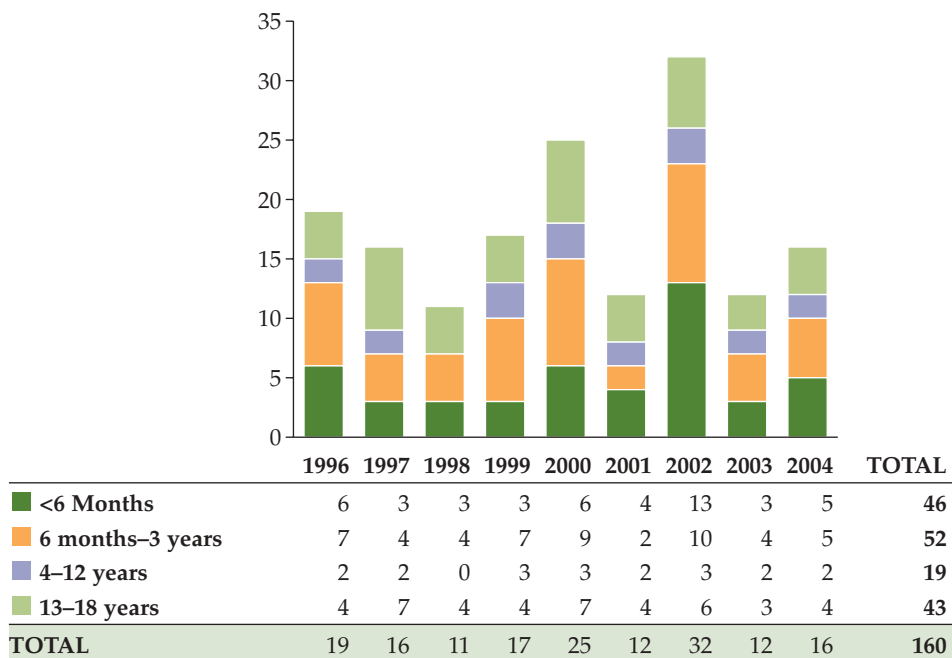
	0–<6 months	6 months–3 years	4–12 years	13–18 years	Total
Female	3	2	1	2	8
Male	2	3	1	2	8
Total	5	5	2	4	16

Age of children who died 1996–2004

Over time, the greatest number of deaths is of children aged between 6 months and 3 years (52), infants younger than six months make up the next group (46); closely followed young people aged between 13 and up to 18 years (43). Primary school age children make up the lowest number of deaths (19).

Infants aged 0–3 years are the most represented age cluster comprising 61 per cent of all deaths within the Child Protection population over time.

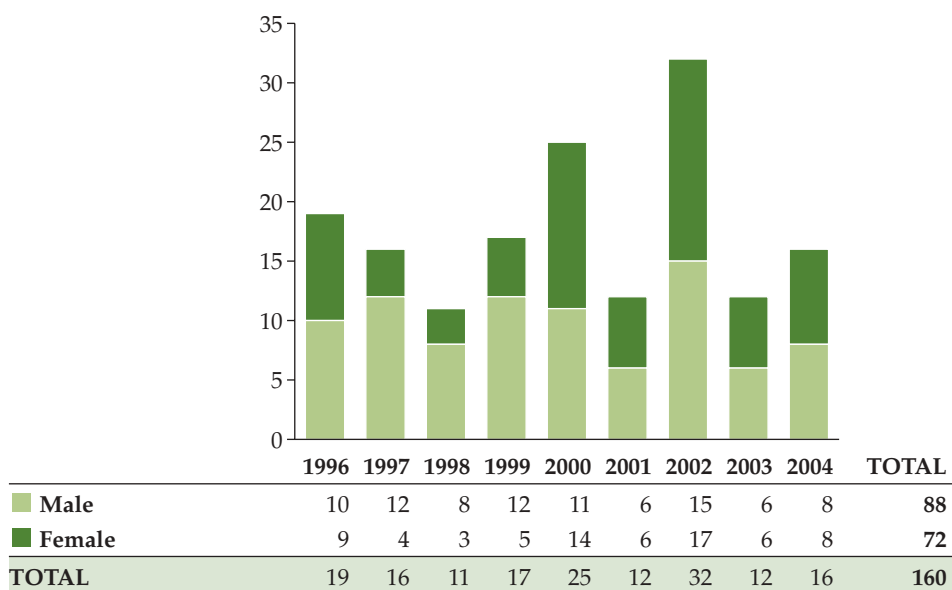
Figure 3.1 Age of children who died 1996–2004 (N=160)



Gender of children who died 1996–2004

Over time, the proportion of male deaths is 55 per cent compared with female deaths at 45 per cent.

Figure 3.2 Gender of children who died 1996–2004 (N=160)



Category of death 2004

The Child Death Inquiry Unit categorises the cause of death on the basis of information from Child Protection client files, medical reports, autopsy reports, forensic reports and coronial findings.

However, in cases where the death occurs after case closure or where the Department of Human Services is not the legal guardian, the department will not have access to full medical records. The death may not be reported to the Coroner if the child or young person has not been a client of Child Protection at the time of death. Category of death is, therefore, more conclusive after a coronial investigation, which is pending for a number of the 2004 deaths. For these reasons, figures may alter across annual reports. In particular, the category of 'not known' is likely to reduce over time as coronial investigations are concluded.

Table 3.4 provides information on the category of death for children who died and were known to Child Protection in 2004. Of the 16 deaths of children known to Child Protection, five were identified as category of death 'not known'.

Of the three deaths categorised as 'accidental' two involved road accidents and one a fall.

Two deaths are categorised as due to 'SIDS' (Sudden Infant Death Syndrome), as stated in coronial reports.

There were four deaths in 2004 that were attributed to an acquired illness. This category includes deaths due to congenital conditions, prematurity, malignancy, acute infections and serious health episodes, such as epilepsy or cardiac arrest.

The two 'drug/substance related' deaths were attributed to methadone toxicity and combined drug interactions.

Table 3.4 Age by category of death in 2004 (N=16)

Category	6 months–				Total
	0–<6 months	3 years	4–12 years	13–18 years	
Accidental death	–	–	1	2	3
Acquired disease/illness	2	1	1	–	4
Drug/substance related	–	–	–	2	2
Non-accidental trauma	–	–	–	–	0
Not known	1	4	–	–	5
SIDS	2	–	–	–	2
Suicide/self harm/risk taking	–	–	–	–	0
Total	5	5	2	4	16

Category of death 1996–2004

Between 1996–2004, the largest category of death among children known to Child Protection was acquired illness, involving 49 children or 30 per cent of total deaths.

During the same period the second largest category was accidental deaths involving 32 children. Fifteen of these deaths involved road accidents. Other accidental deaths included five cases of drowning and three deaths involving fire. The remaining nine deaths were due to a range of other causes.

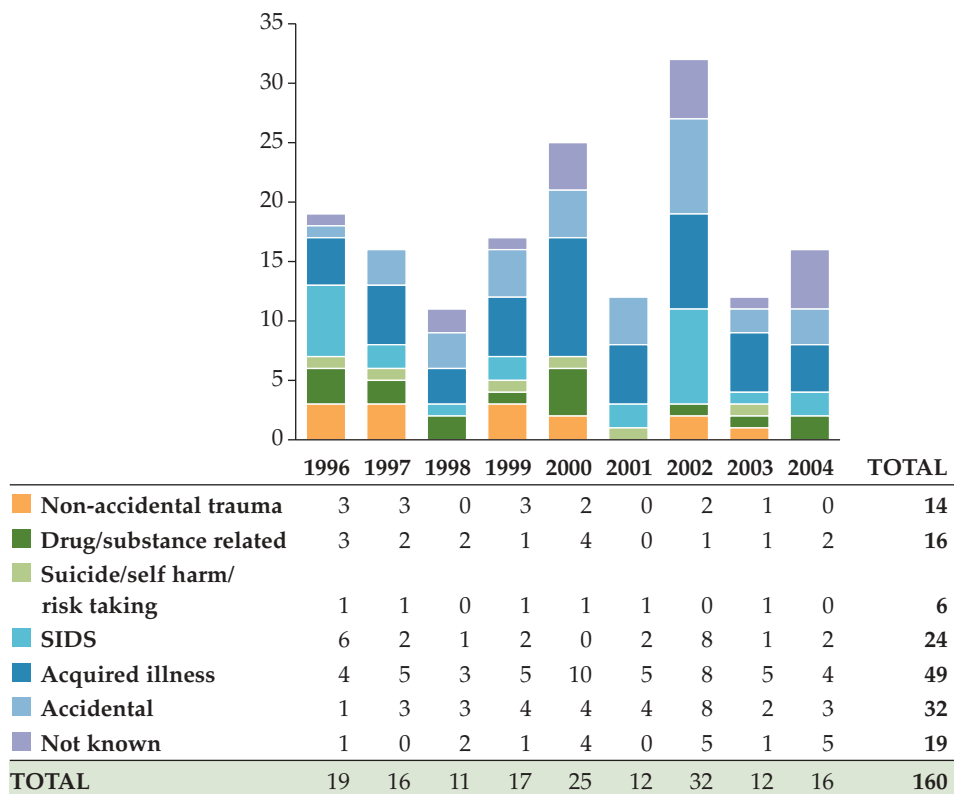
Between 1996–2004 there have been 24 deaths attributable to SIDS. SIDS is a diagnosis of exclusion, applied when no other cause of death can be confirmed.

Between 1996–2004, 19 deaths are categorised as cause of death ‘not known’. This includes deaths pending coronial findings and cases where the coronial findings indicate the cause of death has not been able to be ascertained.

From 1996 to 2004, 14 deaths are categorised as ‘non-accidental trauma’. This categorisation includes deaths due to physical abuse, homicide and cases where a child or young person is missing assumed murdered. The most common non-accidental injury for infants is head injury. Four of the 14 cases of non accidental trauma had minimal involvement with Child Protection.

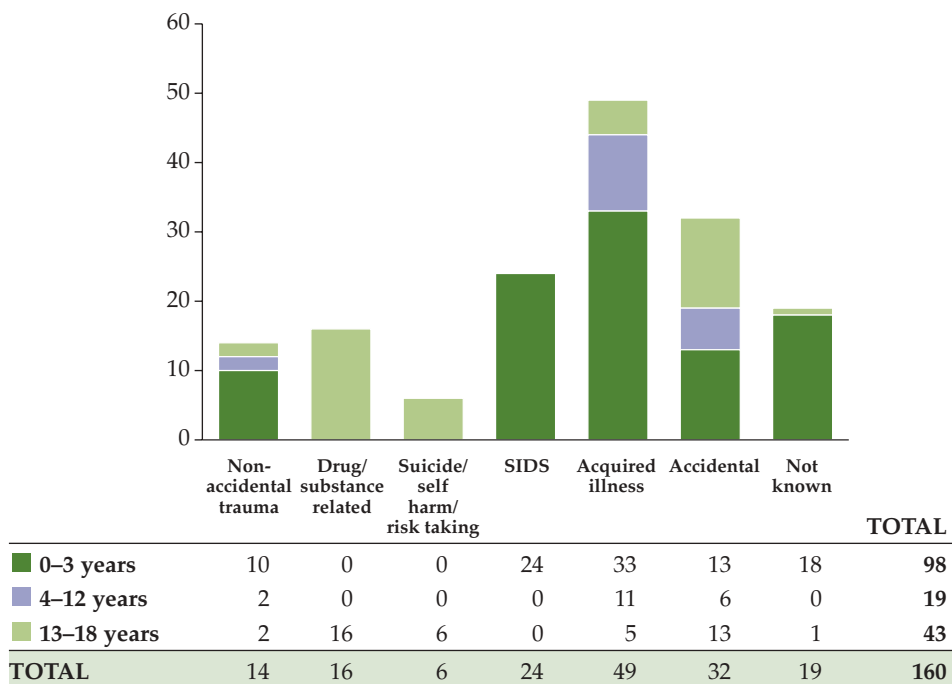
From 1996–2004 the deaths of 16 young people were attributed to substance use. A further six adolescent deaths are categorised as ‘suicide/self harm/risk taking’.

Figure 3.3 Category of death 1996–2004 (N=160)



The VCDRC has found it instructive to analyse category of death by age over time. The following discussion focuses on an analysis of three main age groupings: infants; primary school age children and adolescents.

Figure 3.4 Category of death by age 1996–2004 (N=160)



Infants (0–3 years)

From 1996–2004 there were 98 deaths in the 0–3 age group, comprising 61 per cent of total deaths. Of these, 46 were younger than six months. Deaths of infants younger than six months make up almost 29 per cent of the total deaths (160).

The most common category of death in the 0–3 age group is acquired illness, comprising 33 deaths.

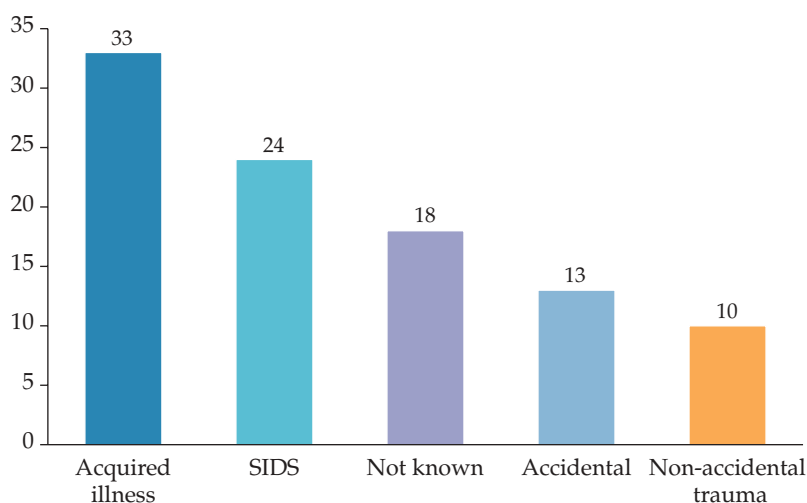
The second largest category of death among infants is SIDS. Between 1996–2004, 24 infants died from SIDS.

Between 1996–2004, 18 infant deaths have been categorised as of unknown cause. Of these, six have been categorised as cause of death ‘unascertained’ by coronial investigation. The other cases have coronial findings pending. Significantly, of the total 19 deaths across all age groups categorised as ‘not known’, 18 were infants aged three years and under. Caution is exercised when categorising infant deaths to ensure accuracy, especially in relation to SIDS deaths.

Over the nine year reporting period, 13 of the 98 deaths among infants aged 0–3 years were categorised as accidental. The majority of these involved drowning, road accidents, or fire.

Between 1996–2004, ten infants aged 0–3 years died as a result of non-accidental trauma. The most common cause of death for these infants is head injury. Significantly, of the total 14 deaths across all age groups categorised as non-accidental trauma, 10 were infants aged 0–3 years.

Figure 3.5 Infant deaths by category of death 1996–2004 (N=98)



Primary school age children (4–12 years)

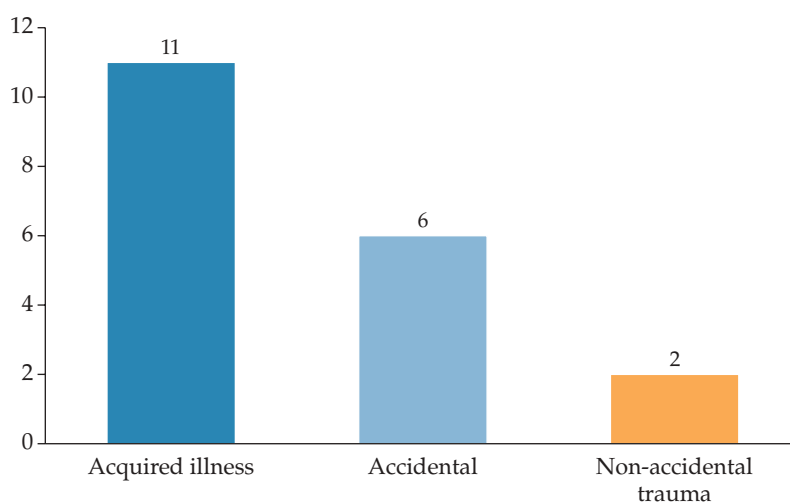
From 1996–2004 there were 19 deaths among 4–12 year olds comprising 12 per cent of total deaths in the period.

Of these 19 deaths, eleven were due to acquired illness, including children who died as a result of a disability, malignancy or acute infection.

Six deaths were categorised as 'accidental' in this age group, with road accidents the most common cause.

The remaining two deaths in this age group were due to non-accidental trauma.

Figure 3.6 Primary school age deaths by category of death 1996–2004 (N=19)



Adolescents (13–18 years)

From 1996–2004 there were 43 deaths among young people aged 13–18 years, representing 27 per cent of the total deaths known to Child Protection in this period.

The most common category of death among adolescents is ‘drug/substance related’, comprising 16 deaths in the nine year period. This category includes cases where death was related to the use of intravenous drugs, inhalants and/or methadone toxicity.

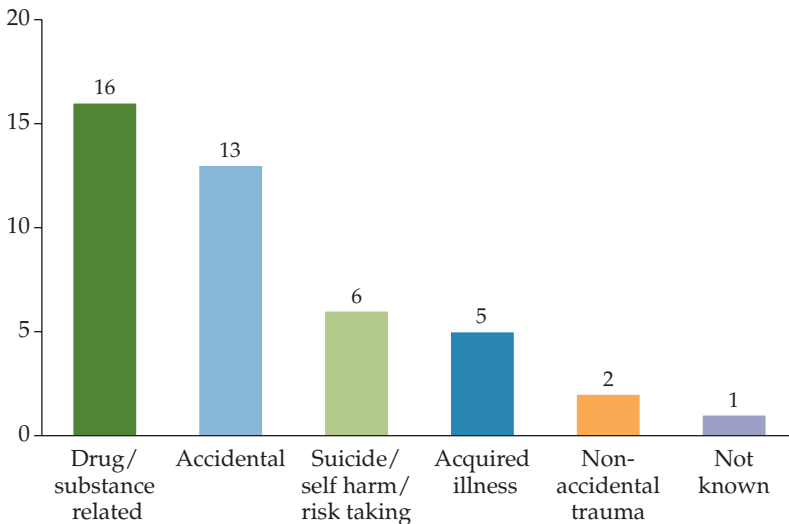
The second largest category of death among adolescents known to Child Protection is ‘accidental death’. Between 1996–2004, most of the 13 accidental deaths among adolescents involved vehicles, including cars, trains and motorcycles.

The category of ‘suicide/self harm/risk taking’ only includes deaths where previous suicidal behaviour or suicidal intent has been indicated. Six adolescents deaths have been categorised as ‘suicide/self harm/risk taking’ over the nine year reporting period.

Between 1996–2004, five adolescents died of an ‘acquired illness’. All of these young people had disabilities and/or long-term serious illnesses.

Between 1996–2004, two adolescents deaths were categorised as ‘non-accidental trauma’. This category includes cases where a child or young person is missing presumed dead.

Figure 3.7 Adolescent deaths by category of death 1996–2004 (N=43)

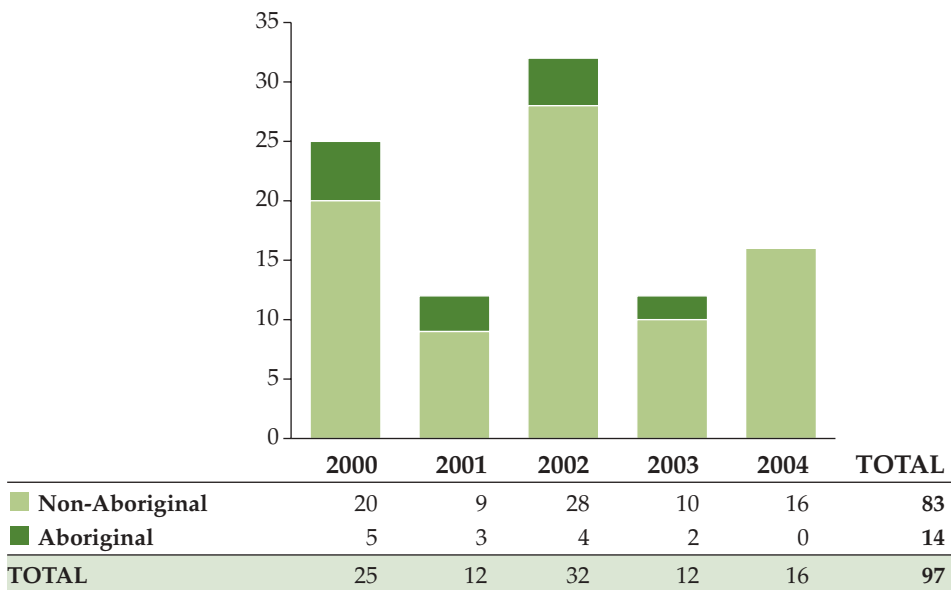


Aboriginal status 2000–2004

Aboriginal children are significantly overrepresented within the Child Protection population. The VCDRC believes it is important to monitor and report on deaths of Aboriginal children known to Child Protection. Consequently, this annual report features a new data set on Aboriginal children that will be continued in future reports. Because the collection of child death information regarding Aboriginal status was inconsistent prior to 2000, data is reported from 2000 onwards.

Between 2000 and 2004 there were 97 deaths in total, 14 of which involved Aboriginal children. There were no Aboriginal child deaths in 2004.

Figure 3.8 Aboriginal and non-Aboriginal child deaths 2000–2004



Protective status at the time of death

The various phases of protective intervention are described in the Glossary and are consistent with the protective phases shown in the client information system, CASIS.

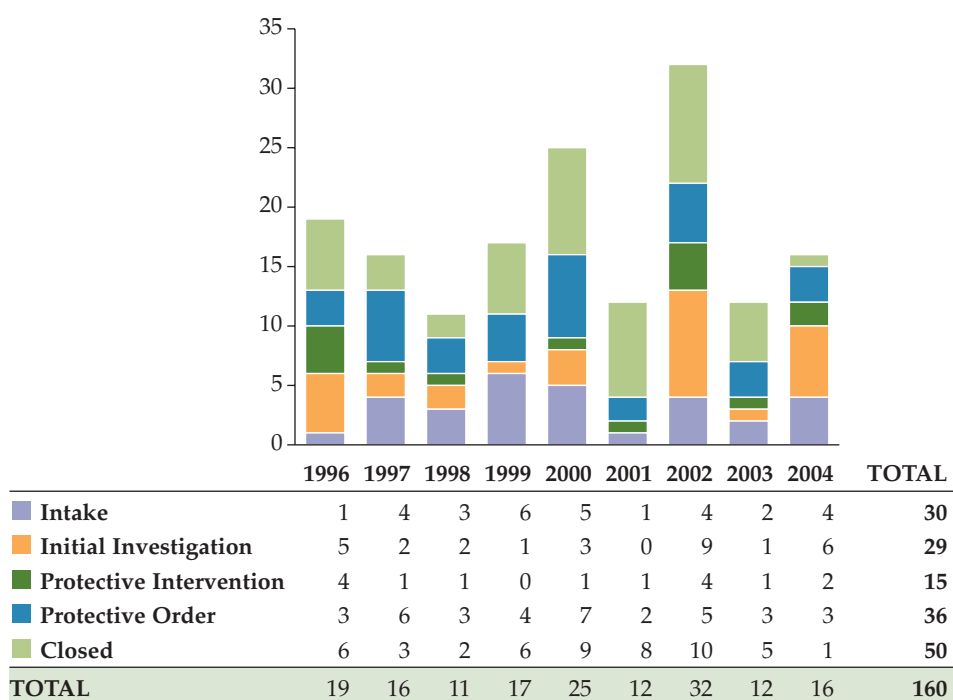
In 2004, ten children (62 per cent) were at the intake or initial investigation phases at the time of their death, two children were at the protective intervention stage, three children were on protective orders, while one was closed.

Table 3.5 Protective status at the time of death for 2004 (N=16)

Protective status at time of death	2004
Intake	4
Initial investigation	6
Protective intervention (includes interim protection order/interim accommodation order)	2
Protective order (includes guardianship, custody or supervision orders)	3
Closed	1
Total	16

From 1996–2004, a total of 59 children (37 per cent) were at the intake or initial investigation at the time of their death, 15 children (9 per cent) were at the protective intervention stage, 36 children (23 per cent) were on protective orders, while a further 50 cases (31 per cent) were closed.

Figure 3.9 Protective status at time of death 1996–2004 (N=160)



Summary

A total of 16 children who were known to Child Protection died in 2004, five for reasons unknown or yet to be determined, four from acquired illness, three from accidents, two from SIDS and two from drug/substance related activities.

In 2004, almost two thirds of child deaths involved infants between 0–3 years of age, consistent with previous patterns in the age distribution of child deaths.

There were no deaths of Aboriginal children known to Child Protection in 2004.

Between 1996–2004, the largest category of death among children known to Child Protection was acquired illness, accounting for 30 per cent of total deaths, followed by accidental deaths (20 per cent) and SIDS (15 per cent). Non-accidental trauma accounted for 9 per cent of all deaths in the Child Protection population during this period.

Between 1996–2004, 61 per cent of all deaths known to Child Protection occurred among infants aged 0–3 years, 12 per cent among children aged 4–12 years, and 27 per cent among young people aged 13–18 years. Deaths of infants aged younger than six months comprised 29 per cent of total deaths during the period.

4. Child death inquiries reviewed in 2004–05

This section provides an analysis of child death inquiries reviewed by the VCDRC in 2004–05. The VCDRC reporting period commenced in April 2004 and continued until March 2005.

The 18 child death inquiries considered in this period relate to a proportion of the deaths that occurred in 2002, 2003 and 2004. While significant learning can be derived from child death inquiries, the group of child deaths reviewed in this period is not a representative sample for epidemiological purposes and the findings below should be interpreted accordingly.

This section includes a description of key child and family characteristics represented in inquiries reviewed in 2004–05 and common themes and issues arising from inquiries reviewed in 2004–05.

4.1 Child and family characteristics

Summary of child death inquiries reviewed in 2004–05

In 2004–05, the VCDRC reviewed a total of 18 child deaths, comprising 15 child death inquiries and three paper reviews.

The 18 deaths reviewed occurred over a three-year period: nine were from 2002, six from 2003 and three from 2004. The VCDRC has now reviewed all deaths that occurred in 2002. Three deaths are yet to reviewed from 2003 and 13 from 2004.

More than half of the deaths reviewed in 2004–05 occurred in rural regions of the Department of Human Services.

Table 4.1 Summary of child death inquiries reviewed in 2004–05 (N=18)

Age at death	Region	Type of review
<i>Involvement with Child Protection</i>		
3 weeks	Metropolitan	Child death inquiry
1 month	Rural	Child death inquiry
1 month	Rural	Child death inquiry
6 months	Metropolitan	Child death inquiry
6 months	Rural	Child death inquiry
7 months	Metropolitan	Child death inquiry
8 months	Rural	Child death inquiry
2 years	Metropolitan	Child death inquiry
2 years	Rural	Child death inquiry
3 years	Metropolitan	Child death inquiry
7 years	Metropolitan	Child death inquiry
9 years	Rural	Child death inquiry
15 years	Rural	Child death inquiry
15 years	Rural	Child death inquiry
16 years	Rural	Child death inquiry
Sub total: 15 deaths		
<i>Little or no involvement</i>		
3 months	Metropolitan	Child death paper review
11 months	Rural	Child death paper review
3 years	Metropolitan	Child death paper review
Sub total: 3 deaths		

Characteristics of the children

Thirteen of the 18 cases reviewed by the VCDRC in this period involved children under the age of three. The VCDRC reviewed two deaths involving children in the 4–12 year age group and three deaths involving adolescents.

There were an equal number of male and female children.

Table 4.2 Child death inquiries reviewed in 2004–05: gender and age (N=18)

Gender	Age 0–3	Age 4–12	Age 13–18	Total
Male	6	2	1	9
Female	7	–	2	9
Total	13	2	3	18

Five of the 18 cases reviewed in this period involved children who had an Aboriginal family background. Four of these children died in 2002.

Table 4.3 Child death inquiries reviewed in 2004–05: Aboriginal status and age (N=18)

Aboriginal status	Age 0–3	Age 4–12	Age 13–18	Total
Aboriginal	3	–	2	5
Non-Aboriginal	10	2	1	13
Total	13	2	3	18

Consistent with data over time, the largest category of death in cases reviewed in this period was ‘acquired disease/illness’. Many of these cases involved infants who were born prematurely and drug dependent with significant medical complications and a limited life expectancy. Some of the cases categorised as ‘not known’ may be re-categorised pending coronial investigation and findings. There was one death reviewed in this period that was due to non-accidental trauma.

Again, consistent with previous trends, there continues to be a high representation of infant deaths in child death inquiries. A total of 13 infant deaths were reviewed in the 2004–05 reporting period: four cases involved infants younger than six months of age, five were children aged 6–12 months and four cases involved infants aged 13 months to three years.

Eight of the 13 infants came from a single parent family structure and were in the care of their mother at the time of their death. Three infants came from a two-parent family structure, one was in the care of extended family and one infant was born with significant medical complications and did not leave hospital after birth.

Child Protection was actively involved in eight of the 13 infant cases at the time of death: two infant cases were in intake, two were in initial investigation, three were subject to protective intervention and one infant was on a protective order.

In the 2004–05 reporting period, the VCDRC reviewed only two child death inquiries involving children in the 4–12 age group. Child Protection was actively involved in both cases, at the initial investigation phase of intervention.

The VCDRC reviewed three child death inquiries involving adolescents aged 13–18 years in the 2004–05 reporting period. Child Protection was actively involved in one of these cases, at the protective order phase.

Table 4.4 Child death inquiries reviewed in 2004–05: age and category of death (N=18)

Category of death	Age 0–3	Age 4–12	Age 13–18	Total
Accidental death	–	1	2	3
Acquired disease/illness	5	1	–	6
Drug/substance related	–	–	1	1
Non-accidental trauma	1	–	–	1
Not known	5	–	–	5
SIDS	2	–	–	2
Suicide/self harm/ risk taking	–	–	–	–
Total	13	2	3	18

Characteristics of the children’s families

Table 4.5 represents the care arrangements in place at the time of the child’s death. The majority of children came from single parent families with the biological mother as the sole carer.

Table 4.5 Child death inquiries reviewed in 2004–05: care arrangements at time of death (N=18)

Two parent families		Single parent families		Alternative care		Total
Biological parents	Grandparent and biological parent	Biological mother	Biological father	Extended family/friends	Hospital	
2	2	9	–	4	1	18
4		9		5		18

A fundamental aspect of Child Protection work is assessing risk to a child. Within the Victorian child protection system, the concept of risk involves the relationship between the degree of harm and the probability of the believed harm occurring (or of protection being provided). This involves a comprehensive process of information gathering and analysis in terms of four key dimensions: severity of harm; vulnerability to harm; likelihood of harm and safety.

Within this context, a range of items are considered, including specific parental characteristics such as substance use, family violence, transience, mental illness, protective services history and intellectual disability. The significance of these characteristics relates to the extent they impact on the parent’s capacity to provide adequate care and protection. Table 4.6 summarises the incidence of these characteristics among the families involved in child death inquiries reviewed in this period.

Table 4.6 Child death inquiries reviewed in 2004–05: overview of parental characteristics (N=14)*

Parental characteristic	Cases present
Substance use	12 (85%)
Family violence	8 (57%)
Transience	7 (50%)
Mental illness	6 (42%)
Protective services history	3 (21%)
Intellectual disability	1 (7%)

* Note: Limited Child Protection involvement in one child death inquiry and three child death paper reviews precluded the VCDRC from identifying parental characteristics in these cases.

Parental substance use was identified in the majority of child death inquiries reviewed—85 per cent of families presented with significant longstanding issues of substance use. The majority of children in the care of parents with substance use issues were aged 0–3 years.

Family violence was identified in over 50 per cent of child death inquiries. These cases involved children from as young as three weeks to 16 years of age. This high incidence of family violence is consistent with broader research regarding the prevalence of family violence in substantiated child protection cases.

Transience was noted in 50 per cent of the cases reviewed by the VCDRC. Family transience was found to have significant implications for wider service system communication, collaboration and delivery of support services.

Parental mental illness was identified in 42 per cent of the child death inquiries reviewed by the VCDRC. The majority of these cases had at least one parent who presented with mental health issues.

The most significant finding regarding parental characteristics of children subject to child death inquiries is the co-existence of a number of parental characteristics that are known to reduce parenting capacity. In eight of the 14 cases where sufficient data was available, families presented with more than one of the parental characteristics described above, most commonly drug use and mental illness, drug use and family violence or drug use and transience. In a further five cases, families presented with four or more of the parental characteristics identified in Table 4.6.

This data reaffirms previous findings regarding the complexity of needs among families whose children are subject to child death inquiries. It focuses attention on the extent of the protective challenge and highlights the importance of cross-sectoral collaboration and a sense of shared responsibility to address multiple needs. Most significantly, it reinforces the need to recognise and address the cumulative impact of trauma and neglect among the children of these extremely vulnerable families.

4.2 Themes and issues

As in previous years, a number of common themes were noted in the VCDRC's review of child death inquiries. Some have more strategic significance than others and these dominate the discussion below. Most have been acknowledged in previous annual reports of the VCDRC and, indeed, many are the subject of wider discourse among Child Protection experts internationally.

Many of the themes and issues raised below have been the subject of systematic, far-reaching reform undertaken by the Department of Human Services in consultation with its community partners in the past year. These reforms, described in Section 6 of this report, are applauded by the VCDRC. Committee members have actively participated in the reform process to date and look forward to further involvement in the year ahead.

Notwithstanding these wider efforts, the purpose of this section of the report is to present issues arising from cases reviewed in the 2004–05 reporting period. It is acknowledged that some of these deaths occurred as far back as 2002 and many of the issues arising may well have been subject to remedial action. Nevertheless, the VCDRC assumes there is always a capacity for quality improvement as part of a continuous learning cycle.

This section of the report has been informed by rigorous qualitative analysis of the issues and themes arising from each child death reviewed by the VCDRC in 2004–05. In the past year, the committee has designed and adopted a new case tracking system that records cumulative data on more than 50 aspects of case practice. This enables all client and case practice characteristics to be cross-referenced and ensures that there is a sound evidence base for all findings reported by the committee.

Once all numerically common features of the cases have been distilled from the data set, the committee considers which of these have the most impact on client outcomes and service provision to vulnerable families. These are prioritised for discussion in the annual report.

Key themes identified from the review of child death inquiries in 2004–05 and discussed below are:

- risk assessment
- case planning
- integrated service provision and shared responsibility
- culturally sensitive case practice with Aboriginal children and families
- timeliness of child death inquiries
- exemplary case practice.

Risk assessment

Inadequate risk assessment was a feature in 14 of the 18 cases reviewed by the committee in the past year. Indeed, concerns about risk assessment have been reported in all of the recent VCDRC annual reports.

Features of inadequate risk assessment noted in this reporting period included lack of thorough risk assessment, over-reliance on other service providers to assess protective risk, not taking into account previous notifications, failing to assess longer term needs, underestimating the degree of risk and failing to reassess the child's safety given new information.

Over-reliance on other professionals

Eleven out of 18 cases reviewed involved an assessment that there was an over-reliance on other service providers, most commonly medical practitioners, maternal and child health nurses and mental health professionals, to assess protective risk. In almost all of these cases the committee was concerned to note that there was a lack of direct contact with the child and/or their family.

Consistent with comments made in the 2004 annual report and with findings of the group analysis, *Who's Holding the Baby? Improving the Intersectoral Relationship between Maternity and Child Protection Services* (2000) this tendency was particularly evident in the deaths of infants with complex medical needs and in children whose families have multiple, complex needs. While a range of health and community services have a critical role to play in supporting vulnerable families and minimising risk to children, it is important that Child Protection remains central in the assessment of risk and parenting capacity. Protective workers have specialist expertise, training, tools and supervisory support in this role: it is the service's core business and should not be wholly transferred to professionals who are not trained to understand protective risk.

As wider system reforms emphasise a partnership approach in which all health and community services are responsible for protecting Victoria's children, it may be necessary to clarify what this means for Child Protection workers at each phase of intervention, to ensure that the capacity for specialist risk assessment is not lost. The challenge is to integrate the views of a range of involved professionals into a coherent, comprehensive protective risk assessment that meets the requirements of the Victorian Risk Framework.

The role of medical professionals in assessment and case management of children with complex medical needs is discussed further in Section 5, which presents findings of the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy*.

Episodic risk assessment and crisis intervention

In more than half of the child death inquiries reviewed in this period, it was noted that an episodic approach to risk assessment was taken in which each notification was considered in isolation from previous ones, failing to recognise the cumulative nature of significant risk factors. As a result, intervention responded to immediate harm, rather than the longer term needs of the child and their family.

The tendency of Child Protection services to operate on a crisis response model, which emphasises control of any immediate danger, followed by rapid withdrawal, has been well recognised both in Australia and overseas. Within Victoria, it has been acknowledged and addressed within two key strategic documents regarding Child Protection, *An Integrated Strategy for Child Protection and Placement Services* (2002) and *Protecting Children: The Child Protection Outcomes Project* (2003).

In this reporting period, the VCDRC reviewed several cases where the following core issues were not sufficiently acknowledged in the risk assessment phase: past notifications; past assessments of poor parenting capacity; recurring family violence; previous sexual abuse; trans-generational trauma and/or patterns of relapse in parental drug use and non-compliance with medication to manage mental illness.

Significantly, an episodic approach was evident in the cases of all three adolescent deaths reviewed in this period, reaffirming the findings of two previous group analyses into adolescent deaths known to Child Protection. These analyses underscored the need for a cumulative risk assessment process that recognises escalating risk behaviour; clear referral pathways between secondary and tertiary services; and the provision of assertive outreach and long term, comprehensive, coordinated services to adolescents. The committee was pleased to review some cases in which Child Protection worked creatively and proactively to remain connected with highly mobile, disengaged young people.

An episodic approach to risk assessment was also evident in the cases of three infants and two preschool and primary school aged children reviewed by the VCDRC in this period.

Initiatives such as the Innovations Projects, which aim to provide an integrated, multifaceted approach to both chronic and crisis driven problems, should complement the acute interventions of the tertiary system, by ensuring long term secondary support is provided. At the same time, it is understood that the new child protection information system, CRIS, is being designed to focus worker attention on previous protective intervention and the presence of longstanding risk factors.

High risk infants

The High Risk Infant and High Risk Adolescent programs were established to provide a specialist protective assessment and response to particularly vulnerable children and young people. Children assessed as 'high risk infants' or 'high risk adolescents' receive specialist, intensive intervention, priority access to services, high level monitoring and greater attention to coordination among service providers.

In this period, only three of the 13 infants whose deaths were reviewed were assessed as high risk infants. In these cases, the specialist infant protective workers made a constructive contribution to risk assessment and case management and their involvement was considered highly beneficial.

Review of child death inquiries in this period has led the VCDRC to conclude that several other infants should have been assessed as 'high risk'. In one case, for example, a child was not identified as a high risk infant despite the co-existence of multiple risk factors, including prematurity and drug dependence at birth, family violence, mother's substance abuse, father's mental illness and substance abuse, the recent separation of mother and father and the family grouping of three children under the age of five.

High risk adolescents

In this reporting period none of the three adolescents whose deaths were reviewed were assessed as high risk adolescents. In two cases, there were a number of significant co-existing risk factors, including substance abuse, transient lifestyle, sexual exploitation, challenging behaviour, criminal activity and mental health concerns. Both of these young people were Aboriginal, whose families shared trans-generational issues of trauma and loss that impacted on parental capacity to protect and nurture. The VCDRC is of the view that these young people would have been appropriately assessed as high risk adolescents.

Two of the adolescent cases involved young women living in sexual relationships with older men. These cases reflect the tension in Child Protection decision making between maintaining the adolescent in a potentially supportive relationship and relatively stable living arrangement, versus the risk of her exposure to sexual exploitation. The choice is extremely challenging for all concerned. One of these two cases involved a young woman who had experienced multiple past traumas, making it very difficult for services to engage with her to ensure her safety. In this case, Child Protection workers demonstrated a strong and commendable commitment to remain engaged, connected and supportive of the young woman even though her choices carried inherent risks.

Risk assessment and premature case closure

Risk assessment lays the foundation for subsequent protective intervention. Where insufficient information is collected or an inaccurate risk assessment is made, decisions are based on untested assumptions about the child's safety and/or the caregiver's capacity to parent.

In several cases reviewed in this period, it was judged that inadequate risk assessment lead to premature case closure. Seven of the 18 cases reviewed in this period were closed at the time of the child's death. In six of these seven cases, the child death inquiry concluded that case closure was premature.

The VCDRC appreciates that one of the greatest challenges facing Child Protection services is to identify those children at highest risk from the large group of children notified, within agreed timeframes and available resources. In the past, a number of different factors have been seen to contribute to premature case closure, including the need to comply with timelines embodied in organisational key performance indicators (KPIs) and demand pressures arising from staffing shortages and/or increased client volume. While these factors may have contextual relevance, in this period it was judged that inadequate risk assessment arising from the specific practices described above lead to an under-appreciation of the level of risk involved in several cases.

Accountability mechanisms and risk assessment

Accountability of Child Protection practice is achieved by a separation of process and decision making within a hierarchical supervisory structure. In at least three cases, it was found that regional accountability structures failed to alert management to the level of risk presented and the complexity of practice issues arising. In these cases, the number of co-existing, significant risk factors should have triggered an immediate, comprehensive and intensive protective response.

Case planning

Difficulties with case planning were identified in 11 of the 18 child death inquiries reviewed in this period. These difficulties included inadequate participation of family members and relevant professionals in planning, poor documentation of decisions and case plan outcomes, and inadequate monitoring and review of the case plan.

As noted above, insufficient information gathering and analysis in the early stages of intervention can undermine subsequent planning. In some cases, the VCDRC noted that key decisions were made in the absence of a well reasoned, documented and coherent plan of intervention that flowed logically from identification of risk and protective factors. Case direction seemed lacking in these instances and, over time, various protective interventions appeared confused and contradictory.

Many of the issues relating to case planning are included in the discussion of risk assessment and integrated service provision.

Integrated service provision and shared responsibility

Over the past decade there has been increasing recognition that the protection and wellbeing of children and young people is a whole of government and community responsibility. Indeed, this has been a central tenet of the current reform of children's and family services described in Section 6 of this report. Informed by a growing evidence base regarding the importance of interagency collaboration, many initiatives have aimed to enhance cooperation, coordination and collaboration between services involved with vulnerable families, in particular, child protection, mental health, drug and alcohol, disability services, family support and health services.

Some cases reviewed in this period included examples of good interagency collaboration, including proactive information sharing, timely case conferencing and shared decision making.

However, difficulties with coordination and collaboration between service providers were noted in 13 of the 18 cases reviewed. These difficulties included a lack of consultation and communication between agencies, inadequate definition of a lead or coordinating agent, poor documentation of task responsibilities and lack of understanding of roles and responsibilities, especially at case closure.

Case conferencing

Many cases reviewed by the VCDRC in this period would have benefited from the timely use of case conferences to clarify roles and expectations, allocate tasks, establish monitoring arrangements and agree on coordinating mechanisms. The importance of documenting the outcome of such conferences and providing this documentation to all participants cannot be overstated.

Role clarity at closure

Clarification of roles and responsibilities is absolutely critical at case closure. Without it, a diffusion of responsibility occurs and accountability for child safety becomes unclear. In this reporting period, the VCDRC saw several cases that would have benefited from more rigorous role definition at closure. This should have involved clear agreement as to who is monitoring a family's ongoing participation with agreed services and specification of the behaviours or events that should trigger further involvement of Child Protection services. Referral to a service does not ensure engagement or even attendance. It is important to focus on outcomes for children and to ensure that the family is properly engaged before Child Protection withdraws involvement.

Number of services

Sometimes, the sheer volume of services involved with some families makes service coordination and collaboration, let alone integration, extremely challenging. Reflecting the complexity of family need, many of the cases reviewed in this period involved five or six service providers simultaneously. In one case, the family was involved with 14 different services simultaneously, five of which were providing in home support. While it is encouraging to note the provision of services across traditional program boundaries, these arrangements place significant demands on the family and undermine the quality of engagement with any single service.

The VCDRC welcomes the department's long term commitment to enhanced service integration and looks forward to ongoing reforms aimed at streamlining service delivery across health, disability and children's and family services. These issues are considered further in Section 5, which presents findings of the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy*.

Aboriginal services and the Department of Human Services

Difficulties in interagency communication, cooperation and collaboration were noted in the five child death inquires involving Aboriginal children reviewed in this period.

While some of these reflect the broader challenges in achieving collaborative practice described above, others relate specifically to the interface between Aboriginal support services in rural Victoria and the relationship between Child Protection and Aboriginal support services.

In 2003, it was determined that inquiries into the deaths of Aboriginal children should involve an Aboriginal co-reviewer to supplement the standard inquiry process. In the current reporting period, the VCDRC considered the first child death inquiries undertaken in this way. The committee has found that the inclusion of an Aboriginal perspective enhances the inquiry process considerably, providing insight into issues that might otherwise go unattended.

The involvement of Aboriginal co-reviewers has assisted the VCDRC's understanding of some of the issues that affect communication and collaboration between Aboriginal and non-Aboriginal services and placed this in its historical and social context. Such understanding is vital to the development of sustainable, trusting relationships between child protection partners.

Many of the Aboriginal children whose deaths are reviewed by the VCDRC come from families with complex configurations, a history of trans-generational trauma and multiple needs. The active involvement of local Aboriginal services is vital to accurate assessment of risk and protective factors within these families.

Comprehensive protocols and partnership arrangements have been established in recognition of the importance of collaboration between Aboriginal and non-Aboriginal services. In recent times, these have been supplemented with targeted relationship building activities aimed at establishing a shared practice framework between services with a stake in the safety and wellbeing of Aboriginal children.

Culturally sensitive practice

All five of the child death inquiries involving Aboriginal children that were reviewed in this period found that case practice could have been more culturally sensitive. Again, the input of Aboriginal co-reviewers in the inquiry process has been valuable in identifying opportunities for improvement.

Two of the five cases involved a failure to appropriately recognise the child's Aboriginality in service intervention. In one case, this had significant ramifications for the identity and psychological wellbeing of the young person concerned.

Other cases involved multiple Child Protection involvements, complex family relationships, and patterns of trauma, loss and unresolved grief spanning several generations that impacted heavily on the quality of parenting available. These factors were not consistently acknowledged in the risk assessment process. It is vital that the historical and social context of Aboriginal communities is factored into all aspects of protective intervention.

A number of child death inquiries highlighted the need for enhanced training of protective workers and renewed efforts to recruit Aboriginal staff into child protection and related roles. Recognising this, as part of the whole of government *Wur-cum-burra* Indigenous employment strategy, the Department of Human Services has implemented an *Indigenous Recruitment and Career Development Strategy, 2002–2005* and recently launched an Indigenous website, identifying service, training and career opportunities for Aboriginal people. Meanwhile, ACSASS was established in 2002 to provide expert advice to Child Protection about culturally appropriate intervention with Aboriginal children and families.

Timeliness of child death inquiries

Throughout 2004–05, the VCDRC has expressed its concern regarding the lack of timeliness in the child death inquiry process. As noted previously, of the 18 deaths reviewed by the VCDRC in this reporting period, nine were from 2002 and six were from 2003. Many of these inquiries lasted more than 18 months from commencement to completion.

These delays undermine the relevance and credibility of the child death review process and place unnecessary stress on all parties involved. While it is acknowledged that the number of child deaths is unpredictable from year to year,

it is incumbent upon the department to maintain a flexible resource capacity that ensures a timely, responsive inquiry process.

The VCDRC has urged the department to establish standard timelines for the commencement and duration of child death inquiries. Such timelines existed when the child death inquiry process was first established, but have since been abandoned. While the VCDRC accepts that exceptional circumstances may prevent achievement of timelines in all cases, it is anticipated that the introduction of an agreed standard will reduce delays and enhance the integrity of the review function.

Exemplary case practice

From time to time, the VCDRC reviews cases where even though the ultimate outcome was the tragic death of a child, the involvement of all services involved was exemplary.

In this reporting period, the committee reviewed one such case. This case is described below as testament to the capacity of the system to respond in a comprehensive, coordinated and timely manner to support a family with multiple, complex needs.

Sam was born critically ill at 27 weeks gestation, as one of a set of twins. He was heroin dependent and had significant lung damage. Sam's long term medical prognosis was extremely poor. Concerns were expressed about the ability of Sam's mother and father to meet the high care needs of the twins. Sam's mother was reportedly using a range of illicit drugs and had threatened to physically assault hospital staff on several occasions. At the time of notification, ongoing access to her children in intensive care was in jeopardy. Sam's mother and father had ended their relationship prior to the birth of the twins and Sam's father was living with his parents, while remaining very involved with the babies.

Child Protection engaged skilfully with Sam's mother and father and utilised specialist expertise available via the High Risk Infant program to inform risk assessment and subsequent case planning. Both parents attended a Parenting Assessment and Skill Development Services (PASDS) to inform the assessment of parenting capacity. As part of a thorough risk assessment process, Child Protection collaborated with drug and alcohol service providers who had been working with Sam's mother for some time and secured a comprehensive psychiatric assessment. The relationship between risk assessment and subsequent case planning decisions was explicit.

Throughout their involvement, Child Protection held several case conferences involving medical staff, drug services, mental health, maternal and child health and a range of support services. Case records were comprehensive and up to date. Role expectations and responsibilities were clear.

A key feature of the case was the sensitive engagement, perseverance and planning that kept Sam's mother centrally involved in decision making regarding her son's care. Though Sam remained in hospital until his death at seven months of age, Sam's twin was successfully discharged to the care of his father, following a brief period of protective intervention.

Child Protection provided support and care to Sam's parents in the period leading up to and beyond his death.

A final word

The VCDRC is cognisant of the inherently difficult work undertaken by Child Protection workers on a daily basis. The job requires that the best decision is made at the time, based on available information and competing demands.

The VCDRC operates with the benefit of hindsight that is not available to practitioners. However, without reflection and retrospection we deny the system the opportunity for growth and improvement.

The VCDRC hopes that its reflections on cases reviewed in 2004–05 make a constructive contribution to services for vulnerable children and families.

5. Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy—Report summary

5.1 Purpose of the group analysis

The group analysis was undertaken at the request of the VCDRC to examine cases where a prognosis of limited life expectancy or a serious medical condition results in a lack of attention to other elements of risk and lack of assessment of overall parenting capacity. The VCDRC was also interested in exploring how case planning for children with complex medical needs impacted on service responses to their siblings.

The group analysis was conducted by an analysis panel comprising Dr John McNamara (Chair), retired paediatrician, Royal Children's Hospital; Tim Harrop, Community Services Manager, Department of Human Services, Barwon South West; and Julie Langdon, External Consultant, Langdon Consulting.

5.2 Overview of the group analysis

Methodology

The analysis panel reviewed 17 child deaths that occurred between January 2000 and June 2003 and involved children with complex medical needs and/or a prognosis of limited life expectancy. The analysis of these cases was informed by relevant research identified through a survey of literature, an examination of Victorian service provision initiatives and two half-day forums held with a range of professionals to promote information sharing on key issues.

Subject group

The child deaths subject to the group analysis shared a number of common features. All 17 cases had identified protective concerns and all cases presented with chronic medical conditions requiring complex and extensive specialist intervention. All 17 children had medical conditions that impacted on their functioning and age related development. All required a high level of carer intervention and the majority of children had disabilities.

A notable feature of this group of children was the presence of significant neuro-developmental delay. This delay places high demands on carers to meet basic needs and often requires the provision of sophisticated, in home medical procedures which may overwhelm the best intentioned and supported families. The evident incapacities of some parents to cope with the dysfunction of their own lives indicated that they had little capacity to meet the special needs of their children.

Research

There has been limited research published in the area of child abuse and children with complex medical needs and a limited life expectancy. A large number of articles related to children with disabilities over the age of five and focused on the relationship between child abuse and disability and the prevalence rates of abuse in this population of children.

Rapid advances in medical technology have resulted in a marked increase in the number of children with significant medical and developmental difficulties. At the same time, there is an expectation that parents will provide care for children with significant disabilities at home, often with questionable levels of support.

Research has indicated that emerging services have not adequately recognised the support needs of families whose children have special care needs. This has significant implications for families who face tremendous emotional and practical challenges and for Child Protection and health professionals providing services to these children.

Service system

An examination of Victorian service provision initiatives found that, over the years, a large number of Department of Human Services provided and funded programs and services have been established to effectively support children with complex medical needs. The services came from a range of program areas including disability, health, early years and child protection.

Child Protection has implemented a range of strategies and programs relevant to risk assessment and planning for this cohort of children and their families, including the Victorian Risk Framework, High Risk Infant Program, Integrated Strategy, Innovations Projects and Public Parenting.

There have been a number of programs established to enhance the capacity of the service system to effectively support families caring for children with significant disabilities. These have developed in different ways, with different funding lines and target groups; but have in common the provision of case management and flexible support packages to families caring for children at home who have significant disabilities. These programs include the Making a Difference Program, Early Choices, Continuity of Care and the Family Choice Program. Consolidation of these programs has been occurring and, since 1 July 2002, all four programs have been aligned as Flexible Support Packages and are now managed by Disability Services.

5.3 Themes and issues

The group analysis report highlighted several themes and issues relating specifically to Child Protection assessment and intervention and to a broader systemic response required for children who have significant and complex care needs.

Assessment of risk

The report identified issues relating to risk assessment processes. Many of the cases did not reflect a child centred and family focused risk assessment. The impact of the child's medical condition on siblings was not adequately assessed.

Many of the cases lacked a detailed understanding of the child's medical condition and its implications for the safety and care requirements of the child. Without understanding the specific needs, risks and vulnerabilities of the child, it is not possible to accurately assess parents' ability to provide care and minimise risks.

A large number of cases involved infants who were not assessed as high risk and therefore did not receive the additional support and services available under the High Risk Infant Program. The report indicated that infants with complex medical needs and/or a limited life expectancy should be recorded on the region's High Risk Infant Register and, consequently, receive the services of specialist infant protective workers.

In the majority of the cases, children were placed in the care of parents who had significant parenting issues. When parental risk factors are identified, the vulnerability of children with complex medical needs and a limited life expectancy tends to be heightened. The capacity of parents to meet the intensive care needs of children with complex medical conditions needs special consideration as part of a comprehensive risk assessment process.

Court processes

The report identified issues relating to the ability of Child Protection workers to adequately use medical issues and the consequential care needs as evidence in Children's Court proceedings or on appeal to higher courts to argue for an appropriate and safe disposition for a child. The report indicated that Child Protection workers had a limited understanding of the significance of medical issues and how to effectively link these to the risk assessment presented in the Children's Court.

The report indicated that there appeared to be limited support by medical specialists to provide evidence to courts. There were many instances where magistrates returned infants with complex medical needs to families where significant protective concerns were evident, without understanding the specific care needs of the infant or child.

The report also indicated that medical advice regarding care requirements is critical. Assessments of child safety and the parent's ability to meet their child's needs, including their ability to acquire the necessary skills, must be informed by a sound understanding of the level of care required.

Support for Child Protection workers

The report indicated that the experience of working with a child with complex medical needs and a limited life expectancy presented both emotional and psychological challenges for the worker and these challenges needed to be addressed within existing support and supervisory structures in Child Protection. The report acknowledged that working with this group of children was not a common experience for Child Protection workers.

Planning and decision making

The report identified that the majority of the families in this group did not receive long term case management; instead, case management was short term and episodic. Case management addressed the presenting crisis and immediate protective concerns, and often only dealt with the medical concerns. Families were referred to services and the case was closed.

Some families received longer term case management from non-government case management programs, however, these programs may not have the child protection focus that is required to address and monitor the entrenched, long term social problems in these families.

For many of the children in this group, planning should consider the deterioration rate of the child's health and, where appropriate, the palliative care requirements that may arise. The implications for other family members, including siblings, should also be an integral component of case management.

The report identified issues relating to planning and case conferencing prior to discharge from hospital. Major concerns were that advice of hospital discharge did not occur in all cases; that children with complex medical needs and serious protective issues left hospital with limited discharge plans; and that relevant professionals did not attend scheduled case conferences.

Quality of life

The report emphasised that enhanced quality of life, not just safety, should be a focus of protective intervention with this group of children. The quality of life for these children was compromised by the deficits within the family environment.

Issues relating to the suitability of hospital settings and their implications for parent-child attachment were also raised in the report. The report found that extended hospital stays and the parents' emotional response to the child's medical condition or disability were likely to impact on attachment.

Information and communication

The report identified a range of issues that related to the interface between Child Protection and medical services. These issues largely related to the exchange of information between these services. In a number of cases there was no evidence that appropriate medical information had been obtained from medical practitioners when conducting the protective risk assessment. A basic understanding by medical professionals of child protection and the legislation is crucial if they are to provide appropriate advice to assist in formulating risk assessments and guide risk analysis.

The report indicated that the Department of Human Services' Disability Services and Specialist Children's Services could provide professional advice and information on various disability types and related care needs. Involvement of these services may enable access to additional relevant knowledge of the family that could assist with risk assessment issues.

The report indicated that the formal process of communication between Child Protection and hospitals was also an issue. A basic mutual understanding of the two systems is critical, not only in working with children with complex medical needs, but other children who are hospitalised during Child Protection involvement. Having medical professionals and Child Protection staff who are well informed about each other's approaches and processes, and the limitations of each system, is important for improved liaison, collaborative practices and better client outcomes.

Systemic issues

The report identified that the lack of consistent service system responses for this group of children and their families made service delivery increasingly difficult. Many of the families were linked to a range of services, however, the parents continued to have difficulties maintaining their children at home.

The report indicated that these issues require a response at a broader systemic and cross-program level and that the way forward was to create flexible programs that enable individualised responses to be tailored to meet the requirements of each situation.

Long term out-of-home care

The report identified a gap in accommodation and care options for children with complex medical needs and a lack of coordination between program areas. Some children in this group remained in hospital or were frequently returned to hospital as 'social admissions', because parents were unable to cope and there were no other options. Hospital admissions are an extremely expensive alternative and, unless required for medical purposes, are generally not suitable placements for children. Currently there is no model of out-of-home care that is able to fill the gap between hospital and respite care, unless it is clear that palliative care is required.

Legal issues

The report identified issues relating to the privacy and confidentiality provisions in legislation. There is significant confusion in the medical and community sectors and in the legal field about the applicability and implications of these pieces of legislation and their impact on the information that a professional or organisation is willing to provide to Child Protection staff.

The report also identified issues relating to the legal provisions that impact on parents who want to voluntarily relinquish care of their children. The only apparent option for some parents to access long term out-of-home care is via the Child Protection system and this is only possible under section 63 of the *Children and Young Persons Act 1989* (CYPA). The report indicated that where the only option is out-of-home care, and protective concerns are not evident or significant enough to remove a child, use of the CYPA is inappropriate and hinders the potential benefits of case management, long term planning and participation of the family in the future of their child.

5.4 Conclusion

Research has indicated that the population of children with complex medical needs is likely to increase as a result of advances in medicine and technology. These children are extremely vulnerable and require a higher standard of parenting than children generally. The consequences of poor parenting are particularly serious, impacting not just on developmental opportunities and quality of life, but also on basic survival.

The report confirmed the view that the prognosis of limited life expectancy, or a serious medical condition, has commonly resulted in a lack of attention to other elements of risk or child wellbeing. There was a lack of assessment of overall parenting capacity, particularly in the context of the specific needs of the individual child and family. The lack of assessment impacted on case planning and management of the child and their siblings, which was further complicated by the multiple and often disparate services surrounding the child and family.

The report identified that systemic issues impacted greatly on the management of these children and their families. Multidisciplinary and multi-sectorial communication, cooperation and coordination, flexible funding models and service development to fill the significant service gaps for these children are urgently required.

The report highlighted the importance of sharing the responsibility for children with complex medical issues and their families. A partnership approach between disability, health, early years and child protection services is required to build collaboration and cooperation. Given the complexity involved with these cases and the specialised knowledge required, joint work with medical staff, as well as with government and non-government services providers, is a necessity. Successful outcomes will only be achieved through a cooperative and committed response throughout the service sector.

The report made 15 recommendations aimed at improving practice and service provision to this extremely vulnerable group of children.

5.5 Recommendations of the group analysis

Risk assessment and planning

1. That Child Protection and Juvenile Justice Branch review its practice guidelines and instructions, which relate to notified children with complex medical needs to ensure that:
 - 1.1 An enhancement of the Victorian Risk Framework is developed for working with children who have been diagnosed as having a complex medical need or a limited life expectancy. This should also occur for siblings in such households to ensure that they are not at risk of abuse or neglect and they have a reasonable quality of life.
 - 1.2 An enhancement of the Victorian Risk Framework is developed that includes specific attention to the risk posed by the complex and repetitive nature of the medical treatment required in the home environment and whether the parents are likely to be able to cope over a prolonged period.
 - 1.3 These children are recorded on regions' High Risk Registers.
 - 1.4 Regional staff more assertively seek adequate medical and specialist advice, including advice from Disability Services and Specialist Children's Services, in order to develop a better understanding of the care requirements that would inform the risk profile of the child and to determine whether transition support from hospital to home could minimise identified risk factors.
 - 1.5 Prevention of neglect and emotional harm is a primary focus in service planning and decision making, particularly the transition from hospital, case planning, the court process and palliative care.
 - 1.6 Regional Child Protection workers actively involve disability service providers (internal and external to Department of Human Services) and Early Childhood Intervention Services in the case planning process.
2. That child death inquiries specifically seek to identify the medical advice that was available to Child Protection staff at the time of notification of a child in order to determine the adequacy of the risk assessment.
3. That Child Protection and Juvenile Justice Branch incorporate training in relation to the impact of a child's terminal condition on Child Protection staff into a relevant training course and that this training be aimed at Child Protection workers and managers.

Child Protection/medical services interface

4. That the Child Protection and Juvenile Justice Branch pursues the offer of the Royal Children's Hospital social work staff to assist Child Protection workers to better understand the operations of the hospital system. That consideration be given to delivering this training to high risk infant managers, specialist infant protective workers, unit managers, team leaders and new Child Protection staff.
5. That the Child Protection and Juvenile Justice Branch, regional Child Protection representatives and health divisions work in partnership to develop a protocol with major obstetric and paediatric hospitals to ensure that in cases of children with complex medical needs, who are subject to a current protective notification, that a case conference be convened prior to discharge, and that discharge planning occur which clarifies roles and responsibilities.
6. That the Department of Human Services seeks to communicate with the Royal Australasian College of Physicians, Victorian State Committee, Paediatrics and Child Health Division and the Royal Australian College of General Practitioners to strengthen

links and improve access to paediatric and general practitioner services in rural and metropolitan areas.

7. That regional Child Protection managers, in conjunction with Metropolitan Health and Aged Care, Rural and Regional Health and Aged Care and the Child Protection and Juvenile Justice Branch, seek to improve access to designated paediatric expertise to provide consultation on medical conditions, and the related care implications, and to provide liaison between Child Protection and medical staff.
8. That Metropolitan Health and Aged Care Division considers the merits of monitoring recent developments in the field of paediatric palliative care and this information is made available to Child Protection on a case by case basis for the benefit of children with a limited life expectancy.
9. That the Child Protection and Juvenile Justice Branch evaluates existing Child Protection training and professional development resources to doctors to ensure that they have a better understanding of issues relating to child abuse, child protection and mandatory reporting.
10. That the Child Protection and Juvenile Justice Branch convenes future forums with professionals, both internal and external to the Department of Human Services, on the needs of children with complex medical conditions and a limited life expectancy in order to continue to seek a broader understanding of this client group and facilitate the exchange of information amongst professionals.

Service directions

11. That the Department of Human Services continues to address the need to minimise the number of programs and funding streams involved in providing individualised packages for children in order to reduce the barriers between the program areas and promote accessibility, flexibility and resourcing based on need.
12. That the Department of Human Services ensures that Funding and Service Agreements with non-government organisation providers of disability services include the requirement that the organisation's staff working with children and families have ongoing Child Protection education and training.
13. That a revised protocol between Child Protection and Disability Services be developed as a matter of priority and that the issue of parents who are caring for children with complex medical needs and who may require long term out-of-home care be considered.

Legal services

14. That the Department of Human Services seeks a definitive legal opinion on the interaction and primacy of the *Children and Young Person's Act 1989*, the *Health Records Act 2001* and privacy legislation during a Child Protection investigation as a matter of urgency. That such an opinion, when obtained, is communicated in a clear form to all relevant health professionals, particularly hospitals and paediatricians in Victoria.
15. That the current legislative review of the *Children and Young Person's Act 1989* and the *Community Services Act 1970* examines options for an alternative pathway to long term out-of-home care for this client group where parents seek to voluntarily relinquish care of their child.

5.6 VCDRC response to the group analysis

The group analysis report was tabled for review by the VCDRC in November 2004.

The VCDRC welcomed the high level of analysis reflected in this report and distilled several key themes considered critical in protecting children with complex medical needs and/or a limited life expectancy. These included:

- the need to assess the capacity of parents to perform complex and repetitive medical procedures in the home environment
- the value of a comprehensive assessment that balances specialist medical advice with an assessment of overall parenting capacity
- the need to ensure siblings are given adequate focus and attention in assessment and case planning
- the need for effective communication and collaboration between child protection, disability services and medical services
- the importance of long term case planning, despite a prognosis of limited life expectancy, that addresses quality of life issues alongside immediate risk
- the need to provide coordinated and intensive family supports early, to enable children to remain in the care of their parents and offer planned, long term care alternatives where this is not possible.

The VCDRC found that the report underscores the fact that improved responses to children with complex medical needs and/or a prognosis of limited life expectancy are contingent upon a range of human services: responsibility does not lie exclusively with Child Protection. While the VCDRC is aware of many initiatives that have been undertaken in recent times to improve the interface between the child protection, disability and health service systems, this vital work must continue.

The VCDRC understands that the Child Protection and Family Services Branch will review the analysis report's recommendations and develop implementation plans accordingly. Within this context, the VCDRC has urged the department to address the following matters as a priority:

- Development of an enhancement to the Victorian Risk Framework that addresses the specific issues pertaining to this group of children.
- Translation of the group analysis's key findings into some best practice principles for children with complex medical needs and/or a prognosis of limited life expectancy, that address long term planning and quality of life issues.

- Implementation of further specific measures to streamline service delivery and enhance collaboration across child protection, disability services and medical services.
- Exploration of alternative pathways to long term out-of-home care that do not require statutory protective intervention.

The VCDRC believes that a specialist focus and response is required to ensure that the particular needs of children with complex medical needs are understood and met. The committee will continue to take an active interest in the department's response to the issues raised in the group analysis report.

6. The year in review, the year ahead

6.1 The year in review

Legislative and Policy Reform

In 2004–05, the Department of Human Service (DHS) continued a number of significant reforms aimed at promoting a shared responsibility for children's health and safety and repositioning child protection within a well resourced and supported children's and family services system.

The Victorian government's comprehensive review and redesign of Victoria's children's and family services system commenced in 2003 with the Allen Consulting Group Report *Protecting Children: The Child Protection Outcomes Project*. The Kirby Panel Report, *The Report of the Panel to Oversee the Consultation on Protecting Children: The Child Protection Outcomes Project* summarised community responses to the Allen Report and suggested broad directions for reform.

In September 2004 the Minister for Community Services launched the government's Ministerial Discussion Paper *Protecting Children: Ten Priorities for Children's Wellbeing and Safety in Victoria* and the department's companion document, the *Technical Options Paper*, which discusses options for policy, system, practice and legislative change. Building on previous reports, these two documents examine the next steps in reforming Victoria's children's and family services.

The government has accepted the broad priorities for reform outlined in the Ministerial Discussion Paper and has begun drafting legislation to reflect these directions. In combination with ongoing policy, practice and service delivery reforms, the new legislation aims to:

- Drive a stronger focus on prevention and early intervention.
- Move from a harms focus to one which promotes healthy child development.
- Strengthen the community's capacity to support families and protect children.
- Foster enhanced collaboration between Child Protection and community services.
- Promote a more active focus on family maintenance and reunification, whilst recognising children's need for stable nurturing relationships, especially in the early years of life.

- Ensure services are more culturally appropriate and that more is done to prevent the significant overrepresentation of Aboriginal children in Child Protection.
- Create more flexible structures for decision making about children and families through alternative court based models.

The VCDRC has been an active participant in the reform of Victorian services for vulnerable children and families and looks forward to further involvement in the year ahead.

Other DHS Initiatives

The VCDRC has been pleased to note that a number of recent DHS initiatives aim to address common themes arising from the review of child deaths.

Over the past year, the Family Support Innovations Projects have been expanded to all regions, providing early intervention and support services to a greater number of vulnerable families. In recognition of the need for effective inter-agency collaboration and coordination, these projects are underpinned by service networks comprising representatives from a broad range of government and community based health and human services. The service networks aim to develop a shared practice framework that strengthens the community's capacity to support vulnerable families and reduces notifications to Child Protection.

The Aboriginal Child Specialist Advice and Support Service has also been expanded in the past year to ensure that culturally relevant advice and consultation is available to Child Protection workers at all stages of intervention.

Other recent relevant initiatives of the Child Protection program include the review and expansion of case planning requirements and significant changes to case closure practice guidelines that emphasise effective referral and engagement practices. Child Protection has commenced its review of the Victorian Risk Framework (VRF), which will focus on child development and cumulative harm in the assessment of risk.

In response to the increasing complexity of needs among families, in the past year the Child Protection and Juvenile Justice Professional Development Unit developed a new training program 'working with family complexity' which addresses the issues of mental illness, disability, family violence and substance use. The program has also finalised a 'child protection and family violence' practice guidance document and is planning for the development of a new protocol with adult mental health services.

Structural changes

In December 2004, new arrangements were announced for the delivery of child related services in Victoria. These include the appointment of a Minister for Children, the establishment of an Office for Children within the Department of Human Services and the creation of Victoria's first Child Safety Commissioner. Many of these changes occurred in response to the Premier's Children's Advisory Committee (PCAC) Report, *Joining the Dots: A New Vision for Victoria's Children*.

Other key government responses to the PCAC report include the establishment of a permanent Victorian Children's Council to provide expert policy advice to the Premier and Minister for Children and a new interdepartmental board to bring together secretaries of departments responsible for children's policies and services.

The new arrangements are designed to enhance integration and coordination across Victorian departments and improve collaboration with local and federal governments. They aim to deliver better outcomes for children through research, policy development and outcomes monitoring. The VCDRC welcomes the emphasis on the early years of life reflected in the new arrangements and is encouraged to hear that attention to universal children's services will be accompanied by a high commitment to the needs of Victoria's most vulnerable children and their families.

The newly created Office for Children will assume responsibility for many of the programs previously provided by the Community Care Division of the Department of Human Services, including Child Protection, Placement and Support, Juvenile Justice and Youth Services, Family Services and Early Years Services, including maternal and child health, kindergartens, early childhood intervention and parenting support services.

The new Child Safety Commissioner will oversee the Child Death Inquiry Unit and its interface with the VCDRC, the Advocate for Children in Care and staff and the new Working with Children check system as it relates to child related services within the Department of Human Services. The Child Safety Commissioner will be directly accountable to the Minister for Children.

The VCDRC has been actively engaged in decision-making regarding the new structural arrangements and looks forward to working with the Child Safety Commissioner to achieve ongoing enhancements in the child death inquiry and review process.

Consultative Council on Paediatric and Obstetric Mortality and Morbidity

As noted in Section 2.1, the Consultative Council on Paediatric and Obstetric Mortality and Morbidity (CCOPMM) has a public health surveillance, reporting and research role in relation to all child deaths that occur in Victoria, while the VCDRC only considers child deaths that are known to Child Protection. It is important that the work of the VCDRC is seen in a broader context and that trends in deaths known to Child Protection are tracked against trends in the general population.

In the past year, the VCDRC and the CCOPMM have committed to a preliminary data sharing exercise that will assist in better understanding how deaths within the Child Protection population compare epidemiologically with deaths in the wider population of Victorian children. It is anticipated that this will present further opportunities for collaboration and joint analysis of specific themes.

6.2 The year ahead

Group analyses

In the coming year, the VCDRC will consider two further group analyses that were commissioned in response to specific clusters of child deaths over recent years.

The first of these examines deaths where there has been parental substance abuse and mental illness. The aim is to understand the nature and level of collaboration between services and the impact of collaboration on service outcomes. More specifically, the analysis will explore access by Child Protection to timely mental health assessments of parents and expert advice when different parental diagnoses are made. It will also review tools that assess the impact of mental health issues and substance abuse on parenting capacity.

The second group analysis examines a cluster of child deaths due to SIDS that occurred in 2002. The aim of this analysis is to establish whether there were known SIDS risk factors in each case, whether current departmental practices addressing risk factors were followed, and to identify strategies that further minimise the risk of SIDS among vulnerable families and the general community.

Monitoring progress on key issues

While the VCDRC has no active or direct role in implementing system change, it has an abiding interest in system reforms that address threshold issues arising from the child death review process.

In the coming year, the committee will take particular note of initiatives that address the quality of risk assessment and promote a holistic, cumulative, historical perspective. The committee understands that legislative and policy

reforms are designed to effect some of these changes and members look forward to ongoing participation in the reform process. It is also understood that the new client information system, CRIS, is being designed to expedite access to historical records and provide alerts to practitioners regarding prior notifications.

In the year ahead, the committee will also monitor action arising from the *Group Analysis of Children with Complex Medical Needs and a Limited Life Expectancy*. The committee looks forward to a departmental response to the report and wide dissemination of its findings. As noted in Section 5, the VCDRC hopes that the group analysis will inform the development of risk assessment tools and best practice principles specific to this small but growing group of children. The committee also anticipates that the report will serve as catalyst for further system reform that streamlines service provision across sectors.

Structural change

The transfer of the child death inquiry function to the Office of the Child Safety Commissioner constitutes a significant shift in responsibilities. It will require good support in the transition phase to ensure that the department maintains the capacity to conduct consistent, high quality inquiries.

At the same time, the new arrangements provide an opportunity to achieve ongoing enhancements to the child death inquiry and review process. As noted previously, the VCDRC is particularly keen to see an improvement in the timeliness of inquiries and believes the adoption of standard timelines relating to their commencement and duration will assist.

Influencing policy, procedure and practice

It is vital that the learning from the child death inquiry and review process is first disseminated and then translated into policy and practice. The VCDRC is keen to use existing training and quality improvement mechanisms within departmental and community sector services to communicate findings and drive change.

The committee is aware of the many and competing messages directed at practitioners and their supervisors and believe it is incumbent on all stakeholders to ensure that practice directions are communicated in an integrated, coherent and effective way. Similarly, there are many competing demands for program development and review that need careful consideration and priority ranking. In short, an ad hoc, reactive approach is not effective in achieving lasting change.

In the year ahead, the VCDRC will seek to forge an agreement with the new Office for Children regarding formal, periodic opportunities to feedback issues arising from the review process and influence policy, procedure and practice in Child Protection and related services for vulnerable children and families.

Glossary and abbreviations

Accidental death	Category of death: includes drowning, fire, road trauma and train fatalities (non-suicidal)
Acquired illness	Category of death: includes prematurity, terminal illness, serious congenital conditions, fatal infection and fatal seizures.
ACSASS	Aboriginal Child Specialist Advice and Support Service. ACSASS provides expert advice to Child protection about culturally appropriate intervention for Aboriginal children and young people.
Group Analysis	Analysis report that focuses on a group of child deaths.
CASIS	Client and Service Information System.
CCOPMM	Consultative Council on Obstetric and Paediatric Mortality and Morbidity.
CDI	Child Death Inquiry also referred to as 'inquiry'.
CDI Executive Officer	Departmental officers providing research and administrative support for Child Death Inquiries.
CDIU	Child Death Inquiry Unit within the Department of Human Services.
CYPA (1989)	Children and Young Persons Act 1989
Custody Order	Order made under the CYPA (1989). This order enables a child to be placed out of parental care, while the parents retain guardianship rights
Committee	Victorian Child Death Review Committee.
Department	Department of Human Services.
DHS	Department of Human Services also referred to as the 'department'.

Drug/substance related death	Category of death: includes drug overdose and deaths related to inhalant abuse.
Guardianship Order	Order made under the CYPA (1989). This order enables a child to be placed out of the care of their parents and transfers guardianship rights to the department.
HRA	High Risk Adolescent program. Protective work team specialising in assessment and management of high risk adolescents.
HRI	The High Risk Infant program. Protective work teams specialising in the assessment and management of high risk infants.
Intake	The section of Child Protection that takes notifications of possible child abuse and neglect and makes initial assessments.
Investigation	Investigation undertaken by Child Protection to assess actual harm or likelihood of harm to a child and need for protective intervention.
Minister	Minister for Children and Minister for Community Services.
Non-accidental death	Category of death: includes death due to physical abuse, assault and homicide.
Notification	Report made to Child Protection of concern that a child is at risk of abuse or neglect.
Paper review	Type of Child Death Inquiry applied when the first notification to Child Protection is due to the incident that resulted in death.
Protective Intervention	Ongoing Child Protection involvement, following substantiation of risk or harm, to ensure the safety and wellbeing of the child.
Region	Regional Departmental Child Protection service which provides services to its locality. There are eight Departmental regions: three metropolitan and five rural regions.

Reviewer	External professional appointed to conduct child death inquiries. Senior departmental officers may also be appointed to conduct child death inquiries.
SIDS	Category of death: Sudden Infant Death Syndrome must be substantiated by coronial documents.
SIPW	Specialist Infant Protective Workers.
Suicide/self harm/ risk taking	Category of death: includes deaths due to suicide and risk taking behaviour.
Substantiation	Abuse or likelihood of abuse or neglect to the child has been substantiated by a Child Protection investigation.
Supervision Order	Order made under the CYPA (1989). This order enables a child to remain in the care of their parents with supervision from the Department.
VCDRC	Victorian Child Death Review Committee also referred to as the 'committee'.
VIFM	Victorian Institute of Forensic Medicine.
VRF	Victorian Risk Framework. A guided professional judgment approach to the assessment of safety and well being for children and young people involved in Child Protection.

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