

Annual report of
inquiries into the deaths
of children known to
Child Protection 2007

Victorian Child Death Review Committee

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Foreword

This is the twelfth Annual Report of the Victorian Child Death Review Committee (VCDRC). The VCDRC provides a multidisciplinary, external review of the deaths of children who are current or recent clients of the state's Child Protection service.

The death of a child has a devastating impact on all those involved. On behalf of the VCDRC, I extend my sympathy to the families and friends of all the children whose deaths are considered and to the many professionals who provided support and assistance.

Victoria's child death inquiry and review process examines the death of each child individually and then in aggregate, to identify common themes and emerging trends. This process is designed to ensure that high standards of public accountability are achieved while promoting a critically reflective culture within Child Protection and related services. Recommendations arising from the process are made to the Department of Human Services through the Minister for Community Services, ensuring that key findings influence future policy and practice.

In this reporting period, the committee's attention has been drawn to the challenge of achieving a partnership approach to protecting children. While the VCDRC shares the government's commitment to making the protection of children a whole of community responsibility, the child death inquiry process provides insight into some of the specific challenges involved. These are explored in detail in this year's report.

As in previous years, the largest group of child deaths reviewed in this period resulted from illness and disease, most commonly associated with congenital conditions. Children born with complex medical needs require a higher standard of parenting than is usual; the consequences of neglectful parenting are particularly serious for these children. This year's report explores some of the specific issues involved in protecting children with additional care needs.

As I approach the final term of my appointment, I take this opportunity to thank my colleagues on the committee for their expertise, professionalism and ongoing commitment to improving service outcomes for vulnerable children. I wish them well in their future deliberations.

The VCDRC hopes that the information in this report will be useful to all those involved in protecting children and promoting their wellbeing.

A handwritten signature in black ink, appearing to read 'Lisa Ward', with a stylized flourish at the end.

Lisa Ward
Chairperson
Victorian Child Death Review Committee
May 2007

Acknowledgements

Many people have assisted with the preparation of this report.

Bernie Geary, Victorian Child Safety Commissioner, is a strong advocate of the committee's work and provides both practical support and resources. Chris Walsh, Manager, Inquiries and Review Unit, is responsible for monitoring recommendations arising from the child death inquiry process while Kay Warn, Program Advisor, Inquiries and Review Unit, oversees data collection and analysis. Their contributions are much appreciated.

Mary McAlorum and her team within the Office of the Child Safety Commissioner oversee the conduct of child death inquiries and provide the Victorian Child Death Review Committee with source material and essential support. Their hard work and commitment to continuous improvement are much appreciated.

Experienced practitioners external to the Office of the Child Safety Commissioner are appointed in some instances to lead the child death inquiry process. Their expertise and sensitivity are gratefully acknowledged.

Johanna Breen, Senior Policy Advisor, Child Protection and Family Services Branch, acts as a liaison point within the Department of Human Services. Her assistance in providing program information and feedback on draft material has been valuable.

Finally, the VCDRC is supported by a part-time Executive Officer, Loula Dounias, who has overseen the production of this report. Her commitment and expertise enable the committee to discharge its obligations effectively and are highly valued by VCDRC members.

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Executive summary

The Victorian Child Death Review Committee (VCDRC), an independent, multidisciplinary ministerial advisory body, has prepared the *Annual report of inquiries into the deaths of children known to Child Protection 2007*. 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. First, it provides quantitative and demographic data about the deaths of children known to Child Protection that occurred in 2006. Second, it provides qualitative analysis of child death inquiries reviewed by the VCDRC in the reporting period between April 2006 and March 2007.

This year, the annual report also presents the findings of the report *Child Death Group Analysis: Effective responses to chronic neglect* (2006).

1. Overview of deaths of children known to Child Protection in 2006

Historical analysis suggests that the death rate in the Child Protection population is broadly comparable with the death rate in the general Victorian community.

A total of 18 children who were known to Child Protection died in 2006: nine from acquired/congenital illness, four for reasons unknown or yet to be determined, four from accidents and one from SIDS.

In 2006, more than half the child deaths involved infants younger than six months of age. Sixty-seven per cent of deaths involved children aged younger than one year. No adolescent deaths were recorded in 2006.

There was one death of an Aboriginal child known to Child Protection in 2006.

2. Overview of child death inquiries reviewed in 2006–07

The VCDRC reviewed 13 child deaths between April 2006 and March 2007. Of these, five children died from acquired/congenital illness, two from accidents, two from non-accidental trauma and one from suicide. In two cases, the cause of death was unascertainable by the State Coroner. Coronial findings are still pending in one other case.

The majority of children whose deaths were reviewed in this period were in the care of family at the time of their death or the events that led to their death.

The most significant feature of the families involved in child death reviews was the co-existence of a number of factors that are known to reduce parenting capacity. These factors include family violence, parental substance abuse and parental mental illness. In 11 of the 13 child deaths reviewed, families presented with more than one of these characteristics, most commonly family violence and substance use or family violence and mental illness.

As a result of their multiple, complex needs, most families involved in child death reviews had contact with several different service systems at any given time. This underscores the importance of clearly defined collaborative arrangements across service systems, based on a common understanding of roles and responsibilities and a shared language and practice framework.

3. Themes and issues

A shared approach to protecting children

In the current reporting period, issues with coordination and collaboration between services were noted in ten of the 13 child deaths reviewed. The consequences of deficient interagency collaboration were most pronounced at the point of Child Protection case closure or discharge from hospital.

The child deaths reviewed in this period indicate that we are still some way from the ideal scenario in which the protection of children is genuinely seen as a shared community responsibility. In several cases, community agencies reported that they lacked role clarity or that they assumed Child Protection was involved and responsible for monitoring child safety. It is vital that **all** services involved with children and families work proactively and assertively to protect children and ensure their wellbeing.

Many of the child deaths reviewed highlighted the need for enhanced partnerships between Child Protection and other service systems including education, disability and acute health services. The VCDRC anticipates that Victoria's new legislative framework will provide an impetus for this work to occur.

- *Education*

Three of the four adolescent deaths reviewed featured a history of interrupted school attendance. One of these included a young person who did not attend school for at least two years prior to his death at 15 years. The VCDRC has recommended that targeted outreach strategies to promote school attendance among high risk adolescent sub groups, be explored by the Department of Education.

- *Disability*

Two child deaths reviewed involved children and/or parents with a registered intellectual disability. In both of these cases collaboration and coordination between Child Protection and disability services was less than optimal. The VCDRC has recommended that the 1993 protocol between disability services and Child Protection be reviewed as a priority.

- *Acute health*

Acute health services played an active role in more than half the cases reviewed in this period. Many of these cases involved children with complex medical needs and/or disabilities. In some of these cases the relationship between Child Protection and acute health services was positive, characterised by proactive information sharing, timely case conferencing, shared decision making and clear role assignment. However, the relationship between Child Protection and acute health services was problematic in other cases. Most commonly, this related to a lack of understanding of roles and responsibilities and the absence of common practice frameworks across the two service systems.

The VCDRC has welcomed recent program development activity within acute health services aimed at addressing these issues. As part of the implementation process, the VCDRC has recommended the development of specific protocols incorporating procedures for achieving role clarity and developing medical treatment plans for children with complex medical needs and/or a limited life expectancy.

Aspects of Child Protection practice

- *Comprehensive family assessment*

Family assessment lays the foundation for subsequent protective case planning. The need for a more comprehensive approach to family assessment was identified in eight of the child deaths reviewed in this period. Common problems included a lack of involvement of the biological father in assessment and case planning processes; a lack of assessment of the child's extended family network and insufficient attention to the historical antecedents of present parental behaviour and the impact of this on future parenting.

- *Case closure*

Premature case closure was identified in six of the child death cases reviewed. Problems with case closure were most prevalent in situations involving chronic neglect where families were subject to multiple notifications over time. In these circumstances, it is vital that Child Protection and its community partners consider the family's history of non-attendance at services and ensure that community agencies are properly engaged prior to case closure.

- *Specialist infant protective workers*

The child death inquiry and review process continues to reinforce the valuable contribution made by Specialist Infant Protective Workers (SIPWs). In several cases reviewed, the SIPW's advice was timely, well informed, insightful and extremely child-centred. Their capacity to operate as a mentor and coach to less experienced workers was evident. In some cases, the SIPWs were particularly helpful in mediating the relationship between health professionals and Child Protection, alerting protective interveners to the types of issues and questions that warrant further investigation.

- *Quality assurance mechanisms*

The VCDRC was concerned to note that in three cases reviewed in this period, regional accountability structures failed to alert management to significant deficits in Child Protection practice. The VCDRC has advocated a range of monitoring and quality assurance mechanisms at the regional level to mitigate the impact of individual worker error or system failure.

Children with complex medical needs

Infants born with complex medical needs and/or disabilities continue to dominate the child death data numerically and pose a unique set of challenges to both acute health and Child Protection practitioners. In this period, six of the 13 child deaths reviewed involved children with high medical support needs; five of the eight infant deaths reviewed are linked directly to prematurity and/or congenital conditions.

Several examples of good practice with these families were noted in the current reporting period. At the same time, children with high medical support needs continue to present a range of case practice dilemmas for Child Protection. Key challenges include balancing the need for comprehensive discharge planning with an uncertain or poor prognosis; developing contingency plans in the face of an uncertain prognosis; and asserting leadership in protective risk assessment with medical and other professionals.

High quality community support

One of the strong themes that emerged in this reporting period was the capacity of community-based services to offer sustained support to very vulnerable families over extended periods of time. In two notable cases, community-based services were persistent in their attempts to engage with families and build a constructive relationship over time while maintaining a child-centred practice focus. These examples inspire confidence in the community partnership approach to protecting children that underpins Victoria's legislative reforms.

4. Effective responses to chronic neglect— group analysis report summary

In this reporting period, the VCDRC considered a group analysis that examines the effectiveness of responses by Child Protection and related services to chronic neglect. The report highlights the need for a strategic, realistic and compassionate approach to addressing the structural and intergenerational patterns associated with chronic neglect and proposes a range of best practice principles to guide future service delivery.

The VCDRC found the group analysis to be a valuable and insightful report and noted several key themes:

- Recognising that neglect often occurs in the context of the child having extraordinary needs, including intellectual and physical disabilities and complex medical needs, that increase both the level of parenting required and the vulnerability of the child to a lack of appropriate care.
- Understanding that children’s developmental histories need to include prenatal information and incorporate factors that are known to increase the probability of neglect occurring and/or heighten its potential impact.
- Appreciating that when neglect co-occurs with other forms of maltreatment, the risk to the child increases exponentially. It is important that neglect not be considered the lesser form of problem, given evidence regarding its harmful consequences. It is also critical that the presence of chronic neglect does not obscure other forms of maltreatment.
- Recognising that universal services, including child care, preschools and schools, have an important role to play in ameliorating the harm arising from chronic neglect and in monitoring the safety and wellbeing of children.
- Understanding that the use of case reviews, audits, internal and external consultants, supervision and case conferences are all important tools in maintaining persistent, sustainable practice and avoiding or correcting case drift.
- Appreciating that referral to secondary support services must occur in a proactive, supportive manner that acknowledges the family’s history of participation with services and ensures meaningful engagement has occurred prior to case closure.

The VCDRC made 17 recommendations in response to the report. All of these have since been accepted by the Department of Human Services and the Office of the Child Safety Commissioner. Most importantly, the report has directly influenced foundational program documentation that will underpin the adoption of Victoria’s new policy and legislative framework.

The VCDRC is pleased to note that the learning arising from this small group of child deaths has been used to directly improve future policy and practice.

5. The year in review; the year ahead

The VCDRC is committed to ensuring that recommendations arising from the child death inquiry and review process are responded to in a timely and direct manner and that their implementation is actively monitored over time. In last year's annual report, the committee indicated its commitment to streamline arrangements for tracking child death inquiry recommendations. The new arrangements are now in place. It is envisaged that they will provide more accurate, timely feedback regarding the impact of the child death inquiry process on future policy and practice.

The VCDRC continues to monitor the progress of initiatives arising from its past group analyses, in particular, *Children with complex medical needs and a limited life expectancy* (2004) and *Tackling SIDS—a community responsibility* (2005). In the past year, the VCDRC has been pleased to note that a range of actions has been taken in response to both inquiry reports.

In the year ahead, the VCDRC will partner with the Office of the Child Safety Commissioner in a communication strategy aimed at explaining the child death inquiry process to key stakeholders. Insights gained in the process will be used to shape future refinements to the child death inquiry and review function. The committee has also sought the Office of the Child Safety Commissioner's assistance in exploring a range of issues related to the categorisation of child deaths in an effort to achieve greater consistency across jurisdictions.

The child death inquiry process is ultimately about achieving better outcomes for vulnerable children and families. In the year ahead, the VCDRC will continue to use every available opportunity to ensure that lessons learned from the death of a child are communicated widely and used to drive ongoing system change.

1. Introduction

This report has been prepared by the Victorian Child Death Review Committee (VCDRC), an external, 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 about the deaths of children known to Child Protection that occurred in 2006. Second, it provides qualitative analysis of child death inquiries reviewed by the VCDRC between April 2006 and March 2007. Most of these inquiries relate to deaths that actually occurred in 2005 and 2006. 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 VCDRC initiates 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 *Child Death Group Analysis: Effective responses to chronic neglect* (2006).

The 2007 annual report is structured as follows:

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

Section 3 provides quantitative and demographic data about the deaths of children known to Child Protection that occurred in 2006. These deaths are placed in an historical context, using additional data relating to the deaths of children known to Child Protection since 1996.

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

Section 5 presents the findings of the report, *Child Death Group Analysis: Effective responses to chronic neglect* (2006). This report provides a review of current research and proposes a range of best practice principles to guide future responses to chronic neglect and associated harms.

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 with child deaths 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, Deaths and Marriages

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 the 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*. Victoria Police assists the Coroner's office in its investigative function.

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 provides specialist medical and scientific services to the Coroner, police and government agencies. The Victorian Institute of Forensic Medicine has specially trained paediatric forensic pathologists who may perform autopsies on 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 the Child Protection service. Similarly, when the Child Protection service is notified of the death of a client, contact is made with the Coroner's office to ensure all parties are aware of Child Protection's involvement with the child. When a current or recent client of Child Protection dies, the Department of Human Services notifies the Office of the Child Safety Commissioner. This individual is then entered onto the Office of the Child Safety Commissioner's Child Death Register and an inquiry into the death is established.

Office of the Child Safety Commissioner

The Office of the Child Safety Commissioner is responsible for establishing and overseeing inquiries into the deaths of all current and recent clients of the state's Child Protection service. These inquiries are conducted in accordance with the processes described in section 2.2 below. The Office monitors the implementation of recommendations arising from the child death inquiry and review process and provides a range of administrative support services to the VCDRC.

Victorian Child Death Review Committee

The VCDRC is a multidisciplinary ministerial advisory committee that reviews child death inquiries prepared by the Office of the Child Safety Commissioner's Inquiries and Review Unit. The VCDRC examines the deaths of all children and young people who are clients of Child Protection at the time of their death or within three months of their death. The VCDRC provides expert advice to the 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 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 Consultative Council on Obstetric and Paediatric Mortality and Morbidity, which includes a range of demographic and descriptive data. These reports inform the council's comprehensive annual report on perinatal, infant and child deaths in Victoria.

Identifying multiple sibling deaths

Under the *Coroners Act 1985*, the State Coroner has the authority to refer the second or subsequent death of a child within the one family to the Victorian Institute of Forensic Medicine for investigation. When a child death is notified to the Registrar of Births, Deaths and Marriages, the Registrar is 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.

2.2 Office of the Child Safety Commissioner child death inquiry process

Establishing a child death inquiry

The *Child Wellbeing and Safety Act 2005* contains a number of provisions regarding the conduct of child death inquiries. The Act states that the object of such inquiries is to promote continuous improvement and innovation in policies and practices relating to child protection and safety (s. 33(2)).

All children who are clients of Child Protection at the time of their death or within three months of their death are recorded on the Child Death Register held in the Office of the Child Safety Commissioner's Inquiries and Review Unit.

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

An Inquiries and Review Unit case reviewer is responsible for conducting case related research and coordinating all activities associated with the inquiry process. An external case analyst is usually appointed to provide expert advice and opinion on case issues, prepare an analysis and develop findings.

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 Child Protection 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 of Human Services and other agencies were adequate and appropriate in providing a service to the client.

The child death inquiry process uses a reflective practice approach in which 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 is properly the role of Victoria Police and the Coroner. The aim of the process is to distil key learnings that will influence future policy and practice approaches, both regionally and at a program level.

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 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 relevant government legislation.

The child death inquiry process relies on the participation of relevant workers within the Department of Human Services, community agencies and experts in relevant fields. The Child Wellbeing and Safety Act requires a range of health and human services to provide information to the Child Safety Commissioner about a child who is the subject of an inquiry. Families and carers of the deceased child are also invited to contribute.

Revisiting the death of a child or young person is an emotional experience for all those involved. The Inquiries and Review Unit briefs participants on the inquiry process and ensures debriefing and support services are made available to participants as required.

Child death inquiry reports

The child death inquiry reports produce findings arising from the investigation process. The VCDRC is responsible for formulating recommendations in response to these findings as required.

A draft child death inquiry report is forwarded to the Department of Human Services and other key stakeholders for comment. The report takes into account 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 key Department of Human Services documents and coronial documentation, where this is available. The VCDRC reviews each child death inquiry and advises the Minister for Community Services of its deliberations in each case and any recommendations arising.

Group analysis of child deaths

The VCDRC, the Child Safety Commissioner or the Minister for Community Services may request an analysis of a group of child deaths that share similar characteristics. The Child Safety Commissioner makes the decision to conduct a group analysis.

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.

This year, the VCDRC commissioned and reviewed the *Child Death Group Analysis: Effective responses to chronic neglect* (2006). A summary of this group analysis is provided in section 5 of this annual report.

2.3 Victorian Child Death Review Committee

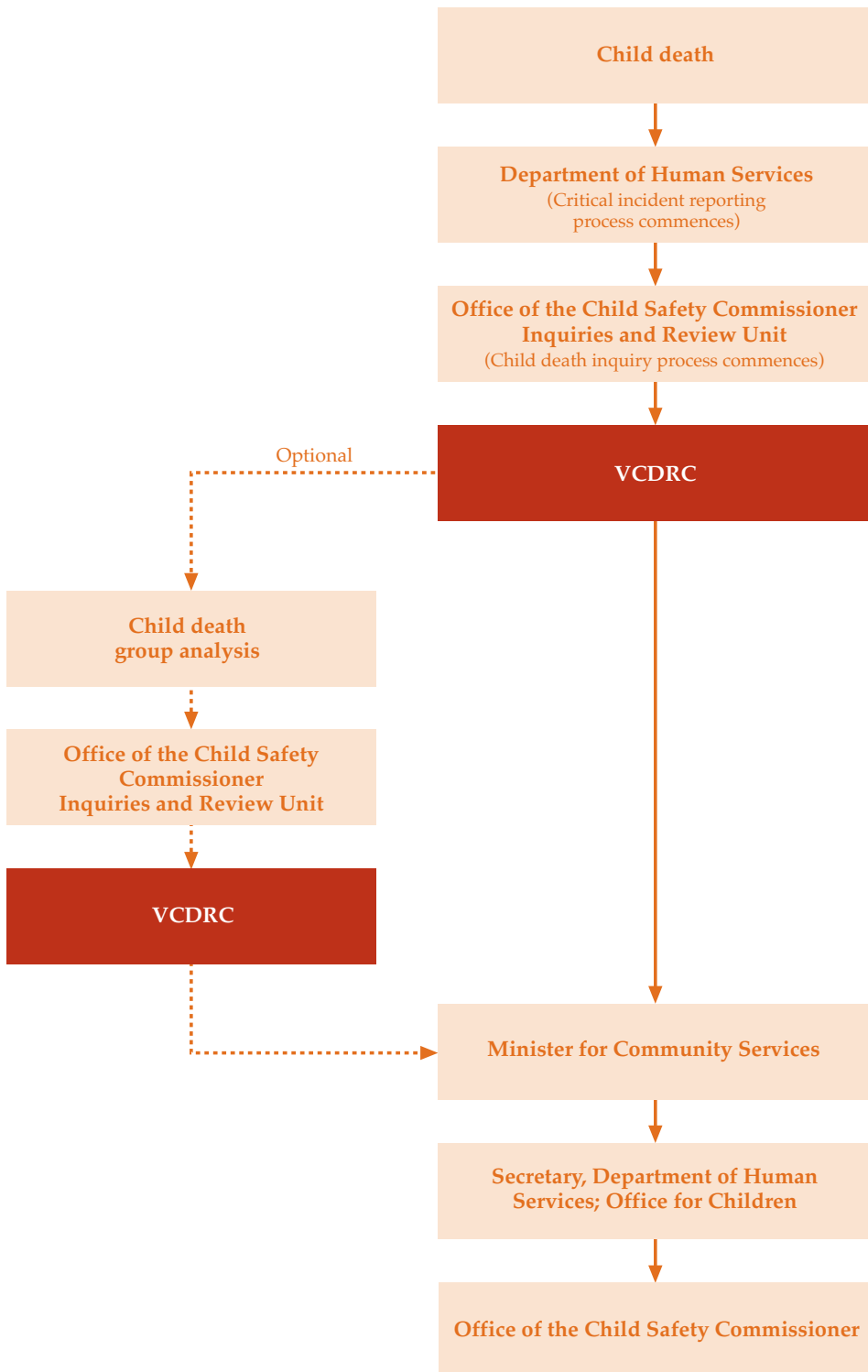
The VCDRC provides a multidisciplinary external review of all child death inquiries prepared by the Office of the Child Safety Commissioner. The committee provides expert advice to the Minister for Community Services on policy, procedural and practice issues arising from these inquiries.

The committee approaches its review task by appointing to each case an individual member as a lead analyst. This member presents the case to the committee, identifying key themes and threshold issues, and leads the group discussion.

Individual child death inquiries produce findings that are referred to the VCDRC for consideration. The committee then determines whether any recommendations for action are required. Recommendations made by the VCDRC may be case-specific or address issues arising from a cluster of cases. The Minister for Community Services is formally advised of the committee's deliberations about each child death reviewed.

In the past 12 months, the Office of the Child Safety Commissioner has worked with the Office for Children within the Department of Human Services to streamline arrangements for tracking and reporting action on recommendations over time. Under revised arrangements, the Office for Children will formally coordinate responses to the child death inquiry process from all other program areas within the Department of Human Services portfolio. A new database has been established within the Office of the Child Safety Commissioner to monitor the implementation status of individual recommendations. It is envisaged that this will provide more timely, accurate and comprehensive feedback on the outcomes of the child death inquiry process.

Figure 2.1: Office of the Child Safety Commissioner child death inquiry model for the 2006–07 reporting period



Terms of reference of the VCDRC

1. To review the deaths of all children and young people who were clients of the Victorian Child Protection service at the time of their death or within three months of their death and advise the Minister for Community Services of the committee's deliberations*
2. To identify particular groups of child deaths that may benefit from further investigation or research
3. To analyse and comment on any themes, trends or patterns that emerge from the review of inquiry reports
4. To comment on service and system responses to children and families arising from the review of inquiry reports and receive feedback on the implementation of service system reforms
5. To provide advice to the Minister for Community Services on the child death inquiry process
6. To prepare an annual report for the Minister for Community Services
7. To perform other functions in relation to child deaths as directed by the Minister for Community Services

* Note that children with no prior Child Protection involvement who are first notified at the time of the incident that leads to their death are not included in this criterion.

Current VCDRC membership

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.

Ms Lisa Ward
Chairperson
Human Services Consultant
Member of the Ministerial Advisory
Committee on Women's Correctional
Services Victoria, Member of the Adult
Parole Board

Dr John McNamara
Consultant Paediatric Physician
(Retired)
Royal Children's Hospital
Member of the Medical Practitioner
Board of Victoria

Ms Paresa Antoniadis Spanos
Coroner
State Coroner's Office
Victoria

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

Ms Robyn Miller
Principal Child Protection Practitioner
Office for Children
Victorian Department of Human
Services

Mr John Leatherland
Regional Director
Eastern Metropolitan Region
Victorian Department of Human
Services

Senior Sergeant Dagmar Andersen
Officer in Charge
Sexual Offences and Child Abuse Unit
Region 2, Division 1
Victoria Police

Ms Lucy Raponi
Barrister at Law

Ms Jill Gallagher
Chief Executive Officer
Victorian Aboriginal Community
Controlled Health Organisation

Ms Sandie de Wolf
Chief Executive Officer
Berry Street Victoria

Mr Bill Stronach
Chief Executive Officer
Australian Drug Foundation

Retired members

Mr Paul McDonald
Community Care Manager
North and West Metropolitan Region
Victorian Department of Human
Services

Superintendent Rod Jouning
Divisional Superintendent
Victoria Police

Ms Margaret Wagstaff
Human Services Consultant
Member of the Adult, Community and
Further Education Board and Director
of the Bendigo Health Group Board
Victoria

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

Mr Laurie Harkin
Regional Director
Southern Metropolitan Region
Victorian Department of Human
Services

Membership changes

In the past year, Mr Paul McDonald, Superintendent Rod Jouning, Ms Margaret Wagstaff, Ms Marg Stewart and Mr Laurie Harkin have completed their terms of appointment on the VCDRC. The committee would like to acknowledge the significant work carried out by all members and express its appreciation for their dedication and professionalism.

In 2006–07, the VCDRC was pleased to enlist the support of several new members: Senior Sergeant Dagmar Andersen, Officer in Charge of the Sexual Offences and Child Abuse Unit, Region 2, Division 1, Victoria Police; Ms Lucy Raponi, Barrister at Law; Ms Jill Gallagher, Chief Executive Officer of the Victorian Aboriginal Community Controlled Health Organisation; Ms Sandie de Wolf, Chief Executive Officer of Berry Street Victoria; Mr Bill Stronach, Chief Executive Officer of the Australian Drug Foundation; and Mr John Leatherland, Regional Director of the Eastern Metropolitan Region, Department of Human Services. The new members bring significant knowledge and skill from their respective professions and backgrounds.

3. Child deaths occurring in 2006

3.1 Overview of deaths of children known to Child Protection in 2006

This section provides an overview of child deaths that occurred in 2006 and an analysis of trends in child deaths from 1996, when the first VCDRC annual report was tabled in Parliament.

Historical analysis suggests that the death rate among 0–17 year olds in the Child Protection population is broadly comparable with the death rate among 0–17 year olds in the general Victorian community. For example, the most recent data on childhood deaths available from the Australian Bureau of Statistics indicate that 495 children and young people between the ages 0–17 years died in Victoria in 2005. This equates to a death rate of 0.43 per 1,000 in the 0–17 year old general population compared with 0.49 per 1,000 active clients in the Child Protection population. Year-on-year analysis reveals a close relationship between the two death rates, with the death rate among Child Protection clients sometimes slightly higher and sometimes slightly lower than that of the general population.

After more than a decade of monitoring child deaths in the Child Protection population, the VCDRC has not observed any meaningful trends in the number of deaths that occur each year. In 2006, 18 children died who were current or recent clients of the state's Child Protection service compared with 32 deaths in 2002, 12 deaths in 2003, 16 deaths in 2004 and 11 deaths in 2005. The child death review process looks beyond numbers and endeavours to build a comprehensive picture of the individual, family, community and service system issues that are relevant in each child's case.

Table 3.1 Deaths of children known to Child Protection in 2006: age and locality (N=18)

Age at death	Category of death	Locality
8 days	Acquired / congenital illness	Rural
9 days	Not known	Metropolitan
12 days	Acquired / congenital illness	Metropolitan
16 days	Not known	Rural
1 month	Acquired / congenital illness	Metropolitan
1 month	Acquired / congenital illness	Metropolitan
2 months	SIDS	Metropolitan
3 months	Acquired / congenital illness	Rural
3 months	Acquired / congenital illness	Metropolitan
3 months	Not known	Metropolitan
6 months	Not known	Metropolitan
11 months	Accident	Rural
12 months	Acquired / congenital illness	Rural
3 years	Accident	Rural
4 years	Accident	Rural
4 years	Acquired / congenital illness	Metropolitan
11 years	Accident	Rural
12 years	Acquired / congenital illness	Metropolitan
Total: 18		

Table 3.2 provides annual data about the number of notifications received by Child Protection, the number of these that are formally investigated, the number where protective concerns are proven or substantiated, and the number of active clients during each period. The table also shows the number of deaths of children known to Child Protection and expresses this figure as a death rate per 1,000 active clients.

Table 3.2 Total notifications, investigations, substantiations, active clients and deaths known to Child Protection 1996–2006

Year	Notifications	Investigations	Substantiations	Active clients	Total deaths	Death rate**
1996	31,010	13,954	6,798	28,337	19	0.67
1997	32,642	14,606	7,126	29,878	16	0.53
1998	34,668	14,524	7,649	31,661	11	0.34
1999	36,291	13,283	7,560	32,268	17	0.52
2000	36,501	12,446	7,341	32,432	25	0.77
2001	38,686	13,220	8,015	34,376	12	0.34
2002	38,850	13,455	7,862	34,430	32	0.92
2003	38,189	12,618	7,309	34,077	12	0.35
2004	38,206	12,404	7,897	34,515	16	0.46
2005	37,242	11,346	7,510	34,710	11	0.31
2006	37,991	11,526	7,367*	36,475	18	0.49

* This number may change as investigations are completed.

** Rate of deaths per 1,000 active clients

Data updates may result in minor variations to data in previous reports.

Age and gender of children who died in 2006

Of the 18 children who died in 2006, 12 (67 per cent) were infants aged younger than 12 months: ten of these were younger than six months of age. Four children were aged 4–12 years. There were no adolescent deaths recorded in 2006.

Table 3.3 Deaths of children known to Child Protection in 2006: age and gender (N=18)

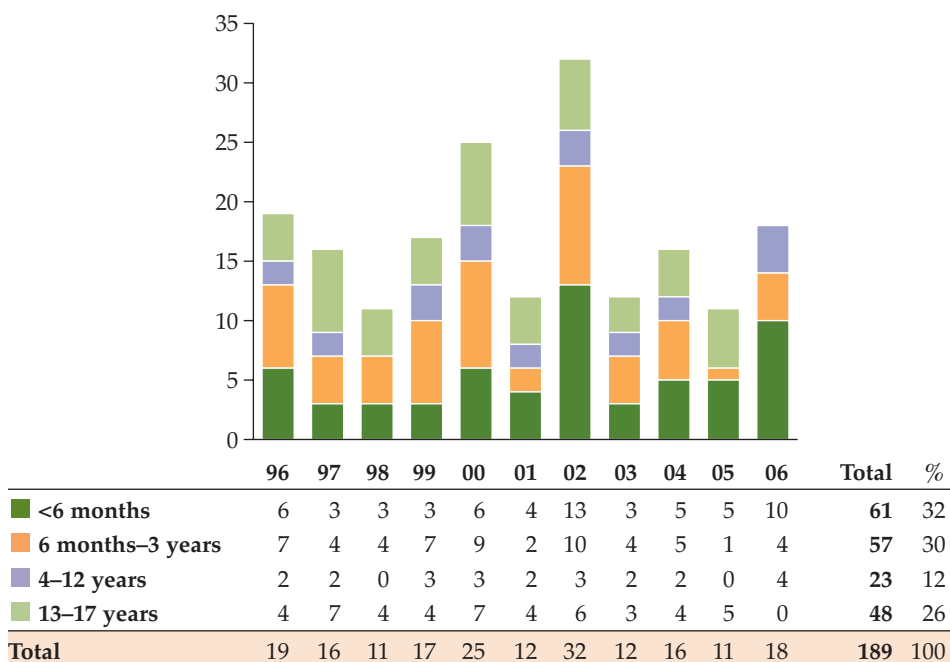
	0–<6 months	6 months–3 years	4–12 years	13–17 years	Total
Female	4	2	1	–	7
Male	6	2	3	–	11
Total	10	4	4	0	18

Age of children who died 1996–2006

Over time, the greatest number of deaths is of infants aged between birth and six months (61); children aged between six months and three years make up the next group (57), followed by young people aged between 13 and 17 years (48). Primary school age children make up the lowest number of deaths (23).

Infants aged 0–3 years are the most represented age cluster, comprising 62 per cent of all deaths within the Child Protection population over time.

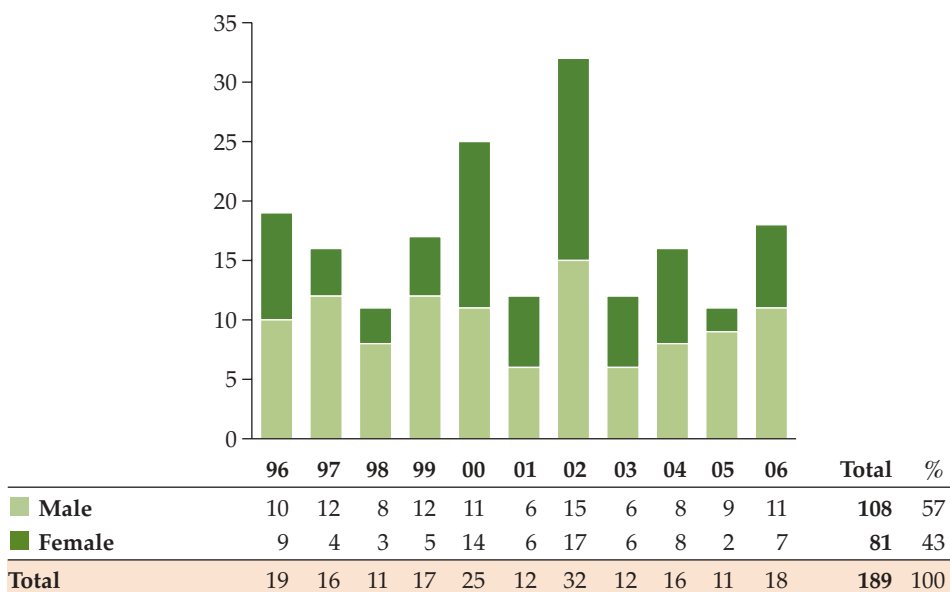
Figure 3.1 Deaths of children known to Child Protection 1996–2006: age (N=189)



Gender of children who died 1996–2006

Over time, the proportion of male deaths is 57 per cent compared with female deaths at 43 per cent.

Figure 3.2 Deaths of children known to Child Protection 1996–2006: gender (N=189)



Category of death 2006

Table 3.4 provides information on the category of death for children who were known to Child Protection in 2006. The Inquiries and Review 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.

Categorisation of death is more conclusive after a coronial investigation, which is pending for a number of deaths that occurred in 2006. For this reason, figures may alter across annual reports. In particular, the category of not known is likely to reduce over time as coronial investigations are concluded. Of the 18 deaths of children known to Child Protection in 2006, four are still pending coronial findings and as such are identified as category of death not known.

In 2006, the four deaths categorised as accidental comprised one death in a road accident, one death in a drowning and two deaths in a fire.

There were nine deaths in 2006 that were attributed to an acquired/congenital illness. The acquired/congenital illness category includes deaths due to congenital conditions, prematurity, malignancy, acute infections and serious health episodes, such as epilepsy or cardiac arrest.

One death in 2006 was attributed to SIDS.

At this stage, none of the child deaths that occurred in 2006 have been attributed to non-accidental trauma, drug/substance abuse or suicide.

Table 3.4 Deaths of children known to Child Protection in 2006: category of death by age (N=18)

Category	6 months–				Total
	0–<6 months	3 years	4–12 years	13–17 years	
Accidental death	-	2	2	-	4
Acquired/congenital illness	6	1	2	-	9
Drug/substance related	-	-	-	-	-
Non-accidental trauma	-	-	-	-	-
Not known—pending coronial findings	3	1	-	-	4
SIDS	1	-	-	-	1
Suicide/self-harm/risk-taking behaviour	-	-	-	-	-
Total	10	4	4	-	18

Category of death 1996–2006

Between 1996 and 2006, the largest category of death among children known to Child Protection was acquired/congenital illness, accounting for 34 per cent of total deaths.

The second largest category was accidental deaths, comprising 20 per cent of child death recorded. Of the 37 deaths attributed to accidents, 17 involved road fatalities, six death by drowning and five deaths involving fire. The remaining nine deaths were due to a range of other causes.

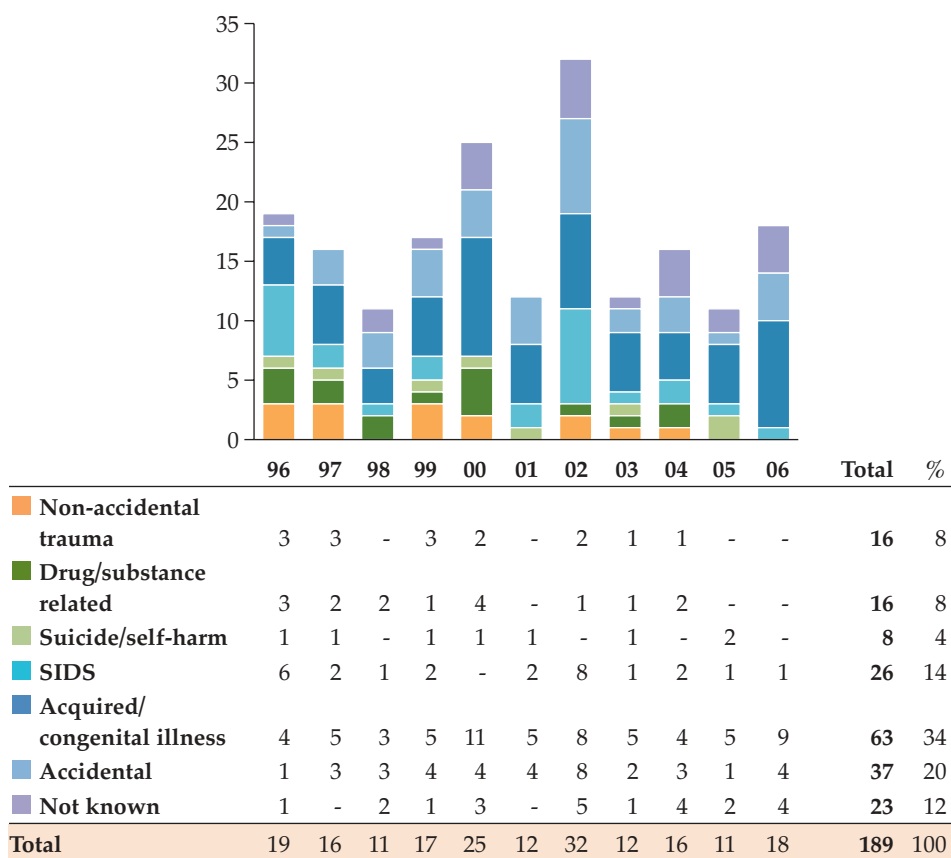
Between 1996 and 2006, there were 26 deaths attributable to SIDS. SIDS is a diagnosis of exclusion, applied when no other cause of death can be confirmed.

Between 1996 and 2006, 23 deaths were categorised as cause of death not known. This includes deaths that are pending coronial findings and cases where the coronial findings indicate the cause of death was not ascertainable.

From 1996 to 2006, 16 deaths were categorised as non-accidental trauma. This categorisation includes deaths due to physical abuse, homicide and cases where a child or young person is missing, presumed dead. Four of the 16 cases of non-accidental trauma had minimal involvement with Child Protection.

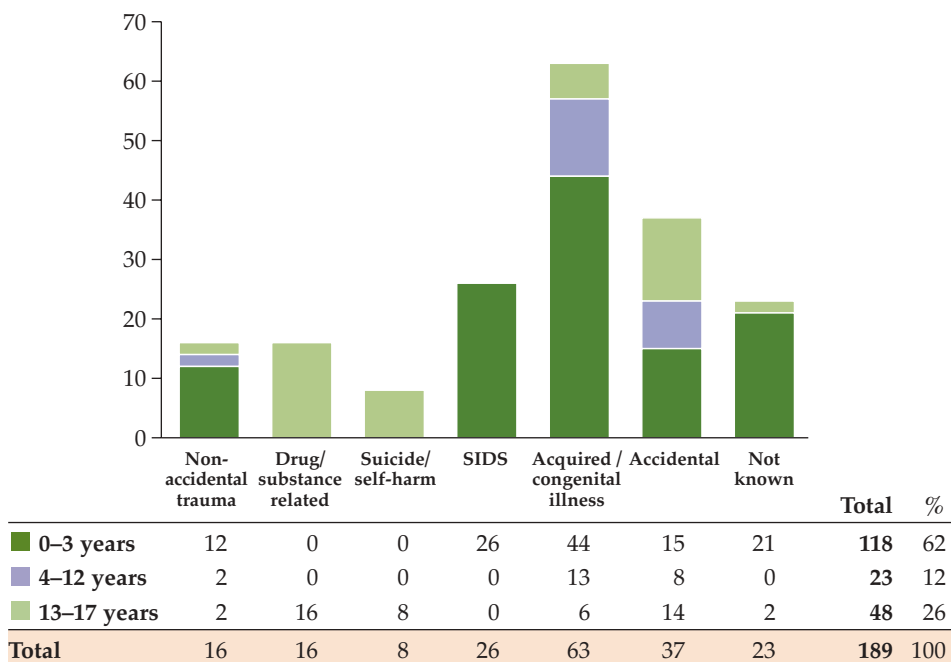
From 1996 to 2006, the deaths of 16 young people were attributed to substance use. This category includes cases where death was related to the use of intravenous drugs, inhalants, methadone toxicity and poly-drug use. During the same period, a further eight adolescent deaths were categorised as due to suicide/self-harm/risk-taking behaviour.

Figure 3.3 Deaths of children known to Child Protection 1996–2006: category of death (N=189)



The VCDRC has found it instructive to analyse category of death by age over time. For example, acquired illness and SIDS have been highlighted as major categories of death for children aged 0–3 years, while drug/substance related deaths and accidental deaths are most common among adolescents. The following discussion analyses category of death in each of three main groupings: infants, primary school age children and adolescents.

Figure 3.4 Deaths of children known to Child Protection 1996–2006: category of death by age (N=189)



Infants (0–3 years)

From 1996 to 2006, there were 118 deaths in the 0–3 age group, comprising 62 per cent of total deaths. Of these, 61 were younger than six months. Deaths of infants younger than six months make up 32 per cent of the total deaths.

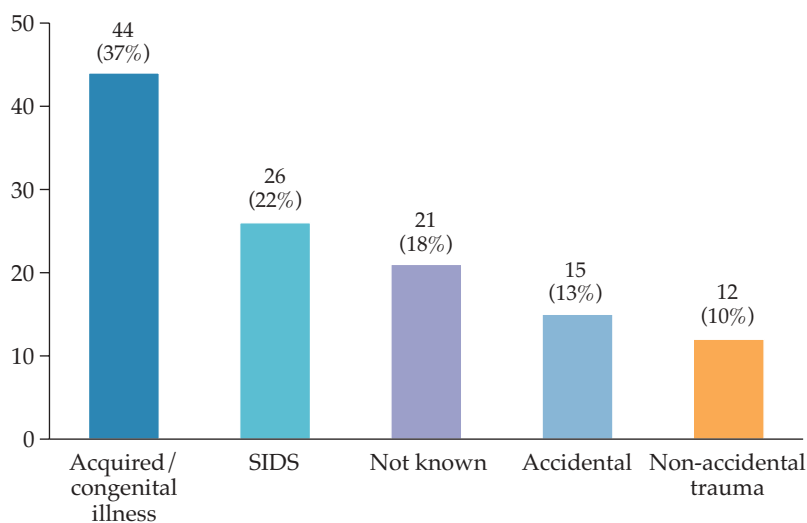
The most common category of death in the 0–3 age group is acquired/congenital illness, comprising 44 deaths. The second largest category of death among infants is SIDS. Between 1996 and 2006, 26 (22 per cent) infants died from SIDS.

Between 1996 and 2006, 21 infant deaths were categorised as of unknown cause. Of these, eight were categorised as cause of death unascertained by coronial investigation. The other cases have coronial findings pending. Significantly, of the total number of deaths across all age groups categorised as not known, 91 per cent were infants aged three years and under. To ensure accuracy, caution is exercised when categorising infant deaths, especially in relation to SIDS deaths.

Over the 11-year reporting period, 15 of the 118 deaths among infants aged 0–3 years were categorised as accidental. The majority of these involved drowning, road accidents or fire.

Between 1996 and 2006, 12 infants aged 0–3 years died of non-accidental trauma. The most common cause of death for these infants is head injury. Significantly, of the total number of deaths across all age groups categorised as non-accidental trauma, 75 per cent were infants aged 0–3 years.

Figure 3.5 Deaths of children known to Child Protection 1996–2006: infants by category of death (N=118)



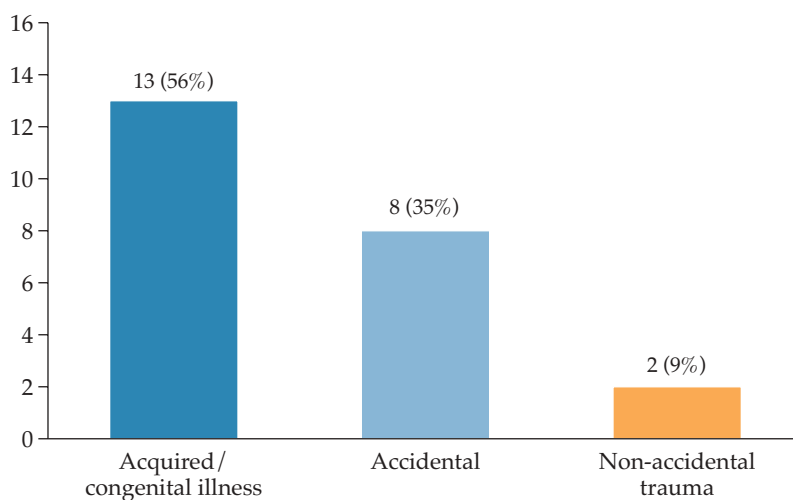
Primary school age children (4–12 years)

From 1996 to 2005, there were 23 deaths among 4–12 year olds, comprising 12 per cent of total deaths in the period. Of these 23 deaths, 13 were due to acquired/congenital illness, which includes deaths as a result of a disability, malignancy or acute infection.

Eight 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 Deaths of children known to Child Protection 1996–2006: primary school age children by category of death (N=23)



Adolescents (13–17 years)

From 1996 to 2006, there were 48 deaths among young people aged 13–17 years, representing 26 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 deaths comprising 16 deaths (33 per cent) in the 11-year period. This category includes cases where death was related to the use of intravenous drugs, inhalants, methadone toxicity and poly-drug use.

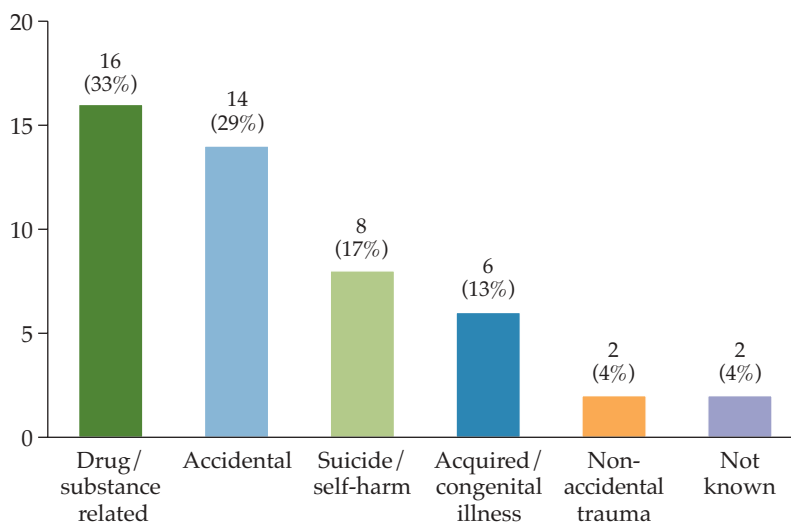
The second largest category of death among adolescents known to Child Protection is accidental death. Between 1996 and 2006, most of the 14 accidental deaths among adolescents involved vehicles, including cars, trains and motorcycles.

Eight adolescent deaths were categorised as due to suicide/self-harm/risk-taking behaviour over the 11-year reporting period.

Between 1996 and 2006, six adolescents died of an acquired/congenital illness. Four of these young people had disabilities and/or long-term serious illnesses.

Between 1996 and 2006, two adolescent deaths were categorised as due to non-accidental trauma. This category includes a case where a young person is missing, presumed dead.

Figure 3.7 Deaths of children known to Child Protection 1996–2006: adolescents by category of death (N=48)



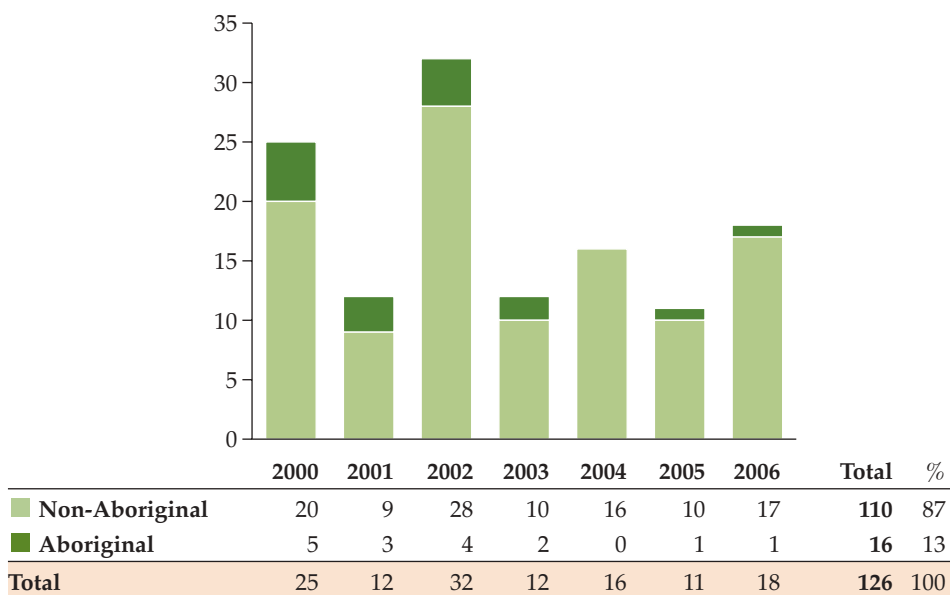
Aboriginal status 2000–06

The VCDRC believes it is important to monitor and report on the deaths of Aboriginal children known to Child Protection. Because the collection of child death information regarding Aboriginal status was inconsistent prior to 2000, data are reported from 2000 onwards.

Aboriginal children are over-represented both within the Child Protection population and within data regarding the deaths of children known to Child Protection. In 2005, Aboriginal children comprised 1 per cent of the total number of children 0–17 years in the Victorian population¹. In 2006, 7 per cent of active clients in the Child Protection population were identified as Aboriginal. In this same period, 5 per cent of child deaths known to Child Protection were identified as Aboriginal. Since 2000, 13 per cent of all deaths known to Child Protection involved Aboriginal children.

Between 2000 and 2006 there were 126 deaths in total, 16 of which involved Aboriginal children. One Aboriginal child death was recorded in 2006.

Figure 3.8 Deaths of children known to Child Protection 2000–2006: Aboriginal and non-Aboriginal deaths (N=126)



1 Australian Bureau of Statistics

Protective status at the time of death

The various phases of protective intervention are described in the glossary at the end of this report and are consistent with the protective phases shown in the Child Protection information system, CASIS.

In 2006, seven children were at the intake phase at the time of death, two were in the initial investigation phase and three children were in the protective intervention phase. Six cases were recently closed.

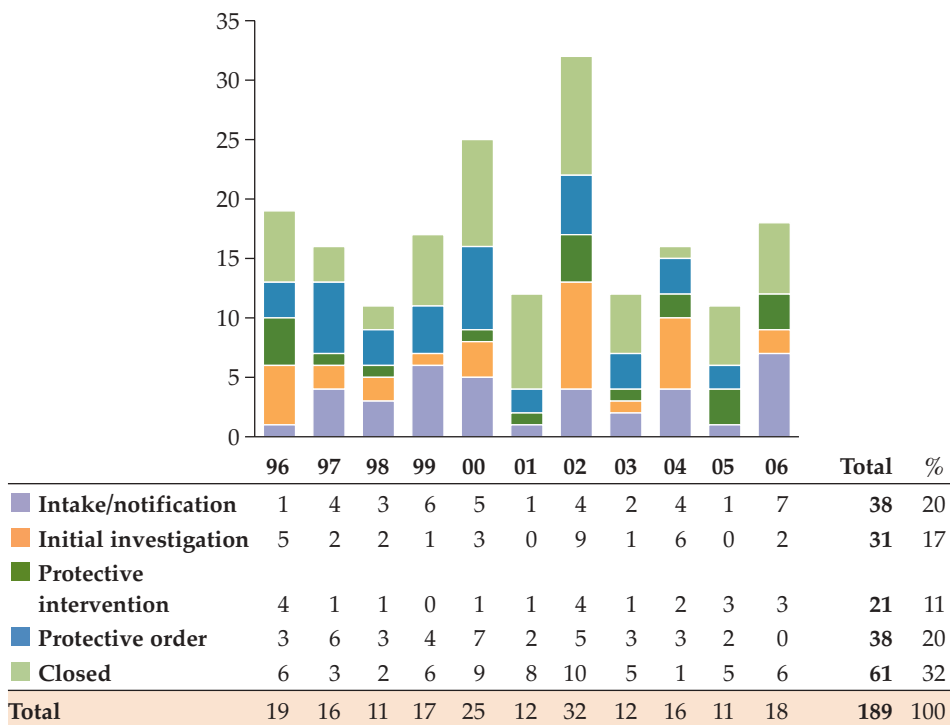
Table 3.5 Deaths of children known to Child Protection in 2006:
protective status at the time of death (N=18)

Protective status at the time of death	2006
Intake (notification)	7
Initial investigation	2
Protective intervention (includes interim protection order/interim accommodation order)	3
Protective order (includes guardianship, custody or supervision orders)	0
Closed	6
Total	18

Notes: 'Notification' status represents children who died subsequent to a notification. This group includes children who were notified in the course of the event that led to their death who had little or no previous involvement with Child Protection. 'Closed' status means the case had been closed three months or less.

From 1996 to 2006, a total of 69 children (37 per cent) were at the intake or initial investigation phase at the time of their death, 21 children (11 per cent) were at the protective intervention stage, 38 children (20 per cent) were on protective orders, while a further 61 cases (32 per cent) were closed.

Figure 3.9 Deaths of children known to Child Protection 1996–2006: protective status at time of death (N=189)



3.2 Summary

Historical analysis suggests that the death rate in the Child Protection population is broadly comparable with the death rate in the general Victorian community.

A total of 18 children who were known to Child Protection died in 2006: nine from acquired/congenital illness, four for reasons unknown or yet to be determined, four from accidents, and one from SIDS.

In 2006, more than half the child deaths involved infants younger than six months of age. Sixty-seven per cent of deaths involved children aged younger than one year. No adolescent deaths were recorded in 2006.

There was one death of an Aboriginal child known to Child Protection in 2006.

Between 1996 and 2006, the largest category of death among children known to Child Protection was acquired/congenital illness, accounting for 34 per cent of total deaths, followed by accidental deaths (20 per cent) and SIDS (14 per cent). Non-accidental trauma accounted for 8 per cent of all deaths in the Child Protection population during this period.

Between 1996 and 2006, 62 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 26 per cent among young people aged 13–17 years. Deaths of infants aged younger than six months comprised 32 per cent of total deaths during the period.

4. Child death inquiries reviewed in 2006–07

This section provides an analysis of child death inquiries reviewed by the VCDRC in 2006–07. The VCDRC reporting period commenced in April 2006 and concluded in March 2007.

In 2006–07, the VCDRC reviewed a total of 13 child deaths. These deaths occurred over a three-year period: two from 2004, five from 2005 and six from 2006. The committee has now reviewed all deaths that occurred in 2004 and 2005 and almost one third of the deaths that occurred in 2006.

This section includes:

- a description of key child and family characteristics represented in child death inquiries reviewed in 2006–07
- common themes and issues arising from child death inquiries reviewed in 2006–07.

4.1 Child and family characteristics

Table 4.1 Summary of child death inquiries reviewed in 2006–07: age, category of death and locality (N=13)

Age at death	Category of death	Locality
9 days	Not known	Metropolitan
12 days	Acquired/congenital illness	Metropolitan
30 days	Acquired/congenital illness	Metropolitan
2 months	Not known	Metropolitan
3 months	Acquired/congenital illness	Metropolitan
1 year	Acquired/congenital illness	Rural
1 year	Non accidental trauma	Metropolitan
3 years	Non accidental trauma	Rural
4 years	Accidental	Rural
13 years	Accidental	Rural
15 years	Acquired/congenital illness	Metropolitan
15 years	Not known	Rural
16 years	Suicide/self harm/risk-taking behaviour	Metropolitan
Total: 13		

Characteristics of the children

Eight of the 13 deaths reviewed by the VCDRC in this period involved children three years and younger; five of these involved children aged younger than six months. The VCDRC reviewed one child death in the 4–12 year age group and four deaths involving adolescents.

In this reporting period, one of the deaths reviewed involved an Aboriginal infant.

Of the 13 deaths reviewed in this period, there were 11 male and two female children.

Table 4.2 Child death inquiries reviewed in 2006–07: age and gender (N=13)

Gender	0–3 years	4–12 years	13–17 years	Total
Male	6	1	4	11
Female	2	-	-	2
Total	8	1	4	13

Of the eight infants whose deaths were reviewed in this period, five were born prematurely and five had complex medical needs. One infant was diagnosed with developmental delay. There is good evidence that these factors increase a child's vulnerability and generally increase the standard of parenting they require.

Of the four cases involving adolescents, three presented with substance abuse issues, three experienced educational difficulties, two were subject to sexual exploitation, one presented with challenging behaviours, one experienced issues of transience, one had an intellectual disability and complex medical needs and one experienced mental health issues. All had been in receipt of support from one or more sources including schools, mental health services, drug and alcohol services or community-based family support agencies.

Table 4.3 Child death inquiries reviewed in 2006–07:
key child/young person characteristics by age (N=13)

Child/young person characteristics	0–3 years	4–12 years	13–17 years	Total
Complex medical needs	5	-	1	6
Premature birth	5	-	-	5
Attachment issues	1	-	-	1
Developmental delay	1	1	1	3
Intellectual disability	-	-	1	1
Substance abuse issues	-	-	3	3
Educational issues	-	-	3	3
Sexual exploitation	-	-	2	2
Challenging behaviour	-	-	1	1
Transience	-	-	1	1
Mental health issues	-	-	1	1

Five of the child deaths reviewed in this period were due to acquired/congenital illness: four involved infants and one an adolescent. There were two accidental deaths, one in the 4–12 age group and one involving an adolescent. Two of the infant deaths reviewed were caused by non-accidental trauma. One adolescent death was as a result of suicide. The cause of death for two of the child deaths reviewed in this period was unascertainable by the State Coroner. One child death reviewed may be re-categorised pending coronial investigation and findings.

Table 4.4 Child death inquiries reviewed in 2006–07:
category of death by age (N=13)

Category of death	0–3 years	4–12 years	13–17 years	Total
Accidental death	-	1	1	2
Acquired/congenital illness	4	-	1	5
Drug/substance related	-	-	-	-
Non-accidental trauma	2	-	-	2
Not known	2	-	1	3
SIDS	-	-	-	-
Suicide/self-harm/ risk-taking behaviour	-	-	1	1

Child Protection was actively involved with 12 of the 13 children whose deaths were reviewed in this period. Of these, four children were at intake phase, three children were subject to initial investigation, three were subject to protective intervention and two children were on Children’s Court orders. Child Protection had recently ceased involvement with one of the 13 children whose deaths were reviewed.

Characteristics of the children's families

The majority of children whose deaths were reviewed in this period were in the care of family at the time of their death or the events that led to their death. Six of the 13 children were living at home in the care of a single parent while another two were living at home with both parents. Three infants who were born with significant and complex medical needs did not leave hospital following their birth. Care arrangements at the time of the child's death are described below.

Table 4.5 Child death inquiries reviewed in 2006–07: care arrangements at time of death by age groupings of children and young people (N=13)

Care arrangements at time of death	0–3 years	4–12 years	13–17 years	Total
Both parents	2	-	-	2
Mother	2	1	1	4
Father	1	-	1	2
Family friend	-	-	1	1
Long term out-of-home care	-	-	1	1
Did not leave birth hospital	3	-	-	3
Total				13

Many factors are known to impact on a parent's capacity to provide adequate care and protection. These factors include family violence, substance use, mental illness, transience, intellectual disability, the parent's young age and their own history as a Child Protection client. The VCDRC examines the child death inquiry reports to identify the prevalence of these factors in families whose children's death are subject to review.

Family violence was present in nine of the 13 families where the death of a child was reviewed in this reporting period. Six of these families had infants under the age of three years.

Parental substance use was a factor in nine of the 13 child deaths reviewed. Five of these families had infants under the age of three years and three had adolescent children.

Mental illness was identified in eight of the 13 child deaths reviewed.

Table 4.6 Child death inquiries reviewed in 2006–07: key parental characteristics by age groupings of children and young people (N=13)

Key parental characteristics	0–3 years	4–12 years	13–17 years	Total
Family violence	6	1	2	9 (69%)
Substance use	5	1	3	9 (69%)
Mental illness	5	1	2	8 (61%)
Transience	2	-	1	3 (23%)
Intellectual disability	1	1	-	2 (15%)
Parents' young age	2	-	-	2 (15%)
Protective services history	1	-	-	1 (8%)

The most significant feature of the families involved in child death reviews was the co-existence of a number of factors that are known to reduce parenting capacity. In 11 of the 13 child deaths reviewed, families presented with more than one of the parental characteristics described above, most commonly family violence and substance use, and family violence and mental illness. In six cases, families presented with more than two parental characteristics identified in Table 4.6.

As a result of their multiple, complex needs, most families involved in child death reviews had contact with several different service systems at any given time. This underscores the importance of clearly defined collaborative arrangements across service systems, based on a common understanding of roles and responsibilities and a shared language and practice framework. This theme is explored further in the discussion that follows.

4.2 Themes and issues

The most important contribution that the VCDRC makes to the child death inquiry process is the identification of common themes and emerging trends across the group of cases it considers. While the individual child death inquiry ensures that any factors unique to a child's death are identified, the review function ensures that collective learning is harnessed and used to inform ongoing system reform.

The Office of the Child Safety Commissioner maintains a comprehensive case tracking system that records cumulative data on more than 50 aspects of case practice, enabling all client and case practice characteristics to be cross-referenced. Drawing on this database, the committee conducts a rigorous qualitative analysis of issues arising from cases reviewed in the current reporting period. 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.

Last year's annual report focused on chronic neglect and the associated cumulative harms. The VCDRC's concerns regarding policy and practice in this area gave rise to the *Child Death Group Analysis: Effective responses to chronic neglect* (2006). This report is summarised in section 5 of this annual report and its implications for future policy and practice are discussed. While several of the cases reviewed in the current reporting period continue to highlight the difficulties of responding to chronic neglect, the committee believes that these issues have been thoroughly canvassed in the context of the group analysis.

In 2007, the committee's attention has been drawn to a number of other issues that are of practical and strategic significance to services working with vulnerable children and families. Key themes identified from the review of child death inquiries in 2007 are:

- a shared approach to protecting children
- aspects of Child Protection practice
- children with complex medical needs
- high quality community support.

A shared approach to protecting children

The new policy and legislative framework that underpins Victorian Child Protection and family services is a direct response to the increasing complexity of need among Victorian families. It recognises that families are often in contact with multiple service systems simultaneously and that outcomes for children improve if these services are integrated and coordinated. This principle is reinforced by review of child death inquiry data.

In the current reporting period, issues with coordination and collaboration between service providers were noted in ten of the 13 cases reviewed. In ten cases, it was found that client outcomes would have been enhanced by the timely use of case conferencing to share information, clarify roles and expectations, allocate tasks and agree on monitoring and coordinating mechanisms.

The consequences of deficient interagency collaboration are most pronounced at the point of Child Protection case closure or discharge from hospital. In five child deaths reviewed this year, there was a lack of role clarity among agencies at closure and little shared understanding of community safety planning. In another case, Child Protection believed that a range of services were engaged in monitoring a newborn's safety on a regular basis, following her discharge from hospital, though none of the agencies interviewed as part of the child death inquiry shared this view. Instead, the agencies understood that they were simply expected to deliver on their primary service function, be that provision of housing support, material aid or drug treatment to the parents. This example underscores the importance of developing common practice frameworks and a shared understanding of key concepts, such as child safety monitoring, across service

systems. At a more practical level, it highlights the importance of documenting roles and responsibilities and conducting case conferences in a way that enables role expectations to be made explicit.

The case example above also indicates that we are still some way from the ideal scenario in which the protection of children is genuinely seen as a shared community responsibility. In several cases reviewed in this period, community agencies reported that they lacked role clarity or that they assumed Child Protection was involved and responsible for monitoring child safety. It is vital that **all** services involved with children and families work proactively and assertively to protect children and ensure their wellbeing. This may involve seeking formal clarification of role expectations, requesting confirmation of the nature of ongoing Child Protection involvement, tenaciously pursuing the outcome of notifications made to Child Protection and clarifying the types of triggers that Child Protection would consider warrant renotification of a child. It is only when all services involved with Victorian families play an active role in ensuring child safety that the protection of children will truly have become everyone's business.

Several cases reviewed this year highlight the need for enhanced formal partnerships between Child Protection and other service systems, including education, acute health and disability services. The VCDRC anticipates that Victoria's new legislative framework will provide an impetus for this work to occur.

The *Child Wellbeing and Safety Act 2005* promotes a whole of community approach to protecting children and requires all services for children and families to give highest priority to the promotion of child safety and wellbeing. It describes a set of principles that apply to all universal, secondary and tertiary services in Victoria. The VCDRC has welcomed the new legislative framework and the opportunity it provides for important partnership development across distinct service systems. The need for such work is reinforced by the experiences of children whose deaths were reviewed in this period.

Education

Three of the four adolescent deaths reviewed featured a history of interrupted school attendance. In one case, a young refugee did not attend school for at least two years prior to his death. During this time, he was socially isolated and unlikely to come to the attention of community members who could offer vital support. Representatives of school services who participated in the child death inquiry process indicated that it was difficult to monitor school attendance and prevent truancy among children from vulnerable, highly transient groups.

A community partnership approach to protecting children requires the active support and participation of educational services. The reality is that this may require outreach models of service delivery that are not traditionally associated with schools. The VCDRC has recommended that these issues be addressed with the Department of Education as a priority and looks forward to learning how the department intends to address its obligations under the *Child Wellbeing and Safety Act 2005*.

Disability

Two deaths reviewed in this period involved children and/or parents with a registered intellectual disability. In other cases, infant developmental delay was observed.

Collaboration and coordination between Child Protection and disability services was less than optimal in both cases involving registered disability clients. Issues included role confusion, lack of involvement of specialist early childhood services in the Child Protection assessment process, lack of understanding of the impact of the parent's disability on current and potential parenting capacity and poor collaboration between disability services and parenting support services. In both cases a large number of support services were involved with the family, providing unique opportunities to gain comprehensive input to the Child Protection risk assessment. Unfortunately, case consultation and conferencing were under-utilised and a shared approach to case management across sectors never realised.

The VCDRC has recommended that the 1993 protocol between disability services and Child Protection be reviewed as a priority. It is understood that this work has now commenced. It is vital that new interagency arrangements clarify program entry points and core roles and responsibilities, particularly in situations where parents are unavailable, incapacitated or unwilling to discharge their guardianship obligations in respect of vulnerable children. Any revised protocol must of course reflect disability services' broader obligations to protect children under Victoria's new legislative framework.

Acute health

Acute health services played an active role in more than half of the cases reviewed in this period: seven of the 13 children died in hospital after a period of illness, three of these never left hospital after birth. Many of these cases involved children with complex medical needs and/or disabilities. In some cases, the relationship between Child Protection and hospital services was positive, characterised by proactive information sharing, timely case conferencing, shared decision making and clear role assignment. One such case is described further on.

However, the inter-relationship between Child Protection and acute health services was problematic in other cases. Most commonly, this related to a lack of understanding of roles and responsibilities and the absence of common practice frameworks across the two service systems.

A basic mutual understanding of Child Protection and acute health is critical to improving outcomes for children and families. Child Protection practitioners need to develop an understanding of hospital processes, the medical decision-making hierarchy and existing case conferencing mechanisms. Medical professionals require a working knowledge of the Child Protection role and mandate and an understanding of the risk assessment process.

It is vital that medical practitioners are equipped and encouraged to provide clear information about a child's medical condition, treatment options, prognosis and, most importantly, the implications of these for the child's home environment and the standard of parenting required. Similarly, Child Protection workers must actively seek this information, clarify discrepancies and pursue formal third party advice where there are conflicting opinions. Protective risk assessment in respect of children with complex medical needs cannot proceed without a precise understanding of the standard of care required to provide the child with a reasonable quality of life.

The VCDRC is pleased to note that program development activity within acute health services is attempting to address many of the issues identified above. *Vulnerable babies, children and young people at risk of harm: Best practice framework for acute health services* (2006) identifies the protection of vulnerable babies, children and young people as core business for hospitals and provides clear information regarding the protective services system. The framework requires that all hospitals have clear, agreed and documented referral and communication protocols and processes that support interagency collaboration with regard to vulnerable children. Most importantly, it establishes that the safety of children is of paramount consideration in working with adult clients who have a mental illness.

The VCDRC welcomes this overarching framework and anticipates the development of a range of supporting protocols and work practices at a local level. As part of this process, the VCDRC has recommended the development of specific protocols incorporating procedures for achieving role clarity and developing medical treatment plans for children with complex medical needs and/or a limited life expectancy.

The VCDRC acknowledges that cross-sector collaboration is one of the most persistent challenges facing human service systems. It has featured consistently in the child death inquiry and review process. Notwithstanding this, the VCDRC is

optimistic that implementation of Victoria's new policy and legislative framework will present important opportunities to increase collaboration across service systems. For example, *A strategic framework for family services* (2007) prescribes a range of mechanisms for improving coordination between Child Protection and family services including the development of service networks, co-location of services to improve communication, single system entry points and, most importantly, common assessment frameworks. These initiatives are strongly supported by the VCRDC.

Aspects of Child Protection practice

The child death inquiry and review process provides a unique window on Child Protection practice. Not surprisingly, it offers a range of insights into the constantly evolving nature of protective intervention. Some of these insights are discussed in the section that follows.

Comprehensive family assessment

Family assessment lays the foundation for subsequent protective case planning. Where insufficient information is collected, incorrect assumptions can follow regarding key risk and protective factors and parental capacity. Eight of the 13 cases reviewed in this period would have benefited from a more comprehensive approach to family assessment. In four cases, the biological father was not subject to assessment nor consulted in the protective decision-making process, in contravention of accepted best practice. In two of these cases, the father was actively involved in the care of the children.

In three other cases, comprehensive assessment of the child's extended family network did not occur despite significant concerns regarding the parents' ability to care for their children and the potential for alternative care arrangements. In one of these cases, the extended family was actively involved. The *Children, Youth and Families Act 2005* makes a strong commitment to maintaining the child's family and natural networks and requires that kinship options be considered ahead of any other placement type. Kinship networks can provide a significant source of stability and nurturing for vulnerable children and should be preserved and enhanced as a goal of protective intervention.

Comprehensive family assessment requires historically sensitive analysis of family functioning. In five cases reviewed in this period, insufficient attention was paid to the historical antecedents of present parental behaviour and the impact of this on future parenting capacity. There is now a significant body of evidence that links childhood trauma to adult mental ill health, substance abuse and relationship difficulties. It is vital the Child Protection workers are trained and supported to identify the impacts of past trauma on parents and to ensure that past parental trauma is identified as a treatment target in case planning.

Unresolved trauma has impacts across time and generations, seriously limiting the capacity of children to parent in the future. It is vital that every effort be made to break this cycle, through comprehensive, well informed Child Protection assessment and referral to treatment services.

Case closure

Premature case closure was identified as an issue in six of the 13 cases reviewed in this period. In three cases, Child Protection made incorrect assumptions about the level of involvement of other services at case closure that ultimately left vulnerable families unsupported and at risk children unmonitored. On at least two occasions, Child Protection involvement ceased, with no alternative support arrangements, despite the persistence of significant risk factors.

Problems with case closure were most prevalent in cases involving chronic neglect where families were subject to multiple notifications over time. Significantly, the four adolescents whose deaths were reviewed in this period were each subject to an average of eight Child Protection notifications. In these circumstances, it is vital that Child Protection and its community partners consider the family's history of non-attendance at services and ensure that community agencies are properly engaged prior to case closure.

Community safety planning for at risk children requires a thorough, planned approach to Child Protection withdrawal. Some good examples of closure practice were noted in the current reporting period. In one case, planning commenced several weeks prior to closure with a case conference involving all key parties. A written plan was developed specifying the roles of all parties and assigning ongoing responsibility for case coordination to a single community agency. Clear events that should trigger renotification were agreed, including, for example, contact between the children and their biological father or disengagement from in-home family support services.

Specialist infant protective workers

The child death inquiry and review process continues to reinforce the valuable contribution made by Specialist Infant Protective Workers (SIPWs). In several cases reviewed in this period, the SIPW's advice was timely, well informed, insightful and extremely child-centred. Their capacity to operate as a mentor and coach to less experienced workers was evident. In some cases, the SIPWs were particularly helpful in mediating the relationship between health professionals and Child Protection, alerting protective interveners to the types of issues and questions that warrant further investigation.

Unfortunately, in two cases reviewed in this period, high quality case planning advice provided by the SIPW was not followed by the allocated worker. It is vital that the contribution of these experienced and highly skilled practitioners is given full weight in the case management process.

Quality assurance mechanisms

The VCDRC was concerned to note that in three cases reviewed in this period, regional accountability structures failed to alert management to significant deficits in Child Protection practice. In one case, a high risk newborn was left without an allocated worker for over five weeks, in clear contravention of agreed practice standards. In another, a high risk infant received minimal intervention despite the allocation of a worker. In both cases, the number of co-existing risk factors should have triggered an immediate, comprehensive protective response.

The VCDRC has long advocated a range of monitoring and quality assurance mechanisms at the regional level to mitigate the impact of individual worker error or system failure. Many such mechanisms are used at present in the Child Protection service, including group case audits, adverse event analyses, independent third party case reviews, regional benchmarking analyses and use of registers to proactively monitor high risk cohorts. It is vital that these and other mechanisms are deployed alongside professional supervision as part of a comprehensive approach to quality assurance.

Children with complex medical needs

In its previous two annual reports, the VCDRC has made special note of issues pertaining to infants born with complex medical needs and/or disabilities. This group of children continues to dominate the child death data numerically and pose a unique set of challenges to both acute health and Child Protection practitioners.

In the past year, six of the 13 deaths reviewed involved children with high medical support needs; five of the eight infant deaths reviewed are linked directly to prematurity and/or congenital conditions. In some cases, Child Protection practice has been outstanding, as the following case study illustrates.

Matthew (pseudonym) was born at 27 weeks gestation with serious disabilities. Medical staff advised that Matthew was likely to survive but would require a high level of care indefinitely. A 14-week stay in the hospital's special care nursery was anticipated prior to discharge. Protective concerns related to the parents' capacity to provide adequate levels of care for Matthew in the home environment.

Child Protection engaged quickly with Matthew's parents and commenced a thorough risk assessment that incorporated a range of historical information regarding both parents. Contact was made with services involved with Matthew's siblings to inform the assessment of general parenting capacity.

An arrangement was made between the hospital and Child Protection that all Child Protection contact with medical professionals would be coordinated by the social work department. This streamlined communication and enabled a structured approach to discharge planning. A series of case conferences were convened as new information regarding Matthew's health became available.

Matthew was identified as a high risk infant from the point of notification. Consultation regarding case direction occurred regularly with the Specialist Infant Protective Worker who assisted the allocated worker to elicit medical information that was essential to Matthew's case plan.

When Matthew's condition deteriorated dramatically and unexpectedly at three weeks, a decision was made to set aside the Child Protection risk assessment process, pending clarification of Matthew's prognosis. Child Protection efforts were redirected to supporting Matthew's parents and siblings. This sensitive and respectful approach strengthened the relationship between Child Protection and the family, providing a strong foundation for further intervention.

When it became clear that Matthew would not leave hospital, Child Protection took a secondary role, ensuring that support agencies with which the family had long-standing relationships were available to provide grief counselling and ongoing assistance.

Child Protection intervention with Matthew and his family was medically informed, well planned, sensitive and commensurate with the shifting level of risk to Matthew's safety and wellbeing. The Child Protection worker received high quality supervision throughout and substantial emotional and personal support.

While other examples of good case practice were noted in this period, children with high medical support needs continue to present a range of case practice dilemmas for Child Protection.

One of the most difficult tasks, it seems, is to balance the need for comprehensive discharge planning with an uncertain or poor prognosis. In one case reviewed in this period, important assessment and case planning functions were deferred pending clarification of the infant's health status. When the child's condition improved and the prospect of discharge emerged rapidly, protective assessment and planning were not sufficiently advanced. In another case, Child Protection persisted with protective intervention, causing considerable distress for the family, despite a very poor prognosis.

Contingency planning in the face of an uncertain prognosis can be extremely difficult. Review of cases in this period highlighted the importance of ongoing dialogue between medical professionals and Child Protection and a partnership approach to discharge planning. Where assessment and discharge planning tasks are deferred, it is important that this is done explicitly, that the rationale is documented and that this is understood by all parties.

Another key challenge is for Child Protection to assert leadership in protective risk assessment despite the existence of complex medical needs. In three cases reviewed in this period, medical aspects of the case appeared to dominate decision making, with considerations of risk and parenting capacity taking a secondary role. While it is important that medical professionals contribute to risk assessment, Child Protection must retain a leadership role. Only Child Protection professionals have access to the training, tools and support that enables integration of information from a range of perspectives into a comprehensive assessment of protective risk and parenting capacity.

The VCDRC acknowledges that it can be intimidating and difficult for Child Protection to assert professional leadership in a medically dominated, acute hospital setting. This is especially so for younger or less experienced workers. It is vital that Child Protection supervisory and support processes recognise and respond to these challenges. In one case reviewed this year, a relatively new Child Protection practitioner was partnered with a more experienced mentor to assist in hospital case conferences. This arrangement worked well as a training and quality assurance measure and provided the young worker with additional personal support as she dealt with the emotionally difficult task of case managing a terminally ill child.

Some newborn cases reviewed in this period were characterised by an overly optimistic assessment of parenting capacity. In two cases, the risk assessment was unduly influenced by the parents' presentation within the hospital setting.

Hospitals are highly controlled environments in which parental activity is monitored and regulated. It is important that Child Protection develops a comprehensive, sophisticated understanding of risk based on parental behaviour over time in the community. In situations where the infant and/or mother are hospitalised for an extended period, there is potential for both hospital and Child Protection staff to develop assumptions about parenting capacity that must be tested against the realities of an independent, often unsupported life in the community.

High quality community support

One of the strong themes that emerged in this reporting period was the capacity of community-based services to offer sustained support to very vulnerable families over extended periods of time. While these efforts may not always be as integrated and coordinated as we would like, the capacity of individual services to engage with families and provide long term support has been impressive.

In one case, a young man with severe physical and intellectual disabilities was provided with extensive support over several years to remain at home in the care of his mother. When his mother could no longer provide full-time care, both parties received sensitive, well planned support as they moved through the difficult relinquishment process. The commitment of the young man's subsequent alternative caregiver was exceptional, ensuring that a vulnerable member of our community achieved a high quality of life, despite significant personal difficulties.

In another example, two adolescent parents who had found it difficult to engage with services in the past, received intensive in-home support, parenting advice and assistance, material aid and practical support from a housing support worker. This involvement exceeded all traditional expectations of the worker's primary role and demonstrated the service's flexibility and commitment to leveraging its strong relationship with the couple to maximum effect. Significantly, the worker embraced the task of monitoring the young child's safety and wellbeing and extended this to include activities such as SIDS prevention education and secondary consultation with the maternal and child health nurse.

These examples illustrate the capacity of services to respond in a flexible, child-centred way to vulnerable families and inspire confidence in the community partnership approach to protecting children that underpins Victoria's legislative reform.

A final word

In the past two years, there has been a concerted effort to increase the timeliness of the child death inquiry process to ensure that findings are relevant and contemporaneous. As a result, interviews with family members and professionals involved with the family are often conducted very soon after the child's death. This can be a painful and difficult process for all those involved.

The VCDRC has been impressed by the ability of staff to engage in open, critical reflection, so soon after a tragedy has occurred. In many cases, the region had already conducted an internal review and proactively addressed operational issues arising. The VCDRC welcomes the initiative and leadership shown by regional Child Protection management and their willingness to take remedial action in response to these tragic events.

5. Effective responses to chronic neglect—group analysis report summary

5.1 About the group analysis

Background

The group analysis was commissioned by the VCDRC and overseen by the Office of the Child Safety Commissioner. The group analysis was conducted at a time of significant legislative and policy reform within Victoria's child protection and family service system. It was designed to contribute to the discussion regarding chronic neglect and cumulative harm and to ensure that the learning arising from a small group of child deaths was used to shape future policy and practice.

The group analysis was conducted by a consortium led by La Trobe University and comprising Associate Professor Margarita Frederico, Director, Post Graduate Programs, School of Social Work and Social Policy, La Trobe University; Ms Annette Jackson, Research Manager, Take Two Berry Street Victoria; and Ms Sue Jones, Research and Evaluation Consultant, Sirius Associates.

Purpose

The group analysis was undertaken to examine the effectiveness of responses by Child Protection and related services to chronic neglect and to identify opportunities to enhance policy and practice in this area.

Subject group

The group analysis examined the deaths of ten children reviewed by the VCDRC between May 2004 and June 2006. The ten children were selected to illustrate case management issues associated with chronic neglect and cumulative harm. Neglect was not identified as a cause of death in these cases; however, it was considered a major risk factor in the lives of these highly vulnerable children.

Methodology

The group analysis used a grounded theory approach. The research methodology integrated an analysis of ten child death inquiry reports and accompanying documents, with an extensive literature review and the construction of a framework for understanding child neglect.

The child deaths included in the group analysis were examined within the context of established Child Protection policies, practice standards and guidelines governed by the *Children and Young Persons Act 1989*.

5.2 Literature review

An extensive literature review was conducted as part of the group analysis. The literature review focused on definitions of neglect, consequences of neglect and theoretical frameworks to assist in understanding neglect.

The literature review found that definitions of neglect differ in a number of ways and are complicated by different definitions of harm and development. To understand neglect, it is important to recognise the many different aspects of child development and the consequences for children when their developmental needs are not met. Types of neglect include physical neglect, including environmental and medical neglect; supervisory neglect; developmental and educational neglect; and emotional neglect.

Chronic neglect incorporates frequent failure to meet the child's needs on many levels, with or without respite. It is unclear how frequent episodes of neglect need to be for it to be considered episodic, intermittent or chronic. Each can involve significant harm but the likelihood of serious harm increases the more pervasive the neglect. There is general consensus that neglect is more likely to be chronic than other forms of maltreatment.

The literature review concluded that neglect, especially emotional neglect, can have more negative consequences than other forms of child maltreatment. Consequences of neglect include death or serious physical injury, poor health, developmental delay, neurobiological impairment, emotional difficulties, behavioural problems, attachment difficulties and impoverished social relationships. If not treated, these consequences can be permanent. The literature review reported that the impact of neglect is mediated by the type of neglect, level of severity, duration and characteristics of the child, family and their social system.

Cumulative harm refers to the accumulation of risk factors associated with neglect. The literature review reported that additional risk factors contribute exponentially to the risk of mental illness, poor cognitive functioning and behavioural problems. It is important that risk factors are considered cumulatively, rather than individually.

The literature review found that although there is no single theoretical framework for understanding neglect, a range of perspectives are useful in analysing its causes and consequences. These perspectives include developmental theories, neurobiological science, attachment theory, developmental psychopathology, trauma theory, social network development, cultural perspectives and ecological theory.

5.3 Themes arising from report findings

The group analysis produced 44 findings, which are presented thematically within an ecological framework. Components of the framework include the children and their experience of neglect; the children's families; the societal and structural influences; the Child Protection service system response to neglect; and the broader service system response to neglect.

The children and their experience of neglect

The report found that nearly all the children in the subject group were younger than two years of age at the time of their first notification and at the time of their death. Chronic neglect can be particularly damaging to children at this age. The report highlighted the need for early identification and intervention to prevent neglect, where possible, and thorough assessment and assertive intervention when chronic neglect is apparent.

Many children experienced significant developmental, behavioural, attachment and health problems. The report found that understanding the child's development is essential in order to recognise the severity of the consequences of chronic neglect if developmental needs are not met. The report highlighted the importance of developmental histories, beginning with the child's prenatal experiences; the use of specialist, multidisciplinary assessments; and access to health and community services.

The report found that the children subject to the group analysis had protective histories ranging from one to 16 notifications. They all came from families with multiple notifications relating to neglect and other risk factors. The report highlighted the importance of using a historical and family perspective to determine whether or not to investigate specific notifications and to inform any subsequent assessment processes.

The report found that all of the children experienced multiple types of neglect in addition to other forms of maltreatment. The co-existence of neglect and other forms of maltreatment increases the risk exponentially. The report highlighted the importance of developing a cumulative harm perspective that enables appropriate levels of attention to the impact of all forms of neglect and other forms of maltreatment.

The children's families

The report found that the families of the children subject to the group analysis were characterised by complex and changing structures. A number of the parents suffered their own experiences of trauma as children and as adults. The report identified the need to conduct thorough and dynamic family assessment of the parent's past and current situation, while maintaining a focus on the child.

The role of the extended family as a means of practical and emotional support was evidenced in some of the children's lives and missing in others. The report stresses the value of supporting extended families' involvement in the lives of children to mitigate some of the harmful consequences of neglect.

The societal/structural influences

The report found that most of the children lived in rural settings and some were isolated from the community. There was evidence of poverty and day to day problems with obtaining practical necessities. The report emphasised the need to understand the child in the context of their family, community and culture, to enable a more comprehensive assessment of risk and strengths.

The Child Protection service system response to neglect

The report found that many children were subject to notifications and renotifications where the harmful consequences to the child were not recognised and sometimes discounted. This highlights the need for increased understanding of child development and the potentially damaging consequences to children if their needs are not met. The report highlighted the need for a cumulative harm perspective to be incorporated into all risk assessments and case planning functions, beginning with the intake phase. This is essential so that the range of harmful consequences resulting from chronic neglect are fully understood and not minimised.

It was noted that Child Protection and family services find it difficult to provide persistent and consistent responses to pervasive and cumulative harm. The report identified the need to develop contingency plans so that when there is a crisis or an absence of sufficient change, other strategies are already available to guide intervention. The group analysis demonstrated the value of having regular case reviews, regular supervision, involvement of internal and external consultants and conducting chronological case audits to ensure practice is both persistent and change oriented.

The report highlighted the need for effective communication and collaboration between services, given the multiple needs of the children and their families.

The broader service system response to neglect

The report stressed the importance of involving the broader service system in responding to neglect. Strategies for promoting a shared responsibility for child wellbeing include cross-sectoral training, common referral processes across universal, secondary and tertiary services, and the development of common frameworks to inform assessment intervention.

The report concluded that intervening with chronic neglect requires a whole of community approach. Health promotion was identified as one approach to support the health and welfare of children and educate the community on the potential risks to children.

5.4 Opportunities for enhancing service system responses

The report reflected on the complexity of chronic neglect and its significant and cumulative impact on the child. It endorsed a strategic, realistic and compassionate approach to addressing the structural and intergenerational patterns associated with chronic neglect.

The report proposed a number of best practice principles to guide responses to chronic neglect:

- The best interests of the child must always remain central in any assessment, planning and intervention process.
- Focus on safety for the child from all forms of harm.
- Focus on meeting the child's developmental needs and enhancing their wellbeing.
- A family focus, not just parents or child—for both assessment and intervention.
- Effectively engaging the family in the process of change.
- Assessing family's history of use of services and analysing what has worked or not worked over time and therefore what needs to be different.
- Working proactively through identified barriers.
- Basing interventions on thorough assessment of the family and the needs and development of the child.
- Use of multidisciplinary assessments, for example, maternal and child health nurse, schools, health services, occupational therapist, physiotherapist, psychologist, psychiatrist.
- Balancing between providing support and validation while being able to directly challenge neglectful and other aspects of poor parenting.
- Providing access to practical, concrete assistance to deal directly with concerns related to poverty.
- Setting and monitoring achievable goals and clearly articulated responsibilities.
- Enlisting informal as well as formal support networks that will remain involved after services have ceased.
- Making effective referrals to appropriate and targeted services.
- Coordinating between services and clarifying roles and communication processes, or establishing clear coordination processes before closure.
- Ensuring that those services involved are informed regarding the risk assessment and what would constitute significant harm for this child.
- Understanding both the utility and limitations of legal action to mobilise the parents towards change, and to ensure the child's safety.

In addition, the report identified a number of opportunities to enhance future service system responses to children at risk of chronic neglect. including:

- Identifying children at risk and providing early intervention services as part of a broad-based health promotion approach.
- Formalising the dual pathway between Child Protection and community-based intake and referral services and developing shared protocols and assessment frameworks across both service systems.
- Formulating a sound developmental assessment from a multidisciplinary perspective to understand both vulnerabilities and resilience factors of the child.
- Developing an ecological approach to assessment. This guides workers to understand the importance of gathering information regarding the histories of parents, siblings, extended family and significant others.
- Developing a cumulative risk perspective in the assessment and case planning processes. This entails keeping an eye to incidents of new harm while developing an overall cumulative picture of the child's experience and planning accordingly.
- Developing a pluralist approach to assessment, case planning and decision making. This approach develops a range of ideas and tests each one that is considered reasonable, while maintaining an open and curious mind.
- Developing a dual focus on forensic and non-forensic approaches. Assessment and planning should consider the possibilities of court intervention in the near or long term, but not be restricted to this.
- Identifying and analysing change or an absence of change. In this context, assessment must be a dynamic process that constantly incorporates new information, using this to challenge previously held assumptions regarding the wellbeing of the child and the progress or lack of progress by the family.
- Promoting a persistent practice focus that may involve switching interventions if change is not occurring.
- Establishing back-up decision making processes that apply in cases involving multiple previous notifications.

Finally, the report identified imperatives for program development activity to support implementation of the new legislative framework, including:

- Developing a definition of chronic neglect that facilitates a common understanding and interpretation amongst Child Protection, family services, legal and court professionals.
- Determining appropriate decision making thresholds for Child Protection and community-based intake and referral services.
- Developing a common understanding between Child Protection and family services workers to distinguish between neglect and unmet need.
- Placing greater emphasis on maternal and child health and public education on the impact of substance abuse, exposure to violence and other prenatal factors in relation to reports made prior to the birth of a child.
- Developing mechanisms to redress significant neglect and trauma experienced throughout the Aboriginal community, given the over-representation of neglect and other forms of trauma within this community.

5.5 VCDRC response to the group analysis

The VCDRC found the group analysis to be a valuable and insightful report and commended the consultants on the quality of their analysis.

The VCDRC noted several key themes in the report that are critical in reducing the incidence and impact of chronic neglect within the Child Protection population. These include:

- Recognising that neglect often occurs in the context of the child having extraordinary needs, including intellectual and physical disabilities and complex medical needs, that increase both the level of parenting required and the vulnerability of the child to a lack of appropriate care.
- Understanding that children's developmental histories need to include prenatal information and incorporate factors that are known to increase the probability of neglect occurring and/or heighten its potential impact.
- Appreciating that when neglect co-occurs with other forms of maltreatment, the risk to the child increases exponentially. It is important that neglect **not** be considered the lesser form of problem, given evidence regarding its harmful consequences. It is also critical that the presence of chronic neglect does not obscure other forms of maltreatment.
- Recognising that universal services, including child care, preschools and schools, have an important role to play in ameliorating the harm arising from chronic neglect and in monitoring the safety and wellbeing of children. However, this must occur in the context of a case plan that clearly describes the roles and responsibilities of all parties.

- Understanding that the use of case reviews, audits, internal and external consultants, supervision and case conferences are all important tools in maintaining persistent, sustainable practice and avoiding or correcting case drift.
- Appreciating that referral to secondary support services must occur in a proactive, supportive manner that acknowledges the family's history of participation with services and ensures meaningful engagement has occurred prior to case closure.

5.6 Recommendations

The group analysis findings were used by the VCDRC to formulate 17 recommendations for future action. These are contained in Appendix 1 of this annual report. The recommendations address issues relating to risk assessment, case planning and decision making, responding to neglect in Aboriginal communities, and promoting a shared response to chronic neglect. All of these have since been accepted by the Department of Human Services and the Office of the Child Safety Commissioner.

The VCDRC is pleased to note that the learning arising from this small group of child deaths has been used to directly improve future policy and practice.

The VCDRC looks forward to following the progress of the recommendations in the year ahead.

The *Child Death Group Analysis: Effective responses to chronic neglect* (2006) report can be downloaded from www.ocsc.vic.gov.au

6. The year in review; the year ahead

6.1 The year in review

Each year the VCDRC identifies a number of strategic priorities to complement the committee's primary case review function. Below is a brief description of progress against identified priority areas in 2006–07.

Chronic neglect group analysis

In its last annual report, the VCDRC indicated its intention to conduct a group analysis to examine responses to chronic neglect in a small sample of recent child deaths. The committee was keen to ensure that this work was conducted in a timely manner to ensure that findings were available to inform program development associated with implementation of the *Children, Youth and Families Act 2005*.

With the assistance of the Office of the Child Safety Commissioner and a consortium of consultants led by Latrobe University, the group analysis was conducted over a four month period, producing a high quality, practical analysis of issues relating to chronic neglect and cumulative harm.

The Department of Human Services and Child Safety Commissioner have accepted all recommendations made by the VCDRC in response to the report and are currently working towards their implementation. Most importantly, the report has directly influenced foundational program documentation that will underpin the adoption of Victoria's new policy and legislative framework.

It is gratifying to see that the learning arising from a small group of child deaths has been used to directly improve future policy and practice.

Monitoring progress: group analysis into SIDS

In last year's annual report, the committee signaled its commitment to monitor progress in implementing recommendations arising from the *Child death group analysis: Tackling SIDS—a community responsibility* (2005). This report contained 21 recommendations directed at a number of services, including Child Protection, acute health, maternal and child health, drug and alcohol, mental health and housing services. Five of these recommendations were targeted for priority action by the VCDRC. It is pleasing to note that all five priority recommendations have since been endorsed by the Department of Human Services and are subject to current action as part of a detailed work plan.

The SIDS group analysis indicated that adult focused services, such as drug and alcohol, mental health, disability and housing support services, are extremely well placed to provide targeted SIDS prevention education to vulnerable parents. Importantly, the group analysis found that this information is best provided face to face, in the context of a supportive professional relationship.

Distribution of generalist health promotion literature to families with complex, multiple problems is far from ideal. The VCDRC urges the adoption of more targeted approaches to SIDS education by adult services. The recent organisational alignment of mental health and drug and alcohol services within the Department of Human Services may provide an opportunity for the development of a specialised approach to high risk parents with multiple and complex needs. Housing and disability services also have a vital role to play in the provision of frequent, consistent SIDS prevention messages to new parents. This should be informed by available evidence regarding the way in which vulnerable families seek and apply parenting advice.

In November 2006, the Office of the Child Safety Commissioner hosted a practitioner forum to disseminate the findings of the SIDS group analysis and promote a collaborative, targeted approach to SIDS education and prevention with high risk families. A cross sector, multidisciplinary working group was established as an outcome of the forum. This group has worked consistently to promote SIDS education among vulnerable families, progress culturally sensitive approaches to prevention within Aboriginal communities, and promote professional development across sectors.

The SIDS forum and working group are testament to the constructive partnership that has developed between the VCDRC and the Office of the Child Safety Commissioner. The Office of the Child Safety Commissioner has demonstrated a strong commitment to progress key findings arising from the child death inquiry process. It has provided the sustained leadership necessary to harness energy and goodwill across service sectors. The VCDRC appreciates the support of the Office of the Child Safety Commissioner and looks forward to further collaboration in the year ahead.

Monitoring progress: group analysis into children with complex medical needs

The VCDRC maintains a keen interest in the progress of initiatives targeting children with complex medical needs and/or a limited life expectancy who are clients of Child Protection. This group continues to feature prominently in child death inquiries reviewed by the committee. In 2006, nine of the 18 child deaths recorded related to prematurity, congenital conditions and/or acquired illness. The population of children with complex medical needs is predicted to increase further as a result of advances in medicine and technology.

The findings of the child death group analysis *Children with complex medical needs and a limited life expectancy* (2004) are as relevant and important now as at the time of publication. While progress has been made, there is a need for ongoing, focused activity to ensure that the particular needs of children with complex medical needs are met.

The VCDRC has recently received the draft *Child Protection work with children with complex medical needs and their families: Practice framework* (2007). This important document was a direct product of the child death group analysis. It acknowledges that children with complex medical needs require a higher standard of parenting than children generally and that special factors must be considered in assessing risk and parenting capacity and developing sustainable case plan options.

The VCDRC is pleased to note that the complex medical needs practice framework has been included in the revised Child Protection Practice Manual that is now available to Child Protection practitioners in an electronic format.

Tracking recommendations

The VCDRC is committed to ensuring that recommendations arising from the child death inquiry and review process are responded to in a timely and direct manner and that their implementation is actively monitored over time.

In last year's annual report, the committee indicated its desire to streamline arrangements for tracking child death inquiry recommendations. Since then, the Office of the Child Safety Commissioner has developed a new database to monitor the implementation status of individual recommendations and rationalised communication with the Office for Children. It is envisaged that the new arrangements will provide more accurate, timely feedback regarding the impact of the child death inquiry process on future policy and practice.

6.2 The year ahead

Communicating with practitioners

The child death inquiry function relies heavily on the willingness of individuals to engage in a process of critical reflection and review. This is greatly enhanced if practitioners understand the way in which the inquiry process works and trust in its capacity to effect real system change.

In the coming year, the VCDRC will partner with the Office of the Child Safety Commissioner in a communication strategy aimed at explaining the child death inquiry process to key stakeholders. Government and community-based service providers will be targeted in a series of forums that will engage participants in a dialogue regarding child death inquiries and their role as both a continuous improvement and public accountability mechanism. Insights gained in the

process will be used to shape future refinements to the child death inquiry and review function.

Categorising child deaths

In recent times, the VCDRC has become aware of a number of limitations associated with the current system for categorising the deaths of children known to Child Protection. These include a lack of consistency between categories used by other Australian jurisdictions and by Victoria's own public health surveillance and reporting body, the Consultative Council on Paediatric and Obstetric Mortality and Morbidity. There is currently no nationally agreed framework for classifying child deaths either within the general community or within the Child Protection population.

At the same time, there is ongoing dialogue, both nationally and internationally, regarding the need to clearly identify child deaths that are attributable to fatal abuse and neglect.

In the coming year, the Office of the Child Safety Commissioner has agreed to explore a range of issues related to the categorisation of child deaths and provide advice on the methodological and strategic issues associated with alternative classification systems.

Influencing policy and practice

The child death inquiry process is ultimately about achieving better outcomes for vulnerable children and families. The VCDRC will continue to use every available opportunity to ensure that lessons learned from the death of a child are communicated widely and used to drive ongoing system change.

In the year ahead, the committee will liaise with the Child Protection Training Unit in the Office for Children to discuss threshold training issues and exchange case material for learning purposes. Members will continue to participate in consultative forums regarding the reform of Victorian services for vulnerable children and families and will provide commentary on draft policy and program documentation as requested. Finally, of course, the committee will continue to formulate and rigorously monitor a small number of carefully targeted recommendations aimed at achieving lasting service improvement.

Glossary and abbreviations

accidental death	category of death; includes drowning, fire, road and rail trauma, falls and poisoning
acquired/congenital illness	category of death; includes prematurity, malignancy, seizures and infection
group analysis	child death inquiry report that focuses on a group of individual child deaths
case analyst	external professional appointed by the Office of the Child Safety Commissioner to provide expert advice and opinion on child death inquiry issues, prepare analysis and develop findings
case reviewer	Office of the Child Safety Commissioner officers responsible for conducting case related research and coordinating all activities associated with the child death inquiry process
CASIS	client and service information system
CRIS	client relationship information system
custody order	court order made under the former <i>Children and Young Persons Act 1989</i> , which enables a child to be placed out of parental care, while the parents retain guardianship rights
drug/substance related death	category of death; includes drug overdose and deaths related to inhalant abuse
guardianship order	court order made under the former Children and Young Persons Act, which provides the Department of Human Services with guardianship rights for the child
intake	the section of Child Protection that takes notifications of possible child abuse 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
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
protective intervention	ongoing Child Protection involvement, following substantiation of risk or harm, to ensure the safety and wellbeing of the child
SIDS	sudden infant death syndrome; category of death; requires autopsy and coronial authentication
substantiation	when abuse or likelihood of abuse or neglect to the child has been substantiated by a Child Protection investigation
suicide/self-harm/ risk-taking	category of death; includes deaths due to suicide and high risk-taking behaviour
supervision order	court order under the former Children and Young Persons Act, which enables a child to remain in the care of their parents with supervision from the Department of Human Services
Victorian Risk Framework	a guided professional judgment approach to the assessment of safety and wellbeing for children and young people involved in Child Protection

References

Department of Human Services 2004, *Children with complex medical needs and a limited life expectancy*, group analysis report, DHS, Melbourne.

Department of Human Services 2007, *Vulnerable babies, children and young people at risk of harm: Best practice framework for acute health services*, DHS, Melbourne.

Department of Human Services 2007, *A strategic framework for family services*, DHS, Melbourne.

Department of Human Services 2007, *Child Protection work with children with complex medical needs and their families: Practice framework*, DHS, Melbourne.

Office of the Child Safety Commissioner 2005, *Tackling SIDS—a community responsibility*, group analysis report, Office of the Child Safety Commissioner, Melbourne.

Office of the Child Safety Commissioner 2006, *Child Death Group Analysis: Effective responses to chronic neglect*, Office of the Child Safety Commissioner, Melbourne.

Appendix 1

Recommendations made by the Victorian Child Death Review Committee in 2006–07

No.	Type	Recommendation
1.	Individual inquiry	That the DHS Office for Children progresses the development of a revised protocol between Child Protection and Disability Services as a priority.
2.	Individual inquiry	That the DHS Office for Children progresses the development of a protocol with Acute Health Services incorporating procedures for achieving role clarity and developing medical treatment plans for children with complex medical needs.
3.	Individual inquiry	That the Victorian Child Safety Commissioner liaises with the Department of Employment, Education and Training to highlight the need to proactively monitor school attendance and provide culturally relevant outreach and support services to children of refugee families.
4.	Cluster Recommendation	That the Child Protection and Family Services Branch, in collaboration with the Mental Health Services Branch, clarify roles and responsibilities for case planning in respect of joint clients who are inpatients of mental health facilities. This should occur in the context of broader protocol development between the two services that builds on the Working Together strategy and describes collaborative arrangements at both the program and local levels.

No.	Type	Recommendation
5.	Cluster Recommendation	That the Child Protection and Family Services Branch develops an enhanced range of services for young people experiencing significant trauma and emotional disturbance. These should comprise home-based and medium term residential care services, therapeutic services and intensive case management support. They should be well integrated with other service system components, in particular, secure welfare and mental health inpatient services for children and young people.
6.	Neglect Group Analysis	That the DHS Child Protection and Family Services Branch utilises the current review of the Victorian Risk Framework to incorporate key concepts and theories referenced in the group analysis report and summarised in the proposed Best Practice Principles, including a developmentally sensitive assessment of the cumulative impact of poor attachment and past trauma.
7.	Neglect Group Analysis	That the DHS Child Protection and Family Services Branch develops a special assessment guide as an attachment to the revised Victorian Risk Framework that incorporates the accumulation of harms as a determinant of severity of harm and encourages the assessment of safety over the longer term, not just in the immediate assessment period.
8.	Neglect Group Analysis	That the DHS Child Protection and Family Services Branch establishes a statewide standard requiring special consultation and endorsement to close cases at intake where multiple past notifications have been received in a short period of time. This standard would require Child Protection professionals to justify why protective investigation should not occur in these circumstances.

No.	Type	Recommendation
9.	Neglect Group Analysis	<p>That the DHS Child Protection and Family Services Branch develops comprehensive practice guidance and supporting decision-making tools for workers in both Child Protection and community service organisations that reflects the proposed Best Practice Principles regarding chronic neglect and describes optimum approaches to:</p> <ul style="list-style-type: none"> • ameliorating and redressing harms to children arising from chronic neglect • assessing and responding to a lack of change within the family using a goal directed approach and formal periodic reviews of progress taken • maintaining a persistent, sustainable approach to practice in which case reviews, case conferences and supervision are used to change case direction and strategy as required • referring to secondary support services in a proactive, supportive manner that acknowledges the family history of participation with services and ensures meaningful engagement has occurred prior to case closure.
10.	Neglect Group Analysis	<p>That the DHS Child Protection and Family Services Branch develops specific practice guidance and practical, experiential training regarding:</p> <ul style="list-style-type: none"> • the relative merits of proceeding with court intervention in matters of chronic neglect • the presentation of evidence to the court regarding the deleterious impacts of exposure to chronic neglect that highlights specific vulnerability factors for the child and draws on current research and/or expert witnesses.
11.	Neglect Group Analysis	<p>That, in the context of implementing the <i>Children, Youth and Families Act 2005</i>, the DHS Office for Children liaises with the Department of Justice and the President of the Children’s Court to ensure that Children’s Court Magistrates receive training regarding child development, trauma and attachment theory, and the deleterious impact of exposure to chronic neglect.</p>

No.	Type	Recommendation
12.	Neglect Group Analysis	That, in the context of implementing the <i>Children, Youth and Families Act 2005</i> , the DHS Legal Services develops a strategy for briefing in-house counsel on optimum approaches to presenting evidence regarding cumulative harm in cases of chronic neglect.
13.	Neglect Group Analysis	That the DHS Child Protection Professional Development Unit develops and delivers a new module on chronic neglect incorporating key concepts and theories referenced in the Group Analysis and summarised in the proposed Best Practice Principles, including the developmental impact of neglect; trauma and attachment theory; pluralist thinking and contingency planning.
14.	Neglect Group Analysis	That the DHS Child Protection Professional Development Unit re-orientes content in the <i>Beginning Practice</i> and the supervisory practice training modules to reflect key concepts referenced in the group analysis and summarised in the proposed Best Practice Principles.
15.	Neglect Group Analysis	That the DHS Child Protection Professional Development Unit and the Children's Welfare Association of Victoria Centre for Excellence utilise the planned joint training strategy for Child Protection, Family Services and Placement Support Services to introduce new risk assessment frameworks and practice guidelines regarding cumulative harm and chronic neglect.
16.	Neglect Group Analysis	That the DHS Office for Children liaises with key stakeholders to ensure that training is provided to maternal and child health nurses regarding the deleterious impacts of chronic neglect, opportunities for early intervention, and the impact of maternal exposure to family violence, substance use and other risk factors in the antenatal period.

No.	Type	Recommendation
17.	Neglect Group Analysis	That the proposed Best Practice Principles and the broader findings and practice implications identified in the group analysis be used to shape the practice framework for community-based intake.
18.	Neglect Group Analysis	That the proposed Best Practice Principles be used as a basis for framing the assessment, case management and data collection tools used by both the Child Protection and community-based intake services.
19.	Neglect Group Analysis	Following discussion with the Victorian Aboriginal Child Care Agency, other Indigenous service providers and the Indigenous Initiatives Program within DHS, that the analysis in the literature review providing a cultural perspective of neglect in Aboriginal communities be used to guide the development of frameworks and training for Child Protection, community-based intake and family services staff regarding responses to neglect of children in Aboriginal communities.
20.	Neglect Group Analysis	That the Child Safety Commissioner convenes a forum of representatives of the primary care, maternal and child health, specialist children's, disability, education, mental health, drug and alcohol and child protection services to consider the report of the group analysis and identify opportunities for cooperative action to intervene early to prevent and ameliorate the impacts of chronic neglect.
21.	Neglect Group Analysis	That the DHS Office for Children emphasises the importance of partnerships with universal services in the development of frameworks for community-based intake and reinforces the need for family services to intervene early to prevent and redress the impact of harm.

No.	Type	Recommendation
22.	Neglect Group Analysis	That the DHS Office for Children gives particular consideration to the support and development of flexible, universal services in rural areas so that these services can work in partnership with child protection and family services and actively contribute to the prevention and amelioration of chronic neglect.

