

Annual report of  
inquiries into the deaths  
of children known to  
Child Protection 2006

Victorian Child Death Review Committee



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# Foreword

This is the eleventh annual report of the Victorian Child Death Review Committee (VCDRC). The VCDRC provides a multidisciplinary, external review of the deaths of children who are clients of the state's Child Protection service at the time of their death or within three months of their death. The aim of this review is to identify issues of practice, policy and procedure as part of an ongoing, reflective learning process.

The death of each child is tragic and distressing for all involved. On behalf of the VCDRC, I extend my sympathy to the families and friends of all the children whose deaths are considered in this report and to those many professionals who provided support and assistance.

The VCDRC is aware of the profound impact that the death of a child has on staff in Child Protection and related services. Despite this, professionals repeatedly demonstrate a commitment to review their practice and identify new and better ways of working, where these are indicated. The ability of these individuals and services to engage in a process of critical reflection is highly commendable.

Because the VCDRC considers the deaths of all children known to the Child Protection service, it is well placed to identify emerging trends and patterns and make recommendations as required. In this period, the committee's attention has been drawn to the ongoing challenge of identifying and responding to *cumulative* harm against children, not just immediate risk. This can prove particularly difficult where chronic neglect and/or family violence are involved. These issues are explored in some detail in this year's report.

As in previous years, most of the child deaths in this period involved either young infants or adolescents. This is consistent with trends in the general population and reflects the particular vulnerabilities associated with these developmental phases. This year's report explores some of the distinct challenges involved in protecting children in infancy and adolescence.

I take this opportunity to thank my colleagues on the committee for their support, advice and expertise and the respectful manner in which they approach the multidisciplinary review process.

The VCDRC hopes the information contained within this report will be useful to all those involved in the design and delivery of services to vulnerable children and families.

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 2006**

# Acknowledgements

Many people have assisted with the preparation of this report.

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 professionalism are much appreciated.

Experienced practitioners external to the Office of the Child Safety Commissioner are appointed to lead the sensitive and complex child death inquiry process. Their wisdom and insights are gratefully acknowledged.

The Office of the Child Safety Commissioner provides administrative support to the Victorian Child Death Review Committee. Kay Warn's contribution to data collection and analysis has been valuable, as always.

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



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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 2006*. 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 2005. Second, it provides qualitative analysis of child death inquiries reviewed by the VCDRC in the reporting period between April 2005 and March 2006.

This year, the annual report also presents the findings of two group analyses: *Tackling SIDS—a community responsibility* (2005) and *Partnerships in caring for children* (2005).

## 1. Overview of deaths of children known to Child Protection in 2005

A total of 11 children who were known to Child Protection died in 2005—five from acquired illness, two from reasons unknown or yet to be determined, two from suicide, self-harm or risk-taking behaviour, one from sudden infant death syndrome (SIDS) and one from an accident.

In 2005, almost half of the child deaths involved infants under six months of age, consistent with previous patterns in the age distribution of child deaths.

One of the 11 deaths in 2005 involved an Aboriginal child.

## 2. Overview of child death inquiries reviewed in 2005–06

The VCDRC reviewed 20 child deaths between April 2005 and March 2006. These deaths occurred over the past three years: three were from 2003, 11 were from 2004 and six were from 2005.

Of the 20 child deaths reviewed, eight children died from acquired disease, three from SIDS, three from drug/substance related activities, three from accidents, two from suicide, self-harm or risk-taking behaviour, and one from reasons unknown or yet to be determined.

The most significant feature of the families involved in child death reviews was the co-existence of factors that are known to reduce parenting capacity. These factors include family violence, substance use, mental illness and transience. Their prevalence reflects the complexity of the Child Protection population and underscores the need for coordinated, collaborative responses across service sectors.

### 3. Themes and issues

Based on a rigorous qualitative analysis of cases reviewed in 2005–06, the VCDRC has identified a number of key themes, including chronic neglect and cumulative harm, family violence, high risk adolescents and infant prematurity and complex medical needs.

Many of the themes and issues raised in this annual report will be impacted by the new legislative and policy framework under which Victorian Child Protection and related services will operate from late 2006. Others have been the subject of more targeted reforms at a central policy level or operationally in regions.

#### Chronic neglect and cumulative harm

Chronic neglect and cumulative harm presented as key features in many of the child deaths reviewed in this period. The neglect typically involved a failure to provide food, clothing, shelter, education, supervision, emotional support, medical care and/or other basic necessities needed to ensure healthy child development.

The VCDRC was concerned to note that some of these children who were experiencing chronic neglect failed to reach the threshold of concern required for intervention by Child Protection. Many were subject to multiple notifications.

It is important that work with families experiencing chronic neglect is historically grounded. The parents' motivation and ability to change must be realistically assessed based on their past commitment to seek help and incorporate new behaviour. Statutory intervention should be used to break the cycle of parental inaction and resistance where appropriate. Referral practices should make it clear who is monitoring the family's involvement with agreed services and specify the behaviours and events that should trigger further contact with the Child Protection service.

Many aspects of the current Victorian government reform agenda are designed to enhance services to families with complex, multiple needs and improve responses to chronic neglect. It is noted that these reforms constitute a fundamental change in approach which must be supported by significant cultural change across the service system.

## Family violence

Family violence was present as a parental characteristic in 17 of the 20 cases reviewed in this period.

While there were some examples of good Child Protection practice in relation to family violence, significant concerns were noted in other cases. These concerns include a failure to engage the violent partner, an over-reliance on the mother's capacity to act protectively, inadequate assessment of the impact of the mother's trauma on her capacity to parent and inadequate exploration of children's disclosure of violence.

In this period, the VCDRC noted instances where the decision to cease involvement was influenced by an overly optimistic assessment of the family's stated commitment to attend services and address violence. Referral to a family violence service is not of itself an intervention: where children are at considerable risk of harm, protective intervenors should ensure the family has attended and is engaged in treatment prior to case closure. Referral information should include a summary of the pattern and history of violence, assessment of its impact on the children and a description of the events that should trigger further contact with Child Protection. Most importantly, there should be a clear understanding of who is monitoring the family's ongoing participation in treatment prior to Child Protection case closure.

Finally, intervention with children must recognise and respond to the trauma associated with family violence. Children and young people should be targeted for treatment and support, along with the violent partner and/or protective caregiver.

## High risk adolescents

Seven of the 20 children whose deaths were reviewed in this period were aged 13–18 years. All of these young people presented with extremely challenging and high risk behaviours and had a multiplicity of needs relating to mental illness, substance use and transience. Many experienced significant trauma, grief and loss associated with past abuse and parental rejection.

Despite the challenges presented, Child Protection delivered a quality service to many of these high risk adolescents. Two previous group analyses of adolescent deaths commissioned by the VCDRC indicated the need for enhanced crisis responses to high risk adolescents. The cases reviewed in this period indicate considerable practice improvements in these areas.

While the case management of young people in crisis was often of a high standard, earlier efforts to intervene with these families were more problematic. In several cases, early protective responses were episodic and did not consider the impact of cumulative harm. The effects of childhood trauma associated with

family violence and/or sexual and physical abuse were not adequately addressed and the opportunity for earlier intervention was lost. In some cases, Child Protection made appropriate referrals to support services, but these were not followed up and no service was provided.

The majority of young people whose deaths were reviewed experienced multiple out-of-home placements and short stays in Secure Welfare, in-patient psychiatric services and/or Juvenile Justice facilities. An enhanced range of intensive therapeutic services comprising home-based and residential care is required for adolescents, to offer an holistic service to young people and their families.

### **Infant prematurity and complex medical needs**

Ten of the 20 children whose deaths were reviewed in this period were aged 0–3 years: eight of these children were aged six months and under. Six were born prematurely and five had complex medical needs. Three infants did not leave hospital after birth.

In this period, the committee noted some very good examples of case practice in relation to infants with complex medical needs. In other cases, risk assessment, case planning and interagency collaboration could have been improved.

Common concerns included an overly optimistic assessment of the family's ability to care for their seriously ill child, an over-reliance on medical professionals to assess protective risk, and problematic communication and collaboration between Child Protection, hospital services and community-based health services.

Antenatal care was inadequate or non-existent in three of the cases reviewed. Retrospective analysis suggests that a pre-birth notification may have been beneficial in respect of at least three infants. The VCDRC has long argued the need for a capacity to make reports regarding the safety of an unborn child and welcomes the inclusion of these powers within the *Children, Youth and Families Act 2005*.

#### 4. Group analysis report summary:

##### *Tackling SIDS—a community responsibility*

In this reporting period, the VCDRC considered a group analysis examining SIDS risk factors in the Child Protection population and strategies to minimise the risk of SIDS among high risk and hard-to-reach families.

The group analysis underscores the fact that SIDS risk reduction is a whole-of-community responsibility and draws attention to the role of many different services in reinforcing health promotion messages. The report makes 21 recommendations.

The VCDRC welcomes the group analysis' focus on the specific educational needs of high risk families and the application of social marketing principles to reduce risk. The committee distilled several key themes considered critical in reducing the risk of SIDS in the Child Protection population. These include:

- recognising that risk factors for SIDS and for child abuse and neglect are common, meaning that the children known to the Child Protection service are likely to be significantly represented among the group of children who die from SIDS
- understanding that 'hard-to-reach families' where mental illness, family violence, drug use, social isolation and/or transience are present require specific health promotion strategies. These strategies should involve provision of frequent, consistent messages about SIDS prevention within the context of an established professional relationship. General practitioners, midwives and Maternal and Child Health professionals are particularly important in this regard
- appreciating that mental health and drug and alcohol services, including those specialist services targeting new mothers, have a critical role to play in SIDS risk reduction among high risk families
- understanding that routine modelling of safe sleeping practices by midwives and domiciliary nurses has a direct impact on sleeping practices subsequently adopted by parents.

The VCDRC identified a number of key priorities for action arising from the group analysis which it will seek to progress over the next 12 months.

## 5. Group analysis report summary:

### *Partnerships in caring for children*

In this reporting period, the VCDRC also considered a group analysis examining the interface between mental health, drug and alcohol and Child Protection services and responses to 'at risk' children in the care of parents who have mental health and substance abuse issues.

This group analysis highlighted the need for enhanced communication and collaboration across sectors, supported by common case management tools and a shared practice framework. The report makes 15 recommendations aimed at enhancing the interface between Child Protection, mental health and drug and alcohol services through a range of joint activities and initiatives.

The VCDRC welcomed the report's strong endorsement of family-centred models of service provision in mental health and drug and alcohol services and highlighted the following additional issues which it believes are critical to understanding the case material included in the review:

- the need for Child Protection to exert leadership in risk assessment, while drawing on the expert views of mental health and drug and alcohol services ideally operating within a common risk assessment and case management framework
- the importance of understanding the impact of trauma on childhood development and the association between childhood trauma and mental illness in adolescence and adulthood
- the importance of understanding the trauma history of the parents as a precursor to drug and alcohol use
- the importance of a cumulative approach to risk assessment that treats each notification as a growing expression of concern, rather than a series of isolated events.

The VCDRC identified a number of key priorities for action arising from the group analysis which it will seek to progress over the next 12 months.

These include the promotion of a more family-centered focus in mental health and drug and alcohol services, the development of common parenting assessment tools across sectors, and promotion of regular case conferencing for parents with multiple needs, especially at the point of discharge from in-patient settings.

## 6. The year in review; the year ahead

The VCDRC is committed to ensuring that insights gained through the child death inquiry process directly influence the way in which services are designed and delivered in future. In the past year, the committee has implemented a number of measures to enhance the translation of key learning into policy and practice. These include the establishment of formal periodic opportunities to communicate key findings to the Office for Children and receive feedback on progress against these, the adoption of a more focused and strategic approach to the development of recommendations, and better use of existing training mechanisms to drive change.

In last year's annual report, the committee indicated its intention to monitor system progress in achieving a more holistic, cumulative and historical approach to Child Protection risk assessment and in addressing issues identified in the group analysis, *Children with complex medical needs and a limited life expectancy* (2004). The VCDRC is pleased to report that the Department of Human Services has responded on a number of levels to these important priorities.

The transfer of responsibility for the conduct of child death inquiries from the Department of Human Services to the newly created Office of the Child Safety Commissioner has constituted a significant shift in responsibilities in the past year. The VCDRC appreciates the support provided by the Office of the Child Safety Commissioner and looks forward to a productive future partnership.

In the coming year, the committee will turn its attention to issues of chronic neglect and cumulative harm which have presented in several of the recent child deaths reviewed. The VCDRC has initiated a group analysis of these deaths and will present key findings in next year's annual report.

Finally, the VCDRC will continue to monitor progress in addressing threshold issues that arise from the child death review process and actively participate in the reform of Victorian services for vulnerable children and their families.



# 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 2005. Second, it provides qualitative analysis of child death inquiries reviewed by the VCDRC between April 2005 and March 2006. Most of these inquiries relate to deaths that actually occurred in 2004 and 2005. 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 two group analyses in sections 5 and 6.

The 2006 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 2005. 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 both child and family characteristics and an analysis of practice and policy themes arising.

**Section 5** presents the findings of the group analysis report, *Tackling SIDS— a community responsibility*. This report explores issues that are critical in reducing the risk of sudden infant death syndrome (SIDS) among high risk, hard-to-reach families.

**Section 6** presents the findings of the group analysis report, *Partnerships in caring for children*. This report examines issues impacting on risk assessment and parenting capacity in families who are experiencing parental mental illness and/or substance abuse.

**Section 7** 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 and this individual is entered on the Office of the Child Safety Commissioner's Child Death Register and an inquiry is commenced in accordance with the processes described in section 2.2 below.

## Office of the Child Safety Commissioner

Victoria's inaugural Child Safety Commissioner was appointed in 2005. At that time, responsibility for the conduct of inquiries into the deaths of children known to Child Protection was transferred from the Department of Human Services to the Office of the Child Safety Commissioner. The office establishes and oversees child death inquiries in accordance with the processes described in section 2.2 below.

The Office of the Child Safety Commissioner also provides administrative support to the VCDRC.

## Victorian Child Death Review Committee

The VCDRC is a multidisciplinary ministerial advisory committee which 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 Children and Minister for Community Services on policy, procedural and practice issues arising from these inquiries. Further details of the VCDRC's operation are provided in section 2.3 below.

## Consultative Council on Obstetric and Paediatric Mortality and Morbidity

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 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 Coroner's Act, the Coroner has the authority to investigate any case involving a second or subsequent child death within the one family. 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

In accordance with new procedures introduced in 2005, child death inquiry reports produce findings arising from the investigation process. The VCDRC translates these findings into recommendations 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 Children and Minister for Community Services of its deliberations in each case and any recommendations arising.

## Group analysis of child deaths

The Minister for Children and Minister for Community Services, the Child Safety Commissioner or the VCDRC 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 considered two group analyses: *Tackling SIDS – a community responsibility* (2005) and *Partnerships in caring for children* (2005). A report summary for each group analysis is provided in sections 5 and 6 of this annual report.

## 2.3 Victorian Child Death Review Committee

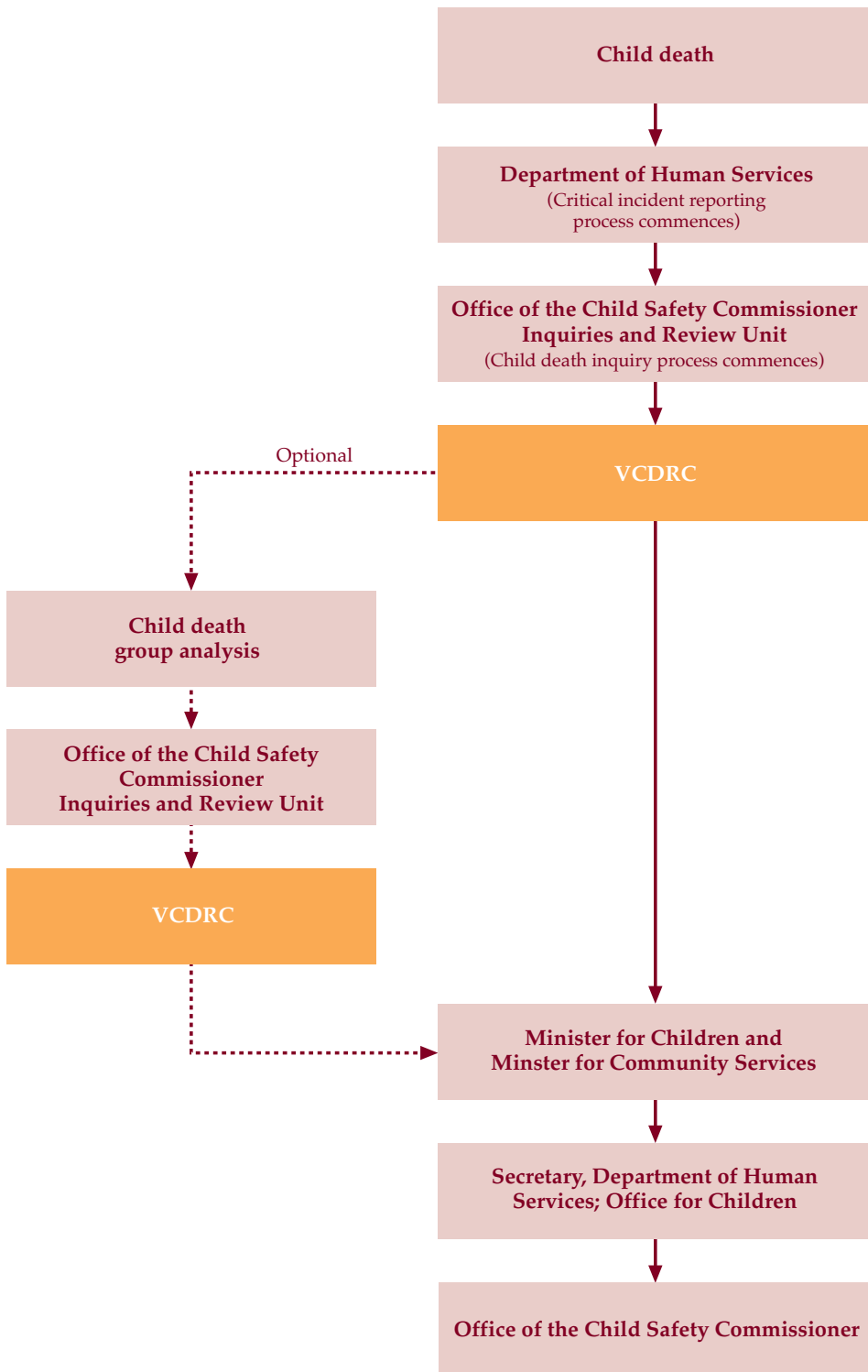
The VCDRC provides a multidisciplinary external review of all child death inquiries prepared by the Office of the Child Safety Commissioner. The committee provides expert advice to the Minister for Children and Minister for Community Services on policy, procedural and practice issues arising from these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

Until recently, individual child death inquiries generated recommendations that were forwarded to the VCDRC for endorsement; however, this produced a large volume of discrete recommendations, with much internal duplication of themes and issues. The committee found it difficult to prioritise threshold issues and monitor action arising.

As a result, individual child death inquiries now produce findings, rather than recommendations. These findings are referred to the VCDRC for endorsement. 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 Children and Minister for Community Services is formally advised of the committee's deliberations about each child death reviewed. It is anticipated that this new model will enable the VCDRC to adopt a more strategic approach in which priority issues are identified and actively promoted.

Figure 2.1: Office of the Child Safety Commissioner child death inquiry model for the 2005–06 reporting period



The Office of the Child Safety Commissioner is currently working with the Office for Children to streamline arrangements for tracking and reporting action on recommendations over time.

### 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 Children and 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 Children and Minister for Community Services on the child death inquiry process
6. To prepare an annual report for the Minister for Children and Minister for Community Services
7. To perform other functions in relation to child deaths as directed by the Minister for Children and 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 Margaret Wagstaff  
Human Services Consultant  
Member of the Adult, Community  
and Further Education Board and  
Director of the Bendigo Health Group  
Board Victoria

Ms Robyn Miller  
Human Services Consultant  
Senior Clinician Bouverie  
(on study leave)  
PhD candidate La Trobe University  
Robin Clark Take Two PhD  
Scholarship

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

Ms Paresa Antoniadis Spanos  
Coroner  
State Coroner's Office  
Victoria

Superintendent Rod Jouning  
Divisional Superintendent  
Victoria Police

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

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

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

## Retired members

Ms Luisa Bazzani  
Barrister at Law  
Clerk Holmes  
Owen Dixon Chambers  
Victoria

## Membership changes

This year the VCDRC was pleased to enlist the support of Dr Neil Coventry, Director Child and Adolescent Mental Health Service. Dr Coventry brings significant knowledge and skill from the mental health profession, further enhancing the committee's multidisciplinary approach to the child death review process.

Ms Luisa Bazzani, barrister at law, tendered her resignation to the committee following her appointment to the Victorian Magistracy. The VCDRC acknowledges Ms Bazzani's significant contribution to the child death review process and wishes her well in her new role.



## 3. Child deaths occurring in 2005

### 3.1 Overview of deaths of children known to Child Protection in 2005

This section provides an overview of child deaths that occurred in 2005 and an analysis of trends in child deaths from 1996, when the first VCDRC annual report was tabled in Parliament.

Significant variations can occur in the number of deaths of children and young people known to Child Protection each year. For instance, in 2002 there were 32 deaths, in 2003 there were 12 deaths, and in 2004 there were 16 deaths. In 2005, 11 children died who were current or recent clients of the state's Child Protection service.

After 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. As such, the 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.

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 429 children and young people between the ages of zero and 17 years died in Victoria in 2004. This equates to a death rate of 0.37 per 1,000 in the 0–17 year old general population compared with 0.46 per 1,000 active clients in the Child Protection population over the same period. 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.

Table 3.1 Deaths of children known to Child Protection in 2005: age and locality (N=11)

Age at death	Department of Human Services region
Two days	Rural
Three weeks	Metropolitan
Six weeks	Metropolitan
Two months	Metropolitan
Five months	Rural
Seven months	Rural
13 years	Rural
15 years	Metropolitan
15 years	Metropolitan
15 years	Rural
16 years	Metropolitan
<b>Total: 11</b>	

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 at the end of 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 1996–2005

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	34,431	32	0.92
2003	38,189	12,618	7,309	34,078	12	0.35
2004	38,206	12,404	7,897	34,520	16	0.46
2005	37,242	11,346	7,250*	34,710	11	0.31

\* The number of substantiations is not yet finalised for 2005. Number is correct as at January 2006.

\*\* Rate of deaths per 1,000 active clients

*(Recent data updates concerning notification, investigation and substantiation numbers for 1996–2004 may result in minor variations to data in previous annual reports.)*

## Age and gender of children who died in 2005

Of the children who died in 2005, 45 per cent were infants under six months of age and 45 per cent were young people aged 13–18 years. In 2005, there were significantly more male deaths than female deaths.

Table 3.3 Deaths of children known to Child Protection in 2005: age and gender (N=11)

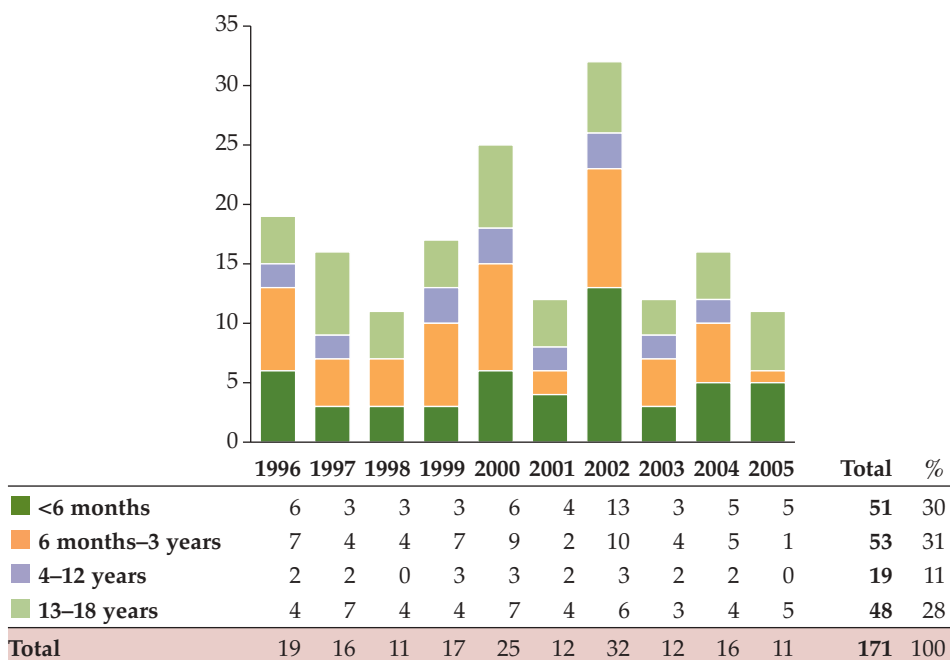
	0–<6 months	6 months–3 years	4–12 years	13–18 years	Total
Female	1	0	–	1	2
Male	4	1	–	4	9
<b>Total</b>	<b>5</b>	<b>1</b>	<b>–</b>	<b>5</b>	<b>11</b>

## Age of children who died 1996–2005

Over time, the greatest number of deaths is of children aged between six months and three years (53); infants younger than six months make up the next group (51), closely followed by young people aged between 13 and up to 18 years (48). Primary school age children make up the lowest number of deaths (19). No children of primary school age died in 2005.

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

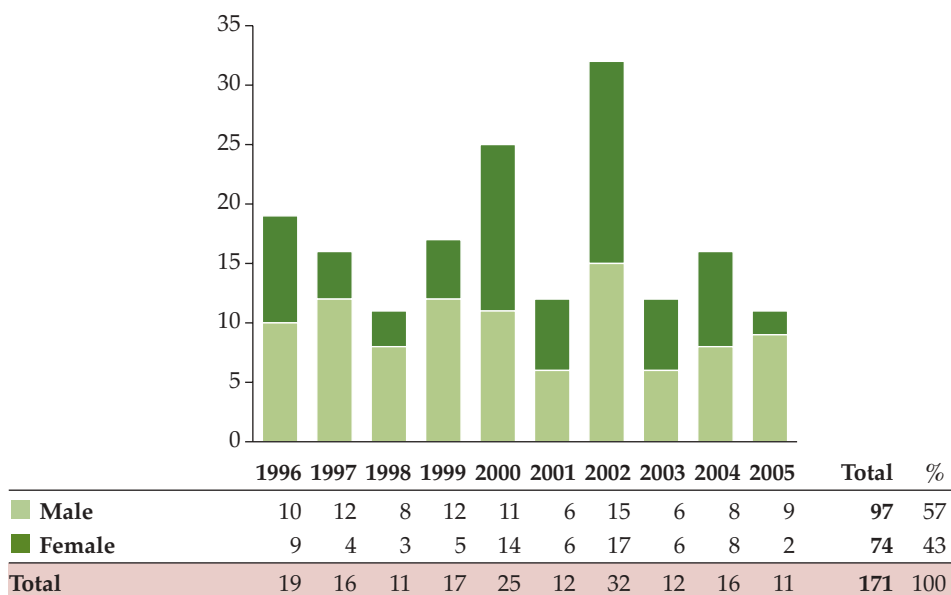
Figure 3.1 Deaths of children known to Child Protection 1996–2005: age (N=171)



## Gender of children who died 1996–2005

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 1996–2005: gender (N=171)



## Category of death 2005

Table 3.4 provides information on the category of death for children who were known to Child Protection in 2005. 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. 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 11 deaths of children known to Child Protection in 2005, two are still identified as category of death ‘not known’.

In 2005, the death categorised as ‘accidental’ involved a vehicle accident. Also in 2005, one death is categorised as due to SIDS in accordance with the coronial report.

There were five deaths in 2005 that were attributed to an acquired illness. This category includes deaths due to congenital conditions, prematurity, malignancy, acute infections and serious health episodes, such as epilepsy or cardiac arrest.

Of the two deaths that are categorised as suicide/self-harm in 2005, one was caused by hanging and one by self-inflicted wounds.

No children who were current or recent clients of the Child Protection service died from non-accidental trauma in 2005.

**Table 3.4 Deaths of children known to Child Protection in 2005: category of death by age (N=11)**

Category	6 months–				Total
	0-<6 months	3 years	4–12 years	13–18 years	
Accidental death	-	-	-	1	1
Acquired disease/illness	2	1	-	2	5
Drug/substance related	-	-	-	-	0
Non-accidental trauma	-	-	-	-	0
Not known	2	-	-	-	2
SIDS	1	-	-	-	1
Suicide/self-harm/ risk-taking behaviour	-	-	-	2	2
<b>Total</b>	<b>5</b>	<b>1</b>	<b>0</b>	<b>5</b>	<b>11</b>

### Category of death 1996–2005

Between 1996 and 2005, the largest category of death among children known to Child Protection was acquired illness, accounting for 31 per cent of total deaths. During the same period, the second largest category was accidental deaths, which involved 33 children. Sixteen of these deaths involved road accidents. Other accidental deaths included five cases of drowning and three deaths involving fire. The remaining nine deaths were due to a range of other causes.

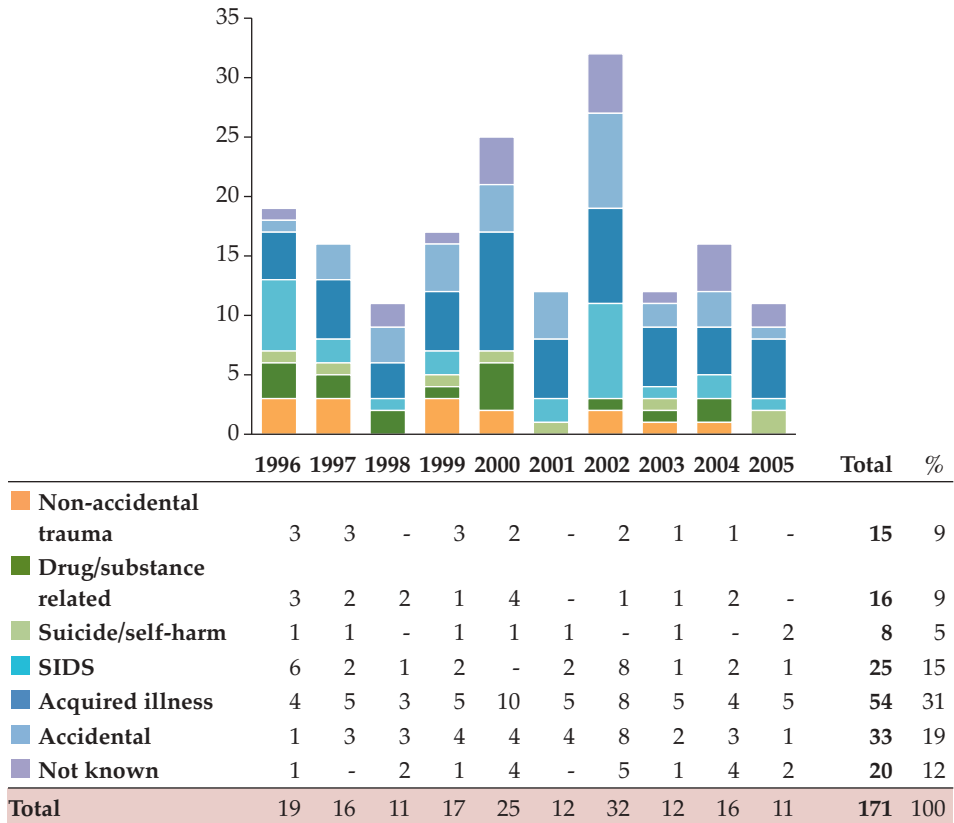
Between 1996 and 2005, there were 25 deaths attributable to SIDS. SIDS is a diagnosis of exclusion, applied when no other cause of death can be confirmed.

Between 1996 and 2005, 20 deaths were categorised as cause of death ‘not known’. This includes deaths pending coronial findings and cases where the coronial findings indicate the cause of death has not been able to be ascertained.

From 1996 to 2005, 15 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. The most common non-accidental injury for infants is head injury. Four of the 15 cases of non-accidental trauma had minimal involvement with Child Protection.

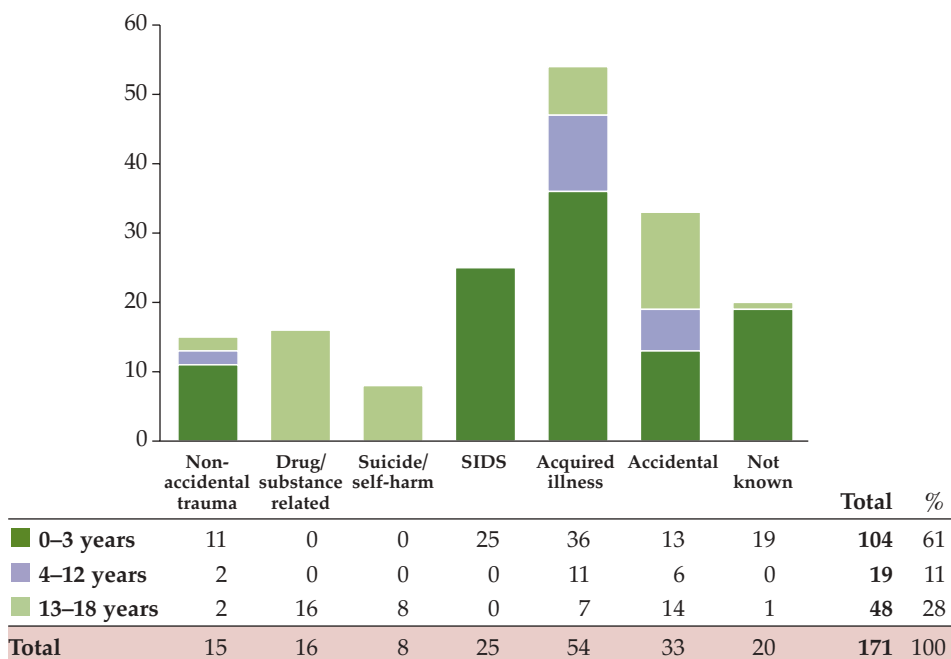
From 1996 to 2005, the deaths of 16 young people were attributed to substance use. There were no drug or substance related deaths in 2005. Eight adolescent deaths have been categorised as due to ‘suicide/self-harm/risk-taking behaviour’ (see Figure 3.3).

Figure 3.3 Deaths of children known to Child Protection 1996–2005: category of death (N=171)



The VCDRC has found it instructive to analyse category of death by age over time. Acquired illness and SIDS have been highlighted as major categories for the children aged 0–3 years. The following discussion focuses on an analysis of three main age groupings: infants, primary school age children and adolescents.

Figure 3.4 Deaths of children known to Child Protection 1996–2005: category of death by age (N=171)



### Infants (0–3 years)

From 1996 to 2005, there were 104 deaths in the 0–3 age group, comprising 61 per cent of total deaths. Of these, 51 were younger than six months. Deaths of infants younger than six months make up 30 per cent of the total deaths (171).

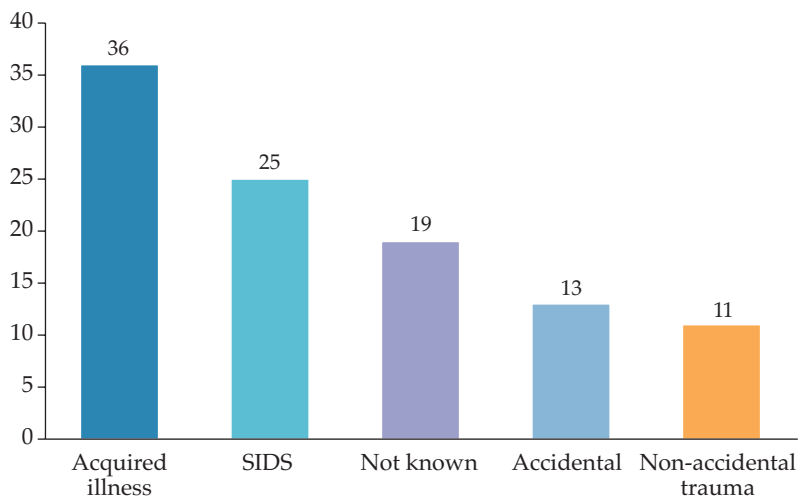
The most common category of death in the 0–3 age group is acquired illness, comprising 36 deaths. The second largest category of death among infants is SIDS. Between 1996 and 2005, 25 infants died from SIDS.

Between 1996 and 2005, 19 infant deaths were categorised as of unknown cause. Of these, six were categorised as cause of death ‘unascertained’ by coronial investigation. The other cases have coronial findings pending. Significantly, of the total 20 deaths across all age groups categorised as ‘not known’, 19 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 ten-year reporting period, 13 of the 104 deaths among infants aged 0–3 years were categorised as accidental. The majority of these involved drowning, road accidents or fire.

Between 1996 and 2005, 11 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 15 deaths across all age groups categorised as non-accidental trauma, 11 were infants aged 0–3 years.

Figure 3.5 Deaths of children known to Child Protection 1996–2005: infants by category of death (N=104)



### Primary school age children (4–12 years)

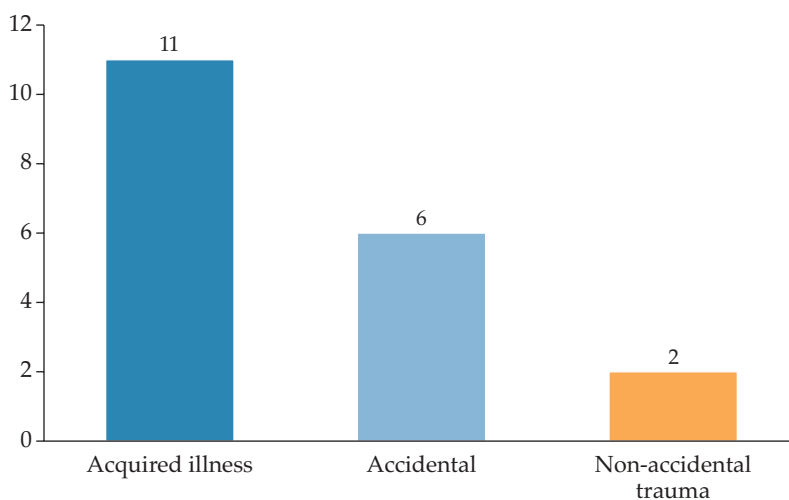
From 1996 to 2005, there were 19 deaths among 4–12 year olds, comprising 11 per cent of total deaths in the period. Of these 19 deaths, 11 were due to acquired illness, which includes deaths as a result of a disability, malignancy or acute infection.

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

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

There were no deaths in this age group in 2005.

Figure 3.6 Deaths of children known to Child Protection 1996–2005: primary school age children by category of death (N=19)



### Adolescents (13–18 years)

From 1996 to 2005, there were 48 deaths among young people aged 13–18 years, representing almost 28 per cent of the total deaths known to Child Protection in this period.

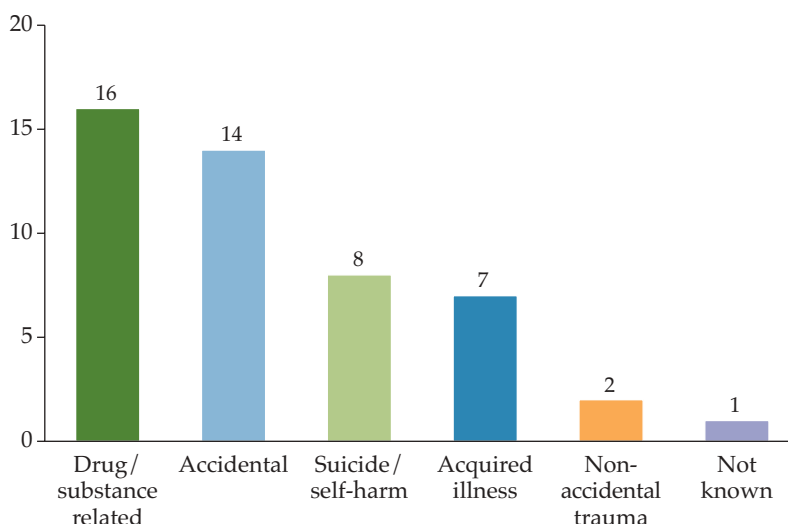
The most common category of death among adolescents is ‘drug/substance related’, comprising 16 deaths or one-third of all adolescent deaths in the ten-year period. This category includes cases where death was related to the use of intravenous drugs, poly-drugs, inhalants and methadone toxicity. There were no drug/substance related deaths in 2005.

The second largest category of death among adolescents known to Child Protection is ‘accidental death’. Between 1996 and 2005, most of the 14 accidental deaths among adolescents involved vehicles, including cars, trains and motorcycles.

The category of ‘suicide/self-harm/risk-taking behaviour’ only includes deaths where previous suicidal behaviour or suicidal intent has been indicated. Eight adolescent deaths were categorised as ‘suicide/self-harm/risk-taking behaviour’ over the ten-year reporting period.

Between 1996 and 2005, seven adolescents died of an ‘acquired illness’. Six of these young people had disabilities and/or long-term serious illnesses. During the same period, two adolescent deaths were categorised as ‘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 1996–2005: adolescents by category of death (N=48)

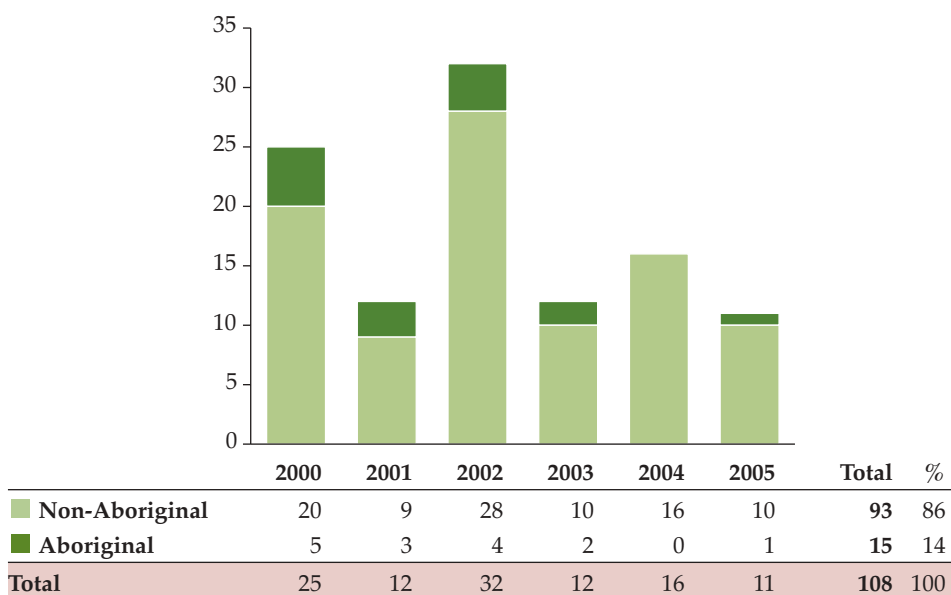


### Aboriginal status 2000–05

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

Between 2000 and 2005 there were 108 deaths in total, 15 of which (14 per cent) involved Aboriginal children.

Figure 3.8 Deaths of children known to Child Protection 2000–2005: Aboriginal and non-Aboriginal deaths (N=108)



### 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 client information system, CASIS.

In 2005, one child was at the intake phase at the time of death, three children were at the protective intervention stage, two children were on protective orders, while five cases were recently closed.

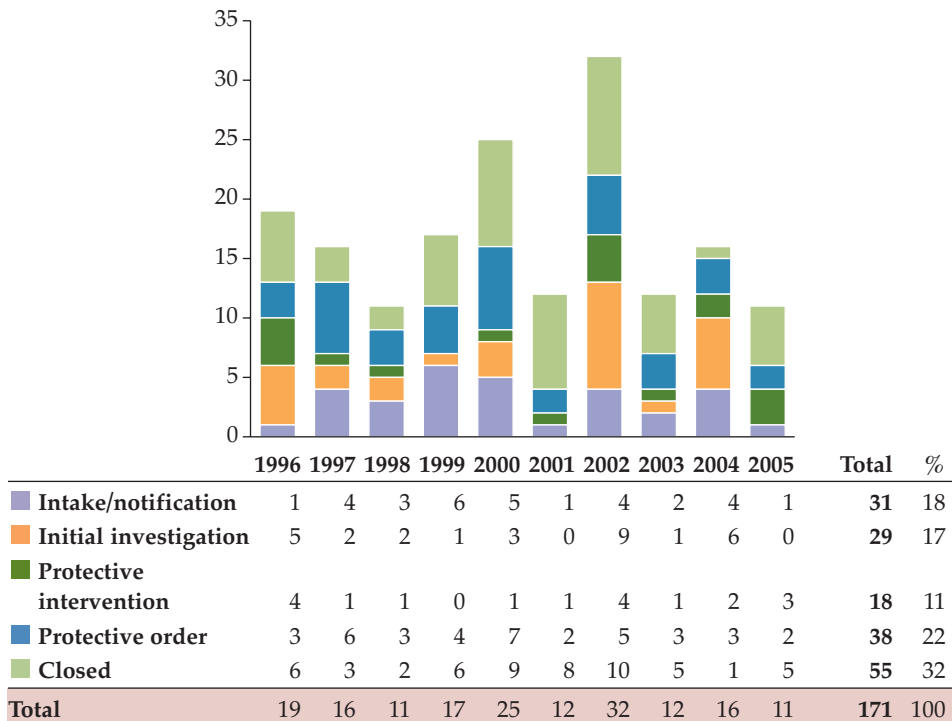
Table 3.5 Deaths of children known to Child Protection in 2005:  
protective status at the time of death (N=11)

Protective status at the time of death	2005
Intake (notification)	1
Initial investigation	0
Protective intervention (includes interim protection order/interim accommodation order)	3
Protective order (includes guardianship, custody or supervision orders)	2
Closed	5
<b>Total</b>	<b>11</b>

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 2005, a total of 60 children (35 per cent) were at the intake or initial investigation phase at the time of their death, 18 children (11 per cent) were at the protective intervention stage, 38 children (22 per cent) were on protective orders, while a further 55 cases (32 per cent) were closed.

Figure 3.9 Deaths of children known to Child Protection 1996–2005:  
protective status at time of death (N=171)



## Summary

A total of 11 children who were known to Child Protection died in 2005: five from acquired illness, two for reasons unknown or yet to be determined, two from suicide, one from an accident and one from SIDS.

In 2005, almost half of child deaths involved infants under six months of age and almost half involved adolescents aged 13–18 years.

There was one death of an Aboriginal child known to Child Protection in 2005.

Between 1996 and 2005, the largest category of death among children known to Child Protection was acquired illness, accounting for 31 per cent of total deaths, followed by accidental deaths (19 per cent) and SIDS (15 per cent). Non-accidental trauma accounted for 9 per cent of all deaths in the Child Protection population during this period.

Between 1996 and 2005, 61 per cent of all deaths known to Child Protection occurred among infants aged 0–3 years, 11 per cent among children aged 4–12 years, and 28 per cent among young people aged 13–18 years. Deaths of infants aged younger than six months comprised 30 per cent of total deaths during the period.



## 4. Child death inquiries reviewed in 2005–06

This section provides an analysis of child death inquiries reviewed by the VCDRC in 2005–06. The VCDRC reporting period commenced in April 2005 and continued until March 2006.

The 20 child death inquiries considered in this period relate to a proportion of the deaths that occurred over the past three years. While significant learning can be derived from child death inquiries, the group of child deaths reviewed in this period is not a representative sample for epidemiological purposes and the findings below should be interpreted accordingly.

This section includes:

- a description of key child and family characteristics represented in inquiries reviewed in 2005–06
- common themes and issues arising from inquiries reviewed in 2005–06.

### 4.1 Child and family characteristics

#### Summary of child death inquiries reviewed in 2005–06

In 2005–06, the VCDRC reviewed a total of 20 child deaths. These deaths occurred over a three-year period: three were from 2003, 11 were from 2004 and six were from 2005.

The VCDRC is pleased to report a significant improvement in the timeliness of the child death inquiry process. As a result, the committee has now reviewed all child deaths occurring in 2003, almost 90 per cent of the deaths occurring in 2004 and 45 per cent of child deaths occurring in 2005.

Table 4.1 Summary of child death inquiries reviewed in 2005–06: age and locality (N=20)

Age at death	Department of Human Services region
Two days	Rural
25 days	Metropolitan
29 days	Rural
Six weeks	Rural
Six weeks	Metropolitan
Two months	Rural
Five months	Metropolitan
Five months	Rural
Six months	Rural
One year	Rural
Four years	Metropolitan
Ten years	Rural
12 years	Metropolitan
13 years	Metropolitan
13 years	Rural
15 years	Metropolitan
15 years	Metropolitan
16 years	Metropolitan
16 years	Metropolitan
17 years	Rural
<b>Total: 20</b>	

### Characteristics of the children

Ten of the 20 cases reviewed by the VCDRC in this period involved children under the age of three years: eight of these involved children aged six months and under. The VCDRC reviewed three deaths involving children in the 4–12 year age group and seven deaths involving adolescents.

Of the 20 cases reviewed, there were 11 male and nine female children.

Table 4.2 Child death inquiries reviewed in 2005–06: age and gender (N=20)

Gender	0–3 years	4–12 years	13–18 years	Total
Male	7	2	2	11
Female	3	1	5	9
<b>Total</b>	<b>10</b>	<b>3</b>	<b>7</b>	<b>20</b>

Of the ten infants, five were born prematurely and/or drug dependent and six had complex medical needs.

Of the three children aged 4–12 years, one child had an intellectual disability, one child presented with considerable educational issues and all three children presented with attachment issues.

Of the seven cases involving adolescents, six presented with mental health and substance abuse issues, six experienced transience and four were involved in criminal activities. All seven young people displayed a range of challenging behaviour and four had a highly disrupted education and/or experienced early school exclusion. There were concerns that five of the seven young people aged 13–18 years were subject to sexual exploitation during adolescence.

Of the 20 child deaths reviewed in this period, one involved an adolescent of Aboriginal descent.

**Table 4.3 Child death inquiries reviewed in 2005–06:  
key child characteristics by age (N=20)**

Key child characteristics	0–3 years	4–12 years	13–18 years	Total
Aboriginal	-	-	1	1
Mental health issues	-	-	6	6
Attachment issues	2	3	3	8
Educational issues	-	1	4	5
Intellectual disability	-	1	-	1
Complex medical needs	5	-	-	5
Inadequate antenatal care	3	-	-	3
Premature birth	6	-	-	6
Substance abuse issues	-	-	6	6
Criminal activity	-	-	4	4
Challenging behaviour	-	-	7	7
Transient lifestyle	-	-	6	6
Sexual exploitation	-	-	5	5

The largest group of child deaths reviewed in this period were due to acquired disease or illness. Six of these deaths involved infants in the 0–3 age group and two children in the 4–12 age group. Three infants died of SIDS as determined by the State Coroner. One infant death is categorised as ‘not known’ at this stage because coronial proceedings are yet to be finalised. There were three accidental deaths: these involved one child in the 4–12 age group and two adolescents in the 13–18 age group. Three adolescent deaths were categorised as drug/substance related and a further two adolescent deaths involved suicide/self-harm/risk-taking behaviour.

Table 4.4 Child death inquiries reviewed in 2005–06:  
category of death by age (N=20)

Category of death	0–3 years	4–12 years	13–18 years	Total
Accidental death	-	1	2	3
Acquired disease/illness	6	2	-	8
Drug/substance related	-	-	3	3
Neglect	-	-	-	-
Non-accidental trauma	-	-	-	-
Not known	1	-	-	1
SIDS	3	-	-	3
Suicide/self-harm/ risk-taking behaviour	-	-	2	2
<b>Total</b>	<b>10</b>	<b>3</b>	<b>7</b>	<b>20</b>

Child Protection was actively involved with 13 of the 20 children whose deaths were reviewed in this period. Of these, five children were subject to initial investigation, three were subject to protective intervention and five children were on Children’s Court orders. Child Protection had recently ceased involvement with seven of the 20 children whose deaths were reviewed in this period.

### Characteristics of the children’s families

The majority of children whose deaths were reviewed in this period came from single parent families with the mother as the sole carer. Care arrangements at the time of the child’s death are described below.

Table 4.5 Child death inquiries reviewed in 2005–06: care arrangements at time of death by age groupings of children and young people (N=20)

Care arrangements at time of death	0–3 years	4–12 years	13–18 years	Total
Both parents	4	-	-	4
Mother	3	3	1	7
Hospital	3	-	1	4
Out-of-home care placements	-	-	5	5
<b>Total</b>				<b>20</b>

The Victorian Risk Framework draws attention to a range of factors that impact on a parent’s capacity to provide adequate care and protection. These factors include substance use, family violence, transience, mental illness, protective services history and intellectual disability.

Family violence was present in 17 of the 20 families where the death of a child was reviewed in this reporting period. The majority of these families had infants under the age of three years.

Parental substance use was a factor in nine of the 20 child deaths reviewed. Five of these families had infants under the age of three years and four had adolescent children.

Family transience was identified in seven of the 20 child deaths reviewed. Family transience was found to have significant implications for wider service system communication, collaboration and delivery of support services. In several cases it undermined the capacity for a cumulative and historically accurate assessment of harm to the child.

**Table 4.6 Child death inquiries reviewed in 2005–06: overview of parental characteristics by age groupings of children and young people (N=20)**

Key parental characteristics	0–3 years	4–12 years	13–18 years	Total
Family violence	9	3	5	17 (85%)
Substance use	5	-	4	9 (45%)
Transience	4	1	2	7 (35%)
Mental illness	2	1	1	4 (20%)
Intellectual disability	1	1	-	2 (10%)
Protective services history	-	1	1	2 (10%)

As in previous years, 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 17 of the 20 child deaths reviewed, families presented with more than one of the parental characteristics described above, most commonly family violence and substance use, family violence and transience and family violence and mental illness. In five cases, families presented with more than two parental characteristics identified in Table 4.6.

These data reflect the complexity of the Child Protection client population more generally and underscore the extent of the challenge facing protective intervenors. They draw attention to the range of service systems that have a role to play in the lives of these very vulnerable families and reinforce the concept that protecting children is a shared responsibility, contingent on coordinated, collaborative responses across sectors.

## 4.2 Themes and issues

The most important contribution 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 any factors unique to a child's death are identified and actioned, the review function ensures collective learning is harnessed and used to inform ongoing system reform.

The committee maintains a comprehensive case tracking system which 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.

Not surprisingly, many similar themes emerge from the child death review process year in, year out. Indeed, these themes dominate the national and international discourse arising from child death reviews and constitute some of the most persistent and significant challenges facing child protection services the world over.

The committee is aware that some of the issues prioritised for discussion below will be impacted by the new legislative and policy framework under which Victorian Child Protection and related services will operate from late 2006. Others have been the subject of more targeted reforms, at either a central policy level or operationally, in regions. The VCDRC applauds these reforms.

The passage of the *Children, Youth and Families Act 2005* will fundamentally change the way in which services are delivered to vulnerable children and families. The VCDRC has strongly supported and actively participated in the change process to date. The committee trusts that learning arising from the deaths of children known to Child Protection will continue to inform the significant volume of policy and program development work ahead.

Key themes identified from the review of child death inquiries in 2005–06 and discussed below are:

- chronic neglect and cumulative harm
- family violence
- high risk adolescents
- infant prematurity and complex medical needs.

## Chronic neglect and cumulative harm

Seven of the 20 children whose deaths were reviewed in this period experienced chronic neglect involving inadequate provision of age-appropriate care over a sustained period of time. The neglect typically involved a failure to provide food, clothing, shelter, education, supervision, emotional support, medical care and/or other basic necessities needed to ensure healthy child development.

The consequences of neglect observed in the cases reviewed include failure to thrive, malnutrition, developmental delay, physical injuries arising from lack of supervision, peer rejection and social isolation, poor self-esteem and/or self-destructive behaviour. For some children, chronic truancy led to low attainment of basic skills.

The VCDRC was concerned to note that some children who were experiencing chronic neglect failed to reach the threshold of concern required for intervention by Child Protection. In four of the seven cases reviewed, early notifications of neglect were screened out of the system without investigation. In two cases, the families were the subject of 16 and 18 notifications respectively. By the time Child Protection became actively involved, the child was already experiencing developmental delay and other long-term adverse effects of neglect.

There is now an overwhelming body of evidence to indicate that chronic neglect has a deleterious effect on early neurological development, with consequences for speech, language acquisition, attachment, impulse control, cognitive development and emotional wellbeing. Its effects are cumulative and permanent. It is vital that this evidence informs risk assessment and drives earlier protective intervention with infants and children exposed to physical, emotional and educational neglect.

While the VCDRC is pleased to note that recent research on the devastating impact of chronic neglect is influencing policies and guidelines in the Child Protection service, practice on the ground seems slower to change. In several of the neglect cases reviewed, practitioners appeared not to consider the past patterns of help-seeking and behaviour change by primary caregivers. In some cases, the Child Protection practitioner appropriately referred the family to community-based support services, but then closed the case before ensuring the referral was activated and engagement had occurred. This practice was noted with families who had demonstrated past reluctance to attend support services.

It is important that work with families experiencing chronic neglect is historically grounded. Parents' motivation and ability to change must be realistically assessed based on their past commitment to seek help and incorporate new behaviour. Statutory intervention should be used to break the cycle of parental inaction and resistance where appropriate. Referral practices should make it clear who is monitoring the family's involvement with agreed services and specify the behaviours and events that should trigger further contact with Child Protection.

Other aspects of the chronic neglect cases reviewed that warrant comment include a lack of comprehensive family assessment, including a failure to explore strengths and protective factors in the extended family and a lack of purposeful, goal-directed case planning. Finally, in three of the seven neglect cases reviewed, allegations of physical and sexual abuse were given less than adequate attention by protective intervenors.

Against this backdrop, it is encouraging to note that many aspects of the current Victorian government reform agenda are designed to enhance services to families with complex, multiple needs and improve responses to chronic neglect. The strengthening of the secondary service system and the ongoing investment in the Innovations projects recognise that many families require long-term, intensive support in a community-based setting. These services are well placed to deliver earlier, more sustained intervention and limit the re-notification of children exposed to neglect.

The VCDRC welcomes the 'best interests' focus of the Children, Youth and Families Act, with its shift in emphasis from the immediate safety of the young person to a longer term, cumulative perspective of harm. It is noted that this constitutes a fundamental change in approach which must be supported by significant cultural change across the service system.

Finally, it is envisaged that new legislative provisions requiring parental cooperation with assessment in the Child Protection investigation phase will be beneficial in a small number of cases where parental resistance is insurmountable.

### Family violence

Family violence was present as a parental characteristic in 17 of the 20 cases reviewed in this period. Consistent with earlier observations about the complexity of the client group, family violence was often accompanied by other parental risk factors, such as substance abuse and mental illness.

In this period, some examples of good Child Protection practice in relation to family violence were noted, including sensitive, comprehensive information collection, exploration of the pattern and history of violence and appreciation of the serious, cumulative emotional and psychological harm to children caused by

ongoing family violence. However, significant concerns were noted with the response to family violence in several other cases. These concerns include a failure to engage the violent partner, an over-reliance on the mother's capacity to act protectively, inadequate assessment of the impact of the mother's trauma on her capacity to parent and inadequate exploration of children's disclosure of violence. In two cases, both parents were interviewed together regarding allegations of family violence, in contravention of accepted minimum practice standards.

There is a well recognised risk that child protection services may prematurely close cases involving family violence on the assumption that immediate risk has been addressed, that a parent is able to provide adequate short-term protection or that the family is engaged with support services.

In this period, the VCDRC noted instances where the decision to cease involvement was influenced by an overly optimistic assessment of the family's stated commitment to attend services and address violence. This was often coupled with an under-appreciation of the strength of the mother's connection to her violent partner and the degree to which violence was entrenched. In some cases, the family was referred to counselling services and the case closed prior to confirmation that engagement had occurred. In one case, key decisions were premised on the fact that the family had actively sought and received counselling. Subsequent investigation in the course of the child death inquiry provided no record of the family's attendance at counselling.

Referral to a family violence service is not of itself an intervention: where children are at considerable risk of harm, protective intervenors should ensure the family has attended and is engaged in treatment prior to case closure. Referral information should include a summary of the pattern and history of violence, assessment of its impact on the children and a description of the events that should trigger further contact with Child Protection. Most importantly, there should be a clear understanding of who is monitoring the family's ongoing participation in treatment prior to Child Protection case closure.

It is now well understood that family violence has a range of negative effects on the neurological, emotional, social and psychological development of children. These vary according to the age of the child, commencing during pregnancy. Aside from cumulative developmental harms, children, and infants in particular, are at risk of being physically harmed during violent incidents. Where family violence is present, children are more likely to experience physical abuse and neglect.

Intervention with children must recognise and respond to the trauma associated with family violence. Significantly, none of the children whose cases were reviewed by the VCDRC in this period received specialist support to deal with the impacts of long-term exposure to family violence. Children and young people should be targeted for treatment and support, along with the violent partner and/or protective caregiver.

It is understood that new guidelines, *Child Protection and family violence: guidance for Child Protection practitioners* (2005), will be introduced across Victoria in 2006, with a complementary training strategy. The VCDRC welcomes this initiative.

It is encouraging to note the strong focus on the developmental consequences of exposure to family violence within these guidelines and their emphasis on direct intervention with children and young people who are affected.

Significant reforms have also occurred within the criminal justice system. The establishment of the Family Violence Division of the Magistrates' Court and the implementation of the Victoria Police *Code of practice for the investigation of family violence* (2004) provide new opportunities to increase the focus on child wellbeing in family violence matters and ensure stronger collaboration occurs between the police, courts and child protection services at the point of notification and beyond.

### High risk adolescents

Seven of the 20 children whose deaths were reviewed in this period were aged 13–18 years. All of these young people presented with extremely challenging and high risk behaviours and had a multiplicity of needs relating to mental illness, substance use and transience. Many experienced significant trauma, grief and loss associated with past abuse and parental rejection.

Despite the challenges presented, Child Protection delivered a quality service to many high risk adolescents. Positive aspects of case management include the effective use of crisis plans to respond to rapidly changing circumstances, the use of assertive outreach, the high level of communication and coordination among service providers, and the integration of drug treatment and medical information into the case plan. There were examples of good collaboration between Juvenile Justice and Child Protection. In several cases, the Child Protection practitioner was able to build a positive relationship and remain engaged with the young person under very challenging conditions.

The VCDRC has commissioned two previous group analyses of adolescent deaths, the first in 1999 and the second in 2003. Both indicated the need for enhanced crisis responses to high risk adolescents, incorporating improved crisis planning and better collaboration between Child Protection, mental health and drug and alcohol services. The cases reviewed in this period indicate considerable practice improvements in these areas.

While the case management of young people in crisis was often of a high quality, earlier efforts to intervene with these families were more problematic.

Of the seven young people whose cases were reviewed, three had an extensive history of Child Protection intervention, commencing in the middle primary years. These young people were subject to multiple notifications over an extended timeframe. In all three cases, early protective responses were episodic and did not consider the impact of cumulative harm. The effects of childhood trauma associated with family violence and/or sexual and physical abuse were not adequately addressed and the opportunity for earlier intervention was lost.

In several cases, Child Protection made appropriate referrals to support services but these were not followed up and no service was provided. It is important that a family's stated willingness to accept support is not interpreted as an indication of reduced risk unless active engagement occurs. The need for more supported, proactive referral by Child Protection and better feedback from support services to Child Protection is indicated once again.

Six of the seven adolescents reviewed had significant educational issues. Most stopped attending school at an early age, following a disrupted educational history. Indeed, the education system is notable for its absence in the lives of at least two children whose deaths were reviewed in this period.

Five of the seven young people experienced multiple out-of-home placements and short stays in Secure Welfare, in-patient psychiatric services and/or Juvenile Justice facilities. Two young women experienced more than 30 placements each. While considerable creativity and persistence were demonstrated in establishing viable placements, this underscored a fundamental lack of accommodation and treatment options for young people with a high level of behavioural and emotional disturbance.

Several young people in the cases reviewed sought the containment, structure and security of Secure Welfare. This provided a circuit breaker in times of escalating crisis and an opportunity for the young person to rest and regroup. The gap between what is available in Secure Welfare and the current range of out-of-home care services is significant. An enhanced range of intensive therapeutic services is required, comprising home-based and residential care, to offer an holistic service to young people and their families.

The provision of properly supported accommodation for adolescents outlined in *Public parenting* (2003) is strongly supported by the facts of the adolescent deaths reviewed in this period. Initiatives such as Take Two, enhancements to the Secure Welfare service model and the establishment of therapeutic foster care should provide a wider set of options for young people with significant behavioural disturbance. The VCDRC welcomes these developments and looks forward to monitoring their impact.

Several young people whose cases were reviewed in this period demonstrated a strong connection to one or more of their parents, even though these relationships had been a source of grief and pain for many years. Some young people bounced constantly between home and out-of-home care. It is important that the strength of family relationships is understood and acknowledged in work with adolescents and that parents are actively supported to develop necessary skills and insights. While parenting support services are often sought for caregivers of infants and children, these services are highly relevant for parents of adolescents and should be routinely considered. Only two of the families of adolescents whose cases were reviewed in this period were referred to parenting services.

### Infant prematurity and complex medical needs

Ten of the 20 children whose deaths were reviewed in this period were aged 0–3 years: eight of these children were aged six months and under. Six were born prematurely and five had complex medical needs. Three infants did not leave hospital after birth.

In this period, the committee noted some very good examples of case practice in relation to infants with complex medical needs, as well as cases where risk assessment, case planning and interagency collaboration could have been improved.

Some cases reviewed in this period were characterised by an overly optimistic assessment of the family's ability to care for their seriously ill child. It is vital that risk assessment is informed by a sound understanding of the infant's medical condition and the exact nature of his or her daily care needs. The capacity of parents to perform complex and repetitive medical procedures in the home environment must be carefully assessed, especially where parental substance use or mental illness is a factor.

The VCDRC has noted that assessments of risk and/or parental capacity may be deferred to medical professionals when the child has very complex medical needs. It is vital that the Child Protection service remains central in these decisions and asserts its professional expertise with regard to matters of child safety. The challenge for Child Protection practitioners is to draw on expert opinion to understand the child's medical status and then integrate this information into a quality risk assessment.

Some of the cases reviewed in this period involved problematic communication and collaboration between Child Protection, hospital services and community-based health services, most commonly Maternal and Child Health services. These cases reinforce the importance of case conferencing to achieve role clarity, especially at case closure.

Antenatal care was inadequate or non-existent in three of the cases reviewed in this period. Retrospective analysis suggests that a pre-birth notification may have been beneficial in respect of at least three infants. The VCDRC has long argued the need for a capacity to make reports regarding the safety of an unborn child and welcomes the inclusion of these powers within the Children, Youth and Families Act.

Research has indicated that the population of children born with complex medical needs is likely to increase as a result of advances in medicine and technology. These children are extremely vulnerable, requiring a higher standard of care than children generally.

In 2004, the VCDRC released the findings of a child death group analysis, *Children with complex medical needs and a limited life expectancy*. This report proposed a number of measures to enhance the protective response to children with complex medical needs and promote cross-sector partnerships. The committee continues to work with key stakeholders to ensure the recommendations arising from the group analysis are actioned. A report of progress to date is included in section 7 of this annual report.

In the meantime, as mentioned, the VCDRC was pleased to note some examples of exemplary practice in relation to children with complex medical needs. One such example is described below to illustrate the capacity of the system to respond in a sensitive, comprehensive way to a family with very complex needs.

### Exemplary case practice

Eliza (pseudonym) was born prematurely at 31 weeks gestation with significant disabilities. Her long-term prognosis was extremely poor. Concerns were expressed about the capacity of Eliza's parents to meet her very high need for care. Both of Eliza's parents were intellectually disabled. Their relationship was violent and the couple was highly transient.

Child Protection engaged skillfully with Eliza's parents. The parents indicated they felt unable to care for Eliza and that they would prefer the paternal grandparents to care for Eliza, should she be discharged from hospital.

Child Protection convened the first of several case conferences with medical professionals, support services and extended family members. They developed a thorough understanding of Eliza's medical status and care needs and this explicitly directed case planning decisions. The hospital and other service providers were engaged in a collaborative partnership, which continued until Eliza's death at nine weeks.

Eliza was identified as a high risk infant and allocated to an experienced Child Protection worker who offered continuity of case management. The specialist infant protective worker was involved throughout, providing case direction and crucial support to the primary worker.

Case records were of a high standard, capturing the rationale for key decisions.

Given the seriousness of Eliza's condition and the life-threatening consequences if she were removed from hospital, a protection application by notice was issued and an interim accommodation order was subsequently granted.

A notable feature of Child Protection's involvement was the sensitivity and respect with which Eliza's parents were treated. The primary worker established a highly effective relationship with Eliza's mother, which ultimately led to an agreed plan to address longstanding family violence.

Child Protection provided care and support to both of Eliza's parents at the time of her death and beyond.

### 4.3 A final word

The VCDRC acknowledges the challenges confronting Child Protection practitioners on a daily basis. We understand the role is inherently difficult, requiring the best decision at the time, moderated by competing demands.

The child death inquiry and review process operates with the benefit of hindsight which is not available to workers in the field; however, without retrospection there can be no learning. In a system that is driven by operational demands, every opportunity for critical review should be actively pursued.

The VCDRC hopes that our reflections on cases reviewed in 2005–06 will make a constructive contribution to policy and practice in Child Protection and related services.



## 5. Group analysis report summary: *Tackling SIDS—a community responsibility*

### 5.1 Purpose of the group analysis

The group analysis was undertaken at the request of the VCDRC to develop a better understanding of SIDS risk factors in the Child Protection population and to identify strategies to minimise the risk of SIDS among high risk and hard-to-reach families.

### 5.2 Membership of the panel

The group analysis was conducted by a panel comprising Dorothy Ford (Chair), Manager, Special Projects, SIDS and Kids (until October 2004); Anne Merkovich, Unit Manager, Child Protection, Department of Human Services Eastern Metropolitan Region; and Dr Jodie Leditchke, Manager, Forensic Technical Services, Victorian Institute of Forensic Medicine.

### 5.3 Methodology

The analysis panel conducted a detailed examination of the deaths of a cluster of children known to Child Protection. The analysis was informed by relevant research and best practice literature on health promotion. A number of diverse stakeholders contributed to the group analysis via focus groups and consultative forums. This enabled in depth exploration of the factors that promote infant safe sleeping practices among high risk families.

### 5.4 Subject group

The group analysis examined the deaths of eight children who were known to Child Protection. The deaths of all children occurred in 2002. The cause of death for all members of the subject group was SIDS, as determined by the State Coroner following a post-mortem investigation.

### 5.5 Research/current knowledge

Public awareness of the ways to reduce the risk of SIDS and fatal infant sleeping accidents has resulted in a dramatic reduction in the SIDS rate since 1990 in Australia; however, some high risk families are 'hard to reach' using mainstream health promotion methods and this has presented challenges for the health professionals who support these families both antenatally and following birth.

Research indicates that the risk of SIDS increases for young teenage parents, young mothers less than 20 years of age with several infants, mothers who have less than 12 years education, and parents with high risk lifestyles, including illicit drug use. These risk factors are similar to risk factors associated with child abuse and neglect.

Research indicates that effective health promotion for behaviour change involves frequent and consistent exposure to the health promotion messages from a variety of sources. Distribution of health promotion resources, along with discussion with parents in the antenatal period, is the preferred approach for SIDS risk reduction awareness. Importantly, this information is most effective when given within the context of an interpersonal relationship.

Research indicates that routine modelling of infant safe sleeping by midwives can influence the infant care practices parents adopt when they take their newborn home from hospital.

## 5.6 Current risk reduction initiatives

There is strong evidence that some sleeping practices for infants significantly increase the risk of SIDS and that some infant sleeping environments are unsafe and may cause fatal sleeping accidents. Knowledge of how to reduce the risk of SIDS and to sleep infants safely is an important aspect of preventative practice for health professionals who provide education and support for new parents.

The risk of SIDS is increased when the infant is placed to sleep on the stomach (prone) or the side (lateral), when the infant's face and head are covered by bedding and when the infant is exposed to cigarette smoke during pregnancy and after the birth. In addition, unsafe sleeping environments may lead to accidental suffocation, choking or strangulation. Use of unsafe cots, cot mattresses, infant bedding and sleeping places may lead to fatal infant sleeping accidents.

Other SIDS risk factors relate to the vulnerabilities of the infant, including low birth weight and prematurity affected by intrauterine growth retardation. Risk factors relating to the mother include young maternal age, cigarette exposure, drug abuse, poor attendance at antenatal care and poverty.

Since 1997, Victorian Child Protection practitioners have been required to include infant sleeping risk within the range of risks assessed when investigating notifications of child abuse and neglect. In cases involving infants under the age of two years, Child Protection practitioners are required to discuss SIDS risk factors and ways to reduce these risks with all families caring for an infant.

## 5.7 Themes and issues

The group analysis highlighted several themes and issues relating to the incidence of SIDS in the Child Protection population, SIDS risk factors in the cases reviewed and the implications of these for Child Protection and allied health and welfare services. The report provides a comprehensive analysis of health promotion strategies targeting high risk families and makes recommendations about emergency responses to unexpected child deaths.

### Incidence of SIDS in the Child Protection population

On average, two to three infants who are known to Child Protection die of SIDS each year. This represents an average of 10 per cent of total SIDS deaths in Victoria each year.

The report found that there is no evidence of an increasing trend in the rate of SIDS in the Child Protection population. Between 1995 and 2003, the rate of SIDS among the Child Protection population was generally not statistically different from the rate of SIDS in the general population, except for two years, 1996 and 2002, when there was an inexplicable increase in SIDS deaths in Victoria and among Child Protection clients.

### SIDS risk factors in the cases reviewed

The report found that in most of the child deaths reviewed, two of the main risk factors for SIDS were present. These risk factors included drugs taken prior to co-sleeping with the infant, the infant being placed to sleep on the side or the stomach, unsafe sleeping places, and face covered by bedding.

### Implications for Child Protection and related services

The report highlighted the importance for Child Protection practitioners to sight the infant's sleeping environment and to record detailed information about the safety of the infant's sleeping environment. The report indicated that sighting the infant's sleeping environment, consulting with specialist infant protective workers and documenting health promotion interventions would improve accountability and assessment of risk for infants.

### Implications for allied health and welfare services

The report focused on the role of allied health and welfare professionals in promoting safe sleeping practices. In all of the cases reviewed, it was noted that there were missed opportunities for professionals to address infant safe sleeping issues with new parents.

Significantly, it was found that midwives in some maternity hospitals are still modelling the lateral (side) infant sleeping position in contravention of agreed safe sleeping principles. This finding was highlighted in a comprehensive survey of maternity hospitals in New South Wales, which found that 30 per cent of nurse unit managers reported placing infants on their side to sleep.

The need for increased training of health professionals in safe sleeping practices and the difficulties of health promotion work with high risk families was indicated.

### Health promotion with high risk clients

The report indicated that health promotion messages to high risk clients are best conveyed frequently and consistently by people who have a working relationship with the parents. The report noted that many high risk families are involved with mental health, drug and alcohol and housing services and emphasised the role these services should play in any targeted health promotion strategy campaign.

The report reiterated that all parents with new infants require information and the opportunity to discuss infant safe sleeping practices with an informed health or welfare advisor. Routine inclusion of risk reduction recommendations in health interventions ensures all parents, including high risk groups, have timely exposure to these important messages.

Television and radio advertising also have a role to play in raising community awareness and educating professionals.

### Emergency responses to unexpected child deaths

The report provided an overview of the emergency responses to unexpected child deaths. It was noted that the SIDS emergency responders' manual does not include an emergency response guideline for Child Protection practitioners following the death of an infant who is a Child Protection client.

## 5.8 Summary of recommendations

The report makes 21 recommendations aimed at increased health professional awareness of SIDS and prevention of sudden infant death in high risk families. The recommendations include:

- to promote social marketing research, particularly into the needs of high risk families, their understanding of risk factors and their sources of information
- to promote opportunities for health professionals to share accumulated practice skill and knowledge
- to promote the development of effective staff training for allied health and welfare professionals, in particular those involved with high risk families.

## 5.9 VCDRC response to the group analysis

The VCDRC found the group analysis to be a valuable and insightful report. The VCDRC welcomed the focus on the specific education needs of high risk families and the application of social marketing principles to reduce risk.

The VCDRC found that the report underscores the fact that SIDS risk reduction is a whole-of-community responsibility and draws attention to the role of many different service types in reinforcing health promotion messages.

The committee noted several key themes in the report that are critical in reducing the risk of SIDS in the Child Protection population. These include:

- recognising that many of the important risk factors for SIDS and for child abuse and neglect are common, meaning that the children known to the Child Protection service are likely to be significantly represented among the group of children who die from SIDS
- understanding that 'hard-to-reach families' where mental illness, family violence, drug use, social isolation and/or transience are present require specific health promotion strategies. These strategies should involve provision of frequent, consistent messages about SIDS prevention within the context of an established professional relationship. General practitioners, midwives and Maternal and Child Health professionals are particularly important in this regard
- appreciating that mental health and drug and alcohol services, including those specialist services targeting new mothers, have a critical role to play in SIDS risk reduction among high risk families
- understanding that routine modelling of safe sleeping practices by midwives and domiciliary nurses has a direct impact on sleeping practices subsequently adopted by parents.

The VCDRC understands that the Department of Human Services will review the report's recommendations and develop implementation plans accordingly. While the committee supports all 21 recommendations, it has identified the following priorities for action by the Department of Human Services:

- enhancement of current Child Protection practice (and the guidelines and training that support practice) to ensure protective workers sight the infant's sleeping arrangements on home visits and record their risk assessment and risk reduction activities with families
- liaison with the department's Metropolitan and Rural and Regional Health and Aged Care Services divisions to enhance SIDS risk assessment and safe sleeping role modelling by maternity services

- liaison with the department's Mental Health Branch, Disability Services Division, Drugs Policy and Services Branch and the Housing and Community Building Division to ensure funded services address SIDS risk reduction in their work with hard-to-reach families
- liaison with the department's Mental Health Branch to raise awareness among clinicians in both adult and child and adolescent mental health services about SIDS risk reduction and safe sleeping practices
- collaboration with the department's Early Years Services Branch to develop guidelines requiring Maternal and Child Health nurses to sight infant sleeping arrangements on home visits.

Public awareness of ways to reduce SIDS has resulted in a dramatic reduction in SIDS deaths in the general community since 1990. Practice, policy and guidelines in Child Protection and other services working with high risk families have been reviewed and modified over this time to reflect the best available knowledge. The group inquiry provides some clear directions for the next phase of this process.

## 6. Group analysis report summary: *Partnerships in caring for children*

### 6.1 Purpose of the group analysis

The group analysis was undertaken at the request of the VCDRC to examine the interface between mental health, drug and alcohol and Child Protection services and the service system responses to 'at risk' children in the care of parents who have mental health and substance abuse issues.

### 6.2 Membership of the panel

The group analysis was conducted by a panel comprising Associate Professor Anne Buist (Chair), Director Banksia House Mother and Baby Unit, Austin Hospital, University of Melbourne; Rosalyn Burnett, Alcohol and Drug Hospital Liaison, Southern Health; and Stuart Lindner, Manager Protection, Support and Juvenile Justice, Department of Human Services Eastern Metropolitan Region.

### 6.3 Methodology

The analysis panel reviewed the deaths of 25 children whose parents had a suspected or diagnosed mental health and/or substance abuse issue. The analysis of these cases was informed by relevant research identified through a survey of literature, an examination of Victorian service provision initiatives and a professionals' forum held to promote information sharing on key issues.

### 6.4 Subject group

The group analysis examined the deaths of 25 children known to Child Protection that occurred between 2000 and 2002. In all cases, identified protective concerns related to reduced parenting capacity associated with parental mental illness and substance abuse. Significantly, the parental substance abuse issues were predominately long-term and chronic in nature. Seventeen of the 25 families considered presented with substance abuse and mental illness. In one family, a parent was identified as having drug and alcohol issues, mental health issues and an intellectual disability.

There was a high representation of infants in the subject group. Twenty-two of the 25 children were two years of age or under; 14 of these children were under the age of six months.

## 6.5 Research/current knowledge

There has been a substantial amount of research on families with mental health and substance abuse issues and the impact of this on parenting capacity. Several themes emerge which are relevant to the protection of children from families where multiple parental risk factors are present:

- The presence of mental illness or substance abuse alone does not necessarily precipitate child maltreatment. The likelihood of abuse is greater where parents have a mental illness and are using a range of substances. The co-occurrence of mental illness and substance abuse exposes those affected to medical and social problems, safety issues and multi-system involvement. It can also create problems with treatment because one diagnosis overshadows another and undermines adequate treatment of either.
- Interagency collaboration is vital, particularly when family needs are complex. An holistic approach must be adopted to address multi-problem, disadvantaged, dysfunctional families and this can be achieved by a partnership between the various professions and agencies involved in child protection, family support and community health. There are many difficulties associated with the diagnosis of a mental illness, including the fact that diagnoses may change from episode to episode. Significantly, the tools used to measure parents' psychological status are only indirectly related to parenting capacity; a diagnosis is provided, but functioning is not assessed. There is a need to assess parenting independently of diagnosis, accounting for protective factors such as the presence of a supportive other, the developmental stage of the child, the history and extent of past abuse and the parents' level of insight into the impact of their behaviour on their children.
- The majority of services for substance users are directed at the adult as the client and do not necessarily record information about the care of children. While research indicates that parental substance use may have a significant and negative impact on the wellbeing of children, drug treatment interventions are not generally designed to encompass child welfare issues.
- Holistic and comprehensive approaches to service delivery are vital, where assessment provides equal emphasis on the child, parent and family. This is best achieved in a service environment that allows for the mutual exchange of information and collaborative working relationships. Case-specific conferences, forums and working groups may be required.
- There are issues associated with the different legislative frameworks under which services operate. Many frameworks contain no specific provision for the needs of the children to be taken into account when treating adult clients.

## 6.6 Service context

Since the mid to late 1990s the Department of Human Services has implemented a range of strategies and programs relevant to risk assessment and planning for 'at risk' children in the care of parents who have mental health and/or substance abuse issues.

The report provides a comprehensive description of these initiatives, across Child Protection, mental health and drug and alcohol services.

## 6.7 Themes and issues

The group analysis report highlighted several themes and issues relating to communication and collaboration, assessment and the interface between voluntary and involuntary services.

### Communication and collaboration

The report identified the need for enhanced communication and collaboration and comprehensive, coordinated planning with more frequent use of case conferencing. There was significant variation in the level of consultation and discussion between the service providers involved with this group of children. One concerning factor was the minimal contact between Child Protection and drug and alcohol services.

The report indicated that systems should be established to enable early identification of families whose multiple and complex issues impact on parenting.

### SIDS

The report found the number of SIDS deaths in this group of children concerning. In six of the eight SIDS deaths in the sample, parents were identified as having current substance abuse issues and in five cases, co-sleeping had occurred prior to death. The report indicated that it was unclear whether drug and alcohol services in general discussed the heightened risk associated with parents who misuse substances. The SIDS issues identified in this report are examined further in the group analysis report, *Tackling SIDS—a community responsibility* (2005) (see section 5 of this report).

## Assessment

The report identified the need for common case management tools across sectors. Interventions to address adult mental illness and substance abuse should acknowledge the individual's network of relationships that positively and negatively impact on treatment regimes. Tools such as the *Parenting support toolkit for alcohol and other drug workers* (2005) which is being used in drug and alcohol services, and the *Crossing bridges: Training resources for mentally ill parents and their children. Reader for managers, practitioners and trainers* (1998) should be routinely used within adult services to focus attention on child safety and wellbeing.

The report highlighted the need to adequately incorporate information about mental illness and the impact of medication into risk assessment processes.

## Obstetric and maternity services

The report highlighted the significant role of obstetric and maternity services in supporting women with substance abuse and mental health issues and facilitating their attendance at antenatal services. The subject group comprised a concerning number of mothers who claimed to be unaware of their pregnancy and did not attend antenatal care.

## Discharge from psychiatric services

The report highlighted the need for appropriate planning and case conferencing prior to discharge from hospital. The report found that a large number of parents with serious protective issues left hospital with limited discharge planning and that relevant professionals did not attend scheduled case conferences.

## Interface between voluntary and involuntary services

The report underscores the importance of developing a shared understanding and service system response when working with parents who have multiple issues. Case conferencing and increased collaboration and communication were considered critical practices to improve the capacity of services to understand the nature and scope of their differing roles and mandates.

## 6.8 Summary of recommendations

The report made 15 recommendations aimed at enhancing the interface between Child Protection, mental health and drug and alcohol services through a range of joint activities and initiatives. The recommendations include:

- to encourage discussion and exchange within the service system through forums and joint training between Child Protection, mental health and drug and alcohol services
- to extend home-based, postnatal services to mothers who have engaged with the Chemical Dependency Unit during pregnancy
- to promote a more family-centered focus in mental health and drug and alcohol services
- to promote the development of common parenting assessment tools for use across sectors
- to enhance regular case conferencing and shared decision making for parents with multiple and complex needs
- to conduct further Australian-based research on early intervention programs and service models for parents with multiple problems.

## 6.9 VCDRC response to the group analysis

The VCDRC found the group analysis to be a useful examination of the issues impacting on risk assessment and parenting capacity in families who are experiencing parental mental illness and/or substance use. In particular, the committee welcomes the report's strong endorsement of family-centred models of service provision in mental health and drug and alcohol services. The group analysis also provides an excellent review of current initiatives in Child Protection, mental health and drug and alcohol services.

In addition to the findings of the group analysis, the VCDRC highlighted the following issues which it believes are critical to understanding the case material included in the review:

- the importance of a cumulative approach to risk assessment which treats each notification as a growing expression of concern, rather than a series of isolated events
- the need to focus on the family's *ability* to parent, rather than their motivation and desire to parent
- the need for Child Protection to exert leadership in risk assessment while drawing on the expert views of mental health and drug services ideally operating within a common risk assessment and case management framework
- the importance of understanding the impact of family violence and trauma on the neurological development of infants and the relationship between the non-offending parent and the children

- the importance of understanding the impact of trauma on childhood development and the association between childhood trauma and mental illness in adolescence and adulthood
- the importance of understanding the trauma history of the parents as a precursor to drug and alcohol use.

The VCDRC understands that the Department of Human Services will review the report's recommendations and develop implementation plans accordingly. While the VCDRC supports all 15 recommendations, it considers the following areas priorities for action:

- promoting a more family-centered focus in mental health and drug and alcohol services which recognises the special needs of adult clients as parents
- developing and adopting common parenting assessment tools for use by mental health and drug and alcohol services in collaboration with Child Protection
- promoting regular case conferencing and decision making for clients with multiple needs who are also parents, especially at the point of discharge from in-patient/residential settings.

The VCDRC looks forward to following the progress of these priority actions in the year ahead.

## 7. The year in review; the year ahead

### 7.1 The year in review

In last year's annual report, the VCDRC identified a number of strategic priorities for 2005–06 to augment the committee's primary case review functions. Following is a brief description of activities and progress against these priority areas.

#### Influencing policy, procedure and practice

The VCDRC is committed to ensuring insights gained through the child death inquiry process directly influence the way in which services are designed and delivered in future. In the past year, the committee has implemented a number of measures to enhance the translation of key learning into policy and practice.

First, the VCDRC has forged an agreement with the Office for Children, which provides formal, periodic opportunities to communicate threshold issues arising from the review process and to receive feedback on action taken to address these. The new arrangements will help to ensure the most important issues are tackled in a timely and meaningful way.

Second, as indicated in section 2 of this report, changes to the child death inquiry process mean that individual inquiry reports now produce findings, rather than recommendations. The VCDRC translates these findings into recommendations as required. Recommendations made by the VCDRC may be case-specific or address issues arising from a cluster of cases. It is anticipated that this model will reduce the duplication of themes noted in child death inquiry recommendations and enable the VCDRC to adopt a more strategic approach in which priority issues are identified and actively monitored.

In addition to making formal recommendations for change, committee members participated in a number of consultative forums in the past year, many of which related to the new legislative and policy framework for Child Protection and family support services. The VCDRC has welcomed the opportunity to contribute to the wider reform agenda and ensure learning arising from child death inquiries shapes future policy and practice directions.

## Training

The VCDRC is committed to using existing training and quality improvement mechanisms within the child and family welfare service system to communicate findings and drive change. In the past year, the committee has consolidated its relationship with the Child Protection Professional Development Unit in the Department of Human Services to ensure learning arising from the child death inquiry and review process is reflected in staff training programs. This culminated in a half-day workshop attended by the VCDRC and the Child Protection training team to explore key themes in the committee's annual report, discuss current and future training responses and exchange case material for learning purposes.

The VCDRC appreciates the skill and professionalism of the Child Protection training team and its responsiveness to new and emerging practice challenges. The committee welcomes the emphasis on training to enhance management and clinical supervision as part of a broader quality assurance strategy.

## Monitoring progress: risk assessment

In last year's annual report, the committee indicated its intention to monitor system progress in achieving a more holistic, cumulative and historical approach to risk assessment in Child Protection and related services. This is one of the most persistent challenges facing services for vulnerable children and families everywhere, and has been the subject of ongoing dialogue between the committee and the Office for Children.

The VCDRC believes key aspects of the new legislative and policy framework will encourage government and community-based services to work together over time to address cumulative harm to children, not just immediate risk. The Innovation Projects are particularly important in this regard. The committee looks forward to following the proposed development of common risk assessment tools across statutory and community-based services.

The VCDRC welcomes the 'best interests' focus of the Children, Youth and Families Act, with its shift in emphasis from the immediate safety of the young person to a longer term, cumulative perspective of harm. This creates the impetus for significant cultural change within the Child Protection service, supported by comprehensive reform of policy and practice guidance. The VCDRC is pleased to learn that reviews of the *Child Protection practice manual* and the Victorian Risk Framework, which commenced in 2005, will have a particular emphasis on cumulative harm and holistic risk assessment.

Finally, it is encouraging to note the new Child Protection client information system, CRIS, has been designed to expedite access to historical records and provide alerts to practitioners about prior notifications.

The VCDRC welcomes the range of initiatives aimed at enhancing Child Protection risk assessment in the past year and acknowledges the Office for Children's commitment to embed these developments in a long-term cultural change process.

### Monitoring progress: group analysis into children with complex needs

In last year's annual report, the committee also indicated its intention to monitor implementation of recommendations made in the group analysis, *Children with complex medical needs and a limited life expectancy* (2004).

The committee is pleased to report that the Office for Children has responded on a number of levels to this important piece of work.

First, consistent with key recommendations, the Office for Children is developing specific guidance about Child Protection work with children with complex medical needs and their families. This document will include prompts to assist practitioners to assess the risks and needs of this group and to plan for their stability, safety and wellbeing. The guidance will make special reference to the needs of siblings of children with complex medical needs, to ensure they are given adequate focus and attention in assessment and case planning.

A new special assessment tool complements the broader practice guidance about children with complex medical needs. This draws practitioners' attention to some specific and unique issues pertaining to this cohort of children.

The group analysis *Children with complex medical needs and a limited life expectancy* (2004) concluded that improved service responses were contingent on better understanding and collaboration between child protection, disability and acute health services. A number of recent initiatives have addressed this issue. In the past year, the protocol between the Child Protection service and the Royal Children's Hospital has been revised and updated to address emerging practice challenges. The Department of Human Services Metropolitan Health and Aged Care Services Division and Child Protection have established the Vulnerable Children Within the Health Sector Project to promote a collaborative approach to vulnerable infants, children and young people receiving hospital treatment and care. Finally, the *Review and redevelopment of support for children with a disability and their families—final report* (2005) provides for enhanced responses to children requiring longer term care and support and fosters collaboration between child protection and disability services.

The group analysis *Children with complex medical needs and a limited life expectancy* (2004) noted that Child Protection practitioners often found it difficult to interpret medical information about a child's illness, treatment and prognosis and to incorporate this information into the risk assessment. The development of a new Forensic Paediatric Advisory Service should assist practitioners in this regard by providing specialist consultation and advice and clinical leadership on forensic paediatric assessments.

The VCDRC commends the Office for Children and its partners on their comprehensive response to this small but growing group of highly vulnerable children who have complex medical needs and/or a limited life expectancy.

### Organisational change

The transfer of responsibility for the conduct of child death inquiries from the Department of Human Services to the newly created Office of the Child Safety Commissioner has constituted a significant shift in responsibilities in the past year. Much energy has been invested in delineating new working arrangements. A joint workshop between the VCDRC and the Office of the Child Safety Commissioner provided an early opportunity to identify mutual expectations and explore a range of refinements to the child death inquiry and review process. These will be described in a forthcoming publication of the office.

The VCDRC appreciates the support provided by the Office of the Child Safety Commissioner and looks forward to a productive future partnership. The committee believes there will be further opportunities for collaboration on strategic priorities as the role of Victoria's Child Safety Commissioner evolves.

### Timeliness of child death inquiries

In last year's annual report, the VCDRC expressed its concern at the lack of timeliness in the child death review process and urged the adoption of standard timelines for the commencement and duration of individual inquiries.

The newly appointed Child Safety Commissioner shared the committee's concerns and agreed to complete all individual child death inquiries within 12 months of the child's death. This has already impacted, enabling the committee to provide a more timely response which in turn enhances the relevance and credibility of the child death review process.

The VCDRC extends its appreciation to the staff of the Inquiries and Review Unit, case analysts and other participants who have worked diligently to improve performance in this regard.

## 7.2 The year ahead

### Group analysis: chronic neglect

In the past two years, the VCDRC has considered the deaths of several children who experienced chronic neglect, characterised by poor hygiene and nutrition, lack of parental supervision and stimulation, and emotional trauma.

Consistent with the discussion in section 4 of this report, the protective concerns in these cases were longstanding and well entrenched—several of the children were the subject of multiple notifications. In these cases, there was a high representation of parental characteristics, such as family violence, substance use, mental illness and intellectual disability, which are known to reduce the capacity of parents to provide adequate care of their children.

The VCDRC's review of individual inquiries into child deaths involving chronic neglect has highlighted a number of common themes regarding risk assessment and case planning. The committee believes that learning from these children's experiences should inform the ongoing policy development associated with the introduction of the Children, Youth and Families Act and the current review of the Victorian Risk Framework.

To this end, the VCDRC, with the support of the Child Safety Commissioner, has recently initiated a group analysis to examine responses to chronic neglect in a sample of ten child deaths reviewed between 2004 and 2006.

The group analysis will be conducted in a focused, timely manner to ensure key learning arising is available to inform current policy and program development activities within the Office for Children. The Office of the Child Safety Commissioner will oversee conduct of the group analysis. The committee looks forward to reporting key findings in next year's annual report.

### Monitoring progress on key issues

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

In the coming year, the committee will monitor implementation of the recommendations arising from the SIDS and the partnerships in caring for children group analyses. Areas of particular interest to the committee are summarised at the end of sections 5 and 6 of this report respectively.

In addition, the VCDRC will take particular note of initiatives that address the needs of high risk adolescents described in section 4 of this report.

The committee believes the new approach to developing recommendations arising from child death inquiries will make it easier to track progress on key initiatives and monitor enhancements in policy and practice in child protection and related services. The Office of the Child Safety Commissioner is working with the Office for Children to streamline arrangements for tracking and reporting action on recommendations over time. The VCDRC looks forward to implementation of the new arrangements.

### **Influencing and supporting the reform agenda**

As noted throughout this report, Victorian services for vulnerable children and families are in the midst of a comprehensive change process. This is aimed at promoting a shared responsibility for children's wellbeing and safety and repositioning child protection within a well resourced children's and family service system.

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

The committee is pleased to learn of the comprehensive change management strategy that will support implementation of the new legislative and policy framework. It is understood that this will provide opportunities for a range of stakeholders to contribute to the detail of new service arrangements. The VCDRC is committed to working collaboratively with the Office for Children and its partners to shape and advance the important reform of child protection and related services.

# Glossary and abbreviations

accidental death	category of death; includes drowning, fire, road trauma and train fatalities (non-suicidal)
acquired illness	category of death; includes prematurity, terminal illness, serious congenital conditions, fatal infection and fatal seizures
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
CRIS	Client Relationship Information System
custody order	court order made under the <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 <i>Children and Young Persons Act</i> , 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; must be substantiated by autopsy or coronial documents
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 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 well being for children and young people involved in Child Protection

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