

**Child Death Review Committee  
Western Australia**

**Annual Report  
2006-2007**

**Child Death Review Committee, Western Australia**

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## Chairperson's Foreword

As a result of the Gordon Inquiry the child death review process was established in Western Australia (WA) in January 2003. The Child Death Review Committee (referred to throughout this report as the Committee) reviews the Department for Child Protection's (referred to throughout this report as the Department), policies, procedures and practice as they have affected a child that has died and been known to the Department.

This is the fifth annual Report of the Committee in Western Australia, which reports on the involvement of the Department with 10 deceased children and their families. An analysis of the trends and issues reflected in these cases is presented as is an analysis of all 54 cases reviewed to date.

The year 2006-07 was very important for child protection in WA as the Prudence Ford review was completed and as a result major reform of the child protection system in WA is underway. The Committee welcomes the reform process and is hopeful that significant improvement will result.

However, as yet little change is apparent and the cases reviewed this year are depressingly similar to those reviewed previously. The Committee continues to make the same recommendations about a holistic approach, critical analysis and assessment, and priority being given to the child. In responding to these recommendations, generally the Department has referred to policy and procedures and the need for training and rarely, if ever, to action taken or to be taken.

In this regard the Committee had become concerned about both the independence and the effectiveness of its function and recommended to the Ford Review that the Ombudsman should have responsibility for the Child Death Review Function. This was endorsed by the State Government and it is understood that the transfer will occur in 2007-08.

During 2006-07 the Committee became particularly worried about the circumstances of extreme neglect in most of the Aboriginal deaths reviewed, and the fact that these deaths should have been preventable. The Committee will commission a 'Group Analysis of Aboriginal Death Review Cases in which Chronic Neglect is present' and this will be completed in 2007-08. In this context the Committee is pleased to note that in 2007-08 the Department will produce a policy on neglect and hopefully some action. On a more positive note, in previous Annual Reports the Committee had commented on the invisibility of fathers and is pleased to note that the Department has commenced the development of a Fathering Framework to raise greater awareness of the importance of the involvement of fathers in the lives of their children.

The number of suicides coming before the Committee has been a matter of concern and the Committee has made a submission to the Ministerial Council for Suicide Prevention.

During 2006-07 Professor Steve Allsop the Director of the National Drug Research Institute at Curtin University of Technology joined the Committee as did Ms Jocelyn Jones PhD Candidate at the Telethon Institute for Child Health Research.

During the year the Committee obtained its own premises and was able to appoint its first Manager. For over 3 years from the inception of the Committee until the Manager was appointed, Ms Anne McMullan was the Committee Advisor, carrying out this role in addition to her other fulltime duties. The Committee

would like to acknowledge her efforts and thank her for her significant contribution to the development of the Committee.

In July 2006 Ms Lani Kaszanski was appointed as Manager. Lani's enthusiasm for the function, her commitment to the position and her desire to make a difference were cut short when she died in December 2006. The Committee has no doubt that had she lived Lani would have continued to make a major contribution to the Child Death Review process and as such dedicates this Annual Report to her. Finally the Committee would like to thank the Committee staff and contract reviewers and the involved Departmental staff for their efforts during what was a very difficult year.

Dr Denzil McCotter  
Committee Chair

December 2007

## **Child Death Review Committee Members**

### **Dr Denzil McCotter Committee Chair**

Dr McCotter has a B.A. Hons. Degree in Psychology, a M.Sc. Degree in Abnormal Psychology and a Ph.D in Social Work and Administration. Denzil McCotter has extensive experience in a range of government Human Service agencies, holding senior executive positions in Community Development, Justice and Health. She has an abiding interest in policy development, implementation and evaluation and all aspects of system development. Dr McCotter has always been concerned with the nexus between policy systems and service delivery. She is the Deputy Chair of the Prisoner Review Board, the Deputy Chair of Ruah Community Services, a member of the Department of Housing and Works Public Housing Review Panel and an Adjunct Research Fellow at Curtin University.

### **Professor Steve Allsop Committee Member**

Steve Allsop is the Director and Professor of the National Drug Research Institute at Curtin University of Technology. He is currently a government appointed member of the Board of the WA Alcohol and Drug Authority and the WA Commission for Occupational Health and Safety, and Chair of the Capital Cities Lord Mayors Drug Advisory Committee. He sits on the International Editorial Board of *Drugs: Education and Prevention and Policy* and is the Deputy Regional Editor of *Addiction*. He has previously worked as A/Executive Director of the Drug and Alcohol Office. He has almost 30 years experience working in the drugs field, focussing on clinical, prevention and policy practice and research.

### **Rosemary Cant M.Psych, Post Grad. Dipl. Business Committee Member**

Rosemary Cant is a Psychologist and researcher with extensive experience in the social welfare area. Ms Cant has been an independent consultant since 1994. Prior to this she held a range of positions in the Department for Child Protection. Ms Cant has been involved in a number of significant reviews and evaluations in Western Australia and nationally, including the evaluation of the New South Wales Police and Department for Community Services joint child abuse investigation teams. She has also been involved in reviewing on a national level early intervention programs with parents.

### **Michael Doyle Committee Member**

Michael Doyle has qualifications in Aboriginal Health Promotion and is currently employed by the Aboriginal Health Council of Western Australia. Mr Doyle brings considerable knowledge and experience to the committee from the fields of sexual health, young offending and drug dependency. He is currently a member of other committees including the State Forensic Mental Health Advisory Committee, the Ministerial Committee of HIV Sexual Health and Hepatitis, the sub-committee for Indigenous Australians' Sexual Health and the W.A. Committee on HIV and Sexually Transmitted Infections.

**Jocelyn Jones**  
**Committee Member**

Jocelyn comes from a nursing background with a Masters in Epidemiology and is currently a PhD candidate with the Telethon Institute of Child Health Research. Jocelyn has extensive experience in the fields of Aboriginal primary health care services, health research, policy development and justice services. She is a reviewer for the NHMRC Indigenous Health Research Panel, a member of the Western Australian Aboriginal Health Information and Ethics Committee and Chairperson of SIDS & KIDS program 'Reducing the Risk of SIDS in Aboriginal communities'.

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# 1. Introduction

## 1.1 Background

The child death review process in Western Australia was established following the Inquiry into Responses by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (known as the Gordon Inquiry), which released a report in July 2002<sup>1</sup>. The Gordon Inquiry was commissioned by the West Australian Government to provide advice on how to respond to endemic levels of family violence and child sexual abuse in Aboriginal communities.

Headed by Magistrate Sue Gordon, the report ran into more than 640 pages and made 197 findings and recommendations. One key recommendation was the appointment of an independent committee to examine child deaths.

In 2003 the government established two committees:

- the Child Death Review Committee (CDRC) to provide quality assurance mechanisms of particular departmental cases where a child has died, and
- the Advisory Council on the Prevention of Deaths of Children and Young People to examine trends for all child deaths with a view to implementing preventative strategies.

The Child Death Review Committee was established with the appointment of four Committee Members and had its inaugural meeting in January 2003 following the Government's announcement of the purpose and functions for the Committee. The Committee was established by Order of the Governor in Executive Council under section 22 of the Community Services Act 1972 and continues pursuant to section 27 of the Children and Community Services Act 2004

Under this Order the general objects of the Committee are to:

- assist the Director General and the Department in bringing about the provision of quality services to vulnerable children and their families, and
- facilitate accountability in relation to the operations of the Department for Child Protection through the provision of an additional quality assurance mechanism in particular cases where children have died.

The Committee is to prepare a report annually on its operations for provision to the Minister to be made publicly available. The Committee has prepared four Annual Reports which have been tabled in the Legislative Assembly.

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<sup>1</sup> Gordon S, Hallahan K, Henry D (2002) Putting the Picture Together: Inquiry into Responses by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities. Department of Premier and Cabinet, Western Australia. State Law Publisher.

In March 2006 the Community Services Act 1972 was repealed and replaced by the Children and Community Services Act 2004. The functions and operations of the Committee outlined in the Order continue pursuant to Section 27 of the Children and Community Services Act 2004.

## 1.2 The functions of the Committee

The functions of the Committee<sup>2</sup> are:

- (a) at the request of the Minister or Director General, to carry out a review of the operation of relevant policies, procedures and organisational systems of the Department in circumstances where a child has died;
- (b) on completion of the review to prepare a written report setting out –
  - i. advice or comments on the operation of the policies, procedures and systems referred to in paragraph (a); and
  - ii. recommendations (if any) for the improvement or modification of those policies, procedures and systems,and to give the report to the Minister and the Director General;
- (c) to identify particular classes of child deaths or related issues that may benefit from further investigation or research; and
- (d) to perform such other functions in relation to child deaths as the Minister directs.

## 1.3 Cases referred for Review

To ensure the deaths of children known to the Department that warrant scrutiny by the Committee are reviewed, two processes have been set in place:

1. Referral criteria have been developed to ensure cases warranting review are reviewed. If a case meets one or more of the following criteria they are referred:
  - a. The deceased child, young person or other children in the deceased child's family have been the subject of an allegation of a child concern report or a child maltreatment allegation recorded by the Department for Child Protection within the past 24 months<sup>3</sup>.
  - b. The deceased child's family has had a number of contacts with the Department for Child Protection within the past 24 months and an emerging pattern is indicated.
  - c. The deceased child was in the care of the Department for Child Protection or a request for Departmental involvement in an out of home care placement for the child or young person had been made within the past 24 months.
2. The Committee examines summary reports on the deaths of all children known to the Department received from the Office of the State Coroner with particular consideration on those cases identified as meeting the review criteria. This process is important as the Committee can identify and undertake reviews separate to the Departmental recommendation and has done so on occasion. The Department has in the past provided both case summaries and monthly data reports, however during

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<sup>2</sup> Government Gazette, WA, 9 May 2003 No. 72, p: 1617.

<sup>3</sup> Under the new Children's and Community Services Act 2004, which came into effect 1 March 2006, reports of concern about children or allegations of maltreatment to the Department are subsumed under the term 'Concern for a child's wellbeing'. Discussions with the Department are currently being undertaken to review criterion 1a to replace the wording allegation of child maltreatment and child concern report with the term report of a concern for a child's wellbeing raised with the Department.

the past financial year the Department determined that due to workload issues, the monthly data reports would no longer be provided. As this resulted in five cases meeting the review criteria failing to reach the Committee the Department agreed to reinstate the monthly case summaries in 2007-2008.

## 1.4 Efficiency and Effectiveness

During the 2006-2007 reporting period, in addition to reviewing child deaths in Western Australia, the Committee has been involved in a number of activities including:

- providing a written submission to the Ford review<sup>4</sup>
- the Chairperson presenting a paper at the Ministerial Roundtable on Child Protection. Committee members also attended the roundtable
- providing a written submission to the Ministerial Council for Suicide Prevention
- developing a proposal for tenders for a Group Analysis of Aboriginal Child Deaths where chronic neglect was present and
- further development and finetuning of the Committee's data base.

Also in the 2006-2007 reporting period the Department commenced procedures which had been endorsed during the previous year. The major change being that the commencement of a Review by the Committee was no longer dependent upon the provision of an Internal Review of each case by the Department. This change was made to prevent duplication of Department and Committee work and to prevent an inevitable backlog of cases, which were awaiting review by the Department, not being able to be actioned by the Committee.

Resourcing and staffing continue to be considerable issues for the operation of the Committee, particularly impacting on timely completion of reviews within the agreed standard that they would be completed within six months of notification.

Accordingly approvals for staffing were actioned by the Committee. This resulted in the appointment of a permanent part time Executive Officer, a full time Manager and a panel of four contract reviewers. Although the Committee had sought permanent reviewer positions in preference to contract reviewers, the funding and resources were not approved.

Separate to Committee staffing, the membership of the Committee was increased to five, bringing additional knowledge and expertise to the examination of review cases.

In April 2007 the Manager position was advertised and following an extensive selection process, Karen Lacy, who had been a reviewer for the Committee, was appointed Manager of the Committee in August 2007.

In addition to Ms Lacy leaving the reviewer panel, three other panel members left throughout the period for a range of reasons including taking up other contract positions and extended leave. The Committee's ability to undertake and finalise reviews was greatly impacted by the loss of staff.

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<sup>4</sup> Ford P (2007) Review of the Department for Community Development

The Committee moved to its own offices in January 2007. The move was seen as important as it reinforced the independence of the Committee from the Department and highlighted its separate identity. Nevertheless, there were some short term consequences. The move had an impact on work capacity during the early part of 2007 and further highlighted the need for the better resourcing of the Committee as more tasks associated with the Committee having its own office, needed to be undertaken.

In March 2007 the Committee and the Department (then known as the Department for Community Development) agreed on the provision of a temporary Senior Project Officer, to support the Manager in undertaking reviews. The Senior Project Officer commenced in April 2007. Previous staffing submissions have indicated that to operate effectively the Committee needed to be supported by an Executive Officer, Manager and minimum of two full time staff.

The events and staff changes in the second half of the reporting period have meant that the Committee's operating capacity has been reduced and therefore 10 of the planned 14 reviews were completed, Of the 10 reviews undertaken in this reporting period a number were complex and challenging.

Finalising these 10 reviews means that since inception, the Committee has completed 54 reviews.

## **1.5 Case Review Process**

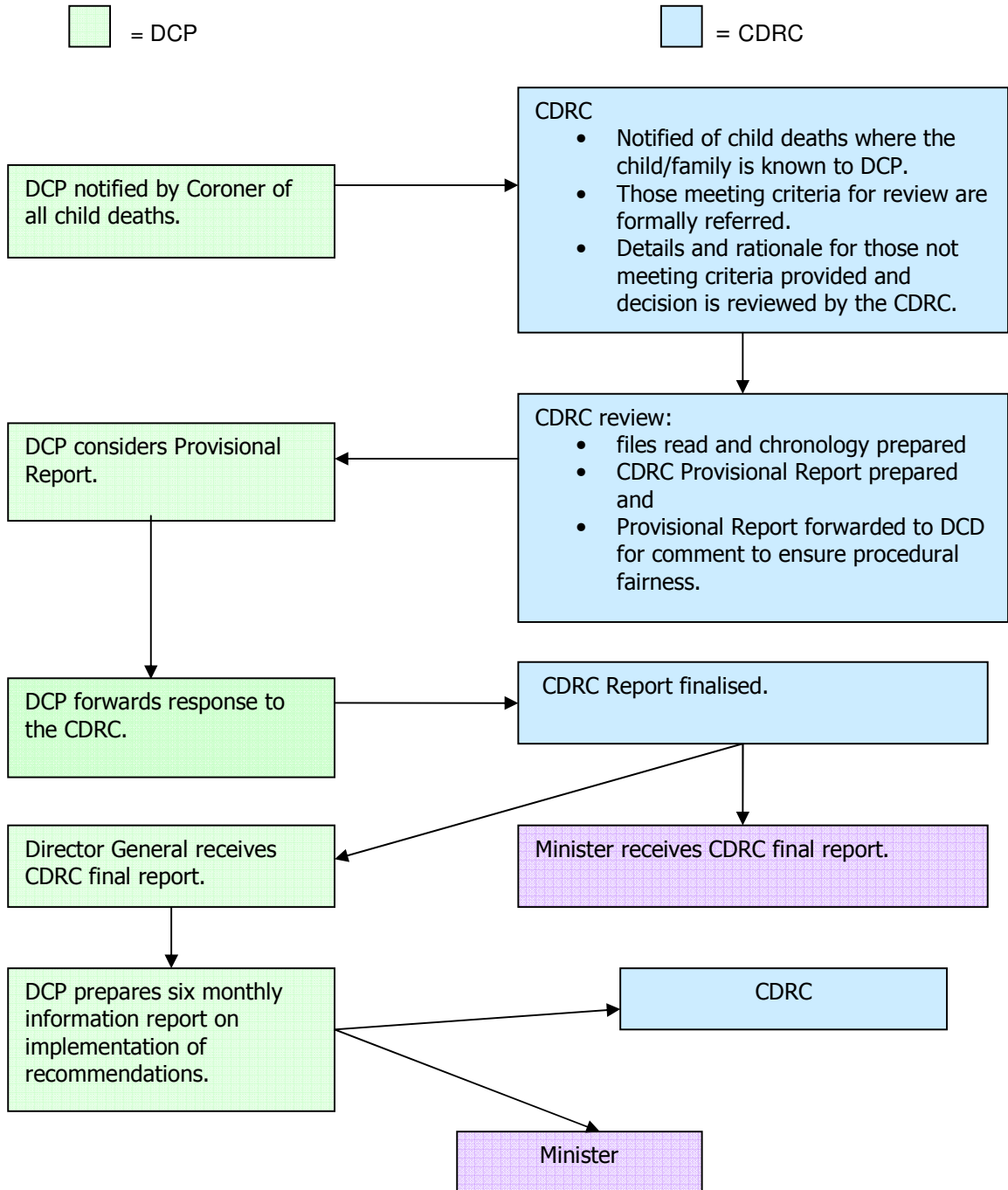
The Committee's review of cases is completed in stages (see Figure 1.):

- once the Committee has received relevant case files, these are read and the relevant factual events of the case are detailed in a chronology
- a Provisional Report is prepared and in accord with procedural fairness principles this Report is provided to the Director General for Departmental comment
- comments received on the Provisional Report are considered prior to finalisation of the Report
- the finalised Report is forwarded to the Minister and the Director General
- the Department provides six monthly information reports regarding the implementation of Child Death Review Report recommendations.<sup>5</sup>

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<sup>5</sup> The Department has not provided the Committee with any information about Child Death Review recommendations since November 2005.

**Figure 1: WA Child Death Review Model**



The time taken for a Review Report to be completed depends on the complexity of the case and the number of electronic or paper file records that are read by a reviewer. In addition reviews may take longer if during the review process it becomes evident that additional information is required from the Department. On some occasions the reviewer may seek professional information from an external source to assist in analysing a particular issue (e.g. drug dependence) identified in the review.

As indicated previously, the Department and the Committee agreed that the provision of additional staffing would enable reviews to be completed within a six month time frame. However due to staffing changes this was not able to be achieved during the reporting period.

The Committee has previously reported concerns that a review model which involves only the consideration of electronic and paper files can be limited. The interviewing of Departmental staff and consideration of the operational context in which a death occurred could contribute to a better understanding of a case. Further, such discussions can provide insight into the relevance and realistic ability of staff to apply Departmental policy and guidelines.

During the reporting period in developing a Memorandum of Understanding (MOU) between the Department and the Committee guidelines for when and how Departmental staff involved in a case will be interviewed, or how their input can be considered, have been the subject of discussions. The Committee believes that the ability of Departmental staff to provide contextual information in cases will enable a more comprehensive analysis of case management issues and the environment in which this occurs.

The Department has provided interim feedback which has indicated concern about 'professional and personal' vulnerability for workers if they are interviewed by the Committee. While the Committee's intention is clearly focused on systemic issues, the Committee understands the reluctance being expressed. It is the Committee's hope that continued discussions with the Department will result in staff feeling they can directly contribute to the Committee's deliberations in the future. It is not the function of the Committee to determine negligence or culpability of any alleged offender or Departmental officer and meetings with or interviews held with staff will not be used to gather information about negligence or culpability.

As previously stated the primary function of the Committee is to examine cases to determine the impact of Departmental policies and practices on the protection and safety of children. Accordingly the Committee's recommendations reflect the identification of risks, the application of child protection policies and practices and the identification of actions that can be implemented to prevent future harm and death to children.

As such the recommendations of the Committee are written to enable the amendment or introduction of policy and practice changes within the Department to protect children. The translation of the recommendations into policy and practice is critical if Departmental staff are to learn from the Committee's examination of child deaths. The extent to which the Department implements the recommendations made to improve policy and practice is significant in determining the value of the child death review process to improving practice.

When the Committee was established in January 2003 it was agreed that the Department would keep a register of the recommendations received from the Committee and provide six monthly reports to follow

the progress of implementing such recommendations. It is with concern that the Committee cannot report on the effectiveness of the recommendations being made on changing practice as the Department has not reported on the status of any of the recommendations made by the Committee during the current period or in fact since November 2005. There is no evidence that Department made any use of the Committee's work, notwithstanding the fact that it was the Wade Scale<sup>6</sup> death that in part contributed to the events of 2005-2006 and the Ford Review.

## 1.6 Confidentiality

The Committee continues to be acutely aware of the sensitive nature of the work being undertaken and the necessity for Members to access confidential records when reviewing service provision, practice and policy.

The Committee has in place comprehensive procedures to ensure that all Committee papers and reports, and information made available to it are held securely and the subject of restricted access.

All Committee members, staff and any contract workers have signed a Code of Conduct based on the Western Australian Public Sector Code of Ethics. This stipulates the member's, staff and contract worker's responsibilities including those concerned with the secure maintenance and use of confidential information.

## 2. Overview of Child Death Review Data

The Director General of the Department for Child Protection is formally notified of the reportable death of a child under eighteen years old by the Office of the State Coroner.

Under the Coroner's Act 1996, the Coroner has a responsibility to determine the cause of a death where this is not clear or known, or where the death occurred under suspicious or unusual circumstances. The State Coroner notifies the Director General of all reportable deaths as defined under the Coroner's Act 1996 where a child or young person is under the age of 18 years. The Department has a responsibility to assess the safety of the deceased child's siblings and review the quality of its case practice where it has been involved with the family, following the notification of a child death.

The Department and the Office of the State Coroner have in place Reciprocal Procedures to facilitate the exchange of information between the two agencies where the death of a child is the subject of inquiry by the Coroner. This exchange enables the Coroner to examine records on the 'wellbeing' of a child where the Department has had contact with the child and/or their family prior to the child's death. It also enables the Department to access information which may be required to protect siblings or subsequent children from harm, injury or death. This exchange of information occurs irrespective of whether the Department has or has not had previous contact with the child and/or their family.

While the Coroner's Office notifies the Department of reportable deaths of all children under 18 years of age, not all children reported are known to the Department.

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<sup>6</sup> The child's name is referred to in this report as it became public.

Further, in many cases where the Department has had contact, the reasons for the contact are varied and diverse and do not concern the possible ill treatment or safety of a child. For example, the contact may have occurred many years ago when the child's mother was a child, or because a parent was in need of financial assistance or advice. Most parents protect their children and do not require Departmental intervention. In the instances where Departmental involvement is required to promote the well-being and safety of a child, there is usually a cluster of indicators evident in the family's history. It is these cases, where a child has died, that are generally referred to the Committee.

Table 1 provides population data for Western Australia (WA) and persons provided one-to-one services by the Department for Child Protection. It can be seen from this Table that the Department provided one-to-one services to 2% of the Western Australian population.

Table 1: Population Data for Western Australia (WA) and persons provided one-to-one services by the DCP 1 July 2006 - 30 June 2007

Population	Number	% of total WA Population
WA Population (2006) <sup>7</sup>	1,959,088	100 %
Children aged 0-18 years old <sup>8</sup>	508,867	26 %
Number of persons in WA provided one-to-one services by DCP 2006-2007. <sup>9</sup>	45,000	2 %

Of Western Australia's population (N=1,959,088) a total of 12,147<sup>10</sup> people died in the 2006-2007 financial year. Of these deaths 97% (N=11,772) were persons aged over 18 years. Deaths of children 0-18 years old (including still-births) comprised 3% (N= 375) of all deaths<sup>11</sup> for the 2006-2007 year. This represents 0.07% of the population of all children aged 0-18 years.

In the 2006 Census<sup>12</sup> about 3% of Western Australian residents identified as being of Aboriginal or Torres Strait Islander origin with more than one third of these residents living in the Perth Statistical Division (36%). The Kimberley Statistical Division while having only 1.5% of the Western Australian population had more than one fifth (21%) of the state's Aboriginal and Torres Strait Islander population.

The Department's Annual Report 2006-2007 notes that about 29% of the Department's client base in 2006-2007 was Aboriginal and Torres Strait Islander.<sup>13</sup>

<sup>7</sup> Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 2068, August 2007

<sup>8</sup> Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 2068, August 2007

<sup>9</sup> Department for Child Protection Annual Report 2006-2007

<sup>10</sup> Breakdown of Registrar General's Death Data 2006-2007. Department of Attorney General: Births Deaths and Marriages

<sup>11</sup> Breakdown of Registrar General's Death Data 2006-2007. Department of Attorney General: Births Deaths and Marriages

<sup>12</sup> Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 1367.5 September 2007

<sup>13</sup> Department for Child Protection Annual Report 2006-2007

Table 2 below presents data on all child deaths in Western Australia excluding still-births and those reported to the Department by the Coroner as a proportion of these deaths, and in turn those referred by the Committee and reviewed by the Committee.

Table 2: Children's Deaths in Western Australia (WA) 1 July 2006 - 30 June 2007

WA Child Deaths	Number	% of WA Child Deaths
Deaths of children 0-18 years old (Excludes still-births; Number of infants 0-1 years = 88) <sup>14</sup>	187	100%
Number of reportable child death coroner notifications received by DCP 2006-2007 <sup>15</sup>	87	46.5 %
Child death notifications where any form of contact had previously occurred with DCP: recent, historical, significant or otherwise	37	19.8 %
Child deaths referred and warranting review by the Child Death Review Committee	17	9.0%

As shown in Table 2, for the period 1 July 2006 to 30 June 2007, 87 deceased children were the subject of notifications received by the Director General of the Department from the Office of the State Coroner. This represents approximately a half (N =87) of all child deaths (N=187) for this period.

In the majority 57.5% (N=50) of child deaths reported to the Department by the Coroner there was no previous contact with the deceased child and/or their family.

Thirty-seven Coroner notifications were received where the deceased child, and/or a member of the child's family such as a sibling, parent or step parent, had recent or historical, significant or non significant contact with the Department. This is a small proportion (approximately 0.082%) of the overall number of persons provided with one-to-one services in any one year by the Department, which in 2006-2007 was 45,000.

The percentage of coronial child death notifications where some form of previous contact had occurred with the Department, as a percentage of all child deaths excluding still-births is 19.8% (N=37). Child death cases referred and warranting review by the Child Death Review Committee in 2006-2007 was 9.0% (N=17).

Of the 87 reportable child deaths received by the Coroner, 42.5% (N=37) concerned cases where the child and/or their family had some form of contact, recent or historical, with the Department. The reason for this is not clear. However, it could be argued that social disadvantage may be one of the key determinants in a family having contact with the Department. For example, in 2006-2007 the key reason (N=14,420) for contact with the Department was for financial problems.<sup>16</sup>

<sup>14</sup> Breakdown of Registrar General's Death Data 2006-2007. Department of Attorney General: Births Deaths and Marriages

<sup>15</sup> Data provided by the Department for Child Protection

<sup>16</sup> Department for Child Protection's Annual Report 2006-2007 p 8

During the process of examining all 37 notifications involving a child or family who had some form of contact with the Department, the Child Death Review Committee received 17 referrals of cases during 2006-2007 which warranted independent review by the Committee. This again is a small proportion of those provided with services by the Department.

The percentage of the total Western Australian population provided with services by the Department is 2%. If one considers the 37 notifications from the Coroner where the Department had some form of contact with a child and their family, as a percentage of the number of all persons provided services by the Department, this equates to 0.08%.

## **2.1 Department for Child Protection Client Profile**

The Department's child protection services are provided to protect children and young people under the age of 18 years who are at risk of harm within their families, or whose families do not have the capacity to protect them from maltreatment and neglect. The Department also provides services to support and assist children, individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning and safety, and services to children in care.

The Department undertakes early intervention and prevention activities to promote the social, physical and cognitive development of young children, and community development work to build capacity in communities to ensure the sustainable wellbeing of community members.

The Department's Annual Report 2006-2007 states that

The Department for Child Protection, through its administration of the Children and Community Services Act 2004, provides for the protection and care of children in circumstances where their parents have not provided, or are unlikely or unable to provide, that protection and care.

The department's offices throughout the state provide services that protect children from harm, and care for children who are unable to live at home. The department also provides family and individual support services and assists people who are in crisis. It has specific services for the adoption of children, licensing of child care services and criminal record checking for persons working with children. The department funds a range of non government services.

Up until 30 June the department had policy offices for issues concerning women, seniors, volunteers, children and young people and family and domestic violence. These offices, along with community development activities undertaken by the former Department for Community Development, were transferred to the Department for Communities on 1 July 2007.<sup>17</sup>

Departmental staff are guided in making decisions by the Department's legislative and administrative policy frameworks, Director General's Instructions, the Department's Case Practice Manual, Field Worker Guidelines, supervision, consultation and advice from senior officers. The Department's legislative framework, Case Practice Manual and Field Worker Guidelines are key reference guides for staff and provide information about case practice standards, policies and procedures.

When undertaking Child Death Reviews, cases are scrutinised against the legislation, case practice standards, policies and procedures, in place during the provision of the Department's service.

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<sup>17</sup>Department for Child Protection's Annual Report 2006-2007 p 3

In March 2006, the new Children's and Community Services Act 2004 came into effect. This has resulted in significant changes to the Department's practice procedures. The Act represents major reform in the areas of child protection and care for children. It is the culmination of much detailed work over many years and repeals legislation that is more than 50 years old. Implementation of the new Act will significantly change how the Department functions. The Act encourages a more inclusive process of involvement with a prime focus on engaging children and families in decision making that affects their lives. Key features of the Act include:

- a focus on the best interests of the child as paramount
- a range of protection orders
- a No Order Principle whereby the Court must be satisfied that the making of an order would be better for the child than making no order at all
- provision for ongoing planning processes for children in care
- principles relating to Aboriginal and Torres Strait islander children and
- review of case planning decisions and external review mechanisms.

The most common reasons for contact with the Department's offices for 2006-2007<sup>18</sup> are listed in Table 3.

Table 3: Primary reason for contact with the Department 1 July 2006 - 30 June 2007

Primary reason for contact	Number
Financial problems	14, 420
Concerns about children's wellbeing <sup>19</sup>	7,642
Carer enquiries from potential foster carers	2,540
Family problems	2,330
Family violence	1,229
Adoption issues	423
Other crisis issues (suicide, psychiatric, medical, legal problems)	371
Custody/access issues	357
Best Beginnings Home Visiting Services	310
Homelessness	262

Note: People may present for a number of reasons however only one is identified as the primary reason for contact.

It can be seen from Table 3 that the most common reasons for contact were for financial problems, concerns about children's wellbeing, carer enquiries from potential foster carers, family problems and family violence.

<sup>18</sup> Department for Child Protection's Annual Report 2005-2006, p.8.

<sup>19</sup> With the implementation of the new Children's and Community Services Act 2004 in March 2006 new terminology for concerns for children was introduced. All child maltreatment allegations and child concern reports are now subsumed under the term 'Concern for a Child's Wellbeing'.

## 2.2 Cases reviewed

In accordance with the criteria established for the Committee's work, ten cases were examined in 2006-2007, bringing the total number of cases reviewed by the Committee since its commencement to 54.

Table 4 provides the number of cases reviewed in each year to 30 June 2007. The increased number of reviews undertaken in 2005-2006 was achieved by the provision of temporary resources to enable a backlog of cases to be undertaken and finalised.

Table 4 provides a summary of the status of cases reviewed by the Committee each year as at 30 June 2007.

Table 4: Summary of child death case reviews

	2003-2004	2004-2005	2005-2006	2006-2007
Cases reviewed	10	10	24	10

During 2006-2007 17 new notifications of children who had died and met the criteria for review were referred by the Department to the Committee. These cases are either currently under review or a review has yet to commence. One of these notifications, which is a case currently under review, is a sibling of a child who was subject to a review in 2005-2006.

## 2.3 Characteristics of cases reviewed

The characteristics of the 10 cases reviewed during 2006-2007 have been analysed. Further, an overall analysis of all 54 cases reviewed from 2003 to 30 June 2007 has also been undertaken.

None of the deceased children who were subject to a review during the reporting period 2006-2007 died in that period. Of the 10 cases reviewed, 1 child died in 2004-2005 and 9 children died in 2005-2006. Table 5 below presents the year of death for all 54 children the subject of completed reviews.

Table 5: Year of death of all 54 children the subject of completed case reviews

Year of death	Number of children
Jan-June 2003	9
2003-2004	20
2004-2005	16
2005-2006	9
Total	54

### 2.3.1 Age and gender

Of the 10 children who were the subject of completed case reviews in 2006-2007, 5 were male and 5 were female. The breakdown of the ages of these children is presented below:

- 4 were less than 6 months old
- 3 were 12 months to 2 years old
- 3 were 13-18 years of age.

The ten cases reviewed in 2006-2007 were similar in gender and age patterns to the 54 cases reviewed to date in which the majority of deaths concerned male children 63% (34) and 52% (28) children being 12 months or younger. Table 6 presents the age and gender of all 54 children whose cases had been reviewed as at 30 June 2007.

Table 6: Age and gender of all 54 reviews completed at 30 June 2007

	Female	Male	Total	
<6mths	9	12	21	39 %
6-12mths	3	4	7	13 %
1-2 yrs	3	7	10	19 %
3-5 yrs	3	2	5	9%
6-12yrs	0	3	3	5%
13-18 yrs	2	6	8	15 %
Total	20 (37 %)	34 (63 %)	54	100 %

The data trends depicted in Table 6 are not unique to the cases examined by the Committee. They are consistent with National Age Specific Death Rates (ASDR) published by the Australian Bureau of Statistics (2006)<sup>20</sup>. These death rates indicate that throughout the lifespan age-specific death rates are higher for males. Further, male death rates were higher than female death rates in all states and territories in 2004.

In 2004, 39.0% of all infant deaths occurred within the first day of birth, with a further 29.4% occurring in the remainder of the neonatal period (first four weeks of life). Since 1984 numbers of infant deaths in each of the neonatal periods - early (under one week), late - (one week and under four weeks), and post neonatal (four weeks and under one year) - have decreased...over the past twenty years male infant deaths have consistently outnumbered female infant deaths. In 2004 there were 680 male deaths, 34% more than the number of female deaths (510). The male infant mortality rate (IMR) has been consistently higher than the female IMR, on average 26.2% higher over the same period.<sup>21</sup>

### 2.3.2 Aboriginal status of children

Of the 10 children who were the subject of completed case reviews in 2006-2007, 5 children were identified as Aboriginal and 5 were identified as non-Aboriginal. All of the 5 children identified as Aboriginal who died were under 2 years of age.

This over-representation of Aboriginal children in child death reviews is also evident in the Committee's analysis of all 54 cases reviewed to date.

Table 7: Aboriginal status of children whose cases have been reviewed as at 30 June 2007

Status	Females	Males	Total	
Aboriginal	12	14	26	(48 %)
Non-Aboriginal	8	20	28	(52 %)
Total	20 (37 %)	34 (63 %)	54	(100 %)

<sup>20</sup> Australian Bureau of Statistics Deaths Australia 2006. Catalogue 3302.0,

<sup>21</sup> Australian Bureau of Statistics Deaths Australia 2004. Catalogue 3302.0, p 15

The average death rate for Aboriginal and Torres Strait Islander infants is nearly three times higher than for other infants<sup>22</sup>. This death rate continues to confirm that Aboriginal and Torres Strait Islander children remain a high risk group. Further, the intersection of family violence, parental drug and alcohol problems and low birth weight is a recipe for health and developmental problems.

Aboriginal and Torres Strait Islander children in all age groups are at higher risk of disease and injury and have higher mortality than other Australian children. Poor socioeconomic circumstances and living conditions and higher rates of pre-term and low birth weight babies all contribute to the higher death rate<sup>23</sup>.

Aboriginal persons are also over-represented in the Department for Child Protection’s client profile as previously noted. This trend is not unique to Western Australia. The Australian Institute for Health and Welfare (AIHW, 2007) identified that ‘...Aboriginal and Torres Strait Islander children were clearly over-represented in the child protection system. Indigenous children were almost 5 times more likely to be the subject of a substantiation than other children.’<sup>24</sup>

### 2.3.3 Family Composition

In the 10 cases reviewed in 2006-2007, 6 were from single parent families (5 of these headed by women) and 4 were from families comprised of both biological parents.

Of the total 54 deceased children who were the subject of completed case reviews at 30 June 2007, 27 (50%) were from single parent families the majority of which were headed by women. Thirty five percent (N=19) of the children were from families comprised of both biological parents and 15% (N=8) were from blended families. Table 8 shows the child’s family composition at the time of death.

Table 8: Family composition of all 54 children at the time of their death

Family Structure		Number of cases	
Two Parent	Biological parents	19	(35 %)
	Blended family*	8	(15 %)
Single Parent	Birth mother	25	(46 %)
	Birth father	2	(4%)
Total		54	(100 %)

\*Birth parent and partner

### 2.3.4 Child maltreatment and/or child concern notifications

Previous child maltreatment and/or child concern notification reports had been recorded in relation to the deceased child and/or siblings and Table 9 reflects these reports.

22 Australian Institute of Health and Welfare (2005) A Picture of Australia’s Children p 13

23 Australian Institute of Health and Welfare (2002) Australia’s children – Their Health and Wellbeing, p: 253

24 Australian Institute of Health and Welfare (AIHW) Child Protection Australia 2005-06, AIHW Cat. No CWS 28, p x Canberra.

Table 9: Previous history of allegations and concerns in cases reviewed

	Reports of Concern	Cases reviewed (N=54)
Deceased child	Child maltreatment allegation(s)	19 (35%)
	Child Concern Report(s)	16 (30%)
Sibling(s) of deceased child	Child maltreatment allegation(s)	29 (54%)
	Child Concern Report(s)	27 (50%)

However, the Committee recommends caution when interpreting Table 9. When examining case information in respect of children who had died and their siblings, the Committee found that not all reported concerns, which met the Department's definition of a maltreatment allegation or child concern report, were recorded by Departmental staff as such in the Department's electronic information system or hard copy files. The Committee found variation between cases and districts as to what reports were categorised as allegations of maltreatment or child concern reports.

Variation between cases and districts as to what resulted in a substantiation of maltreatment was also found. For this reason the Committee has not included data on substantiations. To include this information would not accurately reflect the true nature of valid concerns for children and the true substantiation rate.

What can be seen from Table 9 is that allegations and reports of concern are more likely to have been recorded in respect of a deceased child's older siblings than the deceased child. Given the majority of cases reviewed concern young infants and toddlers under two years of age, this is not surprising. The young age of these children does not allow easy identification of concerns, complicating formal reporting, investigation and categorisation.

In light of this, it is imperative that sibling and family histories are not overlooked. They should be actively sought, read and taken into account when the Department receives contact about these children and/or their families. History of concerns for the children in the family particularly older siblings should be considered as a significant risk factor in any holistic assessment of a case.

Under the new Children's and Community Services Act 2004, which came into effect 1 March 2006, reports of concern about children or allegations of maltreatment are subsumed under the term 'Concern for a Child's Wellbeing'. Under this Act where the Chief Executive Officer (CEO) of the Department receives information that raises concerns about a child's wellbeing, the CEO may cause any inquiries to be made that they consider reasonably necessary for the purposes of determining whether action should be taken to safeguard or promote the child's wellbeing<sup>25</sup>. The Committee anticipates that this will result in concerns for children being recorded with greater frequency and lead to improved assessments of reported concerns.

Uniform understanding and the standardisation of the classification of protective concerns are essential to formulating adequate and appropriate responses. Given the recency of the implementation of the new Act, it remains to be seen whether the reforms expected will result in improved service provision outcomes and greater uniformity and consistency in classifying and responding to concerns about children.

<sup>25</sup> Children and Community Services Act 2004

### 2.3.5 Guardianship and case status

Two of the deceased children who were the subject of completed child death reviews as at 30 June 2007 were children in the care of the CEO and placed in foster care. To date the Committee has therefore reviewed 3 cases in total where children were in the CEO's care at the time of their death out of the 54 cases reviewed

Of the 10 deceased children four children and their families were the subject of open contacts or cases within the Department at the time of the child's death and the remaining 6 were not open cases. Of all 54 cases reviewed 44% (N=24) were the subject of open contacts or cases with the Department at the time of the child's death. The remaining 56% (N=30) were not open cases.

### 2.3.6 Departmental Divisional Areas

Of the 10 cases reviewed in this reporting period 4 of the children's families lived in the metropolitan area (3 in the Metropolitan East Divisional area and 1 from the Metropolitan North Divisional area). Six of the children's families lived in the country (4 in Country North Divisional area, 1 Country South Divisional area and 1 Country East Divisional area).

Of all 54 cases examined to date, 44% (N=24) of the children's families primarily lived in the Perth metropolitan area at the time of the child's death. Fifty six percent (N=30) lived in country areas. Table 10 below provides a breakdown of the Department's Divisional Areas which had the most recent contact or involvement with the deceased children and/or their families.

Table 10: Departmental Divisions with the most recent contact or involvement with cases reviewed

Divisional Area		Number of Cases
Metropolitan	East	14
	North	5
	South	5
<i>Sub Total</i>		<i>24 (44 %)</i>
Country	East	4
	North	20
	South	6
<i>Sub Total</i>		<i>30 (56 %)</i>
Total		54

From Table 10 it is evident that the majority of reviewed child death cases came from rural and remote regions. The Country North Divisional area features predominately in this statistic (N=20). With respect to the metropolitan area the Eastern Division features significantly (N=14).

In respect of the cases reviewed from the Country North Divisional area, the Kimberley District had the highest number (N=12).

The Kimberley has the second lowest life expectancy rate in Australia<sup>26</sup>. The Northern Territory has the lowest. The Indirect Standardised Death Rate (ISDR) for the Kimberley is 11.7 per 1,000 population. This

<sup>26</sup> Australian Bureau of Statistics, Deaths Australia, Catalogue 3302.0, 2004.

is the highest ISDR for the state of Western Australia. Perth for instance, has an ISDR of 6.0 per 1,000 population<sup>27</sup>. It is not surprising therefore, that the number of cases examined by the Committee is higher for the Kimberley than any other area.

### 2.3.7 Preliminary information concerning child deaths

The circumstance of death has been grouped on the basis of preliminary information contained in the Coroner's notification to the Department. Once the cause of death is determined, this grouping is amended accordingly. Cause and nature of death are the subject of inquiry and determination by the Office of the State Coroner in these cases. The determination in respect of a death can be contingent on a range of factors such as autopsy results, inquests being held and other pending proceedings which impact on the time taken for a determination to be finalised. Information concerning the circumstance of death for all 54 child deaths reviewed by the Committee is reflected in Table 11.

Table 11: Information concerning circumstances surrounding children's deaths<sup>28</sup>

Circumstances (Preliminary information only)	Number of Cases
Sudden infant death syndrome <sup>29</sup>	3 (5.5%)
Sudden unexplained death	17 (31.5%)
Acquired illness eg. Pneumonia	4 (7.5%)
Immersion/drowning	7 (13%)
Asphyxiation/Suffocation	2 (4%)
Homicide	7 (13%)
Suicide	1 (2%)
Accident – non vehicle	3 (5.5%)
Accident – vehicle	10 (18%)
Total	54 (100%)

Of the total number of cases reviewed as at 30 June 2007, it can be seen from Table 11 that:

- 31.5% were sudden unexplained deaths of infants
- 18% were motor vehicle accidents
- 13% were drowning/immersion related deaths and
- 13% were homicide.

While the Coroner's Office is concerned with cause of death, the Committee, while noting information about the circumstances of a child's death, is more concerned with service provision practices and family, social and environmental factors evident prior to a child's death. It is these which may help to identify risk factors that can be addressed to help prevent future deaths.

Thus, while the Coroner's Office may determine a death as due to an acquired illness like pneumonia, the Committee examines the Department's service provision to ascertain:

<sup>27</sup> Australian Bureau of Statistics, Deaths Australia, Catalogue 3302.0, 2004.

<sup>28</sup> Some of this information concerning circumstances of death is preliminary information.

<sup>29</sup> Sudden Infant Death Syndrome (SIDS) is different to that of a Sudden Unexplained Death of an Infant. One of the factors important to a SIDS description being applied to an infant's death is that the infant was sleeping alone in their bed/cot.

- whether practice accorded with relevant policy and procedural guidelines
- whether any other action if taken by the Department could have resulted in better service provision
- what preventable risk factors, if any, were evident in the events surrounding the Department's involvement with the child and their family prior to the child's death e.g. medical neglect whereby the child was unwell for some time without their ill health being noticed or addressed.

The Committee received 17 notifications during this reporting period of children who had died and met the criteria for review. The preliminary information suggested that five of these seventeen deaths involved death by suspected suicide. Additional to these notifications Table 11 highlights that there was one case where a review was completed in this reporting period which involved death by suspected suicide. This had been the only death by suspected suicide referred to the Committee for review to date. With the 5 notifications received this reporting period this means the total number of deaths being considered by the Committee where death by suspected suicide appears to have occurred is six. Due to the number of suspected suicides coming to this attention of the Committee in this reporting period the Committee made a submission to the WA State Suicide Prevention Plan, Ministerial Council for Suicide Prevention in August 2007. This submission and any themes apparent from reviewing in the next reporting period these cases where death was by suspected suicide, will be discussed in the Committee's 2007-2008 Annual Report.

### **2.3.8 Co-sleeping**

Of the 10 cases reviewed in 2006-2007, in three cases the child died in circumstances where the child had co-slept with a parent(s)/carer(s). In each of these cases the child was less than six months of age. Out of the total of the 54 cases examined to date, co-sleeping occurred in 26% (N=14). Of these, 86% (N=12) involved children under 6 months of age and 14% (N=2) concerned children aged 6-12 months.

As reported in the Committee's last Annual Report, the literature on co-sleeping indicates the main benefits appear to be in the area of attachment and bonding, encouragement of breastfeeding and better sleeping patterns for both parent and infant. The practice of co-sleeping can pose a number of risks, particularly in regards to the suffocation and/or possible strangulation of the infant. For example, primary hazards of co-sleeping can include suffocation caused by an adult rolling on top of or next to a baby and suffocation resulting from a baby being face down on bedding such as pillows, blankets, or quilts.

Where there are factors such as parental or carer hazardous drug and/or alcohol use, use of medication that causes drowsiness, extreme tiredness, maternal smoking, and a lack of knowledge about infant safety, co-sleeping may increase dangers to the infant.

The Committee has previously raised the issue of co-sleeping with the Advisory Council on the Prevention of Deaths in Children and Young People as a possible area for future research.

The Advisory Council on the Prevention of Deaths in Children and Young People has established the SIDS & Kids Aboriginal project 'Reducing the Risk of SIDS in the Aboriginal Community.' The aim of this project is to assess the Aboriginal communities' knowledge of Sudden Infant Death Syndrome (SIDS) and to develop appropriate resources for the prevention of SIDS. The resources will focus on interventions relating to the reported causes or risk factors associated with a SIDS death. These are infant exposure to cigarette smoke during pregnancy and the first year of life, co-sleeping, hazardous

parental/carer alcohol and substance use, infant sleep position, bedding, overheating and an unsafe sleeping environment.

### 2.3.9 Social and environmental factors

A number of issues are pertinent to the health and wellbeing of children. Their health and wellbeing is largely determined by the living conditions, knowledge, attitudes and lifestyles of the adults who care for them<sup>30</sup>. The Committee has examined the social and environmental factors common to the cases reviewed, many of which co-existed in the cases examined. For example, co-existing mental health and drug problems. Table 12 depicts the notable results of this examination.

Table 12: Common Social and environmental factors evidenced in cases examined.

Social and environmental factors indicated	Number of cases (100 % = 54)
Family violence or parents with histories of violent behaviour	48 (89%)
Parental hazardous alcohol and/or other drug use or histories of misuse	42 (78%)
Significant financial assistance provided over the length of the Department's involvement	40 (74%)
History of transience and/or homelessness	37 (69%)
Parental mental health issues	28 (52%)

Similar percentage proportions to those identified in Table 12 were evident for the subset of the 10 cases reviewed in 2006-2007.

As highlighted in Table 12, the presence of indicators of interpersonal or family and domestic violence was identified in 89% (N=48) of all case histories reviewed. Indications that a child's parents had a history of using hazardous alcohol and/or other drug use was present in 78% (N=42) of all cases reviewed. Mental health difficulties compounded risk factors present in 52% (N=28) of all cases.

Many of the families presented with more than one of the factors listed in Table 12. This multiplicity of factors often requires agencies to join efforts for them to be addressed. No one agency has the capacity to address chronic social and environmental issues. These require an across government approach.

As in previous years, hazardous alcohol and/or other drug use has been identified as a background and/or contributing factor in a majority of cases. This year, eight out of ten cases involved hazardous alcohol and/or other drug use among parents/guardians and/or other people (e.g. other adult family members or siblings) in the child's immediate environment. In most cases, such drug use coincided with other factors such as neglect and domestic violence.

Problems can arise from the acute effects of alcohol/drug use (e.g. increased risk of violence; accidental injury; deliberate self-harm whilst intoxicated) as well as the chronic effects (financial hardship; nutritional problems; chronic neglect). There is also concern that children raised in alcohol/drug affected environments are themselves at increased risk of drug related and other problems. Evidence of an environment where hazardous alcohol/drug use occurs is not always a direct indicator of child risk – other factors, such as the quality of parenting and quality of care are mediating factors. However, such drug

<sup>30</sup> Australian Institute of Health and Welfare (2002) Australia's children – Their Health and Wellbeing p: 253.

use in the child's environment indicates an increased risk to children that should always be carefully assessed. Indications that a child is engaged in hazardous alcohol and/or other drug use should always be investigated – early engagement in such use is high risk and associated with a range of later problems such as drug dependence, mental health problems and social/legal problems.

## 3. Reviews and Recommendations

### 3.1 Service provision themes

The key service provision and case practice issues of concern identified from the 10 case reviews undertaken during this reporting period in the main mirror those highlighted in the 44 previous reviews completed. While examples of good case practice were seen in a number of cases this varied across cases and at different times within an individual case.

The key issues of concern in cases reviewed are presented in Table 13.

Table 13: Key issues identified as of concern

Case practice issues of concern	Description	Number of cases (100% =54)
Gaps in application of case practice/field worker guidelines	Ensuring an adherence to the Department's policies, procedures and field worker guidelines.	51 (94%)
Lack of quality case planning/ decision making	Ensuring case planning is informed by regular holistic reviews, evidence of clear decision making which is informed by critical analysis and assessment.	50 (92%)
Lack of current safety/risk assessment	Assessing the immediate and past risks to a child's safety taking into account past or recent harm, significant risks of harm and any other likely factors that may compromise a child/ren's safety.	49 (91%)
Inadequate assessment and critical analysis of case events and a family's circumstances	Refers to the initial ongoing process of information gathering, holistic information and undertaking critical analysis/assessments to inform and guide decision-making.	49 (91%)
Inadequate documentation	Documentation of client information which clearly documents the Department's involvement with a client ensures accountability and transparency in practice and decision making, and meets public sector standards, legal, evidential and accountability requirements.	47 (87%)
Gaps in knowledge of case	Having a picture of all relevant and available information pertinent to undertaking ongoing assessments and working with a child and their family, as well as an awareness of missing information.	45 (83%)
Absence of developed child safety plans	Developing and implementing clear concrete strategies, action plans and bottom lines for ensuring the ongoing safety and protection of the children in question.	42 (78%)

As can be seen from Table 13 in the majority of cases reviewed (>90%) key issues identified as of concern were:

- gaps in application of case practice/field worker guidelines. The case worker guidelines are seen by the Committee as comprehensive however in most reviewed cases there is limited or no evidence of adherence
- lack of quality case planning/decision making. Quality case planning is informed by critical analysis and assessment
- holistic information gathering. This is crucial and impacts on critical analysis and assessment and
- lack of current safety/risk assessment.

Information gathering coupled with the issue of gaps in knowledge in case were seen as particular issues for all the 10 cases reviewed this reporting period. In undertaking reviews the Committee is acutely aware of the need for Departmental staff to have skills in information gathering (including using the Department's electronic and file tracking systems). The assessment process depends on this being done thoroughly. Assessment of chronic neglect, a particular concern for the Committee, cannot occur without a holistic assessment as opposed to an episodic assessment and response. Departmental staff need time allocated to allow this important task to be effectively undertaken.

In many of the cases where reviews are undertaken the family systems are very complex. The Committee is of the view that the use of a genogram for each case where there are child protective concerns is a necessary feature of 'good' case practice. While genograms were seen in a number of the 54 cases which have been reviewed they were not in file records for all cases. Genograms also enable Departmental staff to recognise who is in the family, hence fathers and significant males are identified. As noted in the 2005-2006 Annual Report the absence of information about fathers and significant males in the family has been a concern for the Committee. This was also noted in a number of cases reviewed this reporting period. For instance in two of the ten cases reviewed this reporting period there was little information known on the males in families where domestic violence was noted as a concern. However, the Committee is pleased to note that the Department has commenced the development of a Fathering Framework.

A particular issue of concern for the Committee was the lack of a child focus. This meant in some cases reviewed not all children in the family were seen and/or interviewed when concerns had been expressed. Recommendations were made about maintaining a child focus in five cases reviewed in this reporting period and reflected the Committee's comment in their last Annual Report:<sup>31</sup>

The Committee's analysis of cases identified that in most, the focus on the deceased child and his/her siblings appears to have been overshadowed by responding to the perceived needs of parents, who appeared in case files to be the workers' primary clients.

Inadequate documentation was also a major concern. In some cases this also related to the lack of a child focus as it was not always clear from file notes who had been spoken to or seen. Any documentation, in the Committee's view, needs to specify which particular children were seen and spoken to and if not, why not. The issue of engaging with significant males in the family should also be properly documented and if no engagement noted this should prompt questions from the Team Leader.

A number of other issues of concern highlighted in the reviews undertaken in this reporting period were also raised in the 2005-2006 Annual report and included:

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<sup>31</sup> Child Death Review Committee Annual Report 2005-2006 p18

- premature case 'closure' was noted by the Committee in 5 of the 10 cases reviewed for the 2006-2007 period. Out of the total 54 cases reviewed this was an issue in 44% (N=24) of cases
- in general, as noted in past reporting periods most of the cases reviewed where Aboriginal children have died have been characterized by hazardous alcohol and/or drug use, family violence, chronic neglect concerns about the children, inadequate housing, and in remote and regional areas in particular inadequate essential services. Mobility was also a factor. The Committee in particular has continued to be concerned regarding the chronic neglect evident in the cases reviewed.

As noted in the Committee's last Annual Report:

Given the complex nature of problems experienced by families in cases reviewed, interagency collaboration and case planning, in the Committee's view, should have been a stronger feature of cases examined, particularly where mental health and alcohol and drug abuse are of concern. Working with other professions in these cases appears critical if change is to be effected. In cases examined different agencies appeared to work in isolation, not necessarily being across the views and interventions of the other.

The social and economic disadvantage of Aboriginal people continues to be an enormous problem. It is critical that the Department work together with families, the Aboriginal community and other government departments to develop positive strategies that are sensitive to the historical interaction between the Department and Aboriginal people to ensure the safety and wellbeing of their children.

The issue of interagency collaboration was also noted as important in the submission the Committee sent to the Ministerial Council for Suicide Prevention in August 2007.

## **3.2 Recommendations**

Apart from identifying key case practice themes the Committee has also examined all recommendations made for the 10 cases reviewed this year to add to information presented in Committee's last Annual Report where recommendations were made in the 44 cases which had been reviewed at that time.

The information in this Annual Report follows on from what was reported last year in that a thematic analysis of the recommendations made can be found in Table 14. The Table lists the broad categories under which recommendations have been grouped and provides example recommendations made as well as the number of cases falling into each category. Examples of recommendations made for the 10 cases reviewed in this reporting period are in italics.

It is important to note that when interpreting Table 14 recommendations from different categories can apply to the same or different cases.

As stated in the Committee's last Annual Report it is also important to note that a child death review may identify a range of matters of concern which the Committee believes should be drawn to the attention of the Department. However, when making recommendations the Committee prioritises the issues identified and actions proposed. For example, if the Committee has previously made a recommendation concerning a matter in a recent earlier review, this is drawn to the Department's attention, but a new recommendation is not always made and other matters will take priority. For this reason, it is not possible to compare definitive percentage figures in Tables 13 and 14.

The most significant recommendation categories are those concerning the need for critical analysis and holistic assessment (78%), children's safety (74%), training (72%), and poor case records and documentation (68%). Recording and documentation issues were noted for the cases reviewed where the child was in the CEO's care.

The need for critical analysis and holistic assessments is crucial for best practice in child protection assessment and intervention.

The Committee noted in its last Annual Report<sup>32</sup>:

Two other particular systemic issues the Committee has made recommendations about concern remote and regional Aboriginal communities in the north of the state and approaches to working with high end multi problematic cases.

The environmental circumstances in which many of the Aboriginal children died in the north of the state are alarming. These environments lacked service provision, infrastructure and were impoverished and unsafe for children. The Committee is very aware of the difficulties involved in working with Aboriginal families in these areas and their extended families. However, those working with these families, including workers from other agencies, appeared to accept as normal the impoverished and unsafe living conditions of children living in Aboriginal transitional or fringe communities. The improvement of living conditions in these communities is beyond the capacity of the Department alone. It is nevertheless critical that the Department's ability to work with these families and to monitor the safety of children in these communities, along with health and law enforcement agencies such as the police, is improved.

During this reporting period the Committee has continued to be concerned about and make recommendations pertaining to responding to children and families from remote and regional Aboriginal communities. Five of the cases reviewed this period were Aboriginal, all were from regional and remote Communities. Four were very young female children. The Committee, whilst acknowledging that in the main the policy and guidelines the Department operates under are comprehensive, continued to be concerned about chronic neglect. This was noted in a number of reviews and in one case reviewed the Committee stated that:

The Committee has assessed that in many of the cases where Failure to Thrive and chronic neglect is a concern the response by the Department is inadequate. The Committee is of the view that Department's implementation of policy regarding Failure to Thrive is ineffective and doesn't adequately consider chronic neglect. The Committee recommends this approach be reviewed.

The Committee as a result of concerns in this area recently developed a proposal to commission a Group Analysis of Aboriginal Child Deaths where chronic neglect was present. This will be commissioned and reported on in the 2007-2008 Annual Report. The Committee is pleased to note that the Department has finally embarked on the development of a 'Neglect Policy'. The Committee is hopeful that this, and more importantly its implementation, will contribute to the prevention of Aboriginal child deaths.

The Committee also continued to make recommendations about interagency collaboration and cross agency service delivery. In specific cases recommendations were made to highlight the need for this to

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<sup>32</sup> Child Death Review Committee Annual Report 2005-2006 p 20-21

occur. Whilst the Committee is only able to consider in its reviews the records of the Department for Child Protection it is mindful that best practice in child protection requires cross agency collaboration and service delivery. Recommendations relating to interagency collaboration and consultation were made in 52% (N=28) of cases reviewed to date. As an example, in a case review completed in this reporting period the Committee recommended that the Department meet with the Princess Margaret Hospital (PMH) and the Health Department to re-examine the Department's Reciprocal Child Protection Procedures with PMH and the Health Department to identify gaps in cross agency referral or practice that may be evident.

As many of the cases reviewed are complex with a range of difficult issues facing families such as domestic violence, hazardous alcohol and/or other drug use and mental health issues the need for interagency collaboration is crucial. The Committee currently has before it a number of cases where a child has died as a result of suspected suicide. While reviews are not complete on most of these cases, preliminary analysis undertaken by the Committee led to the following comment being made in their submission to the WA Suicide Prevention Plan:

It should be noted therefore that the Committee in writing reviews only has access to Department for Child Protection records. The Committee when reading and reviewing these records is however aware of some of the activities of other agencies involved with families. While the Committee can analyse, comment on practice and make recommendations to the Department for Child Protection in reviews about these cases, the Committee is of the view that young people at risk of self harm and/or suicide need a collaborative across agency response.

In last year's Annual Report the Committee discussed intervention in complex cases. A number of the cases reviewed in this reporting period were complex. It remains the Committee's view that these cases merit intensive intervention and supervision. While Intensive Supervision Programs are expensive and require highly skilled staff, they are a worthwhile investment if the total cost of intergenerational dysfunction is calculated, and children are at risk.

Table 14: Recommendation categories<sup>33</sup>

Recommendation category	Examples of recommendations made	Number of cases (100% =54)
Critical analysis and holistic assessment	<ul style="list-style-type: none"> <li>▪ The Department takes appropriate action to ensure senior officers and case workers are trained in child protection, child safety assessments and the bringing of an objective critical eye and analysis to case events.</li> <li>▪ In cases where there are clear referral indicators and evidence of risk, an early comprehensive assessment is using the Department's.... assessment framework be undertaken with support and intervention planned.</li> <li>▪ The Department reinforce the importance of proper assessments being undertaken.</li> <li>▪ In cases where there is a history of the department previously considering statutory action, a comprehensive assessment of current circumstances should be undertaken.</li> <li>▪ Departmental officers shift from a single event based assessment model to holistic assessments of the needs of children and families.</li> <li>▪ <i>Departmental officers to be encouraged to undertake holistic assessments giving consideration to key events in children's lives.</i></li> <li>▪ <i>The Department implement an approach that requires analysis of patterns of multiple contacts so that chronic crisis intervention can be replaced with proactive case management and inter-agency planning.</i></li> </ul>	42 (78%)
Ensuring child/ren's safety	<ul style="list-style-type: none"> <li>▪ The Department examines how, when complex cases involving intergenerational problems are identified, a higher level of reflective analysis and critical review to discuss histories, patterns, strategies to work with the family, consequences for inaction, and the consideration of statutory intervention can be triggered to give direction.</li> <li>▪ The Department encourages through appropriate supervision that when planning for children the subject of serious protective concerns, clear limits or goals are set which if not met, would lead to further action such as apprehension.</li> <li>▪ The Department prompts staff about the application of Director General's instruction 55 which provides guidance about responding to Failure to Thrive cases.</li> <li>▪ A case review be conducted as soon as possible to consider the safety of children in this family if this has not already been done since the death of the child the subject of this review.</li> <li>▪ <i>As a priority a thorough assessment of... capacity to provide care to... be undertaken, if this has not already occurred</i></li> </ul>	40 (74%)
Training	<ul style="list-style-type: none"> <li>▪ The Department ensures senior officers and case workers are trained in child protection, safety assessments and the bringing of a critical eye and analysis to case events.</li> <li>▪ The Department makes information available to staff and supervisors on the 'rule of optimism' and how this can impact perceptions and decision making.</li> <li>▪ <i>Training is undertaken as to what is meant by having a 'child focus' and what is meant to listen to and hear children ie officers using intellectual and emotional intelligence to enter a child's world to hear what children are saying (and not saying) and who is important in their world.</i></li> <li>▪ <i>Training is undertaken on the vulnerability of older children to physical and emotional harm and neglect.</i></li> </ul>	39 (72%)
Case information: poor information and records; incomplete and inaccurate records	<ul style="list-style-type: none"> <li>▪ Staff need to verify information provided [In this case there was a lack of information about all parties].</li> <li>▪ When reports about possible harm to children are received the information should be placed on the Department's client information system without delay.</li> <li>▪ The Department reminds staff of the importance of documenting key decisions made and the rationales for these, including consideration and assessment of all available information, including historical information when forming responses and case plans.</li> <li>▪ The Department take appropriate action to ensure case assessments and decisions are well documented and kept in</li> </ul>	37 (68%)

<sup>33</sup> Recommendations made in this reporting period are in italics. Other recommendations are from the Committee's last years Annual Report.

	<p>chronological order...</p> <ul style="list-style-type: none"> <li>▪ <i>The health and educational needs of children in the CEOs care is monitored and viewed as paramount importance; appropriate reports should be requested and placed on files so as to inform case practice and placement decisions.</i></li> <li>▪ <i>All records pertaining to this names and CCSS IDs (the Department's electronic database) in this case be checked and amended as needed so they are accurate.</i></li> <li>▪ <i>Where there are multiple victims of abuse the Department must have a file and record management system for these cases which details the full investigation process.</i></li> </ul>	
Maintaining a child focus	<ul style="list-style-type: none"> <li>▪ The Department highlights with the staff the importance of maintaining a 'child focus' when responding to or working with parents and families.</li> <li>▪ Department reminds officers of the importance of seeing, observing and interacting with children the subject of an open case and that when this occurs it is noted in file records.</li> <li>▪ <i>Children in care are the subject of thorough and child focused assessments as part of planned case reviews.</i></li> <li>▪ <i>Contact with a child in the CEO's care is clearly documents and if a child is not seen alone (as appropriate for their age/developmental level) this and the reasons why should be clearly documented.</i></li> </ul>	28 (52%)
Inter-agency collaboration and consultation	<ul style="list-style-type: none"> <li>▪ The Department collaborates with other government departments to provide a conjoint response to families in regional areas who have problems with alcohol and drug abuse.</li> <li>▪ The Department explores options and develops protocols that will enable officers to receive expert advice on working with parents who have drug dependence.</li> <li>▪ The Department explores ways of enhancing collaborative work with child health and hospitals statewide.</li> <li>▪ Staff be encouraged to adopt a more rigorous approach to the undertaking of dialogue and working collaboratively with health care and hospital staff about health and social issues regarding the safety and wellbeing of children.</li> <li>▪ <i>Interagency meetings should be convened where there are complex health, educational and psychological issues apparent for children.</i></li> <li>▪ <i>The Department follows up with PMH to ensure that they have clear guidelines in place for the referral of cases to the hospital's Child Protection Unit for further assessment and notification to the Department.</i></li> <li>▪ <i>When a child under five years old presents with a non accidental injury, such as a broken arm, a full skeletal x-ray should be undertaken to ensure no older injuries are evident</i></li> <li>▪ <i>The Department seek to ensure clear protocols are in place with the NT and SA about how similar cases to that of ... are responded to.</i></li> </ul>	28 (52%)
Case management: goal setting, supervision and case closure	<ul style="list-style-type: none"> <li>▪ The Department review its case practice manual guidelines to ensure that a case or open contact period in respect of a child, about whom there are concerns, is not closed without: <ul style="list-style-type: none"> <li>- Clear information being obtained and documented that supports the belief that the child/ren will be adequately cared for by their parent(s) or carer, or</li> <li>- Reasonable steps being taken to ensure the wellbeing of the child/ren the subject of the case or contact period.</li> </ul> </li> <li>▪ The Department takes appropriate action to ensure formal case planning and review are the subject of supervision.</li> <li>▪ <i>The Department reminds senior officers and staff that case closure reports need to demonstrate that all issues have been comprehensively considered.</i></li> <li>▪ <i>Social Work Students be supervised by a senior experienced officer when working with families and are only to have an observer learning role where the undertaking of a safety assessment is required and necessary or a matter requires investigation; a student should not be directed to or be given delegated responsibility for these legislated functions.</i></li> </ul>	26 (48%)
Historical case information and records	<ul style="list-style-type: none"> <li>▪ Departmental officers consider all available information, including historical information, when forming responses to families.</li> <li>▪ The Department takes action to ensure, as appropriate, caseworkers are afforded time to read past files and map relationships, strengths and risks in a family and its support network where safety and care concerns exist for children.</li> </ul>	20 (37%)

	<ul style="list-style-type: none"> <li>Where there is a history of departmental involvement, case managers should be required, as a standard, to read and assess information on file(s) as part of any assessment.</li> </ul>	
Aboriginal and Torres Strait Islander issues	<ul style="list-style-type: none"> <li>The Department reinforce with officers that cultural sensitivity should not diminish or compromise commitment to the safety of Indigenous children and that officers should not adopt an approach that over corrects in respect of Aboriginal clients because of such reports as the 'Bringing Them Home Report'.</li> <li>The Department increase its level of engagement with families and children in Aboriginal ... communities...There needs to be an increased level of partnership around the issues of child and family safety; a heightened capacity for the Department to monitor children in Aboriginal [transitional or fringe] communities; and a collaborative service response to the needs of families and children.</li> <li>A priority be given to addressing the impoverished and unsafe living conditions of children and families who live in transitional communities or fringe communities in the Kimberley [and Pilbara]. This requires an across government effort....</li> </ul>	18 (33%)
District capacity and resourcing	<ul style="list-style-type: none"> <li>The Department continues to lobby Government for more resources to ensure that the field is adequately staffed to provide a high quality service.</li> <li>The Department examines [its] capacity ...to ensure supervision and coaching of inexperienced staff.</li> <li>The Department assess whether [districts are] adequately resourced professionally and practically whereby [they are] in a position to apply relevant departmental policies and guidelines, and take remedial action if necessary.</li> <li><i>Where a child in the CEOs care requires psychological treatment it should be actioned as a priority.</i></li> <li><i>The Department ensures that workers in isolated offices are not working alone and that resources are located to allow for replacement/acting/relieving workers to be used when regular/permanent workers are on leave.</i></li> <li><i>The Department ensure effective systems are in place to provide daily monitoring and prioritizing of cases that are queued.</i></li> </ul>	14 (26%)
Intervention with complex cases	<ul style="list-style-type: none"> <li>The Department examines the applicability of different approaches [such as multi systemic therapeutic approaches]...for use with complex cases...</li> <li>The Department examines how [complex multi problem] cases can be given intensive and stable specialist experienced case worker support irrespective of where the family resides.</li> <li>The Department gives serious consideration to the establishment of a mechanism for identifying families with intergenerational poverty, substance abuse and domestic violence and to systematically managing these families....</li> <li><i>There is a need for greater service provision/responses to address family of origin abuse and trauma issues for ....in this case and other parents in other cases where these issues are apparent.</i></li> </ul>	11 (20%)
Inclusion of men	<ul style="list-style-type: none"> <li>To the extent that it is Departmental culture to focus on women as the primary caregivers and the subjects of intervention, it may be necessary for the department to put in place a strategy to ensure fathers, partners and other male relatives of significance are not forgotten.</li> <li>The Department examine how it can encourage that men significantly involved with a family (fathers, male relatives other men of significance) are not forgotten and enable to participate in case decision and planning.</li> </ul>	10 (18%)
Miscellaneous	<ul style="list-style-type: none"> <li>The Department promotes the monitoring and the evaluation of the effectiveness of the Northbridge Project.</li> <li><i>Sibling contact, when children are in separate placements, should be clearly documented in care plans and involve input from the children as to how much contact and where contact is to take place.</i></li> <li><i>The Department consider the role that on site Community Child Protection Workers might play in a case like this.</i></li> </ul>	8 (15%)
No recommendations		3 (6%)

### 3.3 Agency response

The Committee has been disappointed by the Department's failure to provide six-monthly feedback as required, as to its progress in implementing accepted recommendations. It is the case that 2006-2007 was a challenging year for the Department, and the publicity surrounding two child deaths was a significant part of that challenge. The failure to report has been a major omission that the Committee suspects will not occur once the Ombudsman has jurisdiction for the child death review process.

The Committee has also been concerned by the increasing trend in 2006-2007 in the Department's responses to 'endorse, support, and agree' with the recommendations and to refer to policy, guidelines and the need for training whilst failing to refer to action to be taken and the associated time frame. In the main the Department's policies and guidelines are seen as reasonable. It is their implementation that has been problematic. It is the case that the Committee's recommendations have been depressingly repetitive, emphasising the need for a child focus, a holistic approach, and inter-agency collaboration e.g.

- actually getting to know the child, the siblings and their needs
- sighting the child and not accepting third party views of the child's wellbeing
- providing family support but also insisting that appointments are kept and that drug testing occurs
- properly addressing failure to thrive and neglect
- listening to the serious concerns of family members, neighbours and friends as expressed in the both the Wade Scale and Olive Sturt cases.<sup>34</sup>

The Committee is hopeful that the development of the Department's Neglect Policy and its Fathering Framework will have an impact on practice. Nonetheless in the main, the families under consideration are complex and endure multiple disadvantage. The Committee in its 2005-2006 Annual Report emphasised the necessity of having highly trained specialist staff to deal with these cases. Policy alone is not the solution. The Department of Corrective Services 'Intensive Supervision Program for Juveniles' has been awarded the Australian Crime and Prevention Award for the very positive results the intensive supervision regime has had for both the juveniles and their families. In the Committee's last Annual Report the utilisation of an intensive regime was recommended for those multi disadvantaged, families with chronic intergenerational neglect problems. Once again the Committee is recommending that at the very least the Department examine Intensive Supervision as part of its Child Protection Reform agenda.

## 4.0 Conclusion

Unfortunately the conclusion to this Annual Report has to be the same as last year, in that it is lack of uniform implementation of policy and good practice that remains problematic. There have clearly been examples of good practice and these have been commended. The Committee is very aware that cultural change is required if progress is to be made and that this will take time. Meanwhile at the risk of sounding monotonously repetitive the Committee, pending the handover to the Ombudsman, will continue to make the necessary recommendations and attempt to work collaboratively with the new Director General and administration of the Department in effecting change.

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<sup>34</sup> The children's names in this report are used as their names were made public.