Child Death Review Committee
Western Australia

Annual Report
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Child Death Review Committee, Western Australia

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Chairperson's Foreword

The Child Death Review Committee Western Australia (the Committee) reviews the Department of Child Protection's (the Department) policies, procedures and practice as they have affected a child who has died and been known to the Department.

This is the sixth Annual Report of the Committee. Fourteen cases have been reviewed this year. An analysis of the trends and issues reflected in these cases is presented as is an analysis of all 68 cases reviewed to date.

In its last Annual Report, the Committee expressed particular concern about the circumstances of neglect in most of the deaths of Aboriginal children reviewed. This year the Committee commissioned a 'Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present'. Twenty two cases were examined, and documented in a separate report which explores in detail the limitations of the service system response to Aboriginal children and families in crisis.

This year the number of possible suicides coming before the Committee has continued to be of concern as has the number of deaths of infants. Because of the concerns regarding possible suicide and infant deaths, for the first time, a section on notifications has been included. Notwithstanding its best efforts, because of limited resources, the Committee has never yet been able to achieve its goal of completing a review within six months of the notification of the death.

In 2006-2007 the Government agreed to the transfer of the Child Death Review function to the Ombudsman. This transfer has not yet occurred although representatives of the Ombudsman have been attending the Committee's meetings.

The Child Protection Reform process has continued within the Department and the Committee has been pleased to note that its recommendations have been taken into consideration in many of the reform projects. However, as yet, the Committee has not seen the fruits of the Reform Process as yet again the cases reviewed this year are monotonously similar to those reviewed previously. Once more, the Committee's recommendations primarily concern the lack of critical analysis; the lack of a child focus; inadequate documentation; case supervision and problems with interagency collaboration.

As this is probably the last Annual Report of the Committee, the members would like to reiterate the importance of:

- 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
- properly addressing neglect and Failure to Thrive
- listening to the concerns of family members and friends and the staff of other agencies
- interagency collaboration.

Finally the Committee members wish to express their appreciation for all the efforts made by involved staff, those working for the Committee and those in the Department who assist the Committee. In particular the Committee thanks Loretta St John, the Department liaison officer with the Committee, for her unfailing helpfulness throughout the years.

Dr Denzil McCotter
Committee Chair

November 2008

Child Death Review Committee Members

Dr Denzil McCotter
Committee Chair
Dr Denzil 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 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. Denzil 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 of Technology.

Professor Steve Allsop
Committee Member
Professor Steve Allsop is the Director of the National Drug Research Institute at Curtin University of Technology. He is currently Deputy Chair of the Board of the WA Alcohol and Drug Authority, a member of the WA Commission for Occupational Health and Safety, and Chair of the Capital Cities Lord Mayors Drug Advisory Committee. Steve 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.

Ms Rosemary Cant M.Psych, Post Grad. Dipl. Business
Committee Member
Ms Rosemary Cant is a researcher and evaluator with extensive experience in the social welfare area. Rosemary has been an independent consultant since 1994. Prior to this she held a range of positions in the Department for Child Protection. Rosemary 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.

Mr Michael Doyle
Committee Member
Mr Michael Doyle is a Bardi from the Kimberley region of Western Australian. He has extensive qualifications and experience in Aboriginal health and is currently employed as a Research Associate at the National Drug Research Institute at Curtin University of Technology. Michael brings considerable knowledge and experience to the Committee from the fields of sexual health, young offending and drug dependency. He is a member of the Indigenous Australians' Sexual Health Committee, a sub committee of the Ministerial Committee on HIV Sexual Health and Hepatitis. This is a Ministerial appointment and complements the work of the Committee.

Ms Jocelyn Jones
Committee Member
Ms Jocelyn Jones 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 a member of the Australian Research Alliance for Children and Youth (ARACY).

Content

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[1]. 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 (referred to throughout this report as the 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. 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.

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

- assist the Director General and the Department for Child Protection (referred to throughout this report as 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 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 five Annual Reports which have been tabled in the Legislative Assembly.

1 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.

1.2 The functions of the Committee

The functions of the Committee[2] 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 scrutiny are reviewed. If a case meets one or more of the following criteria it is referred:

    a. The deceased child, young person or other children in the deceased child's family have been the subject of a child maltreatment allegation or a child concern report recorded by the Department within the past 24 months[3]. These are now known as a concern for a child's wellbeing.
    b. The deceased child's family has had a number of contacts with the Department within the past 24 months and an emerging pattern is indicated.
    c. The deceased child was in the care of the Department 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.

1.4 Efficiency and Effectiveness

During the 2007-2008 reporting period, in addition to reviewing child deaths, the Committee has been involved in a number of activities including:

2 Government Gazette, WA, 9 May 2003 No. 72, p: 1617.

3 Under the 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'.

- providing a written submission on neglect to the Department to contribute to the development of its Neglect Policy (2008);
- commissioning an analysis of Aboriginal child deaths where chronic neglect was present;
- consultation with King Edward Memorial Hospital (KEMH) and the Department to discuss the interagency pre-birth protocol;
- consultation on the Australian Government's paper 'Australia's children: safe and well;'[4]
- attendance at the Australasian Seminar on Child Death Inquiries and Reviews in Melbourne 2008 'Promoting the learning from child death inquiries and reviews: where to from here?';
- preliminary analysis of cases referred to the Committee for review where a young person has died from possible suicide;
- preliminary analysis of cases referred to the Committee for review where infants six months and under have died;
- discussions with the Ombudsman's office regarding the proposed transfer of the Committee's functions;
- giving evidence at the Coroner's Court for a case where a review report had been completed; and,
- attendance at 'Babies and Safe Sleeping Forum' presented by the Advisory Council for the Prevention of Deaths and Young People in National Child Protection Week in September 2007.

As noted in section 1.2, one of the functions of the Committee is to identify particular classes of child deaths or related issues that may benefit from further investigation or research. In this reporting period the Committee identified three classes of child deaths and related issues for further investigation, these were:

- Aboriginal children where neglect was an issue;
- infants six months and under; and,
- young people who had died by possible suicide.

A group analysis of 22 Aboriginal neglect cases was undertaken as was preliminary analyses for infants at risk and young people who died by possible suicide.

In the previous Annual Reports the Committee has concentrated on reviewed cases and their characteristics. The Committee has concluded that now it is appropriate to analyse notifications occurring in the reporting year. For two years it has been the goal of the Committee to finalise reviews within six months of notification, and so provide timely and therefore, more useful information to the Department. Because of continuing staff and resource problems this has not always been possible. However, an analysis of the incoming notifications does provide some up to date information, which complements that provided in the completed reviews.

In the reporting period the Committee examined 58 child death notifications involving a child or family who had some form of contact with the Department. For 30 of these notifications no review was recommended by the Department however, the Committee determined that a review was required for two of these notifications. For 28 notifications a review was recommended by the Department. In two of these notifications the Department noted they did not meet review criteria however the Director General requested these cases be reviewed by the Committee. Thus during 2007-2008 a total of 30 notifications were considered as requiring a review by the Committee.

4 Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (2008) Australia's children: safe and well a national framework for protecting Australia's children A discussion paper for consultation.

Fourteen reviews were undertaken during the reporting period. Two of the cases reviewed in this reporting period were for children who died in the year. The remaining 12 reviews were for children who died in previous reporting periods (see Table 11). Since inception, the Committee has completed a total of 68 reviews.

To illustrate a number of issues identified in the reviews, case examples have been used throughout this report. Names used for children are pseudonyms and other identifying information has been altered.

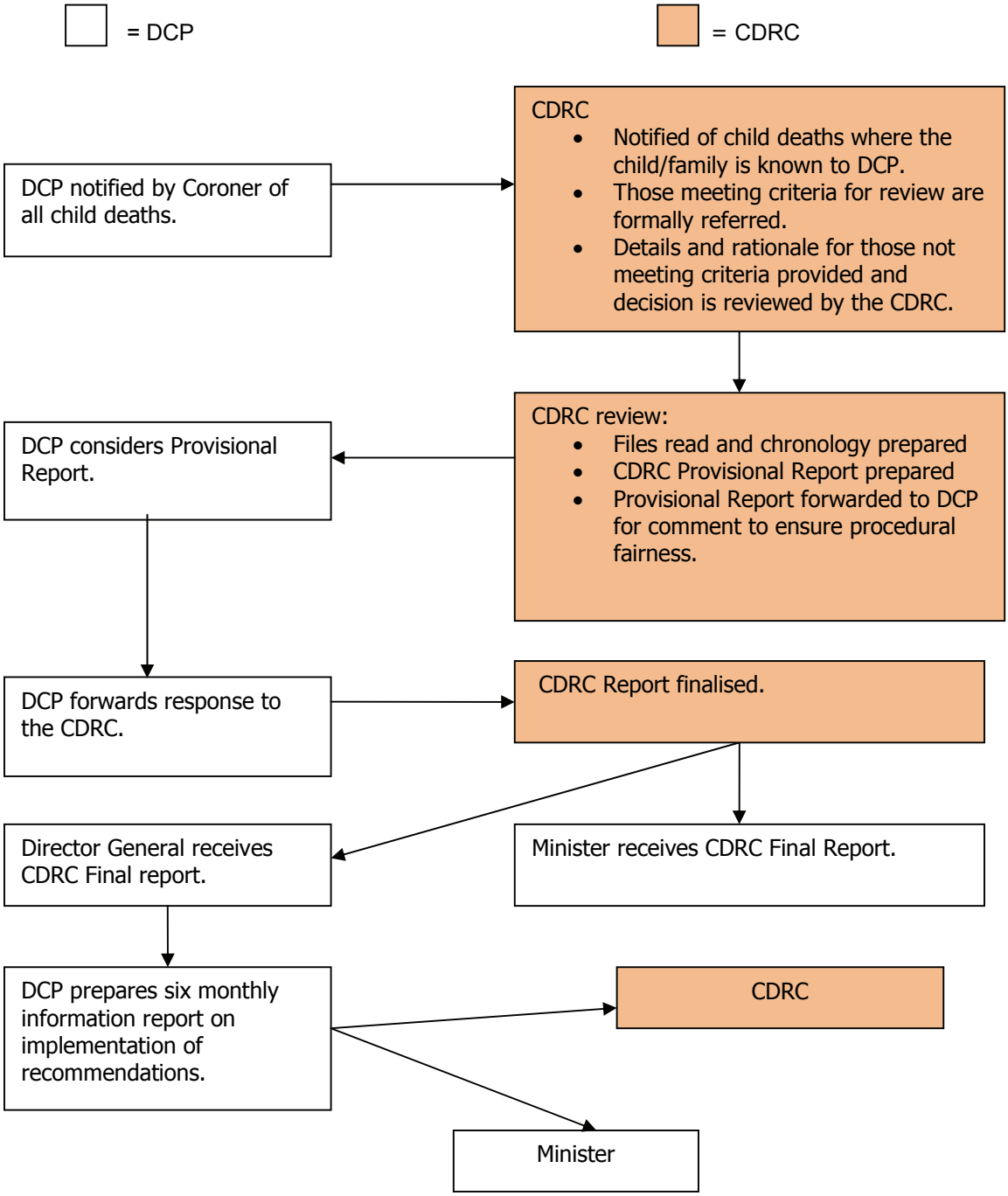
1.5 Case Review Process

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 Final Report is forwarded to the Minister and the Director General; and,
- the Department provides six monthly information reports regarding the implementation of Child Death Review Report recommendations.[5] In this reporting period the Committee has not been provided with six monthly reports by the Department on the implementation of recommendations. In March 2008 the Department wrote to the Committee and advised that the Child Protection Reform Projects would address the themes identified by the Committee in review reports over time. This is discussed in more detail below.

5 The Department has not provided the Committee with six monthly feedback about Child Death Review recommendations since November 2005.

Figure 1: WA Child Death Review Model



The time taken for a report to be completed depends on the complexity of the case and the number of electronic or paper file records that are available to 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.

Since inception the Committee has been concerned that a review model which involves only the consideration of electronic and paper files can be limited. This was highlighted as an issue at the Australasian Seminar on Child Death Inquiries and Reviews which was held in 2008. Jurisdictions where staff were interviewed (and in some jurisdictions, with their agreement, families) spoke of the benefits of this in conducting reviews. The interviewing of Departmental staff and consideration of the operational context in which a death occurred can contribute to a better understanding of a case. Further, such discussions can provide insight into the relevance and practicality of Departmental policy and guidelines.

During the previous reporting period it had been agreed that a Memorandum of Understanding (MOU) to facilitate the Committee having contact with staff, when reviewing, would be developed. Work had progressed on the MOU but early in 2008 the Director General of the Department decided this would not proceed, given the expected transfer of the Committee's function to the Ombudsman in July 2008.

As previously stated, the primary function of the Committee is to examine cases to determine the impact of Departmental polices and practices on the protection and safety of children. Accordingly, the Committee's recommendations reflect the identification of risks, the application of child protection polices and practices and the identification of actions that can be implemented to prevent future harm and death of 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 was of concern to the Committee that in the last Annual Report the Committee could not report on the effectiveness of the recommendations made on changing practice as the Department had not reported on the status of any of the recommendations made by the Committee during that period or since November 2005.

In this reporting period the Committee has not been provided with six monthly reports by the Department on the implementation of recommendations. However, in March 2008 the Department wrote to the Committee and advised that the Child Protection Reform Projects would address the themes identified by the Committee in review reports over time. The Department had listed all the Committee's recommendations and advised that the recommendations made by the Committee in review reports will be addressed in particular by the following Child Protection Reform Projects:

Project 5 (a) Child Protection Practice (Signs of Safety) Framework Project
Project 5 (b) Consistent Intake and Assessment Project
Project 6 (a) DCP Service Delivery Policy Review and Streamlining Project

Project 6 (b)	DCP Field Worker Guidelines Review and Streamlining Project
Project 9	DCP Learning Development Project
Project 10	DCP Workforce Developments Project
Project 14	Family Support Services Strategic Framework and State Plan
Project 27	Interagency Care Plans Project
Project 28	DCP Information Sharing Project
Project 30	DCP Senior Practice Development Officer Project
Project 32 (a)	Multi-Agency Early Intervention: At risk new born babies.

The Department's 2007-2008 Annual Report notes that:

> The projects encapsulate, and were cross referenced against recommendations from the Child Death Review Committee and other recent reviews…[6]

2. Group analysis of child deaths

2.1 Research undertaken: Group Analysis of Aboriginal Child Deaths

In this reporting period the Committee commissioned a Group Analysis of Aboriginal Child Deaths where chronic neglect was present. The National Drug Research Institute (NDRI) at Curtin University of Technology was the successful tenderer. The full report[7] on the analysis is available as a separate document. The purpose of the group analysis was to enhance the quality and timeliness of intervention by the Western Australian child protection service system in future instances where chronic neglect is a major presenting risk factor.

The terms of reference of the analysis were to:

1. provide an extension of the Victorian Child Death Review Committee analysis of the evidence of the impact of chronic neglect on child development and best practice approaches to chronic neglect to include a greater focus on Indigenous children and families;
2. identify and document themes and issues arising from the sample group of children, including the issue of inter-generational abuse;
3. examine the effectiveness of the responses by the Department to chronic neglect in relation to the sample children and their families;
4. examine to the extent possible the effectiveness of other services in responding to chronic neglect in relation to the sample children and their families; and,
5. identify specific mechanisms and opportunities to enhance service responses to children at risk of chronic neglect.[8]

The report notes the methodology for the analysis involved:

> a comprehensive literature review of neglect and chronic neglect; descriptive statistical analysis of all 21 (involving 22 child deaths) cases of Aboriginal child deaths reviewed by the CDRC; and a systematic qualitative analysis of CDRC's case files using a framework adapted from that used by the Victorian Child Death Review Committee, comprising the child's characteristics, those of the family, structural and societal factors, the child protection response, and the broader service systems involved…

6 Department for Child Protection Annual Report 2007-2008 p: 9.

7 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present.

8 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present. p: v11.

> An extensive review of relevant literature highlighted the difficulty of reaching universal definitions of neglect, due to the problem of establishing thresholds agreed to by service providers and complying with community standards. Despite this, there is clear evidence of the detrimental effects of particular behaviours on the development of young children, including: alcohol misuse during pregnancy leading to fœtal alcohol spectrum disorder; failure to provide adequate food or shelter, emotional sustenance, or access to appropriate medical attention; and exposure to violence. The cumulative effect of harm can result in mental health disorders, poor cognitive functioning, behavioural problems, poor school attainment, and even death…
>
> While there is limited research evidence of the efficacy of preventing and reducing neglect in Indigenous families, there is general agreement that measures to improve the general living conditions of Indigenous people are fundamental to any improvement, as well as addressing the interpersonal context of neglect, including family violence, substance misuse, social isolation, and mental illness. Key indicators for risk are largely intergenerational, and attempts at addressing them must acknowledge the harms associated with dispossession, institutionalisation, and separation from family and have a focus on healing and restoration. Recent reviews of child deaths in England, Ireland and Australia stress the need for child centred practices that ensure that cumulative harm associated with chronic neglect informs decision making of statutory authorities. This requires more rigorous risk assessment including major stakeholders.[9]

Some key information noted in the report for the group analysis included:

- the majority of the children who died were aged one year or less, pointing to a greater vulnerability in this age group;
- slightly fewer female children (45%) than male children (55%) were included in this group;
- at the time of death, half the group (50%) were living with both biological parents, almost a third (32%) with their mothers, and the remainder with one biological parent and a step-parent (9%) or with extended family members; (9%)
- almost two thirds of the group (63%) had more than three siblings, and three of the children had siblings who had died;
- half of the children (50%) were from remote communities, more than a third from rural regions (36%) with the remainder from the metropolitan area; and,
- other characteristics of the children included disability in three cases (14%), premature births for three cases (14%), chronic illness and complex health needs for another two cases (9%), with previous hospital admissions recorded for five children (23%).[10]

The report states:

> The identified cause of death was not available for all cases, but the circumstance surrounding the children's deaths included: co-sleeping (45%), drowning (14%), vehicular accident (14%), homicide (9%), and other factors (18%). All families had a long history with the Department, with the average length of contact with the Department being 10.5 years. Parents of the deceased had their own histories of child abuse or neglect in four of the families (19%), and 17 (81%) had a histories of out-of-home care including the placement of the parents themselves as children…Each of the children who died was living in families where there were a number of interrelated risk factors. There was only one case where either alcohol and other drug dependence and/or family violence was not a significant factor in the family circumstances leading to chronic neglect. Other risk factors included homelessness, mental health problems and financial hardship.[11]'

9 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present p: vii-viii.

10 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present. p: viii.

11 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present p: viii-ix.

The following case example illustrates some of the issues apparent in the cases analysed:

Case example 1

William's mother was 14 years of age when she had her first child. William was the youngest of her four children and a number of his siblings suffered from medically diagnosed Non Organic Failure to Thrive.

Contact with William's mother regarding concerns for him and his older siblings revealed that despite the children's chronic medical needs including anaemia, speech delay, boils and other skin infections which resulted in septicaemia requiring hospitalisation caused by poor hygiene, his mother at times resisted medical treatment for the children.

In discussions with Departmental staff, William's mother acknowledged the illness of her children however stated that her husband was in prison, that she did not have her own home and was forced to share a relatives house, which was overcrowded, where adults consumed excessive amounts of alcohol and took food she had bought for her children. Departmental staff sought emergency Homeswest accommodation for the family with Community Health and the local Crisis Centre monitoring the health and treatment of the children. Community Health reported some months later that the children's father had been released from prison and was living in the family's new home. One of the last contacts with the family by the Department related to an allegation that William's mother had been physically assaulted by her husband and had moved to the refuge for safety.

Approximately one year after this last contact the Department was advised that William had died in a car accident. It was alleged no seat belts were worn and that William's father had been drinking.

The Committee recommended that a full assessment of William's siblings be undertaken.

The report noted a number of common themes regarding the service system response. These included:

- unresolved tension between child centred and family focused practice;
- a focus upon single incidents of neglect and the 'start again' syndrome;
- an over optimistic emphasis on small improvements leading to case closure;
- the absence of any direct assessment of the impact of neglect upon the child;
- inadequate risk assessment and management; and,
- inadequate case or safety planning.[12]

The analysis of the data and evidence drawn from the available literature, led to NDRI making a number of recommendations. At the request of the Committee, the recommendations were operationalised with regard to the Department's current reform agenda. Some of the key recommendations can be summarised as follows:

- that the implementation guidelines of the Signs of Safety risk assessment approach which the Department is adopting, provide clear processes for assessing the additional risk of chronic neglect associated with: family violence, chronic substance dependence, intergenerational child abuse and neglect, the increased vulnerability of infants and toddlers and living in remote and rural communities;
- that child impact assessments, assessments of the family/carer/community capacity to care for the child, case management decisions and follow up (which would include evidence of sustained care of the child before the case is closed) be documented;

12 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present p: x.

- that the Department provide training and development to staff regarding the harms arising for children from chronic neglect;
- that the Project 'Interagency Early Intervention: At risk new born babies' includes attention to the increased vulnerability to the harms associated with neglect and chronic neglect for infants and toddlers;
- that the newly constituted Aboriginal Reference Group and the Department consider:
  - the development of partnerships between the Department and appropriate Aboriginal agencies with regard to risk assessment and case planning;
  - the findings of Neglect Group Analysis Report and provide specific direction to the Family Support Services Strategic Framework and State Plan, regarding the need for long term intervention strategies and programs aimed at addressing the intergenerational effects of abuse and neglect – particularly those that address alcohol and other drug dependence and family violence;
  - the practicality of a 'shared care' approach to family support for Aboriginal families;
  - the need for an increase in the number of Aboriginal Child Care Agencies operating in Western Australia, particularly in rural and remote locations.
- that the Department develop policies and guidelines for developing leadership with regard to case planning and management through collaborative arrangements with other lead agencies.[13]

2.2 Preliminary analysis of groups of child deaths

2.2.1 Preliminary analysis of cases where infants have died.

In this reporting period the Committee received 16 notifications of deaths of infants aged six months and younger that are at various stages of review, two of which have been finalised. In addition the Committee reviewed two cases and have under review four cases in this age group that had been notified in an earlier reporting period. Preliminary analysis of these 22 cases suggests that the majority of these infants were either vulnerable due to: health issues, as a result of a Child Protection history for themselves and/or their siblings and/or parental drug/alcohol use. To illustrate:

- two of these infants were in the Chief Executive Officers (CEOs) care at the time of death and had been apprehended at birth due to concerns about their mothers' - one mother had a long history of neglect of other children and hazardous alcohol use;
- two infants were born prematurely after it was alleged their mothers' were assaulted; and,
- some infants were born with health issues – in some cases suspected to be a consequence of their parents' drug/alcohol use.

Some cases highlighted the risks of maternal drug use. In discussing Neonatal Abstinence Syndrome (NAS), the Neonatology Clinical Guidelines from King Edward Memorial Hospital/Princess Margaret Hospital note:

> Maternal illicit drug use is a risk factor for adverse pregnancy and neonatal outcomes including preterm birth. Infants born to mothers using illicit and licit drugs, apart from neonatal drug withdrawal, are at risk of adverse neonatal outcomes.
>
> Neonatal Abstinence Syndrome is a generalised disorder presenting a clinical picture of drug withdrawal in the infant. This includes CNS hyperirritability (tremors, high pitched cry, irritable, sleep disturbance), autonomic symptoms (sneezing, fever, yawning, sweating, mottling) and gastrointestinal dysfunction (excessive sucking, vomiting, possetting, loose/watery stools).[14]

13 National Drug Research Institute Curtin University of Technology (2008) on behalf of the Child Death Review Committee WA: Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present. p: x-xii.

14 Neonatology Clinical Guidelines Section 17 Neonatal Absintence Syndrome King Edward Memorial Hospital/Princess Margaret Hospital Perth Western Australia Revised June 2006 Page 1.

In a recent case reviewed an infant had Neonatal Abstinence Syndrome. In this case the Committee recommended that:

1. For cases involving multiple services the Department ensures that interagency, multidiscipline liaison and planning occurs, especially for cases involving highly specialised areas such as Neonatal Abstinence Syndrome and drug dependence.
2. The Department review and liaise with the Health Department policies and procedures for the care of drug dependent pregnant women and babies particularly where it is anticipated that the babies will be born with Neonatal Abstinence Syndrome with the view of clearly identifying lines of communication and responses and services and the relationship to child protection.

The Department agreed with recommendation 1. The Department did not support recommendation 2 stating it:

> does not: have the role of lead agency when it comes to monitoring pregnant women who are using drugs/alcohol or in situations where newborns deliver with neonatal abstinence syndrome.
>
> Creating and maintaining interagency relationships remains a priority across government. The recommendations of the Ford Review 2007 support greater interagency collaboration and co-ordination.
>
> The Department supports the need for its staff to work collaboratively with agencies that have the expertise in specialised areas such as drug dependency and neonatal abstinence syndrome…[15]

The Department went on to note the various interagency protocols that existed (some of which are discussed above) and the Department's commitment to work in a collaborative manner with other agencies. It should be noted that the Committee did not recommend the Department become the lead agency in such cases, but emphasises the point that the Committee does view the Department as responsible for the protection of children at risk.

15 Correspondence from the Department in relation to a Committee review report 2008.

The following case example illustrates some of the issues apparent in the cases being analysed:

Case example 2

Tony was apprehended at birth due to at history of neglect for his older siblings who had been placed under the care of the Department and were in the care of various relatives. Tony's mother had her first child with the first of four partners at the age of 18 years.

The reason for apprehension at birth was based on the fact that Tony's mother had not been able to care for any of her children as she had a history of alcohol use and transience, which resulted in the chronic neglect of the children, including lack of supervision, which resulted in one child being sexually assaulted. It was also alleged that Tony's father had a history of excessive alcohol use and mental health issues.

Following Tony's birth he was placed with interim foster carers until the assessment of extended family carers could be finalised. During this period Departmental staff supported the parents to have contact with Tony.

While in placement some health issues had been noted for Tony.

When he was approximately three months of age Tony was found deceased in his cot by his carer.

It is the Committee's view that a close working relationship needs to exist between the Department and Department of Health to give early support and services to vulnerable pregnant women particularly where a child protection history, health issues and/or history of alcohol/drug use are evident. It is noted that the Department and King Edward Memorial Hospital have Reciprocal Child Protection Procedures (November 2007), and an 'Interagency Pre Birth Protocol' (April 2008) to which the Committee also made contributions during the consultation process. The Committee regards these as important and useful. The Department also has a Reform Project Interagency Early Intervention: At risk new born babies'-Project 32a, which focuses on early intervention with at risk infants prior to their birth. At present the Department has advised that:

> the project is focussing on holding pre-birth planning meetings for all young mothers in the CEO's care, and women who are pregnant and already have children in the CEO's care who are booked to have their baby at KEMH.[16]

In the Committee's view it is crucial that such a significant project is properly resourced.

The Committee believes it is important in these cases that there is:

- support by both the Department and the Department of Health for all at risk infants while mothers are pregnant. Support needs to be given as early as possible; and,
- clear discharge/case planning– including any medical and/or special care needs (where applicable) - particularly for any infant at risk due to mothers drug/alcohol use while pregnant. For children in the CEOs care and for open cases of the Department copies of discharge planning should be placed on case files and given to parents/carers. Issues relating to the care of the infant including information about safe sleeping should be discussed in detail with the parents/carer.

16 Correspondence from the Department in relation to a Committee review report-2008.

Jurisdictions throughout Australia have highlighted the issue of infants at risk in reviewable child deaths. In New South Wales the Department of Community Services (DoCS) noted that:

> Of the reviewable deaths in 2006, 59 per cent were children aged less than 12 months. Research suggests that many of these children were affected by their mothers drug and/or alcohol use while pregnant.[17]

DoCS has developed the Responding to Prenatal Reports Policy. Reports may arise from concerns that include mental illness, homelessness, domestic violence and drug and/or alcohol abuse during pregnancy. There is close collaboration with the NSW Health. Under the policy, caseworkers identify risks to the unborn child and provide an appropriate response.

2.2.2 Preliminary analysis of cases of possible suicide

Suicide is classified as such if it has been established by Coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of taking his or her own life.

Australian Bureau of Statistics (ABS) data[18] indicate that:

> Suicide continues to be a major public health issue. Although death by suicide is a relatively uncommon event (occurring at a rate of about 1 per 10,000 population per year), the human and economic costs are substantial.
>
> There were 2,101 deaths from suicide registered in 2005, similar to the number registered in the previous year (2,098). Nearly 80% of these were deaths of males.
>
> While suicide accounts for only a small proportion (1.6%) of deaths of persons of all ages, it accounts for a greater proportion of deaths from all causes in specific age groups. For example, suicide deaths make up more than 20% of deaths from all causes, in each five year age group for males between 20 to 34 years. Similarly for females, suicide deaths comprise a much higher proportion of total deaths in younger age groups compared with older age groups.
>
> The highest age-specific suicide death rate for males in 2005 was observed in the 30-34 years age group (27.5 per 100,000) and the lowest was in the 15-19 years age group (9.5 per 100,000). For females the highest age-specific suicide death rate in 2005 was observed in the 35-39 years age group (6.9 per 100,000) and the lowest in the 15-19 years age group (3.6 per 100,000).
>
> In 2005 the most frequent method of suicide was hanging (including strangulation and suffocation) which was used in half (51%) of all suicide deaths.

In considering the Aboriginal population, it is noted that suicide was the leading cause of death from external causes for Aboriginal males for the 2001-2005 year period.

> The suicide rate was almost three times that for non-Indigenous males, with the major differences occurring in younger age groups. For Indigenous males aged 0-24 years and 25-34 years, the age-specific rates were three and four times the corresponding age-specific rates for non-Indigenous males respectively.
>
> The suicide rate for Indigenous females aged 0-24 years was five times the corresponding age-specific rates for non-Indigenous females. For age groups 45-54 years and over, age-specific rates for Indigenous females were similar to, or lower than the corresponding rates for non-Indigenous females.[19]

From its establishment in January 2003 up to 30 June 2008, the Committee has had ten cases referred for review where a young person is thought to have died because of suicide.[20] Reviews have been completed in four of these cases and reviews are currently underway for the remaining six cases.

17 New South Wales the Department of Community Services (DoCS) InsideOut Issue July/August 2008

18 Australian Bureau of Statistics Catalogue 3309.0 - Suicides, Australia, 2005

19 Australian Bureau of Statistics Catalogue 4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2008

The Table 1 shows the year these ten young people died.

Table 1: Year of death of all 10 young people who died by possible suicide

Year of death	Number of young people
2005-2006	4
2006-2007	4
2007-2008	2
Total	10

Some key information from these ten cases in which young people died possibly as a result of suicide is that:

- the ten young people ranged in age at time of death from 11-18 years. Two were 11 years old, one was 13 years old, three were 16 years old, three were 17 years old and one was 18 years old;
- eight of the ten possible suicides were by hanging;
- there were eight males and of these seven were by hanging;
- six of the ten possible suicides involved Aboriginal young people;
- of these six possible suicides involving Aboriginal young people, five were by hanging;
- at the time of death, six young people were residing in the country and four were residing in the metropolitan area;
- seven of the cases were closed cases of the Department at the time of death. Of the three open cases, two of the young people were in the CEOs care at the time they died;
- in nine cases young people and/or their families had previous contact with a variety of agencies (mainly DCP, Health [including hospitals and mental health services], Education, Department of Corrective Services and Police);
- in five cases the young people who died by possible suicide alleged they had been sexually abused in the past;
- in five cases the young person who died by possible suicide had prior self harm and/or thoughts of suicide and/or suicide attempts;
- in two cases another family member had previously committed suicide; and,
- in five cases another family member had either previously committed suicide and/or had thoughts of suicide and/or had self harmed.

The Committee made a submission in this reporting period to the Western Australian Ministerial Council for Suicide Prevention (MCSP) on the WA Suicide Prevention Plan. The report was subsequently written by the MCSP after consultations were held and submissions were received. It is currently under consideration by the Hon. Graham Jacobs, Minister for Mental Health as part of the planning process for a State Suicide Prevention Strategy. In relation to interagency collaboration and coordination, the Committee understands that an Interdepartmental Implementation and Advisory Group on Suicide Prevention meet and the Department can attend these meetings.

20 The Committee is aware that in one case the Coroner has made an Open Finding.

The information below formed part of the Committee's submission to the Western Australian Suicide Prevention Council on the WA Suicide Prevention Plan.

Key themes evident in cases where young people have died by possible suicide.

Multitude of issues in families evident

The young people who died by possible suicide came from families where a constellation of issues were evident. These included domestic violence, child protection issues, health and mental health issues, educational concerns and hazardous/harmful alcohol and drug use. Sometimes many agencies were involved with families sometimes all at the same time and sometimes for different periods. Despite the complex issues prevalent in the families, in the majority of cases the available evidence indicated that intervention was episodic, was not holistic, a thorough assessment had not been undertaken and not all relevant family members were seen while the case was open. The following case example highlights a number of these issues:

Case example 3

Anne grew up in a family characterised by intergenerational poverty, homelessness, hazardous drug and alcohol use, physical and sexual maltreatment.

Anne was the eldest in a large family and although both parents were living together at the time of her death, she at times took on a primary care role of the younger children.

During adolescence Anne demonstrated chronic risk taking behaviour, such as hazardous drug, alcohol and solvent use and street prostitution. Anne was well known to the key agencies required to respond to homeless and at risk youth. Despite her chronic situation and regular contact with agencies, services were provided in an ad hoc manner or in response to crisis, almost on a daily basis. A key issue was an inability for services to be able to reduce Anne's risk taking behaviour or provide services to at least stabilise her situation long enough for other services to engage with Anne. The younger siblings exhibited similar patterns to Anne. After her death concerns for other siblings in the family remained.

In this case the Committee wrote to the Director General requesting that a full assessment of Anne's siblings be undertaken.

Intake processes

How these cases are intaked and a timeframe for response determined by each agency was not clear to the Committee and may warrant further consideration and cross agency discussion. Reciprocal polices may need to be developed for cases involving young people at risk of self harm and/or suicide.

No documented assessment of risk of harm and suicide

While the Committee is only able to consider the files of the Department it was noted that there was no documented risk of self harm and suicide on most of these files. This information may have been apparent on any health files kept. If this was the case it would be expected that this information (with the family's approval) be shared with key agencies involved at the time, including, the Department. It may be that thought needs to be given to the development of a cross agency assessment tool to determine immediate risk coupled with safety strategies.

Training and support to staff and their supervisors

Responding to young people who self harm and/or at risk of suicide is complex. Apart from a need for an assessment tool, the reviews undertaken suggest that many staff and their supervisors are in need of guidance and training on how to respond to these young people and their families.

Interagency collaboration/meetings

Based on the reviews either finalised or in process it is evident that a key theme was the lack of interagency collaboration. Many agencies were involved with these families. Key agencies involved included the Department, Health, Corrective Services, Police and Education. In some cases this appeared to create an assumption that a particular agency was 'case managing the family' and involvement by other agencies could therefore be minimal. In other cases there was a sense of many agencies working with families but not always cohesively and sometimes effecting limited change. It appears important that any interagency work be collaborative with clear communication, meetings being held involving key people and with a clear plan for action being developed. Cross agency service delivery should be paramount. The approach suggested in the 'Strong*families*' model may be appropriate in some of these cases. Any approach adopted should specify the role and responsibility of each agency in working with the family and young person and a lead agency should always be appointed.

Post suicide support to families and in particular siblings

The Committee is unaware of support processes and services that exist for families where suicide has occurred. In all cases reviewed (or currently under review) the deceased young person had siblings. In light of the fact that in a number of these families there had been prior suicides of other family members support to surviving children is crucial.

Responding to Aboriginal young people and their families

The majority of young people who died by possible suicide and were referred to the Committee for review were Aboriginal. Most of the Aboriginal young people lived in the country and died by hanging. The Committee is of the view that there is a need for targeted services for Aboriginal young people who self harm and/or are at risk of suicide. Family support and intervention are also crucial.

In light of the above, in August 2007, the Committee made the following recommendations to the WA Suicide Prevention Plan.

1. There is a need for holistic assessments and interventions targeted at young people who are at risk of self harm and suicide. Thought needs to be given to the adoption of an assessment tool to determine immediate risk coupled with safety strategies.
2. Services to young people at risk of self harm and suicide and their families by the various agencies need to be timely and integrated.
3. Protocols about how to respond to young people who are self harming and/or are at risk of suicide need to be developed so that there is a coordinated and collaborative interagency approach to these young people and their families.
4. Protocols should be integrated and linked in with Departmental policy for each agency: for instance; with DCP policy.

5. Timely planning meetings involving key agencies such as DCP, Health, Education, Department of Corrective Services and Police, the young people and their families are crucial.
6. Staff and their supervisors are in need of guidance and training on how to respond to young people who self harm and/or are at risk of suicide and their families
7. Family members and in particular, siblings in families where self harm and suicide has occurred are in need of assessment, intervention and support. Grief counselling needs to be provided for as long as is required, linking in with agencies with expertise in this area. This is particularly important for Aboriginal families and communities.
8. Data need to be kept which reflect the age group 0-18 and, in particular, it is important to gather data relating to suicides in the age group 5-12 and 13-18 years. The data should include, where possible, information from families about the circumstances leading up to the suicide, agencies involved and any interventions both prior to suicide and post suicide to ascertain what was effective and what could be improved. This information is seen as important in developing future policies and programs.
9. Any suicide prevention plan needs to consider and target strategies and responses to the age groups 5-12 years and 13-18 years. The Committee is of the view that a WA Youth Suicide Prevention Plan needs to be developed. Particular attention needs to be given to responses to, and services for, Aboriginal young people who self harm and/or are at risk of suicide and their families.

3. Overview of Child Death Review Data

The Director General of the Department 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. Following the notification of a child death, 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.

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 its 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.

Further, where the Department has had contact, the reasons for the contact are varied and diverse and in many cases, 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 2 provides population data for Western Australia (WA) and persons provided one-to-one services by the Department. It can be seen from this Table that the Department provided one-to-one services to 2.45% of the Western Australian population.

Table 2: Population Data WA (2006) and persons provided one-to-one services by the Department

Population	Aboriginal	Non-Aboriginal	Not stated	Number	% of total WA Population
WA Population (2006)[21]	58,709	1,773,051	127,328	1,959,088	100%
Children aged 0-17 years old[22]	25,659	424,417	31,767	481,843	25%
Number of persons in WA provided one- to-one services by DCP 2007-2008[23]	14,442	33,437		48,000[24]	2.45%

There were 12,657[25] registered deaths of people who died 1 July 2007 - 30 June 2008. Of these deaths 97% (N=12,258) were persons aged over 17 years. Deaths of children 0-17 years old (including stillbirths) comprised 3% (N= 399) of all deaths for the 2007-2008 year.[26] This represents 0.082% of the population, (N=481,843) of all children aged 0-17 years.

In the 2006 Census[27] about 3% of Western Australian residents identified as being of Aboriginal 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 population. Children aged 0-17years who are identified as Aboriginal make up 5% (25,659) of all children 0-17 years in Western Australia.

The Department's Annual Report 2007-2008 indicates that:

> Aboriginal and Torres Strait Islander people represent less than three per cent of the total population of Western Australia and yet comprise 29 per cent of the department's clients. Forty two percent of the children in the care of the CEO are Aboriginal. As services to Aboriginal children and their families form a large part of the department's business, it is imperative that the department understands, and successfully meets their particular needs. In order to better achieve this, the department restructured its Aboriginal Engagement and Coordination directorate to provide strategic leadership and practical consultancy advice with a team of highly experienced Aboriginal consultants.[28]

21 Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 2068, August 2007

22 Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 2068, August 2007

23 Data provided by the Department for Child Protection 2008.

24 Figure rounded

25 Breakdown of Registrar General's Death Data 2007-2008. Department of Attorney General: Births Deaths and Marriages

26 Breakdown of Registrar General's Death Data 2007-2008. Department of Attorney General: Births Deaths and Marriages

27 Australian Bureau of Statistics: Census Tables Western Australia 2006, Cat 1367.5 September 2007

28 Department for Child Protection Annual Report 2007-2008 p 17

Table 3 below presents data on all child deaths, excluding stillbirths, in Western Australia, 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 3: Children's Deaths in Western Australia 1 July 2007 - 30 June 2008

WA Child Deaths	Aboriginal children	Non-Aboriginal children	Unknown	Total Number	% of WA Child Deaths
Registered deaths of children 0-17 years old who died 1/7/2007- 30/6/2008 (Excludes stillbirths (N=-224); Number of infants 0-1 years = 115) [29]	38	130	7	175	100%
Number of reportable child death coroner notifications received by DCP 2006-2007[30]	37	68	2	107	61%
Child death notifications where any form of contact had previously occurred with DCP: recent, historical, significant or otherwise	30	28	0	58	33%
Child deaths referred and/or warranting review by the Child Death Review Committee	24	6	0	30	17%

As shown in Table 3, the Office of the State Coroner notified the Department of 107 (61%) of the 175 child deaths, for the period 1 July 2007 to 30 June 2008. In 46% (N=49) of child deaths reported to the Department by the Coroner there was no previous contact with the deceased child and/or its family.

Fifty eight Coronial 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. Clearly social disadvantage may be one of the key determinants in a family having contact with the Department. For example, in 2007-2008 the key reason for contact with the Department was for financial problems.[31]. The percentage of the total Western Australian population provided with services by the Department is 2.45%. If one considers the 58 notifications from the Coroner where the Department had some form of contact with a child and its family, as a percentage of the number of all persons provided with one-to-one services by the Department, which in 2007-2008 was 48,000, this equates to 0.12%.

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 (N=175), excluding stillbirths, was 33% (N=58). Thirty (17%) child death cases were referred and/or seen as warranting review by the Committee in 2007-2008. This again is a very small proportion of those provided with services by the Department.

29 Breakdown of Registrar General's Death Data 2007-2008. Department of Attorney General: Births Deaths and Marriages

30 Data provided by the Department for Child Protection 2008

31 Department for Child Protection's Annual Report 2007-2008, 11.

When considering child deaths and Aboriginal status, Table 3 indicates that for this reporting period:

- of the 175 children who had died in the reporting period and had their death registered, 38 were Aboriginal children;
- the child death notifications from the Department showed that of the 38 Aboriginal children who died during the reporting period and had their death registered, 30 children and/or their family had some form of contact, recent or historical, with the Department;
- 24 of the 38 Aboriginal children who died were cases that warranted review by the Committee;
- the child death notifications from the Department show that of the 130 non-Aboriginal children who died in the reporting period and had their death registered, 28 children and/or their family had some form of contact, recent or historical, with the Department; and,
- six of the 130 non-Aboriginal children who died were cases that warranted review by the Committee.

This means that with 24 of the 38 Aboriginal child deaths warranting review in this reporting period, the Committee will review over half of all Aboriginal child deaths in Western Australia for 2007-2008.

3.1 Department for Child Protection Client Profile

The Department's 2007-2008 Annual Report 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 and criminal record checking for persons working with children. The department funds a range of non government services.[32]

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 staff. 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.

In March 2006, the 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 repealed legislation that is more than 50 years old. 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:

32 Department for Child Protection Annual Report 2007-2008 p 4

- 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 children; and,
- review of case planning decisions and external review mechanisms.

The most common reasons for contact with the Department's offices for 2007-2008[33] are listed in Table 4.

Table 4: Primary reason for contact with the Department 1 July 2007 - 30 June 2008

Primary reason for contact	Aboriginal	Non-Aboriginal	Number of people
Financial problems	3,695	4,217	7,912
Concerns about children's wellbeing[34]	2,645	5,238	7,883
Carer enquiries from potential foster carers	625	1,909	2,354
Family problems	572	1,488	2,060
Family violence	394	813	1,207
Adoption issues	7	466	473
Custody/access issues	34	416	450
Best Beginnings Home Visiting Services	45	324	369
Homelessness	73	137	210
Other crisis issues (suicide, psychiatric, medical, legal problems)	56	132	188

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 4 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.

The Department 2007-2008 Annual Report notes that:

> In 2007-2008, about 59 per cent of the department's overall customer base (customer of both department and funded service providers) were female and around 35 per cent were male. Approximately 38 per cent of the department's customers were aged 18 years and younger. About 29 per cent of the department's overall customer base was Indigenous. As in previous years, the department's Indigenous customers were over-represented compared to their proportion of the general Western Australian population.[35]

4. Cases considered by the Committee

This years Annual Report will discuss cases notified to the Committee, when a child had died in the period 1 July 2007- 30 June 2008 where the child and/or its family had some form of contact, recent or historical, with the Department (for the purposes of this report these are referred to as cases notified) as well as those cases the Committee reviewed during this period (for the purposes of this report these are referred to as cases reviewed).

33 Information provide by the Department for Child Protection-2008.

34 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'.

35 Department for Child Protection Annual Report 2007-2008 p: 10

4.1 Cases notified

As previously noted, in the period 1 July 2007 - 30 June 2008 the Committee was notified of 58 Coronial cases of children who died where the child and/or its family had some form of contact, recent or historical, with the Department (referred to as known to the Department). Of these, 30 cases were not recommended for review and 28 were recommended for review.

Two of these 28 cases recommended for review in the Department's view did not meet the criteria for review however the Director General requested they be reviewed. For two of the 30 cases not recommended for review by the Department, the Committee determined a review was warranted and they will be reviewed by the Committee.

Two of the children who died in this reporting period and whose cases were recommended for review were under the care of CEO at time of death and in an out of home placement.

The following tables consider the 58 cases the Committee was notified of during this reporting period where children died and they and/or their family were known the Department.

Gender

Table 5 highlights that of the 58 cases of children who died where the child and/or its family were known to the Department, 37 (64%) were male child deaths and 21 (36%) were female child deaths.

Table 5: Gender for notification to the Committee of cases known to the Department 2007-2008

Gender	Not recommended for review by DCP	Recommended for review by DCP	Not Recommended for review by DCP but Committee determined warranted review	Total	
Males	16	20	1	37	(64%)
Females	12	8	1	21	(36%)
Total	28	28	2	58	(100%)

Aboriginal status of children

Aboriginal children are over represented both within the child protection population and within data about the deaths of children where a review is recommended/warranted. As can be seen from Table 6, 30 (52%) of the 58 children who died and were known to the Department were Aboriginal.

Of the 30 cases where a review was recommended/warranted 24 (80%) of these cases were Aboriginal children. Considering Aboriginal children represent approximately five percent of the population of children 0-17 years in Western Australia and Aboriginal people 29 per cent of the Department's clients, this is a very high proportion of cases and this is of concern to the Committee.

Table 6: Aboriginal status for notification to the Committee of cases known to the Department 2007-2008

Status	Not recommended for review	Recommended for/ warranting review by Committee	Total	
Aboriginal	6	24	30	(52%)
Non-Aboriginal	22	6	28	(48%)
Total	28	30	58	(100%)

Age

The data about notifications for this reporting period are of further interest when the data about age of death and co-sleeping are considered (Tables 7 and 8). As can be seen from Table 7, 25 (43%) of the 58 children known to the Department were infants six months or under and 34 (58.5%) of these 58 cases were children aged two years and under.

Of the 30 cases recommended for/warranting review 16 (53%) were infants six months and under.

Table 7: Age ranges for notification to the Committee of cases known to the Department 2007-2008

	Not recommended for review	Recommended for/ warranting review	Total	
≤6mths	9	16	25	43%
1-2 yrs	6	3	9	15.5%
6-12yrs	4	5	9	15.5%
13-17 yrs	9	6	15	26%
Total	28	30	58	100%

Co-sleeping

Table 8 shows the data on cases notified in this reporting period where a child was six months and under and co-sleeping was a circumstance.

Table 8: Co-sleeping a circumstance six months and under for notification to Committee of cases known to Department

Circumstance of death	Not recommended for review	Recommended for/ warranting review	Total	
Co-sleeping	5	8	13	22.5%
Other	23	22	45	77.5%
Total	28	30	58	100%

In considering these data together with the data in Table 7 on ages of children who died it can be seen that 13 (52%) of the 25 deaths of children six months and under who were known to the Department involved co-sleeping. Nine of these 13 deaths were Aboriginal children.

Eight (50%) of the 16 deaths of children six months and under referred for/warranting review involved co-sleeping and six of these children were Aboriginal.

The eight children where a review was recommended/ warranted were co-sleeping with:

- the mother in three cases;
- both parents in two cases;
- both parents and a sibling in one case;
- the mother and another sibling in one case; and
- the father and a number of siblings in one case.

As these eight cases have not yet had a review completed little is known about the detail of these cases. Not having enough beds for the children to sleep on has however, been noted as an issue in a number of cases. The following cases example illustrates this:

Case example 4

Robert, aged five months slept in a single bed with his father and three siblings aged five years, three years and 18 months. During the evening the father was woken when the three year old moved around in the bed and lay across the father and Robert. The father checked Robert and discovered that he was not breathing. The mother had slept on another mattress on the floor with a two year old child and an older daughter slept in her own room.

This case demonstrates a pattern of potentially unsafe sleeping or multiple sleeping arrangements that is often noted in the Committee's reviews. It is evident that one factor that influences co-sleeping is where families are living without enough beds and/or in overcrowded accommodation. It is also evident in some reviews that families change their normal sleeping arrangements due to the weather, particularly on hot nights when mattresses may be shared and moved closer to open doorways.

As reported in the Committee's previous Annual Reports, 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. Within our culturally diverse community, bed sharing is an accepted child care practice which is becoming more popular in mainstream Australia. In a small Australian study up to 80% of infants spent some time sharing a bed with one or two parents.[36] For some parents, sharing a bed with their infant may be the only practical option. In other instances it is seen as necessary to protect the infant. The continuing discussion regarding the issue of bed sharing or co-sleeping is an emotive and important area and debate regarding the merits as opposed to the dangers of infant parent bed-sharing continues. Population figures are needed that identify the number of infants who co-sleep and who do not die to establish a definitive relative risk of death associated with co-sleeping.

It is important to note that co-sleeping is NOT a cause of death. However, infants sharing a sleep surface increases the risk of infant death that is due to overlaying and other factors. These factors include 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. In these situations, co-sleeping may increase the risk of infant death.

36 Rigda RS, McMillen IC, Buckly P. Bed sharing patterns in a cohort of Australian infants during the first six months after birth. Journal of Paediatric Child Health. 2000;36(3): 181-8.

The Committee notes that there have been a number of safe sleeping campaigns throughout Australia including Western Australia. In New South Wales DoCS recently launched such a campaign. It was noted in a Media Release by Linda Burney, Minister for Community Services NSW to mark National Child Protection Week that:

> Research has been undertaken which found that between January 2005 and December 2007 35 babies died while sleeping in the same bed with either one or both parents. In a great majority of cases, the baby's parents had a history of drug or alcohol misuse… With 29 of the babies, all aged 12 months and younger, there was evidence of the dangerous combination of parental substance abuse and co-sleeping.[37]

The Committee recognises there is limited research regarding the risks of co-sleeping. More research is needed. It may be that some families need very practical support such as the provision of beds.

Departmental District Areas

In Table 9 it can be seen that the majority of deaths in cases known to the Department came from country areas. For the cases where a review was recommended/warranting review in this reporting period, 22 (73%) came from country areas with almost a third of these cases (7) coming from the Kimberley.

Table 9: Location for notification to Committee of cases known to the Department 2007-2008

Location	Not recommended for review	Recommended for/ warranting review	Total	
Metropolitan	16	8	24	(41%)
Country	12	22	34	(59 %)
Total	28	30	58	(100 %)

Other information

For the 30 cases where a review was recommended/warranted, 15 (50%) cases were open to the Department at the time of the child's death. Examples of the circumstance of death include:

- eight cases with co-sleeping (as previously discussed);
- seven motor vehicle accidents;
- three cases involved drowning; and,
- two were possible suicides. The two notifications of possible suicide were discussed as a group earlier in this report under section 2.2.2.

Overall, in this reporting period the majority of notified cases requiring review by the Committee involved the deaths of: Aboriginal children and infants six months and under, with co-sleeping as a circumstance of particular concern.

4.2 Cases reviewed

In accordance with the criteria established for the Committee's work, fourteen cases were reviewed in 2007-2008, bringing the total number of cases examined by the Committee since its commencement to 68.

37 Media release Minister for Community Services NSW Linda Burney 10 September 2008.

Table 10 provides the number of cases reviewed in each year to 30 June 2008. 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 10: Summary of child death case reviews

	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
Cases reviewed	10	10	24	10	14

4.2.1 Characteristics of cases reviewed

In this section the characteristics of the 14 cases reviewed during 2007-2008 have been analysed. An overall analysis of all 68 cases reviewed from 2003 to 30 June 2008 has also been undertaken. It should be noted that of the 14 cases reviewed in the current reporting period, three cases had not been recommended for review by the Department. The Committee considered these cases and determined there had been significant concerns and contact which warranted review. The following example illustrates a case the Committee felt needed to be reviewed even though no review had been recommended by the Department.

Case example 5

Reece was aged four months when he died on a cot mattress which had been placed on the floor alongside his parents' mattress. The family was a blended family with Reece being the youngest of four children. While there was limited contact with Reece because of his age, the Committee was concerned about his mother's admitted misuse of illicit and prescription drugs. There was particular concern that such behaviour had been long term, continued during her pregnancy with Reece and could raise concern for his surviving older siblings. The primary focus of the Committee's review was an older sibling who had been the subject of numerous reports of concerns for his care prior to and subsequent to Reece's death. It was the Committee's belief that this history was indicative of the care that Reece may have been subject to during his short life and as such was concerned that the Department's limited intervention with the family did not correctly identify the risks for Reece and his older sibling. It was also evident that Reece's older sibling was often responsible for the care of his mother, particularly during her depressive episodes and when she was using drugs. The issues within the family were regularly reported to the Department, particularly by the local school Principal and Psychologist who sought help for the family. File records indicate that while these reports were recorded they were considered as being addressed by other agencies, particularly the school. During a six month period, a number of reported concerns for the family were raised however there is no evidence on file as to how these were responded to by the Department. In some of this period Reece's mother would have been pregnant and it may be that her continued drug use, depression and mental health issues impacted on the family after Reece was born.

Of the 14 cases reviewed, two of the deceased children who were subject to a review during the reporting period 2007-2008 died in that period, six children died in 2006-2007 and six children died in 2005-2006. Table 11 presents the year of death for all 68 children the subject of completed reviews.

Table 11: Year of death of all 68 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	15
2006-2007	6
2007-2008	2
Total	68

Age and gender

Of the 14 children who were the subject of completed case reviews in 2007-2008, ten were male and four were female. The breakdown of the ages of these children is presented below:

- four were less than six months old
- two were twelve months to two years old
- one was two years to three years old
- seven were eleven years or older.

The fourteen cases reviewed in 2007-2008 demonstrated a similar gender distribution to the 68 cases reviewed to date in which the majority of deaths 65% (N=44) concerned male children. The age patterns differed in that 50% of cases reviewed this reporting period were for children aged 11 years and over. Table 12 presents the age and gender of all 68 children whose cases had been reviewed as at 30 June 2007.

Table 12 Age and gender of all 68 reviews completed at 30 June 2008

	Female	Male	Total	
<6mths	10	15	25	37%
6-12mths	3	4	7	10%
1-2 yrs	3	10	13	19.5%
3-5 yrs	3	2	5	7%
6-12yrs	0	5	5	7%
13-18 yrs[38]	5	8	13	19.5%
Total	24	44	68	100%

The data trends depicted in Table 12 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)[39]. 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 out numbered 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.[40]

38 18 years has been used in the age range for cases reviewed previously as one young person was 18 years at time of death however had been know to DCP in 2 years prior to death when under 18 years of age.

39 Australian Bureau of Statistics Deaths Australia 2006. Catalogue 3302.0,

40 Australian Bureau of Statistics Deaths Australia 2004. Catalogue 3302.0, p 15

Aboriginal status of children

Of the 14 children who were the subject of completed case reviews in 2007-2008, seven children were identified as Aboriginal and seven were identified as non-Aboriginal. Four of the seven children identified as Aboriginal who died were three years of age and under. The remaining three young people were eleven years or older.

This over-representation of Aboriginal children in child death reviews is also evident in the Committee's analysis of all 68 cases reviewed to date.

Table 13: Aboriginal status of children whose cases have been reviewed as at 30 June 2008

	Females	Males	Total	
Aboriginal	14	19	33	(48%)
Non-Aboriginal	10	25	35	(52%)
Total	24 (35 %)	44 (65 %)	68	(100%)

The national average death rate for Aboriginal and Torres Strait Islander infants is nearly three times higher than for other infants[41]. This death rate confirms that Aboriginal and Torres Strait Islander children remain a high risk group.

> 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[42].

As previously noted, Aboriginal persons are also over-represented in the Department's client profile. 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.[43]

Family Composition

Of the 14 cases reviewed in 2007-2008, four were from single parent families (all headed by women) eight were from families comprised of both biological parents and two were from blended families.

Of the total 68 deceased children who were the subject of completed case reviews at 30 June 2008, 31 (45%) were from single parent families the majority of which were headed by women. Forty percent (N=27) of the children were from families comprised of both biological parents and 15% (N=10) were from blended families. Table 14 shows the child's family composition at the time of death.

41 Australian Institute of Health and Welfare (2005) A Picture of. Australia's Children p 13

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

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

Table 14: Family composition of all 68 children at the time of their death

Family Structure		Number of cases	
Two Parent	Biological parents	27	(40%)
	Blended family*	10	(15%)
Single Parent	Birth mother	29	(43%)
	Birth father	2	(2%)
Total		68	(100%)

*Birth parent and partner

At the time of death of the 14 cases reviewed, 12 children were living with at least one biological family member, one child was living in privately arranged relative care with a single parent female and another child was in the CEOs care and placed in foster care.

Child Protection history

The Department previously had two categories for child protection concerns: child maltreatment allegations and child concern reports. Under the 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 CEO of the Department receives information that raises concerns about a child's wellbeing, the CEO may cause any inquiries to be made that he/she considers reasonably necessary for the purposes of determining whether action should be taken to safeguard or promote the child's wellbeing[44]. Due to these changes, this year's Annual Report will consider data on cases reviewed with child protection concerns noted for either the child who died and/or at least one sibling. Child protection concerns for the purposes of this report means if the Department was notified at any time of a child concern report, child maltreatment allegation or a concern for a child's wellbeing for either the child who died and/or at least one sibling prior to the child's death.

For the 14 cases reviewed in this reporting period, in 11 of the 14 cases there had been child protection concerns reported for the deceased child. In ten of the 14 cases there had been child protection concerns reported for at least one sibling. In one case reviewed it was believed the deceased child was an only child.

Previous child protection concerns have been recorded in relation to the deceased child and/or siblings for all 68 cases reviewed to date and Table 15 reflects these concerns.

Table 15: Previous history of child protection concerns in cases reviewed

	Child protection concerns cases reviewed (N=68)
Deceased child	39 (57%)
Sibling(s)of deceased child	44 (65%)

However, the Committee recommends caution when interpreting Table 15. When examining case information in respect of children who have died and their siblings, the Committee found that not all reported concerns, which met the Department's definition of a maltreatment allegation, child concern report or concern for a child's wellbeing, were recorded by Departmental staff as such in the Department's electronic information system or in hard copy files. The Committee found variation between cases and districts as to what reports were categorised as allegations of maltreatment, child concern reports or concerns for a child's wellbeing.

44 Children and Community Services Act 2004

The Committee reviewed three cases in this reporting period which it felt had child protection concerns even though most of the recent contact was not classified as child protection concerns by the Department.

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 15 is that overall, child protection concerns 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 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, as noted in last year's Annual Report, the Committee remains of the view that 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 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.

Guardianship status

One of the deceased children whose case was reviewed by the Committee as at 30 June 2008 was in the care of the CEO and placed in foster care. Another child was subject to an application for a protection order with the Children's Court.

To date, of the 68 cases reviewed, the Committee has reviewed four cases where children were in the CEO's care at the time of their death.

Case status

Of the 14 deceased children, six children and their families were open cases to the Department at the time of the child's death and the remaining eight were not open cases.

Of all 68 cases reviewed 30 (44%) were open to the Department at the time of the child's death. The remaining 38 (56%) were not open cases.

Departmental District Areas

Of the 14 cases reviewed in this reporting period six of the children's families resided in the metropolitan area (three in the Metropolitan East area, one in the Metropolitan South area and two from the Metropolitan North area). Eight of the children's families resided in the country (four in Country North area and four Country East area).

Of all 68 cases examined to date, 30 (44%) of the children's families primarily resided in the Perth metropolitan area at the time of the child's death. Thirty eight (56%) resided in country areas. Table 16 below provides a breakdown of the Department's District Areas which had the most recent contact or involvement with the deceased children and/or their families.

Table 16: Departmental Districts with the most recent contact or involvement with cases reviewed

District Area		Number of Cases
Metropolitan	East	17
	North	7
	South	6
	Sub Total	30 (44%)
Country	East	8
	North	24
	South	6
	Sub Total	38 (56%)
Total		68(100%)

From Table 16 it is evident that the majority of reviewed child death cases came from rural and remote regions. The Country North area features predominately in this statistic (N=24). With respect to the metropolitan area the Eastern area features significantly (N=17).

In respect of the cases reviewed from the Country North area, the Kimberley District had the highest number with 15 cases.

Circumstance of child deaths

Of the 14 cases reviewed in this reporting period examples of the circumstance of death include:

- three cases of be possible suicide;[45]
- two cases of co-sleeping;
- one motor vehicle accident; and,
- one drowning.

The Coroner's Office determines the 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 such as pneumonia, the Committee examines the Department's service provision to ascertain:

- 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; and,
- 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).

45 The Coroner determined an 'Open Finding' in one of these cases.

Co-sleeping

Of the 14 cases reviewed in 2007-2008, in two cases the child died in a circumstance 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. As previously discussed co-sleeping was a factor in the deaths of half of the infants six months and under who the Committee was notified of as recommended/warranting for review in this reporting period.

Out of the total of the 68 cases examined to date, co-sleeping occurred in 16 cases (24%). Of these, 14 cases (87.5%) involved children under six months of age and 2 cases (12.5%) concerned children aged six to twelve months.

As noted previously in section 4.1 the Committee recognises there is limited research regarding the risks of co-sleeping and more research is needed in this area.

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[46]. 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. In the fourteen cases reviewed during the reporting period:

- family violence was noted in eight of the cases;
- financial difficulties were noted in eight of the cases;
- homelessness/transience was noted in five of the cases;
- medical problems were noted for parents in six of the cases;
- mental health problems were noted for parents in three of the cases;
- alcohol use by at least one parent was noted in seven of the cases;
- illegal drug use by at least one parent was noted in seven of the cases;
- prescription drug use by at least one parent was noted in two of the cases;
- combined alcohol or other drug use by at least one parent was noted in nine of the cases;
- in six of the cases where there was a history of family violence there was also a history of alcohol use by at least one parent;
- in six of the cases where there was a history of family violence there was also a history of illegal drug use by at least one parent; and
- in five cases family violence, and alcohol and illegal drug use coexisted.

46 Australian Institute of Health and Welfare (2002) Australia's children – Their Health and Wellbeing p: 253.

Table 17 summarises the social and environmental factors for all cases reviewed to 30 June 2008.

Table 17: Common social and environmental factors evidenced in cases examined.

Social and environmental factors indicated	Number of cases (100% = 68)
Family violence or parents with histories of violent behaviour	56 (82%)
Parental hazardous alcohol and/or other drug use or histories of misuse	51 (75%)
Significant financial assistance provided over the length of the Department's involvement	48 (71%)
History of transience and/or homelessness	42 (62%)
Parental mental health issues	31 (46%)

As highlighted in Table 17, the presence of indicators of interpersonal or family and domestic violence was identified in 56 (82%) of all case histories reviewed. It was evident that a child's parents had a history of hazardous alcohol and/or other drug use, in 51 (75%) of the reviewed cases. Mental health problems compounded risk factors present in 31 (46%) of all cases.

Many of the families presented with more than one of the factors listed in Table 17. This multiplicity of factors often requires agencies to join efforts for them to be addressed. No single agency has the capacity to address chronic social and environmental issues. These require an across government approach. Many of the recommendations made by the Committee for the cases reviewed this year have been directed at the need for interagency collaboration. Recommendations made will be discussed later in this report.

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, nine out of fourteen 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.

Alcohol and/or other drug use has been a concern of all jurisdictions involved in child protection and child death reviews. 'In NSW, DoCS has estimated that, in 2004-2005, between 42% and 56% of risk-of-harm reports made to the department involved carer drug and/or alcohol abuse.'[47]

There has been an increasing focus on the risk to young people of their own alcohol and/or drug use and of the adults around them.

4.2.2 Reviews and recommendations

Service provision themes

The key service provision and case practice issues of concern identified from the 14 case reviews undertaken during this reporting period in the main mirror those highlighted in the 54 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.

47 Letter to Minister for Families, Community Services and Indigenous affairs from NSW Ombudsman 15 July 2008 commenting on proposals for a national framework for the protection of children

The following example illustrates a case were good practice was evident and highlights the importance of good practice in children's lives:

Case example 6

Martin was an adolescent who had an accident and died as a result of internal injuries. Martin and his younger brother had lived with their parents until they were placed under the care of the Department and moved to foster care. The children had limited intellectual capacity and significant medical needs which were caused primarily from chronic neglect while in the care of their parents who were unable to cope with the children's special needs. While the children were in foster care the Department maintained regular contact between the children and their parents. The Department also ensured that the children received appropriate medical, education and counselling supports, particularly as it became evident that the children may have been sexually abused by a friend of their parents.

The review of this case, revealed case practice that was of a high standard, particularly when the children were placed in Departmental care and provided with a stable placement. From the time of statutory action until the day of Martin's death, the Department routinely phoned and visited the carers, sighted and spoke with the children and maintained a working relationship with the children's biological parents.

File records indicated highly satisfactory file management, documentation, and policy and procedural compliance with the caseworker being able to engage and maintain counselling, medical and treatment services required by Martin and his brother.

In addition, Departmental staff provided ongoing support to the carers, particularly in seeking services to assist the children's behavioural, medical and educational needs. The review found that there was balance in responding to the needs of the parents, carers and, of course, the children with issues being resolved through child focused mediation.

The Committee is of the view that this case demonstrates the positive outcomes that may occur for children in Departmental care. This is particularly evident when comparing the children's circumstances when they were very young and living with their parents, to the progress made while in care.

Another case review undertaken by the Committee highlighted good case practice was evident at times, and for particular children:

Case example 7

Michael's older brother disclosed physical maltreatment by their stepfather and the Departmental staff took action to protect Michael and his siblings, including the timely organisation of police interview.

Michael was also provided with the opportunity to disclose in a safe context and supported to acknowledge what was happening at home whilst still remaining connected to his family. His attachment to his stepfather, despite the physical maltreatment was noted and actions were taken to minimise the impact of placement on him.

Michael thanked the caseworkers for helping him and keeping him safe.

Of the fourteen cases reviewed in this reporting period in:

- 13 cases there were concerns about critical analysis, evidence based decision making, gaps in case knowledge and holistic family assessments;
- 12 cases there was a lack of child focus, concerns about inadequate documentation, gaps in application of guidelines, poor or limited interagency coordination and lack of safety assessments; and,
- 10 cases there were concerns around safety plans and supervision of staff.

The following case example illustrates a number of these concerns:

Case example 8

Brendan was under six months of age in care of a relative when woke with trouble breathing and then taken to hospital where pronounced deceased. Brendan had been to the doctor a few days earlier with a 'runny nose' however was not prescribed any medication.

The Department had contact with the family following Brendan's birth when it was reported that his mother was not coping with caring for older children and the new infant. Concerns were expressed that his mother had been drinking excessively and leaving the children with others which was particularly an issue for Brendan as he was being breast fed. The matter was to be followed up but Brendan died prior to contact with the family being made by the Department.

In this case there are numerous concerns on file relating to a history of alcohol, drug use and violence that appear to have involved both parents. The mother is reported to use drugs and alcohol and left the children for periods of time with others. From evidence on file it appears this case was clearly a child protection case that historically was not recognised or responded to according to policy and protocols. Information on file is of poor quality with inconsistencies in details such as dates of birth. In some instances, information is recorded electronically rather than on files and the limited documentation also indicated more contact with the family occurred than was recorded. Departmental staff appeared to have had a good relationship with the family however ongoing neglect and drug and alcohol use do not appear to have been addressed. There is evidence to indicate the District may have been experiencing workload and staff shortages which may have impacted on staff ability to respond.

The last file record indicates the Department did not know where the mother was and the children were with extended family. It is the Committee's opinion that any children in the mother's care were at risk due to her alcohol and drug use, therefore a comprehensive assessment including safety plans should have been made.

An issue of concern for the Committee was the lack of a child focus particularly as not all children in the family were seen and/or interviewed when concerns had been expressed. Inadequate documentation meant it was not always clear from file notes who had been spoken to or seen. The Committee remains firmly of the view that in child protection cases, children need to be seen, interviewed where age appropriate and any contact with children should be thoroughly documented.

Case examples 6 and 7, which illustrate some good practice, highlight the positive outcomes that can result from child focused practice. The Committee is hopeful that with the introduction of the Signs of Safety approach, which has a particular emphasis on talking to children and tools to assist staff to develop safety plans with children and their families, contact with children will be more evident in file records.

The key issues of concern in all cases reviewed to date are presented in Table 18.

Table 18: Key issues identified as of concern

Case practice issues of concern	Description	Number of cases (68 = 100%)
Gaps in application of case practice/fieldworker guidelines	Ensuring an adherence to the Department's policies, procedures and field worker guidelines.	63 (92.6%)
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.	63 (92.6%)
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.	62 (91%)
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.	61 (90%)
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.	59 (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.	58 (85%)
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.	52 (76%)

As can be seen from Table 18 in the majority of cases reviewed (≥90%) key issues identified as of concern were:

- gaps in application of case practice/field worker guidelines. The caseworker 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.

In this period, as previously discussed, three of the fourteen cases reviewed were not recommended for review by the Department. In the Committee's view, these three cases ***did*** meet the criteria for review. The fact that they were not recommended for review highlights in part some of the issues that the Committee has discussed as concerns in service provision in past reports. These continue to be concerns. Each of these three cases had child protection concerns yet the information was not considered as child protection, but rather as a one off episode and children were not seen. Patterns for contact were very evident to the Committee when undertaking reviews on these cases. These patterns included neglect, mental health issues, hazardous alcohol and/or other drug use, and domestic violence. In one case domestic violence had been evident over years.

As discussed in last year's report, information gathering coupled with the issue of gaps in knowledge in cases, were seen as particular issues in the majority of cases again in 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, as well as domestic violence and child protection, 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. With the introduction of virtual files in the Department this will become even more important.

Recommendations

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 19. 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 14 cases reviewed in this reporting period are in italics.

It is important to note that when interpreting Table 19 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 18 and 19.

For the fourteen cases reviewed in this reporting period there were a number of key recommendations:

- ten cases (involving 16 recommendations) on interagency collaboration and consultation;
- nine cases (involving 12 recommendations) on case information, poor information and records and incomplete and inaccurate records;
- eight cases (involving 10 recommendations) on critical analysis and holistic assessment; and,
- six cases (involving 8 recommendations) on case management, goal setting, supervision and case closure.

The Committee has 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 occur. Whilst in its reviews the Committee is only able to consider the records of the Department, it is mindful that best practice in child protection requires cross agency collaboration and service delivery.
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 problems the need for interagency collaboration is crucial. This is particularly the case for infants identified as high risk, parents with mental health issues as well as adolescents at risk of self harm and suicide.

It is apparent most of these families are in contact with multiple agencies and need effective working relationships and policies across agencies to obtain optimum support and service delivery. The Committee welcomes the transfer of the Committee function to the Ombudsman's office as this will enable contact by other agencies with families to be considered with recommendations across agencies able to be made. This is central to any effective child death review process.

Recommendations relating to interagency collaboration and consultation were made in 10 cases of the 14 reviewed in this reporting period. A total of 16 recommendations were made. Some examples are noted in Table 19. Additional examples include:

1. The Department should ensure a collaborative interagency response to family violence for all cases where repeat presentation is evident.
2. That the Department highlight to other government departments the need to provide a conjoint response to families, the importance of conducting interagency meetings to determine risk, need and services where there is a joint duty of care to a child who has been subject to abuse and/or is self harming and/or discussing suicide.
3. All agencies recorded as having responsibility for children in care be invited to attend all planning meetings and be required to provide a submission on service provision, particularly where representatives are not able to attend such meetings.
4. The Department should ensure a collaborative interagency response to family violence, alcohol and drug use occurs for all cases where the impact on children's wellbeing can be identified and addressed.
5. The Department consult with other agencies around intervention and provide outcome reports on actions provided by the Department.
6. The staff of …. Primary School be congratulated on their unfailing attempts to protect….. and to support his mother.
7. The Department's staff is encouraged to adopt a more rigorous approach to the undertaking of professional dialogue and working collaboratively with health and hospital staff regarding the safety and wellbeing of children. In particular such an approach should document the department responsible for case management in multiple agency cases. This is of particular concern in relation to matters of chronic neglect. It is noted that The Reciprocal Child Protection Procedures revised in October 2002 do not refer specifically to neglect, replacing this concept with the broader description of;

   Child Maltreatment Allegation – referral classification where the information received is sufficient to indicate that a child – may be the subject of persistent actions or inactions which have or are likely result in the child's development being significantly impaired.

   Significant, the adjective used to describe the extent of the impact on the health, mental health or emotional, health, physical or cognitive or social development of the child'

Poor recording keeping and documentation continued to be of concern to the Committee. The Committee is of the view that a genogram is crucial in any assessment of a Concern for a Childs Wellbeing. Evidence based decision making requires good documentation.

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

The Committee has continued to be concerned at the number of Aboriginal cases it has reviewed. The Committee is of the view that the Senior Officer Aboriginal Services (SOAS or another Senior Aboriginal worker) should always be involved in cases where there are concerns for a child's wellbeing and an assessment is undertaken. The SOAS input should be sought about these cases. In a number of cases it is not always clear if a SOAS is involved in the case and/or their input is not always recorded on files. It is the Committee's view that it is important (and respectful), that the input of the SOAS is recorded. The SOAS has the potential to provide critical background information that can inform an assessment, giving context to decision making. It is concerning that appropriate weight is not given to the consultation process with the SOAS, which is reflected in the fact that the input of the

SOAS is rarely recorded and/or the SOAS given the opportunity to sign off and comment on any planning. The Committee, therefore, made a recommendation as follows:

> In cases where an Assessment for a Concern for a Child's Wellbeing has been undertaken for Aboriginal children the assessment form indicates endorsement and comment on any plan developed and the outcome of the assessment by the SOAS or a Senior Aboriginal officer.

The Department responded to this recommendation noting it had developed a form –an Action and Outcome Report where there is an assessment and/or investigation of a Concern for a Child. (DCP 017). This form requires consultation to be recorded by staff and a tick box response and a signature box to be completed by the SOAS. The format limits the opportunity for the SOAS to document their advice. For any consultation process to be meaningful there must be clarity about the issues on which a person is being consulted and the input of the person consulted, recorded prominently in the planning/decision making documents. The Committee understands that the Department is currently reviewing the SOAS role so some of these issues may be addressed by the review process.

Previously the Committee has noted the inappropriate 'normalisation' of chronic neglect and appalling conditions in many Aboriginal deaths. These deaths are preventable, and whilst the challenges involved in working with these families in these environments are substantial, they must be given priority as these situations are unacceptable.

Overall, for the 68 cases reviewed to date, the most significant recommendation categories are those concerning the need for critical analysis and holistic assessment (74%), poor case records and documentation (68%), children's safety (66%) and training (63%).

Table 19: Recommendation categories[48]

Recommendation category	Examples of recommendations made	Number of cases (100% =68)
Critical analysis and holistic assessment	▪ In cases where there is a history of the department previously considering statutory action, a comprehensive assessment of current circumstances should be undertaken. ▪ Departmental officers shift from a single event based assessment model to holistic assessments of the needs of children and families. ▪ Departmental officers to be encouraged to undertake holistic assessments giving consideration to key events in children's lives. ▪ 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 interagency planning. ▪ *Departmental Officers conduct holistic assessment of all family members when responding to concerns for children.* ▪ *The Department should ensure a comprehensive and holistic assessment occurs when concerns are reported about the wellbeing of children.* ▪ *The Department ensures all assessments for a Concern for a Child's Wellbeing are assessed according to the Field Worker Guidelines which includes a holistic assessment incorporating family history and genogram*	50 (74%)
Case information: poor information and records; incomplete and inaccurate records	▪ When reports about possible harm to children are received the information should be placed on the Department's client information system without delay. ▪ 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. ▪ The Department take appropriate action to ensure case assessments and decisions are well documented and kept in chronological order… ▪ 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. ▪ 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. ▪ *The Department ensure through training and supervision proper records are kept on all families.* ▪ *In all cases where a CCW is raised it is a standard requirement that a genogram be completed and placed in a plastic sheet at the front of the file/papers to enable immediate representation of the relationship and distribution of family members for the subject child.*	46 (68%)
Ensuring child/ren's safety	▪ 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. ▪ *The Department undertakes a thorough review of the current circumstances of the family, if this has not yet happened. The completion of a thorough assessment, including future protection strategies, for all the children is considered crucial, particularly as it is understood that one of …. siblings has been sexually assaulted in similar circumstances to those reported by …..*	45 (66%)
Training	▪ 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. ▪ 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. ▪ Training is undertaken on the vulnerability of older children to physical and emotional harm and neglect. ▪ *That Departmental workers reinforce in training, supervision and professional development the importance of critical questioning, exploration of issues, use of alternative information sources for corroboration, observation and analysis when undertaking assessments or investigations into child maltreatment allegations.*	43 (63%)

48 Recommendations made in this reporting period are in italics. Other recommendations are from the Committee's previous annual reports.

	▪ *That new caseworkers receive mentoring and support through the investigation process and are given the opportunity to learn how to conduct interviews and risk assessments from experienced caseworkers. This mentoring should include training in how to scribe interviews and document detailed file notes. Examples of good practice in file notes and assessment reports as well as other key documents be made available as a resource for all caseworkers.* ▪ *All Departmental Officers are trained to correctly search historical records for children and all family members.*	
Interagency collaboration and consultation	▪ The Department explores options and develops protocols that will enable officers to receive expert advice on working with parents who have drug dependence. ▪ The Department explores ways of enhancing collaborative work with child health and hospitals statewide. ▪ Interagency meetings should be convened where there are complex health, educational and psychological issues apparent for children. ▪ 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. ▪ 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 ▪ 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. ▪ *The Department consider the reinstatement of the Drug and Alcohol Office, formally Alcohol and Drug Authority (ADA) as a signatory to the Reciprocal Child Protection Procedures. It is the Committee's view that this agency is a key source for supports and services concerning substance abuse issues. The agency also has a community responsibility in providing these to children or families struggling with substance abuse issues. The ADA had been a signatory to the original Reciprocal Child Protection Procedures in 1997 and it is not known why this agency was not included when the Procedures were reviewed in 2002.* ▪ *The Department review and liaise with the Health Department policies and procedures for the care of drug dependent pregnant women and babies particularly where it is anticipated that the babies will be born with Neonatal Abstinence Syndrome with the view of clearly identifying lines of communication and responses and services and the relationship to child protection.*	38 (56%)
Case management: goal setting, supervision and case closure	▪ 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: - 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 - Reasonable steps being taken to ensure the wellbeing of the child/ren the subject of the case or contact period. ▪ The Department takes appropriate action to ensure formal case planning and review are the subject of supervision. ▪ 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. ▪ *The Department ensure supervision notes are recorded clearly on file with a clear rationale and case plan.* ▪ *The importance of the Department's Supervision Policy is reinforced and standards for supervision developed. These standards should include minimum timeframes and reporting mechanisms to ensure that supervision occurs on a regular basis.* ▪ *Where multiple allegation categories are evident that all categories are responded to and finalised before a case and Departmental involvement is closed.* ▪ *The Department reminds senior staff that case closure reports need to demonstrate that all issues have been comprehensively considered, how this has been undertaken and rationale for case closure with detailed information on appropriateness of the use on non departmental services.* ▪ *That the Department review its guidelines to ensure that case closure reports, particularly those where there has been a Concern for Child's Wellbeing contain a full family assessment, documentation on actions taken to protect the child, the rationale for case closure and evidence that the child had been seen by the worker, either alone or in the presence of another person such as a parent.*	32 (47%)

Maintaining a child focus	▪ The Department highlights with the staff the importance of maintaining a 'child focus' when responding to or working with parents and families. ▪ 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. ▪ Children in care are the subject of thorough and child focused assessments as part of planned case reviews. ▪ 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. ▪ *In investigating Concern for a Child's Welfare (CCW's) a comprehensive assessment using the Department's Child Safety Assessment Framework (CSAF) be undertaken. All family members present should be interviewed about the alleged incident and concerns. The CCW investigator's report should also record details of all other children who are interviewed as a result of the concerns.* ▪ *The Department ensure all children are sighted and an age appropriate interview occurs when concerns for a child's wellbeing exist.*	30 (44%)
Historical case information and records	▪ 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. ▪ 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. ▪ *Concerns for a child and/or siblings of a child, who has been subject to previous allegations of abuse or neglect are given a priority response for sighting and assessment*	21 (31%)
Aboriginal issues	▪ 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'. ▪ 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. ▪ 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…. ▪ *In cases where an Assessment for a Concern for a Child's Wellbeing has been undertaken for Aboriginal children the assessment form indicates endorsement and comment on any plan developed and the outcome of the assessment by the SOAS or a Senior Aboriginal officer.* ▪ *The Department adheres to its policy that investigations should be conducted after joint planning that includes the Team Leader; SOAS and any other cultural expert as required.*	19 (28%)
District capacity and resourcing	▪ The Department examines [its] capacity …to ensure supervision and coaching of inexperienced staff. ▪ 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. ▪ 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. ▪ The Department ensure effective systems are in place to provide daily monitoring and prioritizing of cases that are queued. ▪ *The Department ensure Workload Management instructions are adhered to and fully documented when there are protective concerns for children.* ▪ *In cases that are not allocated the reasons for this are clearly documented and planning for the completion of tasks noted: as per the Workload Measurement and Management Guidelines 2005.*	17 (25%)

Intervention with complex cases	▪ The Department examines the applicability of different approaches [such as multi systemic therapeutic approaches]…for use with complex cases… ▪ 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. ▪ 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….	11 (16%)
Inclusion of men	▪ 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. ▪ 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. ▪ *The Department advise the Committee what steps have been taken by the Department to date to highlight the need with workers for any assessment and intervention to include significant males in the family. In particular, the Committee would like reports of the milestones proposed by the Department to address this recommendation and regular updates on its implementation.* ▪ *The Department ensures contact occurs with the fathers of children as previously recommended in other reviews*	10 (15%)
Miscellaneous	▪ The Department promotes the monitoring and the evaluation of the effectiveness of the Northbridge Project. ▪ 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. ▪ *The Department amend Field Worker Guidelines and Client and Community Services System to classify reports of suicidal ideation, self harm and suicide attempts as Concern for a Child's Wellbeing. Such classification will ensure that the level of assessment of risk and safety for the child will be consistent with that required to respond to investigation of harm or injury. Further this classification be included in interagency agreements such as the Reciprocal Child Protection Procedures.*	15 (22%)
No recommendations		3 (4.5%)

Agency response

Once again the Committee has not received the six monthly feedback on the implementation of accepted Committee recommendations. It has however been pleased to note that its recommendations have been incorporated in many of the Child Protection Reform process projects. The Department has accepted with little variation the vast majority of the recommendations made this year and this is a marked improvement on previous years where existing policies and guidelines were referenced and little or no action proposed.

The number of recommendations regarding interagency collaboration increased this year. This was due to the number of infants and possible suicide cases considered and therefore the involvement or not, of various health services. A key issue in this regard is the question of 'lead agency'. The Department responded to a number of the Committee's recommendations regarding interagency collaboration, by saying that it was not the 'lead agency'. This is not an unreasonable response given the existing arrangements between the relevant agencies, but it begs the question of which agency will take responsibility for the overall management of a situation where children alive or unborn are at risk.

5. Conclusion

Clearly the greatest risk factors for the child deaths subject to review are being 'known' to the Department and being Aboriginal and living in the North of the State. Co-sleeping has also been a feature of a number of the deaths. How this relates to the deaths is as yet unknown.

The suicide death of Susan Taylor in 1999 was a catalyst for the establishment of the Committee. It is an indictment that almost a decade later child suicide, particularly Aboriginal child suicide is a major concern.

At the risk of being boringly repetitive, the Committee, as in previous years, is still of the view that the Department should seriously consider the introduction of an intensive intervention program for at risk families where chronic neglect is present. The Corrective Services Intensive Supervision program continues to produce very positive results for the families involved and at the very least should be investigated by the Department

There have been some very positive developments this year in that the Committee's recommendations have been incorporated in the Child Protection Reform process. Furthermore, in responding to individual case recommendations the Department appears to be more action oriented than in previous years. Unfortunately little has changed with regard to the characteristics of the cases reviewed and therefore the recommendations made. The Committee is mindful that major reform of the child protection system will take time and that statistically child deaths constitute a small part of the total picture. However, the child death reviews are critical for informing good practice. The monotonous repetition of the same recommendations reinforces their importance rather than diminishing their value.