

‘Child Deaths: Child Abuse, Family Violence and the Child Protection System’: Paper presented at XIth ISPCAN European Conference on Child Abuse and Neglect, 18-21 November 2007, Lisbon, Portugal.

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Introduction

“There is probably no other crime that attracts more public condemnation and media attention than the murder of a child.” (Davies and Mouzos, 2007).

In the few weeks before coming to this conference, the deaths of two children dominated the attention of the media in Australia.

Seven-year-old Shellay Ward was found dead, apparently from starvation, at her home north of Newcastle (Madden, 2007).

Two-year-old Dean Shillingsworth’s body was found in a suitcase floating in a pond in Sydney’s south-west (Madden, 2007).

As in the case of these two children, a worrying proportion of deaths due to child abuse and neglect take place among children known to the child protection system (Hochstadt, 2006).

The incidence of child deaths attributable to abuse and neglect are hard to assess and in general are seen as considerably underestimated (Herman-Giddens et al. 1999; Hochstadt, 2006).

Children who are younger are particularly at risk of death and serious injury (Hochstadt, 2006).

Increased community concern over child deaths, particularly child homicides, is one of the key reasons for the development of child death review processes around the world (CCT, 2006).

The first child death review team was developed in Los Angeles in the USA in 1978 following increased concern about child deaths as a result of abuse (Hochstadt, 2006) and

of the underreporting of child abuse deaths (Rimsza et al, 2002). The inadequacy of sources for accurately identifying causes of unexpected deaths among children was recognized and processes for reviewing child deaths were developed (Webster et al. 2003). A multidisciplinary, multi-agency process was seen as an effective way of determining if abuse was a factor in a child's death, as abuse is harder to conceal and less likely to be overlooked when information in relation to the child and the circumstances of death are shared by professionals from different agencies and disciplines (Webster et al. 2003).

During this team's first five years of operation, the cause of death in seven child fatality cases was changed from "natural or accidental" to "death at the hands of another"; as well, one case was reclassified from "homicide" to "natural death." (Elster and Alcalde, 2003).

Multidisciplinary, multi-agency review processes can reduce misclassification of deaths, identify specific interventions for surviving family members, develop public policy to address the prevention of child deaths from abuse, and prevent future deaths (Webster et al. 2003; Hochstadt, 2006).

Indeed, the major purpose of child death reviews is the prevention of future deaths and the improvement of systems providing services to children (Hochstadt, 2006).

Most Australian states and territories have child death review processes, which generally have two separate features (CCT, 2006):

- The first is to conduct reviews into the circumstances of individual child deaths, where the focus is on deaths attributed to abuse or neglect or deaths of children formerly known to the child protection authority, with the aim of establishing whether improvements to practice, policy, legislation or relationships between agencies could decrease the risks of future deaths. Thus, the child death review process provides a mechanism for quality assurance and review of child protection systems.
- The second is to analyse child deaths from all causes and conduct further research into child mortality and morbidity. The aim of this research is to obtain greater understanding of the causes of child death to assist in its prevention or reduction. Recommendations for the prevention and reduction of child deaths are aimed at the community, agencies and government, encompassing a wider focus than the child protection system itself.

The number and purpose of bodies involved in the child death review process vary around Australia (CCT, 2006).

Child death review processes in Australia

Tucci, Goddard and Stevens (2004) have produced a set of best practice benchmarks in relation to child death review systems which will be used to help frame an evaluation of Australia's child death review processes. The benchmarks to be considered are:

1. A formal Child Death Review Team (CDRT) is established;
2. The CDRT has a multidisciplinary composition. A multidisciplinary approach provides a range of perspectives to assist in identifying relevant social, medical, economic, familial, and agency factors (Elster and Alcalde, 2003). A multidisciplinary membership is particularly useful when considering the involvement of other agencies, as well as the child protection authority (CCT, 2006);
3. The CDRT is legislatively based. Establishment in legislation is an important way to protect the independence of the CDRT (CCT, 2006);
4. The CDRT is independent. Independence is essential so that the findings and recommendations of the CDRT are not influenced in favour of the government whose services are being reviewed (CCT, 2006). Preferably, the CDRT should be located externally to the department responsible for child protection and attached to an office that is independent of government (CCT, 2006);
5. The CDRT has a broad scope of review when considering child deaths.
6. The CDRT has the capacity to evaluate the role of agencies or services involved in addition to the child protection authority. Many reports which have recommended the establishment of child death review systems have recognized the necessity of looking beyond the role of the child protection authority in regard to a child's death (CCT, 2006);
7. The CDRT has a public reporting process. This is seen to contribute to the level of independence of the review body, as where findings and recommendations are made public, governments will be more accountable to act on the issues identified (CCT, 2006).

This next section will outline the key child death review processes in each state and evaluate them against the benchmarks.

Victoria

Key processes:

- The Victorian Child Death Review Committee (VCDRC) was established in 1995 (CYPCGQ (a), 2005-06).
- The VCDRC is a multidisciplinary ministerial advisory committee consisting of members from the health, welfare, police, legal and academic fields (VCDRC, 2007).
- It reviews child death inquiries which have been prepared by the Office of the Child Safety Commissioner's Inquiries and Review Unit (VCDRC, 2007).

- The VCDRC focuses on examining the deaths of all children and young people who were child protection clients when they died or within three months of their death (VCDRC, 2007).
- Individual child death inquiries in Victoria are intended to ascertain the facts of the child protection case, determine whether recognized child protection procedures, standards, guidelines and protocols were followed when managing the case, and scrutinize the case management decisions and actions of the Victorian Department of Human Services and other agencies for adequacy and appropriateness in terms of service provision to the client (VCDRC, 2007).
- The VCDRC produces an annual report which presents quantitative and demographic data in relation to the deaths of children known to child protection, and also provides qualitative analysis of child death inquiries reviewed by the VCDRC (VCDRC, 2007).
- The VCDRC reviewed a total of 13 child deaths between April 2006 and March 2007. Five were described as a result of acquired/congenital illness, two from accidents, two from non-accidental trauma and one from suicide (VCDRC, 2007).

Evaluation against benchmarks:

1. A formal body is in place in Victoria.
2. The Victorian CDRT is multidisciplinary.
3. In Victoria the CDRT is a ministerial advisory committee and does not have supporting legislation (CCT, 2006).
4. The Victorian CDRT is supported by the Office of the Child Safety Commissioner. However, in Victoria the Child Safety Commissioner is responsible to the Minister, in contrast to states which have independent children's commissioners, and is therefore restricted in its ability to act independently (Liddell et al. 2006).
5. Victoria does not adopt an epidemiological approach and review the deaths of all children. Child deaths are only reviewed where the child was known to the child protection system at the time or three months before their death (VCDRC, 2007). This timeframe is significantly less than all other states and territories in Australia (CCT, 2006).
6. In Victoria, a range of health and human services are required to provide information to the Child Safety Commissioner in relation to a child who is the subject of an inquiry (VCDRC, 2007). However, the CDRT relies on material provided to it by the Inquiries and Review Unit in the Office of the Child Safety Commissioner and has no power to gather further material (CCT, 2006). In Victoria, the CDRT is able to comment on the contribution of other relevant service providers associated with the child or their family, as well as the child protection authority (CCT, 2006).
7. The Victorian CDRT reports and provides advice on the child death inquiry process to the Minister for Children and the Minister for Community Services,

and also prepares an annual report which is tabled in Parliament (CCT, 2006). This report includes recommendations with regard to practice and policy reform (VCDRC, 2007).

New South Wales

Key processes:

- The New South Wales Child Death Review Team (CDRT) commenced in 1995. Its purpose is to prevent or reduce the number of child deaths in New South Wales (NSWCDRT, 2006).
- The CDRT's members include experts appointed by the Minister for Community Services covering health care, research methods, child development and child protection. It also has nominees from government departments concerned with the safety and well-being of children. There are 16 members including two Aboriginal members (NSWCDRT, 2006).
- The CDRT produces an annual report which aims to identify causes of death of children and young people. It also examines factors connected with the deaths and considers trends and patterns. It makes recommendations for prevention and notes the degree to which previous recommendations have been accepted and carried out in practice (NSWCDRT, 2006)
- The CDRT originally reviewed child deaths from abuse or neglect, or which occurred in suspicious circumstances. However from December, 2002, the NSW Ombudsman took responsibility for reporting on these deaths. Certain other circumstances are also reviewable by the Ombudsman, including deaths of siblings of children known to child protection, and deaths of children in care, in a detention or correctional centre or a residential centre for children with disabilities (CYPCGQ, 2004-05; CYPCGQ (a), 2005-06).
- The Ombudsman reviewed the deaths of 117 children in 2005. In 109 of these cases the death was reviewable because the child or their sibling had been subject to a report to the Department of Community Services (DoCS) in the three years before they died. The other eight were reviewed because their deaths were as a result of abuse or neglect or were in suspicious circumstances. Of the children known to DoCS, 25 deaths were due to abuse or neglect, or happened in suspicious circumstances (NSW Ombudsman, 2006).

Evaluation against benchmarks:

1. A formal body is in place in New South Wales.
2. The New South Wales CDRT is multidisciplinary.

3. In New South Wales, the CDRT is legislatively based (CCT, 2006). The purpose and functions of the CDRT are specified in the *Commission for Children and Young People Act 1998* (NSWCDRT, 2006).
4. In New South Wales, the Ombudsman is an independent office which carries out child death reviews which are separate and independent from the internal review of the Department of Community Services (CCT, 2006).
5. New South Wales child death review processes have a broad scope of reviewable cases, including such circumstances as where death may be due to abuse or neglect or which occurs in suspicious circumstances, where the child was in care or custody, or where a child had a disability and was living in residential care (CYPCGQ, 2004-05). In New South Wales, the timeframe for contact with the child protection system prior to death is three years, which is the equal longest time period in Australia (CCT, 2006).
6. In New South Wales, the review body is able to comment on the involvement of other service providers involved with the child's family, as well as the child protection authority, and is also able to comment on the actions of individual workers and to recommend disciplinary measures (CCT, 2006). Legislation requires departments, agencies and individuals to provide the CDRT with full and unrestricted access to records reasonably required in exercising its functions (NSWCDRT, 2006).
7. The New South Wales CDRT produces an annual report which aims to identify causes of death, factors linked with deaths, trends and patterns, and make recommendations for prevention (NSWCDRT, 2006). The New South Wales Ombudsman also produces an annual report, and may from time to time present a special report to Parliament during the year which details the facts of an individual case (CYPCGQ, 2004-05).

Queensland

Key processes:

- The reports of two key government agencies, the Ombudsman in 2003 and the Crime and Misconduct Commission in 2004, which both demonstrated deficiencies in the Queensland child protection system, led to the introduction of child death review functions in Queensland, commencing on 1 August 2004 (CYPCGQ (a), 2005-06).
- The main process in Queensland's child death review system involves reviews undertaken by the Department of Child Safety in the first instance, with the Child Death Case Review Committee (CDCRC) providing oversight of these (CCT, 2006). The Department of Child Safety is required to supply the CDC with a report within six months of the child's death (CYPCGQ (a), 2005-06).

- The CDCRC is a multi-disciplinary committee made up of experts in paediatrics, child health and investigations. The Commissioner for Children and Young People and Child Guardian is the Chair (CYPCGQ (a), 2005-06).
- The Child Death Case Review Committee Annual Report, 2004-05: Reviews of child deaths known to the Queensland child protection system was submitted to the Premier in October 2006 (CYPCGQ (a), 2005-06). The Annual Report, Deaths of Children and Young People Queensland 2005-06 was also submitted in 2006 (CYPCG (a), 2005-06).
- Nine children died from fatal assault in Queensland between July 2005 and June 2006: 3 deaths resulted from fatal child abuse, 2 from domestic homicide, 2 from domestic violence and 2 were classified as 'other'. Six of the 9 children whose deaths were due to fatal assault were known to the Department of Child Safety (CYPCGQ (b), 2005-06).

Evaluation against benchmarks:

1. A formal body is in place in Queensland.
2. The Queensland CDRT is multidisciplinary.
3. In Queensland, the CDRT is legislatively based (CCT, 2006). The functions of the CDRT are detailed in the *Commission for Children and Young People and Child Guardian Act* (CYPCGQ (a), 2005-06).
4. The Child Death Case Review Committee in Queensland is located with and supported by the independent Commission for Young People and Child Guardian and is an independent body established under the *Commission for Children and Young People and Child Guardian Act* (CCT, 2006).
5. Queensland's scope for reviewable cases is restricted to deaths of children who were clients of the child protection authority, and had contact with the authority in the previous three years (CCT, 2006).
6. In Queensland, the review body only has the ability to make recommendations directed at the department responsible for child protection. It can, however, make recommendations concerning the department's relationship and communication with other government departments, and in some cases, non-government agencies (CCT, 2006).
7. In Queensland, both the review and research bodies submit annual reports (CYPCGQ (a), 2005-06).

South Australia

Key processes:

- The establishment of the Child Death and Serious Injury Review Committee was a key recommendation of the Layton Report, a comprehensive review of child protection, presented in 2003 (CYPCG, 2004-05). The Committee's purpose is to review cases of child deaths or serious injuries and to identify legislative or administrative means of preventing deaths and injuries in the future (South Australia CDSIRC, 2005-2006).
- No other CDRC in Australia has the capacity to provide an in-depth review of cases where a child has been seriously injured and survived (South Australia CDSIRC, 2005-2006).
- The Committee was formally established in legislation in 2006 with the Chair and members officially appointed by the Governor (South Australia CDSIRC, 2005-2006).
- The Committee is a Ministerial Advisory Committee which reports to the Minister for Families and Communities annually and as required. The Committee's annual report is tabled in Parliament by the Minister (South Australia CDSIRC, 2005-2006).
- The South Australian Committee is multi-disciplinary with members drawn from a range of areas including child forensics, psychology, advocacy, health, justice and Aboriginal and youth issues (South Australia CDSIRC, 2005-2006).
- Although the Committee includes the review of serious injury, in 2005-2006 it has not reported on its incidence or conducted in-depth reviews. The Committee reports that it requires further resources to begin work in this area (South Australia CDSIRC, 2005-2006).
- Four children died from fatal assault or neglect in 2005. These children's deaths may be subject to in-depth review by the Committee, once coronial and criminal investigations have been concluded (South Australia CDSIRC, 2005-2006).

Evaluation against benchmarks:

1. A formal body is in place in South Australia.
2. The South Australian CDRT is multidisciplinary.
3. In South Australia, the CDRT is legislatively based (CCT, 2006). The legislation establishing the CDSIRC is contained in Part7C of the Children's Protection Act (South Australia CDSIRC, 2005-2006).
4. The Committee is assisted by a secretariat located within the Department for Families and Communities, and its administrative, financial and human

resource management is overseen by this department (South Australian CDSIRC, 2005-2006).

5. The South Australian timeframe for contact with the child protection system prior to death is three years. The scope of child death review is broad, as the review body has discretion to review any child death or serious injury, not just those known to the child protection authority (CCT, 2006). It also has the capacity to conduct an in-depth review of cases where a child has been seriously injured and survived, which is not possible in any other state or territory (South Australia CDSIRC, 2005-2006). The Layton Report (2003) has commented that one of the deficiencies of child death reviews is that they do not include serious injury. It explains that such events may be equally as instructive as examining cases of fatal child abuse, and involve similar warning signs and causal factors (CCT, 2006).
6. The South Australian review body is able to comment on other service providers involved with the child or their family, in addition to the child protection authority, and has comprehensive statutory powers to collect information from relevant sources (CCT, 2006).
7. In South Australia, the CDSIRC reports to the Minister for Families and Communities annually and as required, with its annual report being tabled in Parliament by the Minister (South Australia CDSIRC, 2005-2006).

Western Australia

Key processes:

- The child death review process in Western Australia was established following the Gordon Inquiry into child abuse and family violence, which reported in 2002. A key recommendation of this inquiry was the establishment of an independent committee to investigate child deaths (CDRC Western Australia 2006).
- In 2003, two committees were formed:
- The Child Death Review Committee (CDRC), which was designed to provide quality assurances in cases where a child known to the department had died, and
- The Advisory Council on the Prevention of Deaths of Children and Young People to examine trends for all child deaths with the aim of applying preventative strategies (CDRC Western Australia 2006).
- Both the CDRC and the Advisory Council provide annual reports (CYPCGQ (a), 2005-06).
- The CDRC scrutinizes cases in reference to existing Departmental policies, procedures, guidelines, standards, research and legislation. Recommendations are made in relation to any deficiencies identified. It also indicates whether any

issues need to be considered more broadly through research (CDRC Western Australia 2006).

- The conversion of the Committee's recommendations into policy, procedures and practice by the Department are seen as critical to improving service provision. Six monthly reports from the Department as to the extent to which the Committee's recommendations have been implemented are required (CDRC Western Australia 2006).
- In 2005-2006, the number of reportable child death coroner notifications received by the Department for Community Development (DCD) was 100; the number of child death notifications involving contact with the DCD was 55; and the number of child deaths referred and warranting review by the Child Death Review Committee was 14 (CDRC Western Australia 2006).

Evaluation against benchmarks:

1. A formal body is in place in Western Australia.
2. The Western Australian CDRT is multidisciplinary.
3. In Western Australia the review body is established by Order in Council (CCT, 2006)
4. In Western Australia, the Committee is physically located within and given administrative and research support by the Department for Community Development (CCT, 2006).
5. In Western Australia, the timeframe for contact with the Department for Community development is 24 months before death (CCT, 2006). Western Australian child death review processes have a broad scope of reviewable cases, including where family members have come to the notice of the Department, or the child has been in an out of home care placement (CCT, 2006; CDRC Western Australia, 2006).
6. In Western Australia, the Committee's role is to focus on the policies, procedures and systems of the Department (CDRC Western Australia, 2006).
7. In Western Australia, annual reports are provided by both the CDRC and the Advisory Council (CYPCGQ (a), 2005-06).

Australian Capital Territory

Key processes:

- In 2004, the Vardon Report, which undertook a review of child protection in the ACT, recommended the formation of a child death review team (CYPCGQ (a), 2005-06).
- The ACT Child Death Review Team takes a multi-disciplinary interagency approach to preventing and reducing children's and young person's deaths. Members include experts in health care, research methodology, child development and child protection (ACT Child Death Review Team, 2006).
- The Team's role is to prepare recommendations to assist policy makers in developing policies and practices to help prevent, or reduce, child deaths in the ACT. This is achieved by two means: firstly, the provision of recommendations from the interpretation of data trends and patterns; and secondly, carrying out reviews to demonstrate the degree to which previous recommendations have been put into practice (ACT Child Death Review Team, 2006).
- The Team has undertaken detailed case reviews of child deaths in the ACT in certain circumstances, such as deaths within educational environments, deaths of children of parents with a mental illness/drug addiction, child suicide, children in care or custody, and autopsies particularly for suspected deaths from Sudden Infant Death Syndrome (SIDS) (ACT Child Death Review Team, 2006).

Evaluation against benchmarks:

1. A formal body is in place in the ACT.
2. The ACT CDRT is multidisciplinary.
3. The ACT CDRT does not have specific legislation underpinning its operations (ACT Child Death Review Team, 2006).
4. In the ACT, the Vardon Report recommended that the Child Death Review Team should be located within an independent agency, such as a proposed Commissioner for Children and Young People, rather than within ACT Health, however this recommendation has not been acted upon (CYPCGQ (a), 2005-06).
5. The CDRT maintains a Child Death Register of the deaths of all children and young people 0-17 years in the ACT, and undertakes detailed case reviews in certain circumstances, such as deaths within educational environments, deaths of children of parents with a mental illness/drug addiction, child suicide, children in care or custody, and autopsies particularly for suspected deaths from Sudden Infant Death Syndrome (SIDS) (ACT Child Death Review Team, 2006).

6. The CDRT has access to a number of data sources including Australian Bureau of Statistics data on cause of death, National Coronial Information System, and clinical data from hospitals in the ACT (ACT Child Death Review Team, 2006).
7. At this time, the ACT CDRT has helped compile a statistical report on child deaths for the period 1992-2003 (CYPCGQ (a), 2005-06).

Tasmania

- There is no permanent, independent child death review process in Tasmania. However, in 2006 the Commissioner for Children, Tasmania, prepared detailed advice to the Minister for Health and Human Services on a Child Death Review Process for Tasmania (CCT, 2006).

Northern Territory

- The Northern Territory currently has no child death review process. The development of new legislation (the draft Care and Protection of Children and Young People Act) provides for the establishment of a Child Death Review and Prevention Committee. It is expected that this committee will have a child death research role and will not undertake individual child death reviews (CCT, 2006).

Discussion

As noted earlier, the inadequacy of means of accurately identifying causes of unexpected deaths among children led to the development of child death review processes as a way of determining if abuse was a factor in a child's death (Webster et al. 2003).

The major purpose of child death reviews is the prevention of future deaths and the improvement of systems providing services to children (Webster et al. 2003).

For child death review processes to be effective and lead to accurate identification of the causes of unexpected child deaths, a number of key features are necessary. In this review, a selection of benchmarks in relation to child death review processes by Tucci, Goddard and Stevens (2004) has been used to help in evaluating the processes in place in Australia.

Most states and territories in Australia, apart from Tasmania and the Northern Territory, have put in place formal child death processes; however these processes vary considerably.

Two important features on which they differ are their level of independence and their scope of review.

In some states the CDRT is clearly independent, such as in Queensland where it is located with and supported by the independent Commission for Young People and Child Guardian (CCT, 2006). Similarly, in New South Wales, child death reviews are carried out by the Ombudsman, which is an office separate and independent from the Department of Community Services (CCT, 2006). Such independent processes are not always established even when they are recommended, however. In the ACT, the Child Death Review Team, although recommended by the Vardon Report to be located within an independent agency in the form of a proposed Commissioner for Children and Young People, still remains within ACT Health (CYPCGQ (a), 2005-06). In Victoria, although the CDRT is supported by the Office of the Child Safety Commissioner, the Commissioner is responsible to the Minister, and therefore is not fully independent (Liddell et al. 2006).

The scope of review is another important point of difference. In order to be of most value in achieving the goal of accurate identification of causes of unexpected death among children, a broad scope of review is necessary, both in terms of time and of categories of cases. In New South Wales, child death review processes have a broad scope of reviewable cases, including such circumstances as: where death may be due to abuse or neglect; may involve suspicious circumstances; where the child was in care or custody; or where a child had a disability and was living in residential care (CYPCGQ, 2004-05). In New South Wales also, the timeframe for contact with the child protection system prior to death is three years, which is the equal longest time period in Australia (CCT, 2006). In contrast, Victoria does not review the deaths of all children, only conducting a review where the child was known to the child protection system at the time of or three months prior to their death, with this timeframe being significantly less than all other states and territories in Australia (CCT, 2006). A narrow scope can lead to the situation where many fewer children's deaths are reviewed: in Victoria, 13 children were reviewed in their latest report (VCDRC, 2007), whereas in New South Wales, 117 were reviewed (NSW Ombudsman, 2006).

A significant difference from other child death review systems is in South Australia, where the review body has the capacity to conduct an in-depth review of cases where a child has been seriously injured and survived, which is not possible anywhere else in Australia (South Australia CDSIRC, 2005-2006). If a CDRC is going to be able to fulfill its purpose effectively, it needs to be able to look at wide range of both deaths and also cases of serious injury, as there are many similar features between the two situations, where death or serious injury may simply be a matter of chance (Stanley and Goddard, 2002).

Conclusion

A process of continuous independent review of possible systemic problems is necessary for improvement of services in this area (Layton, 2003).

As stated by Goddard (2007), "all child deaths should be reviewed whether or not the children were already known to Child Protection."

All state and territory governments should enter into a process of co-operation with the Federal government to put in place a nationally co-ordinated system to review the deaths of all children (Goddard, Stevens and Tucci, 2003).

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