Child deaths reviews:
The challenge of making a difference

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CHILD DEATHS REVIEWS: THE CHALLENGE OF MAKING A DIFFERENCE

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OVERVIEW

- Context in which Child Fatality Review mechanisms operate
- Child homicide data in Australia
- Common findings of Review Panels
- Risk and Safety
- Review Mechanisms and the challenge of multi-system change in the current environment
- Bringing about complex multi-system change

CHILD DEATH REVIEW MECHANISMS

- Fatality reviews are ultimately intended to be a violence reduction and fatality prevention strategy
- Internationally used mechanism to review systems and aim to move beyond looking for the faults of individual practitioners
  - Policy and legislation
  - Organisational operating procedures and practices
- Identify **common** risks, concerns, poor policy and practice which can be reformed

CHILD DEATH REVIEW MECHANISMS

This emphasis on highlighting system-wide areas of change, rather than just individual-level factors, can be seen in the community-level recommendations issued by contemporary DVFR teams. (Storer et al 2013)

CONTEXT IN WHICH CHILD DEATH REVIEW MECHANISMS OPERATE

- Morally confronting and highly emotional social and political context
  - About ‘the unthinkable’
  - Culture of individualising blame to the offenders and to those individuals and agencies responsible for the care, wellbeing and protection of children
  - Belief in the community that all such types of deaths can and should be prevented
  - Values remain about privacy and sanctity of family
    - Parents’ rights and children’s rights

CONTEXT IN WHICH CHILD DEATH REVIEW MECHANISMS OPERATE

- The unspeakable
  - Preventable child deaths will continue to occur
  - It is likely more children would die from preventable causes without existing intervention systems and professionals/practitioners

NATIONAL HOMICIDE MONITORING PROGRAM 2008-2010 (AIC)

- 27 Victims of filicide
- 22 Perpetrators of filicide
  - Perpetrator is parent or step parent of child
- (

Age	Number
Under 1	12
1-9	19
10-14	8
15-17	10

NATIONAL HOMICIDE MONITORING PROGRAM 2008-2010 (AIC)

- 27 Filicide victims – 2 were Indigenous
- Indigenous homicide across all age groups is 4 time higher than for non-Indigenous population
- Notable that for Indigenous population stranger homicide is lower and consistently over time

COMMON FINDINGS OF CHILD FATALITY PANELS

MACRO/STRUCTURAL

- Legislation, policy and procedure did not support pro-active response
- Relatively low levels of State expenditure on Social and Health Portfolios

ORGANISATIONAL

- Lack of information sharing or limited amount of information shared
- Large caseloads and risk assessments completed some time ago when not considered high
- Key agencies did not have all necessary information about family and risk

COMMON FINDINGS OF CHILD FATALITY PANELS

PRACTICE ORTHODOXIES

- Adult focused services limited engagement with child focused and child safety
- Adult focused services did not assess for risk to child or agency had no mechanism for assessing risk of harm to children or parent
- Assessment of risk patchy and variable across agencies and professionals
- CP lack of engagement of men, especially men identified as DFV perpetrators

COMMON FINDINGS OF CHILD FATALITY PANELS

FAMILIAL & INDIVIDUAL RISKS

- 3 Most Common reasons for CPS Referral
  - DFV,
  - Substance dependence,
  - Serious mental illness
- Parents or care givers actively deceived authorities
- Risk indicators: history of violence related crime

PROXY MEASURES OF SAFETY CONCERNING RISK OF VIOLENCE

- Non-offending parent has taken out civil protection order
- Non-offending parent has moved out of home to increase children's safety
- Parent or primary carer is in receipt of counselling or treatment for substance misuse
- Parent or primary carer is receiving support for serious mental ill health (including compliance with medication regime)
- Parent or primary carer attending program as directed by authorities

REVIEW MECHANISMS AND IMPLEMENTING SYSTEM CHANGE

Unlike legislative policies that frequently contain incentives or penalties to promote implementation, voluntary policy reforms rely on persuasion and community prioritization to implement the desired policy response (Storer et al 2013).

FATALITY REVIEW MECHANISMS AND IMPLEMENTING SYSTEM CHANGE

- Large body of literature about the 'implementation gap' in aiming to bring about change or transforming how organisations and practitioners operate

- Front line worker discretion – Lipsky

- Contemporary context: multiple layers of discretion and potential for variability – contracting out, government and not-for-profit services

BRINGING ABOUT SYSTEMIC CHANGE

- David Mandel & Associates
  Safe & Together: Shifting the Paradigm
  (www.endingviolence.com)
- System Practice Continuum Chart
  - Domestic violence informed child welfare system

SYSTEM PRACTICE CONTINUUM (DAVID MANDEL & ASSOC)

- Domestic violence destructiveness
- Domestic violence incapacity

- Domestic violence blindness
- Domestic violence pre-competence

- Domestic violence competence
- Domestic violence proficiency

SYSTEM PRACTICE CONTINUUM (DAVID MANDEL & ASSOC)

- **Destructiveness**: Increase harm
- **Incapacity:** Greater knowledge of risks and harm but focus tends to be on non-offending parent

- **Blindness:** Practitioner awareness but no policy or specialist responses
- **Pre-competence:** external stakeholder driving change still largely individual practitioner commitment

- **Competence**: Tangible policy and specialist practice. Org commitment
- **Proficiency:** Workforce development, practice orthodoxy, across whole of organisation

CONCLUSIONS AND FUTURE

- Fatality review mechanism vary across jurisdictions for child and DFV fatalities
- Commonly they all seek system change to bring about prevention
- Draw out policy and system change from individual experiences
- Hard to measure: their effectiveness as other reforms and changes are co-occurring

CONCLUSIONS AND FUTURE

- Internationally, identify many common issues for those situations where preventable deaths occur
- Implementation gap – difficulty to transform multi-system and individual practitioner responses
- Influencing multi-system change
  - Policy reform
  - Workforce development - large scale
  - Creating new practice orthodoxies across multiple organisations