CCYPD/19/10882 | October 2019

Lost, not forgotten

Inquiry into children who died by suicide and were known to Child Protection

COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

The Commission respectfully acknowledges and celebrates the Traditional Owners of the lands throughout Victoria and pays its respects to their Elders, children and young people of past, current and future generations.

Suggested citation
Commission for Children and Young People, *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection* (Melbourne: Commission for Children and Young People, 2019).

Ordered to be published
Victorian Government Printer, October 2019,
No. 71 Session 2018–19

ISBN 978-0-9945296-9-5

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COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

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Dear Mr Young and Ms Noonan

Lost, not forgotten – Inquiry into children who died by suicide and were known to Child Protection

I hereby request that the Inquiry report produced by the Commission for Children and Young People be tabled in accordance with section 50 of the *Commission for Children and Young People Act 2012* (the Act).

I would be grateful if you could arrange for the report to be tabled in both the Legislative Council and Legislative Assembly on 30 October 2019.

I confirm that the Minister for Child Protection and the Secretary to the Department of Health and Human Services have each been provided with a copy of the Inquiry report in accordance with section 49 of the Act.

Yours sincerely

Liana Buchanan

Principal Commissioner

15 October 2019

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Looking after yourself

This inquiry features descriptions of reported harm and abuse that may be confronting and in some cases, distressing. If anything in this inquiry causes you to feel distress, it is really important that you take steps to look after yourself and talk to someone about your feelings.

The following 24-hour supports are available to help you.

For children and young people

- Kids Helpline: 1800 551 800
  kidshelpline.com.au
- Headspace: 1800 650 890
- ReachOut: **au.reachout.com**

Other resources

- Life in Mind (suicide prevention portal):
  lifeinmindaustralia.com.au
- Head to Health (mental health portal):
  headtohealth.gov.au
- SANE (online forums): **saneforums.org**

For adults

- Lifeline: 13 11 14
  lifeline.org.au
- Suicide Call Back Service: 1300 659 467
  suicidecallbackservice.org.au
- Beyond Blue: 1300 224 636
  beyondblue.org.au/forums
- MensLine Australia: 1300 789 978
  mensline.org.au

Message from the Commissioners

It is devastating to think of someone's life feeling so unbearable that they have no hope for the future, and even more devastating when a child or young person takes their own life. Yet this is, tragically, more common than it should be. For adolescents aged between 15 and 17 years, or Aboriginal children aged between five and 17 years, it is the leading cause of death.

In our role as commissioners for Victoria's children and young people, we are required to review the circumstances of every child who dies having had Child Protection involvement in the 12 months preceding their death. The purpose of this is to examine how effectively risks were managed and whether services provided to the child and their family were adequate and appropriate. Where these inquiries reveal weaknesses, we make recommendations designed to strengthen the service response.

Some of the children whose experiences we review through our child death inquiries have taken their own lives, sometimes at a very young age. Sadly, when we look at these children's lives, we see some distressing themes emerge. In this inquiry we examine these themes, tell the stories of 35 children who died through suicide between 2007 and 2019, and reflect on the responses these children received from different service systems.

These children's lives were marred by family violence, dysfunction and often chronic neglect. For many, their parents' capacity to care for them was impeded by mental illness and/or substance abuse. Half of the children were thought to have experienced sexual abuse. Aboriginal children were overrepresented in the cases we reviewed and their experiences were compounded by the additional pain of intergenerational trauma and grief.

The systems we hope and expect will protect children from adverse experiences did not serve these children well. This report shows that, despite repeated and

often early reports to Child Protection, many cases were successively closed and critical opportunities for much-needed intervention and support missed. Where Child Protection referred these children's families for further support, they were lost in a referral roundabout across a fragmented service system. This meant that despite multiple reports and often severe levels of harm, nothing changed for these children.

This pattern is not unique to the children who come to our attention because they commit suicide. Indeed, we see the pattern described in this inquiry in most of our child death inquiries involving older children; a pattern of multiple reports to Child Protection, followed by case closure, referral to child and family services, followed by no engagement and no effective intervention.

This report also illustrates how, as children grow older and their trauma starts to manifest in challenging behaviour, disengagement from school, risk taking, violence or mental ill health, professionals lose empathy. The children become seen as the problem. Our reviews found these children referred to as 'difficult', 'needy', 'angry' and 'bad'.

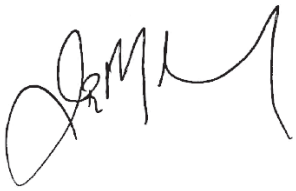
This report highlights the chasm between formal, coercive child protection interventions and a child and family service system reliant on voluntary engagement. Many of the children in this inquiry fell squarely into this system gap.

We initiated this inquiry because these children's experiences are otherwise invisible. Yet, as a community, we need to confront how many children we fail. We need to understand the need for investment in child and family services, in the development of new, intensive models of service to work with families who are struggling, to support parents to address the issues that are preventing them from giving their children safe and loving childhoods. We need to recognise the devastating impact of our current service system on the youngest and most vulnerable members of our community.

The last five years has represented a time of significant reform by the Victorian Government. We have seen efforts to transform responses to family violence and investment in the Child Protection workforce. These efforts are welcome and long overdue. However, this report reinforces that more is needed; radical reform and investment to improve early intervention and better protect children is necessary if we are to prevent the suffering described in this report.

Of course, one limitation of this report is that we could not speak to the 35 children themselves. But from file notes and descriptions we gleaned a sense of children who, despite their circumstances, were incredibly brave and wise beyond their years. Many desperately craved help, safety and recovery for themselves and their families. They deserved hope. We trust their stories will contribute to change – and hope – for children today and in the future.

Liana Buchanan
Principal Commissioner



Justin Mohamed
Commissioner for Aboriginal Children and Young People

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Abbreviations and acronyms

ACCO	Aboriginal Community-Controlled Organisation
ACPP	Aboriginal Child Placement Principle
ADHD	Attention Deficit Hyperactivity Disorder
AFLDM	Aboriginal Family-Led Decision Making
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CCOPMM	Consultative Council on Paediatric Mortality and Morbidity
CCYP Act	*Commission for Children and Young People Act 2012* (Vic)
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
Child FIRST	Child and Family Information Referral and Support Teams
Commission	Commission for Children and Young People
CRIS	Client Relationship Information System
CSO	Community sector organisation (non-Aboriginal)
CYFA	*Children, Youth and Families Act 2005* (Vic)
CYMHS	Child and Youth Mental Health Service
Department	Department of Health and Human Services
IFS	Integrated Family Services
Inquiry	Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection

Definitions

Aboriginal

The term Aboriginal in this report refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a program, report or quotation.

The term Koori refers to Aboriginal people from south-east Australia.

Children

The term children in this report refers to children 0–17 years of age.

Child and family system

The service systems that supports vulnerable children and families, and includes family services (The Orange Door/Child FIRST, IFS (family services) and ACCOs), Child Protection and out-of-home care services.

Child death inquiry

Section 34 of the CCYP Act provides that the Commission must conduct an inquiry in relation to a child who has died and who was a child protection client at the time, or within 12 months, of their death.

Child Protection

The Victorian child protection program is delivered by the department and is specifically targeted for those children at risk of harm where parents are unable or unwilling to protect them.

Child FIRST/The Orange Door

Child FIRST provides a community-based referral point into integrated family services in a geographical area. Children and families are referred to Child FIRST where there are concerns about a child's wellbeing. Child FIRST assesses the risk to and needs of the child and the family, prioritises accepted referrals on the basis of need, then allocates to family services. Under current family violence reforms, Child FIRST is being incorporated into The Orange Door.

Cumulative harm

Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. It may be caused by an accumulation of a single recurring adverse circumstance or event or by multiple circumstances or events.

Development

Under section 3 of the CYFA, development means physical, emotional, intellectual, cultural and spiritual development.

Early intervention

Intervention that occurs when vulnerabilities have been identified for the child or their family. The role of child and family services is to provide critical, timely and responsive services before risks and concerns escalate and lead to Child Protection intervention.

Family service system

Relates to the part of the child and family system that provides family services, including Integrated Family Services.

Family violence

According to section 5 of the *Family Violence Protection Act 2008* (Vic) family violence is behaviour by a person towards a family member that is physically, sexually, psychologically or economically abusive; or is threatening, coercive or in any other way controls or dominates the family member to feel fear for their safety or the wellbeing of another person; or behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of these behaviours.

Harm

Under section 162 of the CYFA, harm encompasses physical injury, sexual abuse and damage to emotional or psychological development, physical development or health. It may result from a single act or omission, or circumstances may be cumulative.

Mental health system for children

The mental health system for children describes a system of funded mental health services for children with moderate to severe mental health problems.

Mental illness

A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. In this report, mental illness refers to a specific diagnosed disorder under section 4 of the *Mental Health Act 2014* (Vic).

Report (to Child Protection)

Consistent with the CYFA, 'a person may make a report to the Secretary if the person has a significant concern for the wellbeing of a child'.

Significant harm

The accepted definition of 'significant' within the child protection system means more than trivial or insignificant but need not be as high as serious; important or of consequence to the child's development and it is irrelevant that the evidence may not prove some lasting permanent effect or that the condition could not be treated.

Statutory child protection system

Relates to the part of the child and family service system that provides the legislative and policy frameworks to protect children from significant harm and neglect.

Suicide

Suicide is defined as 'the intentional taking of one's life.'[1] It is also a category of death; includes deaths due to suicide and high-risk taking behaviours.

Vulnerable child

According to section 5 of the CCYP Act, a vulnerable child includes:

- a child or young person who is or was a child protection client and/or a youth justice client
- a person attending a youth justice unit in accordance with an order of the Children's Court
- a child who is receiving or has received services from a registered community service
- a child who has died from abuse or neglect
- a person under the age of 21 years who is leaving or has left the custody or guardianship of the Secretary to live independently.

1 Mendoza, J, and Rosenberg, S, *Suicide and Suicide Prevention in Australia: Breaking the Silence*, Lifeline Australian and Suicide Prevention Australia, Sydney, 2010, p.12.

Executive summary

'If I died, would you love me? Would you cry?'
A child, aged 13

The Commission conducts a child death inquiry when a child dies, if they were a Child Protection client at the time of death or in the 12 months prior to their death. Through the review of the circumstances in which children's deaths occurred, the Commission identified a pattern in cases of children who died by suicide.

On 3 July 2019, the Commission established an own motion systemic inquiry pursuant to section 39 of the CCYP Act, into the deaths of 35 children from suicide between 1 April 2007 and 1 April 2019.

The inquiry is intended to build upon analysis completed by a previous (and untabled) systemic inquiry completed by the Commission, *Inquiry into issues of cumulative harm and suicide in child deaths* (Cumulative harm inquiry), completed in June 2018. The Cumulative harm inquiry examined the provision or omission of services to 26 children who died from suicide between 1 April 2007 and 22 December 2015, and had a strong focus on evaluating operational and practice-based issues. This inquiry examines a number of the same issues from a broader systemic perspective.

The inquiry provides an important opportunity to reflect upon service provision in the context of a child taking their life, however, it is essential to be clear about its limitations:

- First, this is an inquiry that is primarily focussed on examining the quality and effectiveness of Child Protection and child and family services delivered (or omitted to be delivered) to 35 children, many of whom had been known by Child Protection since early childhood, and the extent to which these services responded to their changing and often significant needs. The services delivered (or omitted to be delivered) to these children occurred in the context of reported abuse or harm and rarely as a result of these children being identified as at risk of suicide.
- Second, the child death inquiries reviewed span a 12-year period, between 1 April 2007 and 1 April 2019. During this time, the landscape has changed significantly. The Commission has exercised careful judgment in balancing the need to honour the experiences of all 35 children, while maintaining a measured focus on exploring systemic issues raised in more recent child death inquiries conducted in the last five years (n=15).
- Third, the constellation of events and characteristics that came together in these cases to produce an outcome of fatality cannot be distilled into a check list of predictive risk factors. The nature of harms experienced by these 35 children and the corresponding level and frequency of exposure, makes them in some ways indistinguishable from other children in contact with the child protection system. In most cases with similar characteristics and experiences, however, a child will not come to such catastrophic harm. Yet there are still opportunities to learn from the lives of these 35 children and the points at which service intervention may help to contain these risks.

- Fourth, this inquiry does not examine in detail the quality and effectiveness of mental health services delivered to these children. The *Commission for Children and Young People Act 2012* (CCYP Act) does not provide the Commission with jurisdiction to review the appropriateness or otherwise of clinical-decision making by a registered health or mental health practitioner. The Commission has focussed instead on identifying the points and scope of mental health service delivery, and its intersection with the child protection system.
- Fifth, it is important to acknowledge the limitations inherent with any review process that seeks to examine the quality and effectiveness of services being delivered to children, without hearing from children themselves. Where available, this inquiry has sought to capture and prioritise the voices and recorded experiences of the 35 children.

Purpose of the inquiry

In Victoria, the importance of earlier intervention has been a major focus of reforms to legislation, government policies and services delivered in the last two decades, including:

- the Victorian Government's 2005 White Paper *Protecting Children: the next steps* established the need for a more integrated system of children and family services, and resulted in the introduction of the *Child Wellbeing and Safety Act 2005* and *Children, Youth and Families Act 2005*
- the Department of Health and Human Services' 2012 *Vulnerable children: our shared responsibility strategy 2013–2022* identified a key role for learning and development services to achieve improved and more timely outcomes for vulnerable children and their families.

Early intervention is a focus of current child and family policy, *Roadmap for Reform: stronger families, safe children* (2016), which advocates for strategic reforms that support children and families in need, with integrated wraparound supports and targeted early interventions.

This inquiry represents an important opportunity to reflect upon the extent to which past reforms have delivered for vulnerable children and their families, and reinforce the need to ensure that ongoing reforms are prioritised for delivery.

What the inquiry found

The 35 children presented with multiple, often chronic, risk indicators that brought them into recurring contact with different service systems. Every recorded contact they had represented an opportunity for positive intervention, particularly in response to early concerns.

What they mostly received, however, was ineffective early intervention – characterised by delays, fragmentation, unsuccessful engagement and shallow focus – and a largely static response from Child Protection, who continued to receive, assess and close re-reports.

For the children, this meant that complex risks, such as exposure to family violence and parental substance misuse, became an entrenched feature of their lives. That mental health issues identified in early childhood remained untreated (beyond prescribed medication) until presenting symptoms escalated and they posed a significant risk of physical harm to themselves or others.

For these children, in almost every case nothing changed as a result of reports to Child Protection.

Nothing changed until the point of imminent crisis, usually much later in life, by which stage, the children were highly vulnerable and traumatised individuals, described variously as 'hard to help', 'needy', 'rageful', 'chaotic', and 'out of control'.

The Commission sees evidence of the systemic issues identified in this inquiry in all aspects of its work. These 35 children died by suicide, and that is a profound point of difference between them and most children known to Child Protection and the family service system. However, in almost all other respects, including the nature of risks identified and the extent to which the child and family system was equipped to respond to these risks, the experiences of these 35 children is reflective of a much wider experience.

The inquiry acknowledges there are inherent challenges in the delivery of intervention services to vulnerable children and their families, particularly where these services are voluntary and rely on families' preparedness to engage – but, if we are to protect children, these are challenges that must be met.

Demand versus investment in early intervention child and family services

The last decade has seen a rapid increase in demand for child protection and child and family services. It is widely acknowledged that the increase in demand has included an increase in demand for families experiencing 'complex' issues.

For example:

- reports to Child Protection have almost tripled in ten years, from less than 42,000 in 2007–2008 to more than 115,000 in 2017–2018
- the number of new cases opened by Child FIRST has increased six-fold in 10 years, from 3,888 in 2007–2008[2] to 22,332 in 2017–2018
- more than 80 per cent of families (18,130 cases) referred to Child FIRST in 2017–2018 presented with complex issues such as family violence, mental health, substance abuse and disability, compared with 66 per cent in 2013–2014, and 55 per cent in 2007–2008[3]
- more than half of families (6,402 cases) who received help from a family service in 2017–2018 were identified to have two or more complex issues, compared with one-third of cases in 2013–2014 (3,436 cases), and one-fifth in 2007–2008 (2,660 cases).

Currently, the demand for Child FIRST and family services exceeds the funding provided to the sector. This has been the case since 2011–2012.[4] Despite a 474 per cent increase in new Child FIRST cases in the last 10 years, funding to Child FIRST and family services has only increased by 176 per cent.

The department has, however, sought to address the need for longer-term responses for families experiencing complex issues by adopting a targeted approach. The Commission acknowledges that since 2014–2015, allocation of funding to Child FIRST and family services has shifted towards investment in the delivery of longer forms of family service response.

This means that cases allocated to a family service are now more likely to receive a longer and more intensive response than 10 years ago. For example, the average number of hours allocated per family by family services has increased from 29 hours in 2007–2008, to 79 hours in 2017–2018 – a 172 per cent increase in hours per case.

It is positive to note that targeted investment in the Child FIRST and family service sector has improved the type and intensity of response available to families. However, based on allocation rates from 2017–2018, only one in three cases featuring a complex issue will be allocated a family service.[5] Under the current system, families identified as having complex issues are nearly twice as likely to not be allocated a family service, and receive instead, only limited entry-level help from Child FIRST.[6]

At the same time, most of Victoria's investment in the broader child and family system is directed towards statutory services at the crisis end. Statutory services relate to those delivered by Child Protection in response to protective intervention and when a child enters out-of-home care.

For example, over the five years from 2013–2014 to 2017–2018, early intervention services received around a quarter of the total investment, with around three-quarters going into statutory child protection and out-of-home care services.[7] The Commission recognises that since 2017, considerable investment has been made into the rollout of The Orange Door.

This inquiry demonstrates however, that further investment and reform in line with the commitments made in *Roadmap to Reform* are urgently needed.

2 The Commission notes that the establishment of Child FIRST was based on a successful pilot between 2003 and 2006, and that full rollout of Child FIRST across Victoria did not occur until 2009–2010.

3 *Roadmap to Reform: stronger families, safe children*, Department of Health and Human Services, Victorian Government Printer, April 2016 at page 10.

4 *Early Intervention Services for Vulnerable Children and Families*, Victoria Auditor-General's Report, Victorian Government Printer, May 2015 at page 23.

5 Calculation based on 2017–2018 cases allocated an IFS (where there is an identified complex issue) (6,605 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 37 per cent allocation rate.

6 Calculation based on 2017–2018 cases not allocated an IFS (where there is an identified complex issue) (11,525 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 64 per cent non-allocation rate.

7 Based on interpretation of Report on Government Services data (see Table 3, page 32).

Suicide and adverse childhood experiences

In Victoria, suicide is the leading cause of death for children aged 15–17 years (30.4 per cent) and the cause of 12.5 per cent of all deaths recorded for children aged 10–14 years.[8]

Factors that make children more vulnerable to suicide include exposure to adverse childhood experiences, including physical and sexual abuse, and neglect. Aboriginal children and children who have contact with the child protection system are at a higher risk of dying by suicide. Children that have contact with the child protection system are at an increased risk of suicide because, as a population, they are more likely to present with the risk factors associated with suicide.

The children

- The 35 children ranged in age from 12 years, 11 months to 17 years, seven months at the time of death. Almost one-third (n=11) had ended their lives by the age of 14.
- 40 per cent of the children were female (n=14) and 60 per cent were male (n=21). Males aged 15 to 17 years at time of death were significantly over-represented, representing 40 per cent of all children reviewed (n=14).
- Aboriginal children were also over-represented among the 35 children with a total of six children (17 per cent) identifying as Aboriginal.
- 49 per cent (n=17) of the children were residing in metropolitan areas at the time of their deaths and 51 per cent (n=18) in regional or rural areas.
- 31 per cent (n=11) of the children were identified as having learning difficulties as a result of developmental delays or an intellectual disability.
- 11 per cent (n=4) were recorded as identifying as lesbian, gay, bisexual, transgender, intersex or queer.
- 71 per cent (n=25) of the children were living at home with at least one parent at the time of their death.
- 83 per cent (n=29) were disengaged from education in the months or weeks preceding their death.

Their experiences of harm

Descriptive details of the children's experiences of harm were not available in all cases. Where the information was available, it revealed that the children had, in most instances, experienced multiple and recurring forms of abuse. The harms these children faced were often severe. Of the many risk factors present in the lives of the children reviewed, the most prominent was family violence. Family violence was a feature of nearly all cases, frequently in conjunction with parental mental illness and substance abuse issues.

- 94 per cent of the children (n=33) were reported to have experienced family violence (several children witnessed severe physical and sexual violence perpetrated against their mothers, including a father punching a mother to the face and breaking her jaw; a step-father head-butting a mother, resulting in a broken nose; a father strangling a mother; a mother being violently raped by her partner; and a mother being thrown to the ground by her throat).
- 89 per cent of the children (n=31) were reported to have experienced one or more elements of neglect during their childhood (one child was described as 'hungry, filthy and had flea bites all over his body'; there were cases involving children living week-to-week in different locations, including one who slept in a barn for two months; school lunches were frequently referenced as containing 'mouldy food' and 'rancid meat'; and there were multiple examples of health issues arising in the context of neglect, such as scabies, hearing problems attributable to wax build-up, sores, loss of teeth, blackened teeth, fleas and lice).

8 https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report

- 51 per cent of the children (n=18) were reported to have been sexually abused by a family member or person known by the family (one child was reported to have been sexually abused by a number of adult males, including her step-father, but did not want to make disclosures to police; another child was reported to have been sexually abused by a number of adult males, including her father and gymnastics coach; and another was sexually abused by a family member from the age of seven and then went on to abuse a younger sibling).
- Where sexual harm was reported, it was always in combination with physical, emotional and neglect abuse types.

Their parents

Most of the children came from families where trauma was entrenched and compounded by the 'toxic trifecta' of family violence, parental mental illness and substance abuse issues:

- 97 per cent (n=34) had a mother who had been the victim of family violence
- 83 per cent (n=29) had a parent with a diagnosed mental illness
- 71 per cent (n=25) had a parent with a reported substance abuse issue
- 63 per cent (n=22) had a parent with a reported history of trauma, including a history of child protection involvement
- 40 per cent (n=14) had a father or step-father who had spent time in prison
- 37 per cent (n=13) of the children reviewed had a parent who had attempted or completed suicide.

It is important to acknowledge that for many of the children reviewed, their experiences of harm represented an extension of the harm experienced by their parents (often in childhood). Unresolved trauma and untreated parental mental illness featured prominently in the majority of cases (n=29).

Contact with Child Protection

For the 35 children, the length and nature of contact with Child Protection varied. For the majority of children (n=26), there was lengthy contact which began early in the child's life.

The key stages for Child Protection processes are intake and investigation, protective intervention and protective order. The inquiry attempted to examine the assessments and decisions made by Child Protection at these stages and found:

- the number of reports to Child Protection ranged from two to 25, with an average of seven reports per child
- 66 per cent (n=23) of the children had their first contact with Child Protection before they turned eight years of age, with the majority of these (65 per cent) having their initial contact in the first three years of life
- for the 35 children, Child Protection received a total of 229 reports
  - 90 per cent (n=206) of the reports received were closed at intake or investigation
  - 78 per cent (n=161) were closed at intake
  - 22 per cent (n=45) were closed at investigation
- of the reports received, 69 per cent (n=158) were closed with no further action and 23 per cent (n=52) were referred to, or recommended to contact, Child FIRST, with a view to engaging community-based child and family services
- of the reports received, 14 per cent (n=33) were substantiated, and of these:
  - 20 were closed with no further action recorded
  - 12 resulted in initiation of Protection Application proceedings in the Children's Court
- for the 12 children who were the subject of a Protection Application:
  - proceedings were initiated (on average) at the seventh report to Child Protection
  - the average time between first report and initiation of protection proceedings was six years, four months.

Responding to Aboriginal children

Aboriginal children were over-represented in the 35 cases reviewed in the following ways:

- 17 per cent of the children identified as Aboriginal (n=6)
- all of the Aboriginal children were recorded as having experienced four forms of child abuse or maltreatment
- intergenerational trauma was a feature in the lives of all Aboriginal children reviewed
- 83 per cent of the children had their first contact with Child Protection by age five (n=5)
- of the 41 reports received by Child Protection in relation to the six Aboriginal children
  - 85 per cent (n=35) were closed at intake or investigation
  - 29 per cent were substantiated (n=12), which was double the rate of substantiation for the non-Aboriginal children in this review (14 per cent)
- although only featuring six Aboriginal children, the inquiry found these children represented 33 per cent of all substantiated reports that resulted in initiation of protective proceedings.

Child Protection response and use of child and family support services

Despite the severity of reported harms received, across multiple and frequently escalating reports, the rate of closure without further action by Child Protection was concerningly high.

Ninety per cent of the total reports received (n=229) were closed at intake (n=161) or investigation (n=45). Where intervention was recommended, families were in most instances assessed to require only periodic community-based child and family service support (n=52).

For the 35 children reviewed:

- approximately 23 per cent (n=52) of reports resulted in children and their families being referred (either directly or indirectly via letter) to Child FIRST with a view to engaging an appropriate community-based child and family service
- the 52 reports resulting in referrals to Child FIRST related to 25 individual children and their families
- of the 25 families, approximately one-third (n=9) expressed a persistent unwillingness to engage with services.

Despite the majority of families indicating a preparedness to engage, the inquiry found that community-based child and family services were, in fact, unable to engage them.

Of the 25 families referred to, or recommended to contact, Child FIRST, the inquiry found that successful engagement of families was impeded by a range of factors, including:

- delays in family service commencement represented a significant barrier to the successful engagement of families in one-quarter of cases reviewed (n=7)
- in almost half (48 per cent) of the cases referred to Child FIRST, services provided by community-based child and family services appeared inadequate to meet the complex and frequently chronic protective concerns that families required help to address (n=12)
- only 10 per cent of families recommended to contact Child FIRST via letter subsequently initiated contact.

Unsuccessful engagement with families did not result in Child Protection adopting a different approach to re-reports or re-referrals. Over half (56 per cent) of the families referred to Child FIRST were referred more than once (n=14). None of the referrals resulted in successful engagement with a family service.

Contact with health, mental health services and police

The inquiry found that the length and nature of contact children had with mental health and other health services varied depending on the child's age, gender and age at first contact with Child Protection.

In terms of the children's mental health:

- 83 per cent were either diagnosed (n=24) or suspected (n=5) to have a mental illness
- 83 per cent were recorded as having engaged in deliberate self-harming behaviours (n=29)
- 69 per cent were recorded as having previously attempted suicide (n=24)
- 60 per cent were recorded as being drug dependent at the time of their death (n=21).

In terms of the children's contact with health and mental health services in the 12 months preceding death:

- 74 per cent (n=26) had contact with a health service for care related to their mental health
- 43 per cent (n=15) had contact with a Child and Adolescent Mental Health Service or Child and Youth Mental Health Service, most frequently following an emergency department presentation
- over 90 per cent of female children (n=13) had contact with a health service for care related to their mental health in the six weeks preceding their death, whereas only 38 per cent of male children had contact with services in the six weeks preceding death (n=7)
- 43 per cent (n=15) attended at an emergency department in the 12 months preceding their death, of which 87 per cent presented with an attempted suicide by overdose (n=13).

Of the 35 children reviewed, 89 per cent had a recorded contact with a mental health service (n=31). Of these:

- 35 per cent had their first contact between the ages of nine and 13 (n=11)
- 39 per cent had their first contact by the age of eight (n=12)
- half of all male children had received a mental health diagnosis by the age of seven (n=9).

The inquiry found that children's contact with mental health services as generally preceded, or occurred simultaneously with, contact from Child Protection. This trend was particularly pronounced for the children who received a diagnosis by age seven, of which:

- 92 per cent had their first contact with Child Protection by the age of three (n=11)
- 50 per cent had been referred to a paediatrician by the age of five (n=6)
- 75 per cent were male children, who all received an initial diagnosis of ADHD and/or ASD (n=9).

Of the children who had contact with a mental health service but remained undiagnosed, 86 per cent lived in regional or rural parts of Victoria (n=6). For this group, their presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.

Contact with police

Of the 35 children reviewed, 51 per cent (n=18) had contact with police in the 12 months before their death and 43 per cent (n=15) within six weeks of death.

Of the children who came into police contact:

- 44 per cent were alleged to have perpetrated violence against a family member (n=8) – in all instances, substance misuse preceded the alleged violence
- 22 per cent came in contact with police for high-risk taking behaviours including fire-lighting, joy-riding and behaving in an offensive manner (n=4)
- 11 per cent had contact with police in the context of ongoing drug use (n=2).

Help-seeking behaviours

In a significant number of cases (49 per cent), there was evidence that children had disclosed an intention or plan to suicide in the seven days prior to death. Of those that did disclose an intent (n=17), 59 per cent told a friend or peer, sometimes via social media.

Notably, help-seeking behaviours were markedly different for the cohort of children aged between 12 and 14 years at the time of death. Of these children, 73 per cent (n=8) disclosed an intention or plan to suicide in the seven days prior to death. In the majority of these cases, this disclosure was made to a worker or mental health professional (n=5).

'Under the radar'

Of the 35 children reviewed, just under one-fifth (n=6) were subsequently identified amongst family members as having flown 'under the radar' prior to their deaths. As one family member reflected 'we just didn't see it coming'. The inquiry found a number of shared characteristics among these children, including:

- All had been exposed to high levels of family violence.
- On average, they were the subject of eight reports to Child Protection, which was higher than the recorded average of seven reports per child recorded for all 35 children.
- None were diagnosed with a mental illness and only one child had received services from a mental health service (but disengaged after one appointment).
- Two-thirds (n=4) were reported to have experienced sexual abuse in early childhood.
- Two-thirds (n=4) were known to use substances, have frequent contact with the criminal justice system and be disengaged from school (usually via suspension or expulsion as a result of violence).
- They were invisible in that there was little or no information recorded about these children, their perspectives or wishes by service providers.

Themes arising from the findings

Responding to children at risk of harm

Children in this inquiry were the subject of multiple reports to Child Protection. Each new report was assessed in isolation, without proper consideration being given to the impact or outcome of earlier reports, or earlier referrals to Child FIRST. As a result, opportunities for timely and escalated intervention were lost, and with this, the ability to help improve the individual circumstances of these children and their families.

The gap between statutory and voluntary services

Children in this inquiry presented with a range of complex and significant issues that consistently fell beneath the threshold for statutory intervention. This meant their families were referred, sometimes repeatedly, to Child FIRST, for potential engagement with voluntary family services. Families who cannot be easily engaged by voluntary child and family services create a specific challenge for the child and family system. The children in these families are at an increased risk of falling between the gap created by disconnected statutory and voluntary service systems.

Identifying and responding to adolescent vulnerability

Children who had reached the point of adolescence were rarely assessed or described as vulnerable. They were frequently characterised as 'hard to help', 'difficult to engage', 'out of control', 'needy' and in one case 'damaged'. Many of these children had been known to Child Protection from early childhood. As young children they were not helped, and as older children, help was increasingly not provided due to their perceived ability to 'self-protect'.

Responding to Aboriginal children

The cases featuring Aboriginal children featured lengthy, intergenerational child protection histories. Despite this, there was no evidence that Child Protection considered cumulative harm when assessing risk or planning. Research establishes that connection to culture is a protective factor for Aboriginal children, particularly those at risk of suicide. For some of the Aboriginal children, connections to culture were inadequately prioritised by both the child and family system and the mental health system.

Failure to engage children

Children were for the most part, invisible participants – neither seen, nor heard by Child Protection on issues central to their safety and wellbeing. There was a notable absence of direct contact by Child Protection with children, particularly during the phases of investigation and protective intervention. Where direct contact occurred, children were required to speak to multiple people within Child Protection, which in some instances resulted in children disengaging completely. Children were rarely interviewed away from family members and rarely engaged in decision-making processes or case planning.

Concurrent contact with child protection and mental health systems

Most of the children in this inquiry had concurrent contact with the child protection and mental health systems. Where contact did coincide, the focus of each system was quite different. Child Protection largely assessed the circumstances of children in terms of mitigating parental risk, without addressing how exposure to these risks may have impacted the child. This was particularly the case where there was family violence. Mental health interventions, by comparison, were child-focussed – in that they focussed on addressing the mental health symptoms displayed by the child – but were not always well-informed regarding family history or the child's exposure to parental risks.

Recovery from childhood abuse and trauma

Children who are known to have experienced childhood abuse and trauma are likely to require help to recover from their experiences. This was not, however, identified as a focus of Child Protection or mental health interventions for the children reviewed.

Coordination and information sharing

Poor coordination and inadequate information sharing contributed to reports to Child Protection being closed without further action in circumstances where children should have received help. The inquiry found a lack of information sharing between the statutory child protection and mental health systems, meaning that in many cases neither system had complete knowledge of children's circumstances.

Findings

FINDINGS RELATED TO THE CHILD AND FAMILY SYSTEM

Finding 1: Statutory child protection – episodic risk assessments that focussed on imminent harm

The Commission found that risk assessments undertaken by Child Protection at the intake and investigation phases were frequently shallow in focus and based on immediate and episodic risk prediction.

This led to children who were at risk of significant harm, including cumulative harm, being left to endure multiple, and often chronic forms of harm, without support or effective and timely intervention.

The inquiry identified a range of barriers to Child Protection undertaking effective and responsive risk assessments in the cases reviewed, including:

- Child Protection appearing to operate as an emergency response service
- failure by Child Protection to identify and respond to risks of cumulative harm
- lack of coordination and information sharing between Child Protection and Child FIRST regarding the outcome of referrals, re-referrals and on-referrals to family services
- absence of timely escalation by Child Protection in cases involving re-reports.

Finding 2: Child FIRST and family services – ineffective early intervention

There was no evidence that any of the 25 children and their families who were referred to Child FIRST were successfully engaged with family services. In all instances, the children and their families referred to Child FIRST were re-reported to Child Protection – in most cases, within quick proximity to referral.[9]

This led, in some cases, to multiple referrals being made to Child FIRST, who made multiple on-referrals to family services. This approach resulted, ultimately, in recurring concerns remaining unaddressed for children at risk of harm.

The ability of the Child FIRST and family service system to successfully engage the families reviewed was impeded by a range of factors, including:

- delays in the allocation of families to particular services
- the intensity and duration of services were inadequate to meet the complexity of issues identified
- the handling of re-reports and re-referrals
- the practice of Child Protection recommending to families, by letter, that they contact Child FIRST for support.

9 The Commission acknowledges that in some cases, re-reports were not made in quick proximity, but occurred across the course of a child's life, and occasionally with multiple years in between.

Finding 3: Statutory child protection – lack of child-focussed practice

The Commission found there was an absence of child-focussed engagement in response to the 35 children reviewed. This resulted in children's voices not always being heard by services, and their experiences often not being taken into account.

Children were rarely interviewed away from family members and rarely engaged in decision-making processes or participated in case planning.

For those children who had reached adolescence, they were rarely assessed or described as 'vulnerable' but frequently described as 'self-protective'. In some cases, the depth of sadness they experienced only revealed itself after their death, in the form of a suicide note or diary entry.

FINDINGS RELATED TO THE MENTAL HEALTH SYSTEM

Finding 4: Ineffective early intervention

For the majority of children reviewed, there was an absence of effective early mental health intervention. The inquiry found a range of systemic barriers to the provision of early mental health intervention, including:

- an absence of specialised mental health services for children diagnosed with mental illness or other mental health presentations by the age of seven years
- a lack of targeted support to help children recover from childhood abuse and trauma
- an inadequate focus on delivering integrated family-based interventions to support the recovery of children experiencing mental illness.

FINDINGS RELATED TO COLLABORATION AND INFORMATION SHARING

Finding 5: Inadequate information sharing and collaborative practice

Children in contact with the statutory child protection and mental health systems benefit from a coordinated service response, which recognises the need to explore the intersection between protective and mental health issues. The inquiry identified a range of barriers to effective information sharing and collaborative practice, including:

- an absence of assertive information sharing by both service systems
- a failure to understand the significance of information potentially held by the respective service systems
- a lack of clarity or understanding regarding the role of each service system in respect of child safeguarding.

Finding 6: A shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences, and their recovery from harm and abuse.

Recommendations

Recommendation 1

That, in line with *Roadmap to Reform*, the Victorian Government develop, resource and implement an integrated and whole-of-system **investment model and strategy** for the child and family system, focussed on:

- earlier intervention and prevention services to reduce risks to children and build child and family wellbeing
- reducing the rate of entry to care
- meeting the distinct needs of children who need to live away from the family home.

The **investment model** should recognise the drivers of demand and the need for coordinated service responses. It should use client data, analytics and service evidence to identify the:

- resource levels needed to meet demand for safe, quality services for vulnerable children and their families
- most efficient and effective investment options to achieve maximum impact.

The **investment strategy** should increase and improve safe, quality services in line with demand, by targeting early intervention and prevention, prioritising the most vulnerable cohorts, including families with chronic and complex issues and children exposed to cumulative harm.

Recommendation 2

That the Department of Health and Human Services develop, resource and implement a set of standard analytical data sets for Child FIRST/ The Orange Door and IFS to monitor and report on the timeliness and effectiveness of their engagement with children and families, including:

- time between initial assessment and commencement of case management
- rates of unsuccessful engagement
- referral outcomes
- re-referrals
- re-reports.

Recommendation 3

That the Department of Health and Human Services review and revise all foundational practice guidance, training and tools to embed children's participation in decision making during the investigation, protective intervention and protection order phases of Child Protection intervention.

Recommendation 4

That the Department of Health and Human Services develop practice advice in relation to children involved with Child Protection who are identified as at risk of suicide. Practice advice should confirm the importance of information gathering, information sharing and service coordination, and include requirements to gather and consider:

- information regarding the child's involvement with different mental health services
- a child's mental health diagnosis
- any known history of exposure to abuse, harm or trauma
- a child's treatment plan and (where relevant) any actions taken or planned to address any history of exposure to abuse, harm or trauma
- the existence of any parent-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- the existence of any placement-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- identifying which service or agency involved is able to co-ordinate a child's access to mental health and other relevant services.

Recommendation 5

That the Victorian Government commit to proceeding with, and investing in, the Child Link Register, with a view to ensuring commencement of its operation by 31 December 2021.

Recommendation 6

That the Department of Health and Human Services develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission into the Victorian Mental Health System.

For noting

The Commission will provide a copy of the inquiry to the Royal Commission into the Victorian Mental Health System, and ask that consideration be given to its findings, particularly those relevant to:

- the points of intersection between the child protection, child and family service and mental health systems
- the need for greater levels of specialist early intervention mental health services for children known to have experienced harm and abuse.

Chapter 1
Introduction

The Commission is an independent statutory body established to promote improvement and innovation in policies and practices affecting the safety and wellbeing of Victorian children. The Commission's oversight functions have a particular focus on vulnerable children.

Jurisdiction

The inquiry was formally established on 3 July 2019 pursuant to section 39 of the *Commission for Children and Young People Act 2012* (the CCYP Act), which provides that the Commission may conduct an own motion inquiry into the provision or omission of services provided by a health service, human service or school to a group of vulnerable children or young persons. The CCYP Act does not provide jurisdiction to review services provided by non-government schools or review the appropriateness or otherwise of clinical decision-making by a registered health practitioner.

Under section 34 of the CCYP Act, the Commission conducts child death inquiries for any child who was a client of Child Protection at the time of death or within 12 months of the death. This inquiry reviewed a sample of child death inquiries completed by the Commission (formerly the Office of the Child Safety Commissioner) between 1 April 2007 and 1 April 2019, where the cause of death was suicide.

Terms of reference

- Consider the circumstances and experiences of 35 children who died by suicide and identify the points at which service intervention occurred.
- Assess the effectiveness of service interventions delivered, with a particular focus on early intervention.
- Review the coordination and integration of services delivered across multiple systems.
- Identify how the children's experiences may inform suicide prevention strategies for other children in contact with the child protection system.

Methodology

The methodology involved:

- analysis of relevant legislation, policy and practice manuals, previous reviews relating to the provision of child protection and mental health services to children, and human rights requirements[10]
- conducting a literature review relevant to adolescent vulnerability, youth suicide and mental health
- reviewing current data relevant to statutory child protection and youth suicide
- identifying child death inquiries where the Commission nominated suicide as the cause of death between 1 April 2007 and 1 April 2019
- reviewing in detail, issues identified in the child death inquiries finalised in the last five years, between 1 April 2014 and 1 April 2019
- reviewing each child death inquiry, noting in particular where reports included interviews with families, carers and services
- aggregating data from each child death inquiry to ascertain the circumstances of the child's background, protective risks and strengths, and engagement with services.

10 For a full list of legislation and policies reviewed, see Appendix A.

Chapter 2
Service systems relevant to this inquiry

The child and family system

The child and family system describes the overarching service system for vulnerable children and families that includes:

- Child FIRST/The Orange Door
- voluntary family services
- statutory child protection.

The child and family system is designed to support families to address risks early by providing voluntary interventions designed to prevent children becoming involved in the statutory child protection system.

The statutory child protection and voluntary child and family service systems (Child FIRST/The Orange Door/IFS) are important subsets of the broader child and family system, and for this reason, are referenced as separate systems by the inquiry.[11]

Vulnerable children and families

Victoria's Vulnerable Children – Our Shared Responsibility Strategy 2013–2022 defined children as vulnerable 'if the capacity of parents and family to effectively care, protect and provide for their long-term development and wellbeing is limited'.

Children may be vulnerable for a range of reasons:

- a parent, family member or caregiver may have a history of trauma, family violence, substance abuse issues or mental illness
- a child may have health issues or disability
- there may be societal factors, including poverty, low-quality housing, and community or cultural disconnection.

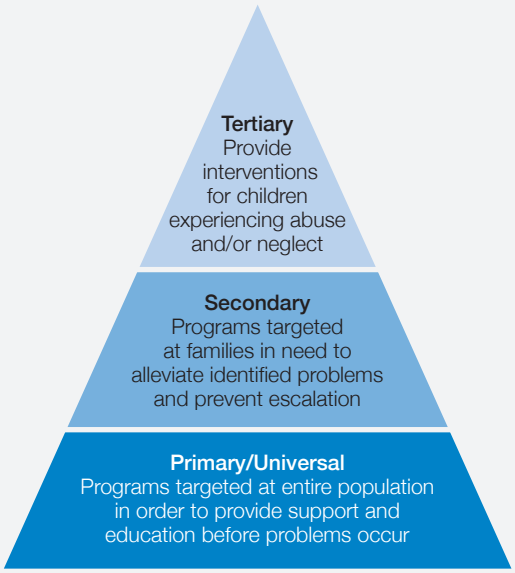
Some unborn children may be identified as vulnerable during a women's pregnancy if particular risk factors are present.

Early intervention

The inquiry refers to early intervention services as intervention that occurs when vulnerabilities have been identified for the child or their family. The role of child and family services is to provide critical, timely and responsive services before risks and concerns escalate and lead to Child Protection intervention.

Figure 1 shows the public health model, which describes the range of interventions that apply to protecting children.

Figure 1: Public health pyramid



Source: Bromfield and Holzer (2008)

11 None of the children reviewed by this inquiry had contact with The Orange Door.

The model depicts a pyramid of escalating interventions:

- Primary or universal interventions are strategies that target whole communities or populations in order to build public resources and attend to the societal factors that contribute to child maltreatment (for example, maternal and child health nurses).
- Secondary interventions are intended to target families who are at risk (or exhibit risk indicators) for child maltreatment and prioritise early intervention (for example, Child FIRST and family services).
- Tertiary interventions are intended to target families in which child maltreatment has already occurred.

Statutory child protection system

The Department of Health and Human Services (the department) operates Victoria's Child Protection service. Child Protection's main functions reflect functions set out in the *Children, Youth and Families Act 2005* and include:

- receiving reports from people with a significant concern for a child's wellbeing or who believe a child is in need of protection[12]
- investigating reports that suggest 'a child is at risk of significant harm' and may be in need of protection,[13] as defined in section 162 of the CYFA (see box adjacent)
- referring children and families to services, including community-based child and family services, 'that assist in providing the ongoing safety and wellbeing of children'[14]
- applying to the Children's Court for a protection order 'if the child's safety cannot be ensured within the family'[15]
- administering protection orders made by the Children's Court.[16]

For a summary of the legal frameworks used when making decisions under the CYFA, please refer to Appendix B.

Section 162 of the CYFA: When is a child in need of protection?

Section 162 provides that a child is in need of protection if certain grounds exist, including:

- the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, from that type of harm
- the child has suffered, or is likely to suffer, significant harm, as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from that type of harm
- the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that their emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from that type of harm
- the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

The harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.

12 Part 3.2 and sections 183-184, CYFA.

13 Department of Health and Human Services, 'Families & Children: Child protection', at **https://services.dhhs.vic.gov.au/child-protection**, as at 19 August 2019; sections 30, 34 and 187 and Part 4.6, CYFA.

14 Department of Health and Human Services, 'Families & Children: Child protection', at **https://services.dhhs.vic.gov.au/child-protection**, as at 19 August 2019; sections 30 and 187, CYFA.

15 Department of Health and Human Services, 'Families & Children: Child protection', at **https://services.dhhs.vic.gov.au/child-protection**, as at 19 August 2019; Parts 4.7-4.9. CYFA.

16 Department of Health and Human Services, 'Families & Children: Child protection', at **https://services.dhhs.vic.gov.au/child-protection**, as at 19 August 2019.

Phases under the Child Protection Manual

The Child Protection Manual sets out five 'phases' of work reflecting Child Protection's functions: intake, investigation, protective intervention, protection order and case closure:

- **intake**, where Child Protection receives and assesses reports and decides on the appropriate response
- **investigation**, where Child Protection investigates reports assessed as being 'protective intervention reports' to determine whether a child requires protection, as defined by section 162 of the CYFA
- **protective intervention**, which is a 'period of intervention with a child and family' following an investigation finding that a protective intervention report is substantiated, and may include seeking a protection order in the Children's Court if Child Protection considers a child is in need of protection
- **protection order**, where Child Protection administers a protection order
- **closure**, which can occur during any of these phases.

Further detail about each phase is provided in Appendix A.

Substantiation

Substantiation is a possible outcome of the investigation phase. The Child Protection Manual states:

The substantiation decision will focus on whether the protective intervener is satisfied on reasonable grounds that a child is in need of protection. This generally involves considering whether the child has experienced, or is likely to be at risk of, significant harm to their safety or development and will focus on current and past harm, and an assessment of likelihood of future harm. An assessment of a person's responsibility for causing harm or likely capacity to cause harm to a child is connected with the substantiation decision.

Increases in Child Protection reports

Reports to Child Protection have surged in the last decade. In the decade from 2007–2008 to 2017–2018, reports to Child Protection almost tripled – from 41,607 to 115,600. Over the same period, investigations substantiated tripled from 6,365 to 18,333.[17]

In its 2017–2018 Annual Report, the department reported that Child Protection received a lower number of reports than forecast for that financial year (121,600). This is described as being 'due to slower growth than historically has occurred as reforms to the intake system provide more appropriate referral pathways'.[18]

In December 2018, the department reported:

> *The number of reports received in 2017–18 was 4.2 per cent higher than the number in the previous year, while investigations increased by 8.5 per cent. Substantiations showed a 10.9 per cent increase from the previous year. Of the 18,621 substantiated cases 3,335 (18.0 per cent) involved children who had been part of a previously substantiated case that had been closed in the previous 12 months.*[19]

Voluntary child and family service system

The CYFA has a focus on early intervention through community services for children and families. One of the main purposes of the CYFA is 'to provide for community services to support children and families'.[20] The Secretary may register organisations as community-based child and family services and allocate funds to them.[21] The CYFA sets out the services' purposes, including providing 'a point of entry into an integrated local service network that is readily accessible by families, that allows for early

17 ROGS Child Protection Services, Table 16A.4 (2019).
18 Department of Health and Human Services annual report 2017–2018, page 92.
19 Department of Health and Human Services, Child Protection and family services additional service delivery data 2017–2018, page 4.
20 Section 1(a).
21 Sections 23 and 46-47.

intervention in support of families and that provides child and family services'.[22]

These provisions were part of major system reforms in 2005 that aimed to increase 'earlier intervention where families have problems'[23] and 'bring the earlier intervention sector and child protection sector together and link them to early childhood services to form a more coordinated system'.[24]

Establishment of the CYFA provided the legal framework for 'a new model of earlier intervention, prevention and service coordination' based on 'community-based intake, assessment and referral services'.[25]

As the then Minister for Children explained, these services would provide 'entry points into voluntary community services' – rather than 'over-relying on child protection to provide a gateway into services for children and families' – and this system would provide 'flexible and graduated' responses for families according to their risks and needs, with community-based services focussing on helping families 'before problems escalate to the point that the children are placed at risk of significant harm' and Child Protection focussing on its 'specialist function' of intervening when children need protection.[26] It was envisioned that the sectors would work together in partnership, and family support services would be targeted to assist 'the most vulnerable children, young people and families'.[27]

Child FIRST and Integrated Family Services (family services)

To give effect to the 2005 legislation, Child and Family Information, Referral and Support Teams (Child FIRST) were established in 2007 as the 'new central community-based intake model' in an 'integrated system of family services' within catchment areas.[28] This system was a central component of the 2007 reform framework, *A Strategic Framework for Family Services*, and came to be known as Child FIRST and IFS (family services). Before Child FIRST was introduced, 'there were multiple entry points into family services, which had led to inefficient and sometimes duplicated services'.[29]

Child FIRST was based on a successful trial conducted by the then Department of Human Services from 2003 to 2006 and implemented from 2007 to 2009.[30]

From that time – and for the period reviewed for this inquiry – Child FIRST has operated as an entry point into the community-based child and family service system, with the object of providing an 'easily accessible entry point' in each catchment area.[31] Its role has been to receive referrals from anyone in the community;[32] conduct intake; engage with families and make initial assessments of risks and needs 'to determine the priority of a response'; and, if necessary, connect vulnerable children, young people and families with family services provided by IFS services (IFS providers) in the local area, to prevent escalation of problems and divert families from becoming involved with Child Protection.[33]

22 Section 22(a). The other purposes are: receiving referrals about vulnerable children and families where there are significant concerns about their wellbeing (s 22(b)); assessing children and families' needs and risks, to assist in the provision of services to them and in determining if a child is in need of protection (s 22(c)); making referrals to other relevant agencies if necessary to assist vulnerable children and families (s 22(d)); promoting and facilitating integrated local service networks working collaboratively to co-ordinate services and supports to children and families (s 22(e)); providing ongoing services to support vulnerable children and families' (s 22(f)).

23 Department of Human Services 2007, *A strategic framework for Family Services*, pages 79-80.

24 Second Reading Speech, *Children Youth and Families Bill*, Minister for Children, 6 October 2005, page 1370.

25 Ibid

26 Ibid

27 Ibid

28 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page 5; Department of Human Services 2007, *A strategic framework for Family Services*, page 7.

29 Ibid

30 Ibid

31 Department of Health and Human Services 2018, 'Child FIRST and family services' at **https://services.dhhs.vic.gov.au/child-first-and-family-services**, as at 24 August 2019; Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page 7.

32 Sections 31-32, CYFA; Department of Health and Human Services 2018, 'Child FIRST and family services' at **https://services.dhhs.vic.gov.au/child-first-and-family-services**, as at 24 August 2019

33 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, pages 7-9; Lonne, B, Brown, G, Wagner, I & Gillespie, K 2015, 'Victoria's Child FIRST and IFS differential response system: Progress and issues', *Child Abuse & Neglect*, 39, pages

Child FIRST can receive referrals from Child Protection and consult with or make referrals to Child Protection. Its functions have also included providing information and advice and 'deliver[ing] timely responses through the provision or oversight of "active-holding responses" that involves [sic] short-term work with children and families, before they are allocated to family services'.[34]

The department has 'the oversight and leadership role of funding the community-based organisations and operated alliances in each catchment area to support an integrated and coordinated service response'.[35] The alliances have included Child FIRST, family services, Child Protection, the Department and, 'where capacity exists', an Aboriginal Community-Controlled Organisation.[36]

In 2013–2014, 96 community-based child and family services were registered and funded by the Department to provide Child FIRST and family services.[37] The number of assessments and interventions provided by Child FIRST increased each year from 2014–2015 (13,576) to 2017–2018 (22,310).[38]

The child and family service system is now undergoing further reform, with a strong focus on early intervention. The department's *Roadmap for Reform: strong families, safe children*, released in 2016, aims to transform 'Victoria's children and family services system' by moving 'from crisis response to prevention and early intervention'.[39]

A key strategic focus is 'integrated wraparound supports and targeted early interventions for children and families in need'.[40] As part of the changes, Child FIRST is progressively transitioning to the new support and safety hubs for women, children and young people experiencing family violence – The Orange Door – that also provide support to families needing help with children or young people's care, wellbeing and development.[41] This 'migration of Child FIRST into the Orange Door' is 'to enable family support and specialist family violence practitioners to work side-by-side and combine their expertise to improve responses to both women and children'.[42]

2015 VAGO audit of Child FIRST and family services

An audit of early intervention services by VAGO in 2015 found that 'Child FIRST and (family services) are failing to provide effective services for vulnerable children and families'[43] and recommended the department undertake a 'comprehensive and urgent review of its current approach to early intervention'.[44] VAGO identified issues including:

- the number and complexity of cases referred to Child FIRST and family services had increased significantly,[45] and Child FIRST and IFS were 'operating above their funded capacity'[46]
- the department had not forecast demand for services or responded to drivers such as family violence adequately[47]
- families who needed early intervention were missing out on services.

The Auditor-General wrote:

> *I found that Child FIRST and (family services) are struggling to cope with the increased number and complexity of referrals. This means that increasingly these services need to focus on families with high needs rather than those families assessed as low or moderate risk. Yet these are the very families that would benefit most from being able to access early intervention services—when intervention is early enough to prevent escalation.*[48]

42–43 and 46.

34 Ibid, page 8.

35 Ibid

36 Ibid

37 Ibid, page 6.

38 Department of Health and Human Services annual report 2017–2018, page 52. Child FIRST provided 15,190 assessments and interventions in 2015–2016 and 20,016 in 2016–2017.

39 Department of Health and Human Services annual report 2017–2018, page 14.

40 See **https://www.strongfamiliessafechildren.vic.gov.au/roadmap-for-reform-strong-families-safe** children.

41 Department of Health and Human Services annual report 2017–2018, page 38; Department of Health and Human Services 2018, 'Child FIRST and family services' at **https://services.dhhs.vic.gov.au/child-first-and-family-services**, as at 24 August 2019.

42 Department of Health and Human Services annual report 2017–2018, page 43.

43 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page xii.

44 Ibid, page xiii.

45 Ibid, page xiii.

46 Ibid, page xiii.

47 Ibid, page xiii.

48 Ibid, pages vii–viii.

VAGO recommended that the comprehensive and urgent review include the 'whole-of-system funding for early intervention to better reflect the impact of demand drivers' on Child FIRST and family services.[49] The department accepted VAGO's recommendations.

Demand versus investment in Child FIRST and family services

The last decade has seen a rapid increase in demand for statutory child protection and child and family services. It is widely acknowledged that the increase in demand has included an increase in demand for families experiencing 'complex' issues.

For example:

- reports to Child Protection have almost tripled in 10 years, from 42,000 in 2007–2008 to 115,000 in 2017–2018
- the number of new cases opened by Child FIRST has increased six-fold in 10 years, from 3,888 in 2007–2008[50] to 22,332 in 2017–2018
- more than 80 per cent of families (18,130 cases or 81 per cent) referred to Child FIRST in 2017–2018 presented with complex issues such as family violence, mental health, substance abuse and disability, compared with 66 per cent in 2013–2014, and 55 per cent in 2007–2008[51]
- more than half of families (6,402 cases) who received help from a family service in 2017–2018 were identified to have two or more complex issues, compared with one-third of cases in 2013–2014 (3,436), and one-fifth in 2007–2008 (2,660 cases).

Currently, demand for Child FIRST and family services exceeds the funding provided to the sector. This has been the case since 2011–2012.[52]

Despite a 474 per cent increase in new Child FIRST cases in the last 10 years, funding for Child FIRST and family services has only increased by 176 per cent.

The department has, however, sought to address the need for longer-term responses for families experiencing complex issues by adopting a targeted approach to its investment. The Commission acknowledges that since 2014–2015, allocation of funding to Child FIRST and family services has shifted towards investment in the delivery of longer forms of family service response.

For example, in 2017–2018, just over half of funds allocated to Child FIRST and family services were directed towards the delivery of long and intensive responses by family services ($71,563,897.90 or 52 per cent of total spend).[53]

Table 1: Number of new cases opened 2007–2018

Case type	2007 –2008	2008 –2009	2009 –2010	2010 –2011	2011 –2012	2012 –2013	2013 –2014	2014 –2015	2015 –2016	2016 –2017	2017 –2018
Child FIRST	3,888	7,331	8,244	9,194	10,169	11,849	12,711	13,891	16,485	21,204	22,332
Family Services	12,359	10,129	8,528	9,531	10,463	10,607	10,317	11,655	12,337	12,570	12,712

49 Ibid, page xiii.

50 The Commission notes that the establishment of Child FIRST was based on a successful pilot between 2003 and 2006, and that full rollout of Child FIRST across Victoria did not occur until 2009–2010.

51 *Roadmap to Reform: strong families, safe children*, Department of Health and Human Services, Victorian Government Printer, April 2016 at page 10.

52 *Early Intervention Services for Vulnerable Children and Families*, Victoria Auditor-General's Report, Victorian Government Printer, May 2015 at page 23.

53 Calculation based on unit prices extracted from the department's financial systems. Total spend calculated by references to case targets as $137,454,955.50.

The change in funding has translated to changes in the following case targets:

- Child FIRST entry response (up to 10 hours) increased by 333 per cent
- family services entry level response (up to 10 hours) decreased six per cent
- family services short response (between 10 and 40 hours) increased 29 per cent
- family services long response (between 40 and 110 hours) increased 61 per cent
- in 2014–2015, a new family services intensive response (between 110 and 200 hours) was introduced, and case targets for this form of response have increased 371 per cent in the last three years.

This means that cases allocated to a family service are now more likely to receive a longer, and more intensive response than 10 years ago. For example, the average number of hours allocated per family by family services has increased from 29 hours in 2007–2008, to 79 hours in 2017–2018, a 172 per cent increase in hours per case.

It is positive to note that targeted investment in the Child FIRST and family service sector has improved the type and intensity of response available to some families.

However, based on allocation rates from 2017–2018, only one in three cases featuring a complex issue will be allocated a family service.[54]

For example:

- Of the Child FIRST referrals received in 2017–2018, less than 40 per cent of these cases resulted in allocation to a family service (8,362 cases or 37 per cent).
- Of the reports that remained unallocated, over 80 per cent involved between one and six complex issues (11,525 cases or 82 per cent).
- Concerningly, over 20 per cent of the unallocated cases involved between three and six complex issues (2,529 cases or 22 per cent).

This means that families identified as having complex issues are nearly twice as likely to not be allocated a family service, and receive instead, only limited entry-level help from Child FIRST.[55] In 2017–2018, 81 per cent of cases referred to Child FIRST had between one and six complex issues (18,130), and of these, only 37 per cent were allocated a family service (6,605). Put another way, 63 per cent of cases identified as having up to six complex issues were not allocated an IFS (11,525 cases).

Despite targeted investment, the actual number of new cases being opened by family services remains concerningly static. The number of new cases opened by family services in 2007–2008 was 12,359, compared with 12,712 in 2017–2018.

Table 2: Allocation rates to family services by complexity 2017–2018

New cases started			No. of complexities								
Financial year	Case type	Case allocated	0	1	2	3	4	5	6	7	Total
2017–2018	Child FIRST	Yes	1,757	2,442	1,994	1,408	632	114	15	0	8,362
		No	2,445	5,461	3,535	1,830	585	102	12	0	13,970

Source: DHHS

54 Calculation based on 2017–2018 cases allocated an IFS (where there is an identified complex issue) (6,605 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 37 per cent allocation rate.

55 Calculation based on 2017–2018 cases not allocated an IFS (where there is an identified complex issue) (11,525 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 64 per cent non-allocation rate.

Table 3: Victoria's comparative investment in child protection services 2013–14 to 2017–2018

Year	Statutory child protection (including out-of-home care)	Intensive family support services and family support services
2013–2014	$618,766,000 (75%)	$201,345,000 (25%)
2014–2015	$665,435,000 (75%)	$215,313,000 (25%)
2015–2016	$733,845,000 (75%)	$244,068,000 (25%)
2016–2017	$816,053,000 (74%)	$282,523,000 (26%)
2017–2018	$942,687,000 (73%)	$350,128,000 (27%)

Source: RoGS, Table 16A.7

At the same time, most of Victoria's investment in the broader child and family system is directed towards statutory services at the crisis end. Statutory services relate to those delivered by Child Protection in response to protective intervention and when a child enters out-of-home care. Over the five years from 2013–2014 to 2017–2018, early intervention services received around a quarter of the total investment, with around three-quarters going into statutory Child Protection services.

It is important to acknowledge that despite child and family services receiving only one-third of the funds provided to statutory child protection, investment in child and family services has increased 74 per cent since 2013–2014, a higher rate of increase than in statutory services (52 per cent).

The Commission also recognises that considerable investment has been made into the rollout of The Orange Door.

This inquiry demonstrates however, that further investment and reform in line with the commitments made in *Roadmap to Reform* are urgently needed.

The child and youth mental health service system

The mental health service system for children and young people consists of a complicated patchwork of services funded by the Victorian Government and the Australian Government, including through Primary Health Networks (PHNs) and the Medicare Benefits Schedule (MBS).

The department distributes funding to Victoria's public mental health services for children and young people with moderate to severe mental health problems. These include child and adolescent mental health services (CAMHS) for people up to 18 years of age, and child and youth mental health services (CYMHS), which has expanded eligibility to 25 years of age and were developed in recognition that 'current barriers between CAMHS and adult mental health services fall at a critical developmental time, and need to be addressed through a response tailored to this age group'.[56]

CAMHS and CYMHS support children and young people through a mix of community-based or outpatient programs and inpatient treatment in hospitals, as well as a small number of community residential programs.

There are also early intervention *headspace* centres for young people aged 12 to 25 years with mild to moderate mental health problems, which are supported by Australian Government funding. These offer enhanced primary care services, including mental health, physical and sexual health, and life skill support around work and study in an accessible, youth-friendly environment 'spanning the divide between traditional child and adult services'.[57]

56 'Child and Adolescent Mental Health Services' at https://www2.health.vic.gov.au/mental-health/mental-health-services/area-based-services/services-for-children-and-adolescents/child-and-adolescent-mental-health-services.

57 Victorian Auditor-General's Report 2018, *Child and Youth Mental Health*, page 20; McGorry, PD 2018, 'Beyond Psychosis: Early Intervention and Youth Mental Health', *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 57, Issue 10, S77.

There are 27 *headspace* centres in Victoria, and 102 nationally.[58]

PHNs were introduced in 2015. There are 32 PHNs across Australia, with six in Victoria. They plan, commission and co-ordinate mental health services, with funding provided by the Australian Government. PHNs have had a role in 'maintain[ing] service delivery within headspace centres, in line with the existing headspace service delivery model' and 'improv[ing] the integration of headspace centres with broader primary mental health care services; physical health services; drug and alcohol services; and social and vocational support services'.[59]

Children and young people who need support for mental ill-health also see general practitioners and private psychologists and psychiatrists, who provide rebated services on the MBS.

The 2019 VAGO report into child and youth mental health

The recent VAGO report *Child and Youth Mental Health* identified successive failures of the Victorian Government to articulate a framework for child and youth mental health services.

The Auditor-General wrote:

> *Under-resourcing combined with a lack of DHHS service co-ordination and oversight mean that many vulnerable Victorians cannot access [child and adolescent mental health services] for the support they need. Those who do get access often need multiple providers that are unable to coordinate around their shared clients' needs …*
>
> *Our analysis of three years of client groups accessing [child and adolescent mental health services] shows that the rates of vulnerable client groups accessing them is low compared to less vulnerable groups.*

VAGO concluded that Victoria's child and youth mental health system is fragmented, over-stretched, under-resourced and unable to meet service demand, and that many children and young people cannot access the support they need.[60] VAGO's findings are consistent with observations in other recent reviews, and from the sector itself. The 2017 Armytage and Ogloff *Youth Justice Review and Strategy* found that '[s]ystem gaps and demand pressures on mental health services currently limit the access of all young Victorians to essential mental health services'.[61]

Royal Commission into Victoria's Mental Health System

In February 2019, the Premier the Honourable Daniel Andrews MP and Minister for Mental Health, the Honourable Martin Foley MP released the terms of reference for the Royal Commission into Victoria's Mental Health System.

The Royal Commission has been asked to make recommendations on how to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

The Commission hopes this inquiry will be considered as a contribution to the Royal Commission's task, particularly its findings relevant to the points of intersection between the child protection, child and family service and mental health systems. The Commission's submission to the Royal Commission can be found on our website at **https://ccyp.vic.gov.au/upholding-childrens-rights/submissions/.**

58 headspace Annual Report 2018, page 6.

59 Department of Health, 'PHN Primary Mental Health Care Flexible Funding Pool Implementation Guide (2016–17)', page 1.

60 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8, 24, 26, 79.

61 *Youth Justice Review and Strategy 2017*, part 2, page 45.

Chapter 3
Suicide and adverse childhood experiences

In Victoria, the main cause of death for children aged between 15–17 years is intentional self-harm or suicide. In 2017, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reported that:

- suicide was the main cause of death for children who died when aged 15–17 years (30.4 per cent)
- suicide was an attributed cause of death for 12.5 per cent of children who died when aged 10–14 years
- rates of death due to intentional self-harm should be viewed as an underestimate.[62]

Suicide and adverse childhood experiences

Adverse childhood experiences are situations which lead to an elevated risk of children experiencing damaging impacts on health, or other social outcomes across the life course.[63] It is not always the case that children will be harmed by exposure to adverse childhood experiences, however, evidence consistently shows that children who are exposed to adverse childhood experiences are at a greater risk of death or injury before reaching adulthood.

Early adverse childhood experiences, such as physical and sexual abuse and parental neglect are risk factors for suicidal behaviour in adolescence.[64]

Research has found that adolescents who are sexually or physically abused in childhood are two to five times more likely to attempt suicide than those who do not have such experiences:[65]

- a 2007 Scandinavian study found that adolescents who had experienced sexual or physical abuse in childhood were at a greater risk of suicide[66]
- a 2008 American study identified an association between childhood physical abuse, witnessing family violence and suicide related behaviours[67]
- a 2010 Canadian study confirmed the link between physical abuse and suicide related behaviours in children under the age of 18[68]
- the renowned New Zealand longitudinal study, the Dunedin Multidisciplinary Health and Development Study, conducted over a 21-year period using a randomly selected group of 1,265 participants, found that rates of suicidal behaviour were related to a wide range of factors, including neglect in early

62 https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report

63 Briere, J et al (2015) Traumatic stress, affect dysregulation and dysfunctional avoidance: a structural equation model, *Journal of Traumatic Stress*, 23 (6), pages 767–774.

64 Brodsky B et al, *Adverse Childhood Experiences and Suicidal Behaviour, Psychiatric Clinics*, Volume 31, Issue 2, June 2008, pages 223–235.

65 Dube, S, Anda, R, Felitti, V, Chapman, D, Williamson, D & Giles, W, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266, no. 24, 2001, p. 3094; Mironova, P, Rhodes, A, Bethell, J, Tonmy, L, Boyle, M, Wekerle, C, Goodman, D & Leslie, B, 'Childhood physical abuse and suicide-related behaviour: A systemic review', *Vulnerable Children and Youth Studies*, vol. 6, no. 1, 2011, pages 1–7.

66 Brent, D.A., Perper, J.A., Moritz, G., Liotus, L., Schweers, J., Balach, L. and Roth, C. (2007) 'Familial risk factors for adolescent suicide: A case-control study.' *Acta Psychiatrica Scandinavica* pages 89, 1, 52–55

67 T Afifi, M Enns, B Cox, G Asmundson, M Stein & J Sareen, 'Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated with Adverse Childhood Experiences', *American Journal of Public Health*, vol. 98, no. 5, 2008, pages 946–952.

68 Dube, S, Anda, R, Felitti, V, Chapman, D, Dilliamson, D & Giles, W, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266 no. 24, 2001, page 3094.

childhood, impaired parenting and poor family function and family violence[69]

- a 2011 Israeli study found that adolescent in-patients exhibiting severe suicidal behaviours reported higher levels of family dysfunction, including physical and emotional abuse and lower levels of maternal bonding when compared with non-suicidal adolescent in-patients.[70]

Early adverse childhood experiences that are traumatic in nature and occur cumulatively have been strongly associated with a significantly increased risk of mental health problems, including post-traumatic stress, eating disorders, depression, anxiety, substance use and suicidality.[71] Research has consistently found that an accumulation of adverse childhood experiences increases the likelihood of poor outcomes for children, particularly when compared with isolated experiences of adversity:

- the 'Adverse Childhood Experiences Study: A Springboard to Hope' (the ACE Study), analysed the lifetime experiences of more than 17,000 people in the United States and identified 10 categories of childhood trauma that predict health, behavioural and social problems as adults
- the ACE Study found that the more categories of trauma experienced in childhood, the more likely it is that a young person will suffer a greater number of health effects, including an increase in the risk of suicide.[72]

It is important to note that categories of adverse childhood experiences are risk factors rather than predictive factors. The extent and depth of impact of cumulative harm on a child or young person will depend largely on the resilience of the individual. The effect of cumulative harm, irrespective of resilience, remains a risk for children.

69 https://dunedinstudy.otago.ac.nz/

70 Freudenstein, O, Zohar, A, Apter, Al, *European Psychiatry*, Published online: 11 March 2011. Doi: 10.1016/j.eurpsy.2011.01.006, 2011

71 Greene, CA, et al (2014) Posttraumatic stress mediates the relationship between childhood victimisation and current mental health burden in newly incarcerated adults, *Child Abuse and Neglect*, 38 (10), pages 1569–1580

72 http://acestudy.org/index.html

Aboriginal children and intergenerational trauma

Aboriginal people in Australia experience significantly lower life expectancy and much higher rates of suicide, with suicide being the leading cause of death for Aboriginal people aged between five to 17 years.[73]

While there is no data relating specifically to Victorian Aboriginal children and young people, the higher rates of psychological distress and higher rates of suicide among Aboriginal children and young people nationally are well-known[74] – and recognised nationally as requiring urgent action.[75] Last year, the Australian Institute of Health and Welfare reported that Victoria (along with Tasmania) had the highest rate of Aboriginal young people aged 15 to 24 years reporting mental health conditions.[76] This is the 'most vulnerable age group of Indigenous Australians… where suicide is over five times more prevalent than in non-Indigenous Australians of the same age'.[77]

The systemic disadvantages faced by Aboriginal families and the overrepresentation of Aboriginal children in the child protection system and in data collected on suicide cannot be understood without recognising the impact of colonisation across generations, including the loss of culture and forced removal of children from their families. This fundamental disruption to social order occurred due to dispossession and continues to be repeated.[78]

73 https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people/close-the-gap

74 See, for example, Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8 and 82. Also see the Australian Institute of Health Welfare's report *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*.

75 See National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019; Royal Australasian College of Physicians Media Release, *Health bodies declare Aboriginal youth suicide an urgent national priority*

76 Australian Institute of Health Welfare 2018, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, Cat. no. IHW 202. Canberra: AIHW, page 129.

77 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*, page 17

78 *Neither seen nor heard*, Commission for Children and Young People (2016), page 19.

The transmission of trauma across generations is now widely accepted as having had a devastating impact on the social, emotional and health wellbeing of Aboriginal children.[79]

Contact with the statutory child protection system

National and international research has found that children who have had contact with the child protection system are at an increased risk of suicide.

In 2001, a New Zealand study found that:

> *Young people in contact with [Child Protection] are about 10 times more likely to kill themselves than New Zealand youth of the same age who have never had contact with the Department.*[80]

In its summary of findings, the New Zealand study was careful to emphasise that the results recorded were 'not intended to imply that contact with child protection services contribute to children committing suicide',[81] but rather confirm, that young people who come into contact with the statutory children protection system are, by definition, a population at a particularly high-risk of suicide. They are at an increased risk because they tend to have many of the risk factors which have been shown to be associated with suicidal behaviour.

In 2012, a Canadian study found that people who had experienced child protection services had significantly worse mental health outcomes over their lifetime and were more likely to report suicide attempts, compared with adults who reported an experience of child abuse but had not had contact with Child Protection.[82]

In 2015, the New South Wales Ombudsman's office reviewed the deaths of all children who had suicided in 2014. There were 26 deaths reviewed, with eight recorded as having had contact with the child protection system. The report found that the children who had a history of child protection involvement were four times more likely to die from suicide than children who have had no contact or involvement with child protection services.[83]

In 2016, the Queensland Family and Child Commission released its Annual Report into the deaths of children in Queensland for 2015–2016. It examined 20 deaths of young people attributable to suicide:

> *Of the 20 deaths, five (25%) were of young people known to the Queensland child protection system within the year before their death. An increased risk of suicide is identified among children known to child protection agencies.*[84]

In its 2017 Annual Report, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) stated that:

> *Children and adolescents with previous or current involvement with Child Protection or Youth Justice are over-represented among those who commit suicide.*[85]

In 2018, in its Annual Report into the deaths of children in Queensland for 2016–2017, the Queensland Family and Child Commission found:

> *An increased risk of suicide has been identified among children and young people known to child protection agencies. The suicide rate for young people known to the child protection system in the 12 months prior to their death was three times the Queensland average for all children over the last three reporting periods.*[86]

79 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Sydney, Human Rights and Equal Opportunity Commission.

80 Beautrais, A, Ellis, P and Smith, D, 'The risk of suicide among youth in contact with Child, Youth and Family', *Social Work Now*, no. 19, 2001, page 9.

81 Beautrais, A, Ellis, P and Smith, D, 'The risk of suicide among youth in contact with Child, Youth and Family', *Social Work Now*, no. 19, 2001, page 9.

82 Afifi TO, McTavish, J, Turner, S, MacMillan, HL, Wathen, CN, 'The relationship between child protection contact and mental health outcomes among Canadian adults with a child abuse history', *Child Abuse & Neglect*, Volume 79, 2018, pages 22–30, ISSN 0145-2134, **https://doi.org/10.1016/j.chiabu.2018.01.019**).

83 **https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0009/28359/CDRT-Annual-Report-2014.pdf**

84 **https://www.qfcc.qld.gov.au/annual-report-deaths-children-and-young-people-queensland-2015–16**

85 **https://www.bettersafercare.vic.gov.au/sites/default/files/2019-05/Mother%27s%20Babies%20and%20Children%20Report%202017_FINAL-WEB.pdf**, page 64

86 Annual Report, Deaths of children and young people in Queensland 2017–2018, page 49 **https://www.qfcc.qld.gov.au/sites/default/files/Chapter_6__Suicide.pdf**).

Chapter 3 at a glance

- In Victoria, suicide is the leading cause of death for adolescents aged 15–17 years (30.4 per cent).
- Suicide is the cause of 12.5 per cent of all deaths recorded for children aged 10–14 years.
- Factors which make children more vulnerable to suicide include cumulative exposure to adverse childhood experiences, including physical and sexual abuse and neglect.
- Aboriginal children and children who have contact with the child protection system are at a higher risk of dying by suicide.
- Children who have contact with the child protection system are at an increased risk of suicide because, as a population, they are more likely to present with the risk factors associated with suicide.

Chapter 4
The children and their experiences

'I'm really not safe here and it's really scary … [mum] can get really bad and scream and bash her head against the walls and I love her and she can be nice and she buys me things and really does care about me and love me but like what I've been through [with her] I really need support … I don't know if that's good information or not but I thought it might help you guys understand that it's not like one huge thing that stops me from being okay here it's a lot of little things as well.'

A child, aged 15 (extracted from a Child Protection file note)

The 35 children whose cases were examined died between 1 April 2007 and 1 April 2019. Fourteen of the children were female and 21 were male. Their ages at time of death ranged from 12 years, 11 months to 17 years, seven months. The average age at the time of death was 14 years, seven months. Due to the small numbers in the sample, comparisons with other data should be made with caution.

Figure 2: Children by age, sex, Aboriginal status

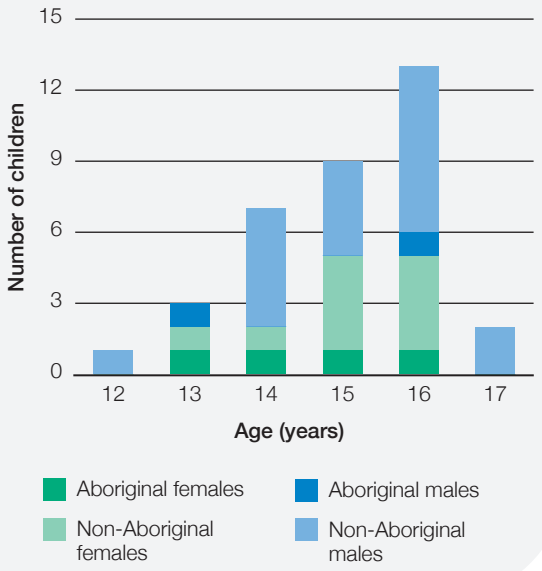


Figure 3: Geographic location prior to death

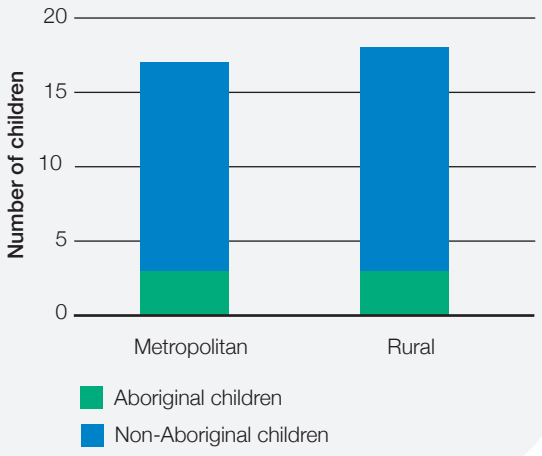


Table 4: Residence immediately prior to death

Residence at death	Aboriginal	Non-Aboriginal	Total
Living with at least one parent	4	21	**25**
Kinship care	2	2	**4**
Residential care	–	3	**3**
Independent living	–	3	**3**

Harms experienced by the 35 children

Descriptive details of the children's experiences of harm were not available in all cases. Where the information was available, it revealed that the children had, in almost all instances, experienced multiple and recurring forms of abuse, including family violence, neglect, sexual and emotional abuse. Of the many risk factors present in the lives of the children reviewed, the most prominent was family violence. Family violence was a feature of all cases, frequently in conjunction with parental mental health and substance abuse issues.

The harms that these children faced were often severe, as the examples in Table 5 demonstrate.

Table 5: Harms experienced by children as known to Child Protection

Nature of harm	Child and young person's experiences
Family violence	• Every case in the sample featuring family violence involved a history of violence toward the children's mother and children witnessing their assaults and injuries. • Several children witnessed severe physical and sexual violence perpetrated against their mothers. This included: a father punching a mother to the face and breaking her jaw, a step-father head-butting a mother, resulting in a broken nose, a father strangling a mother to the point of unconsciousness and incontinence, a mother being violently raped by a partner, a mother being thrown to the ground by her throat. As one child said to the police after witnessing a violent assault on her mother: *'If nothing is done, someone will end up dead'.* • Fifteen male children went on to perpetrate family violence against their mothers, siblings or partners. One child, at aged eight, self-reported to the police after assaulting his mother. Two years earlier he had witnessed his step-father hit his mother repeatedly with a chair. At 13, he threatened his mother with a weapon and told her he wanted to kill her. • All of the boys in the sample who had experienced family violence, had witnessed the perpetration of violence by their fathers or step-fathers. • Thirteen of the 14 girls in the sample had experienced family violence. The remaining child had alleged her parents used physical restraints to restrain her and was also reported as perpetrating family violence herself. The violence she was reported to perpetrate was not assessed to constitute family violence and the case was closed at intake. • Several girls who had witnessed family violence within the home had partnered with violent, sometimes much older males. • Early examples of neglect detailed an overall lack of parental supervision or ability to provide basic care. Two children were observed wandering in the streets unsupervised, late at night, sometimes with a younger sibling. This occurred in the context of feeling unsafe at home because of family violence. The parents of these two children had been raised in institutional care. Both were reported to have suffered institutional abuse.

Table 5: Harms experienced by children as known to Child Protection continued

Nature of harm	Child and young person's experiences
Family violence in combination with drug and alcohol abuse/ parental mental illness	• Several children witnessed their mother or father overdose on drugs. Two were required to call an ambulance. One witnessed their mother inject the family dog with heroin; another had a needle-stick injury as a result of stepping on a needle in their lounge room. • A number of children witnessed their mother or father self-harming or attempting suicide. One child who had witnessed their mother stab herself with a kitchen knife wrote to their Child Protection worker: *'Sorry about all this I feel really bad about it but it's been years and I can't wait any longer. [Mum] can get really bad and she'll scream and bash herself against the walls and I love her and she can be nice and she buys me lots of things and she really does care about me and love me but like after all I've been through I really need support and not only am I not getting support here I'm having the negative temptations and stuff as well here. I'm really not safe here and it's really scary and I'm sick of trying to be strong for the both of us all the time and being such a failure at it all.'* Child Protection closed the case investigation. The child died two weeks later. • One child described living with their mother, who struggled with substance issues and poor mental health: *'I don't know whether I'll get nice mummy or horrible mummy'*. This mother lived in a relationship with a partner who regularly beat her to the point of hospitalisation. The mother described a childhood marred by physical abuse and parental alcoholism.
Neglect, including transience	• One child was described as 'hungry, filthy and had flea bites all over [their] body'. Their mother was a young woman with a suspected learning disability and untreated mental illness. She was identified to have limited social or family supports. • There were cases involving children living week-to-week in different locations; one slept in a barn for two months and another lived and slept on the floor of a caravan. One child described that when the family moved, they moved quickly *'we don't take any personal things or electrical things'.* • An Aboriginal child, aged four at the time, was reported to be underweight, with insufficient access to food and water, which resulted in them drinking the water from a marijuana pipe (bong) while unsupervised. The house was described as *'filthy with dogs living inside and dog faeces on the floor'*. The child's parent was a reported victim of childhood sexual abuse who had used heroin since adolescence. • School lunches were frequently referenced: one child attended school with lunches that contained 'rancid meat', another with 'mouldy sandwiches' and 'mouldy food'. • One child's house was described as *'unclean, with electrical wires hanging from the room, dangerous power points, and no gas available for showers, cooking or heating. The lounge room window was broken and a blanket had been taped to the roof to minimise the wind. A "bong" was observed in the children's bedroom.'* The child's parent was chronically depressed and avoided contact with services because they were 'scared' their child would be removed. • There were multiple examples of associated health issues arising in the context of neglect. These included scabies, hearing problems attributable to untreated wax build-up, sores, loss of teeth due to poor diet and hygiene, fleas and lice. • In one case, a child and their family were reported to have relocated to 12 different schools during the course of 18 months. In another, a child and their mother had moved 13 times in two years.

Table 5: Harms experienced by children as known to Child Protection continued

Nature of harm	Child and young person's experiences
Sexual abuse	• Allegations of sexual abuse by a family member or person known by the family were present in 50 per cent of cases reviewed. • One child, who was reported to have been sexually abused by a number of adult males, including a step-father, refused to make disclosures to the police. There were six separate reports detailing sexual abuse and only one face-to-face contact with Child Protection. All cases were closed at intake. The child death inquiry concluded that this child 'flew under the radar' until their suicide. Their suicide 'shocked the school community'. • One child, who was reported to have been sexually abused by a number of adult males, including their father and sports coach, was raped by a group of men who photographed the incident.
Emotional or psychological violence	• Several children dealt with emotional rejection from their mothers, which impacted on their ability to feel safe and loved. One child, at the age of eight, was present while their mother advised Child Protection *'I've come to the end of my journey with [child]. [The child] has been trouble since they were two years old. I don't want to harm them, but I will. I don't want them.'* This mother had been removed from her family as a young child in the context of severe physical and emotional abuse. She had been violently assaulted by the child's father during her pregnancy and expressed difficulties forming an attachment with the child since birth. These difficulties remained unaddressed and were compounded by escalating family violence between the parents, witnessed by the child. The child's subsequent aggression towards their mother resulted in emotional rejection from which neither recovered. • One child, aged eight, was 'kicked out' of their mother's home after alleging their mother's partner sexually assaulted them.

The impacts of harm as experienced by the children

To understand how these 35 children experienced the child protection system, it is helpful to first gain a sense of how the system experienced and perceived them. Across the sample of 35 cases, a number of themes emerged regarding the perceived strengths, vulnerabilities and circumstances of these children. These themes related largely to how they 'behaved'. In many instances, behaviours were extreme and frequently anti-social, however they could also be self-destructive. A consistent feature of the behaviours exhibited by this sample is that they were almost always shaped by history and circumstance.

Table 6: Impacts of harm on children and coexisting vulnerabilities

Behavioural impacts as experienced by the children
• The children within this sample were frequently described as: 'out of control', 'angry', 'manipulative', 'wild', 'bad', 'difficult', 'hard work', 'high-risk' but also, 'sad', 'needy', 'damaged', 'fragile' and 'vulnerable'.
• All female children engaged in deliberate self-harming, with one child explaining after she had razored her thighs: *'it makes me feel better'.*
• Over half of all children complained of sleep disturbance or insomnia.
• Nearly three quarters of the children used alcohol and drugs, with several using marijuana, cigarettes and alcohol from the age of eight years.
• Many of the children talked about suicide from a very early age. One child made their first threat to suicide at age seven, another at age nine. At age 12, one child asked that for their birthday, they receive: *'a suicide platform, chair and rope'.*
• A number of female children who had been the victims of sexual abuse as young children, engaged in high-risk behaviours as adolescents, which frequently involved alcohol, drugs and older males. Two of these children would run in front of moving traffic.
• The children with symptoms of depression evidenced a lack of self-care: *'[child] will not brush her hair, rarely showers, regularly self-harms, and has not been to school for two years and uses a container in her bedroom to urinate in'.* This child was the subject of six reports to Child Protection, all of which were closed at intake or investigation.
• Nine male children who had been the victims of family violence, frequently in combination with parental substance abuse or sexual abuse, engaged in high-risk activities that saw them come into increasing levels of contact with the criminal justice system. At least three were picked up 'joy-riding'.
• A large number of children damaged property belonging to their parents, carers or school. One boy took to his family home with a baseball bat, another damaged computers at school.
• One child was observed at school to drink liquid paper, cut himself with scissors, extract the blade from a pencil sharpener and cut the insides of his mouth. His behaviours were described by a health professional as 'attention seeking'.
• One child, diagnosed with high functioning autism, made repeated allegations of physical abuse by his step-father that included the use of physical restraints. He exhibited extreme aggressive behaviours, hitting, biting, spitting, made threats to kill students at his school, physically assaulted younger siblings and threw a television at school.
• Two male children and one female child engaged in fire-lighting.
• A number of children were described as 'old before their time'; one 16-year-old female was described as 'always trying to be older than her years'. A 14-year-old boy was described by their parent as 'more like a man, not a boy at all.'

Gender differences

In the cases analysed, there were 14 females and 21 males. The inquiry identified some differences between the impacts and co-existing vulnerabilities for the males and females within the sample, which are consistent with other studies.[87]

Table 7: Nature of impacts and co-existing vulnerabilities for children

	Males		Females		
	n	%	n	%	Total
Exposure to family violence	20	95%	13	93%	**94%**
Disengaged from school	19	90%	10	71%	**83%**
Self-harming	15	71%	14	100%	**83%**
Prior suicide attempts	14	67%	12	86%	**74%**
Use of family violence	19	90%	6	43%	**71%**
Substance abuse	15	71%	8	57%	**66%**
Contact with criminal justice system	15	71%	7	50%	**63%**
Behavioural problems resulting in multiple placements	9	43%	10	71%	**54%**
Reported sexual abuse	10	48%	8	57%	**51%**
Disability	9	64%	2	14%	**31%**

Figure 4: Most common risk indicators in the cases involving female children

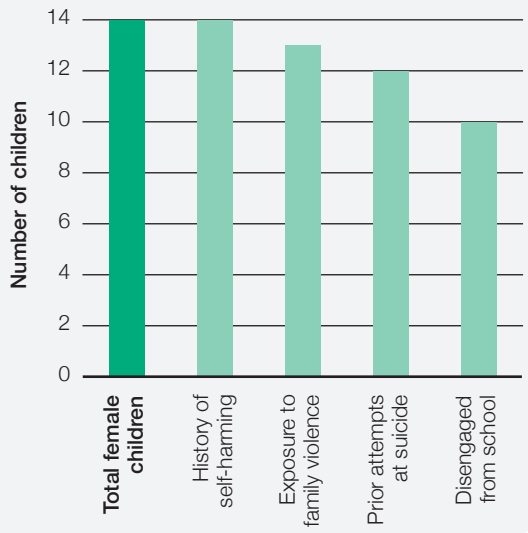
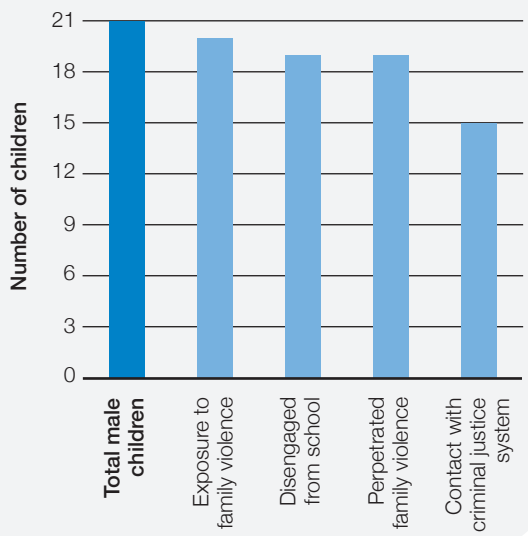


Figure 5: Most common risk indicators in the cases involving male children



87 Doan, J, LeBlanc, A, Roggenbaum, S, and Lazear, KJ (2012). *Youth suicide prevention school-based guide: —Issue brief 3a: Risk Factors: Risk and protective factors, and warning signs*. Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (FMHI Series Publication #218-3a-Rev 2012).

The inquiry found that gendered risk indicators changed depending on the children's age at time of death.

Table 8: Risk indicators per age and gender (children aged 12–14 at time of death)

	Male		Female		
	n	%	n	%	Total
Self-harming	7	100%	4	100%	**100%**
Exposure to family violence	7	100%	3	75%	**91%**
Prior attempt at suicide	6	85%	3	75%	**82%**
Perpetrated family violence	6	85%	2	50%	**73%**
Mental health diagnoses	5	71%	2	50%	**64%**
History of sexual abuse	4	57%	2	50%	**55%**
Substance misuse	3	43%	3	75%	**55%**
Contact with criminal justice system	3	43%	2	50%	**45%**
Disengaged from school	3	43%	2	50%	**45%**
Disability	3	43%	–	–	**27%**

Table 9: Risk indicators per age and gender (children aged 15–17 at time of death)

	Male		Female		
	n	%	n	%	Total
Exposure to family violence	13	93%	10	100%	**96%**
Disengaged from school	13	93%	8	80%	**88%**
Contact with criminal justice system	12	86%	5	50%	**71%**
Mental health diagnoses	9	64%	8	80%	**71%**
Perpetrated family violence	13	93%	4	40%	**71%**
Self-harming	7	50%	10	100%	**71%**
Substance misuse	12	86%	5	50%	**71%**
Prior attempt at suicide	6	43%	9	90%	**63%**
History of sexual abuse	5	36%	6	60%	**46%**
Disability	6	43%	2	20%	**33%**

Younger children (aged 12–14) at time of death

Almost one-third of the children reviewed for this inquiry ended their lives by the age of 14 (n=11). Of these, 21 per cent of the children were Aboriginal (n=3) and over half (64 per cent) had received a mental health diagnosis (n=7).

The inquiry found that this cohort of younger children represented a particularly vulnerable subset. They were proportionately more likely to have engaged in self-harming behaviour, been exposed to and perpetrated family violence and been the victim of reported sexual abuse.

Almost two-thirds (64 per cent) of this group of children had their first contact with Child Protection in the first three years of their life.[88] In all instances, they had come to the attention of Child Protection services following reports of family violence, in combination with parental substance misuse.

In the years that followed, all of the children engaged in self-harming behaviours.

Boys aged 14 and under at time of death, were more likely than girls of the same age to have perpetrated family violence, made a prior attempt at suicide and have a history of reported sexual abuse. For this cohort of children, boys were also more likely to have received a mental health diagnosis, frequently following intervention from primary schools. Of the seven boys, 43 per cent had been assessed as having a disability (n=3).

For the girls aged 14 and under at time of death, they were more likely to have disengaged from school, misused substances (most commonly in the context of relationships with older men) and had some level of contact with the criminal justice system.

Older children (aged 15–17) at time of death

Over two-thirds of the children (69 per cent) died between the ages of 15 and 17 years (n=24). Male children accounted for 58 per cent (n=14) and female children, 42 per cent (n=10). Three of the children were Aboriginal (13 per cent). Young men aged 15 to 17 years were significantly over-represented in the children reviewed by this inquiry, representing 40 per cent of the total number of recorded deaths (n=14).

One third of older children had been assessed to have disability (n=8) and over two-thirds were diagnosed with mental illness (n=17).

Within this cohort, there were extremely high levels of exposure to family violence (n=23) and disengagement from school (n=21).

For older male children, the reported use of violence and aggression was frequent, often serious and generally impulsive. Within this group, boys and young men were often described as ‘rageful’, ‘lacking in remorse’, ‘scary’, ‘explosive’ and ‘unpredictable’.

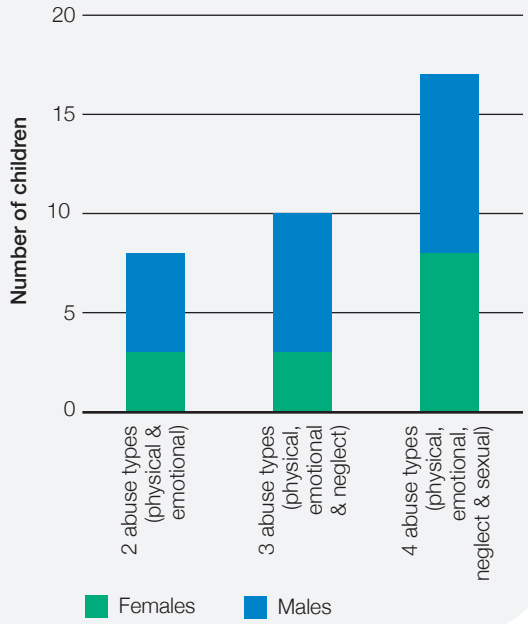
The older cohort of girls and young women were more likely to have a diagnosed mental illness, have made a previous attempt at suicide and experienced sexual abuse. Of note, the older cohort of girls and young women were less likely to have perpetrated family violence and have contact with the criminal justice system. Female children in the older cohort were just as likely as the younger cohort to engage in self-harming behaviours.

Risk factors in the children’s lives

In the majority of cases analysed by the inquiry, the children faced recurring risk and vulnerability issues, with very few verified protective factors. For most of the children, the risk factors occurred on multiple occasions and escalated across reports, whilst the vulnerabilities tended to remain static (for example, the presence of disability) or ebb and flow (for example, maternal ambivalence). This section examines the most frequently occurring and co-occurring types of abuse reported in the cases assessed.

88 The children were the subject of an average of seven reports each. Three of the boys (43 per cent) were the subject of protection orders at the time of death.

Figure 6: Numbers of children who experienced harm, per type



Almost half of the children in the sample (n=17) experienced four co-occurring abuse types that were present during the course of multiple, often recurring reports. In a number of cases, the types of risks and the length of time they had been occurring would fit the definition of a family with 'multiple and complex needs'.

The children and their families

Over half (57 per cent) of the children reviewed by this inquiry came from families who were known to Child Protection as a result of earlier intervention involving a parent (n=20). This occurred in the context of a parent being a former child-client of Child Protection or as a result of previous contact associated with a child's sibling.

Nearly two-thirds of the families reviewed had a known and recorded history of trauma that was both entrenched and unresolved (n=22). It is important to acknowledge that for many of these parents, their experience of parenting was shaped by their own experiences in childhood. These parents' experience of childhood often involved family violence, sexual abuse and untreated mental illness. All of the Aboriginal children had a history of intergenerational trauma, including older family members directly impacted by the Stolen Generations.

In just under half of the cases reviewed (46 per cent), parents were involved in highly acrimonious separations (n=16), frequently in the context of family violence and substance abuse issues.

Of the 35 children reviewed, 69 per cent (n=24) had no or only intermittent contact with their fathers. A high proportion of the children (40 per cent) had a father or step-father who had spent time in prison, which resulted in gaps in contact (n=14). Of these children, half were male children (n=7) and half were female children (n=7).

Nearly all of the parents had a diagnosed or suspected mental illness (n=33). Of these, 45 per cent had attempted or completed suicide (n=13). Four of the children had lost a parent to suicide. All children who died at 14 years or under had a parent with a diagnosed or suspected mental illness, as did all female children (across both the younger and older cohorts).

In terms of the specific risk factors identified, Table 10 outlines those relating to parents in the cases reviewed. The child death inquiries noted that in general, Child Protection had not fully assessed the risk factors associated with the children's parents. However, many were apparent from reading the chronology of service files.

Residence at time of death

Just under half (49 per cent) of the children lived in metropolitan Melbourne (n=17) and 51 per cent lived in regional or rural Victoria at the time of death (n=18).

Almost three quarters of the children (71 per cent) were living at home with at least one parent at the time of their death (n=25). A further 11 per cent were living with family, in kinship care arrangements. For the remaining 18 per cent, their deaths occurred while they were living independently or in residential care (n=6).

The three children who died while in residential care had experienced between five and fourteen placement changes.

Four of the six Aboriginal children were living at home, with at least one parent, at the time of their death. The remaining two children were living in kinship care.

Table 10: Risk factors relating to parents in cases reviewed

Known risk factors in parents	Males		Females		Total
	n	%	n	%	
Mother who had experienced family violence[89]	20	95%	14	100%	**97%**
Parent with a diagnosed or suspected mental illness	19	90%	14	100%	**94%**
Parent with a reported substance abuse issue	17	81%	7	50%	**71%**
Parent with a known history of trauma (including history of reported sexual abuse)	11	53%	11	79%	**63%**
Parent known to Child Protection at time of first report relating to child reviewed	12	57%	8	57%	**57%**
Reportedly acrimonious separation between parents of child	10	48%	6	43%	**46%**
Father or step-father who had spent time in prison	7	33%	7	50%	**40%**

Chapter 4 at a glance

- In the deaths studied for this inquiry, the children faced multiple risk factors and forms of harm, often from an early age. These harms included family violence, sexual abuse, parental substance abuse and untreated mental illness, neglect and community isolation.
- Family violence, often severe, was a feature of 94 per cent of these children's lives, frequently in combination with neglect.
- The children studied for this inquiry presented with different risk indicators based on their gender and age at time of death.
- The impact of trauma manifest differently for boys and girls. Female children were more likely to engage in self-harming behaviours, attempt suicide and have a diagnosed mental illness. Male children were more likely to perpetrate family violence and engage in high-risk taking behaviours that brought them into contact with the criminal justice system. Across both genders, exposure to family violence, disengagement from school and sexual abuse by a family member or person known to the family were relatively equal.
- Children who died by the age of 14 were found to be an especially vulnerable group who were more likely to have had contact with Child Protection in the first three years of their life.
- Most of the children came from families where trauma was entrenched and compounded by the 'toxic trifecta' of family violence, parental mental illness and substance abuse issues. Unresolved trauma and untreated parental mental illness featured prominently in the majority of children's lives reviewed.

89 In one case, violence was only perpetrated against the mother, by the child.

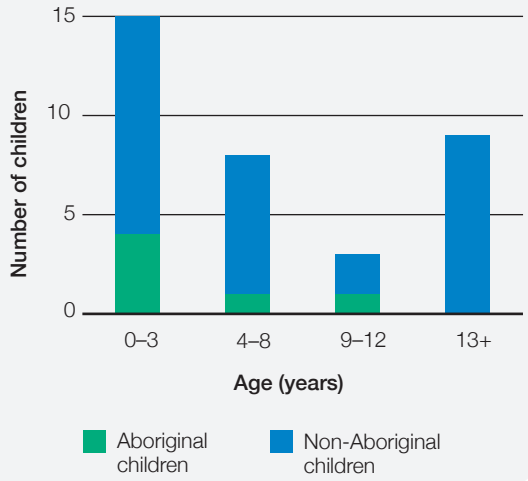
Chapter 5
Contact with the statutory child protection system

Length and nature of contact

The length and nature of contact with Child Protection varied across the cases reviewed, but in most cases, there had been lengthy contact, which sometimes began very early in the child's life. For example, one Aboriginal child was known to Child Protection from the time of birth up until the time they died.[90]

Two-thirds of all children (66 per cent) had their first contact with Child Protection before they turned eight (n=23), with the majority of these children (65 per cent) having their first contact in the first three years of their life (n=15). For the Aboriginal children, 67 per cent (n=4) had contact with Child Protection before they had turned two.

Figure 7: Age at time of first report to Child Protection



For the younger cohort who died by the age of 14 years (n=11), 64 per cent of these children were three years or under at the time of their first contact with Child Protection (n=7).

Children came to the attention of Child Protection an average of seven times. Over half of the children in the inquiry (57 per cent) were the subject of between six and ten reports.

In cases where there were multiple reports, there was an overall pattern of closing cases at intake or after a brief investigation. For example, Child Protection closed the case of one child at intake 13 times from 16 reports – the final three closures occurred in the context of them being recently reunified to their family following several years of living in out-of-home care on a Guardianship to Secretary Order. Another child had their case closed at intake 15 times from 20 reports; the first report was received shortly after their birth (it was closed at intake) and the final report (also closed at intake) five weeks before their suicide.

The average period between when Child Protection closed the final report and the death of the child was three and a half months. One-third (34 per cent) of the children reviewed died within eight weeks of their final report being closed or placed in closure phase (with closure having been communicated to the child) (n=12).

Ten of the 12 children who died within eight weeks of their final report being closed or moved to closure phase had their reports closed with 'no further action' from Child Protection. One child was recorded to have a 'safety plan in place' and another was closed following a case conference. For six of the 12 children, the final report received marked their sixth or more report to Child Protection.

90 This did not mean there had been active Child Protection involvement throughout the child's life.

Table 11: Final report outcomes prior to child's death

	Closed at intake with no further action	Closed with a referral to Child FIRST	Closed with information sent about Child FIRST	Protective intervention or child on current order
Aboriginal children	2 of 6 (33%)	1 of 6 (17%)	n/a	3 of 6 (50%)
Non-Aboriginal children	14 of 29 (48%)	3 of 29 (10%)	3 of 29 (10%)	9 of 29 (31%)
Total	**16 of 35 (46%)**	**4 of 35 (11%)**	**3 of 35 (9%)**	**12 of 35 (34%)**

For those children with closed cases at the time they died, many had previous interventions, including protective intervention. Of the children who had closed cases at the time of their death, approximately 40 per cent had earlier reports substantiated and almost one-quarter had prior protective intervention. In several cases, reports received following periods of protective intervention were assessed with unwarranted optimism, usually in the context of a recent reunification.

Table 12: Reports to Child Protection closed at intake or investigation[91]

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
1	2	2 closed at intake	0	Closed (9 months prior to death)
2	2	1 closed at intake, 1 closed at investigation	0	Closed (5 months prior to death)
3	25[93]	12 closed at intake, 12 closed at investigation (SA) 1 closed at investigation (VIC)	0	Closed (6 weeks prior to death)
4	11	6 closed at intake, 3 closed at investigation	2	Protective order
5	16	8 closed at intake, 5 closed at investigation	2	Closed (4 months prior to death)
6	2	1 closed at intake, 1 closed at investigation	0	Open
7	2	2 closed at intake	0	Closed (8 weeks prior to death)
8	7	6 closed at intake, 1 closed at investigation	1	Closed (4 months prior to death)
9	3	3 closed at intake	0	Closed (11 months prior to death)
10	2	2 closed at intake	1	Protective order
11	7	6 closed at intake, 1 closed at investigation	0	Closed (four weeks prior to death)

91 For further information concerning actions undertaken upon substantiation, see Table 14. For further information concerning statutory intervention via initiation of protective proceedings, see Table 15.

92 The table does not detail reports closed at protective intervention that did not result in protective proceedings. This leads to, in some instances, a greater number of total reports than those recorded as closed at intake or investigation.

93 Only 1 of the 25 reports was received in Victoria, with the remaining received by Families South Australia. Of the 25 reports dealt with by Families South Australia, 12 were closed at intake and the remaining 12 were closed at investigation. Only the Victorian figure has been included in our total calculations.

Table 12: Involvement with Child Protection continued

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
12	2	1 closed at intake, 2nd report in closure phase following investigation	1	Open, closure phase (decision to close communicated to child 5 days prior to death)
13	8	5 closed at intake, 2 closed at investigation	1	Protective order
14	6	5 closed at intake	1	Protective order
15	9	5 closed at intake, 3 closed at investigation	3	Protective order
16	14	7 closed at intake, 5 closed at investigation, 14th report was to be closed at investigation	2	Open, closure phase (decision to close communicated to child 2 weeks prior to death)
17	7	6 closed at intake, 1 closed at investigation	0	Closed (9 months prior to death)
18	5	5 closed at intake, decision to close 5th at intake made 2 days prior to death	0	Closure phase (decision to close communicated to child 2 days prior to death)
19	2	2 closed at intake	0	Closed (3 months prior to death)
20	5	3 closed at intake, 1 closed at investigation	2	Protective order
21	6	5 closed at intake, 1 closed at investigation	1	Closed (two weeks prior to death)
22	7	5 closed at intake, 1 closed at investigation	0	Closed (8 months prior to death)
23	11	8 closed at intake	1	Protective order
24	20	15 closed at intake, 2 closed at investigation	4	Closed (five weeks prior to death)
25	6	3 closed at intake, 2 closed at investigation	2	Closed (10 days prior to death)
26	6	4 closed at intake	2	Protective order
27	3	3 closed at intake	0	Closed (9 months prior to death)
28	9	4 closed at intake, 3 closed at investigation	3	Protective order
29	6	5 closed at intake	1	Protective order
30	4	3 closed at intake, 1 at investigation	0	Closed (10 months prior to death)
31	3	2 closed at intake, 1 at investigation	1	Closed (2 weeks prior to death)
32	2	1 closed at intake, 1 closed at investigation	0	Closed (3 weeks prior to death)

Table 12: Involvement with Child Protection continued

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
33	3	2 closed at intake, 1 closed at investigation	0	Closed (5 months prior to death)
34	8	7 closed at intake	1	Protective order
35	22	17 reports at intake, 5 closed at investigation	1	Closed (decision to close communicated to carer 1 day prior to death)
Total reports	**229**[94]	**78% of reports closed at intake (161 reports) 22% of reports closed at investigation (45 reports) 90% of reports closed at intake or investigation (206 reports)**	**33 (14%)**	

Analysis of actions undertaken by Child Protection at the time they closed reports suggest:

- in 69 per cent of cases, reports were closed without further action (n=158)
- in 23 per cent of cases, reports were closed with Child Protection providing referrals to Child FIRST (or writing to encourage families to make contact with Child FIRST) (n=52)
- in the remaining eight per cent of cases, reports resulted in protective intervention or there was an active investigation at time of death (n=19).

All children who were referred by Child Protection to Child FIRST services were the subject of re-reports. None of the children or their families were engaged with community-based child and family services at the time of their death.

Table 13: Actions undertaken by Child Protection upon closure

	Closed with no further action	Closed with referral to Child FIRST	Closed with information sent about Child FIRST	Protective intervention or active investigation at time of death
Aboriginal children	27 of 33	2 of 33	3 of 33	3 of 33
Non-Aboriginal children	132 of 196	36 of 196	11 of 196	16 of 196
Total	**158 of 229 (69%)**	**42 of 229 (18%)**	**10 of 229 (4%)**	**19 of 229 (8%)**

The 20 children who were the subject of substantiated reports were the subject of, on average, nine reports. Early reports (for example, reports one to five) that were substantiated tended to be closed with no further action, except in two cases (in the first, the parent relinquished care of their child due to mental illness and in the second, the child's parent overdosed and was admitted to hospital).

In 61 per cent of reports where Child Protection found there to be a substantiated risk to the child, Child Protection nonetheless closed the case with no further action (n=20). Where action did occur, it generally involved initiation of protection proceedings (n=12). One substantiated report resulted in closure with a referral to Child FIRST.

94 Excluding the 24 reports received by Families South Australia

Table 14: Actions undertaken by Child Protection upon substantiation

Child	No. of reports	Report substantiated	Action upon substantiation	Re-reports
A	11	Report 2 Report 6	Closure, no further action Protection Application	Yes Yes
B	16	Report 2 Report 3	Closure, no further action Protection Application	Yes Yes
C	7	Report 7	Closure, no further action	No
D	3	Report 2	Protection Application	n/a
E	2	Report 2	Closure, no further action	No
F	8	Report 7	Closure, no further action	Yes
G	6	Report 6	Protection Application	n/a
H	9	Report 2 Report 6 Report 9	Closure, no further action Closure, no further action Protection Application	Yes Yes Yes
I	14	Report 5 Report 14	Closure, no further action Closure, no further action	Yes No
J	5	Report 3 Report 5	Closure, no further action Protection Application	Yes n/a
K	6	Report 6	Closure, no further action	No
L	11	Report 11	Protection Application	n/a
M	20	Report 2 Report 6 Report 13 Report 16	Closure, no further action Closure, no further action Closure, no further action Protection Application	Yes Yes Yes Yes
N	6	Report 2 Report 4	Closure, no further action Closure, no further action	Yes Yes
O	6	Report 3 Report 6	Closure, no further action Protection Application	Yes n/a
P	9	Report 1 Report 2 Report 9	Closure, no further action Closure, referral to Child FIRST Protection Application	Yes Yes No
Q	6	Report 6	Protection Application	n/a
R	3	Report 3	Closure, no further action	No
S	8	Report 8	Protection Application	n/a
T	22	Report 2	Closure, no further action	Yes
178 reports		**33 (19%) substantiated**	**20 reports closed with no further action (61%)** **12 Protection Applications (36%)** **1 closed with referral to CF (3%)**	

For the 12 children who were the subject of protection applications, proceedings were initiated (on average) at the point of report seven. Of these children, three quarters (n=9) had their first contact with Child Protection by the age of three. The earliest reports recorded to result in protective proceedings was report two (in circumstances where the parent had relinquished or was incapable of providing care) and the latest was the sixteenth report. One-third of the children in this subset identified as Aboriginal (n=4).

For the 12 children who were the subject of protection applications, the average time between the first recorded report and the initiation of protection proceedings was six years, four months.[95]

Table 15: Time between first report and initiation of protective proceedings

Child	Age at first report	Report resulting in statutory intervention	Age at statutory intervention	Period between first report and statutory intervention
A	2 years	Report 6	3.5 years	18 months
B	2 years	Report 3	3 years	12 months
C	Birth	Report 2	2 years	21 months
D	10 years	Report 6	13 years	3 years, 10 months
E	2 years	Report 9	17 years	5 years, 3 months
F	8 years	Report 5	14 years	5 years, 9 months
G	5 years	Report 11	15 years	10 years
H	3 months	Report 16	10 years	10 years, 9 months
I	18 months	Report 6	9 years	8 years, 8 months
J	18 months	Report 9	10 years	9 years, 11 months
K	9 months	Report 6	8 years	7 years, 10 months
L	3 years	Report 8	13 years	10 years, 6 months

Table 16: Highest level of intervention received over course of child's life

	Aboriginal	Non-Aboriginal	Total
Intake phase		6	6 (17%)
Investigation phase	2	10	12 (34%)
Protective intervention phase		4	4 (11%)
Interim Protection Order		2	2 (6%)
Supervision Order/Family Preservation Order	1	2	3 (9%)
Custody to Secretary Order/Family Reunification Order	2	4	6 (17%)
Guardianship to Secretary Order/Care By Secretary Order	1	1	2 (6%)
Totals	**6**	**29**	**35 (100%)**

95 The delay in commencing statutory intervention should not be viewed as necessarily reflecting poor practice; provided families are supported in a timely way by community-based services to care for and keep their children safe during the intervening period.

Responding to Aboriginal children

Meaningful and culturally safe practice with Aboriginal children requires an understanding of the role of culture and identity in the child's life, an awareness of the location of the child's family and community, and action to ensure other requirements of the CYFA are met.

Aboriginal children were over-represented in the children reviewed, accounting for 17 per cent of the total children who died (n=6). Of the six children, four were female and two were male. Four of the children had their first contact with Child Protection by the age of two. The Aboriginal children were more likely to have a report substantiated and be the subject of protective proceedings, compared with their non-Aboriginal peers.

Half of the Aboriginal children were recorded as having disability. Five of the six children were recorded to have a diagnosed mental illness. All had a history of self-harming behaviours and reported sexual abuse in early childhood. All of the Aboriginal families had experienced intergenerational trauma – five of the six children were raised by mothers who had spent time in care as children. Five of the six children had a parent with severe mental illness and of these, all had made attempts to take their own life. In two cases, these attempts were made in the presence of their children.

In the six cases involving Aboriginal children:

- Four of the six children were eligible for an Aboriginal family-led decision-making meeting, but a meeting was held for only one of the children.
- Two children were at various stages entitled to a Cultural Support Plan, but in neither case was one completed.
- Failure to comply with the Aboriginal Child Placement Principle was recorded with respect to three of the children placed in out-of-home care.
- Consultation with the Aboriginal Specialist Advice and Support Service occurred in four of the six cases.
- Koori Education Support Officers worked with four of the six Aboriginal children.

Research establishes that connection to culture is protective for Aboriginal children, particularly those at risk of suicide. For the six Aboriginal children reviewed for this inquiry, connections to culture were inadequately prioritised.

Chapter 5 at a glance

- Each child in this inquiry was, on average, the subject of seven reports to Child Protection.
- The children had typically lengthy contact with Child Protection, frequently beginning in early childhood. Two-thirds (n=23) of the children had their first contact with Child Protection before they turned eight years of age, with the majority of these (65 per cent) having their initial contact in the first three years of life.
- There was a pattern whereby Child Protection closed cases at intake or after a brief investigation. Ninety per cent of all reports made raising concerns for these children were closed at intake or investigation.
- Over two-thirds of reports received, 69 per cent, were closed without further action (n=158). Twenty-three per cent (n=52) were referred (via letter or formal referral) to Child FIRST, with a view to engaging community-based child and family services.
- Of the reports that were substantiated (n=33), 61 per cent (n=20) were closed with no further action recorded, while 36 per cent (n=12) resulted in initiation of protection application proceedings.
- For those children who were the subject of a protection application, proceedings were initiated (on average) at the seventh report to Child Protection, with the average time between first report and initiation of protection proceedings being six years, four months.
- Approximately one-third of families (n=9) expressed a persistent unwillingness to engage with services.
- Despite the majority of families indicating a preparedness to engage, the inquiry found that none of the families were successfully engaged by community-based child and family support services.

Chapter 6
Contact with health, mental health services and police

Evidence of mental health status, substance misuse, self-harming

The inquiry found that the length and nature of contact that children had with mental health and other health services varied depending on the child's gender, age and presence of a diagnosed mental illness.

Table 17: Mental health status by sex and selected diagnoses

	Male		Female		
	n	%	n	%	Total
Diagnosed mental illness	**14**	**66%**	**10**	**72%**	**69%**
• Mood (bipolar/depression/major depressive)	5	36%	6	60%	
• Anxiety (anxiety/OCD/PTSD)[96]	5	36%	8	80%	
• Substance (includes substance induced psychosis)	5	36%	1	10%	
• Personality	2	15%	4	40%	
• Behavioural (ADHD/ODD/ASD/conduct)[97]	11	79%	3	30%	
• Schizophrenia	1	7%	–	–	
• Attachment	–	–	3	30%	
Suspected mental illness	**2**	**9%**	**3**	**21%**	**14%**
No evidence of mental illness	**5**	**24%**	**1**	**7%**	**17%**
Total	**21**	**100%**	**14**	**100%**	**100%**

Of the 35 children reviewed, 83 per cent had a diagnosed or suspected mental illness. Of this cohort, 22 (71 per cent) had received multiple or comorbid diagnoses.

Girls and young women tended to present with anxiety and mood disorders, including depression, while male children were more likely to be diagnosed with behavioural based disorders, including ADHD, ASD and various conduct disorders.

All children with a diagnosed mental illness were prescribed a combination of medications. Scrutiny of the reports revealed that at least one child was prescribed medication by their doctor without a mental health assessment.

The Commission's powers preclude an assessment of clinical decision making and therefore this inquiry has not examined whether prescribed medications were considered to be effective, regularly reviewed or whether underlying issues such as trauma were considered.

96 OCD is Obsessive Compulsive Disorder and PTSD is Post-traumatic stress disorder.
97 ADHD is Attention Deficit Hyperactivity Disorder, ODD is Oppositional Defiance Disorder.

Table 18: Evidence of substance misuse

Substance misuse	Male		Female	
	n	%	n	%
Evidence of substance misuse	**16**	**76%**	**8**	**57%**
• Drug dependence	14	88%	7	88%
• Non-dependent substance misuse	1	6%	1	12%
• Insufficient evidence to categorise	1	6%		
No evidence of substance misuse	**5**	**24%**	**6**	**43%**
Total	**21**	**100%**	**14**	**100%**

Among those who were drug dependent at the time of their death, alcohol and cannabis were the two most frequently used drugs.

Of the males aged 10–14 at time of death, 19 per cent displayed evidence of substance misuse (n=1), with 81 per cent displaying no evidence of substance misuse (n=6). By comparison, 88 per cent of males aged 15–17 at time of death displayed evidence of substance misuse (n=12), with only seven per cent displaying no evidence of substance misuse (n=1).

Despite three-quarters of male children evidencing drug dependence (n=16), only one-quarter had accessed drug and alcohol services (n=5).

Despite evidence of drug dependence in 60 per cent of the cases reviewed (n=21), only a quarter (25 per cent) of the children had a diagnosis of substance dependence and less than a quarter (24 per cent) had accessed drug and alcohol services.

Table 19: Evidence of prior self-harming behaviours

	Male		Female	
	n	%	n	%
Evidence of prior self-harming behaviours	15	71%	14	100%
No evidence of prior self-harming behaviours	6	29%	–	–
Total	**21**	**100%**	**14**	**100%**

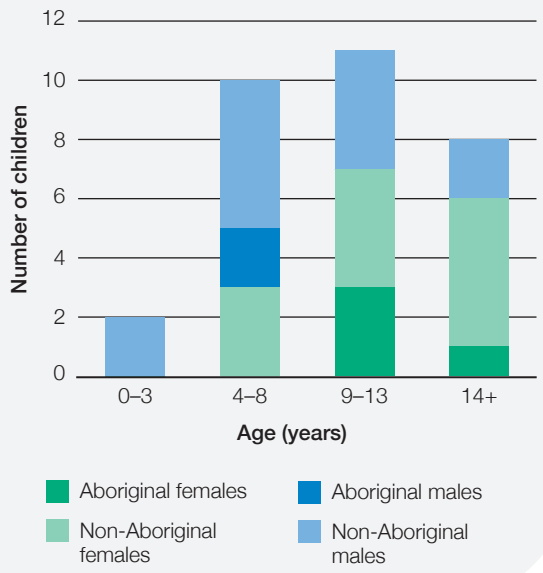
For the girls and young women reviewed, all were recorded to have engaged in serious and long-term self-harming behaviours (n=14).

Significantly, all male children who died by the age of 14 engaged in self-harming behaviours. For the older cohort, aged between 15 and 17 years at time of death, 57 per cent were recorded as engaging in self-harming (n=8). For this cohort, the marked decrease in use of self-harming behaviours was matched by a corresponding increase in the perpetration of family violence, substance misuse and contact with the criminal justice system.

Where self-harming behaviours occurred in the context of a diagnosed mental illness, they were generally considered an adjunct to mental illness, rather than an externalisation or manifestation of trauma. Significantly, all of the children (both male and female) who were reported to have experienced childhood sexual abuse, engaged in self-harming behaviours (n=18).

Early contact with mental health services

Figure 8: Age at time of first contact with mental health services



Of the 35 children reviewed, 89 per cent (n=31) had at least one recorded contact with a mental health service. Of these, a large number had their first contact between the ages of nine and 13 years (n=11). However, most children (39 per cent) had their first contact by age eight (n=12). Significantly, half of all male children who had contact with a mental health service had received a diagnosis by age seven (n=9).

For those children who had received an early diagnosis (by the age of seven) all had been referred to a mental health service by a paediatrician. Contact with a paediatrician was generally preceded by, or occurred simultaneously with, contact from Child Protection. For example, of the 12 children who received an early diagnosis:

- 92 per cent had their first contact with Child Protection by the age of three (n=11)
- 50 per cent had been referred to a paediatrician by the age of five (n=6)
- 75 per cent were male children, of whom all received an initial diagnosis of ADHD and/or ASD (n=9).

Children who received an early diagnosis shared a range of presenting issues:

- they were frequently described as 'out of control', 'angry', 'challenging', 'hard work', 'aggressive', 'violent', 'non-verbal' and 'delayed'
- many presented with self-soothing repetitive behaviours including head-banging, rocking back and forth, biting, chewing, hitting, picking, hair-pulling
- some were reported to display persistent crying and/or screaming
- several displayed sexualised behaviours
- incontinence and encopresis[98]
- insomnia.

They also shared a range of other co-existing vulnerabilities, including:

- 100 per cent had been exposed to severe family violence in early childhood between their mother and father or step-father (n=12)
- 100 per cent were reported to have experienced neglect (n=12)
- 92 per cent had a mother who had reported to Child Protection a history of post-natal depression and difficulties 'bonding' with her child (n=11)
- 75 per cent had a parent with drug and/or alcohol addiction (n=9)
- 75 per cent had no, or limited and sporadic contact with their fathers (n=9)
- 67 per cent had a parent who had attempted or completed suicide (n=8)
- 67 per cent had an intellectual disability (n=8)
- 67 per cent were reported to have experienced sexual abuse in early childhood (n=8).

A large number of children reviewed by this inquiry were considered to have attachment-related issues stemming from poor early attachment with their mothers.

98 Encopresis is the soiling of underwear with stool by children who are past the age of toilet training.

Case study

One child was first reported to Child Protection as a young infant after their mother attended at her general practitioner 'distressed and tearful, expressing difficulties with her child and little support from her husband who works long hours'. She disclosed thoughts about smothering her infant. The mother was diagnosed by her doctor to have post-natal depression and recommended to enlist the support of extended family members to help her care for her children.

Child Protection assessed that adequate family supports were in place and closed the report without further action.

Within eight weeks, the mother had attempted suicide. Her diagnosis of post-natal depression was reconfirmed, and her child placed away from her care for a short time, but nil services were engaged to support her recovery. Child Protection again assessed adequate family supports and closed without further action.

In the next few months, multiple reports detailed numerous hospital presentations by the mother who expressed concerns that she might 'attack' her infant. She repeatedly sought an 'assessment' of the young child, who she described as 'difficult' and 'not sleeping'. At two years of age, the child was referred to a paediatrician who diagnosed the child as having ADHD.

By five years of age and following four more reports, the mother presented the child at another hospital describing him as 'out of control' – the child was witnessed to bite, kick, scream and spit. The child was observed by the hospital to have bite marks and bruising to their back and shoulders. A second assessment by a different paediatrician concluded that 'the child's behaviour is not medically based'.

By this stage, the mother's untreated mental health issues were obscured by the 'behaviours' of her young child, which became the context in which risk was assessed.

By eight years of age, following another seven reports, the mother asked for the child to be 'locked up'.

For this child, as with all children who received early diagnoses, although they had contact with multiple service systems at approximately the same point in their lives, services rarely sought or shared information. The paediatrician who first diagnosed this child at age two had no knowledge of the multiple reports to Child Protection.

Of the 31 children recorded as having contact with a mental health service, 55 per cent had their first contact with mental health services at the point of adolescence (n=19). Of these, 53 per cent (n=10) were male and 47 per cent female (n=9). For the children who received contact (or a diagnosis) in early adolescence:

- 84 per cent presented with self-harming behaviours (n=16)
- 63 per cent received a formal diagnosis by the age of 13 (n=12)
- 58 per cent presented to emergency departments following suicide attempts (n=11)
- 37 per cent had contact with a service, but received no formal diagnoses (n=7)
- 50 per cent received a diagnosis that related to substance use, in combination with depression and/or ADHD (n=6).

These children shared a range of co-existing vulnerabilities, including:

- 89 per cent were reported to have been exposed to family violence (n=17)
- 68 per cent had a parent with a diagnosed mental illness that included a history of suicidal ideation, attempted or completed suicide (n=13)
- 68 per cent were disengaged from school (n=13)
- 58 per cent were reported to have perpetrated family violence against a parent, sibling or partner (n=11)
- 53 per cent had a parent with a reported drug and/or alcohol addiction (n=10)
- 89 per cent of the female children in this group were reportedly sexually active and engaging in high-risk sexual activity, frequently with older males (n=8)
- 70 per cent of the male children in this group were in contact with the criminal justice system (n=7).

Of the children who had contact with a mental health service but remained undiagnosed (n=7), 86 per cent lived in regional or rural parts of Victoria (n=6). This group's presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.

Contact with health, mental health and other services in the 12 months preceding death

Table 20: Contact with health services in the 12 months preceding death

	Male		Female	
Presence and nature of health service contact	**n**	**%**	**n**	**%**
Contact within 12 months	**13**	**62%**	**13**	**93%**
• CAMHS or CYMHS	7	33%	8	57%
• Community-based mental health service	6	29%	9	64%
• Emergency Department	6	29%	9	64%
• Private psychologist	7	33%	3	21%
• School counsellor/welfare worker	4	19%	4	29%
• Drug and Alcohol (including residential detox)	5	24%	3	21%
• General practitioner	4	19%	3	21%
• Private Psychiatrist	3	14%	3	21%
• In-patient admission	3	14%	3	21%
• Recovery and prevention of psychosis service	1	5%	1	7%
No contact within 12 months	**8**	**38%**	**1**	**7%**
Total	**21**	**100%**	**14**	**100%**

Over 90 per cent of female children had contact with a health service in the 12 months preceding their death (n=13). They were most likely to self-initiate contact with a health service via presentation at a hospital emergency department or with a 'walk-in' community-based mental health service, such as headspace or Orygen. By comparison, male children tended to have family members or carers initiate contact with health services via referral to CAMHS or a private psychologist. This meant male children were significantly less likely to self-present at a hospital emergency department or a 'walk-in' community-based service.

Notably, over one-third of male children had no contact with a health service in the 12 months preceding their suicide (n=8).

Table 21: Contact with health services in the six weeks preceding death

	Male		Female	
Presence and nature of health service contact	**n**	**%**	**n**	**%**
Contact within six weeks	**8**	**38%**	**13**	**93%**
• CAMHS or CYMHS	4	19%	5	36%
• Emergency department	4	19%	4	29%
• Community-based mental health service for yp	3	14%	5	36%
• Recovery and prevention of psychosis service	1	5%	0	–
• Private Psychiatrist	2	10%	0	–
• School counsellor/welfare worker	0	–	2	14%
• Private psychologist	2	10%	1	7%
• In-patient admission	1	5%	2	14%
• General practitioner	1	5%	0	–
• Drug and Alcohol (including residential detox)	1	5%	1	7%
• Secure Welfare Service	0	–	0	–
No contact within 6 weeks	**13**	**62%**	**1**	**7%**
Total	**21**	**100%**	**14**	**100%**

Over 90 per cent of the female children had contact with health services in the six weeks preceding death, although overall, the female children had contact with fewer different health service types.

By comparison, the trend for male children shifted significantly. Whereas 62 per cent (n=13) of male children had some form of contact with health services in the 12 months prior to death, this rate drops dramatically to only 38 per cent (n=8) in the six weeks preceding suicide.

Table 22: Emergency department presentations in 12 months and six weeks preceding death

	Male		Female		Total	
	n	%	n	%	n	%
Emergency presentations 12 months	**6**		**9**		**15**	**43%**
• Deliberate self-harm	–	–	1	11%		
• Attempted overdose	6	100%	7	78%		
• Suicidal ideation	–	–	1	11%		
Emergency presentations 6 weeks	**4**		**4**		**8**	**23%**
• Deliberate self-harm	–	–	1	25%		
• Attempted overdose	4	100%	3	75%		
• Suicidal ideation	–	–	–	–		

Of the 35 children reviewed, 43 per cent attended at an emergency department in the 12 months preceding their suicide (n=15). Of those, 87 per cent presented with an attempted suicide by overdose (n=13).

Almost one-quarter of the children reviewed (n=8) had attended at a hospital emergency department within six weeks of death, of these, 88 per cent presented with an attempted suicide by overdose (n=7).

Table 23: Police contact in 12 months and six weeks preceding death[99]

	Male		Female		Total	
	n	%	n	%	n	%
Diagnosed mental illness	**14**		**13**		**27**	**77%**
• Any contact within 12 months	8	57%	5	38%		
• Contact within six weeks of death	8	57%	3	23%		
No diagnosed mental illness	**7**		**1**	**–**	**8**	**23%**
• Any contact within 12 months	5	71%	–	–		
• Contact within six weeks of death	4	57%	–	–		

Of the 35 children reviewed, 51 per cent (n=18) had contact with police within 12 months of their death and 43 per cent (n=15) within six weeks of death.

More than 60 per cent of male children had contact with police in the twelve months preceding their death (n=13) and 57 per cent had contact within six weeks of their death (n=12). Of those male children with no diagnosed mental illness, 71 per cent (n=5) had contact with police in the preceding 12 months and 57 per cent (n=4) in the six weeks prior to death.

By comparison, of the 13 female children with a diagnosed mental illness, only 38 per cent (n=5) had contact with police in the preceding 12 months – one of those as a victim of a rape.

Of the children who came into police contact:

- 44 per cent were alleged to have perpetrated violence against a family member (n=8) – in all instances, substance misuse preceded the alleged violence
- 22 per cent were picked up for high-risk taking behaviours including fire-lighting, joy-riding and behaving in an offensive manner (n=4)
- 11 per cent had contact with police in the context of ongoing drug use (n=2).

99 Information was not available in all cases so the data is potentially underestimated.

Help-seeking behaviours

In a significant number of cases (49 per cent), there was evidence that children had disclosed an intention or plan to suicide in the seven days prior to death. Of those that did disclose an intent, 59 per cent told a friend or peer, sometimes via social media (n=10).

Of the 17 children with a recorded communication of intent to commit suicide in the seven days leading up to their suicide, 12 used informal pathways involving family or peers, with the remaining five using formal pathways involving health professionals or other service providers.

Help-seeking behaviours were markedly different for the cohort of children aged between 12 and 14 years at the time of death. Of these children, 73 per cent disclosed an intention or plan to suicide in the seven days prior to death (n=8). In the majority of cases, this disclosure was made to a worker or mental health professional (n=5).

Table 24: Communication of suicidal intent in seven days leading up to suicide

	Male		Female	
	n	%	n	%
Informal pathways	**3**		**9**	
• Family member			2	(22%)
• Peers	3	(100%)	7	(78%)
Formal pathways	**4**		**1**	
• Mental health practitioner	1	(25%)	1	(100%)
• Worker	3	(75%)		
No known communication of intent	**14**	**57%**	**4**	**21%**
Total	**21**		**14**	

'Under the radar'

Just under one-fifth (n=6) of the children were identified after their deaths as having flown 'under the radar' amongst family members and services. The suicide of each child was met with shock and disbelief. As one family member reflected 'we just didn't see it coming'. As a group, these children were not known to present with mental illness or be considered 'at risk' of suicide; and despite recurring contact with Child Protection, they were never the subject of protective intervention.

The inquiry found a number of shared characteristics among these children, including:

- All had been exposed to high levels of family violence.
- On average, they were the subject of eight reports to Child Protection, which was higher than the recorded average of seven reports per child recorded for all 35 children.
- 83 per cent had been referred to but refused to engage with a school welfare counsellor (n=5).
- None were diagnosed with a mental illness and only one child had received services from a mental health service (but disengaged after one appointment).
- Two-thirds (n=4) were reported to have experienced sexual abuse in early childhood.
- Two-thirds (n=4) were known to use substances and had frequent contact with the criminal justice system.
- Two-thirds (n=4) were suspended from school for selling drugs to other students. The same four misused alcohol and cannabis. One child was repeatedly suspended and ultimately expelled from school for throwing a table at a student. He was described variously as 'explosive', 'intimidating' and 'difficult to engage'. Another was described as 'rude' and 'defiant and confrontational' towards teachers.
- They possessed a shared invisibility – there was a notable absence of information recorded about these children, their perspectives or wishes by service providers.

Chapter 6 at a glance

- The length and nature of contact that children had with mental health and other health services varied depending on the child's age, gender and age at first contact with Child Protection.
- Of the children reviewed:
  - 83 per cent were either diagnosed (n=24) or suspected (n=5) to have a mental illness
  - 83 per cent were recorded as having engaged in deliberate self-harming behaviours (n=29)
  - 60 per cent were recorded as being drug dependent at the time of their death (n=21).
- In terms of the children's contact with health and mental health services in the 12 months preceding death:
  - 74 per cent (n=26) had contact with a health service for care related to their mental health
  - 43 per cent (n=15) had contact with CAMHS or CYMHS, most frequently following an emergency department presentation
  - over 90 per cent of female children (n=13) had contact with a health service for care related to their mental health in the six weeks preceding their death, whereas only 38 per cent of male children had contact with health services in the six weeks preceding death (n=7)
  - 43 per cent (n=15) attended at an emergency department in the 12 months preceding their death; of these 87 per cent presented with an attempted suicide by overdose (n=13).
- 89 per cent had a recorded contact with a mental health service (n=31).
- The inquiry found that children's contact with mental health services was generally preceded by or occurred simultaneously with contact from Child Protection. This trend was particularly pronounced for the children who received a diagnosis by age seven.
- Of the children who had contact with a mental health service but remained without a mental health diagnosis (n=7), 86 per cent of these children lived in regional or rural parts of Victoria (n=6). This group's presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.
- 51 per cent (n=18) had contact with police within 12 months of their death and 43 per cent (n=15) within six weeks of death.
- Almost half of the children had disclosed an intention or plan to suicide in the seven days prior to their death. Of those, 59 per cent (n=10) told a friend or peer, sometimes via social media. Help-seeking behaviours were markedly different for children aged between 12 and 14 years at the time of death.

Chapter 7
Findings related to the child and family system

In Victoria, the importance of early intervention has been recognised in reforms to legislation, government policies and service delivery in the last two decades. This inquiry represents an important opportunity to reflect upon the extent to which these reforms have translated into real change for children and their families.

For the 35 children reviewed by this inquiry, early reports rarely resulted in substantiation or statutory intervention but frequently involved referrals to Child FIRST. Two-thirds of the children had their first contact with Child Protection before they turned eight – with the majority of these children (65 per cent) having their first contact before the age of three. These children needed the system to provide effective and timely early intervention.

What they received instead, was a service response characterised by delays, fragmentation and shallow focus. For these children, an ineffective early intervention system meant that protective concerns, such as exposure to family violence and parental substance misuse, became an entrenched feature of their lives.

As reports multiplied, and more information concerning the children and their experiences was captured via intake and investigation records, the response by Child Protection remained largely unchanged. Ninety per cent of the 229 reports received were closed at intake or investigation (n=206). Of these reports, three-quarters were closed without further action (n=158) and a further 20 per cent (n=42) were closed with a referral to Child FIRST. Re-reports were frequently met with the same response.

For these children, in almost every case nothing changed as a result of reports to Child Protection.

Nothing changed until the point of imminent crisis, usually much later in life, by which stage, the children were highly vulnerable and traumatised individuals, described variously as ‘hard to help’, ‘needy’, ‘rageful’, ‘chaotic’, and ‘out of control’.

Over half of the children were the subject of substantiated reports at some stage (n=20), but over 60 per cent of these substantiated reports were closed without further action (61 per cent).

One-third of the children were the subject of protective proceedings in the Children’s Court (n=12). The average period between Child Protection receiving the first report concerning a child and initiating protective proceedings was six years, four months. This group of children averaged nine reports each, and protective proceedings were initiated (on average) at report seven.

For the children reviewed, opportunities for timely and escalated intervention were missed and with this, the ability to make much-needed positive and long-lasting change for these children and their families.

Statutory child protection system

Child Protection operating as an emergency response service

Reports received at intake were frequently assessed episodically and with a strong focus on ‘triaging’ for imminent risk, similar to an emergency response service. However, Child Protection was commonly triaging a child’s risk based on unverified information, almost always received from a secondary source. In most instances, this required Child Protection to take steps to verify the information by speaking to other sources or situating new information within its historical context. The Commission found that these steps were not always followed.

For the 35 children, 90 per cent of reports were closed at intake or investigation. Of these, over three-quarters (78 per cent) were closed at intake.

Of the children who died in the most recent five years (n=17):

- they were the subject of 91 total reports
- 93 per cent of reports were closed at intake or investigation (n=85)
  - 75 per cent were closed at intake (n=68)
  - 19 per cent were closed at investigation (n=17)
- approximately six per cent proceeded to protective intervention or resulted in the initiation of protective proceedings (n=6).

The Commission reviewed a sample of reports received for those children who died in the most recent five years, to assess how the overlay of 'imminent' risk in the assessment of reports translated in practice terms.

Case study

A child was the subject of their eighth report. The report detailed the child's behaviour was increasingly challenging and had escalated considerably in recent weeks. The child's appearance was dirty and they smelt unwashed. They attended school hungry. The reporter suspected that the child's parent had resumed intravenous drug use.

Child Protection intake reviewed the last contact the family had with a child and family service and contacted the child's school to verify information.

The last recorded contact with Child FIRST was three months earlier (at report six).

Child Protection contacted the child's school and they confirmed the reported concerns and provided additional information concerning the parent's untreated mental illness. Child Protection recommended that the school discuss Child FIRST with the family.

The report was closed at intake with the following rationale: *[The child] has a slight learning disorder. School appears to be [the child's] primary support. School to continue to support."*

Child Protection did not contact the child, the child's parent or Child FIRST. Within three weeks, the child was the subject of a re-report to Child Protection.

This child was the subject of nine reports, eight of which were closed at intake or investigation. Earlier reports detailed a lengthy history of family violence, exposure to drug-use, neglect and sexual abuse. Accompanying these reports was a similarly lengthy history of unsuccessful engagement of the child's parents by child and family services.

The child's child death inquiry found:

> *Closure decisions were often based on untested assumptions that existing services would continue to manage and monitor the situation or that [the child] was able to look after [themselves]. On at least one occasion, Child Protection found that the reporter, a professional with considerable knowledge of the family, did not understand the threshold of Child Protection risk.*[100]

Case study

A child was the subject of their seventh report. The child was missing at the time of report. The report detailed the child's increasingly erratic behaviour, including recent commencement of antidepressant medication, illicit drug use and suspension from school. The child's family was reported as finding it difficult to cope with the child's behaviours.

100 Extract taken from a child death inquiry

The child was located within three days and returned home to their parent.

The report was closed at intake and a letter was sent recommending Child FIRST. No contact was made with the child, the child's family, school or mental health service.

Within one week, the child was the subject of a re-report to Child Protection.

This child was the subject of eight reports, of which seven were closed at intake. Earlier reports detailed a lengthy history of exposure to severe family violence and reported sexual abuse. A number of assumptions were made regarding the seriousness of the report and risk posed to the child. Most notably, risk was framed by the threshold of 'imminence' and the child's 'ability to self-protect' as a young adolescent.

Case study

A child was the subject of their second report. The child was reported to be suicidal and had researched a method, venue and time. The child's parents had recently separated and a current intervention order excluded all contact between the child and their father.

At the time of report, the child was reported to be at home, in the care of their mother.

No contact was made with the child, the child's mother, police or school.

Two days later, the child's school contacted Child Protection and confirmed the child had not returned to school and that the mother was supportive of this decision. The mother had reported to the principal that the child was 'doing better'. The school agreed to refer the child to a mental health service.

The report was closed at intake due to the school's involvement.

Within four months, the child was the subject of a re-report to Child Protection.

This child was the subject of three reports, two closed at intake and one at investigation. An earlier report detailed a lengthy history of severe family violence (commencing in early childhood) and physical abuse. Again, the risk posed to the child in this case was framed by 'imminence' and the child's adolescent age.

The Commission cannot say whether the sample of children reviewed by this inquiry is representative of Child Protection practice more broadly. However, the Commission sees these issues frequently in all child death inquiries involving children who are older when they die. In these 35 children's cases, it is clear that the practice of triaging based on imminent risk resulted in significant risks to these children remaining overlooked and unaddressed.

Failure by Child Protection to identify and respond to risks of cumulative harm

The 35 children were the subject of an average of seven reports per child. The majority of reports received detailed evidence of multiple parental issues and behaviours that were risk indicators for cumulative harm. This was particularly the case for children who had been exposed (from an early age) to ongoing neglect and family violence, in the context of parental drug and alcohol misuse and mental health illness. There was however, little evidence that the impact or effects of cumulative harm on the children was considered.

The CYFA makes explicit that consideration of cumulative harm must inform part of the service response to reports of child abuse or maltreatment.[101] Central to this requirement is the need to avoid an episodic approach to assessing and responding to information that raises concerns about a child's wellbeing.

101 Section 10(3)(e) and section 162(2) of the CYFA.

The department's practice tool *Cumulative harm: a conceptual overview* describes the practice implications of assessing cumulative harm:

> *Each intake/assessment needs to be historically grounded and mindful of the cumulative impacts of harm, and the exponential impact on the child. In practice, the challenge for Child Protection when required is to present evidence to the court that shows the effects of the cumulative nature of harm on children and how it impacts on their development and safety.*[102]

The inquiry found that this advice was rarely translated into practice. As one child death inquiry found:

> *Risk assessments completed in the intake teams considered vulnerabilities and risk factors. What was missing was an analysis of what the information might mean for the [the child's] developmental and emotional trajectory. [The child's] emotional, psychological and cognitive development needed to be viewed through a clinical lens of trauma theory and cumulative harm and the impact on their safety and development.*[103]

Another child death inquiry found:

> *It is impossible to see how decision making in relation to [the child], in light of the multiple reports, could be viewed as having regard to the best interest principles. The importance of reviewing each report to Child Protection and each adverse childhood experience in conjunction with new information cannot be over-emphasised. Despite multiple reports, there was no evidence of an analysis of the likelihood of cumulative harm or its impact upon [the child's] safety and wellbeing.*[104]

And another found:

> *Opportunities for intervention were lost due to a tendency to focus on episodic assessments and to overlook the risk of cumulative harm across a number of separate reports. The consequences of this meant that the problems were entrenched and the cumulative impact of trauma was well-established by the time of adolescence.*[105]

In the majority of cases, consideration of the effects of cumulative patterns of harm was notably absent from the risk assessment processes, particularly those conducted at the intake stage. This was especially so once a child reached adolescence, but also applied to younger children.

In the majority of cases, consideration of 'pattern and history' was shallow or not apparent, which resulted in multiple and episodic risk assessments, where assumptions were drawn regarding the resolution of issues based on a previous report being closed.

In some cases, vulnerabilities such as mental health issues, disability and medical issues were compounded by the cumulative effects of abuse and neglect. However, the intersection between exposure to cumulative patterns of harm and mental health, disability or health issues was rarely explored.

A report involving a 14-year-old child, who had been the subject of a total of seven reports, all closed at intake or investigation found:

> *It was also apparent that each report was viewed in isolation without an adequate consideration of the history and emerging patterns which indicated that the family may not be coping and using inappropriate discipline to manage difficult behaviour. Consequently, overall risk assessment did not adequately incorporate both an understanding of immediate and cumulative harm.*[106]

A report involving a 13-year-old child, who had been the subject of a total of nine reports, eight closed at intake or investigation found:

> *A key learning from the early years of service involvement in [the child's] life relates to the enduring and problematic nature of an approach to reports of abuse which was episodic and event driven. Despite new information, the risk assessment remained static. The report highlights the importance of workers reading and understanding the significance of historical information and during analysis phase of assessment, looking for emerging and repetitious patterns of behaviour and events.*[107]

102 *Cumulative Harm: a conceptual overview*, page 10.
103 Extract taken from a child death inquiry
104 Extract taken from a child death inquiry
105 Extract taken from a child death inquiry
106 Extract taken from a child death inquiry
107 Extract taken from a child death inquiry

For the majority of children, reports were considered and assessed in isolation. A number of these cases identified a concurrent focus on closure.

One child death inquiry observed:

> *A Child Protection staff member interviewed expressed the view that constant heavy demand on the front end of service means that workers are under pressure to close cases at the earliest possible opportunity.*[108]

Another child death inquiry noted:

> *A feature of this case was repeated closures by Child Protection on the basis of inadequate evidence that the children were safe. Closure of the case as soon as the presenting problems are no longer visible is probably premature, particularly in a case where the parent is socially isolated and therefore the main source of information.*[109]

And another:

> *Adequate risk assessment should also have included consideration and assessment of the impact of ongoing neglect and cumulative harm on [the child]. The Commission found that Child Protection needed to assess more thoroughly and intervene earlier to prevent the cumulative harms experienced by [the child] as a result of ongoing abuse and neglect.*[110]

The Commission acknowledges that assessments of risk occur in the context of escalating demand for Child Protection and child and family services. However, a large number of these children were the subject of multiple reports, featuring co-occurring allegations of abuse and maltreatment, and yet the service response remained largely static.

Of the 229 reports received for the 35 children, 90 per cent were closed at intake or investigation. Over two-thirds of reports (69 per cent) were closed without further action. The chronic nature of some reports should have resulted in consideration being given to the impact of cumulative harm, consistent with the Cumulative harm practice resource. Unfortunately, this rarely occurred.

Lack of coordination and information sharing between Child Protection and Child FIRST regarding referrals, re-reports and re-referrals

All of the children referred to Child FIRST were the subject of re-reports to Child Protection and over half (56 per cent) were the subject of re-referrals to Child FIRST by Child Protection.

For the 12 children who died in the last five years, exactly half (n=6) were re-referred or recommended to contact Child FIRST, with no apparent consideration given by Child Protection to the outcome of earlier referrals when making a repeat referral.

There was very little evidence of Child FIRST proactively reporting back to Child Protection where engagement with a family via on-referral to a family service had been unsuccessful, which meant Child Protection rarely factored the history of prior engagement with child and family services into their overall risk assessment. There appeared, in the majority of cases, a disconnect between Child Protection and Child FIRST services that seriously impeded the ability of either service to offer any form of wrap-around support. This disconnect was to the detriment of many of the children included in this inquiry.

It is the Commission's view that assessments of risk should include information about Child FIRST referral outcomes. This will enable patterns of non-engagement to be identified earlier, and consideration given to providing a more assertive approach, including the possibility of statutory intervention where risks are assessed as significant.

There was some evidence, in more recent cases, of child and family services utilising the community-based Child Protection worker to help engage with families. Unfortunately, this did not result in subsequent engagement. However, the Commission found that joint visits featuring child and family services and community-based Child Protection were well attended by parents and nearly always resulted in positive exchanges between parents and workers, and a commitment (or recommitment) from the parent to engage.

108 Extract taken from a child death inquiry
109 Extract taken from a child death inquiry
110 Extract taken from a child death inquiry

The Commission acknowledges that (as outlined in Finding 2) child and family services were not resourced or equipped to provide these families with the escalated, intensive response they needed.

The Commission further acknowledges that families who present with safety concerns that fall beneath the threshold of statutory intervention, yet who resist engaging with voluntary community-based child and family services, create a specific challenge for the current child protection system. The children in these families are at an increased risk of falling between the gap created by the statutory and community-based service systems. For the 35 children reviewed, the impacts of these challenges were especially profound.

Absence of timely escalation by Child Protection in cases involving re-reports

This inquiry does not advocate for the greater use of statutory intervention for children who come into contact with the child and family system. Rather, the Commission advocates for a child and family system that is capable of supporting the principle of limited intervention – one that has the capacity to offer a timely response that meets the needs of complex families before the need for statutory intervention arises. For some families, this is likely to require long-term and intensive supports involving multiple service systems.

Where, however, attempts at intervention are consistently unsuccessful and children remain at significant risk, statutory Child Protection intervention should be pursued in a timely fashion. The Commission found this did not occur in cases involving re-reports.

Only one-third of the children were the subject of protective proceedings in the Children's Court (n=12), despite over three-quarters of these children having had their first contact with Child Protection by the age of three (n=9). One-third of these children were Aboriginal (n=4). The average period between Child Protection receiving the first report concerning a child and initiating protective proceedings was six years and four months. This group of children averaged nine reports each, and protective proceedings were initiated (on average) at report seven.

These children required timely intervention and it did not occur. Because intervention was delayed until the point of crisis, these children entered the child protection system as highly vulnerable and traumatised individuals – frequently characterised as 'too hard to help'.

Finding 1: Statutory child protection – episodic risk assessments that focussed on imminent harm

The Commission found that risk assessments undertaken by Child Protection at the intake and investigation phases were frequently shallow in focus and based on immediate and episodic risk prediction.

This led to children who were at risk of significant harm, including cumulative harm, being left to endure multiple, and often chronic forms of harm, without support or effective and timely intervention.

The inquiry identified a range of barriers to Child Protection undertaking effective and responsive risk assessments in the cases reviewed, including:

- **Child Protection appearing to operate as an emergency response service**
- **failure by Child Protection to identify and respond to risks of cumulative harm**
- **lack of coordination and information sharing between Child Protection and Child FIRST regarding the outcome of referrals, re-referrals and on-referrals to family services**
- **absence of timely escalation by Child Protection in cases involving re-reports.**

Voluntary child and family service system

Ineffective early intervention

Approximately one-fifth of reports made to Child Protection resulted in Child Protection referring families to Child FIRST for assessment and potential allocation to a family service (42 reports or 18 per cent). In response to a small number of reports, Child Protection wrote to families, recommending that they contact Child FIRST (10 reports or 4 per cent). In total, 25 of the 35 children were referred to, or recommended to contact, Child FIRST at some point.

Child and family services are voluntary and so their utilisation requires agreement from families to participate. It is widely acknowledged that engagement with families facing multiple and complex issues can be a challenge for services.[111]

In the cases reviewed by this inquiry, approximately one-quarter of all families (n=9) expressed a persistent unwillingness to engage with community-based child and family services. Of these families, 89 per cent (n=8) were ultimately the subject of statutory intervention.

Nearly three-quarters of families (n=26) however, were recorded as expressing a willingness to engage (either consistently or intermittently) with community-based child and family services. Despite a relatively high number of families indicating a preparedness to engage, the inquiry found that none were successfully engaged.

Of the 25 children referred or recommended to Child FIRST, 12 died in the last five years (between 1 April 2014 and 1 April 2019). The Commission examined the cases of these 12 children in detail in order to assess the quality and effectiveness of early intervention services delivered through the Child FIRST and child and family service system.

For a full summary of the analysis, see Appendix D.

The inquiry found that in most cases, referrals were made in response to earlier reports (reports one to four). For those children and families referred in response to later reports (reports five onwards) the chronic and cumulative nature of concerns served as a considerable barrier to effective engagement.

For one-third of the children, the lack of successful community-based intervention resulted in subsequent reports to Child Protection and, ultimately, the initiation of protection proceedings (n=4).

Concerningly, none of the children and their families referred to (or recommended to contact) Child FIRST, were successfully engaged beyond the point of initial assessment, if at all. The Commission attributes this to a range of factors, including:

- delays in the allocation of families to particular services
- the intensity of services provided being inadequate to address the complexity of identified issues
- the handling of re-reports and re-referrals
- the practice of Child Protection recommending to families, by letter, that they contact Child FIRST.

The Commission assessed (in a less detailed fashion) the extent to which the themes identified for the 12 children who died in the last five years were present in the cases of the remaining children.[112]

111 VAGO Report, *Early intervention services for vulnerable children and families*, May 2015.

112 Unfortunately, detailed information concerning the quality of services provided by community-based child and family services was not available in all cases and so the rates are likely to represent an under-estimate.

Table 25: Themes identified related to ineffective engagement

Delays in commencement of services	Complexity of issues not matched by intensity of service	Refusal to engage by parent or child	Re-referrals from Child Protection	Recommendation via letter unsuccessful vehicle for engagement
7 (from 25)	12 (from 25)	9 (from 25)	14 (from 25)	8 (from 25)
28%	48%	36%	56%	32%

In summary:

- Approximately 70 per cent of families (71 per cent) were referred to, or recommended to contact, Child FIRST (n=25).
- Over half of those (56 per cent) were referred more than once to Child FIRST (n=14), with one family referred to Child FIRST eight times, across the course of 20 reports to Child Protection.
- In almost half of the cases reviewed (48 per cent), services provided by community-based child and family services were deemed by the Commission as inadequate to meet the complex and frequently chronic issues that families required help to address (n=12). The result of this mismatch was that families disengaged from child and family services with alarming regularity.
- Only 10 per cent (n=2) of families who were recommended to make contact with Child FIRST initiated contact and of those, neither were successfully engaged beyond an 'initial assessment'. Most families (80 per cent) who were recommended by Child Protection (by letter) to make contact with Child FIRST, did not (n=8).

Delays in allocation of child and family services

Delays in the commencement or allocation of child and family services were recorded in relation to seven families (28 per cent), although this is likely to be an under-estimation due to a lack of information regarding waitlists for all cases reviewed. Of those cases where waitlisting occurred, the delay in commencement of services ranged from eight weeks to four months.

For the 12 cases examined in detail, delays in allocation that resulted in families being 'waitlisted' was a factor for one-quarter of the families (n=3). The impact of delays in allocation are illustrated by the following example (based on a child death inquiry).

Case study

Referral 2

A child and their family were referred to Child FIRST for initial assessment. This was the family's second referral to Child FIRST and occurred in response to the third report. The protective concerns identified related to childhood sexual abuse (for the parent and child), substance misuse by the parent, neglect, exposure to family violence and disability.

The family was allocated a family service provider, who agreed to a 'long response' involving a 12-week intervention. Due to demand, the family were advised they would be waitlisted for three months before services could commence.

Further concerns were raised for the child while being 'waitlisted' and assessed in the context of 'services soon to commence'.

After three months, an initial visit occurred, goals were set (for the parent) that featured multiple service interventions and a schedule made for weekly visits. Visits failed to proceed weekly, due to illness and service refusal by the parent. None of the referrals intended for other services eventuated.

After six months of unsuccessful engagement, a new report was received. Child Protection consulted with the family service provider who confirmed the status quo. The report was closed with the family service provider agreeing to a joint home visit with the community-based child protection worker.

The joint home visit was attempted, but no-one was home. No further contact was made, and the referral closed.

Referral 3

Child Protection received a further report and another referral was made to the family service provider. There were further delays before the service could commence. This time the approach taken was to provide the family with an 'on-call service' for the next twelve months. The 'on-call service' allowed the family to reach out at times of crisis. No active case management was recorded during this period. After 12 months, the family's file was marked for closure.

Referral 4

Child Protection re-referred the family to Child FIRST 12 months later (following another three reports). A subsequent re-referral to the same family service provider was made. Soon after, protective proceedings were initiated.

This child was first reported to Child Protection as an infant. The risk indicators identified were serious and the level of help required to support this family, intensive. Delays in commencement of services led to a loss of intervention momentum. For this child, the result of this ineffective intervention was an escalation in concerns that resulted, ultimately, in protective intervention later in life.

Intensity of services inappropriately matched to address the complexity of concerns

The inquiry found that in one-quarter of the 12 cases reviewed (n=3), a significant barrier to effective intervention was a mismatching of complexity with the duration and intensity of services provided by community-based child and family services.

The issue was identified for almost half of the 25 children who were referred to Child FIRST (n=12).

One child was referred at report three to a family service. The referral was made to support their parents address a history of intergenerational abuse, drug use and severe family violence. The family received a total of four face-to-face visits across a 12-month period of intervention.

In another case, a child was referred at report six to a family service to support their parents to address significant attachment issues, physical abuse of the child and untreated parental mental illness. Involvement with the service was closed eight weeks later, noting 'goals were met'. Intervention involved two visits and a referral to a health service for the young child to have their 'behaviour assessed'. It was noted during intervention that the parents referred to the child as 'it'.

The experience of the following child who died in the last five years illustrates the impact of services lacking the ability to match the complexity of families needing help.

Case study

A child and their family were referred to Child FIRST for an 'initial assessment'. This was the family's first referral and occurred in response to the second report to Child Protection. The protective concerns identified related to intergenerational sexual abuse (for the parent), historical involvement of child protection services and abuse in care (for the parent), parental substance misuse and neglect.

Referral 1

The family was referred to a family service. They were waitlisted for three months before the service could commence.

The service attempted (without success) to work with the family for six months. At their last visit to the family home, the worker noted 'an overwhelming smell of urine in the house'. The case was closed due to 'lack of engagement'.

Referral 2

Four weeks later, and after a further report to Child Protection, the child and their family was re-referred to Child FIRST. Child FIRST allocated the family a family service provider. The family were waitlisted for two months before the provider could commence.

At the initial visit, goals were set (for the parent) and a schedule of weekly visits was fixed.

Visits didn't proceed due to parental illness and refusal. Attempts made to re-engage via utilisation of the community-based Child Protection worker proved unsuccessful.

The family service provider held open the case for a further 12 months before closing, citing in its closure summary '[parent] unable to be engaged, no referrals made to other services. Child now with [carer]'.

Referral 3

Within a year, the was back with their parent, and their family were re-referred to Child FIRST and reallocated to the same family service provider. The family were waitlisted by the service for three months. Following commencement, the family service kept the case open for six months. During that period, three attempted home visits were made, of which none were successful. The referral was subsequently closed.

This child was first reported to Child Protection as an infant. The risk indicators identified were serious and an intensive level of help was required to support this family. The service was unable to address the complex nature of these issues via utilisation of a standardised approach involving weekly appointments. For this child, the result of this ineffective intervention was an escalation in concerns that resulted, ultimately, in protective intervention later in life.

The handling of re-reports and re-referrals

All of the children referred to Child FIRST were the subject of subsequent re-reports to Child Protection and over half (56 per cent) were the subject of re-referrals to Child FIRST by Child Protection.

The inquiry identified a range of issues related to the handling of re-reports and re-referrals attributable largely, to poor coordination and information sharing between Child Protection and Child FIRST. See finding 2 for further discussion of re-reports and re-referrals.

The practice of Child Protection recommending via letter that families contact Child FIRST

For the 35 children reviewed, 14 letters were sent to 10 families recommending they contact Child FIRST. Of these, only two families initiated contact and they subsequently disengaged. Both families had contact from Child Protection prior to contacting Child FIRST.

For the majority of other families, letters were sent in circumstances where a report had been received by Child Protection and subsequently closed at intake, without contact between Child Protection and the family or child.

Case study

One child was the subject of a report that raised concerns relating to family violence (for parents and child) and untreated mental illness and suicidality (for child). The report was closed at intake, following contact with mental health services and the police. No contact was made with the family or child prior to closure.

Letter 1

Following closure, a letter was sent to the family recommending contact with Child FIRST, a child mental health service and a family violence service.

Letter 2

A further report was received within eight weeks, raising concerns relating to family violence (for parents). The report was closed at intake and a second letter sent to the family recommending contact with Child FIRST. No contact with the family or child was recorded prior to or after closure.

The family did not pursue contact with Child FIRST.

The Commission considers a lack of contact with families when recommending they initiate contact with Child FIRST means it is unlikely they will subsequently engage.

Finding 2: Child FIRST and family services – ineffective early intervention

There was no evidence that any of the 25 children and their families who were referred to Child FIRST were successfully engaged with family services. In all instances, the children and their families referred to Child FIRST were re-reported to Child Protection – in most cases, within quick proximity to referral.[113]

This led, in some cases, to multiple referrals being made to Child FIRST, who made multiple on-referrals to family services. This approach resulted, ultimately, in recurring concerns remaining unaddressed for children at risk of harm.

The ability of the Child FIRST and family service system to successfully engage the families reviewed was impeded by a range of factors, including:

- **delays in the allocation of families to particular services**
- **the intensity and duration of services were inadequate to meet the complexity of issues identified**
- **the handling of re-reports and re-referrals**
- **the practice of Child Protection recommending to families, by letter, that they contact Child FIRST for support.**

113 The Commission acknowledges that in some cases, re-reports were not made in quick proximity, but occurred across the course of a child's life, and occasionally with multiple years in between.

Lack of child-focussed practice

Absence of direct contact with children

Although the importance of seeing and listening to the child is a key aspect of the best interest principles and the associated Best Interest framework[114], there was overwhelming evidence that Child Protection services were not seeing and not speaking directly to children. Significantly, Child Protection practitioners were not always hearing what children were saying.

> *A feature of this case is the repeated contact with the parent and limited conversation with [child] who was the subject of reports.*[115]

> *Child Protection had regular contact with the mother or the mother and [child] together, but one-to-one contact between Child Protection and [child] was minimal, limiting the opportunities for engagement and to assess [child's] self-harming behaviour and suicidal ideation.*[116]

The lack of assessment of the whole family, including the child, resulted at times in a lack of understanding both of the experiences of the child and the parents' ability to meet their needs. This significantly reduced the capacity of Child Protection to assess the risk of cumulative harm posed to a child.

> *The amount of face-to-face contact with [the child] was often limited to enable adequate information to be obtained, to assess risk or safety factors and to plan for these.*[117]

> *For a child that had consistent mental health assessments that referred to her traumatic past and lack of connection to her family and siblings, ensuring that she was part of the decision making process is likely to have provided her with an opportunity to have a voice, be heard, be validated as a child growing up away from family and siblings.*[118]

In a number of cases, there was evidence that children had not been listened to with respect to issues central to their safety.

Inadequate evidence of participation by children in decision making

Ensuring that the voice of the child is heard is an important objective. It is also enshrined in the CYFA that a child's views and wishes, if they can be ascertained, should be given appropriate weight. This principle is consistent with Article 12 of the *Convention on the Rights of the Child.*

To ensure that the voice of the child is heard, Child Protection policy requires the participation of children, where appropriate, in case planning. Unfortunately, there was little evidence of these policies translating into practice. There were many examples of these children feeling unheard and unsupported by the services responsible for protecting them.

In one case, it was observed:

> *Of particular note in the management of this case was the lack of attendance and input from [the child] at family meetings and at critical decision-making points. This is despite it being noted on the file that [the child] expressed a wish to be involved in discussions, 'rather than have all decisions and choices made by my parents'.*[119]

Since the permanency amendments in March 2016, the Child Protection Manual has updated its advice regarding case planning, which confirms:

> *Giving children a voice in planning and decision making which affects them, in age appropriate ways, is at the heart of decision-making principles of the CYFA … if a child is of an age and able to understand, they should be encouraged to participate directly in case planning and be assisted to understand the importance of their role in the process. If a child chooses not to attend a case planning meeting, the practitioner should explore creative ways for the child's voice to be heard.*[120]

There are suggestions for how to help a younger child communicate their wishes without attending the meeting. Additional advice is provided to practitioners regarding the sorts of information needed to be conveyed to a child, including:

114 See Appendix C for further information.
115 Extract taken from a child death inquiry
116 Extract taken from a child death inquiry
117 Extract taken from a child death inquiry
118 Extract taken from a child death inquiry

119 Extract taken from a child death inquiry
120 http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/case-planning/case-planning (accessed October 2019)

- The case manager should engage the child in discussions about the development, progress and review of the case plan.
- Special care must be taken to ensure that the child understands the decisions made and what the case planning process means.
- The case manager should talk with the child about day-to-day care issues as well as the permanency objective and the goals and actions required to achieve the objective.[121]

There is no advice provided that would help practitioners discuss relatively complex case planning practices (for example, how to explain the status of a case plan while there are active court proceedings). There are no suggestions for how practitioners should communicate with children about decision-making processes or internal review processes.

There is a separate section included in the advice entitled 'considerations for good practice' that lists a series of 'questions to elicit the family's safety goals', which are cited from a 1999 source (Turnell, A and Edwards, S). The questions are generic and distinctly adult or parent focussed. Development of similar content that is child-focussed and includes advice on how to describe the concept of 'permanency' may assist practitioners to translate policy into practice.

Multiple contacts involving multiple people

In some cases, there was evidence of children having multiple contacts with multiple people from Child Protection and other services. The Commission found that the greater the number of different interactions with different workers recorded on a child's file, the more disengaged a child became.

A child who had been in out-of-home care for most of her life, wrote of her experience:

> *Don't you remember people saying that friends are not always forever, but family is? What about children like me that are in foster care? We don't have the same stable life style as everyday children, we are owned by people we have never ever met, we have people in suits and fancy clothes come in and out of our lives. How are we supposed to feel normal when other children at school never have to experience what we go through?*[122]

Another child, who was the subject of eight reports, commencing at age seven, was described in the following terms:

> *[The child] was a hard to help child, who had experienced significant adverse life events and was reported to be emotionally detached and lacking in remorse. Workers found it very difficult to form a relationship with [the child].*[123]

Another child, who was the subject of nine reports, commencing at age two, was described in the following terms:

"All services contacted by this inquiry had found [the child] difficult to engage. The very experienced Student Wellbeing Counsellor at [the child's school] described [the child] as having 'severe attachment problems'".[124]

Another case quoted a mother as saying:

> *…there were so many workers, we would get to know one and then they would leave.*[125]

A child protection system that involves direct contact between a vulnerable child and multiple adults is not a system that can be described as child-focussed. Greater attention needs to be given to the importance of minimising the number of adults having direct contact with a child for the purposes of discussing protective matters. A number of the children reviewed were assessed to have problematic attachment issues with care-givers and associated difficulties forming trusting and safe relationships, yet these same children were required, in some instances, to speak about these matters to a revolving number of practitioners.

121 Ibid

122 Extract taken from a child death inquiry
123 Extract taken from a child death inquiry
124 Extract taken from a child death inquiry
125 Extract taken from a child death inquiry

Consistent, relationship-based practice is best practice for children

In order to adequately protect children, multi-agency work is required with an emphasis on relationship-based practices to engage children over a period of time. The significance of relationships between children and their families and carers and case workers cannot be overstated. Among the 35 files, there were a small number of cases where excellence in case management was acknowledged:

> *The case illustrates the value of relationship-based practice where qualified and experienced practitioners have the time and emotional space to engage with young people in crisis like [the child]. Those working directly with young people must have opportunities to read the past history and have access to the background information which enables them to place in context current behaviours and difficulties.*[126]

The Commission found that in all cases involving good practice, there was consistent case management, which enabled the child to form a relationship of trust with a key worker.

The department is currently structured so that responsibility for different 'case phases' are held by different teams, which results in families interacting with different workers depending on what stage a case is at. For children, this involves an in-built change in worker as their case progresses through each phase. This means that children who are deemed most at risk, who traverse each phase of intervention from intake to protective order, experience the greatest number of worker changes. It is the Commission's view that a case phased approach to case management is not child-focussed, nor is it consistent with promoting children's best interests.

Understanding, identifying and responding to adolescent vulnerability

In order to support children, their difficulties need to be recognised and understood. Perceptions of older adolescent children who were assessed as 'difficult to help' emerged as a key theme in many of the 35 cases reviewed.

In some reports, there was evidence that decision makers perceived older adolescents as able to take care of themselves, avoid harm and ask for help when needed. This was used as a basis for limited or no action by services.

Where evidence existed of the Best Interests framework being applied, the 'age and stage of life' component was prioritised above others, in combination with shallow assessments that considered immediate safety needs only. In one case, there was an unfounded presumption of resilience because the child was articulate and viewed as an adult rather than a vulnerable child.

A report involving a 15-year-old child, observed:

> *The assessment of Child Protection was that [the child] was 15 and [their] age meant that [the child] was more resilient to harm from [their] mother.*[127]

A report involving a 14-year-old child, similarly observed:

> *File notes frequently refer to [the child's] ability to 'remove [themselves] from harmful situations' and therefore [they were] not considered vulnerable. However, significant informants, including [the child], extended family, school were not contacted to ascertain actual resilience levels when exposed to constant stresses and dysfunction in [their] family situation.*[128]

For many of the children, previous life experiences and recurring safety concerns were mostly recognised, but not necessarily addressed, as professionals focussed on crisis-based intervention. For examples, exposure to family violence as a child was frequently noted but not necessarily connected with later behaviours, including the use of violence towards siblings.

126 Extract taken from a child death inquiry

127 Extract taken from a child death inquiry

128 Extract taken from a child death inquiry

The reports observed that for a number of the children, their age and behaviour led to services viewing them as young adults rather than vulnerable children.

> *The decision to move from a Custody Order to a Supervision Order was premature and appeared to put in train a process of increasing independence for [the child] that was not dependent on her demonstrating greater capacity to keep herself safe.*[129]

The Commission acknowledges that achieving a balance between respecting the autonomy and wishes of adolescents while recognising their vulnerability is not an easy task for professionals to achieve.

Finding 3: Statutory child protection – lack of child-focussed practice

The Commission found there was an absence of child-focussed engagement in response to the 35 children reviewed. This resulted in children's voices not always being heard by services, and their experiences often not being taken into account.

Children were rarely interviewed away from family members and rarely engaged in decision-making processes or participated in case planning.

For those children who had reached adolescence, they were rarely assessed or described as 'vulnerable' but frequently described as 'self-protective'. In some cases, the depth of sadness they experienced only revealed itself after their death, in the form of a suicide note or diary entry.

129 Extract taken from a child death inquiry

Chapter 8
Findings related to the mental health system

Ineffective early intervention

For children, intervention early in life at an early stage of mental health problems can reduce the duration and impact of the problems.[130] Mental health problems have many causes, including abuse and neglect in childhood, developmental disorders, and physical disability.[131]

Due to the scope of the inquiry, all 35 children had contact with the child protection system. Of these, 89 per cent also had contact with the mental health system (n=31). More than 80 per cent had a diagnosed or suspected mental illness (83 per cent) – of those, 39 per cent had received their diagnoses by the age of seven (n=12).

The Commission reviewed the provision of mental health services to children who died between 1 April 2014 and 1 April 2019 in order to identify any service system issues for these children and their families. Fifteen of the children received mental health services during the five-year period (43 per cent of the 35 children reviewed by the inquiry). Of these:

- 60 per cent were male (n=10) and 40 per cent female (n=6)
- 20 per cent were Aboriginal (n=3)
- 27 per cent were assessed as having an intellectual disability (n=4)
- 67 per cent of the children lived in regional or rural parts of Victoria (n=10) and the remaining 33 per cent lived in metropolitan areas (n=5).

For a full summary of analysis, please see Appendix E.

The inquiry identified multiple themes for the children reviewed, however three featured most prominently:

- an absence of specialised mental health services for children diagnosed with mental illness earlier in childhood, by the age of seven years
- a lack of targeted support to help children to recover from childhood abuse and trauma
- an inadequate focus on delivering integrated family-based interventions that supported the recovery of children experiencing mental illness.

The Commission also assessed (in less detail) the extent to which these themes identified for the 15 children who died in the last five years, were present in the cases of the other 20 children (who died before 1 April 2014).

Table 26: Themes identified related to mental health service provision

Absence of mental health services for children diagnosed with mental illness by the age of seven years	Lack of targeted support to help children recover from childhood abuse and trauma	Inadequate focus on delivering family interventions
11 from 12	20 from 31	20 from 31
92%	65%	65%

130 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 8

131 Ibid

In summary:

- For almost all of the children diagnosed by age seven (92 per cent) there was (or appeared to be) an absence of service intervention (beyond an annual or six-monthly medication review) until presenting issues escalated (usually at the point of adolescence) (n=11).
- Almost two-thirds of the children (65 per cent) were identified by the Commission to lack targeted support to help them recover from early childhood abuse or trauma (n=20).
- Almost two-thirds (65 per cent) were identified as receiving treatment that had an inadequate focus on integrated family-based interventions (n=20).

An absence of specialised mental health services for children diagnosed with mental illness by the age of seven years

The inquiry found that early contact with child protection services largely preceded or occurred simultaneously with contact from mental health services. This was particularly pronounced for the cohort of children who had contact with Child Protection before the age of three (n=15). For this group of children:

- 80 per cent had a diagnosed mental illness (n=12) and all of these children had received their diagnosis by the age of seven
- half of the children that were diagnosed had their first contact with a mental health service by the age of five years (n=6).

Despite receiving diagnoses early in their lives, none of the children received specialist therapeutic intervention (beyond annual or six-monthly paediatric appointments) until their presenting issues had escalated to the point of crisis – where they posed a significant risk of physical harm to themselves or others. It is not evident to the Commission why such a 'light touch' approach to the management of these children's mental health problems was taken, as none of the files recorded the rationale for this approach. What was clear, however, was that the approach was deeply problematic for many of the children reviewed.

Case study

A child had their first contact with Child Protection by the age of two and their first contact with a mental health service by the age of three. Their presenting issues included language problems and aggression. Reports to Child Protection detailed a history of exposure to severe family violence and neglect.

Information concerning the child's child protection history was not shared with the treating paediatrician. The focus of appointments was on addressing the child's 'challenging behaviours'.

The child was suspected as having ADHD and prescribed medication.

Six-monthly appointments with the paediatrician weren't consistently kept but scripts were regularly filled via a GP.

By age seven, the child's aggression had worsened, and new symptoms had emerged. The child was diagnosed with ASD, medications were changed, and a referral made to an Autism Program, for which there was a lengthy waitlist.

By age nine, the child was experiencing new symptoms. The child was rediagnosed and new medications prescribed. A referral was made to CAMHS. The referral was accepted, and the child was placed on a lengthy waitlist.

By 10, the child was reported as 'violent' and also the victim of family violence. A community-based child and family service was recommended.

By 12 years of age, the child had commenced fire-lighting and had attempted suicide. The child was treated by CAMHS as an outpatient for six months before withdrawing with safety plans in place. Information concerning the child's Child Protection history was not shared with CAMHS – even when new concerns arose and were reported during the period of treatment.

During the child's final mental health intervention – an in-patient admission – a report was made to Child Protection. It was closed at intake. At discharge, the hospital closure summary described ongoing family issues, noting 'no value in continuing to see the child at this stage. Will continue to provide secondary consultation to families working directly with [child]. Urgent need for respite.'

Like most of the children whose experiences were reviewed by this inquiry, this child was raised by parents with their own mental health challenges and history of trauma.

The child was the subject of seven reports to Child Protection, six of which were closed at intake and one at investigation. Despite two service systems having repeated contact with this child in early childhood, neither remained connected for long enough to effect positive and sustained change. And like most cases reviewed by this inquiry, there was a notable lack of information sharing between service systems, which meant there were times where neither system had complete knowledge of the child's circumstances.

Case study

A child had their first contact with Child Protection at six and their first contact with a mental health service at seven. Safety concerns related to family violence, neglect and parental alcoholism.

Concerns for the child's mental health had first been raised in kindergarten. By six, the child was displaying aggression at home. As a young child, they were referred to CAMHS. A short period of intervention with CAMHS followed, although was unable to be sustained due to the family 'moving around'. At eight, the child was diagnosed with ADHD and anxiety and prescribed medication. A plan was set for six-monthly paediatric review.

At nine, the child was reported to have experienced sexual abuse and referred for counselling but wasn't taken to the appointments.

By 10, further aggression at home resulted in a referral to CAMHS. By this time, the family was experiencing acute family violence. The child's mother reported to Child Protection that CAMHS had told her the child's aggression was 'behavioural … due to what's happening at home'.

At 12, the child was seen again by the paediatrician and anti-depressants prescribed.

At 13, the CAT team were regularly called in response to the child's 'behaviour'. The consistent assessment was: 'no mental health concerns … child displaying behavioural issues'.

By 14, the child was a client of Youth Justice.

For this child, contact with both systems occurred almost simultaneously. The child was the subject of eight reports to Child Protection, seven of which were closed at intake or investigation. The family received two referrals to Child FIRST, neither of which resulted in successful engagement with a family service. The difficulties successfully engaging this child's parents were identical across both Child Protection and mental health services, yet these difficulties were never shared between the two systems and no attempts at coordination were made.

It is unclear how representative the sample of children reviewed by this inquiry is, in terms of their concurrent contact with the child protection and mental health systems. For these children, however, where contact was concurrent, the focus of each system was quite different. Child Protection largely assessed the circumstances of young children in terms of mitigating parental risks, without necessarily taking steps to address how exposure to these risks may have impacted the child. This was especially the case for children exposed to significant family violence. Mental health interventions, on the other hand, were child-focussed – in that they focussed on addressing the mental health issues the children were experiencing – but were not always well-informed regarding family history or the child's exposure to parental risks.

Inadequate focus on helping children recover from childhood abuse and trauma

The majority of children reviewed by this inquiry had experienced a range of harms, often over the course of many years. These harms, in most instances, had a profound impact on the children and their mental health. In tracing the course of these children's lives, in some cases from birth to death, the inquiry found mental health services often lacked comprehensive information concerning the child's protective history. This impacted on the ability of services to implement longer-term interventions to address earlier abuse or trauma.

Where this information was available to mental health services, for many children the focus of mental health intervention appeared to remain largely episodic and reactive, without a focus on addressing the underlying trauma. The reasons for this were not always straightforward. In some cases, reactive management arose in the context of unsuccessful engagement with a child while in others it was due to treatment being unable to proceed while a child's condition remained 'unstable'.

For the children in out-of-home care, 'unstable' placements sometimes impacted upon their ability to access therapeutic mental health treatment.

Case study

A child was first reported to Child Protection at age three due to their recurring exposure to family violence, in the context of parental substance misuse.

The parents separated and commenced new relationships. As a young child, they witnessed their father seriously assault his new partner, before strangling her to unconsciousness. This report, like others, was assessed in the context of the other parent's ability to 'act protectively'. Impact on the child was never professionally assessed.

In total, seven reports were received during the child's primary school years, all closed at intake. Two referrals were made to Child FIRST – neither resulted in the family engaging with services.

At 13, the child's school referred them to a mental health service for counselling. The child attended all sessions, but the intensity of intervention wasn't able to address the escalation in presenting issues, which included substance misuse and deliberate self-harming.

Following an attempted suicide, a referral was made to CAMHS. CAMHS diagnosed depression in the context of childhood trauma.

A worsening in presenting issues, substance misuse and associated aggression led to the child being placed in out-of-home care. The child's parent indicated to Child Protection their view that substance misuse was at the

core of the child's difficulties and rehabilitation was urgently required. Child Protection never confirmed with CAMHS whether this was in fact, an accurate interpretation.

By this stage, Child Protection and CAMHS were both actively involved with the child.

The child was moved from placement to placement, each ending quickly, as carers struggled to provide safe care.

Appointments at CAMHS were being missed in the context of placement changes and with it, increasingly unchecked substance misuse by the child.

Child Protection never confirmed with CAMHS the child's diagnosis or treatment plan (beyond his medication needs). This meant that prospective carers were equally ill-informed about the child, their mental illness and plan for treatment (beyond their medication needs).

In terms of CAMHS involvement, the instability created by multiple placement changes meant 'there was very little work we could do at that time'.

For this child, placement instability impacted upon their ability to engage in urgently needed therapeutic mental health treatment. Their experience highlights the interdependencies between these two important systems. Children who are unable to live safely at home are reliant on the child protection system to provide them with suitable placements and equally, reliant on the mental health system to provide appropriate therapeutic intervention. When these two systems fail to align, children like those reviewed by this inquiry, face the full force of that misalignment.

Children who are known to have experienced childhood abuse and trauma are likely to require help to recover from this exposure. This was not however, identified as a consistent focus of mental health intervention for the children reviewed by this inquiry.

It is unclear the extent to which this was attributable to a lack of available and appropriate service providers or because engagement with many of these families was particularly challenging.

Case study

A child had their first contact with Child Protection by age one and their first contact with a paediatrician at two years of age. Safety concerns related to intergenerational sexual abuse, intergenerational Child Protection involvement, substance misuse and neglect.

Contact with the paediatrician occurred in the context of the child presenting with delayed speech, aggression and reduced social skills. Advice was provided and follow-up appointments made.

By four years, the child continued to present with increased aggression. A referral was made to a community-based disability support service. The service was unable to successfully engage the family.

At five years, the child was diagnosed with ASD and intellectual disability. By this stage, a further report had been made to Child Protection and referrals made for the family to engage with a child and family support service. The service was unable to successfully engage the family.

At seven, follow-up with the paediatrician occurred and it was observed that the child was 'anxious, aggressive and increasingly difficult to manage'. The child was referred to a clinical psychologist, however, no appointments were made, and no follow-up provided to the paediatrician.

At 10, the child was trialled on anti-anxiety medication. Follow-up appointments with the paediatrician were missed for almost two years.

At some point during this period, the child's school made a referral to CAMHS for 'assessment of a possible emerging psychosis'. The assessment proceeded and the child's parent indicated the family was managing 'okay' but would value further advice and support relating to the child's diagnosis of ASD. On that basis, a full mental health assessment never proceeded. Instead, advice was provided to parent and school regarding behavioural management. No information was sought with respect to the child's family history or contact with Child Protection.

When appointments resumed with the child's paediatrician, it was assessed that the medication prescribed at age 10 continued to be helpful and a plan was made to re-refer the child to a clinical psychologist 'if anxiety increased or behaviour worsened'.

This was the final contact before the child died. Child Protection had received a total of six reports with respect to this child; five were closed at intake. Two referrals were made to Child FIRST. There was no record of any communication between Child Protection and the paediatrician in this case.

Child Protection and the paediatrician both had information that this child had a difficult family history, which included (among other things) trauma and disability. What was missing, however, was a plan for how best to address the child's exposure to and experience of that trauma in the context of failed attempts at service intervention. Complicating matters further, the child's disability tended to overshadow other aspects of risk assessment relating to both mental health and protective interventions. The child death inquiry found:

> *… a failure to refer [the child] to an intensive therapeutic support service to address their anxiety, extreme aggression, sexualised behaviours, trauma and cumulative harm.*[132]

Inadequate focus on integrated family-based interventions

Children in contact with mental health and child protection systems are likely to present with multiple issues, some related to the child and their mental illness and others related to their family and other life circumstances.

Almost all of the children reviewed (94 per cent) had a parent or parents with a diagnosed or suspected mental illness (n=33). Each of these children were recorded to have experienced family violence. More than 60 per cent of families (63 per cent) had a known and recorded history of trauma that was both entrenched and unresolved (n=22). Over half of the families were known to Child Protection as a result of earlier interventions involving a parent of the child (n=20).

The children reviewed by this inquiry existed in the context of their family circumstances and yet, frequently, their resulting 'behaviours' were understood by those outside of the mental health profession as principally a manifestation of mental illness. In the case of Child Protection, a child's diagnosis might be understood as an isolated risk indicator, unconnected from or impacted by family circumstances. This was not always helped by the individualised nature of treatment plans for children that in many cases failed to include integrated family-based interventions.

Where family-related issues were identified by mental health services, the assumption was that such issues were social in nature and required a response from Child Protection. Where that response was not provided (and in most cases, it was not), mental health services expressed growing frustration at the impact that unaddressed safety issues had on their ability to provide therapeutic intervention to the child.

132 Extract taken from a child death inquiry

Case study

A child was the subject of a report to Child Protection at age 12 and had their first contact with mental health services at the same time. Protective concerns related to a history of exposure to parental mental illness, including parental attempts at suicide.

Child Protection closed the report, with a referral to Child FIRST. No referrals were made on behalf of the child to mental health services as the risk was identified as being addressed by the parent receiving mental health treatment.

Additional reports to Child Protection were received after the child refused to return home. An alternate placement with a family member was arranged and a second referral to Child FIRST made.

Over the course of the next six months, the child presented six times to emergency departments, each time having attempted suicide. The child was referred to an in-patient facility but following discharge refused to engage with mental health services.

All mental health services identified '[the parent's] mental health and the difficult parent-child relationship were preventing [the child's] effective engagement with services'.

The child was the subject of six reports to Child Protection, five of which were closed at intake and one at investigation. At no stage was Child FIRST able to successfully engage the family via on-referral to a family service.

This child needed a coordinated service response. What they received was a fragmented response that failed to understand or resolve the interplay between their mental health diagnosis and accumulated exposure to harm. An integrated family-based intervention may have helped identify the impact that parent-related issues were having on the child's ability to successfully engage in therapeutic intervention.

For a large number of children reviewed by this inquiry, their parents or carers were identified as impeding their children's successful engagement with mental health services. For the children who had a recorded contact with a mental health service (n=31):

- 45 per cent of parents were recorded as failing to take their children to appointments (n=14)
- 26 per cent of parents were recorded as actively discouraging their children's engagement with mental health services due to their belief the intervention was unnecessary or unhelpful (n=8)
- where families were offered family-based interventions (such as family therapy) as part of the child's treatment plan (n=10), 90 per cent of parents refused to participate (n=9).

The inquiry found that in some cases, these issues posed a significant protective concern for children and yet these issues were almost never assessed as such. They were seen as a service issue to be remedied by the mental health system, rather than one requiring a collaborative service response between mental health services and Child Protection.

Case study

A child had their first contact with Child Protection before the age of two. The child was involved in a serious family violence incident. Safety concerns related to a history of intergenerational abuse, including intergenerational Child Protection involvement.

Reports to Child Protection detailed the parents' difficulties attaching to the child, struggling to contain their aggression and their use of physical restraints to assert

control. The core issue of family violence was assessed as being resolved when the parents separated and reports were closed.

The child had their first contact with mental health services at age seven. The child was reportedly violent and suicidal. An in-patient admission followed.

Following discharge, the out-patient mental health service noted '[parent] difficult to engage and hasn't kept recent appointments'.

At age eight, a further report was made, and Child Protection met with the parent and child. Child Protection also contacted CAMHS who confirmed that engagement with the family remained an issue and 'parental capacity to care [was] diminishing'.

Child Protection made a referral to an 'intensive' child and family support service. The service refused to accept the referral, indicating their view that 'the family does not require such an intensive service response'. The family was re-referred to a generic community-based child and family service and the referral was closed.

Three weeks later, the parent disengaged the child from CAMHS, citing the service as 'useless'.

The child was relocated to the home of their other parent and had no further engagement with CAMHS until re-presenting as suicidal at age 13. During the intervening period, the child had been the subject of two further reports to Child Protection, detailing multiple placements with extended family members, a dozen school changes and escalating behavioural issues.

The child was the subject of six reports to Child Protection and one referral to a child and family service. Four reports were closed at intake, one closed at protective intervention (without further action) and the final report resulted in protective proceedings. Multiple service systems were unsuccessful in engaging the family of this child. Attempts at involving the parents in the child's treatment plan were not made – it is unclear from the records whether consideration had been given to pursuing family-inclusive intervention.

Finding 4: Ineffective early intervention

For the majority of children reviewed, there was an absence of effective early mental health intervention. The inquiry found a range of systemic barriers to the provision of early mental health intervention, including:

- **an absence of specialised mental health services for children diagnosed with mental illness or other mental health presentations, by the age of seven years**
- **a lack of targeted support to help children recover from childhood abuse and trauma**
- **an inadequate focus on delivering integrated family-based interventions to support the recovery of children experiencing mental illness.**

Chapter 9
Findings related to collaboration and information sharing

Inadequate information sharing and collaborative practice

Information sharing is central to effective child safeguarding. Of the 35 child death inquiry reports, there was only one report in which the failure to share information was not specifically mentioned as an issue. Reports identified issues that ranged from a direct failure to identify risk or protect a child due to lack of information sharing, to the identification of information sharing as an area for service improvement.

Effective intervention requires careful assessment of the child's vulnerability and ensuring the child's rights, views and experiences remain central. Child Protection is often critiqued in child death inquiries for failings in communication and information sharing.

Effective information sharing requires practitioner skills, good systems and a culture that promotes information sharing for the protection of children. This must fit into a wider information-handling process whereby information is critically appraised and used to guide decision making and planning. As one inquiry found:

> *A key learning [from this child death inquiry] is the value of information sharing at the earliest possible stage in a complex case such as this. It was highly problematic that community-based workers who were trying to engage and work with [the child] who was exhibiting very high-risk suicidal behaviour, did not have knowledge of their family history or background experiences, beyond sketchy and at times inaccurate information.*[133]

For the children reviewed by this inquiry, their contact with Child Protection preceded, or coincided with, their contact with mental health services. Despite this, in the majority of cases, there were extremely limited exchanges of information between the two systems, which frequently led to neither system holding 'the complete picture'.

The inquiry also found that the different service systems tended to hold different, but equally significant, information concerning a child and their family.

Child Protection was more likely to hold information relevant to:

- parental history
- parental contact with police for family violence related issues
- parental risks relating to mental illness and substance misuse
- concerns raised by a child's school.

Mental health services were more likely to hold information relevant to:

- a child's presenting issues
- family history of disability or mental illness
- a child's treatment plan, including referrals to mental health services and prescribed medication.

For the children reviewed by this inquiry, mental health services generally had much more direct contact with children, while Child Protection tended to rely on other information sources – particularly when assessing risk at the intake or investigation stages. However, paediatricians and other mental health professionals were rarely used as a source of important information about children.

133 Extract taken from a child death inquiry

Case study

A child was the subject of their first report to Child Protection by the age of three months. They had contact with a paediatrician and received their first mental health service by the age of two.

The child was reported to Child Protection 20 times. Fifteen of those reports were closed at intake. At no stage did either system make assertive contact with the other.

For the children reviewed, paediatricians and other mental health service providers frequently held important information relevant to Child Protection's understanding of a child and their circumstances. By the same measure, in many instances, Child Protection held information that would have been worthwhile and relevant for mental health providers.

For these reasons, it was concerning to see so few examples of information sharing between service systems.

Role clarity and assumptions regarding the role of service systems

As well as sharing information, services and systems also need to be clear about their roles and an understanding of the roles of other services. As one child death inquiry highlighted:

> *Over time, many services attempted to provide support to the family and engage [the child], however, despite these efforts, service provision often appeared to be fragmented, with not all services being fully aware of the role of other agencies.*[134]

It is essential, however, that role delineation does not result in a disjointed service response. The points of intersection between systems are critical for children at risk of suicide. All service systems in contact with vulnerable children have an important role to play in suicide prevention.

A number of case studies referenced in Chapter 8 highlighted that services' assumptions regarding the differing roles of Child Protection and mental health services led to ineffective service intervention across both systems. There was a clear disconnect between issues that were identified as 'protective' versus those characterised as 'mental health', which resulted in a largely disjointed service response for children.

The different approaches and sometimes different lexicon between the statutory child protection and mental health systems reinforce the importance of good multi-agency practice, whereby the respective professionals involved with a family or child share knowledge and expertise and clearly understand each other's priorities.

For these reasons, the Commission recommends that for children at risk of suicide, an overall coordinating lead agency is required to manage the different perspectives and prioritise the child's best interests. If Child Protection is involved, the Commission suggests it appears best placed to assume that coordinating lead role.

The Commission acknowledges the recent, vital reforms to Victoria's child information sharing laws and the development of Child Link.[135] Legislative reform supported by training, combined with Child Link, offer the potential to transform practice and deliver significant benefits to children. At this stage, Child Link is legislated to become operational by 31 December 2021.

134 Extract taken from a child death inquiry

135 Child Link is a digital register that will enable authorised professionals to access specific and limited information related to children in their care or service.

Finding 5: Inadequate information sharing and collaborative practice

Children in contact with the statutory child protection and mental health systems benefit from a coordinated service response, which recognises the need to explore the intersection between protective and mental health issues. The inquiry identified a range of barriers to effective information sharing and collaborative practice, including:

- an absence of assertive information sharing by both service systems
- a failure to understand the significance of information potentially held by the respective service systems
- a lack of clarity or understanding regarding the role of each service system in respect of child safeguarding.

There were opportunities for services to engage and provide a coordinated response but this did not occur.

Finding 6: A shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences and their recovery from harm and abuse.

Shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to prevent suicide in children by ensuring they deliver a service response that prioritises children's particular circumstances and experiences and their recovery from harm and abuse.

The inquiry found that such an approach would have been particularly helpful for those children identified by the inquiry as flying 'under the radar'.

As outlined in Chapter 6, just under one-fifth (n=6) of the children reviewed were identified as having flown 'under the radar' prior to their deaths, amongst family members and services. As discussed, however, these children had contact with Child Protection and a range of other agencies, but there was a notable absence of information recorded about them.

Chapter 10
Recommendations

Recommendation 1

That, in line with *Roadmap to Reform*, the Victorian Government develop, resource and implement an integrated and whole-of-system **investment model and strategy** for the child and family system, focussed on:

- earlier intervention and prevention services to reduce risks to children and build child and family wellbeing
- reducing the rate of entry to care
- meeting the distinct needs of children who need to live away from the family home.

The **investment model** should recognise the drivers of demand and the need for coordinated service responses. It should use client data, analytics and service evidence to identify the:

- resource levels needed to meet demand for safe, quality services for vulnerable children and their families
- most efficient and effective investment options to achieve maximum impact.

The **investment strategy** should increase and improve safe, quality services in line with demand, by targeting early intervention and prevention, prioritising the most vulnerable cohorts, including families with chronic and complex issues and children exposed to cumulative harm.

Recommendation 2

That the Department of Health and Human Services develop, resource and implement a set of standard analytical data sets for Child FIRST/The Orange Door and IFS to monitor and report on the timeliness and effectiveness of their engagement with children and families, including:

- time between initial assessment and commencement of case management
- rates of unsuccessful engagement
- referral outcomes
- re-referrals
- re-reports.

Recommendation 3

That the Department of Health and Human Services review and revise all foundational practice guidance, training and tools to embed children's participation in decision making during the investigation, protective intervention and protection order phases of Child Protection intervention.

Recommendation 4

That the Department of Health and Human Services develop practice advice in relation to children involved with Child Protection who are identified as at risk of suicide. Practice advice should confirm the importance of information gathering, information sharing and service coordination, and include requirements to gather and consider:

- information regarding the child's involvement with different mental health services
- a child's mental health diagnosis
- any known history of exposure to abuse, harm or trauma
- a child's treatment plan and (where relevant) any actions taken or planned to address any history of exposure to abuse, harm or trauma
- the existence of any parent-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- the existence of any placement-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- identifying which service or agency involved is able to co-ordinate a child's access to mental health and other relevant services.

Recommendation 5

That the Victorian Government commit to proceeding with, and investing in, the Child Link Register, with a view to ensuring commencement of its operation by 31 December 2021.

Recommendation 6

That the Department of Health and Human Services develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission into the Victorian Mental Health System.

For noting

The Commission will provide a copy of the inquiry to the Royal Commission into the Victorian Mental Health System, and ask that consideration be given to its findings, particularly those relevant to:

- the points of intersection between the child protection, child and family service and mental health systems
- the need for greater levels of specialist early intervention mental health services for children known to have experienced harm and abuse.

Appendices

Appendix A

Table 27: Summary of Child Protection Phases

Phase	Duration	Details
Intake	Receipt of report through to decision about appropriate response	• Begins 'with a report about a child and concludes when the report is transferred for investigation or closed with or without the provision of advice' to the person who made the report and/or the child or their family, or referral to a community-based child and family service or other agency • Involves 'receiving reports and determining the appropriate response, providing advice to reporters, helping children and families access support services and where appropriate making referrals'
Investigation	Classification of report as 'protective intervention report' through to decision about whether report is substantiated	• A matter is investigated if a report is assessed as being a 'protective intervention report' • An investigation is undertaken to determine whether a child is in need of protection, as defined in s 162 • It 'determines: – the extent and nature of reported concerns, or any other concerns – whether the child has suffered or is likely to suffer significant harm – whether the parents have protected or are likely to protect the child from harm – whether statutory intervention is needed to meet the best interests of the child – whether other interventions are needed to assist the family' • The investigation phase ends 'when a decision is made on whether the report is substantiated' • If a report is not substantiated, the case may be closed

Table 27: Summary of Child Protection Phases continued

Phase	Duration	Details
Protective intervention	Intervention following substantiation through to protection order or closure	• Follows substantiation of a protective intervention report • Involves 'intervention with a child and family' including assessment, service engagement and case management focussing 'on establishing ongoing protection and supporting [the child's] best interests without seeking a protection order where possible' • Child Protection might make a protection application to the Children's Court if satisfied on reasonable grounds that a child is in need of protection – this could include placing the child in emergency care[136] • Three 'possible outcomes' from this phase: – 'Child protection intervention is no longer required and the case is moved to the closure phase' – The Children's Court makes a protection order 'following a protection application being [made]', 'and the case is moved to the protection order phase' – 'A protection application does not result in [the Court making a] protection order and the case is moved to the closure phase'.
Protection order	Children's Court makes protection order through to end of order	• '[B]egins when the Children's Court makes a protection order' • Involves 'administering and monitoring compliance with the court order in accordance with a [child's] case plan'
Case closure	When the decision is made to close a case	• 'It is appropriate to close a case when child protection involvement is either no longer possible, or no longer necessary'. • Cases are closed when (for example): – 'a report has not been classified as a protective intervention report, and necessary actions during intake phase are complete' – 'despite taking all reasonable steps it is not possible to complete an investigation' – 'a protective intervention report is not substantiated' – 'protective intervention by agreement is concluded with protective concerns being sufficiently addressed' – 'further protective intervention is not possible and follow-up is complete' – a protection application is made to the Court but the Court does not grant a protection order – a protection order 'ends and no further order is made'. • The Manual states that the aims of closure include: – finalising 'case practice, implement exit plans and confirm sufficient protection, care and support will continue, through negotiating a closure plan' – completing 'necessary procedures associated with ending child protection involvement including contacting and advising clients, services and others'.

Source: Child Protection Manual[137]

136 CYFA, sections 240–243.
137 The Child Protection Manual is available at **https://www.cpmanual.vic.gov.au/**.

Appendix B

The following laws relevant to vulnerable children were reviewed:

- *Children, Youth and Families Act 2005*
- *Child Wellbeing and Safety Act 2005*
- *Charter for Human Rights and Responsibilities Act 2006*
- *United Nations Convention on the Rights of the Child*

The following Department of Health and Human Services policies regarding vulnerable children were reviewed:

- *The Best interests principles: a conceptual overview*
- *The Best Interests framework for vulnerable children and youth*
- *Best interests case practice model summary guide*
- *Cumulative harm: a conceptual overview*
- *Cumulative harm specialist practice resource*
- *Adolescents and their families specialist practice resource*
- *Adolescents with sexually abusive behaviours and their families specialist practice resource*
- *Families with multiple and complex needs specialist practice resource*
- *Child Protection Manual*, 1 December 2015
- *Child development and trauma specialist practice resource: 12-18 years*

Appendix C

This section examines the legal framework used when making decisions about children under the CYFA.

Children, Youth and Families Act

The *Children, Youth and Families Act 2005* (CYFA) is the legal framework guiding DHHS in child protection.

Best interests of the child

The CYFA is clear that the best interests of the child must always be paramount when making a decision or taking action with regard to a child or young person.[138]

The CYFA doesn't offer a specific definition but does outline guiding principles for decision makers to use when determining a child or young person's best interests. These principles require that Child Protection, family services and placement services must take action to:

- protect children from harm
- protect the rights of children
- promote the development of children.

Decision-making framework

The CYFA ascribes a series of decision-making principles. They derive from accepted principles of natural justice or procedural fairness, and are designed to strengthen the participation of children, young people and family members.

Decision-making principles apply to decision making by courts, family services, out-of-home care services and Child Protection services.

In summary, decision-making principles should:

- be fair and transparent
- be collaborative
- be empowering
- assist children, young people and families to participate in a meaningful way
- promote Aboriginal self-management and self-determination

138 CYFA 2005, s.10; Family Law Act 1975 (Cth), s.60CA; United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989, *Treaty Series*, vol. 1577 (entered into force 2 September 1990), Article 3. CYFA 2005, s.10(2).

Additional decision-making principles for Aboriginal children

In addition to the overarching best interest principles, the CYFA also provides guidance about additional decision making principles for Aboriginal children. These principles give recognition to the distinct and cultural attributes of Aboriginal people and to the importance of maintaining a child's Aboriginal identity.

In summary, the additional decision-making principles relate to:

- recognition of Aboriginal self-management and self-determination in seeking the views of Aboriginal community members to inform decision making
- the need to prioritise the placement of an Aboriginal child requiring out-of-home care within a hierarchy, whereby placement with Aboriginal extended family or relatives is the highest order consideration
- the cultural needs and rights of an Aboriginal child.

The Aboriginal Child Placement Principle

The ACPP is a specific extension of the best interest principles applicable to Aboriginal children. The ACPP prioritises and specifies the criteria for placement of Aboriginal children who are unable to remain safely at home. The hierarchy is specified as follows:

- it is a priority that, wherever possible, an Aboriginal child must be placed with the Aboriginal extended family or with relatives and where this is not possible, with other extended family or relatives
- if, after consulting with an Aboriginal agency, placement with extended family or relatives is not feasible or possible, the child may be placed with:
  - an Aboriginal family from the local community and within close proximity to the child's natural family
  - an Aboriginal family from another Aboriginal community
  - as a last resort, a non-Aboriginal family living in close proximity to the child's natural family
- any placement with a non-Aboriginal family must ensure the maintenance of the child's culture and identity through contact with the child's community.[139]

139 CYFA, section 13

Achieving the principles enshrined by the CYFA, with respect to the protection of children, relies on the relevant services translating best interests principles into effective practice.

Charter of Human Rights and Responsibilities

The Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) sets out the basic rights, freedoms and responsibilities for all people in Victoria and how government should interact with people.

The Charter creates an obligation on all public authorities to act consistently with human rights and to take all human rights into consideration when making decisions.[140]

Of relevance to decision making by family services, out-of-home care services and Child Protection services:

- Families are the fundamental group unit of society and are entitled to be protected by society and the State.[141]
- Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.[142]
- Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community to enjoy their identity and culture.[143]
- Every person has the right to recognitions before the law.[144]
- Every person has the right to life.[145]

The Child Protection Manual requires decision-makers to integrate human rights into Child Protection work and to actively 'think Charter'.[146]

140 *Charter of Human Rights and Responsibilities Act 2006*, s.38
141 *Charter of Human Rights and Responsibilities Act 2006*, s.17(1)
142 *Charter of Human Rights and Responsibilities Act 2006*, s.17(2)
143 *Charter of Human Rights and Responsibilities Act 2006*, s.19(2)
144 *Charter of Human Rights and Responsibilities Act 2006*, s.8(1)
145 *Charter of Human Rights and Responsibilities Act 2006*, s.9
146 http://www.cpmanual.vic.gov.au/our-approach/roles-responsibilities/human-rights-and-child-protection#h3_0 (accessed March 2018)

Convention on the Rights of the Child

Australia ratified the United Nations Convention on the Rights of the Child in December 1990. The convention established the rights of children. It describes in clearest terms what every child and young person needs to survive, thrive and prepare for 'responsible life in a free society', including:[147]

- the best interests of the child shall be a primary consideration in all actions affecting children[148]
- right to protection from abuse, exploitation and neglect, and the importance of the physical and intellectual development of the child[149]
- right to be heard in all matters affecting the child, their views being given due weight in accordance with the child's age and level of maturity[150]
- right to culture[151]
- right to the enjoyment of health, including access to treatment and rehabilitation services[152]
- right to education[153]
- right to recovery and social integration for the child who has experienced neglect, exploitation or abuse.[154]

The CYFA incorporates many of the rights recognised by the Convention and protected by the Charter, including the promotion of:[155]

- children's 'best interests' as paramount
- intervention that is limited to the level necessary to secure the safety and wellbeing of children
- earlier intervention and prevention services for families in need
- improved planning, coordination and delivery of services to families by increased emphasis on partnership and collaboration across and within the service systems
- children's right to be heard, participate and access information
- a strong focus on children and young person's cultural identity and culturally appropriate service delivery
- a commitment to maintaining Aboriginal children's cultural connectedness.

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147 United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989, *Treaty Series*, vol. 1577 (entered into force 2 September 1990), Article 29

148 Article 3

149 Article 19

150 Article 12

151 Article 20 and 29

152 Article 24

153 Article 28

154 Article 39

155 http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/449213/the-best-interests-framework-for-vulnerable-children-and-youth.pdf

Appendix D

Table 28: Engagement with Child FIRST (between 1 April 2014 and 1 April 2019)

Total reports	No. of referrals to Child FIRST	No. of letters recommending Child FIRST	Report no.	Age of child	Complexity of issues	Quality and effectiveness of engagement
2	–	2	Report 1 Report 2	15 years 16 year	• exposure to recurring and severe family violence between parents • child at high-risk of suicide	No record family contacted Child FIRST.
3	1	–	Report 2	14 years	• perpetration of severe family violence by child • contact with criminal justice system • lengthy history of trauma	Contact initiated by parent. Referral closed due to lack of subsequent engagement.
6	2	1	Report 1 Report 3 Report 4	12 years 13 years 13 years	• child at high-risk of suicide • parent with severe mental illness	Parent did not engage beyond initial assessment. All further contact refused.
6	1	–	Report 3	8 years	• history of severe family violence between parents • child at risk of suicide • parent with history of trauma, threatening to relinquish care	Child FIRST refers family to 'family preservation service' but referral not accepted as family deemed not to meet threshold for intensive level of service. Family waitlisted. No engagement achieved by alternative family support service. Complexity of issues not matched to intensity of service.
3	–	2	Report 2 Report 3	16 years 16 years	• child at high-risk of suicide • perpetration of family violence by the child	No record family contacted Child FIRST.

Table 28: Engagement with Child FIRST (between 1 April 2014 and 1 April 2019) continued

Total reports	No. of referrals to Child FIRST	No. of letters recommending Child FIRST	Report no.	Age of child	Complexity of issues	Quality and effectiveness of engagement
9	3	1	Report 1 Report 3 Report 6 Report 8	1 years 7 years 8 years 10 years	• parent with history of trauma, mental illness and substance abuse issues • child displaying sexualised behaviours and aggression • child with disability and PTSD • high-level neglect	Lengthy waitlists for commencement of services. Parent consistently willing to accept supports, no subsequent engagement achieved. Complexity of issues not matched by intensity of service.
6	2	–	Report 4 Report 5 Report 6	7 years 8 years 8 years	• parent with history of trauma, mental illness and substance abuse issues • child displaying sexualised behaviours and aggression • child with disability • high-level neglect	Parent consistently willing to access supports, no subsequent engagement achieved. Complexity of issues not matched by intensity of service.
4	1	–	Report 2	16 years	• child at high-risk of suicide • perpetration of family violence by the child	Parent willing to engage. Child refusing to engage, service closed.
3	1	–	Report 3	14 years	• history of severe family violence between parents • child at risk of suicide • perpetration of family violence by the child	Family waitlisted for allocation. Referral subsequently withdrawn after new concerns raised for child.
3	–	1	Report 1	14 years	• disengaged from school • running away from home • perpetration of family violence by the child • contact with criminal justice system	No record family contacted Child FIRST.
8	1	1	Report 7 Report 8	13 years 13 years	• history of severe family violence between parents • parent threatening to relinquish care	Parent expressed unwillingness to engage.

Appendix E

Table 29: Quality and effectiveness of mental health service intervention

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
Yes	2 years	2	CAMHS Hospital	• Intergenerational trauma • Childhood sexual abuse • Suicidal	Clinically unnecessary inpatient stay No available Aboriginal mental health service Assessed using adult triage as 'low risk' No plan to support recovery from sexual abuse
Yes	18 months	6	Paediatrician CAMHS Hospital Private counsellor School counsellor In-patient admission	• Exposure to severe family violence between parents • Intergenerational trauma • Parental mental illness • Insecure attachment to parent • Longstanding suicidality and attempts at suicide	No plan to support recovery from childhood trauma Failure to successfully engage parents in treatment and recovery plan
Yes	18 months	9	Paediatrician School counsellor CAMHS Clinical therapist CYMHS	• Childhood sexual abuse • Chronic protective concerns • Parental mental illness and substance abuse issues • Dual diagnoses (intellectual disability) • Suicidal	Multiple providers, lack of coordination and information sharing Lack of attendance at appointments – lack of assertive outreach Response to threats of suicide by young children No plan to support recovery from trauma
Yes	9 months	6	Paediatrician Early intervention mental health service Hospital	• Childhood sexual abuse • Intergenerational trauma • Chronic protective concerns • Parental mental illness and substance abuse issues • Dual diagnosis (intellectual disability)	Lack of attendance at appointments Ineffective early intervention Lack of coordination and information sharing
Yes	3 years	8	School counsellor CAMHS	• Exposure to severe family violence between parents • History of trauma • Care experience • Substance misuse	Lack of coordination and information sharing No plan to support recovery from trauma

Table 29: Quality and effectiveness of mental health service intervention continued

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
No	4 years	3	School counsellor Headspace	• Exposure to severe family violence between parents • History of trauma • Parent with significant mental illness • Suicidal	Did not meet the threshold for tertiary mental health support Lack of information sharing
No	7 years	7	School counsellor Psychologist	• Intergenerational child sexual abuse • History of familial suicide • Risk of sexual abuse • Grief	Commenced engagement with a private psychologist but unable to afford cost Did not meet the threshold for tertiary mental health support
Yes	12 years	6	Hospital Early intervention mental health service In-patient admission Orygen	• Recent sexual assault • Parental mental illness • Suicidal • Disengagement from school	Impact of parent-child relationship on effective engagement with child Reactive intervention
No	12 years	3	School counsellor headspace	• Exposure to severe family violence between parents • Perpetration of family violence by child • Parental mental illness and substance misuse	Lack of accessible mental health services No plan to support recovery from trauma
Yes	15 years	2	GP Hospital Telephone triage CAMHS Crisis Assessment Team headspace	• Exposure to severe family violence between parents • Family violence in current relationship with older male • Disengaged from school • Suicidal	Did not meet the threshold for tertiary mental health services Lack of assertive outreach Fragmented response that failed to combine protective and mental health aspects
Yes	13 years	3	GP Psychiatrist Hospital	• Perpetration of family violence by child • Contact with criminal justice system • History of trauma	Lack of coordination and information sharing Unable to successfully engage child

Table 29: Quality and effectiveness of mental health service intervention continued

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
Yes	5 years	3	GP Hospital Youth substance abuse service Psychiatrist CAMHS Private clinic	• Acrimonious relationship between separated parents • Substance misuse by child • Disengaged from school • Suicidal	Reactive engagement by the child Failure to successfully engage parents in treatment and recovery plan Multiple service providers, lack of cohesion regarding diagnosis or treatment
Yes	14 years	4	Psychologist CYMHS headspace In-patient admissions Hospital	• Perpetration of family violence by child • Contact with criminal justice system • Disengaged from school • Substance misuse by child • Suicidal	Lack of coordination and information sharing Assessed using adult triage as 'low risk' Multiple providers, lack of cohesion regarding diagnosis or treatment Use of seclusion Inadequate support for parents as 'carers'
Yes	13 years	2	Early intervention mental health service School psychologist headspace	• History of early childhood trauma • Dual diagnosis (intellectual disability) • Suicidal	Excellent coordination and information sharing by service providers Good example of family inclusive practice
Yes	14 years	3	GP Paediatrician CAMHS Outreach worker	• Contact with criminal justice system • Substance misuse by child • Running away from home • Situational stressors • Suicidal	Triaging of suicide risk as 'low risk' leading to delayed intervention Unable to successfully engage the child Inadequate support for parents as 'carers'

COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

Commission for Children and Young People logo

The logo represents our vision for all children to be strong in health, education, culture and identity, and face the world with confidence.

The people are connected, equal in size and importance, and there is a fluidity that binds them together.

The mission of the Commission is for all young Victorians to achieve these goals.

The symbol is a Koorie design created by Marcus Lee for the Commission.

The Commission respectfully acknowledges the Traditional Owners of the country throughout Victoria and pays respect to the ongoing living cultures of First Peoples.

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