

Australian Centre  
for Child Protection

# The Role of Child Death Reviews in an Integrated System for Enhancing Child Protection Practice

Leah Bromfield

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UniSA



Australian Government

Department of Innovation, Industry,  
Science and Research



*Working together to enhance the lives of children*

# Overview

- The influence of child death reviews on
  - Policy and practice
  - The international body of child protection practice evidence
- Child Death Reviews and the *National Framework for Protecting Australia's Children*



# Purpose of child death reviews and inquiries

“Child death teams attempt to understand cases of preventable death, rather than assign blame, and to uncover ways that child welfare systems (e.g., child protection, public health, juvenile justice) can be improved to prevent future deaths or injuries.”

Hochstadt (2006) p. 659



# Child death reviews can comprise

- Investigation of preventable child deaths and identification of their causes
- Identification of changes necessary to prevent future deaths
- The collection of data to identify trends



# Child death reviews & inquiries are necessary ...

... Why are they the subject of critique?



# Predictable deaths?

If risk to children is considered measurable and manageable. The implication is that harm to children both can and should be prevented – and if it is not, that ***someone is to blame***



# Defining threshold

Changes to threshold at which the *public* choose to contact child protection services reflect changing social values

Changes to thresholds at *internal* decision-making points reflect changing social values *and factors internal to the service system*

Bromfield & Holzer, 2008; Holzer & Bromfield, 2008



# Child death reviews & threshold

High-profile child death reviews and the media response to them, tend to ***create an alarmed community reaction***, and have reinforced increasingly risk-averse practice in recent years

Connolly & Doolan, 2007; Spratt, 2001



# Dangers of overloaded child protection services

- Children in serious jeopardy missed
- Children in need not referred
- Parents who feel more isolated
- Children in care receiving less attention
- Strained relationships between child protection and other services
- Staff experiencing high levels of stress

Scott, 2005



# Can we make reliable predictions?

*What does the research evidence tell us ...*



# Risk assessment tools

- Actuarial based instruments
  - Developed based on empirical analysis of the factors associated with child maltreatment
  - Practitioners score each item. The scores of individual items are summed, and families are assigned to a risk category according to the their overall score



# Risk assessment tools

- Consensus-based instruments
  - Developed based on relevant theory (e.g., attachment theory) and the opinions of experts
  - Individual items guide practitioners to consider risk factors. However, the final decision as to the overall family risk category is usually left to the practitioner's (guided) discretion



# What are we predicting?

- Risk (high, medium or low) of:
  - re-referral
  - re-investigation
  - re-substantiation
  - re-entry into care



# Making accurate predictions

		Observed	
		Did not recur	Recurred
Predicted	Low risk of recurrence (low risk)	✓ True negative	✗ False negative
	High risk of recurrence* (high risk)	✗ False positive	✓ True positive

\* Assuming no intervention provided to reduce risk



# Predictive validity of SDM for re-notifications in Minnesota

		Observed	
		Did not recur	Recurred
Predicted	Low risk of recurrence (low risk)	✓ 78%	✗ 22%
	High risk of recurrence* (high risk)	✗ 60%	✓ 40%

Loman & Siegal, 2004



# Child death reviews and the practice context

Practitioners must make decisions about case prioritisation for each individual case in light of the other cases they are carrying



# Preventable versus predictable

- Preventable
  - Capable of being prevented
- Predictable
  - It happens in the way that you would expect



# Implementing change

- Identification of changes necessary to prevent future deaths
- How are recommendations implemented?



# Procedure and training

- Policy or practice standards
  - eg Qld Child Safety Practice Manual
- Mandatory training
  - 12 topics and 93 subtopics were identified as important to educating competent BSW-level child welfare practitioners in the US (Unrau & Wehrn, 2003)
  - Inquiry into child protection services in NSW comprised 9 recommendations that specified a need for training (Wood, 2008)



# Memory test 1

seven, review, cat, chair, blade,  
bus, moon, pencil, blind, key,  
door, hair, shoe, top, jar, boat



# Memory test 1



# Human reasoning

*“If [people] were perfectly rational, they would carefully consider all evidence before reaching a conclusion ...*

*Research in psychology has shown that **people are not, on the whole, rational thinkers** who have occasional lapses”*

Munro, 1999



# Memory test 2

- Flowers
  - rose, daffodil, alamanda, hibiscus
- Writing Instruments
  - pen, crayon, chalk, pencil
- Transport
  - car, aeroplane, truck, train
- Furniture
  - desk, bed, table, chair



# Memory test 2



# Common errors of reasoning

- Narrow range of evidence
- Biased towards information readily available to them
- Biased towards the memorable
- Errors in communication
- Lack of appropriate scepticism
- Slow to change views

Munro, 1999



# Reframing errors as normative

- *Common errors of reasoning identified in child death reviews were the **errors you would expect** if we apply our **understanding of cognitive psychology** to decision-making in child welfare*

Munro, 1999



# What message do practitioners receive about error?

- Risk assessment in child protection now involves an additional un-stated dimension—risk to the individual or organisation of making the wrong decision



# Proceduralisation

- It is possible to implement procedure to the letter in a child protection case and still miss the vital clues as to what is happening. Lord Laming's justified complaint ... [was] that decisions were *not* pursued, and the procedures were *not* followed. But **the more searching inquiry concerns why they were not pursued and implemented**”

Cooper, 2005, p. 4



# Proceduralisation

- Winkworth & McArthur (2006) noted
  - increasingly complex and procedurally driven care and protection processes mean that there is a risk that the child's experiences of these processes become lost



# Accept error as inevitable

- A non-judgmental acceptance that errors are an inevitable feature of practice might make it easier for people to point out any errors they spot

Munro, 1999



# A systems approach to investigating child abuse deaths

“Public inquiries have “been intelligently conducted, their analyses of practice look accurate, and their recommendations seem very sensible. Yet they are not leading to the desired improvements in outcomes for children and families. It is time to stop, reflect and ask whether there is an alternative way of approaching the problem. Fortunately, there is.”

Munro, 2005



# Starting with human error

- Instead of stopping when human error is identified, a systemic investigation takes this as a starting point
  - Why are humans in this circumstance performing badly
  - What demands do the tasks make on operators knowledge and skills?
  - Do individuals have the necessary capabilities?
  - Are the demands realistic given what we know of human reasoning?



# What do we want practice to look like?

- Informed by guiding values & principles
- Child and family centred
- Passes the 'reasonable person' test
- Comprises sound analysis and clinical judgment
- Practitioners are equipped with evidence to inform practice decisions



# Child death reviews as research evidence

- Representative samples
- Purposive samples
  - positive case examples
  - negative case examples



# Child death review: A negative case example

- *Child death group analysis: Effective responses to chronic neglect.*

Frederico, Jackson, & Jones, 2006



# Good practice stories: A positive case example

- Victorian Government  
National Child Protection Week  
Good Practice Stories



# Client satisfaction surveys: representative sampling

-  **2009 Telephone Survey of Former Protection Service Clients**  
*Because children depend on all of us*
- Method reports
  - how they identified a randomised sample,
  - response rates
  - reasons for refusal and non-completion
- Caution potential for bias



# Survey Questions

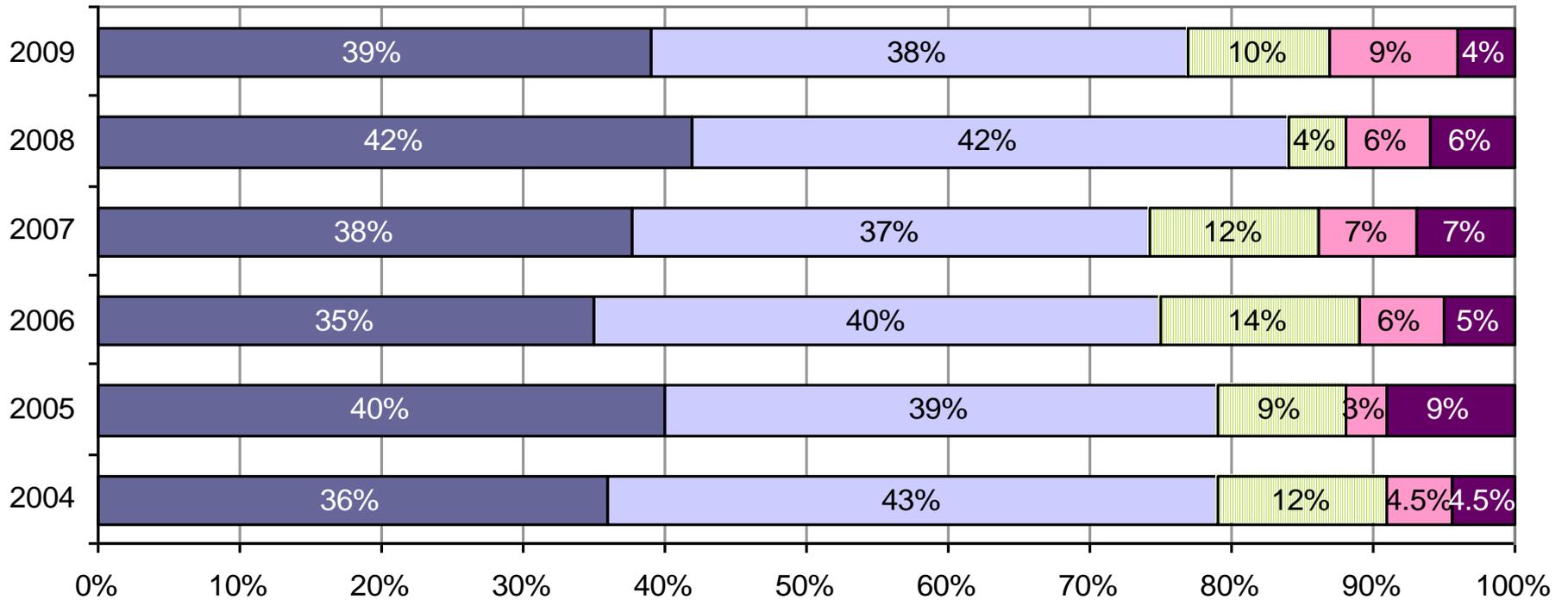
1. My phone calls were quickly returned
2. Clearly explained why CAS was involved
3. Treated with courtesy and respect
4. Enough time was spent with me providing help
5. Felt listened to and treated fairly
6. Worker knowledgeable about children
7. Involved in decisions about my family
8. Clear about what needed to make child safe
9. Ask me about what I needed to keep my child safe
10. Kept informed about what was happening
11. Overall satisfaction with CAS



# How satisfied were you overall with services received from CAST?

2004-2009

Very satisfied Satisfied Neutral Unsatisfied Very unsatisfied

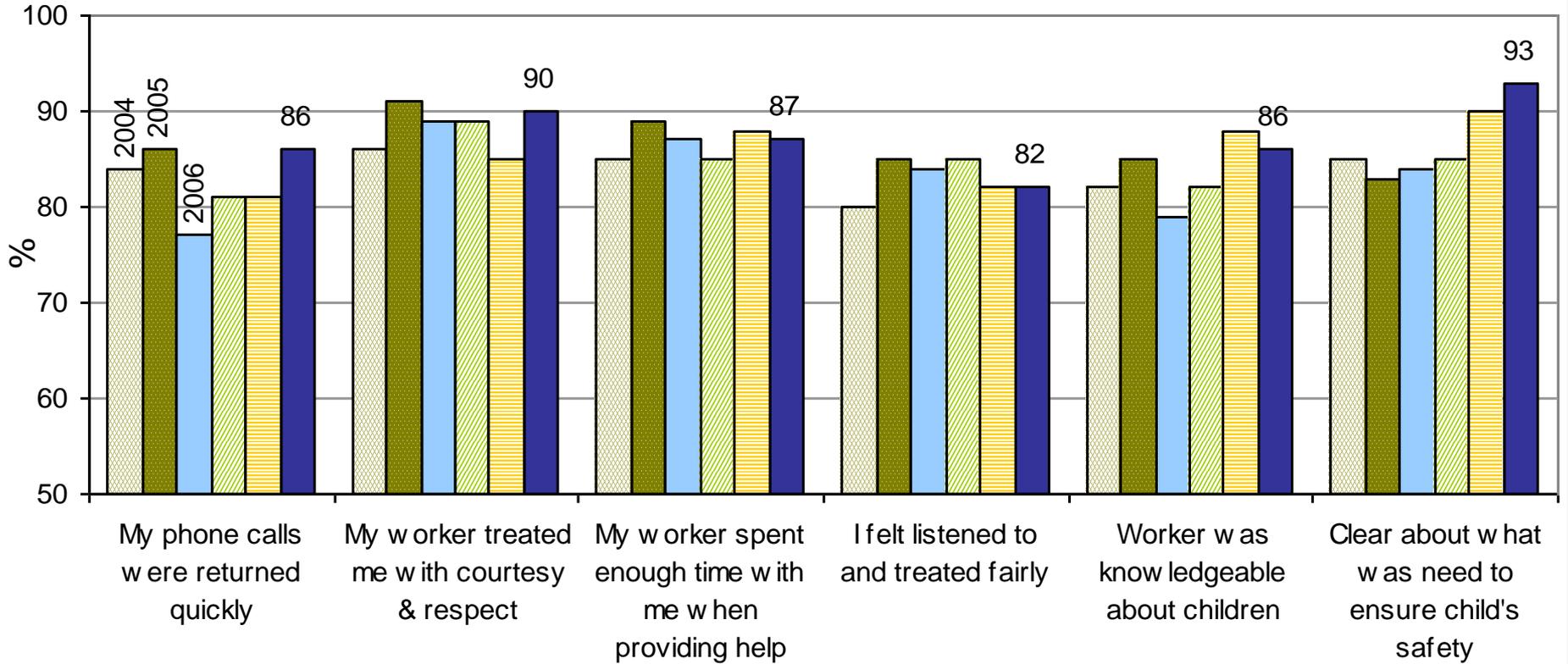


Acknowledgment: Dr Deborah Goodman,  
Children's Aid Society of Toronto



## Service Quality Questions - Respondents Strongly Agree or Agree

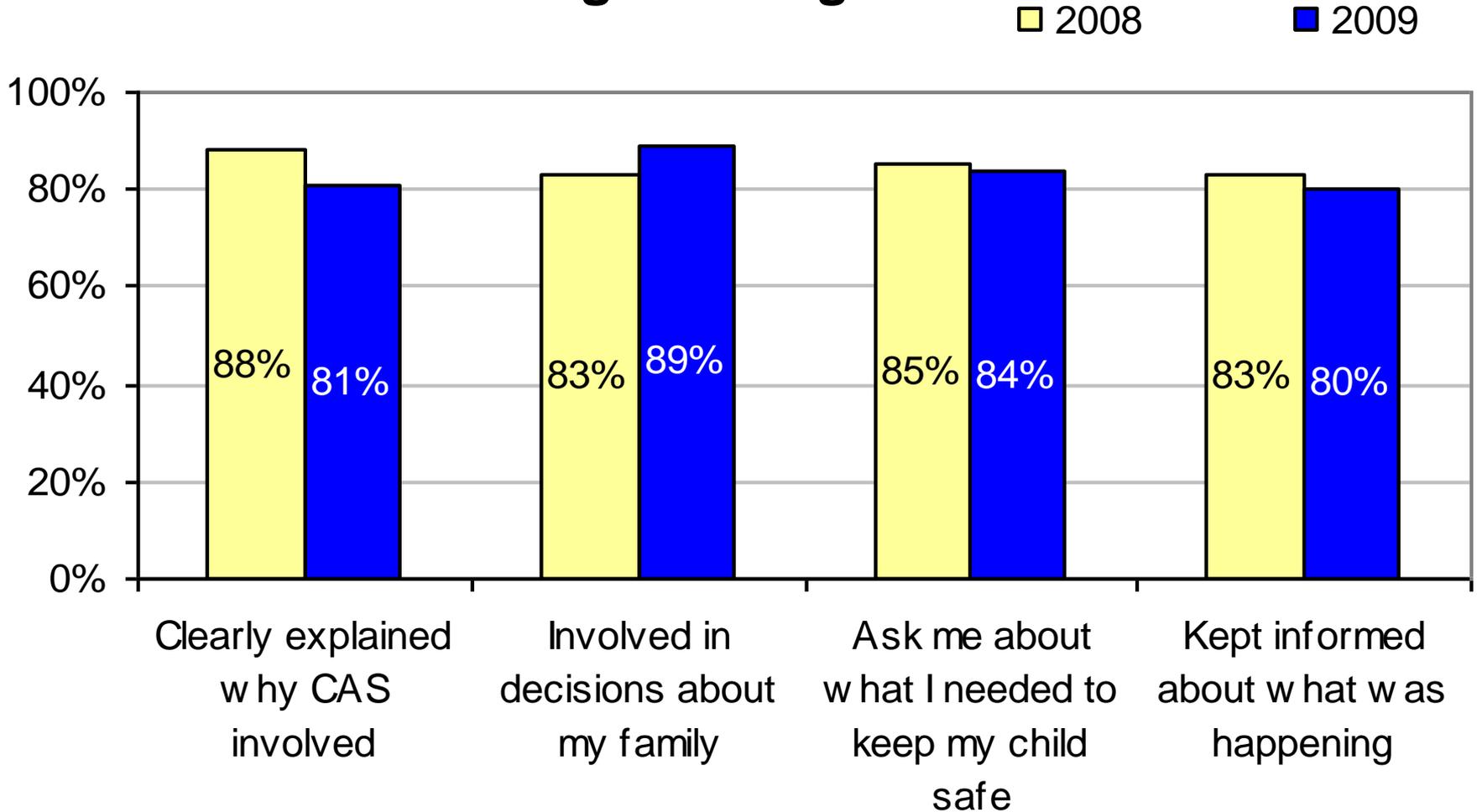
2004 2005 2006 2007 2008 2009



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# New Questions - Respondents Strongly Agree or Agree



Acknowledgment: Dr Deborah Goodman,  
Children's Aid Society of Toronto



# Summary

- Preventable versus predictable
- Practice context
- Prescriptive practice and human reasoning
- Organisational environments that enable the type of practice we want to see
- CDR as research evidence



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# A/Prof Leah Bromfield

Deputy Director

Australian Centre for Child Protection

University of South Australia

[www.unisa.edu.au/childprotection/](http://www.unisa.edu.au/childprotection/)

Leah.Bromfield@unisa.edu.au

08 8302 2924



# References

- Austin, M., D'andrade, A., Lemon, K., Benton, A., Chow, B., & Reyes, C. (2005). Risk and safety assessment in child welfare: Instrument comparisons. Berkeley: University of California. Retrieved, from [http://www.mockingbirdsociety.org/files/reference/Child\\_Welfare\\_System\\_National/Risk\\_and\\_Safety\\_Assessment\\_Instruments.pdf](http://www.mockingbirdsociety.org/files/reference/Child_Welfare_System_National/Risk_and_Safety_Assessment_Instruments.pdf)
- Baird, C., & Wagner, D. (2000). "The relative validity of actuarial-an consensus-based risk assessment systems". *Child and Youth Services Review*, 22, pp. 839-871.
- Bromfield, L. M., & Holzer, P. J. (2008a). *Australian Institute of Family Studies Submission to the Special Commission of Inquiry into Child Protection Services in NSW*. Retrieved from [www.aifs.gov.au/nch/pubs/submissions/nswchildprotect/inquiry.pdf](http://www.aifs.gov.au/nch/pubs/submissions/nswchildprotect/inquiry.pdf)



# References

- Bromfield, L. M., & Holzer, P. J. (2008b). *Protecting Australian children: Analysis of challenges and strategic directions*. Melbourne: Australian Institute of Family Studies on behalf of the Community and Disability Services Ministers' Conference. Retrieved from [www.aifs.gov.au/nch/pubs/reports/cdsmac/protecting.pdf](http://www.aifs.gov.au/nch/pubs/reports/cdsmac/protecting.pdf)
- Connolly, M., & Doolan, M. (2007). Child deaths and statutory services: Issues for child care and protection. *Communities, Families and Children Australia*, 2(1), 26-38.
- Cooper, A. (2005). Surface and depth in the Victoria Climbié Inquiry Report. *Child & Family Social Work*, 10(1), 1-9.
- Frederico, M., Jackson, A., & Jones, S. (2006). *Child death group analysis: Effective responses to chronic neglect*. Melbourne: Office of the Child Safety Commissioner, Victorian Child Death Review Committee.
- Gillingham, P., & Bromfield, L. M. (2008). Child protection, risk assessment and blame Ideology. *Children Australia*, 33(1), 18-24.



# References

- Goodman, D. “2009 Telephone Survey of Former Protection Service Clients: Summary of Results”. *Children’s Aid Society Toronto*.
- Hochstadt, N. (2006). “Child death review teams: A vital component of child protection.” *Child Welfare*, 85(4), pp. 653-670.
- Holzer, P. J., & Bromfield, L. M. (2008). *NCPASS comparability of child protection data: Project report*. Melbourne: Australian Institute of Family Studies. Retrieved from [www.aifs.gov.au/nch/pubs/reports/ncpass/ncpass.pdf](http://www.aifs.gov.au/nch/pubs/reports/ncpass/ncpass.pdf)
- James Cook University. *Memory test*. <http://www.jcu.edu.au/tldinfo/learningskills/studysmart/memory.html>
- Loman, L.A., & Siegal, G.L. (2004). *An evaluation of the Minnesota SDM Family Risk Assessment: Final report*. Institute of Applied Research: St Louis, Missouri. Retrieved 12 Aug 2010 from <http://www.iarstl.org/papers/FinalFRARReport.pdf>



# References

- Munro, E. (1999). “Common errors of reasoning in child protection work. *Child Abuse & Neglect*, 23(8), pp. 745-758.
- Munro, E. (2005). “A systems approach to investigating child abuse deaths”. *British Journal of Social Work*, 35, pp. 531-546.
- Queensland Government. *Child Safety Practice Manual*.  
<http://www.childsafety.qld.gov.au/practice-manual/>
- Scott, D. (2005). “Towards a public health model of child protection in Australia”. *Communities, Children and Families Australia*, 1, pp. 9-16.
- Spratt, T. (2001). The influence of child protection orientation on child welfare practice. *British Journal of Social Work*, 31, 933-954.
- Victorian Government. (2007). *Good Practice: A state-wide snapshot 2007*. Melbourne: Victorian Government.



# References

- Unrau, Y., & Wehrn, K. (2003). "Perspectives on preparing BSW students for competent child welfare practice". *Journal of Baccalaureate Social Work*, 8, pp. 17-36.
- White, A., & Walsh, P. (2006). Risk assessment in child welfare. An issues paper. Sydney: NSW Department of Community Services. Retrieved, from [http://www.community.nsw.gov.au/docswr/\\_assets/main/documents/research\\_riskassessment.pdf](http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_riskassessment.pdf)
- Winkworth, G. & McArthur, M. (2006). "Being 'child-centred' in child protection: What does it mean? *Children Australia*, 31(4), pp. 13-21.
- Wood, J. (2008). Report of the Special Commission of Inquiry into Child Protection in NSW. Sydney: NSW Government.

