

Ombudsman report on the reviewable deaths of children

Embargoed until 12pm, 29th November 2006

The NSW Ombudsman, Bruce Barbour, tabled the second volume of his report of reviewable deaths in Parliament today.

This volume concerns the deaths in 2005 of 117 children.

The definition of reviewable deaths means that most of the child deaths reviewed by the Ombudsman will be children with a history of contact with DoCS. Among the 117 deaths in 2005, there were 109 children whose families were known to DoCS.

Most of the 117 children were very young. Almost three quarters of them were less than four when they died, and 60 were babies under 12 months.

Once again, Aboriginal children were over-represented in reviewable deaths. In 2005, the deaths of Aboriginal children made up 17% of reviewable child deaths.

“My office has been reviewing child deaths for the past three years. While DoCS and other agencies have been working to improve their responses to children at risk, the concerns we have identified have remained largely consistent”, Mr Barbour said.

The concerns include:

- Agencies not consistently recognising when a child may have been at risk, or not effectively making a report to DoCS.
- DoCS not fully assessing, or responding to, the concerns raised in risk of harm reports made to the department.
- Poor coordination between agencies in assessing risk and responding to child protection concerns.

In almost half of the deaths reviewed, the child’s parents had a history of drug or alcohol abuse. A parent’s substance abuse was directly linked to the deaths of eight children.

The reviews found that agencies working with families where substance abuse is a problem face considerable barriers to responding effectively to child protection concerns. Professionals may not have drug and alcohol expertise, and parents who abuse drugs or alcohol can be difficult to engage.

“Parental substance abuse poses particular challenges for agencies – including DoCS, NSW Health and NSW Police – and highlights the critical importance of effective communication and coordination between agencies with responsibilities for ensuring the safety of children, Mr Barbour said.

“We have directed 34 recommendations to DoCS, NSW Health and NSW Police and we will closely monitor their progress in addressing the issues raised by our work.”

Copies of the Ombudsman’s report will be available at: www.ombo.nsw.gov.au shortly after 12pm.

FACTS AND FIGURES

Reviewable deaths

The NSW Ombudsman reviewed the deaths of 117 children who died in 2005. This represents 20% of all child deaths in NSW in 2005 (598 children). The death of a child is reviewable if:

- a risk of harm report was made to the Department of Community Services about the child, or their sibling, in the three years before the child died (referred to in the report as the child being 'known to DoCS')
- the child's death was, or may have been, due to abuse or neglect or occurred in suspicious circumstances
- the child was in care
- the child died in a detention centre or correctional centre.

Why deaths were reviewable

- Among the 117 deaths reviewed, there were 109 children whose families were known to DoCS:
 - 69 children (59%) who died had been the subject of one or more risk of harm report(s)
 - In an additional 40 cases (34%), while the child had not been the subject of a risk of harm report(s), their sibling had.
- 33 children died as a result of abuse or neglect, or in suspicious circumstances. In 25 of these cases, the child and/or their sibling was known to DoCS. Of the 33 deaths:
 - 11 children died as a result of abuse
 - 12 as a result of neglect
 - 10 in suspicious circumstances.

Demographic details

- Most of the 117 children were very young when they died:
 - 60 (51%) were less than 12 months old
 - 86 (73%) were less than four years of age
- Aboriginal children were over-represented in reviewable deaths (17% of reviewable child deaths).
 - In 2005, 44 children who died in NSW were Aboriginal, and 20 of these deaths were reviewable. This means that while 20% of all child deaths were reviewable, 45% of all Aboriginal child deaths were reviewable.
 - One quarter of Aboriginal children (5 children) whose deaths were reviewable died as a result of abuse or neglect, or in suspicious circumstances.