

Report of Reviewable Deaths in 2012 and 2013

**Volume 1:
Child Deaths**

June 2015

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in 2012 and 2013**

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ISBN 978-1-925061-47-5

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Foreword

This report examines the reviewable deaths of children in 2012 and 2013. It also presents the findings of a review of 83 children who died in abuse-related circumstances, and where the person of interest in the death was a family member.

Over the decade, the majority – almost 80 per cent - of children who died in abuse-related circumstances were killed or allegedly killed by a family member. The largest group of persons of interest in the child's death were birth parents. Intimate partners of birth mothers, particularly new partners, also featured significantly.

Well over half of the persons of interest were known to police as perpetrators of violence, including assault and domestic violence prior to the child's death. Most strikingly, the majority of those with a history of violence were known to police as serious violent offenders.

This report represents a decade of my office reviewing the deaths of children in circumstances of abuse and neglect. Much has changed over that time in how the State responds to the deaths of children.

In 2010, responsibility for the NSW Child Death Review Team transferred to my office, and my staff and the Team have focused over the past five years on integrating our review work to minimise duplication, and to maximise effective targeting of prevention efforts. Also in 2010, the NSW Department of Family and Community Services established its own public annual reporting of the deaths of children 'known' to the department, which includes deaths of children in circumstances of abuse and neglect.

The majority of neglect-related deaths – which average 14 each year – are Sudden Unexpected Death in Infancy, fatal transport incidents, or drowning. These cases are considered neglectful because the actions of a carer are identified as significantly careless, or an intentional or reckless failure to adequately supervise. In other cases, deaths occur in circumstances of chronic neglect – the failure to provide for a child's basic needs, including food, shelter and medical care.

In this context, my office is carefully considering how our work in reviewing child deaths can be best positioned to make the greatest contribution to preventing deaths, and to complement the work of the Child Death Review Team, and FACS.

Although many of the children who die in neglected-related circumstances have a child protection history, it may be that the Child Death Review Team is best placed through its work to address the issues of carer supervision and protective behaviours that arise in these cases. We will consult with the Team, and other key stakeholders, about how our reviewable deaths work can best contribute to the prevention of deaths occurring in circumstances of neglect.



Bruce Barbour
Ombudsman

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Executive summary

Reviewable child deaths

The death of a child is reviewable by the Ombudsman if the child died as a result of abuse or neglect, or their death occurred in suspicious circumstances; or at the time of their death the child was in care or in detention.

This report is the eighth report of reviewable deaths, and covers the period 1 January 2012 to 31 December 2013. In this two-year period, 1,067 children died in NSW. We identified 41 (3.8%) of these deaths as reviewable:

- Nine children died as a result of abuse (5), or in circumstances suspicious of abuse (4).
- Eighteen children died in circumstances of neglect (15) or suspicious of neglect (3).
- Fourteen children died while in care; all of whom were in statutory out-of-home care.

The report includes a focus on abuse-related child deaths in the decade to 2013.

Abuse-related deaths of children 2012 and 2013

The proportion of child deaths due to abuse-related circumstances in 2012 (1.0%) and 2013 (0.7%) was lower than the 10-year average (1.8%), and much lower than the previous two-year period.

Most of the children were very young; five were less than five years of age. In eight of the nine cases, the person or persons of interest in the death of the child was a family member. One child died in an incident involving a peer.

This report includes a specific focus on familial abuse-related deaths over the decade from 2004 to 2013.

Neglect-related deaths of children 2012 and 2013

Most of the 18 children who died in neglect-related circumstances were very young; 12 were less than five years of age.

The context of neglect-related deaths

Twelve children died in the context of a significantly careless act on the part of a carer. This included six transport fatalities, and six deaths in sleep-related incidents. Children were exposed to significant risk through a combination of acts on the part of the responsible carer, for example:

- In relation to transport fatalities, excessive speed, defective tyres, and drug use; or inadequate restraint, unregistered vehicle, and mobile phone use while driving.
- In all sleep-related incidents, children were placed for sleep in inappropriate bedding and other unsafe environments, and five died while co-sleeping with parents who were affected by alcohol or cannabis.

The deaths of six children occurred in the context of an intentional or reckless failure to adequately supervise. This included three drowning deaths, two deaths in house fires and one transport fatality. Most (5) of the children were aged less than five years. A consistent feature in the circumstances of the deaths was children being placed in high risk situations and left without supervision appropriate to their age and developmental level.

Family and carer characteristics

Risk factors associated with neglect include a range of socioeconomic factors, and carer characteristics. In relation to the 18 families in which a child died in neglect-related circumstances in 2012 and 2013:

- the majority (15) resided in areas of greatest social disadvantage
- the majority (15) featured carer substance abuse – mainly alcohol and cannabis
- most (13) had a child protection history
- domestic violence was present in 13 families – perpetrated by either or both carers
- either or both carers in 13 families had a criminal history, typically involving both violent and non-violent offences, and

-
- eight families comprised young parents and/or parents who had been the subject of child protection concerns themselves.

Children who died while in care in 2012 and 2013

Of the 14 children who died while in statutory care:

- Seven children died as a result of external (unnatural) causes, including suicide, transport incident and drowning.
- Five children in care died as a result of natural causes. The majority (4) of the children had complex health needs associated with disability or congenital/ degenerative conditions, and one infant had complications related to extreme prematurity.
- Two children died suddenly and unexpectedly after being placed for sleep.

Length of time in care and child protection history

The children had been in care for periods ranging from one month to more than 15 years. Half (7) of the children had been in care longer than five years, and five children had entered care less than 12 months before their death.

Most (10) of the children had a child protection history in the three years before their death, and for six children, this included reports made after their placement in care. All of these children were placed with relatives, mainly grandparents. The reasons for the child protection report(s) included concerns about the child's behaviour or mental health problems (3), carer alcohol or drug abuse (2) or risk of harm from other family members (2).

Familial abuse-related deaths in NSW 2004 - 2013

Between January 2004 and December 2013, 83 children from 75 families died in abuse –related circumstances in which the person or persons of interest was a family member.

The children who died

Three quarters (59) of the children were aged five years or less, and over half (49) were younger than three years of age, including 22 infants aged less than one year. The median age of the children was two years.

Almost two-thirds (52) of the 83 children were male. The predominance of male homicide victims is well recognised in research literature.

Of the 83 children, 15 were identified as Aboriginal or Torres Strait Islander, and almost a quarter (19) of the 83 children had a parent(s) who was born overseas, or had otherwise been identified as having culturally and linguistically diverse backgrounds.

Seventeen children were identified as having personal characteristics or additional needs that may have increased their vulnerability. The most common characteristics included physical and/or intellectual disability or developmental delay; learning difficulties; behavioural problems; and neonatal abstinence syndrome.

Cause and circumstances of death

The NSW Police Force (NSWPF) have identified 94 persons as responsible for, or persons of interest in relation to, the deaths of the 83 children included in this review. Fifty-nine persons have been charged and/or convicted in relation to 52 of the deaths. This includes convictions for murder (12), manslaughter (23), neglect (1) and infanticide (1). Charges have been, or were, laid against 22 other people.

We examined the primary circumstances of the incidents that resulted in the deaths. Our reviews found that:

- Fifty-one children died as a result of inflicted or allegedly inflicted injuries. Post-mortem examinations for 12 children revealed injuries that suggested physical abuse before the fatal event.
- Fifteen children died in murder-suicide incidents. Common factors present in these incidents were mental health issues, both diagnosed and undiagnosed, and current or recent family breakdown.

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- Thirteen children died during what appears to be, or has been identified as, a psychotic episode or other mental illness experienced by the offender at the time of the fatal incident.
 - Four children died in circumstances where harm was not the intention of an action; primarily in circumstances where drugs were administered to pacify or sedate children.

Family circumstances

While all of the children were living with at least one birth parent, two-thirds (50) of the 75 families had experienced separation or family breakdown prior to the child's death. Almost all of the separated parents had formed new intimate relationships.

Over half (40) of the families of children who died in familial abuse-related incidents had a child protection history in the three-year period prior to the child's death.

The persons of interest

The vast majority (89) of the persons of interest were in a parental role with the children who died; most were birth parents. The 94 persons of interest were:

- birth parents (36 mothers and 21 fathers)
- intimate partners of birth parents (31 male and one female), including four step-parents, and
- other relatives (5), including grandparents, cousin, uncle and sibling.

Our previous work has noted that mental illness was a significant contributing factor in the actions of women, mainly birth mothers, who killed their children, and that males, including birth fathers, were most likely to have a previous history of violence and substance abuse if they were in families with a child protection history.

Of note, male intimate partners represented one-third (31) of all 94 persons of interest. The majority of male intimate partners (27) were new to the family, and had formed a relationship with the birth parent less than a year before the child's death. In the majority of cases, the new partner was the person of interest in the child's death.

Our reviews identified that 24 of the new partners were known to police. Most (20) were considered to be serious violent offenders, with charges or convictions for a range of offences, including assault, domestic violence, sexual offences, and manslaughter.

For 13 families that included a new partner, reports to Family and Community Services (FACS) that the child/ren in the family were at risk of significant harm included concerns about the individual. In most of these cases, FACS did not undertake checks of the new partner to inform assessment of risk to the children.

Characteristics of the persons of interest

Our reviews identified factors in many of the families that are commonly reported issues in risk of significant harm reports to FACS, particularly domestic violence, physical abuse, carer drug and alcohol use and carer mental health:

- *History of violence:* Over half (55) of the 94 persons of interest, primarily men, were known to police as perpetrators of violence prior to the child death. The majority (39) of the individuals with a history of violent behaviour were serious violent offenders, with charges or convictions including assault, malicious wounding or inflicting grievous bodily harm, armed robbery, and stalk and intimidate.
- *Substance abuse:* Information about alcohol and other drug use was available for 89 of the 94 persons of interest. Over half (55) had a documented history of substance abuse. Less than half of these individuals (19) had some access to treatment for their substance abuse.
- *Mental health issues:* Information about mental health was available for 85 of the 94 persons of interest. Records indicated that 35 had mental ill-health or contact with mental health services before the child's death. This included 32 people who had been formally diagnosed with, or were receiving treatment for, a mental illness.

Involvement with agencies

Over the past decade, significant steps have been taken by government to respond to child protection risks, including but not limited to the implementation of *Keep Them Safe: A shared approach to child wellbeing and Safe Home for Life*. Contact with agencies by the families or children who died in abuse-related circumstances and considered in our review may have pre-dated these reforms.

Involvement with police

Over three-quarters (58) of the 75 families had come to the attention of police at some point before the child's death; 41 within the year prior to the child's death. For the majority of these families, contact related to criminal activity on the part of either or both carers, including 20 families with very extensive criminal histories.

In the main, contact was in response to reports of domestic violence, including eight families who had repeated contact with police in relation to multiple instances of domestic violence. However, the police contact in the year before death was usually not directly associated with the behaviour of the person/s of interest toward the child. In this period, five families came to the attention of police in relation to physical harm or injury to the child who died and/or a sibling.

Involvement with health services

During the year before the child's death, most (50) of the families had some documented involvement with health services; the nature, frequency and extent of which varied considerably. Families primarily had involvement with four key types of health services; mental health services (28 families), general practitioners (23), maternity and early childhood services (19), and hospital emergency departments (17).

Health practitioners, mainly public providers, made risk of harm or risk of significant harm reports in relation to almost half (24) of the families in the year before the child's death. The most commonly reported issues involved carer drug and/or alcohol abuse; risk of, or actual, physical harm, abuse or suspicious injury; and domestic violence.

Contact with health services: physical injury

For over one-third of the children (33), records indicated evidence of prior injury before the child's death. This included hospital and/or health service presentations and post mortem findings.

Fourteen of the children presented to hospital and/or saw a general practitioner in relation to physical injuries prior to their death. For most of the children, their most recent presentation with physical injuries occurred within four months of their death, including seven who presented to hospital, and all of the children who had seen a GP. Two children had multiple prior presentations to hospital with physical injuries.

Health practitioners, all hospital staff, identified the injuries as suspicious in relation to 10 of the 14 children, and made child protection reports to FACS in relation to eight of these children. The suspicious injuries were brought to the attention of police (or a Joint Investigation Response Team (JIRT)) in relation to six of the 10 children.

Involvement with FACS

Over half (43) of the 75 families had been the subject of a report of risk of harm or risk of significant harm to FACS in the three years before the death. The primary reported concerns related to risk of physical abuse, neglect, exposure to domestic violence, carer alcohol or other drug use, carer mental health, and carer emotional health. For the majority of the families, reports about risk were made in the year before the death, with most reports being made in the six months before the child died.

Half of the families were the subject of up to three reports, 10 families were the subject of between four and eight reports, and 12 families had extensive child protection histories. FACS had undertaken casework or had other substantial and/or intensive involvement with 17 of the 43 families.

Twenty families were reported to FACS in the month before the children died. For the majority (16) of these families, the reports related to concerns about individuals who were subsequently identified as the person/s of interest in the child's death, and/or were about matters that were relevant to the circumstances of the child's death, such as concerns about the child presenting with suspicious physical injuries.

For four of the 20 families, the local Community Service Centre or a JIRT conducted a face-to-face assessment. For the other 16 families, the reports were included in already open plans; were closed prior to secondary assessment or remained open but with no further action; were transferred to another state or territory, or otherwise received no response.

Involvement with non-government agencies

Almost one-third (22) of the 75 families had contact with non-government services in the year leading up to the child's death.

Family support services were the most frequently used service, followed by child care, emergency accommodation, early intervention, parenting skills/playgroups, and child and family counselling. Other services included employment services and post-custody offender programs.

Our reviews found that many non-government services identified and appropriately reported risk, and/or spoke with relevant FACS caseworkers about their concerns. In some cases, services experienced difficulties working with the families, including responding to high needs and intermittent engagement by carers.

Keep Them Safe reforms have formalised and expanded the role of the non-government sector, particularly in relation to out-of-home care services, early intervention, and prevention programs. As a result, these agencies are increasingly working with families with complex needs, and where risks to children are high.

Involvement with education

Most of the children who died in familial abuse-related circumstances were younger than school age.

In the year before the child's death, just over one-quarter (20) of the 75 families had contact with schools, or were otherwise involved with education authorities.

In over half (14) of the 20 families, the children were attending school regularly and there was no recorded concerns about the child or their family. In relation to six of the 20 families, our reviews identified a range of issues particularly relating to follow-up of non-attendance of children.

Interagency responses

Information from a range of sources can provide a holistic picture of risk. Our work has highlighted the need for improved collaborative and cooperative work between agencies and practitioners.

The introduction of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (Chapter 16A) in 2010 made it easier for agencies to exchange information to protect children. However, our reviews of abuse-related deaths of children after that time have continued to identify matters in which critical information, including criminal histories, has not been sought to inform assessments and decisions about risk of harm.

Our work has consistently identified the need for improved practice across agencies, including Health, Education, FACS and Police in their identification and assessment of risk to children. It is also important that agencies not only consider their own information holdings, but also obtain information from other agencies in assessing or responding to children at risk.

Drawing on police information to ascertain risk

Around 60 per cent of reports of risk of significant harm to the Helpline indicate possible criminal behaviour, including domestic violence and physical abuse. Police are therefore potentially well placed to gather information relevant to the assessment of a child's safety.

In considering this issue, we examined the circumstances of 38 families where children who died in abuse-related circumstances had been reported to FACS in the previous three years, and the families had also been in contact with police over the same period.

Of the families who had been in contact with police and had been the subject of a report to FACS Helpline (Helpline), we identified opportunities for improved communication between NSWPF and FACS regarding the nature and/or level of risk to the children, and opportunities to enhance the nature of the child protection response provided. This included, for example, cases where FACS did not seek further information from police in assessing risk, and police held significant relevant information.

We also found examples where co-located FACS caseworkers and police could have assisted in both identifying and driving systemic improvements as a direct consequence of their 'coalface' interface. For example, in some cases there was scope for improved police practice regarding welfare checks and domestic violence cases; in other cases, there were clear opportunities for improving the practice of government and non-government agencies through these agencies more actively seeking police support and/or information in relevant circumstances.

Under *Safe Home for Life* reforms, FACS has sought to increase the openness, flexibility and responsiveness of its intake system. In light of this initiative, and the critical need to improve the child protection system's identification of, and response to, those children and their families where the child protection risks are most significant, consideration should be given to a more streamlined link to police information and support.

Themes and Issues arising from reviews

Over the past ten years, our work in reviewable child deaths has identified numerous practice and systems issues within agencies that needed to be addressed to better protect children and support vulnerable families.

In the main, agencies have acted to implement measures to address many of these concerns. However, some challenges remain, and new challenges have emerged.

Taking into account the substantial child protection reforms that have taken place over recent years and focusing on contemporary issues, significant themes have emerged, in particular:

- The need for practice improvement in critical child protection issues
- The important role of police in improving child protection responses
- The need to enhance the practice of shared responsibility and collaboration in responding to children at risk.

Practice improvement in critical child protection issues

Statutory response to children at risk of significant harm: FACS has made some improvement in the proportion of reports of risk of significant harm that receive a face-to-face assessment, and has implemented a number of important initiatives to improve practice and measure performance. However, the statutory child protection system is still struggling to meet the demands placed upon it.

Response to carer alcohol and other drug abuse: Reviews identified challenges in establishing effective agency and interagency strategies to work with families affected by drug and alcohol abuse, and demonstrated in particular the importance of ongoing reassessment of risks to children in the context of parental undertakings to engage with services.

Support to children of parents with mental illness: Reviews illustrated the importance of ensuring provision of appropriate and timely mental health support to carers and young people. Mental health services and general practitioners must recognise the support needs of patients as parents, and the potential impact of the parent's mental ill-health on children.

Identification of and response to children with suspicious physical injuries: Reviews of abuse-related deaths identified children who were the subject of repeated child protection reports about them presenting with physical injuries, including children who had multiple presentations to hospital with physical injuries before their death. This underscores the importance of practitioners and agencies recognising suspicious physical injury in children, and urgently bringing these matters to the attention of FACS and NSWPF.

Enhancing support to children living with domestic violence: Domestic violence featured in almost half of the families involved in the abuse-related deaths of children over the 10 years to 2013. There is a clear need for improvement in agencies' recognition and reporting of, and response to, the child protection implications of domestic violence. Over the past year, FACS and NSWPF have been working together to develop criteria for identifying serious violent offenders on FACS' child protection database to better inform child protection assessments. We have also recommended that FACS and NSWPF jointly assess whether

certain designated police positions should have direct access to FACS' child protection database (KiDS) system, in order to enable police to quickly access child protection information held by FACS at the time when police are responding to incidents – including many domestic violence incidents – that may involve serious risks to children.

Identification and assessment of risk presented by new partners: Male intimate partners who had formed a relatively new relationship with a birth parent represented almost one-third of all persons of interest in the abuse-related deaths of children in the ten years to 2013. In 2012, FACS developed the 'New Partners and New Household Members' practice tool to support caseworkers in assessing the safety of children when the composition of adult family members changes. However, in some cases, our reviews indicated the tool was not used to inform casework practice and assessment of the risks presented by the new partners.

Response to non-attendance at school: The abuse-related deaths of children highlighted the importance of identifying educational neglect as a child protection risk factor. Addressing educational neglect must include action to follow-up non-attendance at school, and appropriate checks on children receiving home-schooling or distance education. The Department of Education and Communities and other agencies have taken action to identify and respond to educational neglect. While acknowledging the value of this work, significantly more needs to be done to respond effectively to this issue. It is notable that children who are the subject of a risk of significant harm report relating to educational neglect are among those least likely to receive a response from the statutory child protection system.

Enhancing child protection responses in Western NSW: In our review of familial abuse-related child deaths, one-third of those families residing in regional and remote areas resided in West and Far Western NSW. Our investigations and reviews of the deaths of four Aboriginal children over a two-year period, including two children in 2012, identified ongoing systemic problems in the region, involving the recruitment and retention of skilled staff; the quality of child protection practice; and inadequate professional supervision and support. In response to our concerns, FACS has detailed a range of actions it is taking to address the primary issues of capacity, quality, and relationships with communities. While these initiatives are encouraging, more needs to be done to strengthen the overall service system in Western NSW.

Improving foster and relative/kinship carer assessment and support: Inadequate foster and relative/kinship carer assessment and support was evident in a number of reviews conducted for children who died in care in 2012 and 2013. There have been ongoing concerns about variable standards of probity screening for foster carers, including the information foster care agencies obtain to inform this assessment. The forthcoming implementation of a carers register in NSW will provide agencies with information about a potential carer's previous care history and guide agencies through the carer assessment process. In future, carer applicants will not be able to be authorised unless they pass the required checks in the carers register.

Working with police for improved child protection responses

Working with police in identifying and responding to high-risk cases: The relationship between child protection concerns and matters of a potentially criminal nature is clear from our 10-year review of familial abuse-related deaths, which found that over half of the persons of interest in these deaths were known to police as perpetrators of violence prior to the child's death. Of those, the majority were classified as serious violent offenders. This illustrates why police holdings may be a valuable source of information for identifying particularly vulnerable or at-risk children.

Enhancing police support in relation to welfare checks: Reviews of the deaths of children in circumstances of abuse and neglect identified concerns about welfare checks on children conducted by police. There is scope for police to improve the conduct of welfare checks, noting considerable variation in both the quality of the information obtained by police and the subsequent response. We have previously recommended that FACS and NSWPF should work together to, among other things, develop improved guidance and related support to police in relation to their role in conducting child welfare checks.

Referral of relevant criminal matters to police: Reviews have pointed to the need to improve both the identification of suspicious physical injuries to children, and the reporting of criminal child abuse matters to police. Close and collaborative work between FACS and NSWPF is a critical component of an effective child protection response, and it is also essential that other agencies and private practitioners report criminal matters to police. This aspect of the child protection system should be recalibrated to ensure that alleged criminal abuse of children receives an appropriate police response.

Enhancing shared responsibility

Shared responsibility and collaborative practice to better identify and respond to significant risks: There is a growing recognition that effectively identifying and responding to the needs of high risk families requires sophisticated and collaborative service practices, and a service system that drives such practices. Embedding the practice of shared responsibility aligns with major reform challenges such as progressing truly collaborative practice, building strong information exchange practices, and developing efficient and effective service systems within local communities. Our reviews have consistently identified cases where a number of agencies held information about specific and substantial risks to children that was not effectively communicated to other relevant agencies, and we have identified the need for a coherent framework that ensures integrated case management initiatives are informed by the core components of successful collaborative practice.

Proactive information exchange practices and intelligence-driven child protection: Effective, collaborative interagency practice is an important part of building a robust, intelligence-based system that promotes identifying, analysing, prioritising and acting on information held by agencies involved in child protection. There is considerable scope for better identification of, and response to, those children and families most at risk, through sophisticated IT tools to retrieve and allow critical analysis of multi-agency holdings combined with effective collaborative multi-agency practice.

Place-based service delivery

Efficient and effective place-based models of service planning, funding and delivery are an integral part of improving the identification of, and response to, high risk families.

Local planning and service delivery are recognised important contributors to successful child protection responses. Key success factors include developing clear, relevant, shared goals and measures; ensuring that government agencies and other large organisations adopt funding and governance arrangements that are sufficiently flexible to support these local initiatives; and supporting genuine community engagement by having leaders with sufficient authority to drive change.

Recommendations

Response to carer alcohol and other drug abuse

Recommendation 1

In relation to parental substance abuse, NSW Health should advise this office on the outcomes of new clinical processes and forms, in particular how these strategies have:

- a. improved the recognition of risks to children and impacted on mandatory reporting and
- b. increased coordination of care between services.

NSW Health should provide this advice by June 2016.

Support to children of parents with mental illness

Recommendation 2

NSW Health should provide advice to this office as to the strategies that will be put in place to promote appropriate clinical practice and competency in relation to recognising and responding to any potential risk to children of parents with mental illness.

NSW Health should provide this advice by December 2016.

Identification of and response to children with suspicious physical injuries

Recommendation 3

NSW Health should provide advice to this office regarding:

- 3.1 Outcomes of the NSW Kids and Families audit of Root Cause Analysis (RCA) investigations for relevant cases in the reporting period of this report, including:
- 3.2 An update of the work of the Children and Young People RCA Review Sub Committee, particularly relating to:
 - a. The number of cases involving identification of suspicious injury that have been subject to internal review
 - b. Details of lessons learned
 - c. Any recommendation made
- 3.3 Details of progress in the implementation of, and any outcomes relating to, the State-wide 24-hour Child Abuse and Sexual Assault Clinical Advice Line

NSW Health should provide this advice by December 2015.

Enhancing support to children living with domestic violence

Recommendation 4

FACS, in consultation with NSWPF, should develop parameters for, and pursue relevant legislative change to enable, designated police officers to have direct access to the KiDS system. The purpose of police access should be to enhance the capacity of police, in the conduct of their normal duties, to assess, and respond to, risk to children.

Identification and assessment of risk presented by new partners

Recommendation 5

In the context of the significant number of new partners identified as persons of interest in reviews of familial abuse-related deaths over the decade to 2013, FACS should audit or review the use of the New Partners and New Household Members practice tool and identify strategies to further promote the need to consider new partners in assessing risks to children.

Response to non-attendance at school

Recommendation 6

FACS should provide advice to this office on the progress of district led co-design initiatives directed to educational neglect, including:

- a. the outcomes of any district implemented strategies
- b. the implication of such initiatives for a state-wide operational framework for educational neglect

FACS should provide this advice by June 2016.

Enhancing child protection responses in Western NSW

Recommendation 7

FACS should continue to report to this office on a regular basis regarding initiatives to improve practice in the Western Region, and outcomes achieved.

Working with police in identifying and responding to high-risk cases

Recommendation 8

FACS and NSWPF should continue to work collaboratively to develop a plan for police officers to be located at the FACS Helpline, or to be made available to the Helpline. The role of Helpline associated police would be to:

- a. provide advice to inform FACS' assessment of, and response to, relevant reports of children at risk of significant harm,
- b. to assess whether allegations contained in reports warrant a police response, and
- c. in appropriate cases, play an active role in liaising with police commands to improve the effectiveness of responses to welfare checks and other requests for assistance.

Referral of relevant criminal matters to police

Recommendation 9

FACS and police should jointly develop guidance on the factors that should trigger referral of reports for police review and advice.

Recommendation 10

FACS policy and practice should be revised to provide clear guidance to FACS staff about information that should be referred to police. The policy should reflect an integrated approach by FACS, JIRT and NSWPF and should clearly identify what matters are not reportable to JIRT but should be referred to police.

Shared responsibility and collaborative practice to better identify and respond to significant risks

Recommendation 11

NSW Kids and Families and FACS should implement as a priority the proposed strategy to transfer cases reported to the Helpline by health workers that do not meet the statutory reporting threshold to the Health Child Wellbeing Unit, in order for the Wellbeing Unit to work directly with health workers to coordinate the provision of support to families.

Recommendation 12

Legislation to extend access to the Health Child Wellbeing Unit and the extension of information sharing provisions under Chapter 16A to all registered medical practitioners be pursued by NSW Health and FACS as a priority.

Recommendation 13

FACS should advise this office on the progress of, and any outcomes or lessons learned from, the projects in the four districts, particularly in relation to assisting vulnerable young people and increasing the number of children and young people who receive a face-to-face response.

FACS should provide this advice by June 2016.

Chapter 1. Introduction

1.1. Reviewable child deaths

Since December 2002, the Ombudsman has had responsibility for reviewing the deaths of people with disability in care, and of certain children.¹ A child's death is reviewable if they died as a result of abuse or neglect, or their death occurred in suspicious circumstances; or at the time of their death the child was in care² or in detention.

The Ombudsman is required to report on a biennial basis to the NSW Parliament about reviewable deaths.

This report is the eighth report of reviewable deaths, and covers the period 1 January 2012 to 31 December 2013. In this two-year period, the deaths of 41 children were reviewable.

Of the 41 children:

- nine children died as a result of abuse (5) or in circumstances suspicious of abuse (4)
- eighteen children died in circumstances of neglect (15) or suspicious of neglect (3), and
- fourteen children died while in care.

1.2. The purpose of reviews

Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA), the Ombudsman is required to monitor and review reviewable deaths, to maintain a register of these deaths, and to:

- formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of the reviewable deaths of children, and
- undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable.

A key focus in our reviews is on identifying practice and systems issues that may contribute to deaths, or that may expose other children to risks in the future. As part of this work, we consider how agencies and service providers have acted, and can act, to identify and respond to risks and vulnerabilities evident in the lives of the children and their families.

Our reviews involve examining relevant records and information relating to the children who died. We may also request specific information from agencies to assist in our review.

1.3. Other reviews or investigations of child deaths

NSW Child Death Review Team

In addition to having responsibility for reviewable deaths, the Ombudsman is the Convenor of the NSW Child Death Review Team (CDRT), and Ombudsman staff provide support and assistance to the Team in its work. The Ombudsman has had this responsibility since 2011.

1 In 2009, the scope of the Ombudsman's responsibilities changed in relation to children. Prior to 2009, the Ombudsman was required to review the death of any child, or sibling of a child, who had been the subject of a report of risk of harm to Community Services. This requirement was repealed in 2009.

2 'In care' in this context refers to a child under the age of 18 years who is in care as defined in section 4(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This definition includes children in voluntary out-of-home care and disability accommodation services. The full definition is provided in Appendix 1.

The CDRT reviews the deaths of all children in NSW, for the purpose of preventing and reducing child deaths. The Team comprises representatives from key government agencies; two Aboriginal representatives; and independent members who are experts in health care, research, child development and child protection.

Department of Family and Community Services

The Child Deaths and Critical Reports Unit in the Department of Family and Community Services (FACS) reviews the deaths of children 'known to' the agency; children where a risk of significant harm report was received about the child who died, and/or their siblings, in the three years prior to the child's death.³

A substantial number of cases that are reviewed by FACS are also reviewable deaths. We provide advice to FACS about child deaths that meet its review criteria. FACS also provide us with a copy of its completed child death reviews.

The State Coroner

Reviewable deaths are also Coronial deaths under the *Coroners Act 2009*. The role of the Coroner is to determine the cause and manner of death. The Coroner may hold an inquest and can recommend measures to prevent deaths.

NSW Domestic Violence Death Review Team

The Coroner convenes the NSW Domestic Violence Death Review Team, which is constituted by representatives of relevant government and non-government agencies. The Team reviews closed cases of deaths that occurred in the context of domestic violence.

NSW Health

Under certain circumstances, Local Health Districts are required to conduct a root cause analysis in relation to a critical incident. This includes where a death is unrelated to the natural course of illness. Where they have been completed, we include information from root cause analyses in our reviews.

1.4. Developments since our last report

As in previous years, the majority of children whose deaths were reviewable in 2012 and 2013 had a child protection history (34 of 41 children) and/or were in out of home care. In this context, developments and issues relating to the child protection system since our last report are particularly relevant.

Our recent work reviewing the NSW child protection system

The Ombudsman has statutory responsibility for independent monitoring of community services and programs, both generally and in particular cases, and for encouraging compliance with and awareness of the objects, principles and provisions of relevant community welfare legislation.⁴ The outcomes of this work are relevant to reviewable child deaths.

³ NSW Department of Family and Community Services 2013, *Child Deaths 2012 Annual Report*, NSWDFCS, p. 6.

⁴ Section 3(f) and (g) *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

Review of the NSW Child Protection System

In April 2014, we tabled a special report to Parliament, *Review of the NSW Child Protection System: Are things improving?* The report examined a number of the significant issues arising from our earlier review of child protection reforms under *Keep Them Safe*⁵. Among other things, we identified that since 2011, FACS had:

- improved the rate of face-to-face assessments of risk of significant harm (ROSH) reports (from 21% to 28%)⁶
- improved its capacity to measure, monitor and report on issues that impact on FACS' ability to respond appropriately to ROSH reports, and
- changed its internal governance and accountability arrangements through the implementation of a new Performance Reporting Framework and enhanced Quarterly Business Review process.

However, we also noted significant unresolved practice issues, including failure to refer allegations of serious criminal child abuse to police, and failure to determine current potential risk to children when assessing reports about historical allegations. We highlighted the need for a framework to drive collaborative interagency child protection work, including the need to enhance the role of other agencies (including the NGO sector, NSWPF, Education and Health) in responding to high risk matters.

The recommendations in our 2014 report are relevant to many of the issues in our reviews of child deaths in 2012 and 2013.

Audit of the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities

In 2013, we tabled in Parliament our fourth and final report on our three-year audit of the implementation of the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*.

Critically, we found that the capacity and effectiveness of frontline services to respond to child sexual abuse, and child abuse generally, remained limited. This was particularly the case for rural and remote locations with significant Aboriginal populations. Compared to the rest of the state, at that time, these locations had high vacancy rates for child protection positions and much lower response rates to reported child sexual and other abuse. While there have since been improvements in vacancy rates across FACS' districts, Western NSW continues to face challenges in this area.

Our inquiry identified that the JIRT – the multi-agency unit for responding to child sexual abuse – was also facing serious statewide resourcing challenges.

The recommendations of the inquiry focused on what is needed to improve systems and services to respond to Aboriginal child sexual abuse specifically and child abuse and neglect generally, as well as to address the broad disadvantage that characterises many Aboriginal communities. Addressing this disadvantage in an effective and sustainable way is critical to achieving progress in addressing child abuse.

Progress has also been made in a number of critical areas relevant to our reviews of child deaths, including action taken by JIRT partners – FACS, NSWPF and NSW Health – that has led to:

- significantly increased arrest rates in relation to child sexual assault offences as a result of an additional 30 police officers being appointed to the Child Abuse Squad
- enhanced accountability across individual Squads
- a review being undertaken of the adequacy of FACS' JIRT staffing and supervisory structures
- the implementation of a cross-agency database to improve data collection and performance monitoring across the JIRT partnership.
- In March 2015, the NSW government announced an additional 50 investigators and four specialist intelligence and support staff to be allocated to the NSWPF Child Abuse Squad.

5 NSW Ombudsman August 2011, *Keep Them Safe? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* August 2011.

6 The face-to-face response rate to ROSH reports increased from 21% in 2010-2011 to 28% in 2012-2013.

Responding to challenges in the child protection system

‘Safe Home for Life’

In March 2014, the *Child Protection Legislation Amendment Act 2014* was passed by Parliament, enabling changes to the *Children and Young Persons (Care and Protection) Act 1998*. Subsequent changes to policy and practice commenced through *Safe Home for Life* in late October 2014.

FACS has indicated that *Safe Home for Life* builds on the achievements of *Keep Them Safe* ‘to do more of what works, develop solutions to solve problems at a local level and use the right data and measures to better assess the impact of our work’.⁷ *Safe Home for Life* is intended to be outcome focused and built on collaboration and shared accountability, resulting in:

- contemporary IT systems that enable data driven decision making and improve productivity allowing caseworkers to spend more time with families
- more children and young people at risk receiving a face-to-face response
- a lower proportion of children and young people re-reported following a face-to-face response, and
- children and young people in out-of-home care being provided with a stable secure home for life and outcomes for these children more closely matching their peers.⁸

Safe Home for Life initiatives include:

- The establishment of permanent placement principles placing the open adoption of non-Aboriginal children as a preferred option over parental responsibility to the Minister.
- The introduction of timeframes within which the Children’s Court must make decisions about the realistic possibility of a child being restored to their parents.
- Changing existing orders of the Children’s Court that grant parental responsibility to relatives and kin to guardianship orders. This means that relative and kinship carers who have responsibility for a child in their care will become guardians.
- The introduction of parent capacity orders that require a parent to participate in a parent capacity program, service, course, therapy or treatment aimed at enhancing their parenting skills to reduce the risk of harm to their child.

Responding to child abuse

A major area of our focus over the past year has been the development of an integrated, reliable and sustainable death register that provides for efficient extraction of meaningful data for prevention purposes. The new data system, built by Resolve on a SQL Server platform, brings together the data and other information from reviews of the deaths of children in NSW by the CDRT, and the deaths of certain children and people with disability in care that are reviewable by our office. The integrated death register commenced operation in August 2014.

7 Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

8 Correspondence from the FACS Secretary to the NSW Ombudsman, 28 July 2014.

1.5. This report

Percentages in the report have been rounded, so may not add up to 100.

Information sources

Under section 38 of CS CRAMA, it is the duty of a range of agencies to provide the Ombudsman with 'full and unrestricted access' to records that the Ombudsman reasonably requires to complete this work. These agencies include the State Coroner and any NSW government department or statutory authority. The Ombudsman can also require certain information from agencies and private practitioners under the Ombudsman Act.

Our reviews and this report have been informed by a range of sources, including:

- records from agencies – including government, private and non-government agencies – relating to children who died and associated persons
- agency reports or reviews relating to the death of a child, including internal reviews conducted by FACS and root cause analyses undertaken by Local Health Districts
- coronial and police information relating to the death of a child
- judgement and sentencing information from NSW Courts, and
- for cases that have been subject to inquiry or investigation by this office, statements of information from both government and non-government agencies.

This report includes some trend data from 2004, drawn from the NSW Child Death Register, which holds demographic, cause of death, and other relevant information about the children who have died in NSW.

The report includes a ten-year review (2004 – 2013) of familial abuse-related deaths⁹ of children. We note that changes to the *Children and Young Persons (Care and Protection) Act 1998* and major changes to relevant policy and programs since 2010 have significantly altered the child protection landscape in NSW. In this context, and in referring to earlier cases, we have sought to limit description and observations to issues that remain current in our work.

The status of cases identified as being reviewable and/or reviewable in a particular category may change as further information becomes available; particularly Coronial determinations and outcomes of police investigations.

⁹ The children died as a result of abuse or in circumstances suspicious of abuse. The deaths occurred as a result of a violent act perpetrated or allegedly perpetrated by a family member. The death of one child in circumstances of chronic neglect has been included due to the circumstances of the case and subsequent murder conviction.

Key definitions

Reviewable death

We use the following definitions to determine whether a child's death is reviewable:

Abuse

Any act of violence by any person directly against a child or young person that causes injury or harm leading to death.

Neglect

Conduct by a parent or carer that results in the death of a child or young person, and that involves:

- failure to provide for basic needs such as food, liquid, clothing or shelter
- refusal or delay in providing medical care.
- intentional or significantly careless failure to adequately supervise, or
- a significantly careless act.

Suspicious circumstances

Deaths are considered suspicious if:

- there is some evidence or information that indicates the death may have been the result of abuse or neglect
- police identify the death as suspicious at the time of the death or any time later and there is some evidence that indicates the death may have occurred in circumstances of abuse or neglect as defined above¹⁰
- the autopsy cause of death is undetermined and there is an indication of abuse or neglect, or
- the autopsy cause of death is a treatable illness and there is an indication that unjustified delay in seeking treatment may have contributed to the death.

Child in care

A child under the age of 18 years who is in care as defined in section 4(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.¹¹

Child protection history

A child is considered to have had a child protection history if:

- the child and/or their sibling were the subject of a risk of harm or risk of significant harm report to FACS within the three years before their death, and/or
- the child and/or their sibling was reported to a Child Wellbeing Unit within the three years before their death.

Where relevant, this report may also refer to reports that were made outside of the three-year timeframe.

Person of interest

For the purposes of this report, 'person of interest' is used to refer to a person who has been convicted or charged in relation to the death of a child (except in relation to a transport fatality), or is suspected of involvement in the death of a child. This includes cases of murder-suicide.

¹⁰ If subsequent police investigations result in the death no longer being treated as suspicious, we also reassess inclusion of these deaths as reviewable.

¹¹ This definition includes: children under the parental responsibility of the Minister for Family and Community Services; children who are the subject of an out-of-home care arrangement; and children otherwise in the care of a service provider. The full definition is provided in Appendix 1.

Identifying and reporting Aboriginal and Torres Strait Islander status

To improve the accuracy of data and the capacity to report on trends, the CDRT commissioned the Australian Institute of Health and Welfare (AIHW) to provide expert advice on how to best collect and report on the Aboriginal and Torres Strait Islander status of children who die in NSW.

The AIHW's advice included that the CDRT should:

- continue to use its current 'ever-Aboriginal and Torres Strait Islander' method to derive Aboriginal and Torres Strait Islander status, but undertake sensitivity analysis to determine whether the 'ever-Aboriginal and Torres Strait Islander' method or a frequency-based method will provide more meaningful results
- periodically review the quality of Aboriginal and Torres Strait Islander identification in the data sets it uses, and monitor the proportion of children who are identified in more than one data set, in order to decide whether switching to a frequency-based method would be more appropriate¹²
- report the numbers of children identified using at least two data sets and those using only one data set
- ensure that a data quality statement accompanies any data on Aboriginal and Torres Strait Islander child deaths, indicating the quality of Aboriginal and Torres Strait Islander identification from the source data set, and
- report trends from 2005 onwards on children identified in NSW Registry of Births, Deaths and Marriages (BDM) data.¹³

In light of the recommendations of the AIHW, we have modified our processes to, among other things, capture information about the child's Aboriginal and Torres Strait Islander status from all of the available sources; and apply business rules to assign Aboriginal and Torres Strait Islander status. We will also conduct sensitivity analyses to, over time, ascertain the most appropriate identification method.

Appendix 1 includes a data quality statement, indicating the quality of Aboriginal and Torres Strait Islander identification from the source data set; and a report on the numbers of children identified using different data sets.

Unless otherwise indicated, in this report the term 'Aboriginal' refers to people of Aboriginal and/or Torres Strait Islander background.

Report chapters

- **Chapter 2** of this report provides demographic and other information about the children who died in 2012 and 2013, as well as data for the decade 2004-2013
- **Chapter 3** examines the deaths of 18 children that occurred in circumstances of neglect
- **Chapter 4** examines the deaths of 14 children who died while in care
- **Chapter 5** details a review of familial abuse-related deaths of 83 children that occurred in the 10-year period 2004-2013. This chapter incorporates abuse-related deaths of children in 2012 and 2013.
- **Chapter 6** provides a discussion of themes and issues that have arisen from our reviews
- **Chapter 7** details the recommendations we made to agencies in our previous report, and outlines their response.

12 The AIHW has indicated that this should occur when analysis concludes that the current identification process is approaching completeness or overestimating identification.

13 The AIHW advised that it considers the reporting of trends from 2005 onwards using BDM data is appropriate as at this time birth registration data was used to supplement death registration data by the Team, and the quality of these two data sets is sufficient to allow for trend analysis.

Chapter 2. Children who died in 2012 and 2013

This report covers the two-year period from 1 January 2012 to 31 December 2013, and relates to children who died as a result of abuse or neglect, or in circumstances suspicious of abuse or neglect; and children who died while in care.

In the two-year period, 1,067 children died in NSW.¹⁴ We identified 41 (3.8%) of these deaths as reviewable. As shown in the table below, in 2012 and 2013, the number of child deaths that were reviewable was the lowest over the past decade.

In the main, the reduction in the number of reviewable deaths in 2012 and 2013 was due to a decrease in the number of children who died in abuse-related circumstances.¹⁵ The proportion of child deaths due to abuse-related circumstances in 2012 (1.0%) and 2013 (0.7%) was lower than the 10-year average (1.8%), and much lower than the previous two-year period.

Over the past 10 years, deaths in neglect-related circumstances¹⁶ have comprised the largest proportion of reviewable child deaths, representing 43% of all reviewable child deaths in that period. The number of neglect-related deaths in 2012 and 2013 was lower than the 10-year average of 14 deaths each year. Over this period, neglect-related deaths of children occurred in circumstances of:

- a significantly careless act on the part of a carer (12)
- an intentional or reckless failure by a carer to adequately supervise a child (6)

There were no deaths related to failure to provide for basic needs such as food, liquid, clothing or shelter; or due to a failure or delay in providing medical care.

Table 1: Children whose deaths were reviewable in NSW, 2004-2013*, number and (percent of all child deaths)

| | All child deaths in NSW | | Reviewable child deaths | | Abuse-related** circumstances | | Neglect-related** circumstances | | In care | |
|--------------|-------------------------|--|-------------------------|------------|-------------------------------|------------|---------------------------------|------------|-----------|------------|
| | No. | | No. | % | No. | % | No. | % | No. | % |
| 2004 | 632 | | 27 | 4.3 | 9 | 1.4 | 11 | 1.7 | 8 | 1.3 |
| 2005 | 681 | | 36 | 5.3 | 15 | 2.2 | 18 | 2.6 | 4 | 0.6 |
| 2006 | 642 | | 35 | 5.5 | 13 | 2.0 | 18 | 2.8 | 4 | 0.6 |
| 2007 | 631 | | 38 | 6.0 | 9 | 1.4 | 23 | 3.6 | 6 | 1.0 |
| 2008 | 635 | | 31 | 4.9 | 14 | 2.2 | 13 | 2.0 | 4 | 0.6 |
| 2009 | 595 | | 46 | 7.7 | 11 | 1.8 | 19 | 3.2 | 16 | 2.7 |
| 2010 | 620 | | 45 | 7.3 | 14 | 2.3 | 12 | 1.9 | 19 | 3.1 |
| 2011 | 589 | | 33 | 5.6 | 13 | 2.2 | 10 | 1.7 | 10 | 1.7 |
| 2012 | 511 | | 19 | 3.7 | 5 | 1.0 | 6 | 1.2 | 8 | 1.6 |
| 2013 | 556 | | 22 | 4.0 | 4 | 0.7 | 12 | 2.2 | 6 | 1.1 |
| Total | 6,092 | | 332 | 5.4 | 107 | 1.8 | 142 | 2.3 | 85 | 1.4 |

* The deaths of two children were reviewable under more than one criterion

** This includes deaths suspicious of abuse (13) and suspicious of neglect (45).

14 Data from the NSW Child Death Review Team register.

15 In this report 'abuse-related circumstances' includes abuse and suspicious of abuse.

16 In this report 'neglect related circumstances' includes neglect and suspicious of neglect.

2.1. Age and gender of the children

Overall in NSW in the two-year review period, infants under one year of age comprised the majority of all child deaths, followed by young people aged 15-17 years.

In 2012 and 2013, and largely consistent with reviewable deaths over the decade, most (18) of the 27 children who died in abuse or neglect-related circumstances were under five years of age.

Almost three-quarters (10) of the young people aged 15-17 years whose deaths were reviewable were in care. This is a higher proportion than over the 10-year period (52%).

Table 2: Children whose deaths were reviewable, by age and reviewable status, 2012 and 2013

| | Under 1 year | 1-4 years | 5-9 years | 10-14 years | 15-17 years | Total |
|-----------------------|--------------|-----------|-----------|-------------|-------------|-----------|
| Abuse | 1 | 1 | 1 | 1 | 1 | 5 |
| Suspicious of abuse | 1 | 3 | 0 | 0 | 0 | 4 |
| Neglect | 4 | 5 | 4 | 1 | 1 | 15 |
| Suspicious of neglect | 2 | 1 | 0 | 0 | 0 | 3 |
| In care | 2 | 4 | 2 | 1 | 5 | 14 |
| Total | 10 | 14 | 7 | 3 | 7 | 41 |

2.2. Aboriginal and Torres Strait Islander status

Aboriginal and Torres Strait Islander children represent 5.5% of the NSW population under the age of 18 years.¹⁷ However, Aboriginal and Torres Strait Islander children are consistently overrepresented in reviewable child deaths, representing 21% of reviewable child deaths over the past decade.

In 2012 and 2013, almost half (19) of the 41 children whose deaths were reviewable were identified as being Aboriginal and Torres Strait Islander. Twelve of the children died in neglect related circumstances, two in abuse related circumstances and five died while in care.

The majority of Aboriginal children who died (15) had a child protection history, including three children who were in care. FACS has reported an increase in the over-representation of Aboriginal children in child protection, and in the deaths of children 'known' to that agency. Aboriginal children represented 30% of children who died and were known to FACS in 2011, 32% in 2012, and 47% in 2013.¹⁸

While the Productivity Commission recently reported that national mortality rates for Aboriginal children improved significantly between 1998 and 2012, particularly for infants, it also reported poorer outcomes in key indicators that are relevant to reviewable child deaths. In particular, the Commission noted that the rate of Aboriginal children aged 0-17 years on care and protection orders increased from 11.3 to 49.3 per 1,000 children from 2003-04 to 2012-13; and the substantiation rate for Aboriginal children aged 0-17 years in relation to child abuse or neglect increased from 29.5 to 37.9 per 1,000 children from 2009-10 to 2012-13. Nationally in 2012-13, the most common reason for substantiation for Aboriginal children aged 0-17 years was neglect (40.1%).¹⁹

Two-thirds (12) of the Aboriginal and Torres Strait Islander children who died in 2012 and 2013 were under five years of age.

17 Australian Bureau of Statistics, 2014, *3101.0 Australian Demographic Statistics (TABLE 51. New South Wales), Sept 2013 release*, Canberra: ABS; and Australian Bureau of Statistics, 2014, *3238.0 Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Canberra: ABS.

18 Department of Family and Community Services 2014, *Child Deaths 2013 Annual Report*, p. 6.

19 Productivity Commission 2014, *Overcoming Indigenous Disadvantage*.

Table 3: Children whose deaths were reviewable, by Aboriginal and Torres Strait Islander status and age, 2012 and 2013

| | | under 1 year | 1-4 years | 5-9 years | 10-14 years | 15-17 years | Total |
|---|-----------------|--------------|-----------|-----------|-------------|-------------|-----------|
| Aboriginal or Torres Strait Islander | | | | | | | |
| | Abuse-related | 0 | 1 | 0 | 0 | 1 | 2 |
| | Neglect-related | 5 | 4 | 1 | 1 | 1 | 12 |
| | In care | 1 | 1 | 0 | 0 | 3 | 5 |
| Non Aboriginal or Torres Strait Islander | | | | | | | |
| | Abuse-related | 2 | 3 | 1 | 1 | 0 | 7 |
| | Neglect-related | 1 | 2 | 3 | 0 | 0 | 6 |
| | In care | 1 | 3 | 2 | 1 | 2 | 9 |
| Total | | 10 | 14 | 7 | 3 | 7 | 41 |

2.3. Child protection history

A child has a 'child protection history' if their family (the child and/or a sibling) was the subject of a risk of harm or risk of significant harm report to FACS or a Child Wellbeing Unit in the three years before their death.²⁰

As shown in the table below, and consistent with previous years, the families of two-thirds of the children who died in 2012 and 2013 had a child protection history, including:

- five children who died in circumstances of abuse (3) or suspicious of abuse (2)
- thirteen children who died in circumstances of neglect (11) or suspicious of neglect (2)
- ten children who were in care, four of whom were the subject of a child protection report prior to their entry into care.

Table 4: Children whose deaths were reviewable, by child protection history, year and reviewable type, 2004-2013*

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | Total | |
|-------------------------------------|------|------|------|------|------|------|------|------|------|------|-------|----|
| | | | | | | | | | | | No. | % |
| Reviewable child deaths | 27 | 36 | 35 | 38 | 31 | 46 | 45 | 33 | 19 | 22 | 332 | |
| No child protection history | 10 | 12 | 16 | 10 | 12 | 15 | 16 | 12 | 8 | 5 | 116 | 35 |
| Child protection history | | | | | | | | | | | | |
| <i>Abuse, neglect or suspicious</i> | 11 | 21 | 15 | 22 | 15 | 18 | 14 | 13 | 5 | 13 | 147 | 44 |
| <i>In care</i> | 6 | 3 | 4 | 6 | 4 | 13 | 15 | 8 | 6 | 4 | 69 | 21 |

* The deaths of two children were reviewable under more than one criterion

²⁰ Until 2009, the Ombudsman's jurisdiction for reviewable deaths included where a child and/or a sibling had been the subject of a risk of harm report to Community Services in the three years before their death. Reviewable deaths data reflects this jurisdiction.

2.4. Deaths resulting from, or suspicious of, abuse

Between 1 January 2012 and 31 December 2013, nine children died in abuse-related²¹ circumstances, representing 0.8% of all child deaths in the two-year period. The proportion of children who died in abuse-related circumstances in 2012 and 2013 was lower than the 10-year average (1.8% of all child deaths).²²

Eight of the nine children died in abuse-related incidents where the person or persons of interest in the death was a family member.²³ One child died in an incident involving a peer. As shown in the table below, over the past decade, the majority of abuse-related deaths of very young children occurred in a familial context, while the majority of young people died in incidents involving peers.

Most of the children who died in abuse-related circumstances in the period were very young. Over three-quarters (7) were aged seven years and under; most (5) of the children were under three years of age. Two were teenagers. They died in separate incidents, involving blunt force or sharp force injury. In one case, the person of interest died by suicide after killing the child.

The very young ages of victims over the past decade was reflected in 2012 and 2013; of the nine abuse-related deaths, six of the children who died in a familial context were under five years of age, and the death of one young person in the older age group occurred in an incident involving a peer.

Table 5: Abuse-related deaths of children, by age and relationship with person of interest, 2004-2013

| | Under 1 year | 1-4 years | 5-9 years | 10-14 years | 15-17 years | Total |
|-------------------------------|--------------|-----------|-----------|-------------|-------------|------------|
| Familial abuse-related deaths | 22 | 37 | 15 | 8 | 1 | 83 |
| Peer abuse-related deaths | 0 | 0 | 0 | 1 | 15 | 16 |
| Unrelated/unknown | 2 | 1 | 0 | 2 | 3 | 8 |
| Total | 24 | 38 | 15 | 11 | 19 | 107 |

2.5. Deaths due to, or suspicious of, neglect

Consistent with previous years, most of the children who died in circumstances of neglect in 2012 and 2013 were very young; two-thirds (12) of the children were younger than five years of age. As shown in the table below, over the past decade, more than three quarters of the children who died in circumstances of neglect were under five years of age.

Table 6: Neglect-related deaths of children, by age and gender, 2004-2013

| | Under 1 year | 1-4 years | 5-9 years | 10-14 years | 15-17 years | Total |
|--------------|--------------|-----------|-----------|-------------|-------------|------------|
| Female | 26 | 24 | 10 | 3 | 2 | 65 |
| Male | 20 | 44 | 8 | 3 | 3 | 78 |
| Total | 46 | 68 | 18 | 6 | 5 | 143 |

21 'Abuse-related' deaths include deaths due to abuse or suspicious of abuse.

22 Because many of the deaths we have reviewed are open investigations or subject to current criminal proceedings, we have exercised caution in providing information about these matters, and have separated discussion of person of interest characteristics from discussion of cases.

23 Australian Institute of Criminology 2015, *Homicide in Australia: 2010 – 11 to 2011 – 12 National Homicide Monitoring Program annual report*, cat. No. Monitoring Report 23, AIC, Canberra.

Two-thirds (12) of the children who died in neglect-related circumstances in 2012 and 2013, including five children aged less than 12 months, were identified as Aboriginal or Torres Strait Islander. This is higher than previous years. Between 2004 and 2013, Indigenous children accounted for just under one-quarter (33) of all deaths of children related to neglect.

In line with our definitions (see above) neglect-related deaths are classified according to the context in which the deaths occurred.

In 2012 and 2013, 18 children died in neglect-related circumstances:

- Twelve children died in the context of a significantly careless act on the part of a carer. This included six transport fatalities, and six deaths in sleep-related incidents.
- The deaths of six children occurred in the context of an intentional or reckless failure to adequately supervise. This included three drowning deaths, two deaths in house fires and one transport fatality.

There were no neglect-related deaths due to failure to provide for basic needs, or due to failure to provide medical care.

2.6. Children who died while in care

In NSW between January 2012 and December 2013, 14 children in care died. This is less than half the number of children in care who died in the previous two-year period (29 children), but is consistent with the average over the decade. In the decade to 2013, 85 children died while in care – representing 1.4% of all children in NSW who died over the same period, and 26% of all reviewable child deaths.

All of the 14 children were in statutory out-of-home care. There were no deaths of children in disability residential care in this period.

Most (12) of the children died in NSW, and two children died in other states.

Consistent with previous years, most of the 14 children were either very young or were adolescents. Almost half (6) of the children were younger than three years of age, and five children were aged 15-17 years.

Ten of the 14 children who died were male. Over the last 10 years, males have accounted for more than two-thirds (60) of the deaths of children in care in NSW.

Five of the 14 children who died were Aboriginal,²⁴ and five children were of culturally and linguistically diverse backgrounds.

Half (7) of the children in care died as a result of external (unnatural) causes, including suicide, transport fatality and drowning. Five children in care died as a result of natural causes. Four of these children had complex health needs associated with disability or congenital/ degenerative conditions, and one infant had complications related to extreme prematurity. In a further two cases, the children died suddenly and unexpectedly after being placed for sleep.

24 This includes two children who were not identified as Aboriginal from birth/death registration records but where other agency records identify the child was Aboriginal.

2.7. Coronial status

At the time of writing, the State Coroner had held an inquest in relation to one child who died and had suspended the inquests of five other children.²⁵ In 28 cases, an inquest was dispensed with or the case was otherwise closed. The death of one child occurred outside of NSW, and therefore was not within the NSW Coroner's jurisdiction.

Table 7: Children whose deaths were reviewable, by coronial status, 2012 and 2013

| Coronial status | No. of deaths |
|----------------------------|---------------|
| Case closed | 28 |
| Case open (not finalised)* | 6 |
| Suspended | 5 |
| Inquest held | 1 |
| Not in NSW jurisdiction | 1 |
| Total | 41 |

* Including where a hearing has been held and findings are pending

25 Coronial inquest or inquiry will be suspended in the context of criminal charges – the Coroner cannot determine the matter to finality until such processes are completed.

Chapter 3. Neglect-related deaths of children

In 2012 and 2013, 18 children in NSW died as a result of neglect or in circumstances suspicious of neglect. In the past 10 years, the deaths of 142 children were neglect-related, representing 2.3% of all child deaths in that period. The number of child deaths due to neglect in 2012 (6) and 2013 (12) was lower than the 10-year average of 14 deaths per year.

While there is no universally accepted definition of neglect, it is generally understood to be a failure by parents or carers to provide for the physical, psychological, medical and developmental needs of a child.²⁶ However, determining what constitutes adequate care or supervision, or to what degree carers should anticipate harm, is highly contested. The age and developmental level of the child, and a range of socioeconomic, cultural, environmental and behavioural factors influence concepts of neglect.²⁷

Defining fatal child neglect is equally complex. The definition used in this report focuses on those cases where the actions or inactions of the child's carer indicated:

- a failure to provide for the child's basic needs
- refusal or delay in providing medical care
- a significantly careless act, or
- an intentional or reckless failure to adequately supervise the child.

In 2012 and 2013, neglect-related deaths occurred in the context of a significantly careless act (12) or an intentional or reckless failure to adequately supervise a child (6).

The purpose of identifying child deaths as a consequence of neglect is to understand the factors that contribute to avoidable deaths of children, and to identify strategies that may help to prevent them.

In determining whether a death has, or may have, been caused by carer neglect, we consider a range of information, including FACS' holdings, relevant information relating to the cause of death, and whether police consider the death to be suspicious.

Our reviews consider a range of factors, including evidence of the carer's own behaviour, and factors that may have reduced the carer's capacity to care for the child. The interaction between the carer's knowledge and motivation, and the child's developmental stage are also factors that we consider.²⁸ We consider the background of the family, and any involvement they may have had with agencies with responsibilities for child protection and provision of support and intervention to vulnerable families.

3.1. Cause and circumstances of neglect-related deaths in 2012 and 2013

The children died in motor vehicle crashes, drowning, house fires, Sudden Unexpected Death in Infancy (SUDI), or sudden unexpected death of a child.²⁹ All of the children were in the direct care of their parent(s), including two children who had been left at home unattended.

Significantly careless act

Most (12) of the children died in the context of a significantly careless act on the part of a carer. This includes five cases where the cause of the child's death was unable to be determined or has yet to be determined, but there is evidence that the actions of the carer were likely to have been contributory.

26 Scott, D., Higgins, D., & Franklin, R. 2012, 'The role of supervisory neglect in childhood injury', *CFCA Paper*, no. 8, Australian Institute of Family Studies, viewed 4 August 2014. <http://www.aifs.gov.au/cfca/pubs/papers/a142582/05.html>

27 Ibid.

28 Liller, K. 2001, 'The importance of integrating approaches in child abuse/neglect and unintentional injury prevention efforts: implications for health educators', *International Electronic Journal of Health Education*, vol. 4, pp. 283-289.

29 One child was just older than 12 months and was therefore not an infant. For the purposes of reporting, we have included this case in the discussion relating to SUDI.

The deaths of these children typically occurred in the context of the carer acting in a way that resulted in the exposure of the child to harm. The deaths of the children occurred in transport fatalities or after they had been placed for sleep.

Transport fatalities

In 2012 and 2013, the deaths of 69 children in transport fatalities were registered in NSW.³⁰ Six of these deaths occurred in the context of a significantly careless act by a carer which we have classified as neglect. The children were aged two to 15 years.

In each case, more than one significantly careless act on the part of a parent or carer posed a risk to the child, for example: excessive speed, defective tyres, and drug use; or inadequate restraint, unregistered vehicle, and mobile phone use while driving. In this context:

- Four children were being driven by a parent who tested positive for illicit drugs. In each case, a police expert determined that the parent's driving ability was significantly impaired by the illicit substance at the time of the fatality. In one case, the level of the drug was found to be in the toxic to lethal range.
- The seat belt had not been engaged for one child in a booster seat; and the restraints for another child and their sibling had not been anchored to the vehicle.
- In other cases, the driver drove at an excessive speed for the conditions, and the vehicle's tyres were defective; rode a quad bike carrying the child, who was not wearing a helmet; used a hand-held mobile phone to text message while driving.

The Child Death Review Team has reported on current initiatives that are aimed at reducing deaths and serious injury associated with driving under the influence of illicit substances; sub-optimal child car restraint use; and speeding.³¹

Quad bikes are considered to be inherently unstable on anything other than flat terrain, and are currently the leading cause of death and serious injury on Australian farms.³² Quad bike manufacturers provide labels on these vehicles warning of the dangers to child operators, and indicating that passengers should not be carried on quad bikes. The CDRT has highlighted the dangers associated with the use of quad bikes, and has current recommendations aimed at identifying measures to prevent the deaths of children associated with the use of off-road vehicles.³³

Sleep-related deaths

One-third of the 18 children died suddenly and unexpectedly in unsafe sleep environments. All but one of the children were aged less than 12 months, and their deaths were determined to be SUDI.

All of the children were placed for sleep in inappropriate bedding and other unsafe environments, and five died while co-sleeping with parents who were affected by alcohol (4) or cannabis (1).

The CDRT has consistently reported on the modifiable risk factors that are associated with SUDI, including infants sharing a sleep surface with another person (particularly when the person is affected by alcohol or other drugs); loose bedding or other items that can cover the infant's face or head; and sleeping infants in bedding that is not infant-specific.

The families of each of the six children had a child protection history. Research undertaken by the CDRT into the causes of death of children with a child protection history has identified that:

- the SUDI mortality rate of infants with a child protection history is almost 10 times the rate of children without that history, and

30 Data from the NSW Child Death Review Team child death register.

31 NSW Child Death Review Team, 2013, *Annual Report 2012*; and NSW Child Death Review Team, 2014, *Annual Report 2013*

32 Lower T, Pollock K & Herde E, 2013, Australian quad bike fatalities: what is the economic cost?, *Australian and New Zealand Journal of Public Health*, 37(2): 173-178.

33 NSW Child Death Review Team, op. cit.

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- sudden and unexpected deaths of infants with a child protection history are much more likely to be due to external (unnatural) causes, such as accidental suffocation or strangulation.³⁴

The CDRT has current recommendations to Health and NSW Kids and Families that are aimed at improving the response to SUDI and promoting safe sleeping messages.³⁵

Following a recommendation by the Team, FACS has completed a cohort review of SUDI where the infant's family had a child protection history. The agency's recommendations arising from the review are aimed at developing strategies and training resources to assist caseworkers to assess risk for infants and provide casework services to at-risk families.³⁶

Intentional or reckless failure to adequately supervise

The deaths of six children were associated with an intentional or reckless failure on the part of a carer to adequately supervise the child. Three children drowned; two children died in house fires; and one child was hit by a car. Most (5) of the children were aged less than five years. One was a teenager.

A consistent feature of these deaths is children being placed in high risk situations and left without supervision that is adequate for their age and developmental level. Relevant factors include:

- very young children placed in baths and left without supervision while carers undertake other tasks (including fetching other children or preparing food/drink)
- adults leaving children alone in the house for an extended period of time with evident fire hazards
- swimming pool drowning deaths of young children without supervision for a relatively long period of time and where carers were aware of defects in barrier fencing and of the capacity of the child to access water, and
- carer perception of risk in relation to young children around traffic.

The CDRT has emphasised the need for active and arms-length adult supervision of young children around water and fire hazards, and has made recommendations aimed at facilitating the prioritisation of swimming pool inspection programs to premises where young children under five years of age reside or regularly visit.³⁷

3.2. Family and carer characteristics and involvement with agencies

Family and carer characteristics

Risk factors associated with neglect include socioeconomic factors, such as poverty, larger families and unemployment; and carer wellbeing and other factors, such as substance abuse, mental health concerns, child protection history, and domestic violence.³⁸ In relation to the 18 families in which a child died in neglect-related circumstances in 2012 and 2013:

- the majority (15) resided in areas of greatest social disadvantage (SEIFA quintiles 1 and 2)

34 NSW Child Death Review Team. 2014, *Causes of death of children with a child protection history 2002-2011*.

35 NSW Child Death Review Team. 2013, op. cit; and NSW Child Death Review Team. 2014, *Annual Report 2013*.

36 NSW Child Death Review Team. 2014, *Annual Report 2013*.

37 NSW Child Death Review Team. 2013, op. cit; and NSW Child Death Review Team. 2014, *Annual Report 2013*.

38 Scott D. 'Understanding child neglect' *Child Family Community Australia* Paper no. 20 2014; Brandon, M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, Black J, 'Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005' Department for Children, Schools and Families, *Research Report DCSF – RR023*, 2008; Bromfield L, Lamont A, Parker R, Horsfall B, 'Issues for the safety and wellbeing of children in families with multiple and complex problems, the co-occurrence of domestic violence, parental substance misuse, and mental health problems' *Australian Institute of Family Studies*, December 2010.

- the majority (15) featured carer substance abuse – mainly alcohol and cannabis
- most (13) had a child protection history
- domestic violence was present in 13 families – perpetrated by either or both carers
- either or both carers in 13 families had a criminal history, typically involving both violent and non-violent offences, and
- eight families comprised young parents and/or parents who had been the subject of child protection concerns themselves.

For a small number of families, other factors were present, including the prior removal of children from their care (3), overcrowding (2), and itinerancy (2).

For three of the 18 families, records did not indicate concerns about the family, and there did not appear to have been relevant agency contact. For the other 15 families, there was some level of contact with key agencies in the three years before the child's death.

Involvement with FACS

In 2012 and 2013, the families of 13 of the 18 children who died in neglect-related circumstances had a child protection history.

Common issues reported for the 13 families included exposure to domestic violence, and risks related to carer alcohol and other drug use, inadequate supervision, neglect, and carer mental health concerns.

In relation to eight families, FACS had undertaken casework in the year before the child's death, or had an open plan at the time of death. Two families were involved with the Strengthening Families program,³⁹ and three other families had been linked in with non-government family support or after care services.

Three families had been the subject of one or two reports to FACS. The main reported issues involved exposure to violence/ domestic violence and concerns about a carer's mental health. All of the reports were assessed as not meeting the threshold for risk of significant harm. One of the reports was referred to Brighter Futures,⁴⁰ but was closed after the family declined to participate.

Families with a more significant child protection history

Ten of the 13 families had a more significant child protection history, including five families with an extensive history, being more than 10 reports of risk of significant harm. One family was the subject of over 40 reports. The most common reported issues concerned carer substance use and exposure to domestic violence.

In relation to families with a more significant history:

- For two families, reports concerned children who were siblings of the child who died, but who resided in separate premises. In one case, the family was referred to, and received support from, Brighter Futures. In the other case, allegations of sexual harm were investigated by a JIRT and not substantiated.
- One family was the subject of seven reports to FACS. The reports were centred on parental alcohol and substance use, domestic violence, and lack of antenatal care. Three of the reports were received in the year before the child died, in addition to three requests to FACS by the family for financial assistance. The last report was received two months before the child's death; it was merged with existing information, with no action taken.

39 Strengthening Families is a placement prevention program delivered by 240 FACS caseworkers across NSW, targeted at families with children under nine years of age (or unborn) where there is a risk of significant harm involving specific issues relating to parenting capacity. Part of the aim of the program is to reduce risk of significant harm associated with parental issues such as drug or alcohol misuse, domestic violence or lack of parenting skills. (Department of Family and Community Services. 2013, *Child Deaths 2012 Annual Report*, p. 57).

40 The Brighter Futures program delivers targeted early intervention services to families with children aged under 9 years, or who are expecting a child, where the children are at high risk of entering or escalating within the statutory child protection system.

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- FACS received nine reports in relation to one family; five of which were assessed as meeting the threshold for significant harm. The main reported issues concerned domestic violence, neglect, and physical harm. The allocated caseworker conducted face-to-face assessments and connected the family to an intensive family support service. The last report was received four days before the child's death. The caseworker was scheduled to interview the children and parents on the day that the child died.

All five families with extensive child protection histories had been identified as having chronic problems with alcohol and/or substance use, frequent domestic violence, and criminal histories. Three of the families had previously had children removed from their care or placed with extended family.

- One family had been the subject of 18 reports in the three years before the child's death, three of which had been assessed as meeting the threshold of significant harm. The last report was received over 12 months before the death of the child. The matter was allocated, and closed after home visits and receipt of information from non-government services that had been involved with the family.
- One family had been the subject of 18 reports to FACS and one report to a Child Wellbeing Unit. Ten of the reports were assessed as risk of significant harm, involving sexual harm, physical harm, and exposure to domestic violence. Two of the reports were received in the year before the child's death, both of which concerned risks to the child's siblings. At the time the child died, there was an open plan for the family.
- The primary issues reported in relation to one family concerned parental alcohol and illicit drug use, medical neglect and inadequate supervision. The family was the subject of 12 reports to FACS, including eight reports of risk of significant harm; and a report to a Child Wellbeing Unit. FACS closed the case plan for the family two weeks before the child died, noting that the plan had 'partially' addressed the needs of the children and that the family was 'somewhat engaged' with services.
- Chronic parental alcohol abuse was the main issue reported in relation to one family, and was the main reason for the prior removal of another child from their care. The last of the 18 reports to FACS occurred four months before the child's death, and involved a prenatal report about risks to the child from parental alcohol abuse and domestic violence. The family was referred to the Strengthening Families program, and had an open and allocated plan at the time of the child's death.
- One family had an extensive history of chronic neglect, domestic violence, and parental alcohol and other drug use. In the three years before the child's death, the family was the subject of 42 reports to FACS, including 24 reports that were assessed as meeting the threshold of significant harm. Due to the family's itinerancy, casework with the family involved four Community Services Centres (CSCs) over the three-year period. The reports and casework in the year before the child died primarily concerned neglect issues in the home (including inadequate bedding for the children), inadequate supervision, physical harm, and concerns about failure to thrive. There was an open, allocated plan for the siblings at the time of the child's death.

Involvement with police

Almost three-quarters (13) of the 18 families had contact with police at some point in relation to offending behaviour. Five of the families had an extensive criminal history, primarily in relation to assault and domestic violence.

Police reported child protection concerns to FACS in relation to six families, primarily relating to risks associated with domestic violence, and carer substance abuse.

Involvement with health and other services

Many of the families had contact with health providers, including hospitals, community health services and general practitioners.

Overall, while many of the families had substantial issues relating to substance abuse that presented risks to the children in their care, records indicated that few families had been referred to, or were involved with, drug and alcohol treatment or counselling services.

Health reported child protection concerns to FACS in relation to seven families that indicated risks to children relating to carer substance abuse, physical harm, domestic violence, no/poor antenatal care, and medical neglect.

Some families had involvement with non-government services, including refuges, family support and intensive family support services. Services reported concerns to FACS about lack of engagement by families; ongoing risks associated with substance abuse; and neglect of children.

3.3. Themes and issues: neglect-related deaths of children

Chapter 6 details the themes and issues arising from our reviews of child deaths. In relation to the deaths of children in neglect-related circumstances in 2012 and 2013, our reviews identified:

- Issues relating to the adequacy of the work of agencies, separately and together, to address risks associated with carer alcohol and other drug use. This includes actions in response to carers' non-compliance with agreed conditions/ undertakings that were related to minimising risks to their children.
- Concerns about the adequacy of the steps taken by agencies to identify and respond to SUDI risks, including clearly discussing and reinforcing safe sleeping messages with families.
- The need to improve consistency among frontline staff in identifying and reporting risks to children. While agencies, including NSWPF, made reports to FACS relating to some significant child protection risks, there were serious matters that were not reported to external agencies or escalated internally, such as risks relating to chronic drug use in pregnancy.
- Abuse of a potentially criminal nature not being referred to police, including evident bruises and other injuries to children and/or carers caused by or suspicious of abuse. While in some cases services focused on building and maintaining a relationship with the carer, it appeared that services also did not appear to recognise these matters as offences that ought to be reported.
- Deficits in the interagency work undertaken in relation to some of the families, including action to address chronic neglect.

Chapter 4. Children who died while in care

Under the CS CRAMA, the definition of 'child in care' is broad and includes children placed voluntarily in out-of-home care or disability accommodation services; children in supported relative or kinship care placements; and children who are in statutory care.

In NSW between January 2012 and December 2013, 14 children in care died, all of whom were in statutory out-of-home care. Seven children died as a result of external causes, five children died from natural causes, and in two cases, the children died suddenly and unexpectedly after being placed for sleep.

Length of time in care and child protection history

The length of time that the children who died in 2012 and 2013 had been in care ranged from one month to more than 15 years. Half (7) of the children had been in care longer than five years, and five children had entered care less than 12 months before their death.

Most (10) of the children had a child protection history in the three years before their death. For four of the 10 children, their child protection history preceded their placement in care and was the reason for it. For the six children about whom child protection reports had been made while they were in care, all of them were placed with relatives, mainly grandparents (5). The reasons for the child protection report(s) included concerns about the child's behaviour or mental health problems (3), carer alcohol or drug abuse (2) or risk of harm from other family members (2). Two children with disability did not have a child protection history and were placed in long term out-of-home care with parental consent.

Parental responsibility and care status

In NSW, two-thirds of children in out-of-home care are subject to a Children's Court order allocating parental responsibility to the Minister, and 20 per cent are subject to an order allocating parental responsibility to a relative.⁴¹ A small percentage of children are under a supported care arrangement or a voluntary care arrangement, or other care arrangement.

In 2012 and 2013, all children in care who died were subject to a final (13) or interim (1) order of the Children's Court. For most children (10), a family member was allocated at least some aspect of parental responsibility until the age of 18 years: either all aspects (6) or some aspects (4). Parental responsibility for three children was allocated solely to the Minister for Family and Community Services until the age of 18 years.

Placement arrangements – where the children were living

More than half of all children in out-of-home care in NSW live in relative or kinship care, and just over one-third in foster care. A small percentage of children in out-of-home care live with parents (3.5%) or are in residential care (2.8%) or other care arrangements.⁴²

Consistent with the proportion of children in out-of-home care who live with family or kin, more than half (8) of the children in care who died in 2012 and 2013 were placed with a relative. Four children were residing in foster care. FACS had case management responsibility for the majority (10) of the 12 children living in relative and foster care placements.

One young person had left a placement with a relative more than a year before and was living with one of their parents.

One infant died in hospital without being discharged following birth.

41 NSW Department of Family and Community Services 2014, *Community Services Annual Statistical Report 2012/13*, NSWDFCS, Sydney, p. 93.

42 *Ibid.* p. 96.

4.1. Causes of death

In the decade to 2013, more than half (48) of all deaths of children in care in NSW were due to natural causes (diseases or morbid conditions). Just over one-third (18) of these children had significant disability and died while in a disability accommodation service.

The table below shows that external causes were the reason for over one-quarter of the deaths of children in care in the 10-year period. A smaller number of deaths were due to ill-defined causes (10); these deaths were predominantly SUDI (9).⁴³

In 2012 and 2013, more children in care died as a result of external causes (7) than from natural (5) or unknown causes (2).

Table 8: Broad causes of death of children in care, 2004-2013

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | Total | |
|------------------|----------|----------|----------|----------|----------|-----------|-----------|-----------|----------|----------|-----------|------------|
| | | | | | | | | | | | No. | % |
| Natural | 4 | 2 | 1 | 3 | 4 | 13 | 13 | 3 | 2 | 3 | 48 | 56 |
| External | 4 | 1 | 1 | 2 | 0 | 3 | 3 | 6 | 5 | 2 | 27 | 32 |
| SUDI/Unexplained | 0 | 1 | 2 | 1 | 0 | 0 | 3 | 1 | 1 | 1 | 10 | 12 |
| Total | 8 | 4 | 4 | 6 | 4 | 16 | 19 | 10 | 8 | 6 | 85 | 100 |

Natural cause deaths

Five children in care died as a result of natural causes. The majority (4) of the children had complex health needs associated with disability or congenital/ degenerative conditions, and one infant had complications related to extreme prematurity. Four of the children died in hospital and one child died suddenly and unexpectedly while in foster care.

Meeting the health and developmental needs of children in care

The vulnerability of children in care in regard to their physical, developmental, emotional and mental health is widely recognised in literature and in practice. Children who enter care may have chronic, complex, unidentified or unmet health problems related to their history of abuse, neglect and/or trauma. They may also be at increased risk of continuing poor health, social and educational outcomes.^{44, 45}

As part of acknowledging the high needs of this vulnerable group of children, a coordinated 'health pathway' for children entering out-of-home care was introduced in 2011. The model provides a framework for NSW Health, FACS and out-of-home care agencies to provide timely health screening, assessment, intervention, monitoring and review of children both when they enter out-of-home care and when their health management plans are reviewed.

43 Ill-defined and undetermined causes include Sudden Infant Death Syndrome (SIDS) and other sudden and unexpected deaths where the cause is unknown.

44 NSW Health, 2013, *Health Assessment of Children and Young People in Out-of-Home-Care (Clinical Practice Guidelines)*, NSW Ministry of Health, p. 1. http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_010.pdf accessed 8 August 2014.

45 Nathanson, D., & Tzioumi, D. 2007, *Health Needs of Australian children living in out-of-home care*, *Journal of Paediatrics and Child Health* 43, pp. 695-699.

To support health professionals to provide best practice assessment and intervention to children in out-of-home care, NSW Health has published clinical practice guidelines and a detailed literature review on health assessment for children and young people in out-of-home care.⁴⁶ In August 2014, FACS released updated casework practice procedures and information sheets for caseworkers and carers on the health screening and assessment pathway.

Our reviews of children in care who died in 2012 and 2013 identified that for some children, there were problems with FACS' implementation of the health pathway. These problems included poor or incomplete gathering of information about the child's medical history; the child's health background not being provided to carers; and delays in referring children for a comprehensive out-of-home care health assessment.

The model pathway requires a primary health assessment to be commenced within 30 days of a child's entry into statutory care on interim orders, and a comprehensive health assessment completed within 90 days of entering statutory care, if indicated following the primary assessment. In this context:

- One young child who had identified health concerns had been in out-of-home care for seven months before an initial out-of-home care health assessment was conducted. The child did not receive a full paediatric assessment until three months later. A delay in gathering the child's medical history meant that relevant health information was not available to the child's carer, general practitioner and other treating health professionals.
- There was no record on FACS or NSW Health files that an infant who entered care at one month of age, or their sibling, were ever referred for, or received, a comprehensive health assessment.
- One young child who had been in out-of-home care for almost six months before their death had not been referred to the health pathway. The child's older siblings, including one who had complex needs associated with their disability, also had not been referred for a health assessment.

In response to a draft copy of this report, FACS advised that a formative evaluation of the health assessment process and coordination for children and young people entering statutory out-of-home care was commissioned by NSW Kids and Families, and endorsed in April 2015. FACS advised that its out-of-home care Service Improvement Team, and NSW Kids and Families are working to progress the evaluation recommendations. The recommendations include improvements to timeliness and quality of referrals, improvements in performance and outcome data; strengthening of governance and of systems to support the Pathways; and increasing carer engagement.⁴⁷

Supporting children with disability

Our reviews of the deaths of children in care with disability identified varied practice. There were instances of good casework and interagency practice to respond effectively to children's health, disability and medical needs and to support carers and families.

For one child, FACS-CS made timely referrals to Health and to FACS-Ageing, Disability and Home Care (ADHC) when the child's health needs could no longer be managed by community health services. NSW Health Out-of-Home Care Liaison Nurses developed a comprehensive health plan for the child that included specialist medical care and therapy delivered through community health services. There was good collaboration, communication and planning between FACS-CS, FACS-ADHC, NSW Health and the non-government organisation responsible for the child's foster care placement. Intensive foster care support and case management was introduced when the child's support needs increased, and in-home support services were arranged to assist the foster carers. End-of-life care planning was undertaken in consultation with the child's birth family and the foster carers, with appropriate support and advice provided by health professionals.

46 NSW Health, 2013, *Health Assessment of Children and Young People in Out-of-Home-Care (Clinical Practice Guidelines)*, NSW Ministry of Health, http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_010.pdf accessed 8 August 2014.

47 Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

However, good practice was not always evident. In relation to a very young child with severe disability and complex medical needs, our review identified that communication problems between FACS-CS and FACS-ADHC prevented the purchase of necessary equipment that would have helped to minimise health risks and improve the child's quality of life.

We found that FACS-CS was not timely in responding to requests made over a period of some months for critical equipment to support the child's respiratory and other health conditions, and to assist with mobility. The child died from respiratory illness before the equipment was organised. We also found poor communication and conflict between FACS-CS and the child's foster carers in relation to financial and other supports, and lengthy delays in referrals for in-home domestic assistance.

Since the child's death, FACS advised that it has updated casework practice procedures related to consultation and planning for children with disability. The agency also advised that it is revising the *Financial Support for Children and Young People in OOHC Policy and Guidelines (2009)* to ensure timely approval of life-saving aids and supports for children in out-of-home care. In the district where the child resided, FACS reported that there are now regular meetings between FACS (CS, ADHC and Housing) staff to discuss joint cases/clients; processes are now in place for complex or contentious cases to be escalated to the District Directors; and the District ADHC Senior Practitioner is consulted on all cases of children with disability in out-of-home care.

Deaths due to external causes

In 2012 and 2013, seven children in care died as a result of external causes, including suicide (2), transport fatalities (2), drowning, accidental drug overdose, and complications of a surgical procedure to treat a life-threatening health condition. Most of the children were male (4) and Aboriginal (4).

In the 10 years to 2013, 25 children in care have died due to external causes. Suicide was the most common external cause of death for children in care (8), followed by drowning (6), transport fatalities (5) and poisoning (4). The majority (18) of children in care who died as a result of external causes were male, and 10 were Aboriginal.

Young people with complex needs

Young people in care are a particularly vulnerable group who may have complex needs. Our previous reports of reviewable child deaths have noted the ongoing and significant challenges for agencies in engaging and responding effectively to children with complex needs; and the importance of early assessment and intervention before and following entry into care, and effective coordination and collaboration between agencies working with these children.⁴⁸

In 2012 and 2013, two young people died as a result of suicide and one young person died from an accidental drug overdose. Each young person had entered care before the age of six and had lived with relatives for many years. None had received regular casework support from FACS while they were in care. All of the three young people had displayed increasing behavioural and emotional difficulties in the year or two before their death.

- FACS had very little contact with one young person or their carers since final care orders, although the carers received a supported care allowance. In the year before their death, the young person experienced suicidal ideation and behavioural difficulties, was excluded from school, and had problems with peers. The family had recently arranged counselling through a local community agency to help the young person and had not sought additional assistance from FACS.
- One young person had a history of unstable relative placements and had continued to encounter risks associated with carer substance abuse, neglect, and exposure to domestic violence. The young person had many self-directed placement changes in the year before their death, and spent periods of time in juvenile detention. Multiple child protection reports in the three years before their death raised concerns

48 NSW Ombudsman 2013, *Report of Reviewable Deaths in 2010 and 2011: Volume 1 Child Deaths*, p. 42, p. 53.

about the young person's escalating violence, self-harm, substance misuse and emerging mental health problems. FACS assessed the reports as non-ROSH and did not provide a casework response. Supports from NSW Health and Juvenile Justice had limited effect on stabilising the young person, who proved difficult to engage. Internal reviews by FACS and NSW Health after the young person's death identified opportunities for improved practice.

In July 2012, we provided a confidential report to FACS on the service provision challenges in responding to very vulnerable adolescents.⁴⁹ In response, FACS established the '*Vulnerable Teenagers Review*' – now known as *Better Lives for Vulnerable Teenagers* – which recommends strategies to reduce the number of older children and adolescents who are re-entering the Juvenile Justice system; are affected by homelessness; or are entering out-of-home care.

In a recent report to Parliament, we noted that despite in-principle cross-government support for a senior group to be established to develop and implement a coordinated strategy for vulnerable young people, there is still no overarching framework to guide delivery of services that are provided to high-risk adolescents.⁵⁰ Our recommendations included that FACS should deliver a more effective and integrated response in relation to vulnerable adolescents.⁵¹

In response, FACS has acknowledged that:

'outcomes for NSW vulnerable and at-risk children and young people and families cannot be provided by our intervention alone, and that significant changes are required to refocus our child protection interagency work... FACS is committed to working with our government partners through the Prevention and Early Intervention Taskforce and review of the Keep Them Safe Outcomes Evaluation to shape an integrated approach to early intervention and prevention for vulnerable children'.⁵²

Drowning deaths – swimming pool safety

In 2013, a young child in care drowned in a swimming pool located at the carer's home. The child was under the parental responsibility of the Minister and residing in a relative placement that was case managed by FACS.

Following the child's death, police identified that the pool barrier did not comply with the requirements of the *Swimming Pools Act 1992* and the pool gate, which was not self-latching, may have been left open. Our review found that FACS did not record a home/pool safety inspection until some months after the child's placement had commenced, and did not identify any concerns about the standard of the pool barrier.

FACS' internal review of the child's death recommended that FACS' Policy, Programs and Strategy Unit should explore whether current procedures adequately support caseworkers who are responsible for assessing swimming pool safety.

This is the third child in care to drown in a private swimming pool located at a carer's home since 2011. Each of the children were Aboriginal and younger than five years of age. In each case, the agency responsible for authorising and supervising the placement was aware that a swimming pool was located on the premises.

Key factors that contributed to the three drowning deaths were inadequate safety barriers to prevent young children accessing the pool, and inadequate supervision by the carer(s) of the child. In two cases, the pool had fencing and gate defects that were identified after the child's death, and in the third case there was no barrier fence between the pool and the house. In each case, the child drowned in the absence of direct adult supervision.

49 NSW Ombudsman 2012, *Discussion paper: service provision challenges in responding to very vulnerable older children and young people*.

50 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* April 2014, pp. 5-6.

51 *Ibid*, p. 32.

52 Correspondence from Secretary of FACS to NSW Ombudsman, 28 July 2014.

In our last report of reviewable child deaths, we noted that FACS had introduced measures to improve carer and frontline staff knowledge about pool and water safety, including introducing an updated Home Inspection Checklist to include the requirements of the *Swimming Pools Act 1992*, discussions on water safety at Regional Foster Carer Advisory Group meetings, and publication of relevant information in carer and staff resources. The Connecting Carers NSW carer education package had also been updated to include more detail on pool safety and legislative requirements.

Since that time, a Coronial inquest into the drowning death of a child in foster care has recommended that action be taken to ensure all care agencies implement policies and procedures requiring that:

- new foster carers at residences with swimming pools provide a Certificate of Compliance under the *Swimming Pools Act* before being authorised as a carer, and
- agency home visits involve monthly observation of the state of any swimming pool and its safety adherence.

FACS told us that work was underway to implement the Coroner's recommendations about pool safety,⁵³ including strengthening FACS' procedures for authorising carers, and improving its Casework Practice site with links to pool safety resources.⁵⁴

In March 2015, FACS further advised that the Home Inspection Checklist assessment tool for foster, relative and kinship carers was amended in October 2014. New measures have been implemented that address swimming pool safety. As part of the assessment of prospective carers, and prior to their authorisation, a home inspection checklist must be completed if the home has a swimming pool (and also a spa or an inflatable / portable pool). FACS casework staff must ensure that:

- a child resistant pool fence / barrier that meets Australian Standards is properly installed and maintained
- the pool is registered with the Swimming Pool Register; and
- a valid Pool Compliance Certificate has been issued by the local council or an accredited certifier.⁵⁵

The *Child Death Review Team Annual Report 2013* includes recommendations to FACS, the Office of the Children's Guardian and the Association of Children's Welfare Agencies aimed at improving the guidance for staff working with vulnerable families and children in out-of-home care to identify drowning risks to young children, including compliance with the *Swimming Pools Act 1992*.⁵⁶

SUDI and sudden deaths of unknown causes

In 2012 and 2013, two young children in care died suddenly and unexpectedly after being placed for sleep. In both cases, forensic and coronial investigations did not establish a cause of death. Both children were living with a grandparent, with case management from FACS.

One of the children, a two-year-old child, was sharing a bed. The child had received a medical assessment in relation to numerous health concerns, and was reportedly well in the weeks before death.

One child was an infant under 12 months of age. Modifiable risk factors for SUDI were present in the infant's environment, including exposure to tobacco smoke, and multiple loose items of bedding located within the cot where the infant was sleeping (four pillows, two blankets and a quilt). Our review and FACS' internal review found no evidence that caseworkers had discussed safe sleeping practices with the infant's carers or ascertained that a safe sleeping environment was being provided.

FACS' initiatives following its cohort review of SUDI where the infant's family had a child protection history should also be of benefit to children in care. It is important that consistent messages about SUDI risk factors and a safe sleeping environment for infants are delivered to foster, relative and kinship carers.

53 FACS CDCR review following the death of a child in care.

54 Correspondence from the Secretary of FACS to the NSW Ombudsman, 19 September 2014.

55 Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

56 NSW Child Death Review Team 2014, *Annual Report 2013*.

Carer assessment and support

Inadequate foster and relative/kinship carer assessment and support was evident in a number of reviews conducted for children who died in 2012 and 2013.

Carers play a critical role in the safety and wellbeing of children in care. However, they may be required to manage situations that are considerably more demanding than usual parenting, particularly if the children in their care have increased physical, emotional, behavioural and developmental needs. Carers of children with disability may encounter particular problems associated with obtaining specialised services and equipment, dealing with multiple service providers and having less time for themselves.⁵⁷

Effective assessment of carer suitability and capacity, and ensuring appropriate carer supports are in place, is important for placement stability and for achieving positive outcomes for children in care. We found that some carers should have received a more thorough assessment and/or more frequent review. In several cases, it seemed that not enough consideration was given to what effect the additional responsibility of caring for a foster or related child would have on the carers' existing health, financial and psychosocial concerns.

- When FACS arranged a family placement in 2010 for a large sibling group, required probity checks were not completed on the carers or other household members. An assessment of the carers' suitability was not started until three months after the children's placement was arranged. There is no record that a home visit or home safety inspection was conducted. The assessment record was very limited and did not include information about the carers' personal history and parenting skills or what practical or other supports they might need to look after six children who had experienced various traumas, including two who had significant health needs. Probity checks for household members still had not been completed more than a year later when responsibility for supervising the placement was transferred to a non-government organisation.
- A couple that was already caring for two young children with high needs was approved to care for a third child with disability and complex health needs after a telephone interview. FACS did not conduct a home visit to more thoroughly assess the carers' circumstances and had not completed a review of the carers' situation since the couple was approved as foster carers more than three years before. FACS' Casework Practice guidelines require carers to be reviewed annually or when circumstances change.
- FACS placed a child, aged one year, and an older sibling with high needs, with a relative carer without sufficiently assessing the carer's suitability or capacity to meet the children's needs. There were complex intergenerational factors within the family that meant the children were exposed to ongoing risks. The carer assessment was not completed within the required timeframes and it did not sufficiently explore potential risks for the children and the carer. The carer's own health needs and psychosocial issues were not taken into account and no carer support plan was developed. Until the carer indicated they were not coping, no respite was offered. One period of respite care was provided during a crisis, but no further respite was planned.
- FACS placed a family of four children with a relative who was undergoing treatment for a life-threatening illness. The placement assessment did not sufficiently explore what level of support the carer would need, and it was unclear if the psychologist who conducted the assessment was provided with relevant information about the carer's health issues. The carer later informed FACS that she was having difficulty managing one of the children and other concerns were raised about the carer's capacity to manage the children and the level of responsibility placed on the older children to care for the younger ones. This new information did not prompt a review or re-assessment of the carer's support needs.

Chapter 6 details the themes and issues arising from reviews of child deaths. In relation to the deaths of children in care in 2012 and 2013, chapter 6 addresses particular issues relating to carer assessment and support.

57 CREATE Foundation, *Supporting children and young people with a disability living in out-of home care in Australia – Literature Review*, CREATE Foundation, South Brisbane, pp. 32-34. http://www.create.org.au/files/file/Research/CREATE_AmberHall_ChildrenwithaDisabilityLivinginOOHC_Aug2012_publicationedition.pdf, accessed 7 August 2014.

Chapter 5. Familial abuse-related deaths in NSW 2004-2013

This chapter considers the deaths of the eight children who died in familial abuse-related incidents in 2012-2013 in the context of a broader review of 83 children from 75 families who died in incidents involving family members in NSW in the 10-year period from 1 January 2004 to 31 December 2013.⁵⁸

Familial homicide, sometimes referred to as 'domestic' homicide, refers to 'an incident involving the death of a family member or other person from a domestic relationship'.⁵⁹ In this report, a family member includes a child's parent or a person in a parental or caring role for the child (such as a step-parent, de facto parent, or a partner of one of the child's biological parents). It also includes other people related to the child, such as siblings, grandparents, uncles and cousins.

As shown in the figure below, apart from a spike in peer homicides in 2010, the majority of abuse-related deaths of children in NSW have been predominantly associated with family. This is consistent with national research, which identifies that, despite public concerns about the risk of child homicide by strangers, most children who die in abuse-related circumstances are killed within their family unit.⁶⁰

Table 9: Abuse-related deaths of children by offender relationship, 2004-2013

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | Total |
|--------------|----------|-----------|-----------|----------|-----------|-----------|-----------|-----------|----------|----------|------------|
| Familial | 7 | 13 | 11 | 7 | 11 | 10 | 6 | 10 | 4 | 4 | 83 |
| Peer | 0 | 1 | 1 | 1 | 3 | 0 | 7 | 2 | 1 | 0 | 16 |
| Other | 2 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 8 |
| Total | 9 | 15 | 13 | 9 | 14 | 11 | 14 | 13 | 5 | 4 | 107 |

5.1. The children who died in familial abuse-related incidents

Age and gender

Research indicates that child homicides decrease in frequency with age until the teenage years.⁶¹

The ages of the 83 children who died in familial abuse-related incidents ranged from less than one day to 15 years. As shown in the figure below, more than half (49) of the children were younger than three years of age, including 22 infants aged less than one year. The median age of the children was two years.

These findings are consistent with other research, which has identified that domestic homicide most frequently involves younger children, with the greatest risk associated with infants in their first year of life.⁶²

58 The children died as a result of abuse or in circumstances suspicious of abuse. The death of one child occurred in circumstances of severe neglect, resulting in the child's death from starvation. The child's death has been included as a familial homicide in this chapter due to the circumstances of the case, and subsequent convictions against the parents that included murder.

59 Australian Institute of Criminology 2010, *Homicide in Australia: 2007-08 National Homicide Monitoring Program annual report*, cat. No. Monitoring Report 13, AIC, Canberra.

60 Queensland Crime and Misconduct Commission, *Vulnerable victims: child homicide by parents*, Research and Issues paper No. 10, June 2013.

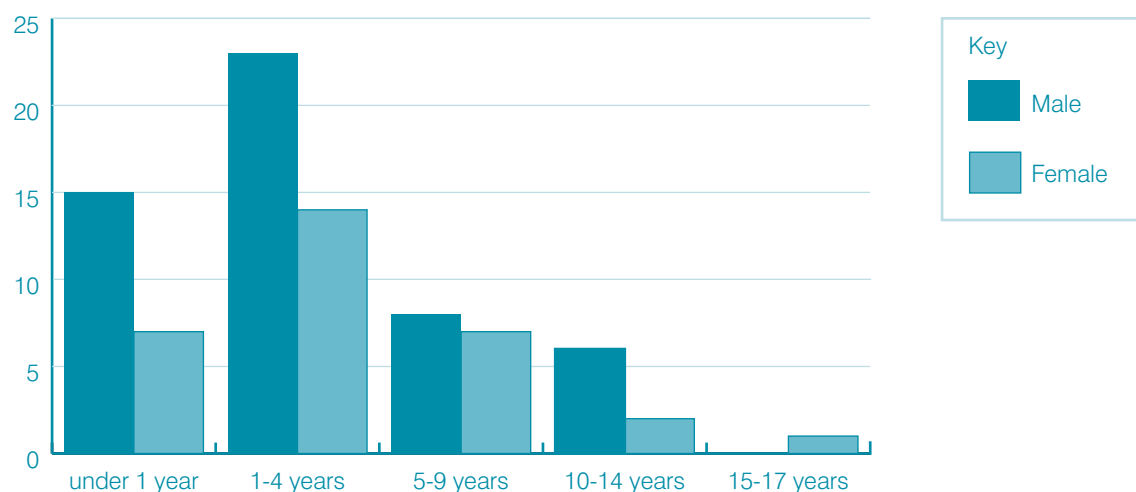
61 Dixon, D. 2011, *Children who die of abuse: an examination of the effects of perpetrator characteristics on fatal versus non-fatal child abuse*, PhD Social Work Thesis, University of South Florida, p. 3; and Harbert, A., Tucker-Tatlow, J., Hughes, K. 2010, *Review of the Literature: Child Maltreatment Fatalities – Risk Factors and Lessons Learned*. SACHS. <http://theacademy.sdsu.edu/programs/SACHS/literature/SACHS-Child%20Fatalities%20Literature%20Review-Feb%202010.pdf>

62 For example: Damashek, A, McDiarmid Nelson, M, and Bonner, B.L, 'Fatal child maltreatment: characteristics of deaths from physical abuse versus neglect' in *Child abuse & neglect* 37.10 (2013): 735-744; Lamont, A, 2011. *Who abuses children?* National Child Protection Clearinghouse, Australian Institute of Family Studies at <http://www.aifs.gov.au/nch/pub/sheets/rs7/rs7.pdf>; and Dixon, S, Krienert, J.L, and Walsh, J, 'Filicide: A gendered profile of offender, victim, and event characteristics in a national sample of reported incidents, 1995-2009' in *Journal of Crime and Justice* ahead-of-print (2013): 1-17.

Young children are more dependent on their parents and other adults in their family, and have higher care needs that are more likely to be associated with stress for their carers.⁶³

As shown in the figure below, almost two-thirds (52) of the 83 children were male. The predominance of male homicide victims is well recognised in research literature.⁶⁴

Figure 1: Age and gender of children who died in familial abuse-related incidents, 2004-2013



Aboriginal and Torres Strait Islander status and cultural background

Aboriginal children are overrepresented in child deaths, including familial abuse-related deaths. Of the 83 children, 15 were identified as Aboriginal or Torres Strait Islander. Of the 15 children, all were aged six years and younger; 11 were male.

Almost a quarter (19) of the 83 children had a parent(s) who was born overseas, or had otherwise been identified as having culturally and linguistically diverse backgrounds. The proportion of children from diverse backgrounds is broadly consistent with NSW Census data on the proportion of the population born outside of Australia.⁶⁵

Other characteristics of the children who died

Seventeen children were identified as having personal characteristics or additional needs that may have increased their vulnerability. Research has identified that children with behavioural, medical or developmental problems are at increased risk of fatal child abuse.⁶⁶

In relation to these 17 children, the most common characteristics included physical and/or intellectual disability or developmental delay; learning difficulties; behavioural problems; and neonatal abstinence syndrome.

63 Heather Strang 1996, *Children as Victims of Homicide*, Canberra: Australian Institute of Criminology, p. 3.

64 Andy Chan and Jason Payne 2013, *Homicide in Australia: 2008-09 to 2009-10*, National Homicide Monitoring Program Annual Report, Canberra: Australian Institute of Criminology, p. 19.

65 The 2011 Census data indicated that approximately 30% of people in NSW are born outside of Australia. Australian Bureau of Statistics 2014, *3105.0.65.001 Australian Historical Population Statistics 2014*, Canberra: ABS.

66 Harbert, A., Tucker-Tatlow, J., Hughes, K. 2010, *Review of the literature: Child Maltreatment Fatalities – Risk factors and lessons learned*. SACHS. <http://theacademy.sdsu.edu/programs/SACHS/literature/SACHS-Child%20Fatalities%20Literature%20Review-Feb%202010.pdf>

5.2. Cause and circumstances of death

Fifty-nine persons have been charged and/or convicted in relation to 52 of the deaths. This includes convictions for murder (12), manslaughter (23), neglect (1) and infanticide (1). Charges have been, or were, laid against 22 other people.

The deaths of over half of the children were due to blunt force or sharp force injuries. Seven of these children had injuries that were consistent with shaken baby syndrome.⁶⁷ Other main causes of death were poisoning,⁶⁸ asphyxiation, and drowning.

In order to understand the factors that contribute to abuse-related deaths within the family, we examined the primary circumstances of the incidents that resulted in the deaths.⁶⁹ Our reviews found that:

- Fifty-one children died as a result of inflicted or allegedly inflicted injuries. Post-mortem examinations for 12 children revealed injuries that suggested physical abuse before the fatal event, including healed or healing fractures, old bruising, internal trauma, inflammation and scarring.
- Fifteen children died in murder-suicide incidents. Common factors present in these incidents were mental health issues, both diagnosed and undiagnosed, and current or recent family breakdown.
- Thirteen children died during what appears to be, or has been identified as, a psychotic episode or other mental illness experienced by the person of interest at the time of the fatal incident.
- Four children died in circumstances where harm was not the intention of an action; primarily in circumstances where drugs were administered to pacify or sedate children.

Where the child died

In relation to the majority (76) of the 83 children, the fatal incident occurred in private homes. In most cases, this was the child's own home, and for 10 children, the fatal incident occurred at the home of a non-custodial parent, or the homes of friends or relatives.

Four children were killed in public places, such as waterways or bush settings.

5.3. Family circumstances

Location and socioeconomic circumstances

As shown below, the majority (46) of the 75 families within which children died in abuse-related circumstances resided in major cities. Over one-third (29) of the families resided in regional and remote areas of NSW.

In 2013 the overall share of the NSW population living in major cities was 74 per cent, and in inner or outer regional areas was 25 per cent.⁷⁰ Data supplied to this Office by the ABS indicate that the distribution of the population aged 0-17 in that year was 73 per cent in major cities and 26 per cent in inner or outer regional areas.

Of those families residing in regional and remote areas (29), one-third (10) resided in West and Far Western NSW. In the decade to 2013, Western NSW was the equal leading location of residence of the Aboriginal children whose deaths were reviewable.⁷¹

67 Shaken baby syndrome is characterised by a triad of pathological findings: retinal haemorrhage, subdural haematomas and encephalopathy. See T. Jacques and B. Harding 2008, 'New Developments in 'Shaken Baby Syndrome', *Advances in Clinical Neuroscience and Rehabilitation*, 8, no. 3.

68 The poisoning deaths typically involved the administration of lethal quantities of prescription medication or opiates.

69 This describes the primary identified circumstance in which the children died, noting that these are not exclusive and other factors may also have been present.

70 ABS 3218.0 - Regional Population Growth, Australia, 2012-13.

71 Almost half (34) of the 70 Aboriginal children whose deaths in 2004-2013 were reviewable resided in Western NSW (17) or Hunter New England (17) districts.

Studies have linked macro variables to child maltreatment fatalities, including poverty and crime rates.⁷² Most of the families resided primarily in areas of greatest socio-economic disadvantage, with over half (42) residing in areas classified as quintile 1 and 2.⁷³

Table 10: Families within which children died in familial abuse-related incidents by remoteness, 2004-2013

| Remoteness | Families |
|---------------------------|-----------|
| Major Cities of Australia | 46 |
| Inner Regional Australia | 20 |
| Outer Regional Australia | 8 |
| Remote Australia | 1 |
| Very Remote Australia | |
| Total | 75 |

Table 11: Families within which children died in familial abuse-related incidents by socio-economic status, 2004-2013

| IRSD Decile (group) | Families |
|----------------------|-----------|
| Quintile 1 (lowest) | 22 |
| Quintile 2 | 20 |
| Quintile 3 | 18 |
| Quintile 4 | 7 |
| Quintile 5 (highest) | 8 |
| Total | 75 |

Family breakdown

While all of the children were living with at least one birth parent, two-thirds (50) of the 75 families had experienced separation or family breakdown prior to the child's death. In relation to the child's household, almost all of the separated parents had formed new intimate relationships; only four birth parents were caring for children as the only adult in the house.

Most of the separated parents who had formed new intimate relationships were living with their partners, with both adults sharing responsibility for care of the child(ren).

Child protection history

Children with a child protection history in NSW have a much higher rate of death from assault than children without this history (6.3 times the rate).⁷⁴ In our review, over half (40) of the families of children who died in familial abuse-related incidents had a child protection history in the three-year period prior to the child's death.⁷⁵ This is a much higher proportion than the average for all child deaths in NSW, in which the families of 20 per cent of the children who died had a child protection history in the three years before the death.⁷⁶

Child protection history has also been shown to increase the odds of children under five years of age dying as a result of assault (odds ratio: 7.6).⁷⁷ In our review, just under two-thirds (37) of the 59 children under five years of age who died had a child protection history.

One-quarter (11) of the children with a child protection history were Aboriginal. Nine children had a culturally and linguistically diverse background.

72 Sheldon-Sherman, V, Wilson, D, & Smith, S (2013). 'Extent and nature of child maltreatment-related fatalities: implications for policy and practice'. *Child Welfare*, 92(2): 41-58.

73 Quintile 1 represents the relatively most disadvantaged 20 per cent, and quintile five the relatively most advantaged.

74 NSW Child Death Review Team 2014, *Causes of death of children with a child protection history 2002-2011*.

75 The 40 families included 43 children who died. All except one of the children had themselves been the subject of a risk of significant harm or risk of harm report. One child had not been the subject of a report, but their sibling had been.

76 NSW Child Death Review Team 2014, *Causes of death of children with a child protection history in NSW, 2002-2011*, p. 3.

77 Ibid.

5.4. The persons of interest

Police have identified 94 persons as responsible for, or persons of interest in relation to, the deaths of the 83 children included in this review. In some cases, more than one person was or is a person of interest.

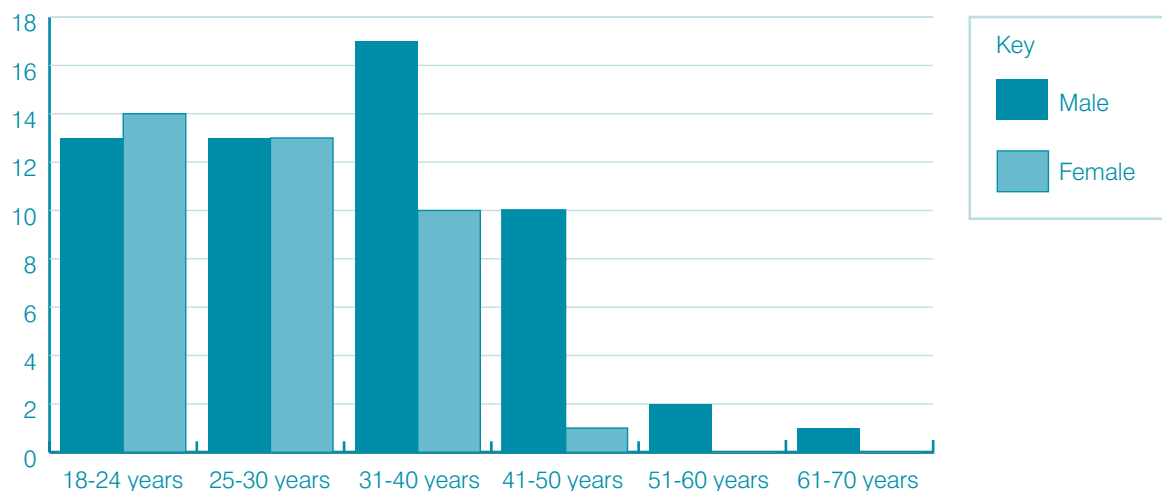
Ten of the incidents in which children were killed involved murder-suicide, resulting in the deaths of 15 children and the 10 perpetrators.

Age and gender

At the time of the homicide(s), the 94 persons of interest were aged between 18 and 69 years. As shown in the figure below, half (48) of these individuals were under 30 years of age at the time of the incident, including five who were teenagers. This finding is consistent with recent research on homicide more generally, which has found that the majority of perpetrators are between 20 and 35 years old.⁷⁸

Almost two-thirds (56) of the persons of interest were male. Males are typically overrepresented as perpetrators of most kinds of homicide.⁷⁹

Figure 2: Age and gender of persons of interest in familial abuse-related deaths of children, 2004-2013



Aboriginal and Torres Strait Islander status and cultural background

Information about Aboriginal and Torres Strait Islander status was available for 82 persons of interest. Just under a quarter (22) were Aboriginal.

Information about cultural heritage was available for 71 persons of interest. Of these, 16 were from diverse cultural backgrounds.

Occupation and education

Research indicates that perpetrators of domestic child homicide typically have lower levels of educational attainment compared to the general population.⁸⁰

78 Chan, A. & Payne, J. 2013, *Homicide in Australia: 2008-09 to 2009-10 National Homicide Monitoring Program annual report*, Australian Institute of Criminology, Canberra, p. 26.

79 Ibid, p. 25.

80 Lysell H, Runenson B, Lichtenstein P & Langstrom N, 2014, *Risk factors for filicide and homicide: 36 year national matched cohort study*, Sweden, *Journal of Clinical Psychiatry* 75(2) 127 - 132.

Information about occupation was available for 64 of the 94 persons of interest. Nearly two-thirds were either unemployed (23), or receiving parenting (13) or disability/sickness (6) benefits. Less than one-third (19) of the individuals were employed or engaged in study. Three persons of interest were not in the workforce.

Information about the highest level of education achieved by the persons of interest was available for 44 individuals. The highest educational attainment for the majority (27) was year 11 or below, with 13 leaving school prior to completing year 10. Ten completed year 12, and seven persons of interest achieved tertiary qualifications.

Relationship between victims and persons of interest

The vast majority of the persons of interest were in a parental role with the children who died; most were birth parents. The 94 persons of interest were:

- birth parents (57 - 36 mothers and 21 fathers)
- intimate partners of birth parents (32 – 31 male and one female), including four step-parents, and
- other relatives (5), including grandparents, cousin, uncle and sibling.

The large majority (34) of the 38 female persons of interest were the biological mothers of the children who died. Male persons of interest had a range of familial relationships with the children.

Birth Parents

Our previous work has noted that mental illness was a significant contributing factor in the actions of women, mainly birth mothers, who killed their children. This was the case for both families with a child protection history, and those without, although the former were more likely to have substance abuse issues.⁸¹

Males, including birth fathers, were most likely to have a previous history of violence and substance abuse if they were in families with a child protection history. Most males who had not previously been linked to child protection concerns had some history of mental illness, and a minority had substance abuse issues.

Intimate partners of birth parents

Research indicates that children residing in households with adults unrelated to them, primarily an adult male, have a higher risk of dying from maltreatment than children in households with two biological parents.⁸²

In our review, male intimate partners represented one-third (31) of all 94 persons of interest. Most (21) were residing in the home with the mother and her child/ren. Male intimate partners of birth mothers featured as both persons of interest acting alone (18), and in deaths involving more than one person of interest (13).

The majority of male intimate partners (27) were new to the family, and had formed a relationship with the birth parent less than a year before the child's death. In the majority (25) of cases, the new partner was the person of interest in the child's death.

Our reviews identified that 24 of the new partners were known to police, including 20 who were serious violent offenders,⁸³ with charges or convictions for a range of offences, including assault, domestic violence, sexual offences, and manslaughter.

In over half (16) of the families that included a new partner, reports to FACS that the child/ren in the family were at risk of significant harm included concerns about the individual. In 13 cases, the information received by FACS included specific identifying details about the new partner. However, our reviews found that, in the

81 NSW Ombudsman 2009, Report of reviewable deaths in 2007: Volume 1, child deaths pp. 46-49 (five year review of child homicides).

82 Harbert, A., Tucker-Tatlow, J., & Hughes, K. 2010, *Review of the Literature: Child Maltreatment Fatalities – Risk Factors and Lessons Learned*. Southern Area Consortium of Human Services.

83 The NSW Police Force has developed a preliminary definition of 'serious violent offender' based on the Australian New Zealand Standard Offence Classification. A serious violent offender is defined as an individual who has been charged with an offence classified in line with certain categories, including acts intended to cause injury (assault, other acts intended to cause injury); homicide and related offences; sexual assault and related offences; and dangerous or negligent acts endangering persons.

majority of the 13 cases, FACS did not undertake checks of the new partner to inform assessment of risk to the children – including checks of its own information holdings or information held by other agencies such as NSWPF. In a small number of matters, the checks or assessments were compromised by incorrect spelling and/or poor communication between agencies. In one case, FACS was aware that the new partner was a serious violent offender, but did not seek further information or adequately assess the risks.

CASE STUDY 1

In 2006, a young child died as a result of multiple injuries inflicted by the mother's new partner. There were 18 reports to FACS about the family in the three years before the child's death, concerning the mother's mental health and parenting skills, domestic violence, physical abuse, and medical neglect. The partner had been in a relationship with the mother for three months before the child's death. During that time, there were nine reports to FACS about the family, including reports of the partner's alleged drug use and physical abuse of the children.

FACS' internal review of the child's death identified inadequate and inaccurate assessment of risk. The agency's own holdings on the family were not reviewed; the children did not appear to have been interviewed; the concerns of family members were not clarified; and information about the new partner was not assessed.

FACS identified that, with the benefit of hindsight, the partner's role as a carer of the children should have been considered more closely and information about his history, reported violence and drug use further investigated. The agency found that the mother's behaviour in allowing the partner to assume a key care role should also have been carefully considered, especially in light of her pattern of intimate relationships.

Our investigation noted information in FACS' review that, while the CSC did not know the full extent of the partner's violent and anti-social behaviour, they were aware that he had a lengthy criminal record with incarceration and a conviction for grievous bodily harm. In addition, a report five weeks before the child's death included allegations that the partner was verbally and physically violent towards the children and had been observed using heroin and ice at the family home. We acknowledged the complex casework challenges in relation to this family, but considered that what was known about the partner should have generated questions about the potential risk he posed to the children, and hindsight was not necessary to identify that the risk the partner presented to the children required further consideration.

In our investigation, we noted that assessment of new partners had been a significant issue in a number of recent cases investigated by our office. In response, FACS advised our office in 2012 that it had developed a 'New Partners and New Household Members' practice tool that seeks to address this issue.

Characteristics of the persons of interest

As part of our reviews, we sought to identify any particular characteristics or issues that may have contributed to the circumstances leading to the child's death, or indicated some risk to the child. Our reviews identified factors in many of the families that are commonly reported issues in risk of significant harm reports to FACS, particularly domestic violence, physical abuse, carer drug and alcohol use and carer mental health.⁸⁴ It has been noted that while these factors can place children at risk, either as single issues or in combination, they are not clear predictors of fatal maltreatment.⁸⁵

84 Family and Community Services Community Services Annual Statistical Report 2012/13, accessed: http://www.community.nsw.gov.au/docswr/_assets/main/documents/docs_data/annual_statistical_report_2012-13.pdf

85 Brandon, M et al 2009, Understanding serious case reviews and their impact, a biennial analysis of serious case reviews 2005 – 2007, Department for Children, Schools and Families, University of East Anglia, p. 118.

History of domestic, other violence and/or criminality

Over half (55) of the 94 persons of interest were known to police as perpetrators of violence prior to the child death,⁸⁶ with offences including assault, domestic violence, property damage, sexual offences, and aggravated break and enter. While the persons of interest with a violent history were primarily men (40), over one-quarter (15) of the female persons of interest also had a history of violent behaviour.

In many (43) cases, the individual's past violence was relevant to consider in the context of the child's death. In many cases, available information indicated:

- an extensive history of domestic violence perpetrated against former and/or current partners
- a history of violence towards the deceased child
- frequent violence within the family
- a background of threats, intimidation and assault of other people, and
- previous self harm and/or threats to kill their partner and/or child.

The majority (39) of the 55 individuals with a history of violent behaviour were serious violent offenders, with charges or convictions including assault, malicious wounding or inflicting grievous bodily harm, armed robbery, and stalk and intimidate.

In addition to violent behaviour, one-third (31) of the 94 persons of interest also had a history of non-violent criminal behaviour, with charges or convictions for theft/robbery, driving/transport offences, property damage, drug possession, and fraud.

Substance abuse

The risks to children associated with carer substance abuse are well known. While it cannot be assumed that all people who misuse substances are unable to adequately care for their children, where parenting capacity is affected the impact on children can be significant.⁸⁷ Carer substance abuse was a significant issue in reviews of abuse-related child deaths within the family. It was also a noted factor in reviews of neglect-related deaths, as described in chapter 4.

Information about alcohol and other drug use was available for 89 of the 94 persons of interest. Over half (55) had a documented history of substance abuse, including 41 who were using multiple drugs, or drug/s and alcohol. Predominantly, substance abuse involved cannabis and alcohol. Other substances used by the persons of interest included heroin (16); amphetamines (14); and misuse of prescription medication (11).

Less than half of the persons of interest (19) had some access to treatment, including 11 who were receiving or had completed treatment programs. Six individuals were receiving methadone to address opiate dependence or chronic pain. In other cases, records indicated past involvement in rehabilitation and/or detoxification programs. In most (32) cases, there was no evidence of specific drug and alcohol treatment.

Child death reviews over the past decade have identified particular challenges in cases where parental substance abuse is a concern, including:

- lack of caseworker and supervisor expertise in the area of substance abuse and the risks this posed to children, including very young and vulnerable babies
- failure to seek relevant information or professional advice in assessing child protection risks
- an over-reliance on parents/carers as key informants about whether they were using or the extent of their substance use
- lack of monitoring of parental undertakings or assurances to take certain actions to minimise risks to a child, and inadequate consideration of the carer's capacity to comply, or the impact on the child's safety of failure to comply.

⁸⁶ Information on history of violence or criminal behaviour was available for 92 of the 94 persons of interest.

⁸⁷ NSW Ombudsman 2006, *Report of Reviewable Deaths in 2005 Volume 2: Child Deaths*.

Our reviews underscored the importance of reflective interagency work with families where substance abuse was an identified issue, in relation to identifying, understanding and monitoring risk, and in tailoring 'collective' action that is commensurate with the level of risk.⁸⁸

Mental health issues

SANE Australia reports that, while people receiving treatment for mental illness are no more violent or dangerous than anyone else, there is *'a slightly increased possibility that someone with a psychotic illness may be violent if they are not receiving treatment, have a previous history of violence, and are abusing alcohol or drugs.'*⁸⁹

The Australian Bureau of Statistics has estimated that almost half of the Australian population of adults aged 16-85 years had a mental disorder some time in their life, and one in five Australians in this age range had experienced a common mental disorder in the previous year. Of these, anxiety disorders were the most common, followed by affective disorders such as depression and substance-use disorders.⁹⁰

Mental health conditions identified before the child's death

Information about mental health was available for 85 of the 94 persons of interest. Records indicated that 35 had mental ill-health or contact with mental health services prior to the child's death, including 32 people who had been formally diagnosed with, or were receiving treatment for, a mental illness.⁹¹ The main mental health concerns were mood disorders (primarily depression) and anxiety disorders. Thirteen of the 32 people had multiple mental health concerns, mainly depression and anxiety; or depression and personality disorder.

The vast majority (27) of the 32 persons of interest with a diagnosed mental illness were receiving mental health treatment. While this primarily involved the prescription of medication, some of the individuals received inpatient treatment in mental health units, and/or accessed acute mental health teams, counselling and psychotherapy.⁹² In relation to 10 of the 27 persons of interest who were receiving mental health treatment, there was evidence they had disengaged from, or were only partially engaged in, treatment.

For the five persons of interest with mental illness who did not appear to have been receiving any treatment, records indicate that two individuals had been referred to mental health services, and one individual had failed to contact mental health services on release from custody.

Mental health conditions identified after the death

For 13 persons of interest, assessments conducted as part of court processes after the death found that they had mental health conditions that had not previously been identified. The main conditions were mood disorders, including depression and post-natal depression; and personality disorders. Eight of the 13 individuals were identified as having multiple undiagnosed mental health conditions.

88 NSW Ombudsman 2006, *Report of Reviewable Deaths in 2005 Volume 2: Child Deaths*; and NSW Ombudsman 2007, *Report of Reviewable Deaths in 2006 Volume 2: Child Deaths*.

89 SANE Australia, *Mental illness and violence*, factsheet 5.

90 Australian Bureau of Statistics 4326.0 – National Survey of Mental health and Wellbeing *Summary of Results 2007*.

91 For the other three people, other information indicated mental health concerns, such as a history of suicidal ideation, and admission for in-patient mental health treatment following deliberate self-harm.

92 Some persons of interest accessed more than one source of mental health treatment.

5.5. Involvement with agencies

The following section considers agency involvement with the families.

Over the past decade, our reviews of child deaths have highlighted concerns about the response of agencies to vulnerable families and children at risk. Over this time, significant steps have been taken by government to mitigate and manage these risks, including but not limited to the implementation of *Keep Them Safe: A shared approach to child wellbeing and Safe Home for Life*.

The cases considered as part of our review of familial abuse-related child deaths cover the periods both before and after major changes to the child protection system in NSW through the implementation of *Keep Them Safe* in 2010.

Keep Them Safe reinforced in particular the concept of child protection as a 'shared responsibility', with all relevant government agencies having prescribed responsibilities for ensuring the wellbeing of children. The changes expanded the concept of child protection to encompass universal services and early intervention, and saw the non-government sector becoming an increasingly significant partner in the provision of services.

Involvement with police

Over three-quarters (58) of the 75 families had come to the attention of police at some point before the child's death. For the majority (45) of these families, contact related to criminal activity on the part of either or both carers, including 20 families with very extensive criminal histories.

The carers had charges or convictions for a range of violent and non-violent offences, including assault; domestic violence; sexual offending; drug cultivation, use and/or supply; and theft. Most of the 58 families came into contact with police for the same criminal charges or convictions which led to one or more family members being categorised by police as serious violent offenders.

Just over half (41) of the 75 families had contact with police in the year before the child's death. In the main, contact was in response to reports of domestic violence (22), including eight families who had repeated contact with police in relation to multiple instances of domestic violence. However, the police contact in the year before death was usually not directly associated with the behaviour of the person/s of interest toward the child. In this period, only five families came to the attention of police in relation to physical harm or injury to the child and/or a sibling.

In some cases, police conducted welfare checks on the request of agencies. Our reviews of the deaths of children in circumstances of abuse and also neglect identified concerns about welfare checks on children conducted by police, and also the coordination of agencies with police. In particular, in recent cases in 2012 and 2013 involving child homicide and neglect, we observed:

- police not meeting requirements for completing or recording welfare checks, including a lack of information as to whether children were sighted
- police not consistently reporting the outcome of the welfare check to the individual or agency that requested the check
- agencies not following-up with police the outcome of the welfare check
- FACS not requesting police welfare checks on children in circumstances where there was information raising serious concerns for the children's welfare and a lack of capacity by FACS to respond.

Involvement with health services

During the year before the child's death, most (50) of the 75 families had some documented involvement with health services. The health services included general practitioners, maternity-related care, early childhood nurses, mental health services, drug and alcohol programs, and hospital emergency departments.

The nature, frequency and extent of contact that families had with health practitioners varied considerably, ranging from single contacts where very little information was obtained, to extensive and ongoing contact with multiple health services over many months.

Our reviews identified that families primarily had involvement with four key types of health services:

- **Mental health services** – more than one-third (28) of the families had contact with public or private health services in relation to mental health concerns. In a number of additional cases there was evidence of past contact with mental health services, but no recent involvement.
- **General practitioners** – Just under one-third (23) of the families had contact with general practitioners, ranging from routine health care for both parents and children, to critical support for more complex issues, including high-risk families with multiple needs. In some cases, general practitioners were the only health providers to have contact with a family.
- **Maternity and early childhood services** – one-quarter (19) of the families had recent involvement with maternity and early childhood services. In four cases, pregnancy, birth and post-natal checks represented the family's only involvement with health services before the child's death.
- **Hospital emergency departments** – many parents and/or children (17) presented to hospital emergency departments in the year leading up to the child's death. The contact ranged from families seeking medical assistance for non-urgent illnesses to injuries such as bruising and burns reportedly sustained as a result of household accidents, inexperienced parenting, or rough play. Four children had multiple presentations to hospital for injuries or illnesses. Adults, mainly mothers, presented to hospital for reasons including injuries (unexplained or as a result of domestic violence), or following excessive alcohol and/or medication or drug use.

Health practitioners, mainly public providers, made risk of harm or risk of significant harm reports in relation to almost half (24) of the 50 families in the year before the child's death. In some cases, health providers made a single report; in other cases, they made multiple reports – there were seven reports in relation to one family in the 12-month period. The most commonly reported issues involved carer drug and/or alcohol abuse; risk of, or actual, physical harm, abuse or suspicious injury; and domestic violence.

Contact with health services: physical injury

For over one-third of the children (33), records indicated evidence of prior injury before the child's death. This included hospital and/or health service presentations and post mortem findings.⁹³

Fourteen of the children presented to hospital and/or saw a general practitioner in relation to physical injuries prior to their death. For most of the children, their most recent presentation with physical injuries occurred within four months of their death, including seven of the 11 children who had presented to hospital, and all of the children who had seen a GP. Two children had multiple prior presentations to hospital with physical injuries.

Health practitioners, all hospital staff, identified the injuries as suspicious in relation to 10 of the 14 children, and made child protection reports to FACS in relation to eight of these children. The suspicious injuries were brought to the attention of police (or JIRT) in relation to six of the 10 children.^{94, 95}

In some cases, our reviews noted issues relating to health practitioners in recognising and establishing non-accidental injury, including not consulting with child protection experts in relevant cases. Where there was collaboration between health services and FACS, in some cases we noted a failure on the part of FACS to recognise the need for medical assessments to be complemented by its own comprehensive risk assessments.

93 For 12 children, prior injury was identified only following the fatal assault.

94 In relation to one of the six children, police had identified the injury and directed the parent to take the child to hospital.

95 In two of the six cases, FACS had contact with police or JIRT following the injury, but it did not involve referral to the police. In one case, FACS contacted police to ask officers to conduct a home visit – police reported that the child was sighted and there were no concerns. In the other case, FACS discussed the matter with JIRT, and was advised that acceptance of a JIRT referral would rely on the medical assessment. FACS contacted the hospital to discuss the medical assessment, and was advised that the assessment had found that there were no unusual circumstances. No further action was taken on this basis.

CASE STUDY 2

In 2006, an infant died from blunt force injury. Examinations after the death found that the child had sustained other injuries in the weeks before death, including multiple bruises and two fractured ribs; and had experienced one or more previous episodes of bleeding in the lungs.

During the previous six months, the child had presented to health professionals with injuries on three occasions – twice to hospital and once to a GP. The injuries included a skull fracture at six months of age; multiple bruising and hair loss at 10 months; and multiple bruising, scratches and a groin injury at 11 months. The child died one month after the third presentation.

Following both hospital presentations, health professionals made two reports to FACS about risk of harm to the child. The first report was made 10 days after the child was seen at the hospital, following a file audit and consultation with specialist staff. The report was closed without assessment on the basis of 'current competing priorities'. The second report, relating to multiple injuries, was referred to JIRT but declined on the basis of the medical examination results and the reasonable explanation provided by the carers. The report was allocated at the local CSC, but closed three days later without further assessment.

Our investigation found that the response by health and child protection authorities to the child's various presentations before death was inadequate. In particular, we identified issues with the assessment of risk in this matter, including:

- poor recognition of cumulative risk – including a failure to consider the pattern of 'accidental' risk-indicator injuries to a young child
- undue weight given to previous assessments, which were limited in nature, and
- poor interagency practice, including inaccurate assumptions about the family's engagement with other services.

Following the child's death, Health and FACS made changes to improve practice, including actions by Health to support better follow-up where child protection concerns have been raised; ensure that comprehensive child protection assessments occur in certain matters; and facilitate the access of nominated senior clinicians to relevant child protection information to support clinical reviews. Among other things, FACS advised of action to improve guidance in relation to intake and assessment, and to conduct quality reviews of CSCs.

Involvement with FACS

Over half (43) of the 75 families⁹⁶ had been the subject of a report of risk of harm or risk of significant harm to FACS in the three years before the death.

The primary reported concerns to FACS related to risk of physical abuse, neglect, exposure to domestic violence, carer alcohol or other drug use, carer mental health, and carer emotional health.

The frequency of the child protection reports to FACS about the children in the three years before their death varied:

- half (21) of the 43 families were infrequently reported, with 1-3 reports
- ten families had been the subject of between four and eight reports, and
- twelve families had extensive child protection histories, including seven families with 15 reports, and five families with 18-29 reports to FACS.

96 The 43 families had 46 children who died in familial-abuse related circumstances.

FACS had undertaken casework or had other substantial and/or intensive involvement with 17 of the 43 families, including one child who was under interim care orders. One young mother was under the parental responsibility of the Minister at the time of her child's death. FACS had previously removed the child or their sibling(s) in relation to five families, and had subsequently restored the children in three of these families.

In relation to the vast majority (39) of the 43 families with a child protection history, reports about risk were made in the year before the death, with most reports being made in the six months before the child died.

Twenty families were reported to FACS in the month before the children died. For the majority (16) of these families, the reports:

- related to concerns about individuals who were subsequently identified as the person/s of interest in the child's death (13 children), and/or
- were about matters that were relevant to the circumstances of the child's death (13 children), such as concerns about the child presenting with suspicious physical injuries.

For four of the 20 families for whom reports to FACS had been made about the child or their siblings in the month before their death, the local CSC or JIRT conducted a secondary assessment.

For the other 16 families, the reports were:

- merged with already open plans at the CSC and not individually assessed before the child's death
- closed by the CSC prior to secondary assessment
- open at the CSC but had no further action
- transferred to another state/territory, or
- otherwise had no response from the CSC.

Involvement with non-government agencies

Almost one-third (22) of the 75 families had contact with non-government services in the year leading up to the child's death.⁹⁷

Family support services were the most frequently used support, followed by child care, emergency accommodation, early intervention, parenting skills/playgroups, and child and family counselling. Other services included employment services and post-custody offender programs.

- Family support services were involved with nine families in our review.⁹⁸ The services were engaged to provide a range of supports, including child behaviour management; household management skills; preparation for restoration of a child; help to secure accommodation; and court support. In many cases, families were referred to the service by statutory authorities seeking to reduce identified risk through practical help and skills development. The extent and length of involvement varied. In one case, support involved a single unsuccessful attempt to engage the parents; other families received regular weekly home-based support over a period of months.
- Eight of the 83 children who died in familial abuse-related circumstances had attended a childcare centre at least one day per week. Childcare staff identified concerns for four of the children, and made child protection reports in relation to three of the four children. In the other case, childcare staff sought advice from another NGO service involved with the family. The concerns included multiple bruises and bite marks; multiple sores and possible scabies; and inadequate supervision of a young child left at home while the mother collected the older siblings.

97 The 22 families do not include those where contact with an NGO service was solely in relation to mental health concerns. Families who had contact with mental health services are included in the discussion regarding health services.

98 Family support services aim to assist families experiencing difficulties that make them more vulnerable and that adversely impact on parenting and family life. They help families in relation to prevention, early intervention, and crisis support.

- Five families had contact with emergency accommodation services in the months prior to the child's death. In each case, the mother contacted or presented to a refuge as a result of domestic violence. One mother presented to a refuge on three occasions, disclosing information about her partner's alcohol abuse and violence after drinking. While the mother attended with her children on the first occasion, on subsequent presentations the mother was alone, advising that she left her children at home or with neighbours. The youngest child was killed by the mother's partner while the mother was staying overnight at the refuge.
- Four families in our review were involved with early intervention services, including two families who were receiving assistance from Intensive Family Based Services in relation to significant risk issues.⁹⁹

Our reviews found that many non-government services identified and appropriately reported risk, and/or spoke with relevant FACS caseworkers about their concerns. However, in one case, two services working with a high-risk family informed statutory authorities that the family's needs were beyond their expertise and staff did not feel capable of addressing the family's significant and complex problems. In other cases, services experienced difficulties working with the families, including intermittent engagement by carers.

Keep Them Safe reforms have formalised and expanded the role of the non-government sector, particularly in relation to out-of-home care services, early intervention, and prevention programs. As a result of this expansion in the roles and responsibilities of the non-government sector, these agencies are increasingly working with families with complex needs, and where risks to children are high.

Involvement with education

Most of the children who died in familial abuse-related circumstances were younger than school age.

In the year before the child's death, just over one-quarter (20) of the 75 families had contact with schools, or were otherwise involved with education authorities. In almost all of these cases (17), the children who died or their siblings were, or had been, enrolled in government schools. Children in two of the families were undertaking their schooling at home supervised by parents, via either distance education or home schooling.¹⁰⁰ Children in three families were enrolled in Catholic schools.

In over half (14) of the 20 families, the children were attending school regularly and there was no recorded concerns about the child or their family. In four of these families, records indicated the children had additional or special needs, including behavioural problems, intellectual and/or learning difficulties, and physical disabilities.

In relation to six of the 20 families, our reviews identified a range of issues particularly relating to follow-up of non-attendance of children.

Chronic school non-attendance was identified as a significant issue in the work of the Special Commission of Inquiry into Child Protection Services in 2008. The Inquiry was in part a response to the death of a young child, 'Ebony'.

⁹⁹ Early intervention programs aim to support children's age-appropriate development before they become involved with the child protection system.

¹⁰⁰ While both distance education and home schooling enable a child to undertake their schooling at home, they are very different programs. Distance education is overseen by the NSW Department of Education and Communities, which has special provisions to deliver educational programs to students who are isolated or whose circumstances prevent them from attending school on a regular basis. Distance education is only available to students who meet eligibility criteria. Home schooling operates under the *Education Act 1990*. In this program, parents are accredited by the Board of Studies and accept responsibility for developing, implementing and evaluating their child's learning program, which must be approved by an Authorised Person from the Office of the Board of Studies.

CASE STUDY 3

In 2007, a seven-year-old child, 'Ebony', died as a result of chronic starvation and neglect. Ebony was not enrolled in school despite reaching the age when she was legally required to attend, and being offered a place in a school that could meet the child's support needs. Ebony's older siblings had a history of chronic absenteeism, poor basic skills, and they were failing to make any progress at school. Education staff made repeated unsuccessful attempts to engage the family, and identified concerns about the circumstances of the children, which were reported to child protection authorities. Action to commence prosecution in relation to non-enrolment and non-attendance did not proceed, and Ebony died two years later without having been sighted by any agency.

We investigated the actions of five government agencies in relation to her death, and the 2008 Special Commission of inquiry into Child Protection Services, drew from the findings and lessons of our work.¹⁰¹ In the course of the Inquiry, we proposed the need for legislative amendment to include 'habitual non school attendance' as grounds for a child protection report. Justice Wood's recommendations subsequently led to legislative change in January 2010.

Our review of the death of one child identified the need for a level of monitoring of children not engaged with schools. The child, who died in 2011, had failed to return to school in term four. When the parents did not respond to contact by the school, the family was referred to the Home School Liaison Officer (HSLO). The school subsequently learned that the child had been withdrawn from government schooling and was being educated at home. The child was not seen again by education staff prior to their death in abuse-related circumstances nearly a year later. Following action taken by our office in relation to this case, the Board of Studies reviewed its Home Education in NSW Information Package to, among other things, expand on the provisions for monitoring children and implementation of the curriculum.

5.6. Interagency responses

Information from a range of sources can provide a holistic picture of risk, through for example, information about the prior removal of children; breaches of undertakings relating to drug use; identifiable risks associated with mental ill-health; and prior unexplained or poorly explained injuries. Reviews have highlighted the need for improved collaborative and cooperative work between agencies and practitioners. In particular, we have identified matters in which multiple agencies were involved with the family, but there was poor communication and inadequate coordination between the agencies, and the absence of a holistic response to very significant child protection risks.

While legislative changes in 2010 have made it easier for agencies to exchange information to protect children,¹⁰² our reviews of the abuse-related deaths of children after that time have continued to identify matters in which critical information, including criminal histories, has not been sought to inform assessments and decisions about risk of harm.

Our reviews have also identified problems with:

- agencies' assessment of information
- the adequacy of the information provided by agencies when making reports of risk of significant harm, including not providing all relevant details
- agencies failing to recognise risk, and
- when risks begin to heighten, agencies failing to escalate matters within their own agency or with partner agencies.

101 Hon James Wood AO QC 2008, Report of the Special Commission of Inquiry into Child Protection services in NSW, p. 3.

102 Namely, the introduction of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.

Our child death reviews, and our related investigative and inquiry work, have consistently identified the need for improved practice across agencies, including Health, Education, FACS and Police/JIRT in their identification and assessment of risk to children. Our reviews identified the value in, and necessity of, agencies not only considering their own information holdings, but also in obtaining information from other agencies in assessing or responding to children at risk.

CASE STUDY 4

In 2007, a young child died from multiple intentionally inflicted injuries. The homicide occurred against a background of previous abuse by the perpetrator, the mother's partner of eight months.

The child was the subject of three reports of risk of harm in the eight months before the homicide; the reports related to extreme neglect, verbal abuse, parental drug use, overcrowding, physical harm, and medical neglect. One of the reports was made after the child presented to a hospital emergency department with facial bruising and swelling, a burn, and finger-mark bruising.

Our investigation – and related agency reviews – found that Health, FACS and NSWPF had failed to take adequate steps, both individually and collectively, to protect the child despite clear evidence of significant risks. We found that contributing to this failure were poor communication within and between agencies; poor planning; administrative failure; inadequate assessment and documentation; and inadequate analysis of relevant information.

The case highlighted the need to effectively implement the principle of shared responsibility between agencies in protecting children. It also illustrated the need for thorough risk assessment analysis from both an intra and interagency perspective, and for relevant agencies to ensure that they focus strongly on the experience of the child. Child protection challenges in this case included:

- inconsistent explanations for injuries, and the need for rigour in relation to decisions about the weight that should be attached to risk and other assessments by various agencies (for example, assessments by health services relating to the possible causes of injuries)
- potential risks associated with new partners, particularly when the new partner has a history of violence and other significant vulnerabilities are evident in the household environment
- difficulties in working effectively to strengthen family environments when clients are hostile and aggressive, and
- achieving efficient and effective collaborative practice in the context of families that require multi-agency involvement.

CASE STUDY 5

In 2011, a young child died as a result of blunt force trauma to the head, inflicted by the mother's de facto partner of less than eight months. The post mortem examination found that the child had received multiple beatings, causing bleeding of the brain.

Four days before the fatal event, the child had been taken to hospital with facial bruising, alleged to have been caused by falling onto the side of a bed. No other features of injury were noted, and the child was discharged home.

Several months before these events, the child and the child's siblings had been the subject of a risk of significant harm report to FACS. A JIRT investigation had commenced, examining the possibility of physical abuse and/or medical neglect.

Among other things, our investigation identified problems with the adequacy of FACS' actions to obtain and consider all relevant information to assess risk to the children, and poor interagency communication. We found that:

- JIRT FACS either failed to conduct a check of its own information holdings in relation to the de facto partner or failed to do so correctly. As a result, staff remained unaware that the partner had a significant history of being an alleged perpetrator and victim of sexual assault.

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- There was a breakdown in communication between JIRT FACS and JIRT Police such that the de facto partner's substantial criminal history (including violence offences, drug use and involvement with an alleged paedophile) remained unknown to caseworkers until after the child's death.
 - JIRT caseworkers failed to view a crime scene recording in order to inform their assessment of risk to a sibling, and did not take reasonable steps to engage with JIRT Police in relation to interviews with the mother and the de facto partner and/or failed to conduct their own interviews to gather highly relevant information for an assessment of risk to the sibling (including drug use and history of violence).

Following the death of the child in this case, Police established a central team, on a trial basis, to consider all referrals and to determine their suitability for a JIRT response. The JIRT Referral Unit has since been established on a permanent basis. However, this very important initiative does not address all of the complex systems challenges raised by this and many other cases.

Our review of the death of one child in 2013 clearly demonstrated ongoing and contemporary practice shortcomings in this area of work. We found that the family's situation was characterised by multiple episodes of domestic violence, with injuries to the mother and the child's siblings. Our review raised questions about the adequacy of interagency work in relation to domestic violence and risks to children, noting that:

- while agencies noted multiple instances of bruising and other injuries to the mother over a six-month period that they suspected may have been due to domestic violence, they did not at any time refer this information to police
- in relation to those incidents involving the family that resulted in a police response, police did not identify or report risks to the children in relation to domestic violence, and they did not undertake a welfare check on the children despite a request from FACS for them to do so, and
- reports made to FACS about the infant's siblings presenting with facial bruises and cuts, and their disclosure that they had been assaulted by their parents, were closed by FACS under competing priorities, and were not referred to the Joint Referral Unit or police.

Drawing on police information to ascertain risk

Around 60 per cent of reports of risk of significant harm to the Helpline indicate possible criminal behaviour, including domestic violence and physical abuse.¹⁰³ Police are therefore potentially well placed to gather information relevant to the assessment of a child's safety. In considering this issue, we examined the circumstances of 38 families where children died in abuse-related circumstances who had been reported to FACS in the three years before the death and had been in contact with police over the same period.

Of the 38 families who had been in contact with police and had been the subject of a report or risk of significant harm report to FACS:

- Records indicated opportunities for improved communication between NSWPF and FACS regarding the nature and/or level of risk to the children in 31 cases. This included, for example, where police held significant information relevant to risk in the family environment that was not provided to FACS.
- In two-thirds (25 families), records indicated opportunities to enhance the nature of the child protection response provided.¹⁰⁴ This included, for example, where FACS did not seek further information from police relevant to assessing risk in the family environment, where police held significant information.

103 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, p. 20.

104 We looked for opportunities to improve responses throughout the family's whole child protection history, not just in the circumstances surrounding the child's death.

We also examined the 38 cases in the context of opportunities to strengthen the initial intake and assessment process. In this regard, we sought to assess whether there might be substantial benefits in police officers being available at the point of initial assessment at the FACS Helpline. In reviewing the files in relation to this issue, we found:

- For 18 of 38 families, police held relevant information relating to child protection risks that was not accessed by FACS at the point of assessment at the Helpline. Availability of police officers to advise at intake would have facilitated exchange of risk-related information between agencies and/or the overall child protection responses.¹⁰⁵ Co-located FACS caseworkers and police officers at the Helpline could have enabled checks of the police system to be promptly conducted in appropriate cases, and FACS advised of highly relevant information relating to child protection risk assessments. In this regard, we found that the COPS database was frequently a source of information that was highly relevant to risks within the family environment.¹⁰⁶
- Helpline assessments involving both FACS caseworkers and police officers could have enabled timely and appropriate streaming of criminal child abuse matters to police for investigation. In overlooking this area of practice, we are aware of a number of criminal child abuse investigations that have either been compromised or made more challenging because relevant allegations of possible criminality have not been *promptly* received by the police.¹⁰⁷ This weakness in the system affects both the capacity to protect children as well as their right to an effective criminal justice response.
- We also found examples where co-located FACS caseworkers and police could have assisted in both identifying and driving systemic improvements as a direct consequence of their 'coalface' interface. For example, in some cases there was scope for improved police practice regarding welfare checks and domestic violence cases; in other cases, there were clear opportunities for improving the practice of government and non-government agencies through these agencies more actively seeking police support and/or information in circumstances where this would have enhanced the child protection response.

Under *Safe Home for Life* reforms, FACS has sought to increase the openness, flexibility and responsiveness of its intake system.

In light of this initiative, and the critical need to improve the child protection system's identification of, and response to, those children and their families where the child protection risks are most significant, consideration should be given to a more streamlined link to police information and support for certain high-risk child protection cases.

Themes and Issues

Over the past ten years, our work in reviewable child deaths has identified numerous practice and systems issues within agencies that needed to be addressed to better protect children and support vulnerable families.

In the main, agencies have acted to implement measures to address many of these concerns. Some challenges remain, and new challenges have emerged.

The following chapter discusses the main themes and issues arising from reviewable deaths in 2012 and 2013, and from our consideration of child abuse-related familial deaths since 2004.

105 In making this assessment, we assumed that the role that police at the Helpline would perform would include both assessment and practice support/development responsibilities.

106 For example, that children were being cared for by adults who had a history of violent offending.

107 In many of these, the report does not clearly indicate allegations that meet the JIRT criteria. These criteria are:

- severe or serious physical injuries to a child or young person that are (a) caused by another person 10 years or over, and (b) are suspicious and/or deliberate and/or inconsistent with the explanations provided
- sexual abuse, and
- neglect, where this is extreme enough to result in physical harm, and/or involves withholding of food or fluid sufficient to result in malnutrition and/or dehydration.

Chapter 6. Themes and issues

Following on from the issues identified above, this chapter discusses the main themes and issues from our consideration of familial abuse-related deaths of children since 2004, and arising from reviewable deaths in 2012 and 2013.

While the abuse-related deaths considered in this report span a decade, we have taken into account the substantial child protection reforms that have taken place over recent years, and have limited discussion to issues relevant to current practice and policy. In this context, significant themes have emerged, in particular:

- the need for practice improvement in critical child protection issues
- the important role of police in improving child protection responses
- the need to enhance the practice of shared responsibility and collaboration in responding to children at risk

This chapter considers each of these themes.

6.1. Practice improvement in critical child protection issues

Statutory response to children at risk of significant harm

While FACS has made some improvement in the proportion of reports of risk of significant harm that receive a face-to-face assessment, it is clear that the statutory child protection system is still struggling to meet the demands placed on it.^{108, 109}

The continuing challenge of responding to the high numbers of children at risk was reflected in our reviews of more recent deaths of children, including those reported as being at risk of significant harm.

More recent reviews of deaths in 2012 and 2013 identified that FACS had provided a response to many of the families for whom there had been ROSH reports, including child protection or Strengthening Families casework, JIRT investigation, and arranging the involvement of non-government intensive family-based services. However, our reviews raised questions about the adequacy and quality of the casework provided, and underscored the need to ensure that staff:

- conduct comprehensive and timely safety and risk assessments that lead to action being taken that is commensurate with the level of risk
- have effective collaborative relationships with key government and non-government partners that enhance both their identification and understanding of high risk families and the 'collective' response to these families
- undertake regular reviews to assess progress, the effectiveness of the intervention, and the potential need for alternative courses of action
- receive sufficient supervision and support, and seek and obtain expert advice when required.

Our 2014 report *Review of the NSW Child Protection System: Are things improving?* noted the work that FACS is undertaking to improve the quality of its practice and to measure its performance, including:

- implementing *Practice First*, a new casework practice model
- the work of the Office of the Senior Practitioner – including reforming and improving casework practice and systems, and providing expert advice and training to practitioners, and
- implementing a new Performance Reporting Framework and enhanced Quarterly Business Review process, including assessing CSC performance against a revised set of practice standards.¹¹⁰

Recommendations from *Review of the NSW Child Protection System: Are things improving?* are aimed at tracking the progress of FACS in relation to these initiatives, as well as other actions to improve quality and address practice shortcomings.

108 The face-to-face response rate to ROSH reports increased from 21% in 2010-2011 to 28% in 2012-2013.

109 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, p. 8.

110 Ibid.

Included in the recommendations is that FACS should enhance its capacity to record, and report on, the nature of responses being provided to all children the subject of reports of risk of significant harm, not just those that result in a face-to-face assessment by FACS. In making this recommendation, we recognised that it is critical to develop and measure the responsiveness of the whole service system – including the non-government sector – in meeting the needs of vulnerable children and their families.

We will continue to monitor FACS' actions to address this recommendation.

Response to carer alcohol and other drug abuse

Carer substance abuse is a substantial issue in many families with a child protection history. FACS data shows that concerns about drugs and alcohol often features in risk of significant harm reports. In 2012/13, carer drug and alcohol abuse was the primary reported issue in 8.3% of the 104,817 reports received by the Helpline – representing the fifth most common primary issue reported to FACS.¹¹¹ When considering *all* of the concerns raised in reports, over 17,000 reports (16.8%) included a concern about drug and alcohol abuse.¹¹²

Parental substance abuse was directly linked to familial abuse-related deaths within the family and to neglect-related deaths in 2012 and 2013. Our reviews identified the challenges in establishing effective intra and interagency strategies being employed with families, and the importance of ongoing reassessment of risks to children in the context of parental undertakings to engage with services.

CASE STUDY 6

A young child died in a motor vehicle incident in which the driver, the child's parent, was significantly impaired by an illicit substance. Toxicology results revealed a methamphetamine level that experts assessed was 'toxic to lethal', suggestive of chronic use, and significantly impairing the parent's driving ability.

At the time of the fatality, a FACS Strengthening Families caseworker had been working with the family for several months, following numerous reports of risk of significant harm associated with parental substance abuse and mental health issues, and the child's exposure to domestic violence. During FACS' assessment, the parent disclosed cannabis use and indicated that their partner, who shared the household and parenting responsibilities, had been abusing methamphetamines for at least a year.

Our review identified that, while FACS was aware of the risk factors associated with carer substance abuse, there was no indication that the agency had assessed the extent of the problem and its effect on parenting capacity. There was no evidence of the carers being referred to services to address the illicit drug use or to assist with relapse prevention. The safety plan included that the partner would not use methamphetamines and would make an appointment with a counsellor in relation to the drug use. However, there is no indication that FACS took steps to ensure that these plans were implemented.

While the parent agreed to engage with other services arranged by the Strengthening Families caseworker – including domestic violence support, child protection counselling and parenting support – their actual engagement was sporadic. The service providers informed FACS that the parent was difficult to contact and often did not keep appointments. The parent also appeared to avoid contact with the Strengthening Families caseworker. In the four months before the child's death, the caseworker saw the parent twice, but did not see the child.

'Strengthening Families' policy requires caseworkers to use assertive and proactive strategies to engage families when they start to withdraw from the program, and to reassess if the program is suitable. In this case, we found that the effectiveness of the program in reducing risk to the child did not appear to have been reviewed.

111 Department of Family and Community Services 2014, *Community Services Annual Statistical Report 2012/13*, p. 108.

112 *Ibid.*, p. 49.

Key agencies have acted to improve responses to risks to children in the context of parental substance abuse. In addition to major program changes discussed earlier in this report, FACS initiatives include establishing a Drug and Alcohol Expertise Unit (Clinical Issues Unit) to provide support and training to frontline staff.¹¹³ In 2012, the Unit developed a resource to support caseworkers in developing safety plans with families when mental health issues, drugs and alcohol misuse or domestic violence impacts on the safety of children and young people.

NSW Health has strengthened guidance for health workers on identifying and reporting risk of harm to children of patients receiving opioid treatment.¹¹⁴ NSW Health also funds Drugs in Pregnancy Services across NSW, which are designed to improve the management of substance use in pregnancy and to improve follow up services for families. NSW Health has advised that NSW Drug and Alcohol services are implementing new clinical processes and forms designed to improve the recognition of any risks to children, mandatory reporting and co-ordination of care between services.¹¹⁵

Recommendation 1

In relation to parental substance abuse, NSW Health should advise this office on the outcomes of new clinical processes and forms, in particular how these strategies have:

- a. improved the recognition of risks to children and impacted on mandatory reporting and**
- b. increased coordination of care between services.**

NSW Health should provide this advice by June 2016.

Support to children of parents with mental illness

Our reviews highlight the importance of ensuring that appropriate and timely mental health support is provided to carers and young people, and that, in relation to parents with mental illness:

- mental health services and general practitioners recognise the support needs of patients as parents, and the potential impact of the parent's mental ill-health on children
- the assessment of and response to risk takes into account the individual's parenting and family contexts, and consideration of their use of alcohol and other drugs
- parents and families are linked to necessary supports and services that include a strong 'child focus', and
- there is adequate communication across health services and private practitioners to enable the coordination of mental health supports and appropriate follow-up.

As noted in chapter 5, our previous report of reviewable child deaths recommended that the Ministry of Health implement strategies to assist the identification of and response to risks to children and support needs of parents with mental illness. Of particular relevance to the issues identified in our reviews is the identification by clinical staff of client's caring responsibilities, and any risk to or particular needs of children in that context.

113 The Drug and Alcohol Expertise Unit has expanded under *Keep Them Safe* to become the Clinical Issues Unit.

114 NSW Ombudsman 2011, *Report of Reviewable Deaths in 2008 and 2009 Volume 1: Child Deaths*, p. 42.

115 Correspondence from the Secretary, NSW Health to the Ombudsman, 14 April 2015, responding to a draft copy of this report.

In July 2013, NSW Health advised that appropriate clinical practice would be promoted through implementation of the NSW Mental Health Services Competencies Framework and additional refined workforce training. However, in April 2015, the Ministry told us that Health Workforce Australia was disbanded in 2014, and a competency document was not endorsed at any level of government, nor was it clear as to whether further national coordination would occur in the future.¹¹⁶ NSW Health noted that:

'NSW has incorporated Parental Status and/or other Carer Responsibilities into standardised routine assessment documentation for Mental Health Services and recently also into Drug and Alcohol assessment documentation.'

As part of the review of the *Mental Health Act 2007*, MH-Children and Young People recommended amendments to the legislation that would require adult mental health services to identify and support consumers who are parents and have responsibility for the care of children below the age of 18 years. In April 2015, the Ministry further advised that, in the consultation phase of the review of the *Mental Health Act 2007*:

An exhaustive stakeholder and expert consultation process did not accept this recommendation, and that routine mental health care in public mental health services already includes the identification and support of clients with parenting responsibility and their children. The recently revised mental health assessment forms used in practice and now also integrated in to the new community electronic records system added four (4) new additional fields related to parenting, to further assist clinicians supporting parenting roles in assessment and care planning.¹¹⁷

NSW Health is working to improve the recognition of, and response to, parents with mental illness and their families, and we note the high rate of compliance with key aspects of the SAFE START guidelines identified in recent evaluation (see *chapter 7*).

Recognising the advice of NSW Health relating to relevant documentation now seeking parental status and/or other carer responsibilities of consumers, in the absence of legislative requirements and a competency framework to assist clinicians, we recommend:

Recommendation 2

NSW Health should provide advice to this office as to the strategies that will be put in place to promote appropriate clinical practice and competency in relation to recognising and responding to any potential risk to children of parents with mental illness.

NSW Health should provide this advice by December 2016.

Identification of and response to children with suspicious physical injuries

One-quarter (21) of the 83 children who died in familial abuse-related circumstances had prior injuries that were known to practitioners before their death, including 14 children who presented to hospital or saw a general practitioner in relation to their injuries.

As most children and families have some contact with health services, frontline health services are in an important position to identify and provide initial assessment of the circumstances, safety, and wellbeing of children and/or their parents. This is particularly so where the nature of contact reflects some of the key risks to children in vulnerable families, including child injury and carer mental health and substance abuse.

¹¹⁶ Ibid.

¹¹⁷ NSW Health Secretary correspondence to the NSW Ombudsman, 14 April 2015, in response to a draft copy of this report.

Previous recommendation: Health internal review

In 2013, in response to the fatal assault of three children in incidents in 2010 and 2011 who had been presented to health services in the weeks or months prior to their deaths, we recommended that if a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility, the child's death should be the subject of internal review. The purpose of review would be to assess whether the interaction of the child and their family with the facility raises any systems issues that should inform future practice and service improvement at a local level and across the NSW health system.

NSW Health advised that it did not have current plans to implement an additional process for conducting internal reviews of serious injury cases and indicated a preference for conducting close internal reviews of relevant child death cases in partnership with this office. In addition in 2015, NSW Health advised of the establishment with the Clinical Excellence Commission of a Children and Young People Root Cause Analysis Review Sub Committee. It is expected that the new sub-committee will increase opportunities for close internal reviews by NSW Health of serious incidents involving child protection and domestic violence and family violence concerns.¹¹⁸

Further information in chapter 7 below, which details responses to previous recommendations.

Our reviews identified children who were the subject of repeated child protection reports about them presenting with physical injuries, including children who had multiple presentations to hospital with physical injuries before their death. Our work in relation to the abuse-related deaths of children has emphasised the importance of:

- practitioners and agencies recognising suspicious physical injury in children, and urgently bringing these matters to the attention of FACS
- practitioners and agencies ensuring that possible criminal child abuse matters, including physical abuse, are promptly reported to police, and
- FACS staff also recognising the significance of reports involving physical injury, and providing an appropriate and timely response to these reports, including ensuring that potential criminal child abuse matters are consistently referred to police.

There has been considerable work to strengthen cross-agency practice in relation to recognising and appropriately responding to the physical abuse of children, including:

- work to improve the health system's ability to identify and respond to child abuse or neglect, including:
 - release in April 2013 of the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* policy directive. The directive provides guidance for health practitioners on indicators of, and response to, child abuse and neglect
 - current trial of a Suspected Child Abuse and Neglect Medical Protocol for use by health practitioners involved in assessing children suspected of being physically abused or neglected, and
 - expansion of the existing Injury Assessment Screening tool in the statewide Paediatric Emergency Department Observation Chart, to increase the number of children that are mandatorily assessed in emergency departments for non-accidental injury.
- the establishment of the Joint Referral Unit – a central team that assesses referrals to JIRT.

Despite these initiatives, more needs to be done to ensure that suspicious physical injuries are identified as early as possible, and that prompt advice is then provided to police in order to protect the children involved, and to avoid prejudicing the criminal investigative process.

118 Correspondence from the Secretary, NSW Health to the Ombudsman, 14 April 2015, responding to a draft copy of this report.

In response to a draft copy of this report, NSW Health advised that it would conduct an audit of cases relevant to the agency in the reporting period, to determine which received a Root Cause Analysis (RCA) investigation. NSW Kids and Families will then review any associated RCAs. NSW Health noted that in future, such RCAs would be reviewed by a newly established Children and Young People RCA sub-committee, inclusive of multiple paediatric specialists.¹¹⁹

NSW Health also told us that the agency is working collaboratively with FACS to improve health services' identification of and response to protection concerns. In this context, Kids and Families is:

- working with FACS to review current processes around identifying and reporting medical neglect concerns
- developing a training and development plan for NSW Health in identifying and responding to domestic and family violence, sexual assault and child abuse and neglect
- working in collaboration with the Sydney Children's Hospitals Network and the Hunter New England Local Health District, to develop a State-wide 24-hour Child Abuse and Sexual Assault Clinical Advice Line to provide expert advice, escalate care and facilitate peer review for staff providing medical and forensic examinations to victims of child abuse and sexual assault. The advice line will commence operation in late 2015.¹²⁰

Recommendation 3

NSW Health should provide advice to this office regarding:

- 3.1 Outcomes of the NSW Kids and Families audit of Root Cause Analysis (RCA) investigations for relevant cases in the reporting period of this report, including:**
- 3.2 An update of the work of the Children and Young People RCA Review Sub Committee, particularly relating to:**
 - a. The number of cases involving identification of suspicious injury that have been subject to internal review**
 - b. Details of lessons learned**
 - c. Any recommendation made**
- 3.3 Details of progress in the implementation of, and any outcomes relating to, the State-wide 24-hour Child Abuse and Sexual Assault Clinical Advice Line**

NSW Health should provide this advice by December 2015.

Enhancing support to children living with domestic violence

Domestic violence is a persistent issue for many families. In 2012/13, over 19,000 reports to FACS (18.6%) included a concern about domestic violence.¹²¹ In 2012, NSWPF recorded 125,000 reports of domestic violence.

As discussed in previous chapters, domestic violence is also frequently identified as an issue in our reviews. It featured in almost half of the families involved in the abuse-related deaths of children over the 10 years to 2013, and was a notable issue in our reviews of the deaths of children in circumstances of abuse and neglect in 2012 and 2013. Our reviews also show that usually, at least one agency was aware of the existence of domestic violence, and that agency was often the police.

119 NSW Health correspondence to the Ombudsman, 14 April 2015, in response to a draft copy of this report.

120 NSW Health correspondence to the Ombudsman, 14 April 2015, in response to a draft copy of this report.

121 Department of Family and Community Services 2014, Community Services Annual Statistical Report 2012/13, p. 49.

Opportunities for improvement in practice arising from our work relate primarily to key agencies not adequately recognising the risks to children associated with domestic violence. In particular, over the past decade, including deaths in 2012 and 2013, we have identified the need for improvements in:

- considering the child protection implications of domestic violence, and recognising the significance and impact of the violence in their work with families
- reporting to FACS the risks to children associated with domestic violence (including when children may not be present at an incident, but police are aware the parties involved are parents), and
- reporting domestic violence to police.

Over the past decade, and following work by our office,¹²² there have been a number of changes to the way NSWPF and other agencies in NSW respond to domestic and family violence, including:

- the release of the Code of Practice for the NSWPF Response to Domestic and Family Violence
- a significantly expanded domestic and family violence team within NSWPF to better develop and monitor the capacity of police to respond to domestic violence; and a comprehensive review of domestic violence training for frontline police
- the funding for 35 additional officers to work in high-risk areas, with a particular focus on targeting repeat offenders; the introduction of a domestic violence prosecution specialist role within the NSWPF to develop and monitor good prosecution practices; and the rollout of domestic violence evidence kits for use by frontline police
- the establishment of a Domestic Violence Death Review Team
- legislative amendments to better protect children affected by domestic violence by requiring the court to include them as protected persons on Apprehended Domestic Violence Orders (ADVOs) where relevant
- amendment of Health's *Domestic Violence – Identifying and Responding* policy directive, which will make explicit that all cases of serious risk from domestic and family violence must be reported to police
- the development of two new Health Education and Training Institute (HETI) online modules, which will focus on identifying and responding to domestic violence in Emergency Departments and on Domestic Violence Routine Screening, and
- the development by the NSW Government of the *It Stops Here* framework, to improve the consistency and effectiveness of the system response to domestic and family violence, including the introduction of the *Domestic Violence Justice Strategy 2013-2017* (with legislative amendments enabling police to issue 'on the spot' ADVOs).

In its *Child Deaths 2012 Annual Report*, FACS reported on a review of its practices in responding to domestic violence reports. Among other things, the review identified the importance of incorporating knowledge about domestic violence dynamics and its effects in order to enhance FACS' risk assessment and intervention, and of recognising risks when multiple violent partners are a recurring dynamic. FACS noted key initiatives to support children and young people experiencing domestic and family violence, including:

- the *It Stops Here* whole-of-government reforms, including a common risk identification tool; central referral points; a statewide network of Local Coordination Points; Safety Action Meetings; and minimum practice standards to enable a consistent and appropriate level of response from mainstream and specialist domestic and family violence services for victims
- the Integrated Domestic and Family Violence Services Program – a multi-agency response that is meant to provide flexible, needs-based casework to people experiencing domestic and family violence, and
- the Domestic Violence Safety Planning training package developed by FACS' Clinical Issues Unit, which aims to improve caseworker skills and confidence to engage in holistic safety planning and risk assessment in families where there is domestic and family violence.¹²³

122 NSW Ombudsman 2006, *Audit of NSW Police Force handling of domestic violence and family violence complaints* A Special Report to parliament under section 161 of the *Police Act 1990* May 2011.

123 Family and Community Services 2013, *Community Services Child Deaths 2012 Annual Report*.

While one of the stated aims of the *It Stops Here* reforms is to ‘seek to ensure better integration between new domestic and family violence referral pathways and those in the child protection system’,¹²⁴ the precise mechanisms by which this will be achieved are not yet clear. As they currently stand, the questions in the Domestic Violence Safety Assessment Tool (DVSAT) are primarily aimed at identifying risk to the safety of the primary adult victim of a domestic violence incident. In contrast, tools used in other jurisdictions, including South Australia and parts of the UK, include more specific questions aimed at identifying risks to children.

In response to a draft copy of this report, the NSWPF advised that the DVSAT now requires police to physically sight any child present at a domestic violence incident to ensure their safety, and to assess their level of threat. The response noted that in September 2014, the DVSAT was launched at five Local Area Commands (LACs).¹²⁵ A further four commands will be included from July 2015, and all police are to be trained in DVSAT by 30 June 2015.¹²⁶ Police also noted that Safety Action Meetings have been launched in the five LACs using the DVSAT, and that ‘through the implementation of Safety Action Meetings, it has been recognised that targeted information-sharing between service providers is key to providing the most coordinated, timely and effective support to victims assessed as being at ‘serious threat’ using the DVSAT’.¹²⁷

FACS and NSWPF have acknowledged that more work is required at a local level to ensure that CSCs and LACs are systematically exchanging risk-related information about high risk domestic violence offenders. Over the past year, FACS and NSWPF have been working together to develop criteria for identifying serious violent offenders on KiDS to better inform child protection assessments. We have recommended that this work result in the implementation of an effective system for defining, identifying and providing to FACS information about serious violent offenders when such information is relevant to risk of harm assessments and related child protection casework.

We have also recommended that FACS and NSWPF should jointly assess whether certain designated police positions should have direct access to the KiDS system, in order to enable police to quickly access child protection information held by FACS at the time when police are responding to incidents – including many domestic violence incidents – that may involve serious risks to children. We have previously noted that providing designated police with access to the KiDS system would ‘not only assist in identifying children in the home, it would also provide Police with relevant child protection information associated with household members. However, it needs to be recognised that providing police with direct access to the KiDS system would require legislative change.’¹²⁸

Recommendation 4

FACS, in consultation with NSWPF, should develop parameters for, and pursue relevant legislative change to enable, designated police officers to have direct access to the KiDS system. The purpose of police access should be to enhance the capacity of police, in the conduct of their normal duties, to assess, and respond to, risk to children.

124 NSW Government, *It Stops Here: The NSW Government’s Domestic and Family Violence Framework for Reform*, February 2014, p. 23.

125 The five commands are Canobolas, Eastern Beaches, Eastern Suburbs, Rose Bay and Botany Bay.

126 The four commands are Bankstown, Parramatta, Broken Hill and Tweed/Byron.

127 Correspondence from the Commissioner of Police to the NSW Ombudsman, 1 April 2015, in response to a draft copy of this report.

128 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* April 2014, p. 21.

Identification and assessment of risk presented by new partners

As noted above, male intimate partners who had formed a relatively new relationship with a birth parent (less than 12 months) represented almost one-third (27) of all 94 persons of interest.

FACS developed the 'New Partners and New Household Members' practice tool in June 2012, to support caseworkers in assessing the safety of children when the composition of adult family members changes.¹²⁹ The tool encompasses adults who have 'significant (regular and/or frequent) in-home contact' with children, including those in a familial or intimate relationship with any person in the home. However, our reviews of familial abuse-related child deaths that have occurred since the tool was introduced have not identified the tool being used to inform casework practice and assessment, or adequate consideration of the risks presented by the new partners.

FACS has noted in correspondence to this office that the practice tool was made available on the Casework Practice site in August 2012, that a number of strategies were used to communicate the availability of the tool to staff, and that promotion of the tool was ongoing. FACS noted that it was difficult to separate and evaluate the use of the tool from other guidance available to staff. With this in mind, FACS advised it was not intended that the tool be formally evaluated.¹³⁰

In the context of the significant number of new partners identified as persons of interest in reviews of familial abuse-related deaths over the decade to 2013:

Recommendation 5

FACS should audit or review the use of the New Partners and New Household Members practice tool and identify strategies to further promote the need to consider new partners in assessing risks to children.

Response to non-attendance at school

The abuse-related deaths of children highlighted the importance of identifying educational neglect as a child protection risk factor. Addressing educational neglect must include action to follow-up on non-attendance at school, and appropriate checks on children receiving home-schooling or distance education.

The Department of Education and Communities (DEC) and other agencies have taken action to identify and respond to educational neglect. Additional strategies advised to us by the DEC include:

- Establishing a child protection team in the Department to bring together the agency's child protection policy, school attendance and out-of-home care units, and working with other agencies to develop an online resource to improve the awareness of, and response to, educational neglect.
- Piloting and evaluation of new collaborative early intervention approaches to students at risk of educational neglect. Education and Communities has advised that independent evaluation findings confirm the value of schools working collaboratively with local service providers to respond to poor school attendance.¹³¹
- Implementing the *Connected Communities* strategy in 10 communities (involving 15 schools).¹³²

129 NSW Family & Community Services Practice Tool, *New Partners and New Household Members*, Community Services, June 2012.

130 Correspondence from FACS in response to recommendations made in our investigation report relating to the familial abuse related death of a child, 14 August 2012.

131 Correspondence from the Executive Director Education and Communities, 30 March 2015, responding to a draft copy of this report.

132 NSW Ombudsman (April 2014), *Review of the NSW Child Protection System: Are things improving?*, pp. 21-22.

In relation to home schooling, in December 2014, the NSW Legislative Council's Select Committee on Home Schooling issued the final report from its Inquiry into home schooling, which included consideration of the regulatory framework for home schooling and the potential benefits or impediments to children's safety, welfare and wellbeing; and support issues for home schooling families. The recommendations include that FACS should review its policies and systems, with the objective of identifying and improving the collection and reporting of data related to child protection matters within the home schooling population.

While acknowledging the value of this work, significantly more needs to be done to respond effectively to educational neglect. It is notable that children who are the subject of a risk of significant harm report relating to educational neglect are among those least likely to receive a response from the statutory child protection system.¹³³

We have previously recommended that FACS should develop and implement interagency operational frameworks to, among other things, deliver a more effective and integrated response in the area of educational neglect. FACS has, however, noted that *Safe Home for Life* will not seek to establish a specific strategy or response to educational neglect, but that '*...district-led service co-design provides a framework and approach to support the development of local service responses and innovation to this issue as required*'.¹³⁴

Noting the importance of responses that reflect local needs, over time, addressing such a significant issue will require an over-arching state-wide framework. The outcomes of co-design initiatives will be instrumental to the development of such a framework.

Recommendation 6

FACS should provide advice to this office on the progress of district led co-design initiatives directed to educational neglect, including:

- a. the outcomes of any district implemented strategies
- b. the implication of such initiatives for a state-wide operational framework for educational neglect

FACS should provide this advice by June 2016.

Enhancing child protection responses in Western NSW

As noted in our review of familial abuse-related child deaths, of those families residing in regional and remote areas (29), one-third (10) resided in West and Far Western NSW. In the decade to 2013, Western NSW was the equal leading location of residence of the Aboriginal children whose deaths were reviewable.¹³⁵

Over an 11-year period, CSCs located in Western NSW have also accounted for approximately one-third of the more than 40 formal investigations and inquiries we have conducted arising from child deaths involving FACS' handling of cases.

133 NSW Ombudsman (April 2014), *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, pp. 21-22. We noted that in 2012-2013, only 11% of educational neglect ROSH reports received a face-to-face response from a FACS caseworker.

134 Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

135 Almost half (34) of the 70 Aboriginal children whose deaths in 2004-2013 were reviewable resided in Western NSW (17) or Hunter New England (17) districts.

Our investigations and reviews of the deaths of four Aboriginal children over a two-year period,¹³⁶ including two children in 2012, identified ongoing systemic problems in the region, involving the recruitment and retention of skilled staff; the quality of child protection practice; and inadequate professional supervision and support.

We stated that a new approach is required to address the longstanding issues that adversely affect the child protection response in Western NSW. There are a broad range of services currently operating in Far West NSW, and each of these services has a brief to respond to particularly vulnerable children and their families, including where there is a significant risk of abuse. In our advice to FACS about long standing issues in Western NSW, we indicated that staffing and resource problems in high-need rural and remote locations warranted serious consideration of how best to aggregate already available services to provide a solid and timely response.

In response to our concerns, FACS has detailed a range of actions it is taking to address the primary issues of capacity, quality, and relationships with communities.

Key actions include:

- filling an additional 20 positions in the district
- establishing a mobile child protection unit staffed by skilled, experienced caseworkers outreaching to the upper western sector
- development of a protocol between FACS and Aboriginal community groups to achieve '*better outcomes in the placement of Aboriginal children in OOHC*'
- delivering leadership and family conferencing training for staff
- involvement in key strategies in communities, including the Bourke Community Hub, Murdi Paaki Regional Assembly on the Local Decision making Accord, and the Interagency Case Coordination Committee in Bourke.¹³⁷

FACS indicated that it is working towards reducing the risk that poor practice will continue. This work includes strengthening qualitative analysis of the data for Western NSW.

The department will be assisted in this work through its implementation of a new Performance Reporting Framework and enhanced Quarterly Business Review process.

While these initiatives by FACS are encouraging, we believe that more needs to be done to strengthen the overall service system in Western NSW, so that these communities receive a return on existing investment. Our discussion below on place-based service delivery is relevant to this issue.

Recommendation 7

FACS should continue to report to this office on a regular basis regarding initiatives to improve practice in the Western Region, and outcomes achieved.

¹³⁶ September 2010 to October 2012. We raised similar concerns again in NSW Ombudsman (April 2014), *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, p. 11.

¹³⁷ Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

Improving foster and relative/kinship carer assessment and support

Inadequate foster and relative/kinship carer assessment and support was evident in a number of reviews conducted for children who died in 2012 and 2013.

Our office has been concerned for some time about variable standards of probity screening for foster carers, including the information foster care agencies obtain to inform this assessment.

Against this background, we have conducted a number of investigations into this issue and have worked with the Children's Guardian in developing a robust policy, practice and legislative framework for carer screening and the implementation of a carers register. The register will provide agencies with information about a potential carer's previous care history and guide agencies through the carer assessment process. In future, carer applicants will not be able to be authorised unless they pass the required checks in the carers register.

In November 2014, the NSW Auditor-General reported that FACS is not meeting its statutory requirement to complete annual placement reviews for all children in statutory out-of-home care, with almost half (46%) of the 2,070 children cased managed by FACS in 2012-13 not having had a placement review completed in the 12 months to 5 July 2014.¹³⁸

The purpose of a regular placement review is to determine whether a child's safety, welfare and wellbeing are being promoted by the placement. The Auditor-General's report points out that without proper review, FACS may not be able to ensure that a child's needs are met. The Auditor-General recommended that FACS should meet its statutory requirement of undertaking annual placement reviews by 30 June 2015.

We note that this issue will continue to be monitored by the Auditor-General.

6.2. Working with police for improved child protection responses

Working with police in identifying and responding to high-risk cases

Through our reviews, we have identified opportunities for FACS and other key agencies to work more effectively with NSWPF in protecting children. Recent research commissioned by this office has identified that Victoria, Queensland, various parts of the United Kingdom, and Canada have all recently trialled or piloted initiatives which involved child protection services working more closely with police. Most of these initiatives included efforts to bring together data held by child protection and police to improve intake assessment and triage decisions.¹³⁹

Targeted investment in police resourcing can deliver significant child protection results:

CASE STUDY 7

Enhancing the capacity of the Joint Investigation Response Team

In our December 2012 report to Parliament on *Responding to Child Sexual Abuse in Aboriginal Communities*, we recommended that the JIRT partner agencies review the adequacy of the resourcing allocated to the JIRT program, given the significant increase in referrals to the program over recent years.¹⁴⁰ A review conducted by the Child Abuse Squad (CAS) – the policing arm of the JIRT – resulted in an additional 30 staff being allocated to the CAS in May 2013.¹⁴¹

138 Audit Office of New South Wales, NSW Auditor-General's Report to Parliament Volume Nine 2014 focusing on Family and Community Services, page 34.

139 Ernst and Young 2015, *Intelligence driven child protection and place based planning initiatives*. Unpublished, NSW Ombudsman. The report will be made available on the Ombudsman website: www.ombo.nsw.gov.au.

140 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993*, December 2012, chapter 9.

141 27 of these positions were filled between May and December 2013 – the remaining three positions were filled in January, February and August 2014. Information provided by the NSW Police Force, 20 January 2015.

The impact of these additional resources has been significant. During 2014, the number of interviews conducted by the CAS was more than 50% higher than the number conducted in 2012,¹⁴² and by 3 December 2014 the CAS had made 733 arrests during the calendar year, compared to 455 in 2012 – an increase of more than 60%.¹⁴³

The review of FACS' JIRT resourcing – undertaken in response to our report – led to an extra 10 caseworker positions being allocated in 2014.

In March 2015, the NSW government announced an additional 50 investigators and four specialist intelligence and support staff to be allocated to the police Child Abuse Squad.

While it is pleasing to see the outcomes achieved from the additional resourcing, it needs to be recognised that the further resourcing burdens on all JIRT partner agencies – which are inextricably linked with these impressive results – will need to be carefully assessed.

The relationship between child protection concerns and matters of a potentially criminal nature is clear from our 10-year review of familial abuse-related deaths, which found that over half of the persons of interest in these deaths were known to police as perpetrators of violence prior to the child's death. Of those, the majority were classified as serious violent offenders. This illustrates why police holdings are a potentially valuable source of information for identifying particularly vulnerable or at-risk children.

CASE STUDY 8

Multiple ROSH reports were made about a young child who died in 2012, including three reports of risk of significant harm in the two months before the child's death, relating to recurring physical injuries that had not been adequately explained. While the reports were repeatedly discussed and assessed by the FACS Community Service Centre, they did not result in contact with the child or the family. The capacity of the CSC to respond to the risks for this child was affected by other high-risk cases, and broader problems with the triage and assessment process.

Our investigation of this case found that the reports of physical harm and injury to the child required an urgent response and that assistance should have been sought from local police to check on the child's welfare, and to investigate the possible commission of serious criminal child abuse. We also identified that the CSC did not seek information from police about whether significant people involved with the child had relevant criminal histories.

The relationship between the police and child protection systems is also demonstrated by FACS data. The table below shows that primary reported issues involving a potentially criminal act (physical abuse, sexual abuse, domestic violence and drug/alcohol use by carer) constituted a substantial proportion of all reports screened in at the Helpline in 2012-2013.

142 This was despite a fall of around 1% in the number of cases managed by the CAS over the same time period.

143 Information provided by the NSW Police Force, 20 January 2015.

Table 12: ROSH reports screened in at the Helpline, 2012-13, by primary reported issue

| | No. | % |
|---|----------------|------------|
| Physical Abuse | 23,878 | 22.8 |
| Neglect | 22,442 | 21.4 |
| Sexual Abuse | 16,376 | 15.6 |
| Domestic Violence | 14,260 | 13.6 |
| Drug/Alcohol Use by Carer | 8,706 | 8.3 |
| Emotional Abuse | 5,758 | 5.5 |
| Carer: Mental Health | 3,827 | 3.7 |
| Child Inappropriate Sexual Behaviour | 2,397 | 2.3 |
| Prenatal report | 2,317 | 2.2 |
| Suicide Risk for Child | 2,019 | 1.9 |
| Drug/Alcohol Use by Child or Young Person | 1,638 | 1.6 |
| Carer: Other Issues | 529 | 0.5 |
| Runaway Child | 422 | 0.4 |
| No Risk of Harm | 148 | 0.1 |
| Other | 100 | 0.1 |
| Total | 104,817 | 100 |

Source: Department of Family and Community Services 2014, Community Services Annual Statistical Report 2012/13, p. 108.

As detailed in chapter 5, our reviews identified the potential for substantial benefit in having police officers co-located at the FACS Helpline.

In response to a draft copy of this report, FACS advised that the agency had developed a project proposal to:

*'provide preliminary evidence on the likely impact and viability of co-location of Police officers at the Child Protection Helpline and reporting to NSW Police Force of all allegations of potential criminal matters received by Helpline.'*¹⁴⁴

Enhancing police support in relation to welfare checks

Our reviews of the deaths of children in circumstances of abuse and neglect in 2012 and 2013 identified concerns about welfare checks on children conducted by police.

We have previously identified scope for police to improve the way that they conduct welfare checks, noting considerable variation in both the quality of the information obtained by police and the subsequent response. We recommended that FACS and NSWPF should work together to, among other things, develop improved guidance and related support to police in relation to their role in conducting child welfare checks.¹⁴⁵

As noted above in relation to domestic violence, FACS' commitment to include additional questions in the risk of significant harm reporting tool used by police should assist in this regard. Our recommendations relating to the potential for police to have direct access to the KiDS system are also relevant to improving practice in this area.

¹⁴⁴ Correspondence from the FACS Secretary to the NSW Ombudsman in response to a draft of this report, 26 March 2015.

¹⁴⁵ NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014.

Noting that reports of risk of significant harm indicating that a child has been subject to serious abuse may not reach the threshold for referral to Joint Investigation Response Teams, or may not be accepted by JIRT:

Recommendation 8

FACS and police should continue to work collaboratively to develop a plan for police officers to be located at the FACS Helpline, or to be made available to the Helpline. The role of Helpline associated police would be to:

- a. provide advice to inform FACS' assessment of, and response to, relevant reports of children at risk of significant harm,
 - b. to assess whether allegations contained in reports warrant a police response, and
 - c. in appropriate cases, play an active role in liaising with police commands to improve the effectiveness of responses to welfare checks and other requests for assistance.
-

Referral of relevant criminal matters to police

Our reviews of familial abuse-related deaths of children in the decade to 2013 have pointed to the need to improve both the identification of suspicious physical injuries to children, and the reporting of criminal child abuse matters to police. These issues have also featured in our reviews of the abuse and neglect-related deaths of children in 2012 and 2013.

Since 2009, we have conducted a number of investigations into the handling of matters where FACS failed to notify police of child abuse of a criminal nature. In this context:

- In January 2014, the agency told us that, following a trial of a revised policy on the reporting of criminal allegations to police at three CSCs, it was developing clearer procedures to guide frontline staff on when and how to refer relevant criminal allegations to police.
- On 29 September 2014, FACS advised that it had commenced work with NSWPF to develop an electronic criminal reporting system between the two agencies. FACS has indicated that an interim strategy is being developed while a longer term IT system is resolved, and practice advice and a communication strategy was released to all staff via an internal message in mid-August 2014.
- Most recently, on 24 November 2014, FACS further advised that it had developed an interim casework practice procedure to inform the referral of serious indictable matters to police.

In response to a draft copy of this report, the NSWPF noted that a process was trialled whereby FACS would report all serious crime to PoliceLink, the NSWPF's multi media contact centre, rather than to the relevant LAC. The process was '*suspended due to FACS withholding informant details from the information.*' Police advised that as at April 2015, the trial was being conducted by the Child Abuse Squad '*where all reports of non-urgent, serious, indictable crime are accepted, regardless of whether informant details are included.*'¹⁴⁶

¹⁴⁶ Correspondence from the Commissioner of Police to the NSW Ombudsman, 1 April 2015, in response to a draft copy of this report. PoliceLink incorporates the Police Assistance Line, Triple Zero, Child Wellbeing Unit, and Crime Stoppers.

Current FACS policy is that *'FACS staff should make a report to the Police if information is received in the course of your duties that lead you to know, or believe that a serious indictable offence has been committed.'*¹⁴⁷ The Crimes Act defines a serious indictable offence as an indictable offence that is punishable by imprisonment for life or for a term of 5 years or more.

In a recent investigation, we noted that a focus principally on serious indictable offences will not adequately address the child protection risks associated with violence perpetrated on children.¹⁴⁸ We recommended that allegations of physical abuse committed against a child should be provided to police unless FACS has compelling evidence on hand which demonstrates that the level of physical force was either lawful or trivial or negligible. This was on the basis that:

- the threshold of serious indictable offence would not provide adequate protection for children and was too high a threshold for reporting a matter to police, and
- child protection workers would not have the necessary information or legal skills to make a judgment as to whether an allegation may involve a serious indictable offence.

Close and collaborative work between FACS and NSWPF is a critical component of an effective child protection response. It is also essential that other agencies and private practitioners also report criminal matters to police. This aspect of the child protection system should be recalibrated to ensure that alleged criminal abuse of children receives an appropriate police response.

Recommendation 9

FACS and NSWPF should jointly develop guidance on the factors that should trigger referral of reports for police review and advice.

Recommendation 10

FACS policy and practice should be revised to provide clear guidance to FACS staff about information that should be referred to police. The policy should reflect an integrated approach by FACS, JIRT and NSWPF and should clearly identify what matters are not reportable to JIRT but should be referred to police.

¹⁴⁷ Procedure: Serious events (critical, reportable and emergency).

¹⁴⁸ We note that FACS' interim casework practice procedure also recognises other kinds of matters that should be referred to police, but we consider that further work on clarifying these matters is required. In particular, while the procedure attached to the correspondence notes that 'any assault causing injury to a child or young person should be reported', this advice is contained in a section about serious indictable offences. Furthermore, it needs to be recognised that in many cases, reports to FACS will not contain sufficient particulars to enable FACS caseworkers to ascertain whether there has been an assault and/or physical injuries to a child. In addition, the procedure fails to draw a strong link between reporting matters to police and the protection of children; instead, it is largely concerned with the reporting of crimes per se.

6.3. Enhancing shared responsibility

Shared responsibility and collaborative practice to better identify and respond to significant risks

There is a growing recognition that effectively identifying and responding to the needs of high risk families requires sophisticated and collaborative service practices, and a service system that drives such practices. Children and families with complex or high needs are a group for whom there is a particularly clear need for an effective collaboration framework.¹⁴⁹

The evaluation of *Keep Them Safe* noted that while there are 'promising signs' of shared responsibility for child protection and early intervention, stakeholders reported continuing challenges and significant bureaucratic delays in relation to information sharing.¹⁵⁰

Notably, initiatives in other jurisdictions identified by recently commissioned research referred to above were multi-agency in approach, involving health services, education providers and community groups as well as community services and police.

Embedding the practice of shared responsibility aligns with other major reform challenges such as progressing truly collaborative practice, building strong information exchange practices and intelligence driven child protection, and developing service systems within local communities that are efficient and provide a strong return on investment.

It is important to recognise that not all of the abuse-related deaths we reviewed involved families that were known to agencies, and those that had contact with agencies did not necessarily give agencies cause for concern. However, our reviews have consistently identified cases where a number of agencies held information about specific and substantial risks to children that was not effectively communicated to other relevant agencies.

Our reviews identified that police and health providers had the greatest contact with the families of children who died in familial abuse-related circumstances. Reviews have also identified cases in which multiple agencies were involved with the family, but there was poor communication and inadequate coordination between the agencies, and the absence of a holistic response to very significant child protection risks.

In response to a review in 2012 of the fatal assault of a young child that highlighted issues in the joint work of FACS and an Intensive Family Based Service, FACS developed a practice paper for frontline practitioners and key partner agencies.¹⁵¹ The themes identified by FACS as important to the achievement of effective collaborative practice include a shared focus on the experience of the children, and a shared understanding about the nature of the risk of harm to the children; agreement about the changes required of the parent/carer to provide greater safety; and quality formal and informal communication and information exchange.

The importance of collaborative practice was underscored in the findings of a coronial inquest in 2014 into the death of a child that was associated with medical neglect. The Coroner found that 'the shared approach to child wellbeing was specifically relevant' in this matter, noting that the risks to the young person could not have been effectively managed without joint child protection and health service intervention. The inquest found that intervention did not occur for a number of reasons including:

149 NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities A report under Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, December 2012 Recommendation 64.

150 Cassells R, Cortis N, Duncan A, Eastman C, Gao G, Giuntoli, G, Katz I, Keegan M, Macvean M, Mavisakalyan A, Shlonsky A, Skattebol, J, Smyth C and valentine k (2014), *Keep Them Safe Outcomes Evaluation Final Report*, Sydney: NSW Department of Premier and Cabinet, p. 10.

151 Department of Family and Community Services (September 2014) *Achieving effective collaborative practice with high risk families*.

*'lack of communication between Health and CS, a lack of understanding by health staff of CS processes, a lack of understanding by CS staff of [the child's] medical condition due to inadequate records and a failure to share and seek appropriate information so the full risks to [the child] were not properly identified and followed up.'*¹⁵²

We have previously noted that various attempts to 'create more holistic responses to high-needs children and their families' in NSW had not generally produced lasting results, because they were '*not embedded within a broader interagency framework to identify, and respond to, the needs of vulnerable children and families across the continuum of need.*'¹⁵³ We identified the need for a coherent framework that ensures integrated case management initiatives are informed by the core components of successful collaborative practice, including:

- a clear and practical commitment to collaboration
- an agreed definition of the problem and the proposed solution
- a joint design and robust ongoing review processes
- strong governance processes to drive implementation, including but not limited to the technical skills to obtain evidence regarding implementation 'success' and the outcomes achieved, and
- collective responsibility for delivering results.

In the absence of an overarching framework, the system will continue to be characterised by a piecemeal response to children and young people at risk of significant harm. In this regard, we will closely monitor:

- The 'integrated approach to early intervention and prevention for vulnerable children' FACS has advised us it is working on.
- The strategy being proposed between NSW Kids and Families and FACS to transfer cases reported to the Helpline by health workers that do not meet the statutory reporting threshold to the Health Child Wellbeing Unit. The strategy would see the Wellbeing Unit working directly with health workers to coordinate the provision of support to families, to close the loop on cases that would otherwise not have received a response.¹⁵⁴
- Moves to expand access to the Health Child Wellbeing Units to general practitioners and practice nurses across NSW. Proposed legislative amendments would extend information sharing provisions under Chapter 16A to all registered medical practitioners, and allow them access to the Health Child Wellbeing Units under 'alternative reporting arrangements (section 27A of the *Children and Young Persons (Care and Protection) Act 1988*).

Recommendation 11

NSW Kids and Families and FACS should implement as a priority the proposed strategy to transfer cases reported to the Helpline by health workers that do not meet the statutory reporting threshold to the Health Child Wellbeing Unit, in order for the Wellbeing Unit to work directly with health workers to coordinate the provision of support to families.

Recommendation 12

Legislation to extend access to the Health Child Wellbeing Unit and the extension of information sharing provisions under Chapter 16A to all registered medical practitioners be pursued by NSW Health and FACS as a priority.

¹⁵² State Coroner's Court of NSW 2014, Inquest into the death of AA.

¹⁵³ NSW Ombudsman (April 2014), *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, pp. 24-5.

¹⁵⁴ NSW Health Secretary correspondence to the Ombudsman, 14 April 2015, in response to a draft copy of this report.

Proactive information exchange practices and intelligence-driven child protection

We have previously noted that effective, collaborative interagency practice is an important part of building a robust, intelligence-based system that promotes identifying, analysing, prioritising and acting on information held by agencies involved in child protection.¹⁵⁵

In April 2014, we noted a number of developments towards improved reporting tools to assist in making available critical information relevant to child protection risks, in particular, FACS and NSWPF exploring ways to identify and flag serious violent offenders on the police database. Under this proposal, *'any child risk assessment undertaken by police involving an SVO could potentially lead to an automatic notification to FACS within 24 hours, together with advice that the individual is an SVO and the provision of relevant criminal antecedents.'* In addition, there would be scope for Child Wellbeing Units and FACS to check with police on receipt of a child at risk report whether a person has been flagged as a serious violent offender and, if so, request relevant details.

In September 2014 FACS advised us of improvements to KiDS to enhance records and relationships searching, including information relating to persons of interest and persons causing harm.¹⁵⁶ The enhancements will enable caseworkers to search for a person, identify any person that is alleged/caused harm to a child, view all children that the individual caused harm to, and identify patterns of allegations of harm. Further enhancements include prompts to finalise recording information in KiDS relating to a person causing harm and alerts if a person is added as a person of interest or person causing harm and they are also listed as, or apply to become, a carer. FACS has indicated that the changes will be supported by the development of a formal policy on persons of interest and practice procedures.¹⁵⁷

FACS also told us that NSWPF has now provided data on serious violent offenders to the department, and this information was being evaluated to determine its usefulness in child protection decision-making at the Helpline and local CSCs.¹⁵⁸

While these are important initiatives, there is considerable scope for better identification of, and response to, those children and families most at risk, through sophisticated IT tools to retrieve and allow critical analysis of multi-agency holdings combined with effective collaborative multi-agency practice.

An effective intelligence system requires a number of elements. As we have previously noted:

[...] an effective intelligence system would require key agencies to work together in systematically identifying, making readily available (through IT solutions and/or other strategies), analysing, prioritising; and acting on the information that is held by these agencies which best identifies potentially extreme levels of child protection risks.

While in some cases a single information holding may justify determining that an extreme risk exists, an effective intelligence system would also involve analysing aggregated data from key agencies. Electronic reporting tools will often be the best means by which aggregated data of this kind can be made available. However, even with sophisticated reporting tools, there needs to be clear business rules, and careful analysis of information, to ensure successful intelligence driven practice.¹⁵⁹

155 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014.

156 Advice from the Secretary FACS to the Ombudsman, 29 September 2014.

157 Ibid.

158 FACS advised that the evaluation would include 'analysis of volume, whether information about serious violent offenders would have come earlier in the life-cycle of statutory assessment and intervention, and the likelihood that a different decision to protect the child would have been made if serious violent offender information had been available.' FACS has advised that, depending on the outcome of the analysis, it will consider incorporating serious violent offender information into structured decision-making tools, and investigate the introduction of an alert system. Advice from the Secretary FACS to the Deputy Ombudsman, 15 September 2014.

159 NSW Ombudsman 2011, *Keep Them Safe?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* August 2011, p.12.

Recent research commissioned by this office notes that initiatives in various parts of the United Kingdom, and also in NSW and Victoria, involve the combination of child protection authorities' holdings with those of other agencies to improve the identification and assessment of vulnerable families. In relation to these initiatives, IT supported small, co-located multidisciplinary teams, which were responsible for identifying the family's needs and ensuring a coordinated suite of appropriate service responses.¹⁶⁰

Place-based service delivery

As an integral part of improving the identification of, and response to, high risk families, we have emphasised efficient and effective place-based models of service planning, funding and delivery, especially in relation to vulnerable communities.¹⁶¹

In particular, this should involve:

- a cohesive approach to local decision making by federal, state and local government agencies, key non-government agencies and community representatives¹⁶²
- relying on evidence to identify need and to determine priority areas for funding, as part of an ongoing 'whole of community' service planning and mapping exercise
- funding services in a coordinated manner based on the priority areas that have been identified (and according to a rigorous procurement process that assesses the capacity of individual services to deliver), and
- ensuring that the level and nature of services that are provided by funded agencies are tracked, and the related outcomes are monitored.

Also of vital importance are strategies to engage with, and indeed build the capacity of, the local community when undertaking place-based work.¹⁶³ A number of the organisations working in NSW on place-based, collective impact initiatives have recognised the critical need for whole of community engagement.¹⁶⁴

Local planning and service delivery are recognised important contributors to successful child protection responses. There are various reasons why a local focus is important, including differences between areas in relation to the demographic characteristics and vulnerabilities of the client population, and differences in the configuration of the local service system. Key success factors include developing clear, relevant, shared goals and measures; ensuring that government agencies and other large organisations adopt funding and governance arrangements that are sufficiently flexible to support these local initiatives; and supporting genuine community engagement by having leaders with sufficient authority to drive change.¹⁶⁵

160 Ernst and Young 2015, *Intelligence driven child protection and place based planning initiatives*. Unpublished, NSW Ombudsman. The report will be made available on the Ombudsman website: www.ombo.nsw.gov.au

161 NSW Ombudsman 2010, *Inquiry into service provision to the Bourke and Brewarrina communities* A Special Report to Parliament under s.31 of the *Ombudsman ACT 1974* December 2010; NSW Ombudsman 2011, *Addressing Aboriginal disadvantage: the need to do things differently*; and NSW Ombudsman 2012, *Responding to Child Sexual Assault in Aboriginal Communities* A report under Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, December 2012.

162 In this regard, the Harwood Institute's work identifying the conditions necessary to engage effectively with communities is particularly relevant. In addition, Peter Shergold has strongly referred to the importance of engagement at the individual level. See, for example, Peter Shergold 2013, *Service Sector Reform. A roadmap for community and human services reform*, report to the Victorian Council of Social Service.

163 NSW Ombudsman 2014, *Review of the NSW Child Protection System: Are things improving?* A Special Report to Parliament under s.31 of the *Ombudsman Act 1974* April 2014, p. 30.

164 In addition to the examples we mentioned in our special report, we are also aware of the work being done by the Local Community Services Association, in partnership with the Harwood Institute, to build capacity for innovation among local and neighbourhood associations.

165 Ernst and Young 2015 *Intelligence driven child protection and place based planning initiatives*. Unpublished, NSW Ombudsman. The report will be made available on the Ombudsman website: www.ombo.nsw.gov.au

In response to a draft copy of this report, FACS advised that place-based service delivery is being facilitated through a number of approaches, including the Service Delivery Reform and co-design work, and that *'collaborative place-based work'* is occurring in four FACS districts:

- Illawarra Shoalhaven, where the area of focus is child wellbeing in Aboriginal Communities, and which also participated in a co-design project around increasing the number of children and young people who receive a face-to-face assessment.
- Central Coast, which is aiming to work with government agencies NSW Health, Premier and Cabinet, NSWPF, DEC, and Department of Justice to design *'a joined-up approach to social disadvantage, with a particular emphasis on delivering local solutions and service system improvement for vulnerable young people.'* FACS notes that the Central Coast is also the first pilot project using FACS' co-design approach in relation to Safe Home for Life, with the intention to establish a multi-agency local intake and service point centre based in Wyong. The desired outcome is to *'build a responsive intake system, staffed by people drawn from FACS, the NSW Police Force, Education and Communities and NSW Health, which possesses strong understanding of the local service system.'*
- South Western Sydney District is to *'look for opportunities to 'increase the rate of children being seen in the District. Three opportunity areas have been finalised – Joint Assessment and Intervention, Breaking Barriers, and Streamlining Reporting.'*
- Western Sydney District has held an intent session and workshops are planned to *'develop ideas and solutions for implementation and prototyping.'*¹⁶⁶

Recommendation 13

FACS should advise this office on the progress of, and any outcomes or lessons learned from, the projects in the four districts, particularly in relation to assisting vulnerable young people and increasing the number of children and young people who receive a face-to-face response.

FACS should provide this advice by June 2016.

6.4. Concluding observations

In a number of reports over the last five years,¹⁶⁷ we have identified the importance of intelligence-driven child protection and place-based service delivery as potential contributors to a child protection system that can better identify and appropriately respond to at-risk children. All of these reports have drawn on the evidence we have obtained from investigations, audits and reviews into both the circumstances of individual children and their families and key components of the child protection system.

It needs to be recognised that, over the same period, NSW government agencies and their non-government partners have been actively involved in reforming the child protection system.

Keep Them Safe recognised the need for a shared approach to child protection at the local level, and sought to achieve it through cultural change initiatives, capacity-building, and establishment of new services. In late 2014, FACS announced an important new multi-year reform agenda, *Safe Home for Life*.

166 Secretary FACS correspondence to the NSW Ombudsman, 26 March 2015, in response to a draft copy of this report.

167 Two examples we have already cited in this report are our special reports to Parliament *Keep Them Safe? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* August 2011 and *Review of the NSW Child Protection System: Are things improving? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* April 2014. Other important reports include our Inquiry into service provision to the Bourke and Brewarrina communities (December 2010); *Addressing Aboriginal disadvantage: the need to do things differently* (October 2011); and *Responding to Child Sexual Assault in Aboriginal communities* (December 2012).

In emphasising localisation in service planning and delivery, *Safe Home for Life* should help to move the child protection system toward an intelligence-driven and place-based service delivery model. The NSW Government has also recently begun to explore options for financing social services that have the potential to support strong social outcomes, including social benefit bonds. More recently, Treasury and the Department of Premier and Cabinet have jointly published a Social Impact Investment Policy,¹⁶⁸ which outlines other funding options such as pooled funding and place-based impact investments.¹⁶⁹

These initiatives depend on the availability of reliable outcomes data, which in turn relies on effective program evaluation. Recent relevant evaluations include the *Keep Them Safe* outcomes evaluation, evaluations of individual *Keep Them Safe* initiatives including Child Wellbeing Units and Family Referral Services, and Professor Eileen Munro's assessment of FACS' *Practice First initiative*.

In addition, the NSW Government is investing in a range of initiatives to improve the sector's capacity to evaluate social policy reforms more generally, including an evaluation unit inside Treasury, a whole-of-government evaluation framework, and the NSW Data Hub, which will provide details on the human services provided by the Department of Education and Communities, FACS, Health, Justice and Transport clusters. The Hub will enable agencies to identify gaps, reduce duplication, and identify areas for greater coordination. These are positive initiatives.

In 2011, we stated:

[...] there is [...] the need at this time, to properly consider 'where we are at' against the challenges that must be met in order to more effectively deliver on the Wood Inquiry's vision.¹⁷⁰

Given the substantial reform work that has been undertaken over recent years, the findings from related evaluations, and the clear signs that social policy planning and delivery will involve a broader range of stakeholders in the future than has been the case in the past, we believe that a 'stock-take' is again warranted. This should identify the important progress that has been made in reforming the child protection system, as well as the key priority areas for ongoing reform.

168 http://www.dpc.nsw.gov.au/programs_and_services/social_impact_investment/other_investment_models

169 The significant overlap between place-based service delivery and these financial reforms is underlined by the fact that the chair of the NSW Social Impact Investment Expert Advisory Group is Professor Peter Shergold – a noted expert in community engagement with public services.

170 NSW Ombudsman 2011, *Keep Them Safe? A Special Report to Parliament under s.31 of the Ombudsman Act 1974* August 2011, p. 19.

Chapter 7. Monitoring recommendations

This section details the recommendations we made to agencies in our previous report and outlines their response.

7.1. The needs of children of parents with mental illness

Our recommendation - 1(a)

The Ministry of Health should consider the issues raised, and provide advice regarding current or proposed strategies to:

- a) Equip frontline staff in both mental health services and other health facilities, including emergency departments, with an understanding of potential risks to, and needs of, children of a parent with a mental illness.
-

Progress

NSW Health advised that it supports the practice of frontline clinicians through:

- mandatory statewide clinical documentation for mental health services, including a flag for clinicians to identify, at the initial assessment stage, those consumers who have children
- the development and dissemination of the NSW Health policy on *Children of Parents with a Mental Illness* (COPMI) Framework for Mental Health Services (2010-2015), and
- the provision of COPMI-designated positions across the Local Health Districts (14.5FTE positions at May 2012).

The Ministry advised that MH-Children and Young People held a one-day COPMI Forum in 2013 to engage the adult mental health workforce and partner NGO services to:

- proactively enquire about children, and record parents with a mental illness, at initial contact and assessment, and
- provide an evidence-based intervention model that better supports adult mental health staff to focus on their clients' parenting roles as a key component of personal recovery.

Health also provided information about the following projects and evidence-based interventions in working with parents with a mental illness and their children:

- The Family Focus intervention is a web-based training resource that is designed for mental health professionals treating parents with depression and/or anxiety to foster resilience in their children and the family unit.
- The Let's Talk psycho-educational intervention facilitates collaboration between a mental health clinician and a parent, including support for the parent to manage the impact of the mental illness on his or her children. The Ministry is currently reviewing Let's Talk for statewide implementation in mental health services.
- To address an identified service gap, MH-Children and Young People is working in partnership with the University of Wollongong on the development of evidence-informed parenting resources for mental health clinicians working with parents with a personality disorder, to enhance their parenting capacity.

Our recommendation - 1(b)

The Ministry of Health should consider the issues raised, and provide advice regarding current or proposed strategies to:

- b) Ensure that a history of a patient's children and child caring responsibilities is identified and considered in psychiatric assessment or review.**
-

Progress

In response to this recommendation, the Ministry advised in July 2013 that specialist mental health services are one of many agencies and organisations that have a significant role to play in identifying parents and recording any issues such as risks for the children. We were advised that appropriate clinical practice would be promoted through implementation of the NSW Mental Health Services Competencies Framework and additional refined workforce training.

We sought further information from Health about its plan for finalising and implementing the Framework and delivering the training. In July 2014, the Ministry advised that, while this activity was suspended pending the work of Health Workforce Australia developing the National Mental Health Workforce Core Capabilities, it is now significantly progressed and is expected to be released in the second half of 2014.

In April 2015, however, the Ministry advised that Health Workforce Australia was disbanded in 2014, and a competency document was not endorsed at any level of government, nor was it clear as to whether further national coordination would occur in the future. The Ministry advised that NSW has incorporated parental status and/or other carer responsibilities into standardised routine assessment documentation for mental health services.

Our recommendation - 1(c)

The Ministry of Health should consider the issues raised, and provide advice regarding current or proposed strategies to:

- c) Promote and monitor adherence within Local Health Districts to the Children of Parents with Mental Illness (COPMI) and Safe Start guidelines and principles, particularly in relation to linking parents and families to appropriate supports and services.**
-

Progress

The Ministry advised that compliance with the 'Supporting Families Early' initiatives (including SAFE START) is monitored through the Maternal and Child Health Primary Health Care policy. The policy requires the (then) Area Health Services to ensure compliance with the outlined practices and procedures and to 'evaluate on a regular basis that this is occurring'; and to prepare an annual report for submission to Health on its Families NSW activity, including SAFE START.

An external three-year statewide evaluation of SAFE START was completed in June 2013. The evaluation found that 98% of services surveyed were screening pregnant women and new mothers for depression and other mental health problems; 97% were assessing for psychosocial risk including domestic violence; and 93% had multidisciplinary case discussion meetings in place. During the evaluation, Local Health District (LHD) survey data was collected, and the Ministry is currently providing this LHD-specific data for local service improvement purposes.

The SAFE START evaluation findings will inform a review of the 'Supporting Families Early' policy package, which is due for completion by the end of 2015.

COPMI

In relation to promoting and monitoring adherence within LHDs to the COPMI framework, the Ministry emphasised that mental health services are required to identify and record parents who have responsibility for caring for children at the initial assessment. The Ministry indicated that MHDAO is identifying and promoting examples of good practice, including an annual census of active adult consumers to identify the prevalence of parent consumers with children aged 1-17 years. The census has shown some effect in changing service culture to be more family-focused, and has been promoted to all LHDs via the Clinical Advisory Council for Mental Health.

The Ministry also advised that, as part of the review of the *Mental Health Act 2007*, MH-Children and Young People recommended amendments to the legislation that would require adult mental health services to identify and support consumers who are parents and have responsibility for the care of children below the age of 18 years. However, in April 2015, the Ministry further advised that, in the consultation phase of the review of the *Mental Health Act 2007*:

An exhaustive stakeholder and expert consultation process did not accept this recommendation, and that routine mental health care in public mental health services already includes the identification and support of clients with parenting responsibility and their children. The recently revised mental health assessment forms used in practice and now also integrated in to the new community electronic records system added four (4) new additional fields related to parenting, to further assist clinicians supporting parenting roles in assessment and care planning.¹⁷¹

Our recommendation - 1(d)

The Ministry of Health should consider the issues raised, and provide advice regarding current or proposed strategies to:

- d) Apply and share lessons learnt from root cause analysis to inform practice and responses to parents with mental illness across NSW health facilities.**

Progress

In response to the recommendation, the Ministry advised that the Mental Health and Drug & Alcohol (MH/DA) RCA Review Subcommittee meets monthly to review the Root Cause Analysis investigation reports involving mental health patients or patients in general health settings where the mental health of the patient was considered to be a factor associated with an incident. Where issues or practice improvements are identified that have statewide implications, they may be dealt with in several ways, according to the level of urgency or concern about the issue. Responses may include bringing one mental health service's issues and improvement action to the attention of the wide mental health service system through, for example:

- presentations at meetings of senior clinical and mental health management
- issuing a 'Safety Alert' to mental health or the wider NSW Health system
- designing, developing and implementing a new clinical care system and training initiative, and
- developing new statewide policy and practice guidelines for relevant NSW Health clinical areas.

The Ministry advised that, to date, the MH/DA RCA Review Subcommittee is not aware of any local RCA reports where the findings and recommendations have statewide implications for practice improvements in the care of people with mental illness who are the parents of young children and adolescents.

171 NSW Health Secretary correspondence to the NSW Ombudsman, 14 April 2015, in response to a draft copy of this report.

Our comments

We note the considerable work Health is undertaking to improve the recognition of, and response to, parents with mental illness and their families, and the high rate of compliance with key aspects of the SAFE START guidelines identified in the evaluation.

Recommendation 2 in this report relates to current and further work to improve support for children of parents with mental illness and we will continue to monitor these issues.

7.2. Responding to physical injury

Our recommendation 2(a) and (b)

2. Noting that processes will need to be put in place to advise the Ministry of Health and Local Health Districts of the suspicious death or injury of a child:
 - a) If a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility, the child's death should be the subject of internal review. The purpose of review would be to assess whether the interaction of the child and their family with the facility raises any systems issues that should inform future practice and service improvement at a local level and across the NSW health system.
 - b) In addition, the Ministry of Health should consider whether this process of review could be applied to circumstances in which a child is seriously injured in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility.
-

Progress

In July 2013, Health advised that NSW Kids and Families and the Ministry supported the recommendation, but noted that the scope of the review, the detail and level of work involved, and its implementation would require further discussions.

In December 2013, we met with representatives of NSW Kids and Families, NSWPF, and the Office of the State Coroner to discuss options for facilitating the recommended internal Health reviews. To assist in progressing this work, we agreed to draft a process to enable the Ministry and Local Health Districts to be notified of suspicious child deaths, for the consideration of each of the agencies.

In relation to recommendation 2a, we proposed a process in which the Police Homicide squad would notify a central contact point in Health of a suspicious death of a child (with advice as to whether or not Health may commence an internal review); and the key contacts in the Ministry and Local Health Districts would communicate and coordinate the internal review of the child's death and identification of systems issues.

In relation to recommendation 2b, we noted that in most cases the child would be presenting to a health facility for treatment of the serious injury and, as such, the health services themselves would be responsible for instigating the process of identifying and notifying the relevant matters for review.

In response, NSW Kids and Families advised that broad consultation within Health had highlighted concerns about our suggested process for internal reviews, and indicated that:

- Health would prefer to conduct close internal reviews of relevant child death cases in partnership with the Ombudsman, similar to the process followed in relation to a prior child death. In that matter, we established the facts of the case and raised specific issues for consideration by agencies; the Ministry

then convened an expert group that provided advice on actions to improve practice in response to the specific issues raised by the case. The relevant Local Health District also conducted a close internal review of the case.

- In addition to Health reviewing child deaths in the manner described above, NSW Kids and Families will examine opportunities for further involving forensically oriented paediatricians in Health's frontline child protection responses, similar to the designated specialist safeguarding/child protection professionals operating in the UK.

NSW Kids and Families advised that Health does not have current plans to implement an additional process for conducting internal reviews of serious injury cases. NSW Health's *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* policy directive is clear about the responsibilities of health workers in conducting, documenting and acting appropriately on the outcomes of medical assessments of children and young people who present to health facilities with possible maltreatment. The NSW Health *Incident Management* policy is also applicable if a breach of policy at the time of the previous presentations is identified, including any previous failure to report a child protection concern.

Health also told us that since release of our report, the Ministry had undertaken considerable work to improve the health system's ability to identify and respond to child abuse or neglect, including:

- issuing the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* policy directive, which includes guidance for health practitioners on the potential indicators of child abuse and neglect
- trialling a Suspected Child Abuse and Neglect Medical Protocol for use by health practitioners involved in assessing children or young people suspected of being physically abused or neglected, and
- expanding the existing Injury Assessment Screening tool in the statewide Paediatric Emergency Department Observation Chart to be included in the charts for all age groups up to 12 years, which will increase the number of children that are mandatorily assessed in emergency departments for non-accidental injury.

In July 2014, in response to our inquiries relating to the death of a child in neglect-related circumstances in 2013, NSW Health advised that the Children and Young People RCA Review Sub Committee was recently established by NSW Kids and Families and the Clinical Excellence Commission. The sub-committee is co-chaired by the senior manager of the Paediatric Healthcare Team, NSW Kids and Families, and the Paediatric Clinical Advisor from the Clinical Excellence Commission. It is expected that the new sub-committee will increase opportunities for close internal reviews by NSW Health of serious incidents involving child protection and domestic violence and family violence concerns.

Our comments

We remain of the view that Health should conduct an internal review following the death of a child in suspicious circumstances within a year of receiving care or treatment in a public health facility. However, we appreciate the existing challenges for the department in facilitating an automatic process in this regard, and note that Health remains committed to undertaking internal reviews of child death matters raised by our office, and has established the Children and Young People RCA Review Sub Committee.

We will monitor the effectiveness of this approach through our work, particularly through recommendation 3.

We continue to refer matters arising from our child deaths reviews to Health and its Local Health Districts for consideration and internal review, when necessary. Overall, we have seen a positive and high quality response to these matters, including consultation with appropriate professionals, such as Health's child protection experts and advisors.

Appendix

Appendix 1. Definitions and methods

Definitions

Reviewable death

We use the following definitions to determine whether a child's death is reviewable:

Abuse

Any act of violence by any person directly against a child or young person that causes injury or harm leading to death.

Neglect

Conduct by a parent or carer that results in the death of a child or young person, and that involves:

- failure to provide for basic needs such as food, liquid, clothing or shelter
- refusal or delay in providing medical care
- intentional or significantly careless failure to adequately supervise, or
- a significantly careless act.

Suspicious circumstances

Deaths are considered suspicious if:

- there is some evidence or information that indicates the death may have been the result of abuse or neglect
- police identify the death as suspicious at the time of the death or any time subsequent to the death and there is some evidence that indicates the death may have occurred in circumstances of abuse or neglect as defined above¹⁷²
- the autopsy cause of death is undetermined and there is an indication of abuse or neglect, or
- the autopsy cause of death is a treatable illness and there is an indication that unjustified delay in seeking treatment may have contributed to the death.

Child in care

A child or young person under the age of 18 years:

- who is under the parental responsibility of the Minister administering the *Children and Young Persons (Care and Protection) Act 1998*, or
- or whom the Secretary of the Department of Family and Community Services or a designated agency has the care responsibility under s49 of the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is a protected person within the meaning of s135A of the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is the subject of an out-of-home care arrangement under the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is the subject of a sole parental responsibility order under s149 of the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is otherwise in the care of a service provider.

Child – a person under the age of 18 years.

¹⁷² If subsequent police investigations result in the death no longer being treated as suspicious, we also reassess inclusion of these deaths as reviewable.

Child protection history – a child is considered to have had a child protection history if:

- the child and/or their sibling were the subject of a risk of harm or risk of significant harm report to FACS within the three years before their death, and/or
- the child and/or their sibling was reported to a Child Wellbeing Unit within the three years before their death.

Where relevant, this report may also refer to reports that were made outside of the three-year timeframe.

Co-sleeping – a child or children sleeping with an adult on a shared surface such as a bed, sofa or mattress.

Familial abuse-related death – ‘an incident involving the death of a family member or other person from a domestic relationship’.¹⁷³ In this report, abuse-related includes closed homicide cases and open cases where person/s of interest are family. A family member includes a child’s parent or a person in a parental or caring role for the child (such as a step-parent, de facto parent, or a partner of one of the child’s biological parents). It also includes other people related to the child, such as siblings, grandparents, uncles and cousins.

Infant – a child less than one year old.

Person of interest – for the purposes of this report, person of interest is used to refer to a person who has been convicted or charged in relation to the death of a child (except in relation to a transport fatality), or is suspected of involvement in the death of a child. This includes cases of murder-suicide.

Peer – for the purposes of this report, a ‘peer’ is a young person who is the same or similar age and/or social grouping.

Remoteness – a measure of distance from services. There are five levels of remoteness specified in this report: highly accessible (major cities), accessible (inner regional), moderately accessible (outer regional), remote and very remote. Remoteness was measured using the Aria-Plus index,¹⁷⁴ a measure of access to services using proxy measures of distance to the five nearest centres of defined populations. The breakdown of population by age categories in the six ARIA categories as of 30 March 2012 was supplied by the ABS to order.

The product supplied by the ABS contains estimates of the resident populations (ERPs) by 2006 Census Collection Districts (CDs) or CD-derived areas of Australia, produced by the ABS. These estimates correspond with preliminary 30 June 2011 ERP by Statistical Local Area as released on 30 March 2012 in *Regional Population Growth, Australia, 2010-11* (cat. no. 3218.0). The CD and CD-based ERPs are not standard ABS output, but rather are customised data available for purchase as an information consultancy. Thus, these estimates are not published on the ABS website.

Because the ABS has updated its underlying geographic spatial structures from Australian Standard Geographical Classification (ASGC) to Australian Statistical Geography Standard (ASGS), this is the first year that data listed by ASGS has been used in this report. Addresses that were assigned to a given area in the ASGC may be grouped slightly differently under the ASGS and, consequently, geographic patterns may have changed slightly compared with previous reports. While it is likely that the changes are minimal at the higher level of remoteness grouping, caution should be applied when analysing and interpreting changes through time.

173 Australian Institute of Criminology 2010, *Homicide in Australia: 2007-08 National Homicide Monitoring Program annual report*, cat. No. Monitoring Report 13, AIC, Canberra.

174 Australian Population and Migration Research Centre, 2013, ARIA (Accessibility/Remoteness Index of Australia), Adelaide: APMRC. http://www.adelaide.edu.au/apmrc/research/projects/category/about_aria.html, accessed 11 July 2014.

Socioeconomic status – the relative access to material resources of an individual or group. The indicator of the socioeconomic status of a child used in this report is the Index of Relative Social Disadvantage (IRSD) of the area in which a child usually resided.

Socioeconomic status is reported in quintiles. Quintile 1 represents the relatively most disadvantaged 20%, and quintile 5 represents the relatively least disadvantaged 20%.

In this report, socioeconomic status is not included in calculations for children whose usual residence was outside of the state or overseas, or for those where insufficient information was available for their usual place of residence.

Young person – a person aged 16 or 17 years.

Sudden Unexpected Death in Infancy (SUDI)

In this report, SUDI is defined as: where an infant less than one year of age dies suddenly and unexpectedly. Included in SUDI are:

- deaths that were unexpected and unexplained at autopsy (i.e. those meeting the criteria for Sudden Infant Death Syndrome)
- deaths occurring in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life threatening
- deaths arising from a pre-existing condition that had not been previously recognised by health professionals, and
- deaths resulting from accident, trauma or poisoning where the cause of death was not known at the time of death.

Sudden Infant Death Syndrome (SIDS)

SIDS is a category of SUDI and is a diagnosis of exclusion. In this report, SIDS is defined as:

The sudden and unexpected death of an infant under one year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, and review of the circumstances of death and the clinical history.

Causes of death

ICD-10 is the International Statistical Classification of Diseases and Related Health Problems, 10th revision (World Health Organisation). The ICD-10 has more than 12,000 unique codes in more than 2,000 categories. The highest level classification is the chapter level (22 chapters). ICD-10-AM is the Australian modification of ICD-10.

Underlying cause of death is defined by the World Health Organisation as the 'disease or injury that initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury'. Unless otherwise indicated, in this report the cause of death relates to underlying cause. The underlying cause of death is recognised as the single most essential element to understanding causes of death.¹⁷⁵

Direct cause of death is the final condition or event that results in death. Intervening causes of death are other conditions that may have given rise to the immediate cause of death. Contributory causes of death are conditions or events that were present during the sequence leading to death, but may not have been necessary influences.

¹⁷⁵ National Centre for Health Information Research and Training 2011 *Review and recommendations for the annual reporting of child deaths in NSW*. Sydney: NSW Ombudsman. Unpublished.

Identification of Aboriginal and Torres Strait Islander children

Individual children are identified as Aboriginal or Torres Strait Islander if:

- The child has been identified as either Aboriginal or Torres Strait Islander on their NSW Births Deaths and Marriages (BDM) death certificate.
- The child or their parent/s have been identified as either Aboriginal or Torres Strait Islander on their NSW BDM birth certificate.
- Agency records identify the child as Aboriginal or Torres Strait Islander through a number of records, which are corroborative. Records used to do this include the NSWPF Computer Operated Policing System (COPS) and FACS' KiDS client database, which often hold information that can support Aboriginal or Torres Strait Islander identity. NSW Health and other agency records were also used to assess the child and family background.

Data description

The child death register records information on all children whose deaths have been registered in NSW, including whether any of the children were Aboriginal or Torres Strait Islander Australians.

Data on Aboriginal and Torres Strait Islander status is compiled from a range of sources. The number and source of the records is partially dependent on the cause of death for each child.

Record requests can take some time after a death has been registered, and information is added as it becomes available. Data published in this report for 2012 and 2013 Aboriginal and Torres Strait Islander status are therefore subject to change.

Changes in 2012 and 2013

In line with recommendations by the AIHW, and practice subsequently adopted by the CDRT our process for collecting Aboriginal and Torres Strait Islander status for reviewable deaths changed in 2012 and 2013. Previously, information from BDM was used as the primary source, with other sources taken into account where other records clearly indicated the child was Aboriginal or Torres Strait Islander.

For deaths registered from 2012 onwards, information about a child's Aboriginal or Torres Strait Islander status has been collected from all sources available for each case. Business rules have been applied to assign Aboriginal and Torres Strait Islander status for each child. For reporting on reviewable child deaths in 2012 and 2013, an 'ever-Indigenous' rule has been used. That is, where a child has been identified as Indigenous in any source collected by this office in the course of the case review, the child has been nominated as Aboriginal and/or Torres Strait Islander in the register and the case reported as such.

However, for reporting on trends in deaths over time, only BDM birth and death data has been used. BDM data is the primary source for Indigenous status, and should be used exclusively to analyse trends to avoid compounding errors from differences in accuracy of secondary data sources through time.

List of sources

| | |
|---|------------------------|
| BDM death | BDM birth |
| National Coronial Information System (NCIS) | Other coronial records |
| NSW Police Force databases (COPS/PODS) | Other Police records |
| Education records | NSW Health records |
| FACS KiDS person summary | Other FACS records |
| CWU database – Wellnet | Other CWU records |
| GP/Private practitioner records | NGO records |
| Other sources | |

Sources of Aboriginal and Torres Strait Islander identification of reviewable child deaths in 2012 and 2013

As indicated in the table below, of the 19 children who were identified as Aboriginal and/or Torres Strait Islander in 2012 and 2013, 16 (84%) were identified by two or more sources. The remaining three children were identified as Aboriginal and/or Torres Strait Islander by only one source.

Fifteen of the 19 children (86%) were identified in BDM records; over half (8) of whom were identified in both birth and death records. BDM information (birth and/or death) was the only source of identification for two children, one of whom was identified using a single BDM source (birth or death). Four children were identified as Aboriginal and/or Torres Strait Islander only by sources other than BDM.

Table 13: Sources of Aboriginal and Torres Strait Islander identification, 2012 and 2013

| | Total sources | No. of children |
|---|---------------|-----------------|
| Aboriginal or Torres Strait Islander | | |
| BDM birth or death | | 7 |
| | 1 (BDM only) | 1 |
| | 2 | 1 |
| | 5 | 3 |
| | 7 | 1 |
| | 8 | 1 |
| BDM birth and death | | 8 |
| | 2 (BDM only) | 1 |
| | 5 | 1 |
| | 6 | 2 |
| | 7 | 1 |
| | 8 | 3 |
| Other source/s only | | 4 |
| | 1 | 2 |
| | 2 | 1 |
| | 5 | 1 |
| Non Aboriginal or Torres Strait Islander | | 22 |
| Total | | 41 |







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