Ombudsman
New South Wales

Report of Reviewable Deaths 2014 and 2015

Child Deaths

Volume 1

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Foreword

This report considers the 'reviewable' deaths of 54 children that occurred in NSW in 2014 and 2015. These were reviewable deaths because the children died in circumstances of abuse or neglect, or were living in care at the time of their death.

The report also focuses on a vulnerable group of young people in care who died by suicide or in risk-taking circumstances. Since 2004, when the Ombudsman's role in reviewing 'reviewable' deaths commenced, we have reviewed the deaths of 117 children in care. Of these, 13 per cent – 15 young people – died by suicide or risk-taking. All these young people had high and complex needs. Our review of their deaths highlights the critical importance of intensive case management, a consistently supportive and therapeutic care environment, and close monitoring and support of placements.

A second focus in this report is a review of 124 neglect-related deaths that occurred in NSW over a 10 year period from 2006 to 2015. The death of a child as a direct result of chronic neglect is rare, and neglect-related deaths most often result from intentional or reckless acts on the part of a carer, often in the context of an environment of neglect. Our work shows that a prominent and disturbing feature in the neglect-related deaths of children was carer alcohol or other drug abuse. The role of alcohol and/or other drugs in the deaths of children will be a targeted area for our research over the next year.

In connection with our review of neglect-related deaths, we commissioned Dr Deborah Scott at the Australian Institute of Family Studies to prepare a literature review with a focus on fatal neglect definitions, and to review our reporting of fatal neglect. Her report – *Reporting of Fatal Neglect in NSW* – is being published alongside this report, and chapter 7 below provides an overview.

Dr Scott's review notes that this office's reporting of reviewable child deaths, and in reporting for the NSW Child Death Review Team, are consistent with international best practice. Dr Scott also considers that further changes could be made to strengthen a public health approach to the reporting of child deaths in NSW.

The changes proposed in her report will need to be considered closely by the Ombudsman's office and a range of stakeholders. In particular, it is important for government to determine how the various review mechanisms coexist and complement each other, and achieve the end result of improving our capacity to prevent the deaths of children. In that context, we will be seeking advice on the proposals and future strategies from government and other relevant stakeholders.

Professor John McMillan AO

Convenor, NSW Child Death Review Team

Acting Ombudsman

Contents

Recommendations

Family and Community Services

Recommendation 1

Family and Community Services (FACS) should consider the issues raised in this report relating to the suicide and risk-taking deaths of young people in care, in particular:

i) Response to reports of risk of significant harm (ROSH), particularly relating to self-harming and risk taking behaviour (including suicide attempts and threats of suicide, and substance abuse)

ii) Identification of and response to escalating risk-taking behaviour

iii) Lack of placement stability and homelessness

FACS should provide details of current or proposed strategies to address these issues.

NSW Health

The following updates recommendation 3 of the *Report of Reviewable Child Deaths in 2012 and 2013* (see chapter 9). The intent of the recommendation is to provide a mechanism that would allow NSW Health to review, and potentially learn from, the handling of an injury presentation where a child subsequently dies in suspicious circumstances.

Recommendation 2

If a child dies in suspicious circumstances within 12 months of being presented to a NSW public health facility with a physical injury, and the NSW Ombudsman considers an internal review is warranted, NSW Health, in conjunction with the Clinical Excellence Commission, should establish a process for comprehensive review of the interaction of that facility with the child and their family.

The following relates to recommendation 2 of the *Report of Reviewable Child Deaths in 2012 and 2013* (see chapter 9). The intent of the recommendation is to monitor strategies to promote appropriate clinical practice and competency in relation to recognising and responding to any potential risk to children of parents with mental illness.

Recommendation 3

NSW Health should provide advice on the outcome of the review of the *Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015*

Previous recommendations relating to statutory child protection issues

Chapter 9 below details agency responses – primarily Family and Community Services - to 13 previous recommendations from our *Report of Reviewable Child Deaths in 2012 and 2013*.

FACS/Ombudsman Integrated Governance Framework

Over the past 18 months, our office has worked with FACS to establish the *FACS/Ombudsman Integrated Governance Framework (IGF).*

A key component of the IGF is a joint document used to track FACS' progress towards implementing systemic reforms and addressing discrete practice issues that we have identified from our oversight work, including child death reviews. As many of the recommendations from our *Report of Reviewable Child Deaths* relate to broader systems issues in child protection, and as noted in chapter 9, these recommendations will be monitored through the IGF. We will continue to report on the outcomes of the IGF where relevant in our future reports of reviewable child deaths. We are also working with FACS to develop a public version of the framework.

Chapter 1. Introduction

1.1. Reviewable child deaths

Under part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA), the NSW Ombudsman has responsibility for reviewing the deaths of people with disability in care, and of certain children.[1] The death of a child aged less than 18 years is reviewable 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[2] or in detention.

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

This report is the ninth report of reviewable deaths, and covers the period 1 January 2014 to 31 December 2015. In this two-year period, the deaths of 54 children were reviewable:

- 17 children died as a result of abuse
- 17 children died in circumstances of neglect (16) or suspicion of neglect (1)
- 23 children who died were in the care of the state or a service provider; 21 children were in statutory or supported out-of-home care; and two children were in disability respite care.

The categories of reviewable deaths are not exclusive. In 2014 and 2015, two children who were living in care died in circumstances of abuse, and one in circumstances of neglect.

1.2. The purpose of reviews

CS CRAMA requires the Ombudsman 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 of our reviews is to identify 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. Further work

Arising from reviews of child deaths, we may take further action in individual cases. This includes making a report to a service provider or other appropriate person or body on a matter relating to a reviewable death, making preliminary inquiries, or investigating agency conduct in relation to a reviewable death.

The outcomes of this work are included as appropriate in this report.

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1. Prior to July 2009, a reviewable death included 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. Following legislative change, reviewable deaths of children were limited to deaths occurring as a result of abuse or neglect or in suspicious circumstances, and the deaths of children in care. In order to provide for analysis of trends, child deaths in this report include only those cases that meet the current criteria of reviewable deaths.
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 CS CRAMA. This definition includes children in voluntary out-of-home care and disability accommodation services. The full definition is provided in Appendix 1.

1.4. Related reviews or investigations of child deaths

NSW has a number of established mechanisms for reviewing the deaths of children.

1.4.1. 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 the office of the Ombudsman provides support and assistance to the Team in its work. The Ombudsman has had this responsibility since 2011.

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.

Reports of the Child Death Review Team are available at:

http://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team

1.4.2. Department of Family and Community Services

The Serious Case Review Unit in the Department of Family and Community Services (FACS) reviews the deaths of children 'known to' the agency. The Unit reviews the death of a child if the child and/or their sibling(s) were the subject of a risk of significant harm report (ROSH) in the three years prior to the child's death, or where the child was in out-of-home care at the time of their 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 provides us with a copy of its completed child death reviews.

1.4.3. 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.

1.4.4. 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 deaths that occurred in the context of domestic violence, including the deaths of children.

1.5. The Report of child deaths in 2014 and 2015

This report presents information about children who died in 2014 and 2015, and trends in the reviewable deaths of children over the past decade.[4] The report includes two key areas of focus:

- A review of risk-taking and suicide deaths of young people in care that occurred between 2004 and 2015 (chapter 4). This review was undertaken against the background of previous reviewable child death reports in which we identified the need for improved agency responses to vulnerable older children and young people in care. This work examines the circumstances of 15 young people in care between the ages of 13 and 17 who had complex needs and died in the context of risk-taking or by suicide.

3. NSW Department of Family and Community Services 2015, *Child Deaths 2015 Annual Report Learning to Improve Services*, p 5.
4. Our data has been adjusted to reflect changes to legislation and working definitions.

- A review of neglect-related deaths of children that occurred between 2006 and 2015 (chapter 6). This review was prepared against the background of work we commissioned in 2015 on definitions and reporting of fatal neglect in NSW. This work was undertaken by the Australian Institute of Family Studies, and is released alongside this report.

1.5.1. Definitions

As noted, the death of a child is reviewable 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. We define these circumstances as follows:

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 - 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 above[5]
- 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*.[6]

Other key definitions

Aboriginal and Torres Strait Islander status is drawn from Registry of Births, Deaths and Marriages (BDM) data, and/or from other official records that record the child's status as Aboriginal or Torres Strait Islander.

Appendix 1 provides further detail about definitions used in this report.

1.5.2. Methods

In reading the report, please note:

- Trend data in this report provides information about reviewable child deaths 2006 – 2015, in two-year intervals. In trend tables, the categories of abuse and neglect include suspicious deaths. Between 2006 and 2015, 45 of the 229 reviewable child deaths that occurred in abuse or neglect-related circumstances are classified as suspicious. In most cases, this is because available information does not conclusively determine that a death was the result of abuse or neglect.

5. If subsequent police investigations result in the death no longer being treated as suspicious, we also reassess inclusion of these deaths as reviewable.
6. 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.

- The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). In the tables in section 2 below, the number of reviewable deaths will therefore not equal the total of the three categories.
- The tables below include 38 deaths that are 'suspicious' of abuse or neglect.
- Percentages are rounded.

Report methodology is described in detail at appendix 2.

1.5.3. Information sources

Information for this report has been drawn from the NSW register of child deaths and the register of reviewable deaths. The Ombudsman maintains these registers.

Under section 38 of CS CRAMA, it is the duty of a range of agencies and practitioners to provide the Ombudsman with 'full and unrestricted access' to records that the Ombudsman reasonably requires for the purpose of exercising his reviewable death function.

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
- judgment 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.

Chapter 2. Reviewable child deaths in 2014 and 2015, and trends

In the two-year period January 2014 to December 2015, 1010 children died in NSW.[7] We identified 54 (5.3%) of these deaths as reviewable. As detailed in the following table, the number of reviewable deaths is generally under six per cent of all child deaths in NSW.

2.1. Trends in reviewable child deaths, 2006 to 2015

Table 1: Children whose deaths were reviewable in NSW, 2006 to 2015, number and percent of all child deaths in two-year intervals by reviewable status*

		2006-2007	2008-2009	2010-2011	2012-2013	2014-2015[8]	**2006-2015**
All child deaths in NSW		1,227	1,179	1,173	1,066	1,010	**5,655**
Reviewable child deaths	**No.**	69	74	78	39	54	**314**
	%	5.6	6.3	6.6	3.7	5.3	**5.6**
Abuse	**No.**	21	25	27	8	17	**98**
	%	1.7	2.1	2.3	0.8	1.7	**1.7**
Neglect	**No.**	38	29	22	18	17	**124**
	%	3.1	2.5	1.9	1.7	1.7	**2.2**
Child In care	**No.**	10	20	29	13	23	**95**
	%	0.8	1.7	2.5	1.2	2.3	**1.7**

* This table and following tables include 38 deaths that are 'suspicious' of abuse or neglect

It is difficult to determine with confidence trends in the rate of reviewable child deaths over time. The table above shows that the number and percentage of deaths that are reviewable has fluctuated.

Overall, just under two per cent (1.7%) of all deaths of children in NSW were abuse-related; and just over two per cent (2.2%) occurred in circumstances of neglect.

Trends in the deaths of children in care are influenced by changes in the number of children living in care. As noted, reviewable deaths of children in care include those in voluntary care and disability respite care. It is difficult to identify a base population for this group as a whole in order to identify trends. As with other categories, the number and percentage of children who die in care has fluctuated, averaging just under two per cent (1.7%) of all children who die in NSW. This is a small but significant proportion. In 2015, for example, 17,585 children in statutory out-of-home care represented 1 per cent of children in NSW.[9]

2.1.1. Age and gender

As illustrated below, the majority of children who died in abuse or neglect-related circumstances between 2006 and 2015 were males (62 per cent). This was reflected in 2014 and 2015.

7. Data from the NSW Child Death Review Team register.
8. The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). The number of reviewable deaths will not equal the total of the three categories.
9. http://www.facs.nsw.gov.au/facs-statistics/objective-1

Table 2: Children whose deaths were reviewable in NSW 2006-2015 in two-year intervals, gender by reviewable status

		2006-2007	2008-2009	2010-2011	2012-2013	2014-2015[10]	Total
All reviewable child deaths		69	74	78	39	54	**314**
Abuse	Male	18	15	17	7	7	**64**
	Female	3	10	10	1	10	**34**
	Total	**21**	**25**	**27**	**8**	**17**	**98**
Neglect	Male	22	18	15	8	11	**74**
	Female	16	11	7	10	6	**50**
	Total	**38**	**29**	**22**	**18**	**17**	**124**
Child In care	Male	7	14	20	8	14	**63**
	Female	3	6	9	5	9	**32**
	Total	**10**	**20**	**29**	**13**	**23**	**95**

As demonstrated in the table below, in 2014 and 2015, and consistent with reviewable deaths over the decade, almost two thirds of the children who died in abuse or neglect-related circumstances were under five years of age.

Table 3: Children whose deaths were reviewable in NSW 2006-2015 in two-year intervals, age by reviewable status

		2006-2007	2008-2009	2010-2011	2012-2013	2014-2015[11]	Total
All reviewable child deaths		69	74	78	39	54	**314**
Abuse	Under one year	7	4	3	1	5	**20**
	1 - 4	6	9	7	4	5	**31**
	5 - 9	2	6	4	1	3	**16**
	10 - 14	2	4	2	1	3	**12**
	15 - 17	4	2	11	1	1	**19**
	Total	**21**	**25**	**27**	**8**	**17**	**98**
Neglect	Under one year	17	9	8	7	8	**49**
	1 - 4	18	14	9	5	3	**49**
	5 - 9	2	3	2	4	4	**15**
	10 - 14	0	1	2	1	2	**6**
	15 - 17	1	2	1	1	0	**5**
	Total	**38**	**29**	**22**	**18**	**17**	124
Child In care	Under one year	4	4	5	2	3	**18**
	1 - 4	2	4	6	4	5	**21**
	5 - 9	2	1	5	2	4	**14**
	10 - 14	2	4	2	1	5	**14**
	15 - 17	0	7	11	4	6	**28**
	Total	**10**	**20**	**29**	**13**	**23**	95

10. The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). The number of reviewable deaths will not equal the total of the three categories.
11. The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). The number of reviewable deaths will not equal the total of the three categories.

2.1.2. 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.[12] However, as shown in the table below, Aboriginal and Torres Strait Islander children are consistently over-represented in each category of reviewable child deaths, representing around 20 per cent of reviewable child deaths over the past decade.

In 2014 and 2015, almost one third (16) of the 54 children whose deaths were reviewable were identified as being Aboriginal and Torres Strait Islander. Six of the children died in neglect-related circumstances and four in circumstances of abuse. Eight Aboriginal and Torres Strait Islander children died while in care, including two children who died in abuse-related circumstances. At June 2015, 37 per cent of all children in out-of-home care in NSW were Indigenous.[13]

Table 4: Children whose deaths were reviewable, Aboriginal and Torres Strait Islander status 2006-2015 in two year intervals, by reviewable status

		2006-2007	2008-2009	2010-2011	2012-2013	2014-2015	Total
All reviewable child deaths		69	74	78	39	54[14]	**314**
Abuse	Aboriginal or Torres Strait Islander	2	2	9	2	4	**19**
	Not Aboriginal or Torres Strait Islander	19	23	18	6	13	**79**
Neglect	Aboriginal or Torres Strait Islander	10	8	5	11	6	**40**
	Not Aboriginal or Torres Strait Islander	28	21	17	7	11	**84**
Child In care	Aboriginal or Torres Strait Islander	3	8	9	4	8	**32**
	Not Aboriginal or Torres Strait Islander	7	12	20	9	15	**63**

2.2. Coronial status

At the time of writing, the State Coroner had held an inquest in relation to nine children who died and had suspended the inquests of ten other children in the context of criminal charges being laid.

2.3. Child protection

A central question in reviewing the deaths of children-particularly those that occur in circumstances of abuse or neglect-is whether there was evidence of prior maltreatment and if so, whether possible risk to the child was known and responded to by agencies. For children who die while in care, it is important to consider child protection history.

For this report, a child is considered to have a child protection history if the child, and/or their sibling(s) had been the subject of a report about risk of significant harm to Family and Community Services, or the subject of a report to a Child Wellbeing Unit.[15]

12. 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
13. http://www.facs.nsw.gov.au/facs-statistics/objective-1. The total number of children in care at June 30 2015 was 17 585
14. The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). The number of reviewable deaths will not equal the total of the three categories.
15. This includes all reports made to FACS that were subsequently assessed as either ROSH or non-ROSH. It also includes reports of 'risk of harm' made to FACS prior to 24 January 2010, which is the date the threshold for reporting to FACS changed to 'risk of significant harm'. The definition encompasses all reports of harm and child wellbeing reports to provide for consistency in reporting trends and issues inclusive of periods prior to 2010.

Based on an analysis of child deaths over a 10-year period (2002 – 2011), the NSW Child Death Review Team identified that children with a child protection history had a higher overall mortality than children without this history (1.4 times the rate).

This difference was much more pronounced for external (injury-related) causes of death. Children with a child protection history were 2.8 times more likely to die as a result of injury than children without a child protection history. In regard to fatal abuse, children with a child protection history had 6.3 times the mortality rate of children without this history. They also had a much higher mortality rate for particular causes of death that are often related to fatal neglect, including:

- Sudden Unexpected Deaths in Infancy (SUDI) (9.8 times the mortality rate of children without a child protection history)
- fire (23.8 times the mortality rate)
- accidental poisoning (5.5 times the mortality rate)
- drowning (2.7 times the mortality rate).

2.3.1. Child protection history: children who died in 2014 and 2015

As shown in the table below, and consistent with previous years, the families of two thirds (36) of the children who died in 2014 and 2015 had a child protection history. Half of the 17 children who died in circumstances of abuse had a child protection history, as did just over half of the children who died in neglect-related circumstances. Eighteen of the 23 children who died while in care had been the subject of a report indicating child protection risk in the three years prior to their death.[16] In 11 cases, this was while they were in care.

Table 5: Children whose deaths were reviewable, child protection history 2006-2015 in two year intervals, by reviewable status

		2006-2007	2008-2009	2010-2011	2012-2013	2014-2015	Total
All reviewable child deaths		69	74	78	39	54[17]	**314**
Abuse	Child protection history	13	13	13	4	8	**51**
	No child protection history	8	12	14	4	9	**47**
Neglect	Child protection history	24	19	15	12	9	**79**
	No child protection history	14	10	7	6	8	**45**
Child In care	Child protection history	8	15	25	11	18	**80**
	Child protection history – pre entry into care*	8	13	22	11	18	**75**
	Child protection history – while in care*	6	4	14	6	11	**41**
	No child protection history	2	5	3	2	2	**14**

*The number of children in care with a child protection history will not equal the total of the sub categories because some children were the subject of child protection reports both before and after they were taken into care. Child protection reports for children in care related to a range of issues, including for example, the conduct of carers, risks to children from adults or peers outside of the placement and self-harm or risk-taking behaviour by the child or young person.

16. Reports did not necessarily relate to the period the child was in care.
17. The deaths of three children were reviewable under more than one criteria (in 2014 and 2015). The number of reviewable deaths will not equal the total of the three categories.

2.3.2. Responding to child protection concerns

The Ombudsman's 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 particular, the need to:

- Address the challenges associated with implementing shared responsibility for child protection across government and non-government agencies, including progressing truly collaborative practice, building strong information exchange practices and developing efficient and effective service systems within local communities.
- Improve the proportion of reports of risk of significant harm that receive a face-to-face assessment. Reviews also identified the need to improve assessment of risk in some specific circumstances, such as the involvement of new partners in a family at risk.
- Establish effective agency and interagency strategies to work with families affected by drug and alcohol abuse.
- Ensure provision of appropriate and timely mental health support to carers and young people.
- Work across agencies to ensure practitioners are well equipped to identify and respond to suspicious physical injury in children.
- Improve agencies' recognition and reporting of, and response to, the child protection implications of domestic violence.
- In regard to children living in care, improve foster and relative/kinship carer assessment and support.

As illustrated below, these and other emerging themes continue to be identified through our work in reviewing child deaths and more broadly, in monitoring the delivery of community services. However, it is important to note that significant changes have and are being made to the child protection system in NSW.

2.4. Developments since our last report

2.4.1. Safe Home for Life

In 2014, changes to the child protection system known as 'Safe Home for Life' commenced in NSW. A key objective of the reforms is to reduce the number of children entering the statutory care system and increase the number exiting care through restoration to parents, guardianship[18] or adoption. Safe Home for Life includes a range of measures intended to:

- increase parental accountability and expand the range of options for working with families to address child protection concerns
- provide support to families earlier to prevent children from entering out-of-home care, and
- provide permanency and greater stability for children and young people in out-of-home care.

Safe Home for Life emphasises the need for early decision-making about permanency for children entering care. In 2014, placement principles were introduced into the *Children and Young Persons (Care and Protection) Act 1998* that reflect this. The principles make it clear that in circumstances where restoration is not possible, the preferred order for the permanent placement of a child or young person is guardianship, followed by open adoption (for non-Aboriginal children), and lastly, parental responsibility to the Minister and placement with foster carers when all other options are exhausted or inappropriate.

18. Guardianship orders were introduced into the *Children and Young Persons (Care and Protection) Act 1998* as part of the Safe Home for Life reform agenda. In terms of legal status, the child on a guardianship order is regarded as being in the care of their guardian, not in out-of-home care.

As part of the reform program, FACS is trialling a Quality Assurance Framework for out-of-home care. The purpose of the framework is to identify and measure safety, permanency and wellbeing outcomes for children in out-of-home care, improve casework practice, and help agencies to provide and use more reliable data to improve service delivery.[19] Outcomes under the framework relate to the areas of safety and permanency, cultural and spiritual identity, mental health, cognitive and social functioning, and physical health and development.[20]

Legislative changes accompanying Safe Home for Life also strengthened provisions relating to the use of parent responsibility contracts and introduced new parenting capacity orders. To give parents an opportunity to address issues relating to their child's safety and wellbeing before more intrusive statutory intervention is necessary, the Children's Court may register a parent responsibility contract or make an order requiring a parent to participate in therapy treatment, or a parenting course aimed at enhancing their parenting capacity and reducing the risk to their child.[21]

To support the range of Safe Home for Life initiatives, work within FACS is underway to upgrade and replace existing frontline information technology systems (including KiDS) with a new, integrated platform called 'ChildStory'. The new system is currently being rolled out and will include enhanced capacity to draw from a range of sources to provide a consolidated snapshot of a child's reported history, service interventions and current circumstances. Certain other agencies and service providers will also have access to ChildStory. FACS expects that this will help streamline information exchange and improve the coordination of care and support to families.[22]

2.4.2. Transfer of out-of-home care services to the non-government sector

Over 17,500 children and young people live in out-of-home care in NSW. Of these children, around 13,000 are in statutory out-of-home care, where the Minister for Family and Community Services has parental responsibility. Other children are in supported care, and placed with relatives or kin. One of the key recommendations of the 2008 Wood Special Commission of Inquiry into Child Protection was that the government transfer responsibility for the delivery of statutory out-of-home care to the non-government sector. The rationale for the transfer was that non-government organisations could deliver higher quality services. At the time, non-government out-of-home care providers had lower casework ratios than the department, and were reported to have stronger links with the community.[23]

Key objectives of the transfer include that:

- by 2017, all children in statutory out-of-home care will be case managed by a non-government organisation, and
- by 2022, all Aboriginal children will be placed with Aboriginal carers and supported by Aboriginal agencies.

The transition of out-of-home care service delivery to the non-government sector started in early 2012. Since that time, 57 percent of children and young people in statutory care have been transferred.[24] This has resulted in both an increase in the number of designated agencies providing out-of-home care and the growth of existing agencies, particularly in the Aboriginal out-of-home care sector.

19. NSW Family & Community Services, *Quality Assurance Framework – an Overview*, accessed from **http://www.facs.nsw.gov.au/reforms/children,-young-people-and-families/quality-assurance-framework** on 16 January 2017.
20. NSW Family & Community Services, *Quality Assurance Framework – an Overview*, accessed from **http://www.facs.nsw.gov.au/reforms/children,-young-people-and-families/quality-assurance-framework** on 16 January 2017.
21. NSW Family & Community Services fact sheet, *Safe Home for Life – Parenting resources*, accessed from **http://www.facs.nsw.gov.au/__data/assets/file/0013/302431/3355_FACS-_SafeHomeForLife_ParentingResources.pdf** on 28 February 2017.
22. **https://childstory.net.au/** on 28 February 2017.
23. The Hon James Wood AO QC, November 2008, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, volume 2: pp. 656 – 660.
24. FACS submission to the Legislative Council Inquiry into Child Protection, July 2016.

2.4.3. Independent review of out-of-home care

In 2016, the NSW Government commissioned an independent review of the out-of-home care system. The review was initiated in response to the growth of the out-of-home care population and evidence of continuing poor outcomes for the most vulnerable children and families.[25] In June 2016, the Government announced that it would adopt the findings of the review, noting a key finding of the review that *'the current OOHC system required immediate change and was financially unsustainable'*.[26]

According to the Government's announcement, the review recommended resourcing the current growth in out-of-home care while at the same time *'investing substantially in interventions to change the long-term trajectory of children and young people in care'*.[27] The review also emphasised the need to identify those families and children most likely to experience poor outcomes and prioritise targeted intervention initiatives accordingly, including:

- reconfiguring and expanding existing family preservation and restoration services to include a greater focus on therapeutic and clinical support
- investing in an additional 900 places for children and families to access family preservation and restoration services, with priority given to Aboriginal children and families
- trialling new evidence-based intensive preservation and restoration programs
- introducing a range of measures to address the over-representation of Aboriginal children in care
- establishing a trauma treatment centre for children in care, and
- increasing funding towards resources and initatives designed to lift the adoption rate.[28]

In response, the Government has committed to the introduction over the next three to five years of tailored support packages, initially targeted to children and young people in out-of-home care, families with children at imminent risk of entry to care and young people leaving care.[29] The key features of a tailored support package will include:

- a needs assessment drawing on a range of sources, including the child or young person, parents and family members and relevant professionals, and
- integrated case management with a flexible budget to enable the purchase of services designed to meet identified needs.[30]

2.4.4. The Office of the Senior Practitioner and implementation of Practice First

The Office of the Senior Practitioner (OSP) was established in 2012 as a unit within FACS dedicated to practice leadership. Since its establishment, the OSP has implemented a number of strategies to support caseworkers in their work, including:

- The development and rollout of a new service delivery model known as Practice First. The focus of Practice First is on changing the practice culture across all aspects of FACS' work with families, including assessment, intervention and collaboration with partner agencies. The model has an emphasis on building practice skills, shared management of risk and developing genuine, respectful relationships with families.[31]

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25. NSW Government (2016), *Their Futures Matter: A new approach. Reform directions from the Independent Review of Out of Home Care in New South Wales*, accessed from https://www.facs.nsw.gov.au/__data/assets/file/0005/387293/FACS_OOHC_Review_161116.pdf on 16 January 2017.
26. Minister for Family and Community Services, Media Release, NSW Budget – reforms for kids needing care 18 June 2016. https://www.facs.nsw.gov.au/about_us/media_releases/media_release_archive/nsw-budget-reforms-for-kids-needing-care
27. Minister for Family and Community Services, Media Release, *NSW Budget – reforms for kids needing care 18 June 2016.*
28. NSW Government (2016), *Their Futures Matter: A new approach. Reform directions from the Independent Review of Out of Home Care in New South Wales*, accessed from https://www.facs.nsw.gov.au/__data/assets/file/0005/387293/FACS_OOHC_Review_161116.pdf on 16 January 2017.
29. NSW Government (2016), *Their Futures Matter: A new approach. Reform directions from the Independent Review of Out of Home Care in New South Wales*, accessed from https://www.facs.nsw.gov.au/__data/assets/file/0005/387293/FACS_OOHC_Review_161116.pdf on 16 January 2017.
30. Minister for Family and Community Services, Media Release, 18 June 2016.
31. Practice First has been independently evaluated. The evaluation report is available on FACS' website at http://www.facs.nsw.gov.au/reforms/children,-young-people-and-families/practice-first.

- The launch in 2015 of Care and Protection Standards. The 10 standards are based on theory underpinning the essential skills required for good child protection practice.[32]
- The Clinical Issues Team, which is is a state-wide service located in the OSP. The team's clinical consultants provide specialist advice to assist frontline workers assess and manage cases where drug and alcohol misuse, mental illness and/or domestic violence presents a risk to the safety and wellbeing of children and young people.
- The new casework practice site, launched in December 2016, was developed to support practitioners working with children, young people and families, including the provision of up-to-date information and advice.

2.4.5. Realignment of Brighter Futures

Brighter Futures is an early intervention program delivered by non-government organisations across NSW. The program delivers services to families of children under the age of nine who are at high risk of entering the statutory child protection system. Eligible families may receive services, including case management, home visiting, access to parenting programs and childcare.

In July 2014, Brighter Futures was realigned to target the program towards families of children assessed to be at risk of significant harm. This change was intended to prevent children from escalating within the statutory child protection system and enable a *'greater focus on addressing the drivers of child protection, including mental illness, domestic violence and drug and alcohol misuse'*.[33]

2.4.6. Domestic and family violence: State and national priorities

Reducing domestic violence is a current priority of the NSW Premier, with a target of reducing the proportion of domestic violence perpetrators re-offending within 12 months by five per cent. In 2016, the NSW Government released the *NSW Domestic and Family Violence Blueprint for Reform 2016 – 2021: Safer lives for women, men and children*. The Blueprint outlines key directions for the response to domestic violence in NSW over the next five years, with actions intended to prevent violence, intervene early with vulnerable communities, support victims, and hold perpetrators accountable.

Responding to children living with violence is also a national priority area. The *National plan to reduce violence against women and their children (third action plan)* includes strategies aimed at improving the interactions between family law and child protection systems, and addressing service gaps and building capacity of specialist and mainstream service providers to recognise and respond to the impacts of violence on children.[34]

2.4.7. Legislative Council inquiry into child protection in NSW

In May 2016, the Legislative Council General Purpose Standing Committee No.2 established an inquiry into child protection in NSW. The inquiry report was released in March 2017 and included 28 recommendations to the NSW government and some government agencies to strengthen and improve early intervention; the capacity of the statutory system to respond to risk of significant harm reports; processes related to Children's Court proceedings; and outcomes for children in out-of-home care.[35]

32. Family & Community Services submission to General Purpose Standing Committee No.2 Child Protection Inquiry dated 29 July 2016.
33. Family & Community Services fact sheet, *Brighter Futures realignment*, December 2014.
34. Commonwealth of Australia (Department of Social Services) 2016. *Third Action Plan 2016 – 2019: National plan to reduce violence against women and their children 2010 – 2022*. Commonwealth government, Canberra
35. Legislative Council General Purpose Standing Committee No. 2, Child Protection Inquiry Report, March 2017, accessed from **https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6106/Final%20report%20-%20Child%20protection.pdf** on 22 March 2017.

Overall, the Inquiry found that, despite significant reform over the past decade, the child protection system in NSW is not meeting the needs of vulnerable children and families. Key recommendations include that:

- the NSW Government increase funding for evidence-based prevention and early intervention services
- the NSW Government commission an independent review of the Department of Family and Community Services' screening and assessment tools and processes
- the Department of Family and Community Services, in consultation with the NSW Ombudsman and stakeholders, develop a framework that focuses on the needs of vulnerable young people
- the NSW Government, in consultation with stakeholders, develop additional resources, training and support for carers
- the Department of Family and Community Services develop, in partnership with stakeholders, a broader workforce training and development framework for staff working with vulnerable children, young people and families
- the NSW Government review the provisions of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, to improve information sharing across jurisdictions for child protection matters.

2.4.8. FACS/Ombudsman Integrated Governance Framework

In 2015, the Ombudsman's office and FACS developed a joint process of monitoring identified issues in child protection. The FACS (Community Services)/Ombudsman Integrated Governance Framework is a joint mechanism for tracking FACS' progress towards implementing broad systemic reforms as well as addressing discrete system/practice issues that we have identified through our work, including issues and recommendations arising from our child death reviews. The Auditor-General noted the importance of developing this governance framework in his 2014 FACS financial audit report. We have discussed with FACS the scope to make a version of the IGF public for the purposes of promoting transparency and accountability.

Where relevant, this report draws on FACS' latest advice in relation to the issues we are monitoring via the Framework.

The following chapters describe our work, findings and observations relating to the deaths of:

- children in care
- children who died in circumstances of abuse, and
- children who died in neglect-related circumstances.

Chapter 3. Deaths of children in care

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* has a broad definition of 'child in care'. The definition includes children the subject of a statutory care order and those living with relatives or kin in a supported care arrangement. It also includes children placed voluntarily in out-of-home care, usually in disability accommodation services.

Between 1 January 2014 and 31 December 2015, 23 children in care died in NSW, representing two percent of all children in the state who died over that period. Of these children, 21 were in statutory or supported out-of-home care because of child protection concerns, and two were in the voluntary care of a disability respite service when they died.

Of the 22 children for whom cause of death information was available at the time of writing, ten died from natural causes and nine as a result of injury. For three children, a cause of death was unable to be established following coronial inquiries, including two infants who died suddenly and unexpectedly after being placed for sleep.

The deaths of three children in care were also reviewable because they occurred in circumstances of abuse (2) or neglect (1). These deaths are considered in detail in the relevant chapters of this report (5 and 6).

This chapter is presented in two parts. The first section considers the deaths of the 23 children who died in 2014 and 2015. The second section presents the findings and observations of a review of the deaths of 15 young people aged 13-17 years who died by suicide (9) or as a result of injury sustained in a context of risk-taking (6) between 2004 and 2015.

3.1. Out-of-home care in NSW

As noted above, the majority of children who die in care in NSW are in the statutory out-of-home care system. As at 30 June 2015, there were 17,858 children and young people in out-of-home care in NSW.[36] While the number of children in out-of-home care continues to rise[37], the rate of death of children in care has remained relatively stable over the last decade.[38]

Since the introduction of 'Safe Home for Life' in 2014, there has been a 14 percent increase in the number of children entering care, but a seven percent decrease in the overall number of children in the out-of-home care system. The decrease is largely attributable to the introduction of guardianship orders, which changed the legal status of a significant number of children in relative or kinship placements.[39] Children on guardianship orders are not considered to be in out-of-home care.[40]

It is well established that Aboriginal and Torres Strait Islander children are over-represented in out-of-home care, and continue to enter care at a rate much higher than that of non-Indigenous children.[41]

Children who enter out-of-home care are also likely to have greater health and developmental needs compared to peers who have not been in care. When they enter care, many children have a range of physical, developmental, emotional and mental health issues, some of which may not have been previously identified or addressed. It is also known that children in out-of-home care experience poorer long term health outcomes than children in the general population.[42]

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36. As defined in the *Children and Young Persons (Care and Protection) Act 1998*, this means a child or young person who is under the parental responsibility of the Minister or a person other than a parent as a result of a Children's Court order or decision by FACS.
37. NSW Department of Family and Community Services data dashboard - **http://www.facs.nsw.gov.au/facs-statistics/objective-1**
38. Over the last 10 years, the Crude Mortality Rate for children in care was 0.06 per 100,000 children.
39. Since October 2014, guardianship orders have replaced existing orders of the Children's Court granting parental responsibility to relatives and kin. Under a guardianship order, a child or young person is not considered to be in out-of-home care because they are in the independent care of their guardian. Unless there are other Children's Court orders in place that require FACS to remain involved, FACS does not provide ongoing casework support to children under guardianship orders.
40. As at 30 June 2015, 2,418 children and young people were the subject of a guardianship order; 796 of whom were Aboriginal. See NSW Department of Family and Community Services data dashboard - **http://www.facs.nsw.gov.au/facs-statistics/objective-1**
41. FACs submission to the Legislative Council Inquiry into Child Protection, July 2016.
42. Osborn A., & Bromfield, L. (2007), *Outcomes for children and young people in care*, National Child Protection Clearinghouse Brief No. 3: Australian Institute of Family Studies.

3.2. Children in care who died in 2014 and 2015

3.2.1. Characteristics of the children who died

Twenty-three children in care in NSW died between 1 January 2014 and 31 December 2015, representing two percent of all children in the state who died over the same period.

In line with the age profile of all children in care who died over the last 10 years, most of the 23 children who died in care in 2014-15 were either very young or were adolescents, eight were four years of age or younger (including four infants) and six were aged 15-17 years.

The majority of the children who died (14) were male. This has consistently been the case, with male children accounting for two thirds of the deaths of all children in care over the 10-year period to 2015.

Eight children who died in 2014-15 and more than half (32) of the children who died in care over the last 10 years were of Aboriginal or Torres Strait Islander background.[43] This reflects the high proportion of children in out-of-home care who are Aboriginal. In 2015, 37 percent of all children in out-of-home care were Indigenous.[44]

Six of the children who died in 2014-15 were identified as being from a culturally and linguistically diverse background.

3.2.2. Cause of death

Ten children in care died as a result of natural causes in 2014-15. Nine children died from injury-related causes, and cause of death for three children was unable to be determined following coronial inquiries. For one child, information about cause of death was unavailable as coronial processes had not been finalised at the time of writing.

Deaths due to natural causes

The 10 children who died as a result of natural causes had conditions including Rhetts Syndrome, Leigh's Syndrome, Sandhoff disease and cerebral palsy. Associated health conditions included epilepsy, sensory impairment, developmental delay, scoliosis and recurrent chest infections.

Deaths due to injury-related causes

Six of the nine children who died from an injury-related cause died as a result of unintentional injury:

- Two children died in transport fatalities. In both cases, the driver of the vehicle was a peer. In one case the circumstances indicated risk-taking behaviour and is considered below.
- Two children drowned; one in a backyard swimming pool at the carer's home and the other at the beach. The child who drowned in a swimming pool accessed the water while unsupervised. The pool did not have an up-to date compliance certificate, and police and council inquiries after the child's death identified a number of pool barrier defects, including that the gate was not self-latching. Our review found that the supervising non-government out-of-home care agency did not undertake a home/pool safety inspection after the pool had been installed, or otherwise check the pool barrier for compliance with relevant legislation during subsequent home visits. The agency's internal review of the child's death made a number of recommendations, including reinforcing the need for caseworkers to specifically look out for safety risks in carer households as part of placement monitoring.

43. This includes four children who were not identified as Aboriginal in birth/death registration records, but other agency records identified that the children were Aboriginal.
44. NSW Department of Family and Community Services data dashboard - http://www.facs.nsw.gov.au/facs-statistics/objective-1

- One young person died as a result of multiple drug toxicity. The coronial inquest found that there was no evidence that the young person administered the drugs with the intention of causing harm.
- One young child died as a result of choking on food, highlighting the importance of effective education strategies that promote carer and caseworker knowledge about safe feeding practices.

Three children died as a result of intentional or inflicted injury:

- One young person died by suicide.
- Two children died as a result of blunt force or multiple injuries; both deaths are open police investigations. These cases are included in chapter 5, abuse-related deaths of children in 2014 and 2015.

SUDI and sudden deaths of unknown cause

Two infants and one child died suddenly and unexpectedly. In each case, forensic and coronial investigations were unable to establish a cause of death. Records indicate that the children had been well in the weeks before their deaths.

- Two infants died suddenly and unexpectedly after being placed for sleep. The supervising agency's internal review of one infant's death identified the need for consistent messages about SUDI risk factors and safe sleep environments to be delivered to foster, relative and kinship carers.
- One child died suddenly and unexpectedly at home. No suspicious circumstances were identified and a cause of death was unable to be ascertained.

3.2.3. Parental responsibility and care status

In NSW, the majority of children in out-of-home care are subject to a Children's Court order allocating parental responsibility to the Minister.[45] Sixteen children in care who died in 2014 and 2015 were subject to final orders of the Children's Court:

- parental responsibility for 12 children was allocated to the Minister for Community Services until 18 years of age
- parental responsibility for two children was shared between the Minister for Community Services and a relative of the child until 18 years of age
- parental responsibility for two children was allocated to a relative or carer of the child.

In addition, care proceedings were underway for three children who were the subject of interim Children's Court orders when they died.

3.2.4. Length of time in care and child protection history

The length of time that the children who died in 2014-15 had been in care ranged from less than one month to more than 14 years. Close to half (10) of the children had been in care for more than five years, and seven children had entered care less than 12 months before they died.

The majority of the children were assumed into care following child protection reports that raised concerns about their safety. Two children with significant disability did not have a child protection history and were under the parental responsibility of the Minister at the request of their parents. One child resided with foster carers and the other was placed in the long term care of a disability accommodation service.

45. NSW Department of Family and Community Services data dashboard - http://www.facs.nsw.gov.au/facs-statistics/objective-1

Most (18) of the children had been the subject of a child protection report to FACS within three years of their deaths. For the majority of these children, the child protection history preceded and was the reason for their entry into care. However, 11 of the 18 children were also the subject of one or more child protection report(s) while they were in care. The reasons for the child protection reports included concerns about the child's risk-taking behaviours and/or mental health problems or exposure to risk of harm from adults outside of the placement.

For four children, reports related to the children's carers. The reports concerned allegations of abuse and questions about carer capacity to act protectively or to adequately meet the child's high needs. These reports were allocated and assessed by FACS, and in one case, Police.

As a result:

- at the time of one young person's death, criminal proceedings for assault were underway against a staff member at a non-government residential care service where the young person previously lived
- another placement was subject to increased supervision and monitoring, and
- additional support and training was provided to the carers of the other two children.

3.2.5. Placement arrangements – where the children were living

Almost half of all children in out-of-home care in NSW live with relatives or kin, and over 40 percent in foster care.[46] A small number of children live in residential care services or other types of care. Most of the children in care who died in 2014 and 2015 were residing in placements provided or funded by FACS:

- the majority (14) of the children were living in foster care, with case management responsibility held by FACS in eight cases and a non-government organisation in six cases
- four children were living in relative/kinship care supported by FACS, and
- two young people were living in residential care services run by non-government organisations for children with complex needs
- two children the subject of a voluntary care arrangement died in the care of a disability respite service
- one child under the parental responsibility of the Minister and with significant disability and associated health needs was residing at a service funded by NSW Health.

3.2.6. Vulnerable young people in care

Young people in care are a particularly vulnerable group who may have complex and chronic needs with regard to their behaviour, development, emotional and mental health. Young people in care with complex needs have often experienced significant histories of abuse (as victims, perpetrators or both), mental health issues, school suspension or expulsion and difficult familial relationships. They are also typically involved with multiple service providers at any one point in time.

As noted above, four of the children who died in care in 2014 and 2015 were adolescents who died from injury-related causes, including transport incidents, unintentional drug overdose and suicide. These young people were reported to have high needs stemming from repeated exposure to violence and other traumatic events both before and during their time in care.

46. As at 30 June 2015, 47% (8,221) of all children in out-of-home care were in a relative or kinship placement and 45% (7,861) were placed with foster carers. See NSW Department of Family and Community Services data dashboard - http://www.facs.nsw.gov.au/facs-statistics/objective-1

The Ombudsman's office has previously identified concerns about the adequacy of service provision to vulnerable older children and young people and have highlighted two recurring themes from our review work:

- the need for targeted, timely and coordinated intervention and support for young people at risk, and
- the importance of early intervention, both early in life and early in need.[47]

Given the importance of effective collaboration between FACS and other agencies working with young people at high risk, in previous reports to Parliament the Ombudsman has also recommended that a clear framework be developed to guide interagency practice and more clearly define the role of partner agencies in identifying and responding to young people with high and complex needs.[48]

The chapter below examines the deaths of 15 young people between the ages of 13 and 17 who had complex needs and died in the context of risk taking or by suicide.

47. NSW Ombudsman (2015), *Report of Reviewable Deaths in 2012 and 2013 Volume 1: Child Deaths*, accessed from https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths-vol-1/report-of-reviewable-deaths-in-2012-and-2013-volume-1-child-deaths

48. NSW Ombudsman (2011), *Keep Them Safe?*; NSW Ombudsman (2014), *Are Things Improving?*. Both reports can be accessed from our website – www.ombo.nsw.gov.au.

Chapter 4. Risk-taking and suicide deaths of young people in care

Since our role in examining 'reviewable' deaths started in 2004, 47 young people aged 13-17 who were in care in NSW have died.[49] The majority (28) of these young people died from natural causes, often associated with significant disability or progressive health conditions.[50] Of the 18 young people who died as a result of injury-related causes, our reviews identified that the majority (15) died by suicide (9) or in circumstances of risk-taking (6).

As detailed in the section below, we reviewed the circumstances of these 15 young people. For the purposes of our review, we considered a death to occur in risk-taking circumstances if the young person was involved in an activity or behaviour in the period immediately preceding their death that posed a significant foreseeable risk to their safety. Four of the six young people whose deaths occurred in risk-taking contexts died following an unintentional drug overdose, and two died from injuries sustained in motor vehicle crashes.

All 15 young people whose circumstances we reviewed had been identified by relevant agencies prior to their deaths as having high and complex needs. The scope and complexity of the problems experienced by the young people is discussed below.

4.1. Cause and circumstances of death

4.1.1. Deaths by suicide

Based on an analysis of child deaths over a ten year period (2002-2011), the NSW Child Death Review Team identified that the suicide mortality rate for children and young people with a child protection history was 4.1 times higher than those without this history.[51]

The nine young people in care who died by suicide accounted for five percent of all suicide deaths of young people aged 13 to 17 years in NSW over the period. Six of the nine young people were 15 years or older when they died and five were male. One young person was Aboriginal. In all nine cases, suicide risk had been identified by carers or professionals prior to the young person's death.

Mental health difficulties and adverse and traumatic events in childhood can be precipitating factors in suicide attempts or suicides. In particular, physical abuse, sexual abuse and family violence have been associated with suicide attempts.[52] Child protection histories for all nine young people documented significant trauma and experiences of abuse before they came into care. The nine young people also experienced mental health problems. These factors are detailed below.

4.1.2. Deaths in the context of risk-taking behaviours

Young people typically face different risks compared to younger children, as they move towards greater independence and come into contact with wider social networks. They are also more likely to engage in risk-taking behaviours that make them vulnerable to harm.[53]

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49. The deaths occurred between 2004 and 2015.
50. A cause of death for one young person was unable to be determined following coronial inquiries.
51. NSW Child Death Review Team (2014), *Causes of death of children with a child protection history*. NSW Ombudsman, Sydney.
52. Suicide Prevention Australia (2010), op cit.
53. Gorin, S. & Jobe, A (2013), 'Young people who have been maltreated: Different needs – different responses', *British Journal of Social work*, vol. 43, pp. 1130-46.

Taking risks is a part of the adolescent developmental stage and can provide young people with a way to learn more about themselves and their environment. A moderate amount of risk-taking has been shown to assist with the development of social competence and the transition to adulthood. However, problematic or extreme risk-taking can place the young person at risk of serious harm and increase the likelihood of poor longer term outcomes.[54]

For the six young people in care who died in a context of risk-taking:

- Four died from drug toxicity. They were aged between 15 and 17 years. Two were living in residential care, one had recently self-restored to a parent and the other was staying in refuge accommodation at the time of death. In each case, the Coroner found that the young person's death was unintentional and resulted from the combined effect of multiple substances. The four young people were the subject of reports to FACS within 12 months of their deaths concerning an escalation in risk-taking behaviours, including drug and alcohol misuse.
- Two young people aged 13 and 15 years died from injuries sustained as passengers in single motor vehicle crashes. One was living with foster carers and the other in a long-term relative placement. Contributing factors identified by police in both cases included speed, driver blood alcohol over the legal limit, no restraint use, dangerous driving and over-crowded vehicles. Post mortem results indicated that both young people were also affected by alcohol at the time of the crash. One young person was travelling in the tray of a utility vehicle when the driver lost control and the other was unrestrained and sitting on the passenger seat window.

4.2. Care status and circumstances

Nine of the 15 young people were the subject of court orders allocating parental responsibility to the Minister when they died. The others were placed with relatives or kin pursuant to a supported care arrangement or were otherwise in the care of a service provider. Living arrangements for the 15 young people at the time of their deaths was as follows:

- four were living in a residential care service
- four were living with foster carers
- three were living with a relative or kin carer
- two had self-restored to a parent, and
- two were homeless and had been staying intermittently in refuge accommodation.

Half of the young people (9) had been in their current placement for less than two years; seven for less than 12 months.

Later entry into care has been associated with increased placement disruption, greater likelihood of placement in residential care and poorer outcomes in adolescence, particularly in relation to emotional and behavioural difficulties.[55] The age at which the young people first entered care ranged from shortly after birth to 16 years. However, the children tended to be older: nine of the young people were 10 years or older at the time they entered care.

The length of time that the young people had been in care varied. Of the 15 young people, six had been in care for two years or less, four had been in care for between three and nine years, and five had been in care for 10 years or more. FACS' data shows that over the past decade, children in out-of-home care are increasingly entering care at a younger age and are staying for longer periods of time.[56]

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54. Lemer, R & Galambos, N. (1998), 'Adolescent development: challenges and opportunities for research', *Annual Review of Psychology*, 49: 413-46; Schimied, V., & Walsh, P. (2010), 'Effective casework practice with adolescents: perspectives of statutory child protection practitioners', *Child and Family Social Work*, 15: 165-175.
55. Osborn A., & Bromfield D (2007), 'Outcomes for Children and Young People in care', *NCPC Brief No. 3*, Australian Institute of Family Studies.
56. FACs submission to the Legislative Council Inquiry into Child Protection, July 2016.

4.3. Identified vulnerabilities and risk factors

All of the 15 young people had been identified by relevant agencies as having high and complex needs. They were known to, and had some level of involvement with, support services prior to their deaths, including health practitioners or programs to address risk, including mental health problems, risk of suicide, drug and alcohol use and offending behaviours. In the 12 months before they died, the majority of the young people:

- exhibited challenging and/or risk-taking behaviours of such intensity, frequency and duration that they placed themselves (and sometimes others) at serious risk of harm, and/or
- experienced mental health problems to an extent that impacted their ability to access services and participate in education and other day-to-day activities.

For a number, records indicate a significant escalation in challenging and risk-taking behaviours in the months prior to their death. The section below illustrates the vulnerabilities and risk factors present in the lives of the 15 young people.

4.3.1. Trauma and child protection history: reported issues prior to entry into care

It is well documented that young people in care, particularly those with serious behavioural or emotional problems, are likely to have experienced significant trauma from exposure to multiple and ongoing stressors associated with abuse, neglect, grief, and/or complicated family relationships.[57]

The impact of past experiences of trauma often manifest in disruptive or challenging behaviours that can be harmful to the young person and/or others.[58] Such behaviours include drug or alcohol misuse, violent or aggressive behaviours, criminal offending, sexually inappropriate behaviours and running away. Research indicates that these types of behaviours are associated with poor impulse control or regulation of emotions, resistance to boundaries, social isolation and limited capacity to form trusting relationships.[59]

Records indicate that each of the 15 young people had experienced traumatic or adverse events throughout their lives and had extensive child protection histories that predated, and were the reason for, their entry into care. Parental alcohol and/or drug misuse, parental mental illness, neglect, exposure to domestic violence and physical abuse were the main concerns reported for the young people before they were assumed into care. Reported concerns did not occur in isolation for any of the 15 young people, with eight having been reported in relation to multiple risks. For most, child protection reports indicated early exposure to significant risks.

A number of the young people had also experienced other traumatic events prior to their entry into care, including substantiated sexual abuse, abandonment or relinquishment of parental care, and the death of a parent.

Intergenerational risk factors were identified in relevant records for some of the young people. In the case of three young people living with relatives under a supported care arrangement, carer suitability assessments and/or FACS records identified that the carers may have experienced traumatic events and/or been exposed to violence or abuse during their own childhood. FACS reviewed the deaths of two of these young people. These internal reviews found deficiencies in aspects of carer assessments, including the need for greater rigour in assessing the impact of a prospective carer's history and capacity to understand the needs of children with a trauma background.

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57. Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012; cited in Youth Health Resource Kit, NSW Kids and Families, 2014, p. 84.
58. McAloon, J (2014), *A Literature Review – Developing a Framework for Therapeutic Out of Home Care in NSW*, Association of Children's Welfare Agencies.
59. McLean, S., Price-Robertson, R., Robinson, E., (2011), 'Therapeutic residential care in Australia: Taking stock and looking forward', Australian Institute of Family Studies, *NCPS issues*, no. 35 (2011).

It is widely acknowledged that appropriate and timely therapeutic responses are necessary to address the underlying impact of trauma and associated behaviours, and research indicates that demonstrated commitment and continuity are crucial elements of working effectively with young people at high risk.[60] A trauma-informed approach to the provision of care recognises that challenging and risk-taking behaviours are often directly linked to the experience of trauma and likely reflect coping mechanisms developed by the young person over time.[61]

In 2016, FACS and the Association of Children's Welfare Agencies (ACWA) finalised a framework for therapeutic out-of-home care in NSW, including young people with high and complex needs residing in residential care. The aim of the framework is to provide guidance for carers and casework staff on supporting children and young people to recover from traumatic experiences in their past. FACS also published an evidence based model for therapeutic residential care in 2016, noting that the essential elements of the model could also be applied across all placement types.[62]

Given the significant trauma histories and associated high support needs of the young people in our review group, our reviews reinforced the need for suitably qualified carers and staff, with appropriate and ongoing training, supervision and support, to provide quality and trauma-informed care to young people with high support needs.

4.3.2. Interpersonal difficulties

There is an increasing understanding of the significant impact of early abuse, neglect and disrupted attachment on the capacity of young people to build positive and trusting relationships with others.

Records for the 15 young people whose deaths we reviewed revealed a lack of stable and secure relationships at critical periods in their lives. For the majority, child protection reports indicated a lack of reliable adult attachments before their assumption into care and movement between different caregivers after being taken into care.

This lack of stability can have an adverse impact on the young person's ability to meaningfully engage with therapeutic support services.[63] For example, in the case of one young person whose death was subject to Coronial inquest, the Coroner referred to expert evidence which noted that *'due to [the young person's] traumatic upbringing, [the young person] was unlikely to have tolerated any counselling or psychotherapy in any meaningful sense. The distressing reality is that the abuse and trauma that [the young person] had experienced…meant that she was unable to take advantage of the support services that she so desperately needed'*.[64]

The majority of the young people also experienced difficulties in their relationships with carers, caseworkers and family. Conflict in relationships with peers, including being the perpetrator and/or victim of bullying, aggressive or violent behaviours was also evidenced for some young people, including at school and within placements. In addition, some of the young people also appeared to have experienced complicated grief reactions associated with their entry into care, including as a result of parental rejection or disconnection to culture.

The following case study illustrates the importance of developing and implementing timely strategies - with relevant clinical input- to address evidence of escalating risks and interpersonal conflict.

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60. Schimied, V., & Walsh, P., (2010), 'Effective casework practice with adolescents: perspectives of statutory child protection practitioners', *Child & Family Social Work*, vol 15(2): 165-175.
61. McAloon, J (2014), *A Literature Review – Developing a Framework for Therapeutic Out of Home Care in NSW*, prepared for NSW Department of Family and Community Services and Association of Children's Welfare Agencies, accessed from **http://www.facs.nsw.gov.au/_data/assets/file/0011/386786/TC-Fwk_Literature-Review-for-public-consultation.pdf** on 18 January 2017.
62. NSW Department of Family & Community Services (2016), *Therapeutic Care Framework FAQs*, accessed from **http://www.facs.nsw.gov.au/reforms/therapueticcare**, on 18 January 2017.
63. Ludy-Dobson, CR & Perry, B.D (2010), The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma, in *Working with Children to Heal Interpersonal Trauma: The Power of Play.* Edited by Eliana Gil: *The Guilford Press, New York.*
64. NSW State Coroner inquest findings, Inquest into the death of M, 12 September 2016, accessed from **http://www.coroners.justice.nsw.gov.au/Documents/m-finding.pdf**.

CASE STUDY

One young person had been in a stable placement with foster carers from a very early age. Responsibility for managing the placement resided with a non-government out-of-home care agency. In the year before the young person's death, the carers raised concerns with the out-of-home care agency about deterioration in the young person's mental health, increased conflict within the placement and an escalation in risk-taking and absconding behaviours. The young person had been suspended from school on a number of occasions and commenced at a new school two months before death due to ongoing conflict/bullying by peers. The young person had also been receiving mental health counselling and support. An internal review by the supervising out-of-home care agency following the young person's death found that a behaviour management plan was not developed for the young person, contrary to policy requirements and against the background of evidence of escalating risk. The review noted that *'a plan would have provided an opportunity for the carers to provide input into the plan, and for clinical advice to be sought. In particular a more holistic review of the various medical treatments being recommended could have been undertaken including liaising with professionals involved in [the young person's] support'*.

4.3.3. Mental health and emotional difficulties

Records for nearly all (14) of the 15 young people indicated that concerns about mental or emotional difficulties were known to relevant agencies prior to death, including FACS, Health, Education and out-of-home care agencies with case management responsibility for the young person.

Research indicates that young people in care have an increased risk of suicide and/or self-harm compared to peers who have not been in the care system.[65] Seven of the young people had been diagnosed with a mental illness, predominantly depression and/or anxiety. Other conditions included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, emerging personality disorders and adjustment/conduct disorders.

Almost all (13) of the young people, including all with a diagnosed mental illness, had accessed mental health services prior to their deaths, with a number having received treatment from one or more professionals. Records indicate regular engagement with mental health and/or counselling services for nine young people over the 12-month period before they died. The main sources of support were psychiatrists, psychologists or counsellors, Child and Adolescent Mental Health Services (CAMHS), NSW Health Acute Services, Headspace programs and/or school counsellors.

Most (6) of the young people with a diagnosed mental illness had been prescribed medication to help manage their condition. For two young people, records indicate non-compliance with medication regimes in the weeks or so prior to their deaths.

Records documented that most (12) of the 15 young people – including the nine who died by suicide – had previously threatened or expressed suicidal intent to carers, health or other professionals; seven had a history of self-harm and one or more previous suicide attempts.

Within 12 months of their deaths, six of the 15 young people had presented to hospital on at least one occasion for a suicide attempt, as a result of a suicide threat or ideation and/or for an acute episode related to their diagnosed mental illness:

- two young people who died by suicide were admitted involuntarily to hospital, each on more than one occasion following a suicide attempt
- four young people presented to hosptial after engaging in self-harming behaviours and expressing suicidal intent to a carer or other adult; two died by suicide and two following an unintentional drug overdose.

65. Katz, L.Y., Au, W., Singal D., et al (2011), 'Suicide and suicide attempts in children and adolescents in the child welfare system', *Canadian Medical Association Journal*, 183: 1977-81.

These hospital presentations resulted in an overnight or longer admission, followed by mental health assessment. Upon discharge, the young people were linked to Acute Care Services or Child and Adolescent Mental Health Services for support. At the time of their deaths, four of the young people had been accessing mental health support services on a regular basis. However, records indicate that the other two young people repeatedly refused attempts by carers, caseworkers and health staff to engage them in sustained treatment and support.

Eleven young people had a history of self-harming behaviour, sometimes in addition to threats or disclosures of suicidal thoughts and/or attempted suicide. Self-harming behaviours ranged from infrequent occurrences to frequent episodes over a long period, sometimes requiring medical treatment for resulting injuries.

For some young people (8), carers, schools or other support services had raised concerns to FACS, supervising out-of-home care agencies and/or health providers about a recent deterioration in the young person's mental health in the months or weeks before they died. For example, reports indicated that these young people were displaying increased behavioural and emotional difficulties, including self-harming behaviours and/or expressed suicidal intent.

The eight young people were referred to relevant mental health services; however, some persistently refused to attend appointments or demonstrated reluctance to meaningfully engage. Others experienced periods of homelessness or placement instability that adversely impacted on their capacity to engage with mental health and other support services in an ongoing way.

For young people experiencing complex and chronic mental health problems, the case studies below illustrate the importance of coordinated service provision and timely communication between all involved agencies, including mental health practitioners, carers, out-of home care service providers and FACS.

CASE STUDY

One young person who died had a history of significant mental health problems, including self-harm and suicidal ideation, and was placed in a non-government service for adolescents with high and complex needs. NSW Health was providing mental health support to the young person, and FACS was providing case management. Both agencies conducted reviews following the young person's death, each identifying the challenges in working with young people with complex needs, and finding that communication between the relevant agencies could have been improved. A Root Cause Analysis (RCA) completed by NSW Health identified that there was no established process between mental health services and the out-of-home care agency to facilitate information sharing and collaboration. In addition, there were no regular interagency case reviews or planning meetings to assess the effectiveness of treatment interventions, and inform decision-making in relation to the young person's overall care plan. The RCA noted that *'while not a contributing factor [to the young person's death], these issues present as barriers to providing comprehensive holistic care'*. As a result, the Local Health District implemented a service level agreement between the relevant mental health service and out-of-home care agency to provide a framework for collaborative care for young people.

CASE STUDY

Two young people who died were case managed by FACS in high needs placements provided by non-government out-of-home care agencies; one resided with foster carers and the other in a residential care service. Both had identified high needs in relation to their behaviour and mental health, and had a history of self-harm and suicidal behaviour. The young people had received support from mental health services and had also demonstrated a degree of non-compliance with mental health recommendations. For example, records indicated that neither had complied with prescribed medication in the weeks before they died. Our reviews identified opportunities for practice improvement and coordination of services to both young

people. Following recommendations from FACS' internal review into the death of one young person, the supervising CSC convened a meeting with relevant health services to examine the management of the case and to develop a plan to improve service delivery to young people in statutory care at high risk. The out-of-home care agency also completed a review of the young person's death and made a number of recommendations aimed at improving its practice, policy and procedures including in relation to carer assessment, authorisation and review; staff supervision and support; and assessment of, and attention to, the young person's needs. In the second case, FACS recommended that the region facilitate a case practice discussion with relevant managers and caseworkers to consider identified practice and systemic issues and how to incorporate learning from the review into casework practice.

4.3.4. Problematic substance use

Research indicates that young people in out-of-home care are at greater risk of problematic drug and alcohol use than peers without a child protection or care history.[66] Substance misuse can increase vulnerability and risk of harm for young people.[67] In addition, the relationship between co-occurring substance misuse and mental health problems has been found to be one of mutual influence, with each condition serving to maintain or exacerbate the other.[68]

Our reviews identified long standing and problematic substance use for nine of the 15 young people, including misuse of alcohol, cannabis, amphetamines, opiates and prescription drugs. Four of these nine young people died following an unintentional drug overdose and five by suicide.

The nine young people with a history of identified substance misuse also exhibited significant and escalating risk-taking behaviours, and had experienced mental health difficulties in the year preceding their deaths. Five had been diagnosed with a mental illness, including depression, anxiety and personality disorder.

Three of the nine young people had presented to a hospital emergency department within 12 months of death due to intoxication, and in some instances, related injuries. Two were residing in a residential care service, and the other - who was intermittently experiencing housing instability during the period - presented intoxicated to hospital on multiple occasions. The young people were treated and discharged to the care of the residential care providers, or in the case of the young person who was homeless, the FACS specialist adolescent team providing support.

Records indicate that the young people were repeatedly offered assistance from carers, caseworkers and/or other involved professionals to help the young person access support services to address harmful substance use. A number of the young people persistently declined to participate and records documented that these young people were assessed to demonstrate a lack of willingness or readiness to engage.

Records for three of the young people document referral to an alcohol and other drugs service for assessment and treatment. Two of the young people participated in residential rehabilitation programs in the three years before they died. One participated in treatment on two separate occasions but self-discharged before completing the program on each occasion. Another young person was exited from the program after engaging in threatening and aggressive behaviour towards another patient. The third young person participated in a drug and alcohol program during a period of detention and attended a number of sessions with a drug and alcohol counsellor in the community before refusing to further engage.

In response to a draft of this report, NSW Health advised that *'the NSW Government, through the Ministry of Health, has increased funding to tackle alcohol and other drug misuse in NSW communities by $75 million over four years. The Youth Treatment Services Project is one element of*

66. Braciszewiski, J & Sout, R (2012), 'Substance use among current and former foster youth: A systematic review', *Child Youth Review, 34(12): 2337-2344.*
67. Bromley E, Johnson JG, Cohen P (2006), 'Personality strengths in adolescence and decreased risk of developing mental health problems in early childhood', *Comprehensive Psychiatry*, 47 (4): 317026.
68. NSW Health (2015). Effective models of care for comorbid mental illness and illicit substance use: Evidence check review.

this funding…[and involves] an investment of $16 million to expand youth specific detoxification and treatment services for more than 1,000 young people. The investment will include enhancements to medical workforce capacity as well as supporting new treatment services'.[69]

4.3.5. Child protection reports while in care

Fourteen of the 15 young people were the subject of child protection reports to FACS whilst in care. Reported concerns related mainly to the risk taking behaviour of the young person, including for example: absconding and risk of homelessness; alcohol and/or drug misuse by the young person; risk of sexual harm/exploitation from peers or adults outside of the placement; self harming or suicide risk; and criminal offending or violent/aggressive behaviours. For many of the young people, these problems were co-occurring. In the 12 months prior to their death, the frequency of reports to FACS about the fourteen young people varied, ranging from six to 60 reports.

Of the 14 young people who were the subject of child protection reports within 12 months of their deaths, a number (6) had open reports and/or case plans with FACS when they died, in some cases with specialist adolescent or intensive support teams. Casework was largely focused on securing emergency accommodation or other immediate/crisis supports, and receiving and/or providing relevant information to out-of-home care providers and health services in relation to the young person's challenging or risk-taking behaviours.

For the eight young people without an open and allocated case at FACS, few received a face-to-face assessment or child protection response in response to reports received in the year before they died. In the main, reports that raised concerns about the young person engaging in self-harm or serious risk-taking behaviour were either screened out by the Helpline as not meeting the threshold for statutory intervention, or closed due to competing priorities by CSCs, and where relevant, referred to the agency with case management responsibility for action.

FACS' Case Management Policy outlines the circumstances in which FACS should remain actively involved with a child or young person following case management transfer to a non-government out-of-home care agency. These circumstances include the receipt of a child protection report, children who experience multiple placement breakdowns, children who are placed in residential care and children with high and complex needs who require specialist supports.[70]

Following our review of the death of one young person in a long term foster care placement managed by a non-government agency, we asked FACS about the adequacy of its response to non-ROSH reports that indicated a significant increase in harmful and risk-taking behaviours by the young person. In response, FACS advised that the agency was developing guidance for FACS staff about how to respond to both ROSH and non-ROSH reports relating to children and young people in care who receive case management from a non-government out-of-home care agency. FACS told us that the guidance will emphasise the importance of collaboration, including joint fieldwork with non-government providers in appropriate cases, but will make it clear that FACS has responsibility for assessing child protection risks. In reponse to a draft copy of this report, FACS advised this guidance has now been incorporated into newly developed casework practice mandates.[71]

4.3.6. Placement instability and absconding

Young people who have had multiple placement breakdowns, a history of absconding from placements and/or who experience homelessness are more likely to become disengaged from education and employment, and are at increased risk of developing substance dependence or mental health problems.[72] For example, a longitudinal study examining outcomes for children in out-of-home

69. Correspondence from NSW Health to NSW Ombudsman, 8 June 2017.
70. NSW Family & Community Services (2015), *OOHC Case Management Policy*, accessed from **http://www.community.nsw.gov.au/__data/assets/file/0020/340553/OOHC-Case-Management-Policy.PDF** on 18 January 2017.
71. Correspondence from NSW Department of Family and Community Services to NSW Ombudsman, 2 June 2017.
72. Department of Families, Housing, Community Services and Indigenous Affairs (2008), *Literature Review: Effective Interventions for Working with Young People who are Homeless or at Risk of Homelessness,* Institute of Child Protection Studies and Australian Catholic University.

care in NSW found that outcomes across a range of domains were poorest for young people who experienced six or more placement breakdowns.[73] Young people in out-of-home care are also over represented amongst those who experience housing instability or homelessness.[74]

Care histories for the majority of the 15 young people in our review group were characterised by significant disruption and multiple placement changes, often across different care settings. This was particularly the case for the 10 young people who first entered the out-of-home care system after the age of 10 years. Half of the young people (5) who entered care at a later age had care histories that were highly unstable, with each having had more than five placement breakdowns and periods of time spent in residential care, refuge accommodation and/or detention after placements with relative or foster carers had broken down due to the carers' inability to manage the young person's extreme self-harming, absconding and/or aggressive behaviours.

Nine of the 15 young people were the subject of reports to FACS within 12 months of their death raising concerns about the young person running away from their placement, for periods ranging from several hours to several days. Reports indicated that a number (4) absconded frequently, including three of the young people who were living in residential care when they died.

In many instances, police were contacted by FACS or the relevant out-of-home care agency to locate the young person. Reports concerning the young person's absconding were not generally prioritised for assessment by FACS once the young person had been located and returned to their placement. However, most of the young people had some level of involvement with other support service services, predominantly health or clinical supports either arranged or provided by the supervising out-of-home care agency. In a number of cases where FACS had case management responsibility, FACS' casework responses were focused on securing crisis accommodation or alternative placements. In other cases, active casework by agencies with designated case management responsibility was evident, including referrals to, and supporting the young person to access, relevant services.

The case study below illustrates the heightened risks facing young people who experience significant placement instability and some of the challenges for the agencies supporting them.

CASE STUDY

Two young people in the review group died following accidental drug overdose. Both of the young people entered care during adolescence and were subject to case management by FACS. They had complex needs which placed them at high risk, including intellectual disability, substance misuse and extremely challenging and at times violent behaviour. Both young people had also experienced ongoing placement instability and periods of transcience, including in the period just before their deaths. One young person had mental health issues and a history of presentations to hospital for treatment of self-inflicted injuries. The other exhibited chronic and significant offending behaviour, resulting in periods of time in juvenile detention. In each case, the young person received extensive casework and had some involvement with supprt services, but with limited outcomes. The high level of instability in the young people's circumstances presented challenges for professionals supporting them. Our reviews identified that casework responses were largely reactive and crisis based. Placement instability and a lack of continuity in carers and support workers compounded the other significant risk factors present in the lives of these young people and appeared to further impede their capacity to maintain engagement with relevant services.

73. Osborn, A.L., Delfabbro, P., & Barber J (2008), 'The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care, *Children and Youth Services Review*, vol 30(8): 847-860.

74. Australian Institute of Health and Welfare (2016), *Vulnerable young people: interactions across homelessness, youth justice and child protection – 1 July 2011 to 30 June 2015*. Cat. no. HOU 279. Canberra: AIHW.

4.3.7. Educational engagement while in care

Children and young people who experience significant interruption to their schooling are not only at a disadvantage in terms of educational attainment and long term outcomes, but also lose the social network and structure that school can provide, and may be exposed to other risks.

Education histories for the majority of the 15 young people indicated disrupted schooling. This was predominantly due to placement changes and/or behavioural problems resulting in suspensions and sometimes expulsion. Available records document a history of chronic school absenteeism for eight of the young people; four ceased attending school some time before reaching the minimum school leaving age and refused attempts to re-engage them by schools, caseworkers and carers.

Five of the young people had been suspended from school on at least one occasion for exhibiting violent behaviours towards school staff or other students. Records indicate that a number of these young people were also the subject of aggression or bullying by peers.

CASE STUDY

A young person living in a residential care service had not attended school for more than 12 months before they died, effectively leaving school at 14 years of age. FACS held case management for all but the last few months of the young person's life, when case management was transferred to a non-government out-of-home care agency. Our review identified that residential care staff made two documented attempts to engage the young person in an education program that caters to young people who have disengaged from mainstream school. The young person partially attended two sessions before declining to participate any further. Our review found that there was no documented education plan for the young person as required by Department of Education policy. We found no evidence of effective interagency collaboration between FACS, the Department of Education and the non-government out-of-home care agency in relation to the young person's educational needs and to facilitate enrolment and participation in an appropriate program.

The Department of Education's Home School Liaison program aims to re-engage children and young people who are not attending school regularly. For most of the 15 young people, our reviews found that schools developed education plans and behaviour support plans for those young people who were engaging in challenging behaviours at school. In addition, at least three of the young people were referred to the Home School Liaison program. However, records indicate that involvement in the program did not result in a sustained increase in attendance for these young people.

Our office is currently undertaking a separate review of school attendance data for a sample of 128 children and young people placed in residential out-of-home care. This work is part of a broader inquiry by the Ombudsman into school behaviour support across NSW.

Preliminary results from this review indicate high levels of school non-attendance amongst the 128 children and young people. In the 2016 school year, the children and young people in our review group did not attend an average of 88 school days for a range of reasons, including suspensions, expulsions, delayed enrolments and students' refusal to attend. We also found that over 70 per cent of the children had identified additional support needs at school, and 55 per cent had one or more disabilities.

4.3.8. Contact with the criminal justice system while in care

The majority (10) of the young people had some level of involvement in the criminal justice system, either as alleged victims, alleged offenders, or both.

Five of the young people had been charged with at least one criminal offence resulting in a period of detention for three young people. The main offences for which the young people were charged included theft, malicious damage, break and enter and assault. A number of the offences were committed by young people at a time when they were living in residential care, including for example, property damage and physical assaults against staff or other residents.

For two of the young people who had spent time in juvenile detention due to chronic offending and breach of bail conditions, our reviews identified that the roles and responsibilities of FACS – as the agency with case management responsibility – and Juvenile Justice were at times unclear and resulted in missed opportunities to implement joint strategies to assist the young people post-release. The circumstances of one of these young people is outlined in the case study below, illustrating the importance of effective interagency communication and collaboration to effectively support young people after release from detention and reduce the risk of re-offending.

CASE STUDY

A young person who died in 2012 had a history of unstable relative placements and risks in care, including carer substance abuse, neglect and exposure to domestic violence. The young person was under the case management of FACS, and had multiple self-directed placement changes in the three years before death. The young person also spent periods of time in juvenile detention due to chronic offending behaviour and breach of bail conditions. Multiple child protection reports raised concerns about the young person's escalating violence, self-harm, substance misuse and emerging mental health problems. FACS assessed that the reports did not meet the risk of significant harm threshold and therefore the young person did not receive a casework response. Supports from NSW Health and Juvenile Justice had limited effect on stabilising the young person who declined further engagement and frequently missed scheduled appointments. Reviews conducted by FACS and NSW Health after the young person's death identified opportunities for improved practice, including more effective liasion between FACS, Juvenile Justice and health professionals to plan for the young person's release from detention, and to clarify roles and responsiblities for ongoing support. Our review noted that this lack of clarity resulted in missed opportunities to implement joint strategies to assist the young person.

In 2014, FACS and Juvenile Justice entered into a Memorandum of Understanding, with accompanying Joint Operational Practice Guidelines, that aims to clarify the roles and responsibilities of the respective agencies in relation to children or young people who are shared clients.

As noted above, our review of the 15 young people found that most who were placed in residential care had some level of contact with police in relation to incidents that occurred at the service. Specific to this issue, over 2014-15, our office worked with a range of stakeholders to develop and implement a state-wide 'care and crime' protocol to reduce the contact of young people in residential out-of-home care with the criminal justice system. The protocol aims to:

- reduce police involvement in responding to behaviour by young people living in residential services
- improve relationships, communication and information sharing between residential services and police
- enhance police efforts to divert young people from the criminal justice system by providing them with better information to inform the exercise of their discretion
- ensure that appropriate responses are given to young people living in residential services who are victims, including referring reports of alleged abuse to police.

The signatory agencies to the protocol have acted to implement the protocol, and to promote it to frontline residential staff. The implementation of the protocol will also be supported by procedures for residential care workers and a document outlining policing responses to incidents in residential care services.

4.4. Issues and observations arising from reviews

Chapter 8 details our overall observations and findings from reviews, focusing on deaths that occurred in 2014 and 2015.

Taking into account changes over the period of our review (as detailed in Chapter 2), our review of suicide and risk-taking deaths of young people in care has highlighted a number of key observations and issues:

- the young people all had high and complex support needs and exhibited escalating risk-taking behaviours
- reports relating to the young person's behaviour were not always assessed holistically or prioritised for a child protection response
- coordination of care and support to address complex needs was not always evident, and
- where support services were offered or provided, some young people were difficult to engage.

4.5. Recommendation

Recommendation 1

FACS should consider the issues raised in this report relating to the suicide and risk-taking deaths of young people in care, in particular:

i) Response to reports of ROSH, particularly relating to self-harming and risk taking behaviour (including suicide attempts and threats of suicide, and substance abuse)

ii) Identification of, and response to, escalating risk-taking behaviour

iii) Lack of placement stability and homelessness

FACS should provide details of current or proposed strategies to address these issues.

In response to a draft copy of this report, FACS indicated that the agency accepts the recommendation in full and is currently working on a range of strategies to address the issues raised in this report. We will monitor and report on FACS' progress to implement the recommendation in our next report of reviewable child deaths.

Chapter 5. Abuse-related deaths

This chapter considers the 17 deaths of children that occurred in circumstances of abuse in NSW during 2014 and 2015. The term 'abuse' refers to any act of violence by any person directly against a child or young person that causes injury or harm leading to death.[75]

The 17 abuse-related deaths represent 1.68 percent of all children who died in NSW over the same period,[76] a rate of 0.50 per 100,000 children. This is a higher number and rate than we reported in our report of reviewable child deaths in 2012 and 2013 (eight deaths, a rate of less than 0.20 per 100,000 children). In NSW over the 10-year period 2006-2015, 98 children died in abuse-related circumstances, a rate of 0.60 per 100,000 children.[77] The number of abuse-related deaths fluctuates, and trends in this context are difficult to discern.

The 17 children died in a range of circumstances, in 15 separate incidents:

- The majority (15) of the children were killed, or allegedly killed, by a family member. In most cases (14) the person of interest was a parent. Six of the children died in four separate murder-suicide[78] incidents.
- One young person died in the context of a peer assault. Another child, an infant, died as a result of the actions of an unrelated adult.

Two of the 17 children were under the parental responsibility of the Minister ('in care') at the time they died.

This chapter focuses on the children who died, the alleged perpetrators or 'persons of interest', and the context in which the deaths occurred. We have used the term 'person of interest' to refer to a person who has been convicted or charged in relation to the death of a child, or is suspected of involvement in the death of a child.

Many of the deaths we have reviewed are open investigations or subject to current criminal proceedings. As a result we have exercised caution in providing information that may be identifying.

At the time of writing, legal processes have been finalised only in four cases, involving the deaths of six children. Two matters were finalised in the criminal court. One person was convicted of manslaughter in relation to the death of an infant; the offender was also convicted of causing the deaths of two other individuals in the same incident, and of grievously harming a number of other people. Another person charged with the murder of an infant was found not guilty by reason of mental illness, but detained for the purposes of receiving ongoing treatment.[79]

A Coronial inquest was held in relation to the other two finalised cases, involving the deaths of four children. The Coroner confirmed the deaths occurred in the context of murder-suicide, and that both parents (two fathers) were responsible for the deaths of their children and spouses.

Legal processes are still underway in relation to the remaining 11 cases. Ten people have been charged in relation to eight deaths; these matters are currently before the Courts. No charges are possible in relation to the deaths of another two children (in separate incidents) because the person identified by police as responsible for the deaths also died in the incident. In the final case, the police investigation remains open.

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75. Excluded from this definition are lawful acts which result in the death of a child, for example police discharge of a firearm to bring a dangerous individual under control.
76. During the two years a total of 1,010 children died in NSW from all causes.
77. 'Abuse-related' includes children who died as a result of abuse or in circumstances that are suspicious of abuse.
78. Murder-suicide refers to the murder of child/ren accompanied by the suicide death of the perpetrator.
79. An accused person found not guilty by reason of mental illness can be detained at a place and in a manner as determined by the Mental Health Review Tribunal, pursuant to s 39(1) of the *Mental Health (Forensic Provisions) Act 1990*, until released by due process of law.

5.1. Abuse-related deaths of children 2006-2015

As shown in the table below, apart from a spike in peer homicides[80] in 2010, almost all persons of interest in abuse-related deaths of children in NSW were a person with whom the child had a family relationship. In most cases, the person of interest is a parent, and the circumstances are classified as filicide.[81, 82]

Table 6: Abuse-related deaths of children by relationship with person of interest, 2006-2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Familial	11	6	11	10	6	10	3	4	8	7	**76**
Filicide	11	5	9	8	6	9	3	4	8	6	**69**
Other family member*	0	1	2	2	0	1	0	0	0	1	**7**
Peer	1	1	3	0	7	2	1	0	0	1	**16**
Other	1	1	0	1	1	1	0	0	1	0	**6**
Total	**13**	**8**	**14**	**11**	**14**	**13**	**4**	**4**	**9**	**8**	**98**

* Other family members include extended family (4 deaths), a grandparent (2 deaths), and a sibling (1 death).

The age of the child killed is closely associated with the context of fatal abuse. In NSW, and as shown in the table below, the majority (66 of 76) of familial homicides involve children aged less than 10 years of age. Younger children are at higher risk; children under five years of age accounted for over two thirds of all abuse-related deaths over the 10 years 2006–2015. Conversely, homicides involving older teenagers and young people aged 15-17 years generally occur in the context of peer-related assault (15 of 19 deaths). Homicides of older adolescents primarily involve male victims.[83]

Table 7: Abuse-related deaths of children by age and relationship with person of interest, 2006-2015

	Under 1 year	1-4 years	5-9 years	10-14 years	15-17 years	Total
Familial	18	31	16	10	1	**76**
Peer	0	0	0	1	15	**16**
Other	2	0	0	1	3	**6**
Total	**20**	**31**	**16**	**12**	**19**	**98**

5.2. Abuse-related deaths of children in 2014 and 2015

5.2.1. Cause and circumstances of abuse-related deaths

The 17 children died from various causes, including blunt force or sharp force injuries, gunshot wounds, asphyxiation and fire. Most fatal incidents occurred at the child's home. Three children were killed in other locations, such as a public recreation area or roadway.

80. Peer-related homicide generally relates to young people in a context of confrontational violence between friends, acquaintances and strangers. Peers are generally close in age and social status. Peer homicides account for just over 14 percent of fatal assault deaths of children and young people in NSW over the past 15 years.
81. A parent refers to a person acting in a parental role on the basis of their biological, step/defacto or legal relationship with the child.
82. Filicide is the killing of a child by their parent or a person acting in a parental role.
83. During the 10 years 2006-2015, 75% of 10-14 year olds, and 90% of 15-17 year olds who died in circumstances of abuse were male.

The deaths of 14 of the 17 children are classified as filicide – the killing of a child by their parent or a person acting in a parental role. These deaths fall into two categories – inflicted injury or murder-suicide:

- Seven children died as a result of inflicted or allegedly inflicted injuries sustained during incidents of severe abuse. Five of the children were subjected to multiple instances of physical abuse during the days or weeks prior to the fatal injury. Another child died in the context of the carer's undiagnosed major depressive illness with psychotic symptoms. Almost all (7 of 8) the children were very young, including four infants under one year, and three toddlers aged between one and four years. Most of the incidents involved a single male person of interest – either the intimate partner of the child's mother (3) or the child's father (2).
- Six children died in four incidents where the parent who killed the child/ren – either their father (3) or mother (1) – subsequently died by suicide. In two of the four incidents, other family members were also killed. The other two murder-suicide incidents involved the death of a single child and the person of interest.

Three children died in incidents where the person of interest was not a parent or household member:

- One child died during a violent incident involving an extended family member.
- Two children were killed by unrelated adults. One child, a teenager, allegedly died in the context of peer assault. The second child, an infant, died when an unrelated person deliberately set and ignited a fire at his business premises for personal financial gain; the resulting fire and explosion caused the deaths of the child and two adults. The NSW Supreme Court found the offender was motivated to destroy the property to avoid pressing business debts and to make a claim under his insurance policy.[84]

5.2.2. The children who died

The children were aged six weeks to 16 years. Consistent with previous years,[85] more than half (10) were less than five years old, including five infants under one. Three children were aged five to nine years, three children were 10-14 years old, and one child was a young person aged between 15 and 17 years.

More females (10) died in circumstances of abuse during the period than males (7). On average, however, the number of males (65%) who died as a result of abuse has consistently outnumbered the number of females (35%) over the 10 year period 2006 to 2015.

Three of the 17 children were identified as Aboriginal. Indigenous children are consistently over-represented in abuse-related deaths; 18 per cent of children who died in abuse-related circumstances over the past decade were of Aboriginal or Torres Strait Islander background.

Records indicate that five of the children who died in circumstances of abuse had a disability. Disabilities included physical, intellectual/developmental and neurological (such as Attention Deficit Hyperactivity Disorder and Autism).

5.2.3. The families of the children who died

The 17 children belonged to 15 families. Most (11) of these families resided in areas of the greatest socio-economic disadvantage, with half (6) also characterised by lowest educational and occupational attainment. Three families lived in areas of highest socio-economic advantage with the highest level of educational and occupational attainment.

In nearly half the families (8), one or more parents were from a culturally and/or linguistically diverse background.

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84. NSW Supreme Court Judgement Summary, *R v Khan* [2016] NSWSC 1073; and Remarks on Sentence, **https://www.caselaw.nsw.gov.au/decision/57a280e1e4b058596cb9e156**
85. The Ombudsman's 10-year review of the deaths of children in abuse-related incidents involving family members found three quarters of the 83 children were very young, aged five years or less. See NSW Ombudsman (2015), *Familial abuse-related deaths in NSW 2004-2013*, Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child Deaths, p 38-55.

Consistent with previous years,[86] nine of the 15 families had experienced family breakdown. In some cases (5) birth parents had re-partnered and were residing with new partners and/or children from previous relationships. Four other children were living in a variety of family situations (extended family, out-of-home care, single parent). The remaining six families were noted as intact nuclear families.

5.2.4. The persons of interest

Police have identified 18 adults (13 males and five females) as responsible for, or suspected of being responsible for, the deaths of the 17 children. In three cases, more than one person is a person of interest.[87]

Half of the persons of interest (9) were birth parents – five fathers and four mothers. Other roles include male intimate partners/step-parents of biological mothers (4); other close family members (3); a friend or other unrelated person. Female persons of interest were generally the biological mothers of the children who died (4 of 5); male persons of interest had a range of relationships with the children. Two of the four male intimate partners/step-fathers were in new relationships with the child's mother (6 months or less duration) at the time of the fatal abuse.

5.3. Risk factors associated with fatal abuse

The context and circumstances of child homicide varies, depending on a range of factors, including motives of offenders, precipitating events and the personal characteristics of both victims and perpetrators.[88, 89]

Our reviews over the past 12 years have identified factors in many of the families that are commonly reported child protection issues, particularly an offender history of domestic or other violence, alcohol and other drug abuse, and mental illness.[90]

The families of more than half of the children who died in abuse-related circumstances over the past decade had a child protection history, often reflecting the issues above. The NSW Child Death Review Team has previously identified that children with a child protection history are 6.3 times more likely to die from fatal abuse than children without a child protection history.[91]

While these factors can place children at risk, they are not clear predictors of fatal abuse or serious injury, and can also be present in families not characterised by child homicide.[92] However:

> *They are (especially in combination) risk factors for child maltreatment and emotional harm, where child death or serious injury is always a possibility. Recognising these risk factors is an important step in helping and protecting children at all levels of intervention.*[93]

Fatal abuse can also occur in families where there is no known history of risk or previous evidence of abuse. In five of the 13 families where a child died in 2014 or 2015, and the person of interest was a family member, there was little or no child protection history, and no known or minimal indication that the offender posed any risk to the child/ren prior to their death. However, in a number of these families, post death investigation identified that risks were present at the time. This included the sudden onset of mental illness in a parent/carer, or evidence of chronic alcohol abuse and violence within the family, that had not come to the attention of any external agency.

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86. The NSW Ombudsman's 10-year review (2004-2013) of familial homicide found two thirds of the 75 families had experienced separation or family breakdown prior to the child's death.
87. Includes alleged perpetrators/offenders and persons of interest.
88. Cussen & Bryant (2015). Op cit.
89. Sidebotham (2013), p 305.
90. Family and Community Services Annual Report 2012-2013, accessed http://www.facs.nsw.gov.au/__data/assets/file/0010/279037/3005_FACS_AR_2012-13_WEB_FACS_R.pdf
91. NSW CDRT (2014). *Causes of death of children with a child protection history in NSW, 2002-2011*, April 2014.
92. Mayers, J et al. (2010). Risk factors for intra-familial unlawful and suspicious child deaths: a retrospective study of cases in London. The Journal of Homicide and Serious Incident Investigation, vol. 6, no. 1, pp 77-96.
93. Brandon, M et al. (2009) Understanding serious case reviews and their impact: a biennial analysis of serious case review 2005-2007, University of East Anglia, Norwich, p 118.

In this context, our work aims to identify risk that may have been evident in the life of the child, and actions and behaviours of those caring for or involved with the child.

The following section considers child protection history and specific risk factors for the children who died in abuse-related circumstances.

As noted above, most children who die as a result of fatal abuse in NSW are killed by a member of their family. In that context, the following section relates only to the 15 children (from 13 families) who were killed by a parent or other family member.

5.3.1. Child protection history

The families of the children who died in the context of familial homicide were more likely than not to have a child protection history[94]; nearly two thirds (8) of the 13 families had been the subject of a report to Family and Community Services (FACS) relating to the child who died or their sibling(s) within the three years before the child died.[95] Reported issues did not necessarily include concerns about physical harm or risk of physical harm, and often related to concerns about the behaviour of carers – domestic/family violence, neglect, drug and/or alcohol abuse, and more general issues such as guardianship, wellbeing, and risk of emotional harm.

Response to child protection concerns

Within the 12 months prior to their death, six children had been the subject of one or more risk of significant harm reports (4) or non-ROSH reports (2). In an additional two cases, the child's sibling/s[96] had been the subject of risk report/s. Three cases were open child protection matters with an allocated FACS caseworker assigned to the family at the time the child died.

Three reports included direct concerns about physical safety or harm for the child who subsequently died. Specific reported concerns included suspicious bruising and physical injury, and carer homicidal ideation. In each of these three cases, the nature of the family's child protection history was relevant to the circumstances of the child's death:

- One child was identified with bruising and reported to FACS on the basis that the parent's explanation for the bruising was not convincing. The report was deemed to be non-ROSH. We raised this screening issue with FACS, and following review, the agency agreed that the report should have been screened as non-accidental injury and referred to the JIRT Referral Unit. FACS also advised that it would undertake broader systems review of report screening.
- For one child, FACS received several reports raising concerns about a carer's aggressive behaviour towards health professionals, suspected domestic violence, and physical harm to the child – the carer allegedly harmed the child during feeding, with resulting injury. Risk was assessed as very high, and a further home visit planned, however the child died prior to this visit taking place.
- In one case, a report raised concerns about a carer's alleged harm and threats to harm the child. The report was deemed to be ROSH and referred to a Family Referral Service, which made subsequent referrals for early intervention. Our investigation of this case found, in relation to this report, that given the seriousness of the reported issues and the vulnerability of the child, further information should have been gathered to fully inform the CSC's decision regarding the need for a safety and risk assessment.

94. As noted above, our definition of child protection history includes all reports made to FACS that were subsequently assessed as either ROSH or non-ROSH.
95. This includes one child in out-of-home care who was the subject of a report to the Helpline within the three year period that was assessed to be non-ROSH.
96. Or other related children residing in the same household

For other families, reports related to other child protection concerns, including exposure to domestic violence, carer drug and alcohol abuse, and neglect:

- In one of these cases, the family's child protection history highlighted the presence of chronic problems likely to pose ongoing risk to children, including violence by the person of interest towards their spouse, and excessive physical discipline of the children; alcohol and illicit drug misuse by both parents; and neglect. In addition, the parents' own history of childhood trauma suggested a pattern of intergenerational abuse and neglect. While risk was identified as high, minimal casework was undertaken with the family during the months prior to the child's death, and the case plan that was developed did not address the entrenched problems affecting the children.
- In another case, a family with a lengthy history of reported concerns, including family violence, were the subject of reported concerns about a related child being exposed to domestic violence. The report was screened as non-ROSH and closed.

Our previous work reviewing familial abuse-related deaths of children identified concerns about FACS' capacity to respond to children at risk of significant harm, particularly through face-to-face assessment. We also identified the need to ensure that child protection staff conduct comprehensive and timely safety and risk assessments that lead to action being taken that is commensurate with the level of risk.[97] Our reviews highlighted the need for staff to regularly assess progress in a case and to monitor the effectiveness of intervention and the potential need for alternative courses of action. Linked to this is the need for staff to receive adequate supervision and support, and to seek and obtain expert advice when required. These issues continued to be apparent for abuse-related deaths in 2014 and 2015.

At the time of writing, FACS had completed a review of its involvement with seven families known to FACS where the child died in circumstances of abuse.[98] Among other factors, FACS' reviews highlighted the need for their caseworkers to undertake holistic and thorough assessments, the importance of understanding the dynamics of intergenerational abuse and neglect, the need to support new caseworkers to develop good practice skills, and for managers to review casework decisions when the evidence suggests that intervention has not effectively reduced risk.

Response by other agencies

Noting that child protection is a shared responsibility, our reviews identified the critical involvement in some cases of other services accountable for responding to child protection risks, including NSW Health, NSW Police, non-government organisations and private providers.

Our reviews mostly found that agencies responded appropriately to child protection risks in families. In some cases, however, we identified practice issues and opportunities for improvement.

CASE STUDY

In 2014-15 we investigated the actions of agencies in response to concerns about the safety and welfare of a child who died in circumstances of abuse. The child and family had complex needs. As a result, the family was provided with a high level of support from a number of agencies. In this context, it was important that the actions of all involved agencies were co-ordinated and informed by the interventions, strategies, identified issues and outcomes of work by other involved agencies. Our investigations found that this was not the case. We found that:

- Despite the family's significant contact with services, none of the involved agencies sought to bring all of the parties together to:

97. NSW Ombudsman (2015). Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child deaths.
98. FACS' Serious Case Review unit (SCR), formerly known as the Child Deaths and Critical Reports unit, reviews FACS involvement with the families of children who have died and were reported (or their sibling was reported) to be at risk of significant harm within three years prior to their death. The unit also completes a review where a child was in care when they died.

- clarify the roles and responsibilities of each agency
- discuss the child protection risks and how these would be monitored and escalated if required
- discuss what and when information needed to be shared between the agencies and
- agree on a plan for coordinating the provision of services.

- There was inadequate communication between relevant services about the progress and outcome of respective service interventions – as a result, it appears that agencies often made assumptions about the nature, effectiveness and protective impact of work by other agencies.

Some practitioners tended to respond to changes in family circumstances by making new referrals, rather than reviewing the effectiveness of existing interventions or therapeutic strategies, and adjusting the intensity or focus as indicated. Although it was not always evident what improvements were being achieved by the involvement of multiple services, it appears that for some practitioners, the number of services involved was in and of itself considered protective for the child. The circumstances of the child's death resulted in internal reviews by involved agencies, and interagency discussions to identify barriers to good practice and strategies for change.

Children with no recorded child protection history

Five of the 13 families where the person of interest in the child's death was a family member had no recorded child protection history in the three years prior to their death.

Where families had no documented child protection history, our reviews considered issues such as whether the families should have been known to child protection services, but were not; and whether any other agencies involved with the families had knowledge of circumstances indicating the children were, or may have been, at risk.

In three of the five families with no history, the children died in the context of murder-suicide or apparent murder-suicide. In the one murder-suicide incident involving a family with a child protection history, the history was recent and limited, and a range of services were working with the family.

The families with no child protection history were involved with a range of services, primarily health-related. Professionals involved with those families held no concerns about risk posed by the person of interest to others prior to the fatal incident. In three cases, health care professionals had identified mental health-related concerns for the person of interest, but there was no indication that this concern extended to potential risk to the child. For another family, the child's school did have concerns about the child's frequent absences from school; however they were not aware that the child was experiencing ongoing physical and verbal abuse at home. Post death investigations revealed the child had been experiencing severe abuse over a number of years, and that the child had made some disclosures to school friends.

- In one case a murder-suicide occurred in the context of what a Coronial inquest identified as the perpetrator's feelings of hopelessness for the future, inability to envision life as a separated couple, and 'pseudo altruistic motivation'.[99]
- In another case a parent was experiencing ongoing stress and depression associated with caring for two children with significant special needs, and held concerns about anticipated future difficulties the children and parents would face. The couple had also at one point considered divorce in response to ongoing marital and family stressors.
- In the third case, a non-custodial parent appears to have become increasingly anxious about access to the child following family breakdown.

99. NSW State Coroner inquest findings, 9 October 2015, p 17.

Regardless of whether families were known to child protection authorities, our reviews considered key factors associated with risk to children: domestic violence, carer alcohol and other drug abuse, and carer mental illness. The following discussion focuses on these factors.

5.3.2. Domestic and other violence

Domestic and/or other violence is frequently a feature of families where a child has died in circumstances of fatal abuse involving a family member.[100]

Many of the persons of interest associated with these deaths were known to police as perpetrators of violence, including assault and domestic violence, before the child's death. FACS data shows domestic violence was the primary reported issue in 12.9% of the 126,146 reports screened as ROSH at the Helpline in 2014-15; and represents the fourth most common primary issue reported to FACS.

Domestic and/or other violence was present in six of the 13 families where children died in abuse-related circumstances in 2014 and 2015, and half (8) of the persons of interest had some documented history of previous violence or threatening behaviour. The extent of the person's of interest history varied. Half (4) had convictions in the recent past for a range of offences, including assault in a domestic and/or other context. Another two persons of interest had a history of prior convictions as juveniles for affray and assault; in one case, the conviction was decades earlier. In two cases, the persons of interest had no convictions but were recorded as displaying threatening or aggressive behaviour.

In our previous report, we noted that over half of the persons of interest in abuse-related child deaths were known to police as serious violent offenders.

In 2014 and 2015, four carers were persons of interest in four separate murder-suicide incidents; in these cases, we found no documented history of violence.

Nearly all of the persons of interest (7 of the 8) with a previous history of violence were men, six of whom had been convicted of one or more violent offences including assault, assault occasioning actual bodily harm, property damage, breach of AVO, aggravated break and enter, and resist officer.

Four persons of interest had a record of being, or suspected of being, previously violent towards or physically harming a child. This includes child protection records identifying the person as a 'person causing harm' through, for example, excessive physical discipline of children, physical and verbal abuse, and physical assault.

All but one of the families where there was some history of domestic or other violence were known to FACS. However, violence was generally not identified as a current concern:

- In two cases, domestic violence in the family was linked to a previous partner. These two persons of interest were in new relationships with the birth mothers of the deceased children at the time of the fatal incident; however in both cases, child protection authorities were not aware of the new partner's presence in the household.
- In one case the previous violence appeared to be an isolated assault which occurred many years earlier, when the parent/carer was a juvenile.
- In another case the parent/carer's history of violence was limited to threatening behaviour linked to an associate.

For three families, violence was a current and ongoing concern at the time the child died. Two of these families had allocated child protection caseworkers working with them to address risk issues; however assessments were either still underway, or the extent and significance of risk was

100. Our review of 83 children who died in circumstances of fatal abuse involving a family member during the 10 years to 2013 found domestic violence was a feature in almost half the families involved. NSW Ombudsman, *Report of Reviewable Deaths in 2012-13, Volume 1: Child Deaths*, June 2015. The *Crimes Act 1900* (NSW) defines domestic violence as: a personal violence offence committed against a person who has been married to, or had a defacto or intimate personal relationship with, the person who commit the offence. The definition includes violence against a person living in the same household as the offender, or a person who is a relative of the offender.

not adequately understood prior to the death. In the other family, chronic family violence was not escalated for a child protection response; and risks associated with violence within the extended family were minimised, dismissed and/or overlooked.

Prior and unreported physical abuse of children

Post death investigations found evidence that five children who died in circumstances of abuse had sustained previous physical injuries that were either not known, or not reported to, child protection authorities until after the child's death. These injuries were identified through post mortem examinations and interviews with police. They include collar bone and rib fractures and other skeletal injuries, significant burns, bruising to various body parts, and soft tissue damage.

In three cases – including two infants - the children were not presented for medical treatment or assessment of physical harm. The other two children with physical injuries were seen by health practitioners; however, in both cases the injuries were regarded as accidental.

- In one case health clinicians assessed the explanation for facial 'grazing' observed on a toddler as plausible and considered that the injuries were most likely accidental in the absence of evidence to the contrary.
- Another toddler was the subject of a report about suspicious bruising one month prior to the fatal incident; this report was screened as non-ROSH and closed. Other records show that unbeknown to FACS, the child subsequently sustained significant burns which were assessed by a general practitioner as superficial, despite being assessed as requiring two months healing time. Following the child's death the burns were reviewed by an expert who noted the injuries were not consistent with the explanation provided, and that the doctor failed to appreciate the severity of the injury.

Two of the cases where injuries were identified after the child's death, both involving infants under one, were open and allocated at the time of the death:

- In one case, post mortem examination identified a number of severe, non-accidental internal injuries. There was evidence that injuries had been inflicted on separate occasions, and over time. At the time of the child's death, FACS caseworkers were working to address entrenched family problems against a background of concerns about the family's ability and willingness to engage with services. Our review found caseworkers did not fully understand the nature and severity of risk in a family characterised by chronic domestic violence, alcohol and drug misuse, and carer mental health problems, and that the infant was highly vulnerable in this environment.
- In the other case, an infant was found to have a number of healing fractures after the fatal incident. Reports to FACS raised concerns about a parent's aggressive behaviour towards health professionals, domestic violence, neglect and other behaviour causing harm. The family had been allocated a caseworker four weeks prior to the child's death, and assessment of risk was underway at the time of the fatal incident.

FACS receives thousands of reports about children being at risk of significant harm through domestic violence which do not result in the death of a child. Furthermore, many children present each year to public health facilities and private health providers with a range of injuries; in the overwhelming majority of these cases, injuries sustained are accidental. In that context, it is challenging for practitioners to identify those cases where children are at grave risk.

Because of this difficulty, it is critical to learn from cases and identify where practice can be improved. This issue has been the focus of previous work undertaken by this office in relation to responding to physical injury.[101] We are also monitoring and consulting with NSW Health in relation to a recommendation that the Department conduct close internal review of cases where a child dies in suspicious circumstances within 12 months of receiving care or treatment for an injury from a NSW public health facility. In response to a draft of this report, NSW Health advised that the Ministry and

101. NSW Ombudsman (2013). Report of Reviewable Deaths in 2010 and 2011, Volume 1: Child deaths.

the Clinical Excellence Commission have agreed to develop a process for the joint review of applicable cases. The Ministry and the Clinical Excellence Commission will also develop a joint governance structure, communication plan and agreed methodology for the case reviews. NSW Health anticipates that this work will be completed by June 2017.[102]

Our work also identified the importance of child protection awareness in private practice. For example, our review noted a private allied health professional who saw a child one month prior to the death and identified general concerns about the child's welfare; however these concerns were not reported to the FACS Helpline, and were not documented until after the child's death.

5.3.3. Alcohol and other drugs

Carer drug and alcohol abuse is also frequently a feature of families where a child has died in abuse-related circumstances.[103] FACS data shows that carer drug/alcohol use was the primary reported issue in 9.2% of the 126,146 reports screened as ROSH at the Helpline in 2014-15, and represents the fifth most common primary issue reported to FACS after physical abuse, neglect, sexual abuse, and domestic violence.[104]

For cases of familial abuse-related deaths in 2014 and 2015, nearly half (7) the 16 persons of interest were known to child protection, health services or police for drug or alcohol abuse. Alcohol (5) and cannabis (4) were the most commonly abused substances, followed by amphetamine and/or methylamphetamine (3).

Five of the seven persons of interest were recorded as using multiple substances, including alcohol, prescription medication and/or illicit drugs. Only one person of interest was known to be receiving current professional support in relation to their substance abuse; in this case provided by a general practitioner and psychologist in the context of addressing broader mental health issues.

Our reviews considered the risk to children associated with parental / family alcohol and other drug misuse. We found that adult substance abuse was a significant factor in five families. In two of these five cases we also found adult mental health was a significant or concerning concurrent concern.

Records indicate that only two of the five families had been the subject of a report to Community Services about alcohol and/or other drug abuse; and in one of these cases, the report related to a non-custodial parent not associated with the child's death.

Post-death investigation processes indicate, however, that some of the persons of interest (4) were, or were likely to have been, affected by drugs and/or alcohol at the time of the fatal abuse, and that their substance use may have been a contributory factor in the child's death:

- One person of interest was charged with drug offences in addition to charges related to causing the child's death, and may have been affected by methylamphetamine (ice) at the time of the fatal abuse.
- One person of interest reportedly consumed excessive levels of alcohol on a daily basis, becoming increasingly aggressive as the day progressed and their level of intoxication increased.
- One person of interest was reportedly affected by ice, cannabis and alcohol at the time of the fatal incident.
- Another person of interest was found to have been using illicit drugs on a regular basis during the months prior to the fatal abuse, including daily use of cannabis and weekly use of 'ice', which caused the person to become aggressive.

Only one of these four persons of interest was the biological parent of the child who died; two of the adults were acting in a parental role at the time of the fatal abuse, and one was an extended family member.

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102. Correspondence from NSW Health to NSW Ombudsman, 8 June 2017.
103. NSW Ombudsman (2015). Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child deaths.
104. When considering all of the concerns raised in reports screened as ROSH at the Helpline, 31,488 reports (25%) included domestic violence, carer drug/alcohol use or carer mental health as the primary reported issue **http://www.facs.nsw.gov.au/facs-statistics/objective-1**, Dashboard 5.

5.3.4. Mental illness

A history of mental illness has been identified as a risk factor among filicide perpetrators, particularly mothers.[105] FACS data shows carer mental health was the primary reported issue in 2.9% of the 126,146 reports screened as ROSH at the Helpline in 2014-15. However, it is also important to note that at least 20% of adults are affected by mental illness every year, with anxiety disorders and depression identified as the most common types of illness.[106] Research indicates that many people with mental illness are parents.[107] Most function very well, but some may be impaired in their ability to care for dependent children.[108]

Of the 16 familial persons of interest, eight were identified either prior to (6) or after (2) the child's death as having a mental health condition. All the cases where adults had a known mental health condition prior to the death involved diagnosed depression, including postnatal depression; some persons of interest also had a concurrent history of anxiety, suicidal ideation (2), Attention Deficit Hyperactivity Disorder, and probable Substance Use Disorder (1). All six persons of interest with diagnosed conditions had previously received, or were still receiving, some form of mental health support, including prescribed medication.

Our reviews identified the adults' mental health was a significant factor in four of the six cases where the person of interest had a previously diagnosed mental health condition:

- One carer had a diagnosis of major depressive disorder, with a history of suicidal and homicidal ideation that had been the subject of a ROSH report to FACS. Child protection authorities closed the report, however the family were involved with other support services, including mental health.
- Another carer had been diagnosed with anxiety and depression, and had a history of self harm and suicidal ideation.
- One carer had diagnosed depression. The Coroner found the parent had 'dropped out of treatment' and then 'disregarded the excellent services available to persons contemplating self harm'. The parent and child died, along with the parent's spouse, in a murder-suicide incident.
- A person of interest had previous diagnoses of substance use disorder, ADHD and depression. The adult had sporadic prior contact with mental health specialists, but no recent involvement.

The other two cases where the adult's mental health was noted as a significant factor involved those matters where the parents/carers had undiagnosed conditions. In both cases the undiagnosed illnesses were identified after the child's death by Courts (criminal, coronial), and included depression and post natal psychosis/depression.

All but one case where mental health was a significant factor in the child's death involved a biological parent killing their child/ren, regardless of whether the condition had been diagnosed.

In most cases (4 of the 6), the adults with known mental health conditions were not considered by agencies or practitioners who were involved with the families as posing an urgent risk to themselves or others. However some risk was noted in two cases:

- In one matter a professional was concerned about the person's deteriorating mental health and disengagement from support during the weeks preceding the child's death, but was unsuccessful in getting the carer to make contact with services.
- In another case, the mental health service involved had assessed the carer no longer required ongoing support prior to the child's death.

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105. Ericksson, L., Mazeroll, P., Wortley, R & Johnson, H (2016), Maternal and Paternal Filicide: Case Studies from the Australian Homicide Project', *Child Abuse Review*, Vol. 25: 17-30; Monash University Filicide Project submission to Royal Commission on Family Violence (Victoria), accessed from **http://www.rcfv.com.au/getattachment/33C65A20-EB27-44AB-917C-7240A1CD7438/Monash-Filicide-Project---Monash-University** on 8 June 2017.
106. SANE Australia, Fact vs myth: mental illness basics, Factsheet.
107. Maybery, D.J., Reupert A.E., Patrick, K., Goodyear, M., & Crase, L (2009), 'Prevalence of mental illness in Australian families', *Psychiatric Bulletin*, 33(1): 22-26; NSW Department of Community Services (2008), *Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families – literature review*, accessed from **http://www.community.nsw.gov.au/__data/assets/pdf_file/0004/321646/research_parentalmentalhealth.pdf** on 9 June 2017.
108. Reupert, A E., Maybery, D, J & Kowalenko, N, M (2013), 'Children whose parents have a mental illness: prevalence, need and treatment', *Medical Journal of Australia*, 199 (3 Suppl): S7-S9.

Our reviews have highlighted the importance of ensuring appropriate clinical practice and competency in relation to recognising and responding to any potential risk to children of parents with mental illness.[109] In response to a draft of this report, NSW Health advised that a review of the *NSW Children of Parents with a Mental Illness (COPMI) Framework 2010-2015* is underway and expected to conclude by the end of 2017.[110]

5.4. Issues and observations arising from reviews

Chapter 8 details our overall observations and findings from reviews, focusing on deaths that occurred in 2014 and 2015.

In relation to abuse-related deaths in 2014 and 2015, we found:

- the majority of children who die in circumstances of abuse are killed by a member of their immediate family, generally a parent or person acting in a parental role
- young children are most vulnerable to fatal abuse
- the nature and extent of risk was not always recognised or understood, and
- frontline services, particularly health providers, have a key role in identifying and responding to child protection issues in vulnerable families, particularly in response to physical injury and mental health.

5.5. Recommendations

NSW Health

The following recommendation updates recommendation 3 of the *Report of Reviewable Child Deaths in 2012 and 2013*. The intent is to provide a mechanism that would allow NSW Health to review, and potentially learn from, the handling of an injury presentation where a child subsequently dies in suspicious circumstances.

Recommendation 2

If a child dies in suspicious circumstances within 12 months of being presented to a NSW public health facility with a physical injury, and the NSW Ombudsman considers an internal review is warranted, NSW Health, in conjunction with the Clinical Excellence Commission, should establish a process for comprehensive review of the interaction of that facility with the child and their family.

The following relates to recommendation 2 of the *Report of Reviewable Child Deaths in 2012 and 2013*. The intent of the recommendation is to monitor strategies to promote appropriate clinical practice and competency in relation to recognising and responding to any potential risk to children of parents with mental illness.

Recommendation 3

NSW Health should provide advice on the outcome of the review of the *Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015*.

109. NSW Ombudsman (2015). *Familial abuse-related deaths in NSW 2004-2013*, Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child Deaths, p 38-55.
110. Correspondence from NSW Health to NSW Ombudsman, 8 June 2017.

Chapter 6. Neglect-related deaths of children in NSW

The following chapter examines the deaths of 124 children that occurred in circumstances of neglect in NSW between 2006 and 2015. This includes the deaths of 17 children that occurred in 2014 and 2015. Over the 10-year period, we determined 101 of the deaths resulted from neglect and a further 23 were suspicious of neglect.[111]

At the time of their death, most of the children – 112 (90 %) – were in the care of a parent or parents,[112] or carers with whom they normally shared a household. Twelve children were being cared for by unrelated carers, or relatives not usually involved in their day-to-day care.

This chapter also touches on the concept of fatal neglect, and the scope of reviews of neglect-related deaths in NSW. This discussion is explored in more detail in chapter 7 below, which draws on a report prepared by Dr Deborah Scott at the Australian Institute of Family Studies (AIFS) about the review and reporting of fatal neglect in NSW. The full report is available on our website: www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team/reporting-of-fatal-neglect-in-nsw.

6.1. Neglect and fatal neglect of children

6.1.1. Child neglect

There is a common understanding that neglect is the failure of a parent or caregiver to provide basic requirements for a child to thrive. However, there is no standard, universal definition of neglect. Neglect is further divided into subtypes, generally classified by what is not provided, for example educational, physical and medical needs and emotional support or abandonment.[113]

Although neglect is common, it remains one of the most difficult forms of maltreatment to substantiate because it is closely connected to issues of poverty, family structure, gender (it is frequently seen to be associated with mothers rather than fathers), single parenthood, ethnicity and access to resources.[114]

The impact and outcome of neglectful behaviour on the part of a parent or caregiver will vary according to the developmental age of the child, the length of time the child is exposed to neglect, what that neglect fails to provide for the child and the degree to which the child is resilient. For example, children who are neglected may suffer more frequent injuries (supervisory neglect), have lower educational outcomes because they do not attend school regularly (educational neglect) or, on the extreme end of the continuum may starve to death (physical neglect).

6.1.2. Fatal neglect

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* requires that the Ombudsman include in reviews of reviewable deaths *'a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances.'*

The Ombudsman's working definition to meet this requirement in relation to neglect is:

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*

111. In some cases, a death cannot be assessed with certainty as resulting from the actions of a parent or carer. This includes cases where the cause of death is unable to be determined, or where following Coronial investigation, the degree to which the actions of a carer contributed to a child's death remains unclear.
112. Parent includes a step parent and defacto partner
113. Scott, D. (2014). Understanding child neglect. In CFCA (Ed.), Issues Paper (Vol. 20). Melbourne: AIFS.
114. Scott, D. 2014

- *intentional or reckless failure to adequately supervise, or*
- *a significantly careless act.*

Deaths are considered suspicious if there is evidence or information that indicates the death may have been the result of abuse or neglect. For example, police may identify a death as suspicious, 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.

Fatal neglect is a relatively subjective categorisation of the circumstances in which a child died. While we apply rules to determine if a death meets the criteria of reviewable, decisions can, to a large degree, be dependent on the scope and quality of investigation of the circumstances of the child's death, and available records. Additionally, the concept of fatal neglect can change over time, and be influenced by broader community change. For example, changes to legislation to enforce child safety – such as pool barrier fencing or motor vehicle restraints – may change community expectations of the expected actions of parents or carers.[115]

Our reviews consider a range of factors, including evidence of the carer's own behaviour and influences 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 in determining neglect.[116] 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.

The purpose of identifying child deaths as a consequence of neglect on the part of carers is not to place blame. The purpose is to understand the factors that contribute to avoidable deaths of children, and to identify any subsequent strategies that might help to prevent them.

6.1.3. Reviews of fatal neglect in NSW

The circumstances of and issues arising from deaths that result directly from chronic neglect – where there is a failure to provide for a child's basic needs such as food, liquid, medical care, clothing or shelter – are most comparable to fatal abuse cases.

CASE STUDY: The death of Ebony

In 2007, 'Ebony', a seven year old child, died as a result of chronic starvation and neglect.[117] Ebony was severely malnourished, dehydrated and wasted when she died. She had been starved over many months, her hygiene was seriously neglected and she lived in squalid conditions. Ebony's mother and father failed to meet her basic needs, and were charged and convicted respectively of murder and manslaughter. The sentencing Judge noted the complete inaction of Ebony's mother as it became more and more inevitable that Ebony would die, and that her father provided no care at all 'and he did not care'.[118] Ebony's family were well known to a number of key agencies, including FACS; Ageing, Disability and Home Care; Housing; Education and Police. Our investigation of these agencies' actions as they related to the family found that they did not work together effectively, which meant that vital information was not shared and warning signs went unnoticed. Ebony's death became one of the main catalysts for the NSW Government initiating a Special Commission of Inquiry into child protection services in NSW. The Inquiry resulted in significant change to the structure and delivery of child protection services.

115. Business rules for assessing whether a death occurred in circumstances of neglect have been revised since 2002. All neglect-related deaths were re-assessed according to new criteria in 2010.
116. Liller, K.D. (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, 4: 283-289.
117. NSW Ombudsman 2008. *The death of Ebony: The need for an effective interagency response to children at risk*. Special report to Parliament under section 31 *Ombudsman Act 1974*. NSW Ombudsman, Sydney.
118. *R v BW & SW* (no 3) 2009 http://www.austlii.edu.au/au/cases/nsw/NSWSC/2009/1043.html.

The death of a child as a direct result of chronic neglect, as in the case of Ebony, is rare. Neglect related deaths most often result from unintentional or reckless acts on the part of a carer that may occur in a broader environment of neglect. Between 2010 and 2015, 293 children who died and were known to FACS had experienced neglect, or there was a significant history of neglect within their family. Of these children, just under one quarter (68) died in circumstances where neglect was a *'contributing factor'*.[119] Similar observations have been made in England; Brandon et al have noted that while neglect is very rarely the primary and immediate cause of child death, *'neglect was evident in the majority (60%) of serious maltreatment and fatality reviews'*.[120]

The most common causes of death associated with neglect in reviewable child deaths in NSW are drowning, SUDI and transport fatalities. In these cases, the conduct of a parent or carer resulted in the death of a child-regardless of the carer's intent and irrespective of whether the child lived in a neglectful environment.

CASE STUDY 2

A child aged less than three years and an infant sibling were in a vehicle being driven by their parent on a dual carriageway road with a 100km per hour limit. The vehicle negotiated a slight bend and crossed into the path of an oncoming truck. At the time of the collision the parent was sending a text message on their mobile phone. The restraint being used for the child had not been correctly fitted and was not properly fastened. Police determined the inadequate restraint contributed significantly to the child's injuries. The parent was charged with a number of offences, and was convicted of dangerous driving occasioning death.

CASE STUDY 3

A child under the age of two was left to play unsupervised in the rear of the family's yard. At the time of the incident two family members were caring for the child. The magnetic latch closure to the pool gate was faulty, and the gate could be opened easily by pushing; this fault was well known to the family. The child was left alone for around 20 minutes. At some point the child accessed the pool by pushing on the gate, and subsequently entered the pool. CPR was administered, but the child was unable to be revived.

CASE STUDY 4

A baby less than a month old had been left at home in the care of a young person while the parents spent the evening at a local hotel. At closing time, the parents purchased take-away alcohol and moved to another address where they continued drinking. They returned home in the early hours of the morning and placed the baby with them to sleep on a mattress. Some hours later, the parents found him cold and unresponsive. While the cause of the baby's death was unable to be determined, the classification of Sudden Unexpected Death in Infancy noted the context of co-sleeping.

119. NSW Government, Family and Community Services. 2016. Child Deaths 2015 Annual Report – learning to improve services, accessed 15 February 2017. http://www.community.nsw.gov.au/__data/assets/file/0003/387030/child_deaths_report_2015_fullreport.pdf
120. Brandon M et al, 2014, *The role of neglect in child fatality and serious injury Child Abuse review* vol 23, p 236.

6.2. Children who died in neglect-related circumstances, 2006-2015

6.2.1. Child and family background

Age and gender

As shown in the table below, most children who died in neglect-related circumstances in the decade to 2015 were very young; close to 80 percent of the children were aged less than five years of age.

Over one third of the children who died (49) were infants under 12 months old, reflecting the vulnerability of very young children and their strong reliance on carers to meet their basic needs and to keep them safe. The majority of the infants (36) died in the context of a 'significantly careless act' on the part of a carer; and of these infants, almost all (34) were SUDI. In the main, carer actions related to co-sleeping while impaired by drug and/or alcohol use. In some cases, a cause of death could not be determined with certainty, for others suffocation was the identified cause of death. Unsafe sleep environments were also primarily associated with the deaths of very young infants.

Over one third of the children (49) were aged one to four years. Children in this age group are most likely to die in the absence of adequate adult supervision (31). At this developmental stage, children are becoming independently active and curious, and a basic responsibility for carers is to ensure the safety of the child's environment. Most of the children of this age drowned, often being left alone near water that could easily be accessed. Also common were transport fatalities where the child was unrestrained and/or being driven in a vehicle by an adult whose driving ability was impaired by drugs and/or alcohol.

Older children were overall less likely to die in neglect-related circumstances; children aged five to nine years (15), 10 to 14 years (6) and 15 to 17 (5) years together accounted for less than 20 per cent of neglect-related deaths over the decade. In all age groups, the deaths were most likely to occur as a result of a significantly careless act on the part of a carer. In the main, the children died in transport fatalities similar to younger children; unrestrained in a vehicle where the carer was driving under the influence, or otherwise with disregard to safety. Medical neglect was primarily identified in the older age groups.

All 23 deaths that remain suspicious of neglect were children under five years of age, with most (19) under 12 months. All 19 infants died suddenly and unexpectedly, and in most cases (14), the Coroner was unable to determine a cause of death. Neglect was indicated with suspicions that carers were drug and/or alcohol affected while co-sleeping, or there was some evidence that basic needs were not met for the infant – for example, signs of dehydration or untreated illness.

Table 8: Neglect-related deaths of children – age and gender 2006 - 2015

	Under 1 year	1-4 years	5-9 years	10-14 years	15-17 years	**Total**
All children	49	49	15	6	5	**124**
Male	23	34	10	3	3	**73**
Female	26	15	5	3	2	**51**

Overall, our work has identified more male children in neglect-related deaths over the last decade (73; 59%).

Aboriginal status

Almost one third of the children (37) who died in circumstances of neglect were identified as Aboriginal. A child of Aboriginal background was seven times more likely to die in neglect-related circumstances than a non-Indigenous child.[121] Almost half of the Indigenous children (17) were infants under the age of 12 months.

Indigenous children have overall higher mortality rates than non-Indigenous children, and are over-represented in the child protection system. Neglect is the most commonly substantiated form of harm for Aboriginal and Torres Strait Islander children.[122]

The reasons for high rates of alcohol and substance abuse, high levels of family and other violence, economic deprivation, and related impacts on children's wellbeing are complex, and often associated with structural and historical inequities facing Indigenous communities. These include intergenerational traumas, such as the effects of child removal; social and community dislocation; consequent or related mental health problems; marginalisation from social services; and more generally, the loss of power and community cohesion associated with colonial experiences.[123]

Identified disability

Children and young people with disability experience violence, abuse, and neglect at rates considerably higher than their peers.[124] Records indicated that eight (7% per cent) of the children who died in neglect-related circumstances had a disability. Disabilities included physical, developmental and neurological. All except one of the children were over the age of five years.

Socio-economic status

Information about socio-economic status was available for 2011 to 2015 (41 families). Over three quarters (33) of the families of children who died in neglect-related circumstances lived in areas of greatest socio-economic disadvantage (SEIFA quintiles 1 and 2).[125] Over half of the families (24) lived in the most disadvantaged areas (quintile 1).

Poverty is often associated with neglect. Families that experience poverty are also more likely to experience inadequate housing, homelessness, and lack of capacity to meet basic needs, among other disadvantages.[126] Scott notes that:

> *Families who experience poverty are more likely to have larger families, be single-parent households, or have a child with a disability, and may be more likely to come to the attention of support agencies.*[127]

We identified the status of the family and the number of children living in the household at the time of the child's death for 105 of the children considered in our review.[128] Of the families or households:

- Almost one half (46%) were larger households with three or more children; 22 households (21%) had three children and 26 households (25%) had four or more children. This is a higher proportion of larger households than generally identified in the population. Census data

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121. The Crude Mortality Rate for Aboriginal children was 4.01 per 100.000 Aboriginal and Torres Strait Islander children, and the rate for non-Indigenous children was 0.56 per 100,000.
122. Australian Institute of Family Studies 2016, *Child protection and Aboriginal and Torres Strait Islander children* CFA Resource sheet October 2016 https://aifs.gov.au/cfca/publications/child-protection-and-aboriginal-and-torres-strait-islander-children.
123. Libesman T, 2004, Child Welfare approaches for Indigenous communities: International perspectives NCPC Issues no 20, Australian Institute of Family Studies https://aifs.gov.au/cfca/publications/child-welfare-approaches-indigenous-communities-international-perspectives.
124. Robinson S, 2015. Preventing abuse of children and young people with disability under the National Disability Insurance Scheme: A brave new world? Australian Social Work v 68 no 4, 469.
125. Quintile 1 (57.1%) and quintile 2 (21.4%) of the Socio-Economic Indexes for Areas.
126. Scott D, 2014. *Understanding child neglect*. CFCA paper no 20, page 6. Child and Family Community Australia, accessed February 2017 https://aifs.gov.au/cfca/publications/understanding-child-neglect/introduction.
127. Ibid.
128. Of the 112 children who were in the care of a parent or parents, or carers with whom they normally shared a household, information on family composition and/or number of children in the household was available for 105. Household size includes all children related or unrelated if living in the household.

indicates that around 80 per cent of families have one or two children under 18 years of age. In 2011, 15 per cent of Australian families had three children less than 18 years of age, and five per cent had four or more children.[129]

- Of the 105 households, the majority were two-parent (72, 69%), and around one quarter were headed by a single parent (28; 27%). Comparatively, across different census years, one-parent families accounted for 22% of families in Australia.[130]

6.2.2. Cause and circumstances of neglect-related deaths

As noted above, we classify neglect-related deaths according to the context in which they occurred:

- a significantly careless act on the part of a carer
- carer refusal or unjustified delay in providing medical care
- an intentional or reckless failure to adequately supervise a child
- a failure to provide for basic needs such as food, clothing or shelter

Over the 10-year period 2006-2015, over half of the children (68) died as the result of a significantly careless act. Almost one third of the children (39) died in the context of intentional or reckless failure by a carer to supervise. Eleven children were not provided with timely medical care, and in six cases, the basic needs of a child to sustain life were not met.

At the time of the incident that resulted in or contributed to their death, most of the children (105) were under the direct supervision of a primary carer or carers; 48 children were being cared for by their mother, 16 by their father and 39 were in the care of both parents. In two cases, the children's primary carer was an extended family member or unrelated carer.

The other 19 children were in the care of grandparents (9), other extended family (9), or non-related carers (1). In most cases, the child was visiting or travelling in a vehicle with the person.

Significantly careless act

Sixty eight children died in the context of a significantly careless act on the part of a carer. This included 15 children 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 contributory.

The deaths of these children occurred in two broad contexts; where the carer acted in a way that resulted in the exposure of the child to harm, or where the carer failed to provide a minimum level of protection to the child in a risky situation. The deaths of the children occurred after they had been placed for sleep, or from physical injury.

Sudden Unexpected Death in Infancy

Over half (36) of the 68 children who died in the context of a significantly careless act on the part of a carer were infants who died suddenly and unexpectedly. For the majority of the infants (28) the cause of death remained unexplained after investigation.[131] In the 10 cases where a cause of death was determined by the Coroner, the children died as a result of suffocation and strangulation in unsafe sleep environments. Most of the children died while sharing a sleep surface with an adult, who in almost all cases was affected by illicit drugs and/or alcohol.

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129. Weston R, Qu L, Baxter J. 2013. Australian families with children and adolescents. Australian Family Trends No. 5 July 2013. Accessed February 2017 2006, 2011. https://aifs.gov.au/publications/australian-families-children-and-adolescents. Census years 2001, The authors note that *'arrangements are by no means as clear-cut as suggested here, for after parental separation, children classified as being in one-parent families may spend a considerable number of nights with each parent'.*
130. Ibid.
131. Unexplained SUDI is where a cause is unable to be identified following investigation, including post mortem. In one case a coronial finding is pending.

In cases where infants were placed for sleep in inappropriate bedding – in non-infant specific bedding with additional risks such as pillows, loose bedding and other objects – the degree of risk posed to the children was significant. In most cases, the infants were not of the age or developmental stage to move bedding, shift their position or respond to overheating.

Many of the infants' families had a child protection history, with concerns often relating to carer drug and alcohol abuse, and including child neglect, physical abuse and domestic violence. Families with a child protection history have consistently been over-represented in SUDI. Infants with a child protection history are almost 10 times more likely to die suddenly and unexpectedly than children without such history.[132] In addition, sudden and unexpected deaths of infants with a child protection history were much more likely to have been due to external (unnatural) causes, such as accidental suffocation or strangulation.[133]

In 2014, the CDRT recommended that FACS and NSW Health consider initiatives in other jurisdictions that target high risk populations, with a view to considering their applicability to NSW.[134] FACS has advised the CDRT that a number of resources have been developed, or are in development, to assist frontline practitioners to improve their knowledge, skills and practice in addressing SUDI risks. This includes a SUDI training package and plans for an e-learning package.

NSW Health has advised that new resources have been developed to ensure that parents of newborns are provided with safe sleeping advice. The resources include posters, an information sheet and Frequently Asked Questions. In addition, NSW Health launched a Safe Sleep eLearning Module in 2017. The module is designed to assist health workers to effectively deliver safe sleeping messages to families.

Transport fatalities, drowning and other injury

In 32 cases, children died in transport crashes (23), as a result of drowning (8) or exposure to heat or fire (2) resulting from a significantly careless act by a carer.

Carers are required by law to provide a certain level of protection to their children, and requirements over the past decade have been upgraded. For example, new rules introduced in NSW in 2010 require children to be placed in age-graduated restraints in vehicles.[135] Boating requirements were also changed in 2011, with children under the age of 12 years now required in most circumstances to wear a life jacket in vessels less than 8 meters.[136] In 2012, pool barrier fencing laws were changed to provide for mandatory registration of private swimming pools and a program of inspection by local councils. In 2016, the NSW government introduced requirements for compliance certification for pools on newly leased or purchased properties.[137]

A significantly careless act by a carer included a failure to restrain children appropriately in a vehicle, often in addition to driving recklessly and/or under the influence of alcohol or drugs. Deaths also resulted from incidents where a child with little developmental capacity to manage risk was left alone near or in swimming pools and baths; where smoke alarms were disabled in circumstances where fire was a known possibility; and where children were left in situations that should reasonably be identified as very high risk.

More than half (18) of the families of the children who died in these circumstances had no child protection history, and there was no indication that neglect was a factor in the life of the child or family.

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132. NSW Child Death Review Team. 2014. *Causes of death of children with a child protection history 2002-2011* special report to Parliament, Sydney, NSW Ombudsman.
133. NSW Child Death Review Team. 2016. Child death review report 2015. NSW Ombudsman, Sydney.
134. NSW Child Death Review Team. 2015. Annual Report 2014, p 78. NSW Ombudsman, Sydney.
135. *Road Rules*, 2008, NSW.
136. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney.
137. NSW Child Death Review Team. 2016. Child death review report 2015, p 120. NSW Ombudsman, Sydney.

Intentional or reckless failure to adequately supervise

Thirty nine children died in circumstances where there was an intentional or reckless failure on the part of a carer to adequately supervise the child. Most of the children (30) died in drowning incidents. A common scenario was the drowning death of a very young child unsupervised for a relatively long period of time, and where carers had knowledge of and had not attempted to rectify defects in barrier fencing to stop the child accessing the water. Seven of the infants who drowned died in bathtubs when left unsupervised, or in the care of an adult under the influence of alcohol or drugs.

Fire, exposure to heat and animal attack also caused the deaths of children who were unsupervised.

Refusal or delay in providing medical care

Eleven children died from an illness where timely medical attention may have prevented the death. In these cases, no assistance was sought, or there was an unjustifiable delay in seeking assistance.

The children died as a result of acute illness (pneumonia, gastro-intestinal disease, dehydration), chronic conditions (diabetes, epilepsy, obesity, asthma), and injury (poisoning, brain injury).

The circumstances in which the deaths occurred varied, however in all cases, the child was clearly very unwell and deteriorating and needed medical attention. In some cases, parents or carers had been advised to seek medical attention, or had identified the need to seek medical attention but did not take any action to do so. In others, parents or carers had been warned by medical practitioners of the dangers of taking a particular course of action, or of the need to take certain actions to avoid injury or death but had not heeded those warnings. For two of the children, severe illness was not addressed due to the carer's refusal to engage with mainstream medical services.

Failure to provide for basic needs

Six children died in circumstances where their basic needs were not met. For these children, a carer's failure to provide adequate food or an environment to sustain life directly contributed to their deaths (3) or most likely contributed (3). Causes of death related to lack of nutrition or hydration and lack of assistance to newborn babies.

6.3. Evidence of previous neglect and/or maltreatment

An important consideration in preventing neglect-related deaths of children is whether the child was identified as being at risk before they died. This section details evidence of neglect or other maltreatment that was experienced by the child or other children in the family prior to their death.

As noted above, 12 children were in the care of persons, both related and unrelated, who did not normally share a household with the child. The child's death was generally associated with a reckless failure to adequately supervise the child, or through a significantly careless act resulting in the death of a child. In most cases, the children drowned or died in motor vehicle crashes.

In the context of examining whether neglect or other maltreatment was a factor in the lives of the children, the following section relates to 112 children who were in the care of their parent, or persons sharing the child's household, at the time the child died.

6.3.1. Child protection history

The families of children who died in neglect-related circumstances and who were in the care of a parent or other household member were more likely than not to have a child protection history; two thirds of the families (74) had been the subject of a report of risk of harm or risk of significant harm[138] to FACS relating to the child who died or their sibling(s) within the three years before the child died.

138. In 2010 changes under 'Keep Them Safe' reforms extended responsibility for child protection responses to reports to a range of agencies, with the statutory responsibility of Community Services being focused on children at risk of significant harm.

In the majority of these families, reported issues included concerns specifically about child neglect such as basic physical needs not being met, inadequate supervision, inadequate nutrition, educational neglect, poor physical state of the home and prenatal reports raising concerns about lack of ante-natal care. In many cases, these reported issues were related to parental substance abuse, mental health concerns and/or domestic violence.

Our reviews found that the nature of the child protection history for two thirds of the 74 families (49) was relevant to the circumstances of the child's death.

CASE STUDY

An older child had a chronic illness and was non-compliant with a medication regime to manage symptoms. The child became acutely unwell at home, with no access to medication. The child's carers did not seek medical assistance, nor did they attempt to obtain medication. Emergency services were called after the child was found unresponsive, and the child was pronounced deceased.

The family had been the subject of numerous reports to FACS over the child's life. Reported issues raised concerns about neglect and other maltreatment, including inadequate supervision, inadequate nutrition and medical treatment not provided.

The family also had contact with other agencies including health services and a voluntary early intervention service, but often declined assistance when that was offered, or failed to attend scheduled appointments. Another government agency had been in the home in the months before the child died, and identified that the home was in a poor state, with evident mould and vermin, which may have exacerbated the child's condition.

Child protection histories of some families indicated that neglect was a longstanding issue. However, neglect was rarely the only concern raised through reports, and was most often identified along with concerns about physical and/or sexual abuse.

6.3.2. Children with no recorded child protection history

Of the 112 children who died in neglect-related circumstances and the carer was a parent or household member, one third (38) had no recorded child protection history in the three years prior to their death.

In half of these cases, the death related to a significantly careless act on the part of a carer, where there was no – or very limited – recorded history of issues that may have posed a child protection risk. The circumstances in which children died included, for example:

- car crashes where a carer was driving recklessly and/or under the influence of alcohol, with the child unrestrained in the vehicle
- drowning deaths in the context of vulnerable age, open access to water and inadequate supervision of the child, and
- life threatening illness that was identified by carers as serious, but did not result in reasonable action to seek appropriate medical assistance.

For some families with no child protection history, other agencies had documented concerns. For example, health services had noted alcohol and other drug issues, or mental health concerns; and police recorded a history of violence. In the main, the level of concern did not extend to the safety of children.

However, in a small number of families (6), there was evidence that carers were dealing with issues that could have indicated risk of harm to the children. In these families, contact with agencies or services was often limited:

- Visibility of concerns may have been limited for three families, all of which comprised pre-school aged children and there was minimal or no engagement with antenatal or post-natal home visiting services. Two of the families also lived in isolated areas.
- Another four families were not usually resident in NSW, and for two, there was some indication of involvement with child protection services in other states.

CASE STUDY

In one family, an infant died suddenly and unexpectedly while sharing a bed with a carer. The child's death was determined to be a result of natural causes, but in the context of injuries considered 'indicative of non accidental injury'. The carer had also smoked heroin in the day prior to the child's death, raising concerns about possible overlay. The carer had a history of chronic narcotic abuse. Health records indicate an awareness by that agency of parental substance abuse, depression, housing stress, lack of support systems and poor financial circumstances. Health assessed and managed identified risk issues within its own system. Social work assessments provide evidence these issues were taken seriously, but were not considered concerning enough to warrant a risk of harm report to FACS.

6.3.3. Identified risk factors

Where concerns were identified about possible risks to children, the concerns were primarily linked to alcohol or other drug abuse, mental health and domestic violence. In a quarter of the families (28), all of these concerns were identified together; and most (25) of these families had a child protection history.

Alcohol and other drugs

Our review identified that alcohol and/or other drug abuse was the most significant single risk factor contributing to the neglect-related deaths of children, and the predominant risk in the background of the children who died.

Fifty nine of the children were living in families where one or both parents or carers had a recorded history of abusing alcohol or other drugs. In most of these families (52), the concerns were considerable and resulted in reports to FACS that the children were at risk of harm or significant harm.

Carer(s) were identified in post death investigation processes as being affected by drugs and/or alcohol at the time of the child's death in one-quarter (29) of the cases. For most, the level of intoxication was a contributory factor in the child's death. Alcohol and/or other drugs were a possible contributory factor in another ten deaths. For only two children, alcohol or other drug abuse was identified as a key contributing factor in the child's death, but was not recorded as an issue prior to that time.

CASE STUDY

A young child passenger died in a motor vehicle collision after the car the child was travelling in swerved and veered into the path of an oncoming vehicle. The family had been the subject of risk of significant harm reports in relation to domestic violence and drug abuse, which resulted in a referral to – and sporadic engagement with – a support service. Toxicology revealed the driver was under the influence of a toxic to lethal range of illicit drugs at the time of the crash. Pharmacology determined that the amount of drug would have significantly impaired driving ability, and was most likely the major factor in the collision.

Alcohol was the predominant identified issue, either alone or associated with other drugs. Poly-drug use was often noted, and 13 families included a carer or carers using amphetamine and methamphetamine. Ten families were known to include at least one carer with a background of heroin addiction, either current or managed by methadone.

Domestic and other violence

For 38 families, domestic violence was a current concern when the child died. All but one of the 38 families had a child protection history, and in most of these families (29), domestic violence was often present with alcohol and other drug issues. An additional 21 families had previously experienced domestic violence, but this had ceased as a result of separation of the perpetrator from the family.

Carer mental health

Records indicated that around one third (44) of the families had at least one carer with a recorded mental health condition. Most predominantly, this was a history of depression and/or anxiety, sometimes with other disorders. A small number of parents or carers (7) had diagnosed major disorders, including schizophrenia and bipolar disorder.

A mental health condition alone is not of itself indicative of risk of harm to children; and while most of the 44 families had a child protection history, this was often related to the co-existence of mental health concerns with drug and/or alcohol abuse, and/or domestic violence. For some families, there was evidence that mental health issues were significant in relation to the impact on children, particularly where mental health conditions resulted in a physical or mental lack of availability to the child.

CASE STUDY

An infant just over a month old died after sustaining an unintentional injury while in the care of the mother, who had a history of mental illness and had been diagnosed with postnatal depression. The mother had a history of chronic alcoholism. Shortly after the child's birth, the mother was presented to hospital due to severe depression; she was unable to get out of bed and care for herself or her children. The mother disclosed that she had resumed drinking after a period of abstinence. In the weeks prior to the child's death, the mother's contact with police and mental health services raised concerns about alcohol dependency, mental health issues and relationship difficulties and violence within the family. Child protection reports were made by health staff about the mother's emotional state and alcoholism, however the reports were not allocated for response. FACS noted that while the decision not to allocate the reports was appropriate and within guidelines, information that may have assisted in reviewing the decision not to allocate was not communicated to the casework manager.[139]

6.4. Observations and issues arising from reviews

Chapter 8 details our overall observations and findings from reviews, focusing on deaths that occurred in 2014 and 2015.

Taking into account changes over the period of our review (as detailed in Chapter 6), our review of 124 neglect-related deaths of children has highlighted a number of key observations and issues:

- very young children and Aboriginal children are most vulnerable to fatal neglect

139. In response to a draft copy of this report, FACS advised that the agency has made a number of systemic changes to improve functionality of KiDS to ensure that all information reported by agencies is recorded appropriately to inform local decision making.

- a history of neglect was evident in many of the families of children who died in neglect-related circumstances
- alcohol was the predominant identified issue affecting carer capacity, either alone or associated with other drugs
- neglect was not always recognised, or prioritised for response, and
- where services were offered or provided, families were often difficult to engage.

These observations are detailed in chapter 8.

Chapter 7. Reporting of fatal neglect in NSW

As noted above, in 2016 we contracted Dr Deborah Scott at the Australian Institute of Family Studies (AIFS) to undertake a literature review with a focus on fatal neglect definitions and reporting, and to provide advice relating to the NSW Ombudsman's defining and reporting of fatal child neglect in NSW.

There have been some important changes to the reporting of child deaths resulting from neglect since our work in this area commenced in 2002:

- From July 2009, the definition of a reviewable death under the *Community Services (Complaints, Reviews and Monitoring) Act* no longer included child protection history as a sole category of reviewable deaths.
- As Convenor of the NSW Child Death Review Team since 2010, the Ombudsman now has responsibility for reporting on all child deaths in NSW.
- The deaths of children with a child protection history are also subject to internal review and annual public reporting by Family and Community Services (FACS). FACS does not include fatal neglect as a category for reporting purposes, but does consider the extent to which neglect was associated with children who died. FACS' recent report of child deaths included a special focus on neglect.[140]

The Ombudsman's dual responsibilities in reviewing and reporting on child deaths in NSW are fulfilled via two separate processes:

- review of the deaths of all children, and
- review of a subset of children (reviewable child deaths).

The Ombudsman reports on each function separately to the NSW Parliament, with the same aim of identifying trends and patterns, and making recommendations as to policies and practices, and-for the CDRT-legislation to prevent the deaths of children.

The CDRT does not specifically describe fatal neglect through its reporting. The CDRT's reporting does however, consider the role of neglect as a risk factor through the identification of parental/carer behaviours that play a role in the child's death. Failure to supervise adequately and exposing children to risk through high-risk behaviour or failure to provide a safe environment for children meets the definition of neglect, regardless of whether or not neglect is explicitly outlined and reported in the data. In addition, many of the causes or circumstances of death associated with neglect are considered closely in the CDRT's work, including Sudden Unexpected Death in Infancy and motor vehicle crashes.

In the context of our dual review role, the report made a number of key observations and recommendations. In summary, the key proposals are:

> In order to support the public health purpose of the reviews further, the following amendments could be implemented:
>
> i) rather than identify deaths in the CDRT as due to neglect, report them in the context of preventability associated with modifiable risk factors
>
> ii) in the CDRT report of all child deaths prevention of deaths could be considered in terms of supervisory neglect and neglect through failure to provide a safe environment for children without explicitly identifying deaths as neglectful
>
> iii) in the Reviewable Deaths report, due to the similarities between abuse and neglect at the severe end of the spectrum, consider all deaths where a wilful and knowing act has contributed to the death of a child as 'maltreatment related' to enable reporting rather than separating abuse from neglect.

The sections below at 7.1 are drawn directly from Dr Scott's report. The full report can be accessed at: www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team/reporting-of-fatal-neglect-in-nsw.

140. NSW Government, Family and Community Services. 2016. Child Deaths 2015 Annual Report – learning to improve services. Accessed 15/2/2016: http://www.community.nsw.gov.au/__data/assets/file/0003/387030/child_deaths_report_2015_fullreport.pdf

In practical terms, the proposed changes would only affect the reporting of child deaths in NSW.

First, the threshold for a child's death being 'reviewable' by the Ombudsman would be raised. At present, a reviewable death includes deaths resulting from a 'significantly careless failure to adequately supervise' and 'a significantly careless act' on the part of a carer. In most cases, these circumstances indicate an omission that would not meet the criteria of maltreatment. Some deaths that are presently reviewable would be excluded under such criteria, for example:

- drowning deaths of children where carers were aware of the possibility that a child could access a swimming pool and failed to supervise accordingly and/or restrict access to the water, and
- transport fatalities involving a child in a vehicle being driven recklessly while the child was unrestrained or inappropriately restrained.

Following on from this, CDRT reporting would give greater emphasis to preventability of deaths where the action or inaction of carers may have been contributory, but falls short of maltreatment. This approach is to some degree already evident in the work of the CDRT to date; for example, the Team's work on Sudden Unexpected Death in Infancy has highlighted the role of carer alcohol and other drug use in SUDI, and recommendations have been targeted to interventions for vulnerable families.

As stated, the proposed changes focus only on the reporting of child deaths in NSW; they would not affect the scope of review of child deaths and associated liaison with agencies such as FACS, NSW Health and the State Coroner's office.

Over the coming months, it is our intention to consult with key stakeholders on the report findings and recommendations.

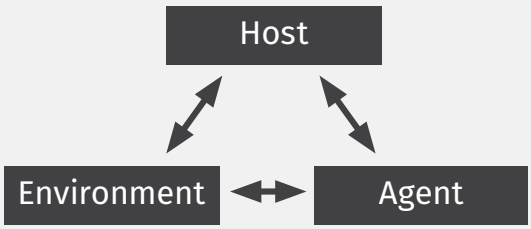
7.1. Excerpt: Reporting of fatal neglect in NSW

The following is an excerpt from *Reporting of fatal neglect in NSW*, prepared for the CDRT by Dr Deborah Scott, Australian Institute of Family Studies.

7.2. Approaches to review of neglect-related deaths

The broadest definitions of fatal neglect occur in the public health context. Public health responses are based on the presence of risk factors that occur in one of three areas: host, agent, or environment. The condition/disease - in this case fatal neglect - can only occur where there is interaction between the three areas. Public health strategies are based on interfering with the cycle in some way so that there cannot be interaction to cause the condition/disease in the host (prevention).

Figure 1: Public Health Triangle[141]



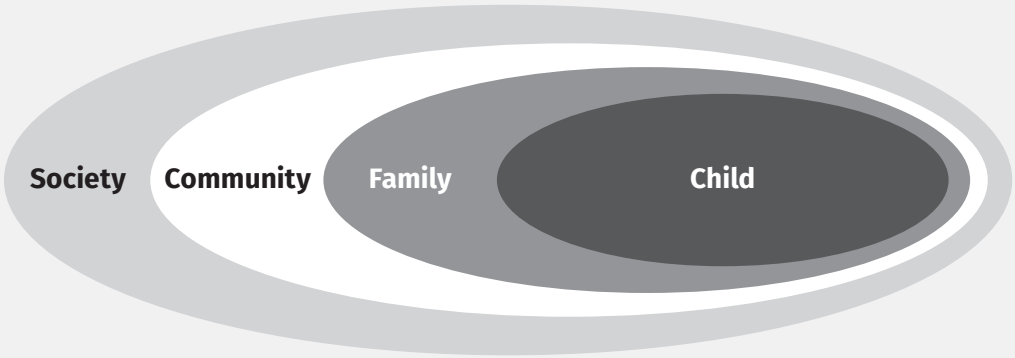
141. Host – person in which disease occurs
Agent – organism or force that causes disease e.g.) bacteria to cause malaria, cigarettes cause lung cancer
Environment – the environment that allows for the interaction of the host and agent e.g.) wetlands where mosquitoes breed and people work, pubs and clubs where smokers smoke and wait staff are exposed to second-hand smoke

A public health definition of fatal neglect does not specify actions/intent or perpetrator and does not restrict the environment where fatal neglect occurs and so results in a very broad definition. Under a public health definition of neglect, it is possible for a government or system to be identified as responsible for neglect, not just a parent or caregiver.

7.2.1. An ecological approach to understanding fatal neglect in a public health context

An ecological model of child well-being situates child maltreatment across four related domains: child, family, community and societal. Risk and protective characteristics may arise from each of these domains.[142] Krug et al (2002) adapted this in their model to explain risk factors for interpersonal violence. Research has recommended that any assessment of fatal neglect in children necessarily must include contributory factors at the parental, community and societal levels[143] (Bonner, Crow, & Logue, 1999) and this framework accommodates these elements.

Figure 2: Ecological model for risk and protective factors for child maltreatment



Source: (Krug, Dahlberg, Mercy, Zwi, & Lorenzo, 2002, p 12.

As this model suggests, it is impossible to isolate the impact of risks or protective factors for neglect in child characteristics from those in the family, community or the society in which the child lives.

For example: The death of a child in a house fire while his/her mother is at work may be influenced by factors at each of the ecological levels:

- Child – age, developmental stage that allows ability to recognise danger, knowledge and competence to know how to respond effectively to the fire;
- Family – more than one parent/caregiver so child is not left unsupervised, education of parents to earn sufficient money to pay for appropriate supervision if parent/caregiver unavailable, parental capacity to teach child to recognise and respond appropriately to danger;
- Community – availability of fire department, safe housing with appropriate fire exits, access to affordable, effective childcare; and
- Society – enforced building codes to maximise fire safety and use of smoke detectors, funding for fire department to enable effective and timely response to fire.

The developmental stage, personality, resilience of the child will be influenced by the structure, size, parental education and income of the family. These in turn will influence

142. LaPosata, E., & Verhoek-Oftedahl, W. (2005). Rhode Island's Child Death Review Team. In J. Fulton (Ed.), Public Health Briefing. Providence: Rhode Island Department of Health.
143. Bonner, B., Crow, S., & Logue, M. (1999). Fatal child neglect Neglected children: Research, Practice and Policy: Sage.

and be influenced by the safety, culture, and connectedness of the community where the family lives and all of these will be affected by the laws, expectations and support systems of the society they form part of. While neglect is most commonly thought of as a parent or caregiver failure, the role of community and society cannot be overlooked in preventing it.

7.2.2. Options for the future reporting of fatal neglect

The NSW Ombudsman and CDRT report on child deaths, including those due to fatal neglect, comprehensively and in a manner conducive to effecting change and reducing child deaths. Compared to other CDRT reports, the NSW Ombudsman reports are of high quality and provide enough detail to understand not only the causes of death of children in NSW but also to gain an understanding of the potential risk factors associated with those deaths. There is, however, some potential scope to improve the reporting of fatal neglect.

A strength of the Ombudsman's reporting is its ecological approach, however, the definition of neglect that underpins this is narrow and focused only on parent or carer conduct. It may be useful to expand the focus of the definition of fatal neglect to take a broader, ecological, public health approach, that does not restrict neglect to the actions of parents and/or caretakers and has a strong focus on modifiable risk factors.

Options for reporting fatal neglect in CDRT reports

A potential benefit in a broad approach to the identification and reporting of fatal neglect is enabling population estimates of numbers of children and families affected by fatal neglect. However, the potential downside to explicitly identifying fatal neglect is the likely stigmatisation of families and the perception that the prevention messages do not apply to them because 'they are not neglectful' and that prevention campaigns are the response of a 'nanny state' where all are expected to comply because of a few who can't or won't.

Given that the aim of death review for the NSW Ombudsman is to prevent child deaths and not to provide population measures of fatalities, it is not necessary to explicitly classify deaths as fatal neglect in any formal manner in CDRT reports. Instead, deaths could be reported based on modifiable risk factors. A system of classification similar to that of LaPosata & Verhoek-Oftedahl (2005) may be more useful:

- definitely preventable – reasonable intervention would prevent the death
- probably preventable – preventable but with stronger intervention and less certainty than in the 'definitely' preventable
- probably not preventable – reasonable intervention may still have resulted in death
- definitely not preventable – death would not have been preventable regardless of any attempt at intervention

It is important to note that there would be few deaths where preventability would be as clear-cut as this classification suggests. A similar, but less rigid, classification of probably preventable or potentially preventable, based on risk factors and the ability to modify and control for those risks in the child's environment would be more workable within the constraints of accessible information and reporting requirements of the NSW Ombudsman. This system would allow for a very broad, ecological approach and sit within a public health prevention model.

Options for reporting fatal neglect in Reviewable Death Reports

The definition of fatal neglect has evolved over time to include some acts of commission as well as those of omission. These deaths are similar in nature to abuse related deaths. In both abuse and neglect related deaths where there has been a deliberate act, whether it be

to perpetrate violence against a child (as in abuse) or to deprive a child of the necessities for life (as in neglect), the risks factors and outcomes are very similar regardless of whether the death is defined as abuse or neglect. For these deaths, a more useful and workable classification may be 'maltreatment related deaths'.

The prevention strategies for deaths where a child was deprived of basic requirements to thrive due to a knowing and wilful act (for example a child who dies from malnutrition or when a drunken or drug affected parent chooses to drive recklessly with their children unrestrained in the car) will be quite different to those where the deprivation is due to a lack of knowledge or access to services. Thus, it would make sense to identify and report deaths separately and include those due to knowing and wilful acts in the Reviewable Death Report rather than the CDRT.

7.2.3. Summary

There are variations in definitions and operationalisation of those definitions according to the context where they will be applied. These range from more specific approaches within the legal system to public health approaches, which offer the broadest context in terms of definition and operationalisation. All child death review processes aim to prevent child deaths, including those related to fatal neglect, and so, are consistent with a public health approach.

To that end, this review has found that the NSW Ombudsman's approaches to the review of fatal neglect within Reviewable Death Reports, and all child deaths in the CDRT reports are consistent with international best practice in the context of a prevention focused approach. However, in order to support the public health purpose of the reviews further, the following amendments could be implemented:

i) rather than identify deaths in the CDRT as due to neglect, report them in the context of preventability associated with modifiable risk factors

ii) in the CDRT report of all child deaths prevention of deaths could be considered in terms of supervisory neglect and neglect through failure to provide a safe environment for children without explicitly identifying deaths as neglectful

iii) in the Reviewable Deaths report, due to the similarities between abuse and neglect at the severe end of the spectrum, consider all deaths where a wilful and knowing act has contributed to the death of a child as 'maltreatment related' to enable reporting rather than separating abuse from neglect.

The benefit of this public health approach to defining and reporting fatal neglect is that it improves the understanding of the associated risk and protective factors across all causes of death, and potential lethal consequences of child neglect as well as potential to understand the magnitude of the problem. This knowledge can, in turn provide an evidence base to inform system-level change that will result in fewer child deaths.

Chapter 8. Observations and issues

The following section draws together key observations from our reviews of the deaths of children in 2014 and 2015, and our longer term assessment of neglect-related deaths (2006 – 2015) and of vulnerable teenagers who died while in care (2004 – 2015).

The circumstances surrounding the deaths of children in care, and children who die in circumstances of abuse or neglect clearly differ, and the observations below reflect this. However, some issues raised through our reviews have commonality and where relevant, we identify these as systems issues.

In considering neglect-related deaths and the deaths of vulnerable teenagers in care, it is important to note that significant changes have been made to the child protection system in NSW over the period of review. Child protection is now a shared responsibility across government agencies and between government and non-government agencies. Responsibility for the delivery of out-of-home care services is also in the process of being transferred to the non-government sector, and programs and policies have changed and evolved. Some notable developments are described in the introduction to this report.

In regard to statutory child protection issues, the Ombudsman and FACS have established an integrated governance framework to track recommendations made by the Ombudsman across different functions, including reviewable child deaths. The framework also tracks higher level systems issues, including:

- building an intelligence driven approach to child protection
- implementing a place-based service delivery strategy in high need locations
- improving responses to particularly vulnerable target groups
- supporting the core components of successful collaborative practice
- improving capacity to respond to risk of significant harm reports, and
- improving accountability and business performance.

Taking into account these developments, our reviews have highlighted a number of key observations and issues.

Very young children and Aboriginal children are over-represented in abuse and neglect-related deaths

Over the 10 year period from 2006 – 2015, almost 80 percent of the children who died in neglect-related circumstances were aged less than five years of age, and 40 percent were infants under 12 months of age. Children under five years of age accounted for over two thirds of all abuse-related deaths over that ten-year period.

Aboriginal children were seven times more likely to die in neglect-related circumstances than non-Indigenous children, and have consistently been over-represented in abuse-related deaths. Just under half of these children were infants aged less than 12 months.

The young age of children who died in abuse and neglect-related circumstances reflects their vulnerability and reliance on carers, and highlights the importance of universal services in contact with vulnerable families – early childhood nurses and health visitors, general practitioners – having a strong child protection focus.

A prior history of abuse and neglect was evident in many of the families

The presence of child abuse or neglect in families is not a predictor of fatal abuse or neglect. However, children with this background are over-represented in abuse and neglect deaths, and a history of trauma was also a significant factor in the lives of the young people in care who died

by suicide or in risk-taking circumstances. The prior history of abuse and neglect underscores the importance of effective recognition of risk, holistic risk assessment, and capacity to respond where children are at risk of significant harm.

Most of the families of children who died in neglect-related circumstances had a child protection history that included concerns about neglect, and half of the families of children who died in abuse-related circumstances had a child protection history that included concerns about the behaviour of carers – domestic/family violence, neglect, drug and/or alcohol abuse, and other general wellbeing issues. In cases of neglect, we found that alcohol and/or other drug abuse was the most significant single risk factor contributing to the neglect-related deaths of children, and the most predominant risk in the background of the children who died. In cases of abuse, alcohol and other drug abuse was often present with other risk factors, including adult mental health issues, domestic and/or other violence and family breakdown.

In the context of neglect-related deaths determined to be Sudden Unexpected Deaths in Infancy, the NSW Child Death Review Team – convened by the Ombudsman – is currently monitoring the work of NSW Health and FACS to target safe sleeping and related messages to families involved with child protection services.[144]

Our review of young people in care who died by suicide or in risk-taking circumstances found that all had high and complex support needs and histories of major trauma, including abuse and neglect before they were taken into care. In addition, more than half experienced a high degree of placement instability after they entered care. It was also evident that the majority of the young people experienced a range of significant and often co-occurring problems while they were in care, including for example, mental health issues, substance misuse, homelessness, disrupted schooling, contact with the criminal justice system and conflict in relationships with carers, family, professionals and/or peers.

The extent and the seriousness of the vulnerabilities and reported issues for the young people underscores the need for intensive support and multi-agency involvement to address high and complex needs of young people in care. Specific consideration needs to be given to the needs of young people who enter care later in childhood.

The NSW Child Death Review Team has recently reported on youth suicide, and has sought advice from NSW Health about existing or planned strategies relating to suicide prevention.[145]

Risk to children was not always recognised, assessed holistically or prioritised for intervention

Our previous work reviewing familial abuse-related deaths of children identified concerns about FACS' capacity to respond to children at risk of significant harm, particularly through face-to-face assessment. We also identified the need to ensure that child protection staff conduct comprehensive and timely safety and risk assessments that lead to action being taken that is commensurate with the level of risk.[146] These issues were again apparent in our work relating to children who died in 2014 and 2015.

For the majority of children considered in this report – whether their death resulted from abuse, neglect or suicide and risk taking – most had been subject to concerns about their welfare and wellbeing. However the level of risk they were experiencing was not always recognised, particularly where risk was escalating or cumulative. Across our reviews, we identified cases where consecutive reports, both ROSH and non-ROSH, were not considered cumulatively. In these cases, child protection reports together provided a picture of escalating risk and/or information warranting comprehensive assessment.

In particular, we found:

- Our reviews of abuse-related deaths of children in 2014 and 2015 identified some missed opportunities to consider whether children had been subject to abuse, rather than accidental injury. While recognising that health services – including general practitioners and public

144. NSW Child Death Review Team, 2016. *Child Death Review Report 2015*. NSW Ombudsman, Sydney. p 116 http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0009/39474/CDRT_review_report_2015_final.pdf
145. NSW Child Death Review Team, 2016. *Child Death Review Report 2015*. NSW Ombudsman, Sydney. p 102 http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0009/39474/CDRT_review_report_2015_final.pdf
146. NSW Ombudsman (2015). Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child deaths.

hospitals – deal with many presentations of children with injuries that are accidental, they have an important role in recognising signs of abuse. Our work has previously emphasised the importance of practitioners and agencies recognising suspicious physical injury in children, and we have recommended close review of cases by NSW Health where children who die in these circumstances have previously been presented with physical injury.[147]

- Agencies in contact with families did not consistently recognise the significance of neglectful behaviour or environments, or share information about indicators of neglect; for example, household squalor, dirty or inadequate clothing and lack of personal hygiene, child obesity or underweight, failure of adherence to recommended treatment regimes. Reports relating to neglect of children were often not considered to reach the threshold of risk of significant harm. Subsequent reports were often assessed without comprehensive consideration of escalating or cumulative harm. As FACS has noted in relation to serious case reviews:

  'Neglect is more likely to be overlooked than other forms of maltreatment (such as physical abuse) as each episode in isolation may not appear to reflect high risk when compared to other forms of maltreatment.'[148]

- Entrenched and chronic risk factors, particularly drug abuse and family violence, were also not consistently identified or understood as posing significant risk to the physical safety of children. We also found at times, an over-reliance by caseworkers on self-reports and assurances of parents, a lack of clear and direct communication about the presenting risks, and insufficient focus on the specific and individual needs of children.
- Decisions about screening and prioritisation were sometimes problematic. Screening of reports at the Helpline to determine whether reported information meets the threshold for risk of significant harm – and is therefore referred to a CSC – is a critical part of the child protection response. A single report raising concerns about a child may represent the only opportunity professionals have to gain an understanding of a child's circumstances and any risks present.

Responding to vulnerable young people in care

Almost all of the young people in our review of suicide and risk-taking were the subject of multiple reports to FACS when they were in care. Reports predominantly related to the young person engaging in harmful or risky behaviours, or concerns about the young person's mental health/emotional state. Our reviews found that a high proportion of these reports were either screened out by the Helpline as not meeting the threshold for statutory intervention or were closed due to competing priorities without further assessment, often on the basis that other agencies or practitioners were providing support to the young person. When cases were allocated for a child protection response, we identified instances where casework responses appeared to be narrowly focused and crisis driven. For example, responses were often centred on resolving immediate needs – such as finding the young person a bed for the night – but did not adequately address the young person's longer term needs, including establishing greater stability for the young person. Given the nature of the issues and risks facing the young people, our reviews identified the need for intensive case management, a consistently supportive and therapeutic care environment and close monitoring and support of placements.

FACS has introduced a range of initiatives to improve the agency's capacity to respond to risk of significant harm. However, as noted in our recent submission to the Parliamentary Inquiry into Child Protection, the caseworker response rate for ROSH reports remains low at 29 percent.[149] We have previously highlighted the need to enhance and define the role and responsibilities of partner agencies – both government and non-government – in relation to work with high risk families.

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147. NSW Ombudsman (2015). Report of Reviewable Deaths in 2012 and 2013, Volume 1: Child Deaths, p 48.
148. Family and Community Services Child Deaths 2015 Annual Report –Learning to improve services, p 58.
149. Relevant initiatives are described in our submission to the recent Parliamentary Inquiry into child protection https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-submission-details.aspx?pk= 55906.

Where services were offered or provided, families and children were sometimes difficult to engage

Engagement of families

Our reviews identified that referral to early intervention services was often a main response in relation to concerns about neglect. However, this did not consistently result in an effective outcome for the child and family. Early intervention services are generally voluntary, and in at least 18 families in our review of neglect-related deaths, we noted the family either declined assistance or engaged sporadically with the services offered.

Our reviews of abuse-related deaths found that in some allocated cases, the nature and extent of risk was not always fully recognised or appreciated, and caseworkers and other professionals did not gain an accurate understanding of the child's experiences. In some cases this lack of understanding was because a family was difficult to engage. In other cases there was minimal casework or contact with the family, or children were not spoken to or directly engaged to gain insight into their experience. The need to develop meaningful relationships with children and families where possible, and to engage in effective interagency collaboration, highlights the responsibility of agencies to ensure that frontline workers have the opportunity to develop skills in this area.

Engagement of young people in care

For young people in care, our reviews identified that referral to counselling, mental health services, drug and alcohol treatment programs or education support were main responses in relation to concerns about the young person's mental health and/or harmful risk-taking behaviours. However, this did not consistently result in an effective outcome for the young person.

Our reviews highlighted the challenges for support workers and practitioners working with young people to help resolve identified problems and risks. For example, more than half of the young people referred to relevant supports repeatedly declined assistance or only engaged sporadically with the services offered. In some instances, persistent follow up by the support service and/or out-of-home care agency resulted in re-engagement by the young person, but assertive follow-up did not always result in this outcome.

In many cases, our reviews also identified that the young person displayed challenging behaviours of such intensity, duration and frequency that it adversely affected their capacity to meaningfully engage with support services.

Putting shared responsibility into practice was challenging in complex cases

Shared responsibility for protecting children has been the hallmark of the NSW child protection system since 2010. It refers to the principle that child protection is the collective responsibility of the whole-of-government and the community.

Our previous reports of reviewable child deaths have noted the ongoing and significant challenges for agencies in engaging and responding effectively to families with complex needs. We have also highlighted the importance of early assessment and intervention, and effective coordination and collaboration between agencies working with these families.

When multiple agencies are providing a service, with each targeting different needs or aspects of family functioning, it can be challenging for any one agency to understand the family's overall needs and holistically review the effectiveness of service interventions/casework strategies to meet these. There is also a risk that a clear focus on child protection may be lost if there is a lack of clarity across agencies about respective roles and responsibilities and ineffective interagency communication. Our reviews and investigations have underscored the importance of ensuring truly collaborative practice and delivery of services.

Following an independent review of the out-of-home care system in 2016, the government has acknowledged that there have been barriers to implementing the principle of shared responsibility, including that:

- the current child protection system is not client centred but designed around programs and service models rather than the needs of vulnerable families, and
- vulnerable children and families have needs that cross the boundaries of government agencies, yet the approach to shared responsibility has not achieved improvement in the outcomes for children and families with complex needs[150]

We have previously identified that collaborative approaches to service delivery are a critical component of shared responsibility, and a pre-condition for effective service responses to vulnerable families who have complex needs that cannot be met by any one agency. We have stressed the need for an 'intelligence-driven' child protection system that, as part of a broader, place-based model of service delivery, promotes identifying, analysing, prioritising and acting on information held by agencies with child protection responsibilities. This is consistent with the principle of 'shared responsibility'.[151]

Vulnerable young people in care

Our reviews highlighted some of the challenges for agencies working with young people in care who have complex needs, mental health issues and behaviours that place them at significant risk of harm.

As noted above, records for the young people in our review of suicide and risk-taking identified a need for multi-faceted and intensive supports to address their complex needs. In the 12 months before they died, almost all of the young people were receiving support and assistance from multiple agencies, often simultaneously. In this context, our reviews identified the need for a high level of case coordination. For some, information exchange and case planning appeared to be well-coordinated, in others this was not the case and service provision and support was fragmented at times.

For many of the young people who were involved with multiple agencies, our reviews identified issues relating to interagency communication and coordination. In some cases, we found that a lack of effective interagency communication at critical points - for example, following risk of significant harm reports, post-release from juvenile detention or after discharge from a hospital/health service - meant that relevant information gathered by the different agencies was not always drawn together and analysed holistically. This in turn reduced the ability of any one agency to fully understand the young person's circumstances and associated risks, and to inform case planning and service interventions.

We have previously recommended that a clear framework be developed to guide interagency practice and more clearly define the role of partner agencies in identifying and responding to young people with high and complex needs.[152] The recent report of the NSW Legislative Council's inquiry into child protection also made a similar recommendation.[153]

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150. NSW Government (2016), *Their Futures Matter: A new approach – Reform directions from the Independent Review of Out of Home Care in New South Wales*, accessed from https://www.facs.nsw.gov.au/__data/assets/file/0005/387293/FACS_OOHC_Review_161116.pdf on 22 March 2017.
151. See our submission to the recent Parliamentary Inquiry into child protection https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-submission-details.aspx?pk= 55906. Through the NSW Ombudsman/FACS Integrated Governance Framework, this office is monitoring FACS' progress in relation to collaborative practice, intelligence-driven child protection practice and place based service delivery.
152. NSW Ombudsman, *Are things Improving?* (2014) and *Keep Them Safe?* (2011).
153. Legislative Council General Purpose Standing Committee No. 2 Child Protection Inquiry Report, March 2017, accessed from https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6106/Final%20report%20-%20Child%20protection.pdf on 22 March 2017.

Chapter 9. Monitoring recommendations

We monitor the results of recommendations made in our reports. We do this by seeking information from agencies about progress with implementation. In our Report of Reviewable Deaths in 2012 and 2013 we made 13 recommendations. The section below details the recommendations we made to agencies and outlines their responses.

Responses from the NSW Police Force and NSW Health are produced in full below, followed by our comments. We monitor FACS' progress in implementing our recommendations through the FACS (Community Services)/Ombudsman Integrated Governance Framework. The Integrated Governance Framework is a joint FACS/Ombudsman mechanism for tracking FACS' progress towards implementing systemic reforms and addressing discrete systems/practice issues that we have identified through our work. The section below draws on FACS' latest advice in relation to the issues we are monitoring via the framework.

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.

Information requested by the NSW Ombudsman	NSW Health's response
This recommendation relates to NSW Health's advice relating to strengthened guidance, clinical processes and administrative arrangements. We would appreciate further details of: • The outcomes of any review of the impact of these strategies. • Specific measures that are targeted to improving responses to children of parents with substance abuse concerns. • Copies of any new procedures or forms that are targeted to improving responses to children of parents with substance abuse concerns.	The Drug and Alcohol Community Health and Outpatient Care (CHOC) program involves the development of a state-wide information system for drug and alcohol. The CHOC system is currently being rolled out to Local Health District Drug and Alcohol Services across the State as part of the Electronic Medical Record (eMR) project (see sample at Attachment 4). The CHOC program involves new clinical processes and forms that are designed to improve clinical practice, including recognition of any risks to children, mandatory reporting requirements and improved coordination of care between services. Child wellbeing screening tools and transfer of care processes have been added to CHOC to enable the gathering of reportable data from Drug and Alcohol Services in support of recommendation 1a. Attachment 4 is a screenshot of the Child Wellbeing component of the Drug and Alcohol electronic medical record.

Comments:

We acknowledge the work by NSW Health to implement a state-wide electronic information system for drug and alcohol services which incorporates new prompts and standardised screening forms with a focus on identifying child protection risks to children, and will not seek further information about this specific recommendation.

Through our reviews, we will consider the adequacy of systems within Health to identify, and respond to, child protection risks in the context of service provision to parents who present with problematic drug and alcohol use.

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.

Information requested by the NSW Ombudsman	NSW Health's response
This recommendation was made in the context of advice that a proposed recommendation by MH-Children and Young People for a legislative amendment that would require adult mental health services to identify and support consumers who are parents and have responsibility for children under 18, would not be implemented. We note the advice provided by NSW Health in September 2015. In addition, we note that the policy directive *NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010 – 2015* was due for review in 2015. We would appreciate: • An update of strategies to date or planned aimed at improving responses to children of parents with mental illness, including the status of the Project Air Strategy Parenting program and Whole Family Teams. • Advice as to whether the COPMI framework was reviewed in 2015 and the outcome of that review.	<u>Family Focussed Mental Health Service Improvement and Workforce Development</u> An online Family Focussed Recovery Community of Practice has been established on the NSW Child and Adolescent Mental Health Service workforce development site and is available to all staff with a health email address http://www.camhs.nswiop.nsw.edu.au. The site promotes family focussed training, resources and information that support the mental health of parents and the safety and wellbeing of children. Videos of the presentations given at the Family Focussed Recovery Forum are available on the site. NSW continues to be one of the highest jurisdictional users of evidence based training and resources developed by National COPMI in working with families where parents have mental health problems. In the 5 months between September 2015 and January 2016: • A total of 5,952 resources were disseminated across NSW including: "How can I help my child", "Best for me and my baby", "Family Talk", When your parent has a mental illness" etc. • 196 NSW users registered for National COPMI e-learning training. <u>Let's Talk About Children (Let's Talk) Training:</u> • Let's Talk is an effective brief evidence-based intervention via structured discussion with parents who experience mental illness about parenting and the needs of their children. • NSW was one of the first jurisdictions to facilitate the roll out of Let's Talk face-to-face training. MH-CYP/Mental Health and Drug & Alcohol Office (MHDAO) negotiated with COPMI National to deliver workshops for NSW adult mental health staff in both metro and rural locations. Over 120 staff were trained in NSW across 2014 - 2015. In November 2015, 20 Let's Talk champions were specifically trained in leading local implementation of Let's Talk in adult mental health services.

Information requested by the NSW Ombudsman	NSW Health's response
	• In addition, many NSW clinicians have completed the online Let's Talk training since it was offered in 2014. Parenting Project Air Project Air is an innovative service delivery model for the treatment of parents with Borderline Personality Disorder (BPD) to support improvements in treatment delivered to this clinical population and deliver benefits to children and families. The Project Air Parenting Program, funded by NSW Ministry of Health and developed in 2015, has been incorporated into the existing Project Air Strategy training being implemented throughout Local Health Districts across NSW in order to maximise the reach of these principles and resources to clinicians who work with people with personality disorder who are parents. All developed resources are available to NSW Mental Health Workers online at the Project Air Strategy website www.projectairstrategy.org MH-CYP/MHDAO in collaboration with the Project Air Team has distributed hard copies of the Parenting Project Air resources to support NSW Mental Health Clinicians across NSW in their clinical role when they are working with parents with Borderline Personality Disorder. Whole Family Teams (WFTs) WFTs (located in Nowra, Lismore, Newcastle and Gosford) provide tertiary specialist mental health and drug and alcohol services for families in their home, where there are mental health and/or drug and alcohol problems and substantiated child protection concerns exist. Referrals from Community Services are prioritised and WFT services are delivered in partnership with Community Services, primary care, NGOs and private providers. An independent evaluation (2014) found: • clinically significant improvements in parental mental health; • improved parental drug and alcohol outcomes; • significant improvements in all domains of family functioning (including parenting, family relationships and child wellbeing); and • significant improvements in child safety, as evidenced by the substantial reduction (58.4%) in the rate of ROSH reports to Community Services for children in families who completed the WFT program. Under the NSW Government response to Living Well: A Strategic Plan for Mental Health in NSW 2014-2024, three additional community based WFTs are being funded. In 2015/16, two new teams will be established (South Western Sydney and Nepean Blue Mountains) and in 2016-2017 an additional WFT will be established (Western Sydney LHD).

Information requested by the NSW Ombudsman	NSW Health's response
	NSW Children of Parents with a Mental Illness (COPMI) Framework The policy directive NSW Children of Parents with a Mental Illness (COPMI) Framework 2010-2015 http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_037.pdf was developed in the context of a national movement to promote mental health, prevent the development of mental disorders and reduce their impact on individuals and their families. The policy is being implemented across NSW. Review of the policy is underway MH-CYP commissioned the Sax Institute to deliver a literature review on Parenting as a focus of recovery from mental illness to inform directions for the revised policy. A report was prepared by internationally recognised COPMI authors, Associate Professor Andrea Reupert and Professor Darryl Maybery. Findings and recommendations from the report were presented at the Family Focussed Recovery Forum held Thursday 3 December 2015 in Sydney. The forum was attended by mental health clinicians and managers across New South Wales who work with parents with mental health problems, their children and families. The report will be disseminated shortly following publication to a peer reviewed journal. The Expert Reference Group will review the Framework in 2016 and will be informed by the report and recommendations generated at the Forum.

Comments:

This recommendation was made in the context of:

- advice from NSW Health that a proposed recommendation by MH-Children and Young People for legislative amendment to require adult mental health services to identify and support consumers who are parents and have responsibility for children under 18, would not be implemented, and
- the policy directive *NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015*, being due for review.

We acknowledge the work that NSW Health is undertaking to improve the recognition of, and response to, parents with mental illness and their families, including the dissemination of training and resources to health staff, and the expansion of Whole of Family Teams in three new locations. We also note NSW Health's advice that an independent evaluation of Whole of Family Teams in 2014 found a clinically significant improvement in parental mental health, and substantial reductions in parental drug and alcohol misuse and ROSH reports for families who completed the program.

In relation to the *COPMI Framework for Mental Health Services 2010-2015*, we note Health's advice that review of the policy directive is underway and will be informed by a literature review completed by the Sax Institute. We will continue to monitor the outcome of NSW Health's review of the framework.

A number of the issues and observations in this report relate to current and further work to improve support for children of parents with mental illness and we will continue to monitor these issues.

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

Information requested by the NSW Ombudsman	NSW Health's response
Recommendations 3.1 and 3.2 relate to recommendations in our report of reviewable deaths in 2010/11 (in 2013): that the suspicious death of a child within 12 months of receiving care or treatment from a public health facility should be the subject of internal review. The purpose would be to assess the interaction, with a view to learning and service improvement. **Recommendation 3.1:** In 2015, Health proposed a review of relevant cases that had been subject to RCA. In September 2015, we provided copies of seven RCAs for this purpose. We would appreciate advice on the outcomes of the audit, including: • lessons learnt from the RCAs, and • lessons learnt about the process of RCA **Recommendation 3.2:** NSW Health originally supported this recommendation, but following consultation within NSW Health, proposed an alternative 'close internal reviews' in partnership with the Ombudsman's office. Health also advised that there is a Children and Young People RCA sub-committee – which would *'increase opportunities for close internal reviews by NSW Health of serious incidents involving child protection and dv concerns'*.	A discussion of lessons learnt from the RCA audit is attached. Overall the information provided an analysis undertaken by the Local Health Districts in each of the seven cases audited was variable. Not all appear to have had a child protection health specialist on the investigation and as a consequence, the likelihood of identifying contributing factors and root causes was decreased. NSW Health is undertaking further work to establish a more effective mechanism for the RCA process. The RCA process is unlikely to be the most appropriate investigation methodology for examining a suspicious child death that occurred within 12 months of receiving care or treatment from a NSW public health facility. This is because these types of cases may often involve multiple presentations to health services, sometimes by different family members. These cases also may include a combination of health and social risk factors, an analysis of which is not well suited to the RCA approach. The Ministry of Health and the Clinical Excellence Commission have agreed to develop a process for the joint review of applicable cases. As previously noted, a RCA is unlikely to be the most appropriate methodology for the case review; however, a formal review process

Information requested by the NSW Ombudsman	NSW Health's response
While the RCA process is a valuable tool, it is noted that the deaths of most concern to this office – children who died in suspicious circumstances who had previously been presented to a public health facility with physical injury – are unlikely to meet the criteria to trigger a RCA. On the basis of discussions with the Ministry of Health that this office could notify Health of relevant child deaths in this context, we would appreciate advice regarding the nature of, and any barriers to, the conduct of close internal reviews by NSW Health of children who die in suspicious circumstances who were presented to a public health facility with physical injury within the 12 months prior to their death. **Recommendation 3.3:** NSW Health should provide advice to this office regarding 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.	will be established. The Ministry and the Clinical Excellence Commission will develop a joint governance structure, communication plan, and agreed methodology for the case reviews. It is intended that this work will be completed by 30 June 2017. In relation to recommendation 3.3, the working group responsible for implementing the Child Abuse and Sexual Assault Clinical Advice Line is in the process of finalising the contract with the technology providers. Clinical guidelines to support the operation of the phone line are also near completion.

Comments:

Recommendations 3.1 and 3.2 above relate to recommendations in our *Report of reviewable deaths in 2010 and 2011*, that the suspicious death of a child within 12 months of receiving care or treatment from a public health facility should be the subject of close internal review by NSW Health. The recommendation was based on our observation that there would be valuable insight to be gained by Health from a close review of matters where children present with injury and subsequently die in 'suspicious' abuse-related circumstances.

In response to our original recommendation, NSW Health advised that they support the recommendation, but the scope of review, the detail and level of work involved, and its implementation would require further discussion. We met with representatives of the Ministry of Health on a number of occasions between 2013 and 2016 who advised that Health remains committed to undertaking reviews in line with the intent of our recommendation and are currently working to refine the parameters, criteria and process of review.

In 2016, NSW Health completed an audit of relevant cases that had been subject to RCA. While the audit identified a number of practice and system issues across the cases, we note NSW Health's advice that they do not consider RCA's to be the most appropriate method for examining the suspicious deaths of children within 12 months of receiving care or treatment. As such, the Ministry of Health will work with the Clinical Excellence Commission to develop an appropriate legal and governance framework for undertaking internal reviews.

More broadly, NSW Health also told us that the agency had undertaken considerable work to improve the health system's ability to identify and respond to child abuse and neglect, including:

- Reviewing the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* policy directive, NSW Health has advised that the review is currently on hold pending the redesign of the child protection intake, assessment and referral system as part of *Their Future Matter*. In the interim, the Ministry of Health will issue a bulletin to supplement the policy directive, including

information about the inclusion of certain private health professionals within Chapter 16A provisions, and clearer guidance in relation to documenting child protection issues in medical records and identifying and responding to medical 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.
- 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.
- Reviewing its child protection training. NSW Health has advised that the review objectives include targeting of child protection training to better match the diverse needs of the NSW Health workforce. Significant projects in the review include the development of a revised mandatory online training module, which will be launched in October 2017. Key messages from the training inlcude that reporting to the Child Protection Helpline is only one of several responses to child protection risk, and that health workers must proactively work with vulnerable families to reduce risk. To complement the mandatory child protection training, an additional flexible training option for emergency department doctors is also being developed. This training package will be delivered by Directors of Emergncy Medicine Traiing as part of compulsory in-service medical training requirements.

We acknowledge the work undertaken by NSW Health to strengthen practice in relation to the identification of, and response to, child protection concerns. We also note that NSW 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 continue to monitor NSW Health's progress in establishing criteria and processes for matters requiring internal review. We will also continue to refer matters arising from our child death reviews to NSW Health and Local Health Districts for consideration and review, when necessary.

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.

Information requested by the NSW Ombudsman	NSW Police Force's response
The Department of Family and Community Services (FACS) has previously advised that due to legislative constraints the NSW Police Force (NSWPF) is unable to access KiDS directly. We would appreciate advice regarding any steps taken with FACS to allow designated police officers access to KiDS and/or the new platform ChildStory.	FACS continues to work on implementing the new platform – ChildStory. The NSWPF Child Wellbeing Unit (CWU) continues to collaborate with FACS during the development of the platform. Changeover to ChildStory will allow designated CWU sworn police and unsworn officers to access the platform. The selection of officers with access will be vetted depending upon the security and role classification of the individual officer. Further benefits of the project for frontline police will include more relevant information feedback from e-reporting. It was anticipated that the platform was to be live and active for NSWPF officers by July 2017. FACS has advised that the rollout of ChildStory will extend beyond July 2017. The CWU continues to work closely with FACS to ensure improved data exchange. This includes: a trial on the electronic transfer of reporting on Immediate Risk of Significant Harm (IROSH) matters from frontline police to FACS; and ongoing work on the exchange of information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* using iASK.
	FACS' advice Audit work was undertaken collaboratively to test the viability of co-locating Police at the Helpline and providing Police with access to KiDS. There was insufficient evidence to indicate these strategies would be beneficial. FACS, the NSW Police Force and NSW Ombudsman agreed to consider other ways of improving information exchange, such as having a priority system for Chapter 16A requests from FACS to Police. NSW Police CWU staff will have access to the CWU elements of the ChildStory platform from November 2017. Police will also be able to lodge E-reports from November 2017 and see feedback on the progress of those reports.

Comments:

The focus of this recommendation was to enhance the capacity of police, in the conduct of their normal duties, to have access to the information they need to assess, and respond to, risk to children. It appears that certain police officers will have access to the new ChildStory, which will go some way to this outcome.

We will continue to monitor this recommendation and related issues through our broader work in oversight of the delivery of community services.

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.

Information requested by the NSW Ombudsman	FACS' advice
A progress update in relation to the implementaion of this recommendation via the FACS/NSW Ombudsman Integrated Governance Framework.	The New Partners Tool has been reviewed and updated and is now one of 26 new Practice Advice topics added to the new Casework Practice intranet site. Relevant mandates point to this advice as a way of encouraging staff to reflect on the risk that new partners may pose. The Office of the Senior Practitioner is currently working with ChildStory to develop insight panels for release two of ChildStory. This advice topic is in scope for an insight panel when practitioner's are completing their safety assessments.

Comments:

The focus of this recommendation is on ensuring that the presence of a new partner or other change in household composition is adequately reflected in safety and risk assessments.

We note FACS' advice that the New Partners Practice Tool has been modified with accompanying practice advice published on the FACS casework practice intranet site.

We will continue to monitor this recommendation and related issues through our broader work in oversight of the delivery of community services.

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

Information requested by the NSW Ombudsman	FACS' response
A progress update in relation to the implementaion of this recommendation via the FACS/NSW Ombudsman Integrated Governance Framework.	FACS advised us that although the Educational Neglect Interagency Workgroup held its last meeting on 9 April 2015, the meetings resulted in much improved ongoing relationships between FACS and the Department of Education, which continue at an informal level as needed. District-led initiatives, such as the SafeCare program being piloted in Batemans Bay, have the potential to assist parents to develop the skills to get their children to school, which Schoolzin case studies found was an issue. In addition, online resources aimed at increasing professional awareness of educational neglect for both FACS and DoE staff have been developed and posted on FACS and DEC websites in April 2015. FACS further advised that the agency's neglect practice resource is due for release in 2017. The resource will be underpinned by a contemporary literature review that will look at: • Key concepts in defining neglect and sub-types of neglect (including medical neglect) • Risk factors associated with neglect • Protecting children against neglect • The impact of neglect • Intervening in cases of neglect • Practice challenges and prompts in cases of neglect The resource will be in two parts: **Part One:** aims to improve practitioner's recognition of the cumulative impact of neglect. The target audience for this section of the resource is Helpline staff and managers. It aims to assist in the prioritisation of neglect by improving practitioners understanding of the causes and consequences of neglect. Practitioners will receive guidance to assist them to seek the information that they need to gather in order to gain an understanding of each child's unique experience so that the potential dangers and risk that may arise for each child are more visible.

Information requested by the NSW Ombudsman	FACS' response
	This section will look at neglect and its impact for children of all ages – pre-natally through to adolescence. The resource is designed to provide managers with the evidence and practice support needed to help them see the urgency of neglect and in doing so improve allocation rates. **Part Two:** aims to provide practitioners with the skills they need to work with a family where neglect is a feature. Aimed particularly at caseworkers, this section will provide advice on interventions that work, tools to support their practice and guidance to help them see each child's experience of neglect. The resource will also encourage practitioners to look for signs of neglect, even when that is not the reported issue. The neglect resource will draw on the Practice Notes developed from the Research to Practice Seminar held on 9 May 2017. This seminar included key note presentations from experts in the field of neglect. Local representatives from Department of Education and Westmead Children's Hospital spoke about educational and medical neglect. The effectiveness of the neglect practice resource on FACS work with children and families will be evaluated. The resource does not however include a measurement framework for educational neglect.

Comments:

We note that FACS is continuing to work with the Department of Education and other agencies to identify and implement further actions to deliver a more integrated and effective response to educational neglect. We will continue to monitor FACS' work with partner agencies to improve responses to educational neglect, including how FACS intends to measure and monitor performance in this area.

As part of our broader work in oversight of the delivery of community services, we will continue to monitor the development by the Office of the Senior Practitioner of a resource for FACS staff on neglect, including educational neglect.

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.

Information requested by the NSW Ombudsman	FACS' advice
A progress update in relation to the implementaion of this recommendation via the FACS/NSW Ombudsman Integrated Governance Framework.	**Practice improvement** Mobile Child Protection Unit The Mobile Child Protection Unit (MCPU) was established in February 2015 initially for a period of two years to address the need for more timely and responsive child protection services across the upper sector of the Western NSW district. The team is based in Dubbo and services the Bourke, Brewarrina, Walgett and Cobar Local Government Areas and has now been embedded into ongoing operations within the District. As at May 2017, the MCPU has 1 x MCPU Manager Casework, 6 x MCPU Caseworkers, 1 x Casework Support Worker and a Casework Specialist who provides specialist support from the Office of the Senior Practitioner. MCPU caseworkers respond to allocated ROSH reports as the primary caseworker, with the local caseworker as the secondary worker. MCPU caseworkers are based in Dubbo and travel to communities to complete assessments. Local caseworkers retain responsibility of supporting families to reach the identified case planning goals. The team works with other government agencies (Police, Education, Health, Juvenile Justice), service providers and community groups to better support families to reduce family breakdown and minimise the numbers of children and young people entering formal care. The MCPU has been a very positive addition in the District. More children and young people are being seen (and in a more timely manner) by a caseworker after a risk of significant harm (ROSH) report is received and better outcomes are being achieved for children who are in care. To date, the MCPU has responded to 94 families with ROSH reports, made 722 home visits and completed 78 case plans for children who require statutory child protection work or are in the Minister's parental responsibility. Evaluation results have shown for the 12 month period February 2015 to February 2016 the time available for casework in the area serviced by the MCPU has increased by 45%. The number of secondary assessments completed has increased by 58% and the number of home visits increased by 172%.

Information requested by the NSW Ombudsman	FACS' advice
	The mobility of this child protection unit means a greater number of skilled and experienced caseworkers work across a number of remote communities. In doing this, FACS better responds to children reported at ROSH. The expanded team and the changed working arrangements meant staff were able to devote themselves to casework rather than desk work, reaching 23,808 casework hours in 2015, compared to 16, 214 during the same period in 2014. For the financial year 2016/17 to April 2017, the MCPU has conducted face to face assessments for just under 200 children across Bourke, Brewarrina, Cobar and Walgett. Maragnuka Community Hub in Bourke The Maranguka Hub commenced operations in May 2015. The Hub is designed to create a soft entry point and better coordinated support for vulnerable families and children in Bourke. The initiative involves establishing community-led, multi-disciplinary teams working in partnership with relevant government and non-government agencies and organisations. Partners include the Maranguka Initiative, FACS, NSW Kids and Families (Health), Western NSW Local Health District (LHD), the Department of Education (DE), and Uniting Family Referral Service (FRS). FACS currently has an administration assistant position based at the Hub. FACS has recently established an Engagement Officer in Bourke from February 2017. The role of the Engagement Officer is to coordinate whole of government responses to complex families through the Case Coordination Committee (CCC). The role acts as a conduit between families and the broader service sector with the ultimate aim that families engage earlier with the service sector prior to a crisis response. It is anticipated that the position will assist in other local planning processes for government, non-government and community, including working closely with the Maranguka Initiative and the FRS. FACS Western NSW District has also supported the initiative through in kind support, including the provision of data and has facilitated regular interagency meetings inclusive of Maranguka since February 2015. Coonamble Integrated Service Delivery (ISD) Project and the Together Burral Bina partnership The ISD Project was initiated by FACS with the recognition that many young children, young people, and families in rural and remote communities are not getting the help they need and the service system is highly 'siloed' and not well integrated. Coonamble was chosen as a site to trial a new way of working between all levels of government, non government agencies and community groups.

Information requested by the NSW Ombudsman	FACS' advice
	The shape of the project was drawn from other district led co-designed projects under the FACS Safe Home for Life (SHFL) reforms and with the broader service system under the DPC Service Delivery Reforms program. Strong governance was established at local, regional and state level to guide the implementation of the project. The Stage 1 Report in October 2016 indicated significant early success in building a strong coalition of willing community groups and stakeholders, and a demonstrable appetite for change. A Partnership Coordinator has been appointed in early 2017 to drive the next stage of project implementation in partnership with the key stakeholder groups. Human Resources issues In the March 2017 quarter, Western NSW had a 4% caseworker vacancy rate. The District has maintained a historically low vacancy rate below 5% over the last 2 years. The District is working in partnership with strategic HR and Frontline Resource Management on the HR improvement initiatives and the OSP on Practice Improvement Initiatives. Out-of-home care issues Western NSW District was provisionally accredited by the OCG in 2016 and is currently undergoing assessment for full accreditation by November 2017. Western NSW district is supporting the implementation of evidence-based intensive family preservation and restoration services under the Their Futures Matter (TFM) reforms to OOHC. A Multisystemic Therapy for Child Abuse and Neglect (MST-CAN®) team will be located in Dubbo and early implementation activities are currently underway. Aboriginal Community Protocols Western NSW commenced development of Aboriginal Community Protocols in 2014 as a way of involving Aboriginal communities more in decision making about placement of Aboriginal children in out of home care. The protocols are being progressively rolled out across the District and as at April 2017 community protocols have been signed in Dubbo, Bourke, Brewarrina, Orange and Parkes and in progress in Walgett, Condobolin and Wagga. Following signing of the protocol document a Community Advisory Group is established in each location with the provision of training and support for members by FACS. Case Coordination Committees Case Coordination Committees (CCC's) are currently operational in Walgett, Bourke and Coonabarabran. CCC's objective is to improve the inter-agency risk management

Information requested by the NSW Ombudsman	FACS' advice
	of children and young people and their families, providing a pathway to better manage and support individuals with multiple and complex needs through interagency collaboration, at a local level. The Case Coordination Committee provides senior level multi-agency advice and is a consultation and action group. Its function is operational, but has the ability to recognise wider service or policy gaps so that strategic work can be taken forward in other forms to mitigate identified risk to children and young people and their families. The overall intent is to deliver a strategic and coordinated interagency approach and actions to keep children safe.

Comments:

This recommendation relates to strategies by FACS to improve responsiveness to ROSH reports, improve casework practice, increase face-to-face assessments and achieve better outcomes for children and families in Western NSW.

FACS has agreed to continue to report to this office on a regular basis regarding initiatives to improve practice in the Western Region, and outcomes achieved. We will continue to monitor this recommendation and related issues through our broader work in oversight of the delivery of community services.

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.

Information requested by the NSW Ombudsman	NSW Police Force's response
We note that a joint audit between FACS, NSWPF and the NSW Ombudsman's Office found insufficient evidence to indicate that co-locating police at the FACS Helpline would be of benefit. We would appreciate advice on current or planned strategies that reflect the intent of this recommendation.	In August 2015 the NSW Ombudsman and the NSWPF conducted an exercise to test the value of co-location of staff at the FACS Helpline. The workshop compared information held by FACS and NSWPF on randomly selected cases. The results of the comparison saw no discernible variation in outcome. The Office of the NSW Ombudsman undertook further analysis of the cases to confirm this result. The NSWPF is currently assisting FACS with its proposed new computer system ChildStory with a view to more efficient information exchange between the agencies. If a Risk of Significant Harm (ROSH) report does not meet the JIRT criteria, the matter is referred to a Local Area Command for investigation by police. The matter is also referred to a FACS Community Service Centre. Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* allows for the exchange of information for the safety and wellbeing of the child or young person.
	FACS' advice In relation to the co-location of Police at the Helpline, joint audit work by FACS, the NSW Police Force and the NSW Ombudsman found insufficient evidence to indicate that co-locating Police at the Helpline would be a beneficial activity for the purpose of achieving the desired outcome. FACS, the NSW Police Force and the NSW Ombudsman agreed to consider other ways of improving information exchange, such as having a priority system for Chapter 16A requests from FACS to Police. FACS also advised that, with Police, they have undertaken a preliminary analysis of child protection reports from Police to determine whether the presence of a 'serious violent offender' (SVO)6 is likely to assist in identifying children and young people most at risk so they can be prioritised to receive a service or assessment. Information from Police (including SVO[154] involvement/presence) on

Information requested by the NSW Ombudsman	NSW Police Force's response
	the children and young people they had reported over the two year period 2011-12 to 2012-13 was provided to FACS and matched with our child protection information. This analysis is currently being finalised. Future analyses will examine child protection reports from all reporters in the same way. Initial findings indicate that the proportion of reports from police involving an SVO is low. Although not tested, it would be reasonable to assume that the proportion of reports from other reporters such as Health and Education involving an SVO would be even lower.

Our comments:

This recommendation is focused on examining the value of police involvement in assessing risk of harm at the intake stage, drawing on police holdings about alleged persons causing harm.

As part of this, in August 2015, our office, FACS and Police jointly reviewed a sample of ROSH reports to test the hypothesis that ready access to relevant policing information at the time of receiving a ROSH report would assist FACS staff to acquire a better understanding of the presenting risks. Overall, the preliminary findings of the joint review provided limited evidence that co-locating police at the Helpline would improve the current assessment process.

As part of our broader work in oversight of the delivery of community services, we will continue discussions with FACS and Police to explore the potential for enhancing the role of police officers in gathering evidence to inform safety and risk assessments conducted by FACS.

154. In accordance with the preliminary definition developed by the NSW Police Force in line with the New Zealand Standard Classification Office, a 'serious violent offender' is an individual who has been charged with certain categories of offence, including acts intended to cause injury (e.g. assault); homicide and related offences; sexual assault and related offences; and dangerous or negligent acts endangering persons.

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.

Information requested by the NSW Ombudsman	NSW Police Force's response
We would appreciate advice regarding the outcomes of the trial being conducted by the Child Abuse Squad where all reports of non-urgent, serious, indictable crimes are accepted, regardless of whether informant details are included. We would also appreciate other information relating to the adequacy of current arrangements with and guidance for FACS staff in relation to referring criminal matters to police.	On 10 November 2014, a trial commenced whereby all non-urgent reports of crime were sent from FACS to the Child Abuse Squad via a shared mailbox system. It was intended that FACS would send through serious crime reports that were obtained through the course of their duties; serious crime reports being reports that met the threshold of Serious Indictable Offences not requiring an immediate police response. During the trial a number of issues arose from reporting these matters to a single point. On numerous occasions during this trial period, FACS inappropriately reported matters requiring urgent police attention via the shared mailbox portal. As a result of the risk this posed, it was found that the most appropriate method of reporting these matters by FACS was via the relevant Local Area Command (LAC), as the area of service delivery. From July 2015, LACs became responsible for accepting and actioning these reported serious crime reports from FACS. To assist in this change, the NSWPF and FACS amended the Standing Operating Procedures for the reporting of serious crime to ensure clear lines of reporting are in place. The NSWPF continues to work with FACS to ensure the appropriate section of the NSWPF receives, records and responds to reports of serious crime. The Child Abuse Squad is working with the Safe Home for Life (Child Safety & Permanency), Design, Innovation, Safety & Permanency section within FACS to update the FACS form for reporting serious crime and the relevant SOPS. The original intent of this reporting process was to enable the Child Protection Helpline to maintain its capability to answer phone calls without losing staff as they attended the local police station to make reports of serious crime that they would come across during the course of their work. Since this time, the local

Information requested by the NSW Ombudsman	NSW Police Force's response
	Community Service Centres (CSC) have started to make reports via this method. The NSWPF has discussed this issue with FACS and determined that this form of reporting is for Child Protection Helpline staff only. It has been agreed that CSCs can make reports of serious crime as per the most appropriate method of reporting – via the relevant LAC, as the area of service delivery.
	FACS' advice FACS and the NSW Police Force have worked together to develop procedures to support and promote the reporting of criminal allegations to Police, including the development and implementation of the 'FACS Crime Report' to Police. FACS also revised their 'Serious events (critical reportable and emergency)' casework procedure. Section 1 of the procedure - 'Reporting to the Police' - has been updated in consultation with the Ombudsman. It contains clear advice to FACS staff regarding matters that should be reported to Police and clear guidance on how to make a report. Amendments to the procedure address the Ombudsman's concern about the 'serious indictable offence' threshold for reporting matters to Police being too high. The procedure still states that a 'serious indictable offence' must be reported to the Police. However, the procedure now indicates that any allegation of physical assault/abuse, sexual assault or indecent assault of a child or young person should be reported to Police, regardless of whether or not it constitutes a 'serious indictable offence'. The procedure will be incorporated into a streamlined Serious Events Practice Mandate as part of FACS' Casework Practice Simplification Project. The Practice Mandate will be provided to the Ombudsman for review before publication and launch of the new Casework Practice website in November 2016. FACS and the NSW Police Force will continue to work together to identify a longer-term solution to the reporting of criminal allegations to Police.

Comments:

This recommendation relates to improved identification and referral of criminal matters to police by FACS staff through the development of policy and associated guidelines.

In 2016, FACS finalised its revision of the practice mandate on referring criminal allegations to police. The revisions to the mandate address previous concerns raised by our office in relation to FACS' policy in this area, including by establishing a more appropriate threshold for making a report to police and providing clearer guidance to FACS staff on reporting offences, including offences of a historical nature and serious offences other than serious indictable offences.

We will continue to monitor practice against the revised mandate and related issues through our broader work in oversight of the delivery of community services.

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.

Information requested by the NSW Ombudsman	NSW Health's response
Noting that NSW Health committed to a staged roll-out of this recommendation, we would appreciate detailed advice regarding: • the number of non-ROSH medical neglect cases redirected from the Child Protection Helpline to date • details of further stages of the roll-out and the timeframe for each stage, and • whether and how the strategy to transfer cases will be reviewed.	NSW Health remains committed to the strategy of transferring non-ROSH medical neglect reports from the Child Protection Helpline to the Health Child Wellbeing Unit. NSW Health has had several meetings with the NSW Helpline Director, most recently on 2 June 2016. A draft agreement has been prepared regarding the sharing of non-ROSH medical neglect reports received at the Helpline, with further rollout dependent on the outcome of a 6 month trial period. Since 2 October 2016, the NSW Child Protection Helpline has been transferring screened out (non-ROSH) medical neglect reports made by health workers to the NSW Health Child Wellbeing Unit (CWU) for review. In the period 2 October 2016 to 2 May 2017, 40 reports were sent to the NSW Health CWU for review. The aims of the strategy are for the CWU to: • consider whether the quality of the information provided to the Helpline could have been enhanced to assist the Helpline in making a determination • reappraise all available information and identify any need for a new suspected ROSH report to be made (based on cumulative harm) • hear from the health worker of any actions already taken or planned, along with them making a report plan (with the health worker and their LHD/Network) any interventions and actions that Health can take to mitigate the safety, welfare or wellbeing risks identified • identify any training needs of health workers and workplaces in relatino to child wellbeing and protection responsibilities • enable where appropriate, LHD child protection management to coordinate the provisino of support to families and to address any systemic child protection related reporting or responding issues. NSW Health and the Child Protection Helpline met on the 20th March 2017 to review the progress and outcomes to date of this strategy and to revise procedures and

Information requested by the NSW Ombudsman	NSW Health's response
	criteria as required. The findings from NSW Health's analysis of the first 29 reports sent to the CWU were presented at the meeting. A key finding of the analysis was that in a significant majority of matters the CWU took further actions to respond to low level (non-ROSH) risk concerns. In relation to further roll-out, it has been identified that not all screened out health medical neglect reports are being sent to the CWU due to problems in the Child Protection Helpline recontacting the mandatory reporter to gain consent. The Child Protection Helpline is considering processes to increase the number of medical neglect reports being forwarded. In July 2017, when the strategy is next reviewed, Health and FACS will identify whether this has led to an increase in matters reviewed as well as the resources required for this strategy. The timing and extent of further rollout will be dependent on the review. In addition, the Central Coast Multi-Agency Response Centre (CCMARC) Governance Group has agreed to progress a similar approach whereby the Health Wellbeing Coordinator will review certain NSW Health non-ROSH reports at CCMARC. The purpose of the reviews is to identify: • whether the quality of the information provided could have been enhanced • if a new suspected ROSH report is to be made • plan any actions/interventions to ensure safety and wellbeing • identify any local training needs and themes The CCMARC Governance Group is overseeing this local initiative to identify the resources required and review outcomes over time. It is anticipated that an evaluation of CCMARC will encapsulate this work.
	FACS' advice During 2016, FACS undertook: • Data analysis of non-ROSH medical neglect matters in preparation for meeting with the NSW Health Child Wellbeing Unit to progress the recommendation • Scoping work to determine the viability of a system within ChildStory that will enable reporters to provide consent so that their details, and that of the report, can be provided to their respective Child Wellbeing Units. Once consent has been obtained, the Child Wellbeing Unit will be automatically notified of outcomes where the ROSH threshold has not been met so that they can follow up with the reporter as they deem appropriate.

Information requested by the NSW Ombudsman	NSW Health's response
	In 2017, the work between the Helpline and the Health CWU is continuing. Updates from NSW Health CWU to the Helpline in March 2017 indicated that an early analysis of the data sent to the Health CWU from the Helpline had been completed by NSW Health. Twenty nine reports made to the Helpline from NSW Health staff were referred to the CWU for review. CWU staff contacted the NSW Health reporters to discuss the report and gain insight into the reasons why the non-ROSH reports were made to the Helpline. NSW Health CWU is continuing their efforts to change the reporting culture in Health including providing specific training on reporting to FACS.

Comments:

The strategy proposed between NSW Health and FACS involves transferring cases reported to the Helpline by health workers which do not meet the statutory reporting threshold, to the Health Child Wellbeing Unit. It would see the Health Child Wellbeing Unit working directly with health workers to coordinate the provision of support to families in cases that would otherwise not have received a response.

We welcome NSW Health and FACS's advice that a draft agreement has been entered into in relation to referral by the Helpline of relevant non-ROSH matters to Health Child Wellbeing Units for follow up and action.

Through our broader responsibility for monitoring the delivery of community services, we will monitor the next stage of work by NSW Health and FACS to finalise and implement the draft agreement, review the rationale for non-ROSH screening decisions by the Helpline and extend the initial focus (medical neglect) to other reported issues.

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.

Information requested by the NSW Ombudsman	NSW Health's response
We note that s 245B of the *Children and Young Persons (Care and Protection) Act 1998* (the Act) was amended in 2015 to provide for individuals to be prescribed by regulation for the purposes of information exchange under Chapter 16A. We would appreciate advice regarding: • action taken or planned to amend the Children and Young Persons	On 6 May 2016, the Children and Young Persons (Care and Protection) Amendment (Private Health Professionals) Regulation 2016 came into effect. The regulation, which amends the *Children and Young Persons (Care and Protection) Act 1998*, extends the operation of section 245B of the Act (Chapter 16A) to nurses, registered medical practitioners, registered midwives, registered psychologists, occupational therapists and speech pathologists. The ability to share relevant safety, welfare and wellbeing information will enable these

Information requested by the NSW Ombudsman	NSW Health's response
(Care and Protection) Regulation 2012 (the Regulation) to give effect to this provision, and • the expected timeframe for completion. In relation to legislative amendments to facilitate access by medical practitioners to the Health CWU, we note that clause 18 of the Regulation extended the operation of s 27A of the Act to allow certain general practitioners and nurses to access it on a temporary basis. We note that this clause ceased to have effect on 30 September 2013. We would appreciate advice on any action taken or planned to ensure access by registered medical practitioners on a permanent basis.	professionals to develop a complete picture of the child or young person and their circumstances, and therefore provide a better, holistic service response. The regulation also extends the operation of the section 27A alternative reporting arrangements to registered medical practitioners and general practice nurses. Accordingly, those health professionals can now consult the Health Child Wellbeing Unit when they have child protection concerns. Following the regulation change, the Ministry of Health wrote to the learned Colleges, relevant professional organisations and other health stakeholders to notify them of the legislative changes. NSW Health also published two fact sheets for private health professionals providing guidance on the operation of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* and accessing the NSW Health Child Wellbeing Unit. These are available on the NSW Health website at http://www.health.nsw.gov.au/kidsfamilies/protection/Pages/info-exchange-safetv-child-youth.aspx The Ministry of Health is engaging the Royal Australian College of General Practitioners to deliver a webinar and publish education material for their members about information sharing and alternative reporting arrangements. It is anticipated that the webinar will be delivered in September 2017.
	FACS' advice This work has been completed. The amendments to the Children and Young Persons (Care and Protection) Regulation 2012 commenced in May 2016. From this date, the following are prescribed bodies for the purpose of information sharing under Chapter 16A and section 248 of the *Children and Young Persons (Care and Protection) Act 1998*: nurses; registered medical practitioners; registered midwives; registered psychologists; persons registered under the Health Practitioner Regulation National Law to practise as occupational therapists (other than students); and speech pathologists eligible for membership of Speech Pathology Australia.

Our comments:

The focus of this recommendation is on achieving the necessary legislative amendments to enable certain private medical practitioners to exchange information about the safety, welfare and wellbeing of children, and for them to be able to access Health Child Wellbeing Units.

We welcome the commencements of regulatory provisions that expand the range of medical professionals that can exchange information under Chapter 16A and report to, and access advice from, the Health Child Wellbeing Unit.

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.

Information requested by the NSW Ombudsman	FACS' advice
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.	<u>Co-design projects</u> • In 2015, the Central Coast Multi Agency Response Centre (CC MARC) was launched. The CC MARC is a local child protection intake line and assessment model. This initiative provides a localised FACS child protection helpline to support better, more timely and more targeted responses to child protection. • Co-design projects are also being rolled out in other districts, including Western Sydney and Nepean Blue Mountains. The projects are designed to bring together local stakeholders to work on developing solutions that respond to the needs of local communities, with a particular focus on improving outcomes for vulnerable children and their families. Examples of initiatives include: – Working with local Aboriginal communities in Bourke, Brewarrina, Walgett and Dubbo to establish Aboriginal Advisory Panels and identify how they can operate more effectively and in partnership with community leadership. – Working in partnership with other agencies and the local community in Nowra on improving wellbeing outcomes for Aboriginal families – with a current focus on educational engagement for Aboriginal children under the age of nine. The initiative is aimed at identifying new ways of funding and delivering services, such as multi-agency response to pooling resources. Authority will be given to local community leaders to test governance models and strategies that improve service delivery for Aboriginal children and families. • Safe Home For Life will oversee and support the development of local service delivery options; and will monitor and report on the progress of each District led solution as part of an ongoing evaluation as they progress. • Co-design activities are the subject of monthly reporting at a district and central office level. Governance arrangements are via the Safe Home for Life Program Outcomes Board, and as requried, the FACS Board. Outcomes of co-design are used broadly across FACS to inform policy redesign processes, for example, the experience at the CC MARC referral centre is being used to inform consideration of future models of intake. • The most recent data shows that ROSH contact volumes are rising more slowly on the Central Coast than for NSW as a whole, while non-ROSH volumes are declining more

Information requested by the NSW Ombudsman	FACS' advice
	• rapidly. This points to a positive impact from CC MARC. In the first full year of operation (November 2015 to October 2016), ROSH contacts increased by 3.9% on the Central Coast (compared to the same period a year earlier), versus a 12% increase for NSW. In the same period, non-ROSH contacts declined by 13.7% for the Central Coast versus a 5.8% decline for NSW. <u>Collective impact and Knowledge Hub projects</u> • Together with Education and several NGO partners, FACS is participating in an action research project led by Professor Ross Homel. The project aims to examine the conditions required for achieving a 'collective impact' approach to improving child wellbeing in disadvantaged communities. • The Innovation, Co-Design and Implementation Knowledge Hub is an approach to support and embed innovation, co-design and implementation science in FACS to improve outcomes for clients. The Knowledge Hub is currently in a scoping, consultation and planning stage. The proposed objectives of the Knowledge Hub include: – defining innovation, co-design and implementation science and developing methodologies of practice – establishing a mechanism to share knowledge, practice and evidence on innovation, co-design and implementation science – providing in-house consultation and expertise on innovation, co-design and implementation – facilitating resource allocation to support innovative strategies/initiatives across FACS. The Knowledge Hub has delivered to date: • a series of intranet resources for FACS staff including methodological information, practical co-design tips and tools, and training opportunities • face to face information sessions providing an introduction to co-design and how we use it to inform policy and service development • provision of in-house consultation including gap analysis, strategy development and feedback on a number of projects incorporating co-design.

Comments:

We note the progress to date by FACS to explore new ways of assessing and responding to child protection concerns. It will be important to ensure that any successes and failures are used to inform work unfolding elsewhere and that initiatives are appropriately integrated within an overarching interagency governance structure.

We will continue to monitor practice against the revised mandate and related issues through our broader work in oversight of the delivery of community services.

Appendix 1

Definitions and methods

10.1. Definitions

10.1.1. Reviewable child deaths

We use the following definitions to determine if the death of a child 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 above[155]
- 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
- for 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 s 149 of the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is otherwise in the care of a service provider.

Child in detention - A child or young person under the age of 18 years who was an inmate in, or was temporarily absent from, in a detention centre, a correctional centre or a lock-up.

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

10.1.2. General definitions

Child – a person under the age of 18 years.

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.

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'*.[156] 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/aunts and cousins.

Infant – a child aged less than one year.

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 by police as being involved or possibly involved 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,[157] a measure of access to services using proxy measures of distance to the five nearest centres of defined populations.

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%.

Sudden Unexpected Death in Infancy (SUDI) – In this report, SUDI is 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.

Young person – In this report, terms such as 'young person' or 'teenager' are used descriptively for older children.

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156. Australian Institute of Criminology 2010, *Homicide in Australia: 2007-08 National Homicide Monitoring Program annual report*, cat. No. Monitoring Report 13, AIC, Canberra.
157. 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

10.2. Methods

10.2.1. Causes of death

Cause of death is classified by the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), 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.

Analysis of cause of death in this report relates primarily to underlying cause of death, which is defined as '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'.[158]

10.2.2. 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 NSW Police Computer Operated Policing System and Community Service 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.

10.2.3. 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.

- Reporting of cause of death in this report is by the International Statistical Classification of Diseases and Related Health Problems (ICD) system. The ICD is the international standard health classification published by the World Health Organisation (WHO).
- In relation to describing rates of death:
  - Mortality rates used in this report are Crude Mortality Rates. This is the rate per 100,000 persons (for this report, persons are all those aged under 18 years). Rates are not calculated for numbers less than four because of lack of reliability.
  - An exception to the use of Crude Mortality Rate is where discussion is exclusively related to infants. Infancy is the period from birth to less than 12 months of age. In this case, the Infant Mortality Rate is used. This is the rate of infant deaths per 1,000 live births. Where this measure is used, it is stated in the report.

158. World Health Organisation (2008), *International Statistical Classification of Diseases and Related Health problems, 10th revision*. WHO: Geneva.

Appendix 2: Methods – Fatal Neglect Review

A comprehensive review of the literature relating to defining fatal neglect was performed. This included peer review papers, grey literature and reports from child death review teams (CDRT) in Australia, Canada, the United Kingdom (UK) and the United States (US).

A literature search was conducted across the EBSCO, Pubmed and Google Scholar databases. Initially the search terms *'fatal child neglect definition'* were used but this yielded few references so the search terms were broadened to *'fatal neglect'*. There were 148 titles identified that were narrowed to 54 after the abstract was reviewed. After reviewing the papers, another 14 were excluded because they did not include a definition of neglect and were epidemiologic studies or were considering characteristics of families and children where fatal neglect had occurred. Ultimately, this literature review included 40 papers that provided a definition of neglect or fatal neglect and/or debated that definition in some way. (See Appendix A for a summary table of papers included and excluded in the review) Table 1 presents an overview of the results of the literature search.

Table 9: Results of literature search

Database	Number of papers title reviewed	Number of papers abstract reviewed
Google Scholar	74	35
PubMed	55	8
EBSCO Host	10	3
Snowball techniques	9	8
Total	**148**	**54**

A search for Child Death Review Team identified a total of 80 separate jurisdictions across Australia, New Zealand, Canada, United States (USA) and the United Kingdom (UK). In some jurisdictions multiple death review teams relating to child deaths were operating. There was significant variation in the terms of reference for these teams. Reviews ranged from comprehensive (all child deaths) to selective (deaths associated with maternal and premature birth deaths, only those known to child protection services, those where maltreatment was likely to be associated with the death and deaths where the coroner or medical examiner identified that the death warranted additional review). There was also variation in the criteria applied in relation to the age of the child at death. Some jurisdictions included all deaths from 20 weeks gestation, some from post-natal hospital discharge and this ranged through to children up to 14 years, 18 years or 25 years. In some jurisdictions there was 'more intense' review of children up to 2 years or if there was suggestion that the death was associated with maltreatment.

Table 10: Summary of identified child death reviews and reports

	Total CDRT jurisdictions identified	Report identified	Review all deaths	Review of select deaths
Australia	8	8	5	3
New Zealand	1	1	1	-
Canada	14	4	7	7
USA	50	48	42	8
UK	7	5	5	2
Total	**80**	**66**	**60**	**20**

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