Ombudsman
New South Wales

Report of Reviewable Deaths in 2010 and 2011

Volume 1: Child Deaths

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Ombudsman's Foreword

This report concerns the deaths of 77 children in 2010 and 2011. My office reviewed these deaths under my statutory responsibilities because they occurred as a result of abuse or neglect or in suspicious circumstances, or while the children were in care.

The report includes a specific 10-year review of teenagers who died following incidents of violence with their peers. This work illustrates that much more needs to be done to make sure we respond effectively to young people at risk; and in part, this means intervening early in the life of a child so that child protection concerns do not become entrenched problems in adolescence.

Two-thirds of the children who died in 2010 and 2011 and whose deaths were reviewable were from families with a child protection history.

Our past reports of reviewable child deaths have highlighted recurring problems in the child protection system, and this report again identifies a lack of capacity in government and non-government agencies to respond effectively to children at risk of harm, or risk of significant harm

Notably, the two-year period covered by our reviews coincided with the implementation of *Keep Them Safe*, the NSW Government's significant reform plan for child protection services. In this context, it is important to note two things in reading the report. Firstly, many of the factors that lead to a child protection report – including domestic violence, substance misuse and parental mental illness – are not of themselves predictors of risk of fatal assault or fatal neglect. Secondly, the issues and observations in this report reflect a period of change and early days in reforming this state's approach to child protection. The report describes a range of initiatives that have been, and are being, put in place to meet the challenges we have identified in a more comprehensive way than we have seen before.

It is our hope and expectation that completed reforms will result in demonstrable improvements in the capacity and performance of agencies with child protection responsibilities. It would be particularly concerning if, in two years time, we were unable to report that the reforms had been translated on the ground into significantly better outcomes for more vulnerable children and families.

Bruce Barbour
Ombudsman

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Executive summary

Reviewable deaths of children

The death of a child is reviewable by the Ombudsman if:

- the child died as a result of abuse or neglect, or their death occurred in suspicious circumstances;
- at the time of their death, the child was in care;
- at the time of their death, the child was in detention.

Over the two-year period from 1 January 2010 to 31 December 2011, 1170 children died in NSW. We identified 77 (6.6%) of these deaths as reviewable:

- 27 children died as a result of abuse (24) or in circumstances suspicious of abuse (3)
- 21 children died as a result of neglect (14) or in circumstances suspicious of neglect (7)
- 29 children died while in care.

Half (38) of the children who died were under five years of age, and over two-thirds were male children. Almost one-third (23) of the children were identified as being Aboriginal or Torres Strait Islander.

Two-thirds of the families of children who died had a child protection history. This means the child and/or their sibling had been the subject of a risk of harm report, or a risk of significant harm report, to Community Services or to a Child Wellbeing Unit within the three years prior to their death.

Abuse-related deaths of children

Most of the children who died in abuse-related circumstances were either very young, or were teenagers; 16 were aged 12 years or less, most of whom were under six years of age. Eleven were teenagers.

The age of the children was reflected in the circumstances of their deaths; all of the younger children died in abuse-related circumstances within the family, and all teenagers died in community–level incidents of violence.

Most of the teenagers (9) were killed in incidents of confrontational violence involving a peer or peers. These deaths are considered in the report a separate focused review of peer-related homicides over a ten-year period to 2011.

Abuse-related deaths within the family

In the case of children under 12 years of age, the offender or alleged offender was either the child's parent, or a person in a parental or caring role to them. These deaths occurred either in a context of intentional harm to a child, sexual abuse of a child; or parental psychotic illness.

The families of half of the children who died in abuse-related circumstances had a child protection history. Families of children who died in the context of parental psychotic illness were more likely to have had prior involvement with mental health and drug and alcohol services.

Information was available for 19 offenders relating to the deaths of 14 children that occurred within the family. 'Offender' in this report includes both known and alleged offenders:

- Twelve of the 19 were known to police, and all had come to the attention of police at some stage for domestic violence.
- Twelve had been previously identified in reports to Community Services as being a person causing harm or posing a risk to children.
- Mental health issues were noted in the history of ten offenders, including diagnosed mental illness or illnesses in four cases.
- Nine offenders had reported problems related to alcohol and other drug use, with six identified as having a chronic problem.

Themes and issues: abuse-related deaths of children within the family

For children who died in abuse-related circumstances within the family, our reviews identified:

- Issues related to Community Services' capacity to respond to children who were determined to be at risk of significant harm. This included reports of risk of significant harm being closed without full assessment because of competing priorities, and risk assessment that was not fully informed, and/or not inclusive of interviewing the child.
- Concerns about the adequacy of agency identification of risks to children, particularly in the context of parental mental illness, and hospital presentations for physical injury of young children.
- Where families were involved with different agencies, there was not always effective information exchange and/or effective coordination.

Peer-related homicides 2002 - 2011

Nineteen young people aged between 14 and 17 years died between 2002 and 2011 in incidents involving a peer(s).

The victims

Most (16) of the young people who died were male and three were female. Four victims were Aboriginal, and nearly one-third (6) of the victims were identified as coming from other culturally and/or linguistically diverse backgrounds.

Just over half of the victims were friends or social acquaintances of the offender. The most common scenario in which young men died involved an altercation with another young male(s), which then escalated to physical violence. These incidents included confrontations

arising at social gatherings, and in a small number of cases, the incidents appeared to be linked with 'gang' rivalry. Other scenarios included unprovoked attacks and fatal injuries sustained while handling guns.

More than one-third (7) of the victims were known to multiple agencies as vulnerable or 'at risk' adolescents. Typically, these agencies included police, Community Services, health, Juvenile Justice and education authorities, as well as other support services.

The offenders

Thirty-one persons were identified as offenders in relation to the 19 deaths. Offenders ranged in age from early teens to young adults in their twenties. Just over half were aged 14 to 17 years at the time of the incident. All but one offender was male. Six offenders were Aboriginal, and seven were from culturally and/or linguistically diverse backgrounds.

Overall, offenders had a high level of prior involvement with police. This contact ranged from relatively minor incidents – for example, fare evasion – to significant contact comprising multiple arrests and charges for offences including violence.

Seventeen of the 31 offenders had a documented history of alcohol and/or other drug use. In ten of these cases, records indicated significant and chronic substance abuse.

Half (15) of the 31 offenders had, at some point in their lives, been identified as children or young people at risk. Ten had been the subject of a report of risk of harm or risk of significant harm to Community Services during the three years prior to the offence, and five had earlier histories.

Observations arising from our review of peer homicides

Notable issues identified through our review of peer-related homicides were:

- Victims and offenders often had similar profiles. A significant number of young people, whether victims or offenders, were involved in risky or dangerous behaviour, including drug and alcohol misuse, offending and other anti-social behaviour.
- Alcohol and/or drug use was common amongst victims and offenders – both in terms of a documented history of misuse, and as a possible factor relevant to the circumstances of the fatal incident.
- Many of the victims and offenders had previously come to the attention of police for risk-taking, and violent or anti-social behaviour, highlighting the critical role of police in providing a coordinated interagency response to this cohort.
- Offenders frequently left school early, and before completing high school. The importance of this issue is emphasised by recent legislative change to expand the statutory grounds for reporting risk of significant harm to include educational neglect and cumulative harm, as well as a government initiative to raise the school-leaving age in the NSW.
- For most young people, reports of risk of harm did not elicit a comprehensive response. This was generally because of competing priorities, but also because of the challenges of effectively engaging young people.

Neglect-related deaths of children

Between 1 January 2010 and 31 December 2011, 21 children in NSW died as a result of neglect (14), or in circumstances suspicious of neglect (7). The large majority of the children were very young; most (17) were under four years of age, and over a third were infants less than one year old.

The majority of the children (16) were male; five were female. Over one-third of the children (8) were identified as Aboriginal.

The families and carers

In 2010 and 2011, the majority (15) of the families of children who died in neglect-related circumstances had a child protection history. The issues of concern raised in reports included child neglect, such as sub-standard home environments, inadequate supervision, and families failing to engage with needed services. Reports for families commonly raised concerns about parental drug abuse and domestic violence.

Seven families had some involvement with police, relating to offending behaviour. Five of these families had an extensive history, primarily for drug and/or alcohol related offences and domestic and other violence.

Families were mostly involved with health services related to antenatal and early childhood services, and drug and alcohol treatment. These services in the main did not consistently identify child protection concerns.

Cause and circumstances of neglect-related deaths

The majority of the children (14) died in the context of a significantly careless act on the part of a carer. Nine of the 14 children died suddenly and unexpectedly in sleep environments that were unsafe, including five infants who died while co-sleeping with adults. Two children died in motor vehicle crashes. One child drowned and two other deaths were caused by heat exposure and smoke inhalation. In half of the 14 cases, the deaths were considered neglect-related in part due to the carer(s) being, or suspected of being, affected by drugs and/or alcohol at the time the child died.

Six children died in circumstances where there was an intentional or reckless failure on the part of a carer to adequately supervise the child. All six children drowned. A common scenario – both in this reporting period and over the nine years of reviewing neglect related deaths – is the

drowning death of a very young child unsupervised for a relatively long period of time, *and* where carers were aware of defects in barrier fencing and the capacity of the child to access water.

One child died as a result of a failure on the part of carers to provide adequate medical care and assistance.

Themes and issues: neglect-related deaths of children

Notable issues for the families of children who died in neglect-related circumstances were:

- Where child protection reports relating to neglect reached the threshold of significant harm, they were often unable to be assessed due to more urgent demand for statutory intervention at the local level.
- While early intervention services were a potential support for families, we identified some problems with families being deemed ineligible for assistance, and in some cases, with services being withdrawn from families because of lack of engagement on the part of parents.
- The most commonly identified issue of concern in families where a child died in circumstances of fatal neglect was parental alcohol or drug misuse.

Children who died while in care

Between January 2010 and December 2011, 29 children who died in NSW had been living in care. Twenty-one of the children were in out-of-home care because of child protection issues, and eight of the children were placed in disability accommodation services.

Most of the children in care who died were either very young or were adolescents. The majority (16) were children under 10 years of age, and 11 were aged 15-17 years. Two thirds of the children were male. Eight children were Aboriginal and one child was Aboriginal and Torres Strait Islander; this reflects the number of Aboriginal and Torres Strait Islander children in the NSW out-of-home care population (34%).

The majority (23) of the 29 children had a child protection history, including five children who were in voluntary care. For some children, the child protection history preceded and was the reason for their entry into care; however 12 of the children were the subject of one or more child protection report while they were in care.

Most (19) of the children in care who died in 2010 and 2011 were residing in placements provided or funded by Community Services. Eight children were placed in a disability accommodation service. One infant died in hospital without ever being discharged following birth, and one young person was homeless.

Causes of death for children in care

Half (15) of the children in care died as a result of natural causes, often related to significant disabilities or congenital or degenerative disorders. Eight children died as a result of unintentional injury, including drowning and poisoning, and one young person committed suicide. Four children died from ill-defined causes, including Sudden Infant Death Syndrome. In two cases, information was not available about cause of death.

Themes and issues: deaths of children in care

Notable issues arising from our reviews of the deaths of children in care were:

- The significant challenges for agencies in engaging and responding effectively to children with complex needs, and the need for:
  - early assessment and intervention both before and following entry into care; and
  - effective coordination and collaboration between agencies working with these children.
- In the context of the number of children who died as a result of preventable injury, the need for agencies to have robust policy and practice and education initiatives for staff and carers that enhance child safety in foster and relative/kinship care placements. Particular areas of focus should be swimming pool safety, safe storage of medicines and safe sleeping practices for infants.

Themes and issues: reviewable child deaths in 2010 and 2011

Noting the context of reform and rapid and continuing change in the child protection system, our reviews of child deaths in 2010 and 2011 identified a range of themes and issues as described below.

Responding to risk of significant harm

Community Services did not have capacity to respond to a number of families that had been the subject of frequent reports to the agency. In these cases, we found that risk at times was not assessed, or not assessed adequately because of competing priorities and gaps in casework. In particular:

- Reviews identified shortcomings in assessing cumulative harm and gathering adequate information to make an informed assessment of risk, including the failure to interview children.
- At times, there was poor information exchange and lack of coordination between agencies, which presented barriers to effective intervention with families.
- In relation to young people, we found little evidence of agency liaison and integrated support.

2010 and 2011 were the first two years of *Keep Them Safe*. Reforms are also ongoing, and a number of initiatives are currently being rolled out to improve the agency's capacity to respond more effectively to risk of significant harm.

Identifying and responding to children at risk: health and education

Reviewable deaths of children in 2010 and 2011 raised specific issues about support for children of parents with mental illness, dealing with physical injury, recognising risk in an education context, responding to young people with complex needs, and effectively managing early intervention.

Parents with mental illness

Mental illness has been identified through court processes as a directly contributing factor in the fatal assault deaths of four children in 2010 and 2011, and was a likely contributing factor in the death of a fifth child.

Psychotic or mental illness has been identified through criminal investigations and proceedings as a primary or contributing factor in one-fifth (18) of reviewable child deaths since 2003. In the large majority of cases, the offender was the child's parent or carer.

Many people with psychotic illness are parents. Most function very well, but some may be impaired in their ability to care for dependent children.

NSW Health policies relevant to parents with mental illness underscore the importance of a focus on children, and the identification of risks and need for family support. However, it was apparent that mental health services were not always cognisant of the support needs of patients as parents, or of the possible impact of the parent's mental health concerns on children.

Our recommendation

We have recommended that the Ministry of Health consider the issues raised in this report relating to parental mental illness, and advise us about current or proposed strategies to promote understanding of, and an effective response to, the needs of children of a parent with a mental illness.

Responding to physical injury

In 2010 and 2011, three children who were fatally assaulted had been presented to NSW hospitals or private medical services for treatment of physical injury in the months or days prior to their death. The three children were aged six years or younger.

Since 2003, we have identified that ten other children who subsequently died in abuse-related circumstances were presented to a NSW public hospital with injuries within the months prior to their death. All of the children were aged six years or less; nine were under three years of ages, including three infants.

Health services deal with many presentations of children with a range of injuries. Even where there is some suspicion of physical abuse, formulation of forensic opinion can be difficult. However, the importance of accurate assessment or identification of abusive injury when children are presented for treatment is a serious issue.

In a prevention context, and noting the increased responsibility health services have under *Keep Them Safe*, valuable insight and learning could be gained from close review of cases where children who present with injury subsequently die in suspicious circumstances.

Our recommendation

We recommend that the Ministry of Health undertake an internal review if a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility.

Identifying risk in an education context

In 2010 and 2011, three children who died in circumstances of abuse or neglect had a recorded history of chronic school absenteeism.

Over the past four years, this office's work in a number of areas has raised issues relating to agency responses to chronic school absenteeism. Children who experience significant interruptions to their schooling are deprived of a fundamental right relating to their development, and lose the social support network and structure that the school community can provide. There is a need for a strong interagency approach in a child protection context, and holistic assessment of children who have significant school attendance issues.

A number of strategies are under way in NSW that aim to address responses to educational neglect, including the piloting of an early intervention program for students below the risk of significant harm threshold who may be at risk of educational neglect.

Managing risk through early intervention

There is a 'service gap' between early intervention services and child protection.

Four families of children who died in 2010 and 2011 were considered to be candidates for early intervention services following a child protection report, and were referred to them, but the families either declined a service, or were deemed ineligible for one. In all cases, this meant that there was no further assessment or other action in relation to child protection concerns at that time.

Four families did engage with early intervention, but services were withdrawn from two of the families because they achieved limited progress in addressing entrenched issues, or failed to participate effectively in the program.

Community Services has introduced the *Strengthening Families program*, which provides for Community Services' early intervention teams to work with families with more complex needs in an early intervention context. The NSW government has also proposed introduction of stand-alone orders requiring a parent or primary caregiver to attend a parenting capacity program or other treatment or program.

Appropriate support and intervention for young people

Our review of peer-related homicides between 2003 and 2011, and the deaths young people in care who had complex needs, highlighted two recurring themes:

- The need for targeted, timely and coordinated intervention and support for young people at risk, including young people engaging in risk-taking and anti-social behaviour.
- The importance of early intervention, both early in life and 'early in the pathway'. Reviews provided a clear illustration of young people – both victims and offenders – who had child protection histories early in their lives, and/or whose behaviour indicated their psycho-social needs were not being met as adolescents.

These themes are not new. This office's work has highlighted concerns about the adequacy of service provision to vulnerable older children and young people, including young people in care, over a number of years.

There is a broad acknowledgement across agencies of the pressing need to improve responses to adolescents at high risk.

Monitoring recommendations

In the context of rapid and far-reaching change for agencies in relation to the protection of children at the time our previous reviewable child deaths report was published in August 2011, we made no recommendations. Instead we provided our report to agencies with child protection responsibilities and sought specific feedback from relevant agencies on key issues raised, including:

- Capacity and service improvement through *Keep Them Safe* (including capacity to undertake comprehensive assessment of risk to children, enhancement of the role of early intervention services, and support for young mothers and high needs adolescents living in care);
- Developments in swimming pool safety measures, particularly consideration of Coronial and Child Death Review Team recommendations.

We received detailed information from the Department of Family and Community Services (Community Services and Housing NSW) and the Ministry of Health.

In relation to capacity and service improvement issues, Community Services provided an overview of current reforms in child protection, and capacity to undertake comprehensive assessments for children through initiatives including Structured Decision Making, Practice First, and Practice Framework. The Ministry of Health provided information about how the capacity of NSW Health and its workers has been enhanced through *Keep Them Safe* initiatives such as NSW Health Child Wellbeing Units, the Mandatory Reporter Guide, capacity to share information through Chapter 16A of the *Care Act*, the NSW Interagency Guidelines, the appointment of NSW Health Child Wellbeing Coordinators, Family Referral Services, Safe Start and Whole Family Team programs.

In addition, Community Services provided advice regarding the implementation of its Pre-Natal reports policy and related procedures, and other programs and initiatives within the Early Intervention and Placement Prevention spectrum. The Ministry of Health also provided detailed information regarding expanded early intervention services through its *Getting On Track in Time (Got It!)* program, and Sustaining NSW Families health home visiting program.

Housing NSW provided comprehensive information about a number of initiatives that focus on providing housing assistance and support to people who are homeless or at risk, as well as details regarding the recently released *Going Home Staying Home* Reform Plan.

All three key agencies - Housing NSW, Community Services, and the Ministry of Health – provided information regarding the provision of support for young mothers, particularly those who are homeless or in marginal housing, as well as support for high needs adolescents living in care. Agencies referred to screening, assessment, review and intervention processes, psychological services, and other state-wide and local-based program initiatives such as those funded under the National Partnership Agreement on Homelessness.

In relation to swimming pool safety, we note the significant developments in promoting the safety of young children around private swimming pools, including legislative change, highlighting information drawn from the NSW Child Death Review Team's work and recommendations in this area.

Recommendations

Recommendation 1: 50

The Ministry of Health

The Ministry of Health should consider the issues raised [section 7.5], and provide advice regarding current or proposed strategies to:

- Equip frontline staff in both mental health services and other health facilities, including emergency departments, with an understanding of potential risks to, and needs of, children of a parent with a mental illness.
- Ensure that a history of a patient's children and child caring responsibilities is identified and considered in psychiatric assessment or review.
- Promote and monitor adherence within Local Health Districts to the Children of Parents with Mental Illness (COPMI) and Safe Start guidelines and principles, particularly in relation to linking parents and families to appropriate supports and services.
- Apply and share lessons learnt from root cause analysis to inform practice and responses to parents with mental illness across NSW health facilities.

Recommendation 2: 51

The Ministry of Health

Noting that processes will need to be put in place to advise the Ministry of Health and Local Health Districts of the suspicious death or injury of a child:

- If a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility, the child's death should be the subject of internal review. The purpose of review would be to assess whether the interaction of the child and their family with the facility raises any systems issues that should inform future practice and service improvement at a local level and across the NSW health system.
- In addition, the Ministry of Health should consider whether this process of review could be applied to circumstances in which a child is seriously injured in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility.

1. Introduction

1.1 Reviewable child deaths

Since December 2002, the Ombudsman has had responsibility for reviewing the deaths of people with disabilities in care, and of certain children.[1] A child's death is reviewable by the Ombudsman if:

- the child died as a result of abuse or neglect, or their death occurred in suspicious circumstances
- at the time of their death, the child was in care[2]
- at the time of their death, the child was in detention.

The Ombudsman is required to report to the NSW Parliament biennially about reviewable deaths. This report covers the period 1 January 2010 to 31 December 2011. In this period, the deaths of 77 children were reviewable:

- 27 children died as a result of abuse (24) or in circumstances suspicious of abuse (3)
- 21 children died as a result of neglect (14) or in circumstances suspicious of neglect (7)
- 29 children died while in care.

1.2 The purpose of reviews

Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the functions of the Ombudsman are 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 deaths of children in care, children at risk of death due to abuse or neglect, children in detention centres, correctional centres or lock-ups or persons in residential care (s.36 (1) (b)); and*
- *To undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable (s.36 (1) (d)).*

Consideration of how to prevent or reduce deaths of children includes an understanding of any risk factors that were evident in the lives of the children and their families, and if so, whether risks or vulnerabilities were identified and responded to.

Our reviews consider child and family involvement with government and non-government agencies, particularly those that have responsibilities relating to the health, welfare and wellbeing of children. We consider any systems or practice issues that may have directly or indirectly contributed to the death of a child, or that may expose other children to risks in the future; or whether there were missed opportunities to intervene to support families. This work involves examination of relevant records and information relating to the children who died, and we may also request specific information from agencies to assist in our review.

In some cases, our reviews may highlight issues that warrant further inquiries about the conduct of an agency. Under the *Ombudsman Act*, we can make preliminary inquiries for the purpose of deciding whether to investigate the conduct of an agency, or we can move directly to investigate an agency's conduct in relation to the person that died. The *Community Services (Complaints, Reviews and Monitoring) Act 1993* also enables us to make reports to agencies about matters related to reviewable deaths, or issues that arise generally from our work, and to seek information about these issues.

For child deaths in 2010 and 2011, we commenced eight investigations and made preliminary inquiries under the *Ombudsman Act* in relation to the deaths of seven children. The subject agencies were Community Services, NSW Health, the NSW Police Force and Education.[3] We also made 23 reports to, and sought further information from, agencies in relation to the deaths of 15 children. Subject agencies included Community Services, Local Health Districts, the NSW Police Force, non-government service providers and local councils.

1.3 Other reviews or investigations of child deaths

The NSW Coroner

Reviewable deaths are also Coronial deaths under the *Coroners Act 2009*. The role of the State Coroner is to ensure that all deaths are properly investigated. The Coroner may hold an inquest and can recommend measures to prevent deaths.

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

NSW Child Death Review Team

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

1. In 2009, the scope of the Ombudsman's responsibilities changed in relation to children. Prior to 2009, the Ombudsman was required to review the death of any child, or sibling of a child, who had been the subject of a report of risk of harm to Community Services. This requirement was repealed in 2009.
2. 'In care' in this context refers to a child under the age of 18 years who is in care as defined in section 4 (1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.
3. One investigation was discontinued. Three deaths subject to further action were subsequently determined to be not reviewable.

The CDRT reviews the deaths of all children in NSW. The purpose of this work is to prevent and reduce the deaths of children. The Team comprises representatives from key government agencies including Community Services, the Ministry of Health and the NSW Police Force; two Aboriginal representatives; and independent members who are experts in health care, research, child development and child protection.

Community Services

The Child Deaths and Critical Reports Unit within Community Services reviews the deaths of children 'known to' the agency; those children where a report was received about the child and/or his or her siblings in the three years preceding the child's death.[4]

A significant number of cases that are reviewed by Community Services are also reviewable deaths. We provide advice to Community Services about child deaths that meet its review criteria. Community Services also provides this office with a copy of its completed child death reviews.

NSW Health

Under certain circumstances, Local Health Districts are required to conduct a root cause analysis in relation to a critical incident. This includes where a suspected homicide has been committed by a person who has received care or treatment from a Local Health District within six months of the death. In some cases, this may relate to the death of a child.

Where they have been completed, we include information from root cause analyses in our reviews.

1.4 Child protection in NSW: *Keep Them Safe*

Child protection responses are an important consideration in reviewable deaths. In late January 2010, significant reforms to child protection services in NSW came into effect with the implementation of *Keep Them Safe: A shared approach to child wellbeing*.[5]

The main goal of *Keep Them Safe* is to make child protection a shared responsibility across government agencies and between government and non-government agencies, and to limit the statutory role of Community Services to children at greatest risk. All agencies now have prescribed responsibilities for child protection. Changes and initiatives that have and are taking place under *Keep Them Safe* are extensive and incorporate universal and targeted services.

Broadly, changes related to the delivery of services to families where children are identified as being at risk have encompassed:

- Raising the statutory reporting threshold to 'risk of significant harm'. The policy definition of risk of significant harm is:

  > *What is meant by "significant" in the phrase "to a significant extent" is that which is sufficiently serious to warrant a response by a statutory authority, irrespective of a family's consent. What is significant is not minor or trivial, and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child's or young person's safety, welfare, or wellbeing. In the case of an unborn child, what is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child.*[6]

- Introduction of new intake and referral pathways, including:
  - The establishment of Child Wellbeing Units in key public sector agencies (Family and Community Services, police, education, health). The Units assist agency staff to identify child protection concerns that constitute risk of significant harm, and to respond to children and families where risk is below that threshold.
  - The establishment of Family Referral Services in the community. These services are targeted to families where child protection reports do not meet the threshold of risk of significant harm, but the family may need support. Family Referral Services assess need and facilitate referrals to appropriate support services in their local area. Family Referral Services were piloted and evaluated in 2010 and 2011, and as at January 2013, were operating in eight locations, with planned further roll-out of 12 services.
- Legislative amendment to permit the exchange of information relating to the safety, welfare and wellbeing of children between certain government and non-government human service and justice agencies.
- Transferring out-of-home care services to non-government providers. The transition of statutory out-of-home care services from Community Services to the non-government sector is now underway and staged to take place over the next five to 10 years.[7] At December

4. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p.18.
5. NSW Department of Premier and Cabinet 2009, *Keep them safe*: *a shared approach to child wellbeing 2009 - 2014*, NSWDPC, Sydney.
6. NSW Government 2012, *Keep them safe: Significant harm policy definition,* NSW Government, viewed 21 December 2012, <http://www.keepthemsafe.nsw.gov.au/v1/reporting_children_at_risk/significant_harm_policy_definition>.
7. Ministerial Advisory Group on Out of Home Care 2011, *Transition plan: stage 1 – the 'who' and the 'when'*, NSW Department of Family and Community Services, Sydney.

2012, over 580 children have been transferred from Community Services to accredited non-government out-of-home-care providers.[8]

- Enhancing the provision of early intervention and community based services:
  - The *Brighter Futures* program is now delivered by non-government agencies across NSW.
  - The *Early Intervention & Placement Prevention* program, also delivered by non-government agencies, provides support to families to address problems before they escalate, and aims to reduce the likelihood of children and young people entering or remaining in the child protection and out-of-home care systems.
- Early intervention has been expanded to families with more complex needs through the *Strengthening Families* program within Community Services. Through the program, Community Services can provide early intervention services to families with an unborn child or a child under nine years who is at risk of significant harm, where parents have one of a number of issues, and where the risk for any of the children and young people in the family is high or very high, but they are assessed as being safe enough to remain at home.[9]
- Establishing Aboriginal and Child Family Centres in nine areas across NSW. The centres bring together a range of early childhood, health and family support services for Aboriginal families.

While the large majority of the deaths of children considered in this report occurred after the introduction of *Keep Them Safe*, the involvement of some of those families who had prior contact with child protection services spanned a period both prior to and following the introduction of the new child protection system.

Supporting structural changes

Structural changes to child protection have been supported by a range of related policy changes. Community Services have, for example, introduced Structured Decision Making tools to guide various stages of child protection assessments, and is trialling a new service delivery model, 'Practice First', that prioritises direct work with families. The agency has also started introducing new systems associated with workload management and performance measurement and monitoring.

Cross agency working groups are also considering specific issues, including those relevant to the issues raised in this report. For example, a state-wide adolescents with complex needs panel, chaired by Ageing, Disability and Home Care (ADHC), is focusing on appropriate and coordinated responses to adolescents with complex needs, where the current service system has been unable to meet their needs. The panel includes Community Services, Housing NSW, Juvenile Justice NSW, the Department of Aboriginal Affairs, the Department of Education and Communities and the NSW Ministry of Health[10] In addition, the *Keep Them Safe* Senior Officer's Group is working to develop systems for improved agency responses to educational neglect.[11]

Initiatives aimed at improving health outcomes for children in out-of home care are well advanced. Community Services and NSW Health Local Health Districts have jointly implemented the *Health Screening and Assessment Pathway* for children and young people who enter statutory out-of-home care and who are expected to remain in care for 90 days or more. An accommodation framework for additional models of accommodation and support for children with a disability, including for out-of-home care, has been endorsed by the Ageing, Disability and Home Care and Community Services Senior Officer Group. [12]

1.5 About this report

Information sources

Under the legislation governing reviewable deaths, it is the duty of a range of agencies to provide the Ombudsman with 'full and unrestricted access' to records that the Ombudsman reasonably requires to complete this work.[13] These agencies include the State coroner and any NSW government department or statutory authority. The Ombudsman can also require certain information from agencies under the *Ombudsman Act*.

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

- Government agency records, from agencies including Community Services, Health, Police and Education, relating to children who died and associated persons.
- Agency reports or reviews relating to the death of a child, including internal reviews conducted by Community Services and root cause analyses undertaken by Local Health Districts.

8. Advice provided by Community Services, correspondence dated 15 February 2013.
9. Advice provided by Community Services, correspondence dated 15 February 2013.
10. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p.7; NSW Department of Family and Community Services 2012, *Child deaths 2011 annual report: learning to improve services,* NSWDFCS, Sydney, p. 64.
11. Advice received by the NSW Ombudsman from Department of Premier and Cabinet in response to *Keep Them Safe?,* November 2012.
12. Advice provided by Community Services, correspondence dated 15 February 2013.
13. Section 38, *Community Services (Complaints, Reviews and Monitoring) Act*, 1993, NSW.

- Coronial and police information relating to the death of a child.
- Judgement and sentencing information from NSW Courts.
- For cases that have been subject to inquiry or investigation by this office, statements of information from both government and non-government agencies.

This report includes some trend data from 2003. In 2011, the Ombudsman became Convenor of the NSW Child Death Review Team (CDRT), and the functions of that Team transferred to this office. Over the past year, we have reviewed the capacity of the NSW Child Death Register, and remediated data held in the register, with a view to establishing a single register for all child deaths and reviewable child deaths in NSW. This report has drawn on the CDRT register for data relating to all child deaths in NSW.

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

Key definitions

Reviewable death

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

Abuse

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

Neglect

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

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

Suspicious circumstances

Deaths are considered suspicious if:

- There is some evidence or information that indicates the death may have been the result of abuse or neglect.
- Police identify the death as suspicious at the time of the death or any time 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.[14]
- The autopsy cause of death is undetermined and there is an indication of abuse or neglect.
- 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.

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*. This definition includes children in voluntary out-of-home care and disability accommodation services.

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 Community Services within the three years prior to their death; and/or
- The child and/or their sibling was reported to a Child Wellbeing Unit within the three years prior to their death.

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

Homicide/domestic homicide

Homicides include cases involving a murder or manslaughter (except in relation to transport-related deaths), and all murder-suicides and other deaths classed by police as homicides.

Domestic homicide is an incident involving the death of a family member or other person from a domestic relationship.[15]

Offender

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

Peer

For the purposes of this report, a 'peer' is a young person who is of the same or similar age and/or social grouping.

14. If subsequent police investigations result in the death no longer being treated as suspicious, we also reassess inclusion of these deaths as reviewable.
15. These definitions are drawn from the Australian Institute of Criminology National Homicide Monitoring Program. See Australian Institute of Criminology 2010, *Homicide in Australia: 2007 – 08 National Homicide Monitoring Program annual report*, cat. no. Monitoring Report 13, AIC, Canberra.

Report chapters

- Chapter 2 of this report provides demographic and other information about the children who died in 2010 and 2011, as well as data from 2003; the first full year of the Ombudsman's responsibility for reviewable deaths.
- Chapter 3 considers the deaths of 27 children that resulted from, or were suspicious of, abuse.
- Chapter 4 details a review of 19 teenage 'peer' homicides that occurred between December 2002 and 2011.
- Chapter 5 examines the deaths of 21 children that occurred in circumstances of neglect.
- Chapter 6 examines the deaths of 29 children who died while in care.
- Chapter 7 provides a discussion of themes and issues that have arisen from our reviews.
- Chapter 8 discusses information received from agencies about issues identified in our previous report relating to child deaths in 2008 and 2009.

2. Children who died in 2010 and 2011

This report covers the two year period from 1 January 2010 to 31 December 2011, and relates to children who died as a result of abuse or neglect, or in suspicious circumstances, and children who died while in care.

Over this two-year period, 1170 children died in NSW.[16] We identified 77 (6.6%) of these deaths as reviewable.[17] As detailed in table 1, this is generally consistent with previous years; over the nine-year period since 2003, 6 percent of child deaths in NSW have been reviewable.

The notable increase in the deaths of children in care from 2009 in part reflects the increased number of children living in care over that period. Over the time this office has had responsibility for reviewable child deaths, the number of children in out-of-home care has increased by 78 percent from 10,059 children at 30 June 2003 to 17,896 children at 30 June 2011.[18]

Table 1: **Children whose deaths were reviewable in NSW, 2003-2011*, number and (percent of all child deaths)**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Child deaths in NSW	**653**	**616**	**659**	**622**	**605**	**606**	**574**	**593**	**577**	**5,505**
Reviewable child deaths	47 (7.2%)	27 (4.4%)	36 (5.5%)	35 (5.6%)	38 (6.3%)	31 (5.1%)	46 (8%)	45 (7.6%)	32 (5.5%)	**337 (6.1%)**
Abuse-related ** circumstances	20 (3.1%)	9 (1.5%)	15 (2.3%)	13 (2.1%)	8 (1.3%)	14 (2.3%)	12 (2.1%)	14 (2.4%)	13 (2.3%)	**118 (2.1%)**
Neglect-related ** Circumstances	21 (3.2%)	11 (1.8%)	18 (2.7%)	18 (2.9%)	24 (4%)	13 (2.1%)	18 (3.1%)	12 (2%)	9 (1.6%)	**144 (2.6%)**
In care	8 (1.2%)	8 (1.3%)	4 (0.6%)	4 (0.6%)	6 (1%)	4 (0.7%)	16 (2.8%)	19 (3.2%)	10 (1.7%)	**79 (1.4%)**

* The deaths of four children were reviewable under more than one criteria.
** This includes deaths suspicious of abuse (12) and suspicious of neglect (48).
Percentages in this table have been rounded.

2.1 Age and gender of the children

Table 2 shows the age range of children whose deaths were reviewable in 2010 and 2011, against the deaths of all children in NSW. While the large majority of children who died in NSW were infants, the largest single age grouping for reviewable child deaths was teenagers aged 15 – 17 years, followed by children aged 1 – 4 years.

Table 2: **Number and proportion of children whose deaths were reviewable (2010 and 2011) by age**

	<1	1-4	5-9	10-14	15-17	Total
Reviewable	16	22	10	6	23	**77**
Not reviewable	711	113	62	79	128	**1,093**
Percent reviewable	2.2%	16.2%	13.9%	7.1%	15.2%	**6.6%**

Table 3 shows that half (49%) of the children whose deaths were reviewable were under five years of age. Neglect-related deaths were concentrated amongst very young children, reflecting the particular vulnerability of the under-four year age group. However, young people aged 15 to 17 years were the largest single age group in relation to abuse-related deaths. As illustrated in table 4, this is not consistent with previous years, and reflects an unusual increase in teenage homicides in 2010.

Table 3: **Children whose deaths were reviewable (2010 and 2011) by age and reviewable status**

	<1	1-4	5-9	10-14	15-17	Total
Abuse / suspicious of abuse	3	7	4	2	11	**27**
Neglect / suspicious of neglect	8	9	1	2	1	**21**
In care	5	6	5	2	11	**29**
Total	**16**	**22**	**10**	**6**	**23**	**77**

16. Data from the NSW Child Death Review Team 2012 *NSW Child Death Register*, NSW Ombudsman, Sydney.
17. As noted, the criteria for a reviewable death changed in 2009. All data relating to 'reviewable deaths' in this report reflects the changed criteria.
18. NSW Department of Community Services 2005, *Trends in the numbers of children and young people in out-of-home care in NSW*, NSWDCS, Sydney, p.13; NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, p.46.

Table 4: **Children whose deaths were reviewable (2003-2011) by age and reviewable status***

	<1	1-4	5-9	10-14	15-17	Total
Abuse / suspicious of abuse	27	39	16	13	23	**118**
Neglect / suspicious of neglect	43	71	18	7	5	**144**
In care	16	17	11	13	22	**79**
Total	**86**	**127**	**45**	**33**	**50**	**341***

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

In 2010 and 2011, over two-thirds of the children whose deaths were reviewable were male. As noted above, there was an unusual peak in teenage homicides in 2010, all of whom were male. This accounted for a larger number of reviewable deaths of males in the 15-17 year age group, as shown in table 5. Notably, the other nine deaths in this age and gender group were young people living in care, and their deaths were reviewable for this reason.

Table 5: **Children whose deaths were reviewable (2010 and 2011) by gender and age**

	<1	1-4	5-9	10-14	15-17	Total
Female	7	7	6	1	3	**24**
Male	9	15	4	5	20	**53**
Total	**16**	**22**	**10**	**6**	**23**	**77**

The over-representation of males in reviewable deaths has been consistent over the past nine years, as illustrated in table 6. Male children aged one to four years are particularly over-represented, with this group accounting for one quarter of all reviewable deaths since 2003. The majority of these children died in circumstances of abuse or neglect.

Table 6: **Children whose deaths were reviewable (2003-2011) by gender and age**

	<1	1-4	5-9	10-14	15-17	Total
Female	37	44	22	13	14	**130**
Male	47	82	23	19	36	**207**
Total	**84**	**126**	**45**	**32**	**50**	**337**

2.2 Aboriginal and Torres Strait Islander status

In 2010 and 2011, almost one-third (23) of the 77 children whose deaths were reviewable were identified as being Aboriginal or Torres Strait Islander children.

Aboriginal and Torres Strait Islander children are consistently over-represented in reviewable deaths. While approximately five percent of the NSW population under 18 identify as indigenous,[19] on average, a quarter of reviewable deaths each year are Indigenous children.

As table 7 also illustrates, the proportion of Aboriginal and Torres Strait Islander children in reviewable deaths has increased. This in part may reflect the increasing number of children living in care; the deaths of eight of the 23 children who were Aboriginal or Torres Strait Islander were reviewable because they died while in care.

Table 7: **Aboriginal and Torres Strait Islander status of children whose deaths were reviewable (2003-2011)**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Not Aboriginal or Torres Strait Islander	41	25	29	30	28	23	35	33	21	**265**
Aboriginal or Torres Strait Islander	6	2	7	5	10	8	11	12	11	**72**
Total	**47**	**27**	**36**	**35**	**38**	**31**	**46**	**45**	**32**	**337**

19. Australian Bureau of Statistics 2012, *New South Wales, Aboriginal and Torres Strait Islander Peoples (Indigenous) profile, Census 2011,* cat. no. 2002.0, ABS, Canberra.

Over one-half of the Aboriginal and Torres Strait Islander children who died in 2010 and 2011 were aged under five years, as shown in table 8. Table 9 illustrates that this age concentration is strongly reflected in deaths since 2003; almost three-quarters of the Indigenous children whose deaths were reviewable were aged under five years.

Table 8: **Children whose deaths were reviewable (2010 and 2011) by Aboriginal and Torres Strait Islander status and age**

	<1	1-4	5-9	10-14	15-17	Total
Non-ATSI	12	13	6	5	18	**54**
ATSI	4	9	4	1	5	**23**
Total	**16**	**22**	**10**	**6**	**23**	**77**

Table 9: **Children whose deaths were reviewable (2003-2011) by Aboriginal and Torres Strait Islander status and age**

	<1	1-4	5-9	10-14	15-17	Total
Non ATSI	63	95	36	28	43	**265**
ATSI	21	31	9	4	7	**72**
Total	**84**	**126**	**45**	**32**	**50**	**337**

2.3 Child and family circumstances

Where the children lived

Most children whose deaths were reviewable lived with at least one biological parent. Children in care resided in a range of situations: the most common was with foster, relative or host families.

Table 10: **Where the child was living at the time they died (2010 and 2011)**

Child's living situation	Number of children
With biological parent(s)	46
With other family member(s)	2
In care	
– Foster/relative/host family care	20
– Residential care	5
– Biological parents	2
– Hospital	1
– Homeless	1
Total	**77**

2.4 Child protection history

A child has a 'child protection history' if the family – that is, the child and/or a sibling – had been the subject of a risk of harm report, or a risk of significant harm report, to Community Services or to a Child Wellbeing Unit within the three years prior to their death. This definition enables comparison of reviewable deaths from 2003, and reflects the State Coroner's jurisdiction concerning the deaths of children.[20, 21] The three-year timeframe is also aligned to the criteria for Community Services' internal reviews of the deaths of children or siblings of children known to that agency.[22]

Under this criteria, two-thirds of the families of children who died had a child protection history. This is consistent with previous years, and is illustrated in table 11.

In 2010 and 2011, the association with a child protection history was most apparent for children in care (23 of 29 children). While this would appear obvious, particularly given that the care of children may have been assumed within the three year period because of child protection reports, it is interesting to note that 14 of the 23 children were the subject of a report after being placed in care. Just under three-quarters of children who died in neglect-related circumstances and half of the children who died in circumstances of abuse had a child protection history.

20. Section 24, *Coroners Act,* 2009, NSW.
21. Until 2009, the Ombudsman's jurisdiction for reviewable deaths included where a child and/or a sibling had been the subject of a risk of harm report to Community Services within the three years prior to their death. Reviewable death data reflects this definition.
22. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p.5.

Table 11: **Child protection history within three years of the child's death (2003-2011) by year and reviewable type**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Reviewable child deaths	**47**	**27**	**36**	**35**	**38**	**31**	**46**	**45**	**32**	**337**
No child protection history (within three years)	13	9	9	14	10	12	16	17	9	**113 (34%)**
Child protection history										
– All	34	18	27	21	28	19	30	28	23	**224* (66%)**
– Abuse, neglect or suspicious	29	11	23	17	22	15	17	13	15	**162 (48%)**
– In care	5	7	4	4	6	4	13	15	8	**66 (20%)**

*The deaths of four children were reviewable under more than one criteria; numbers will therefore not total exactly.

2.5 Deaths resulting from, or suspicious of, abuse

Table 12 shows that the largest single age group represented in abuse-related deaths in 2010 and 2011 was 15 – 17 year olds, most of whom died in incidents involving their peers. This is not reflective of usual trends in abuse-related deaths; table 13 shows that over the nine years from 2003, most abuse-related deaths occurred within the family, with the majority of victims being four years of age or less. The increase in peer-related homicides occurred in 2010, when seven young people died in separate incidents. In 2011, two young people died in these circumstances.

For 15 of the 27 children who died as a result of abuse, or in circumstances suspicious of abuse, the perpetrator, or alleged perpetrator, was a family member. In two cases, the child died as a result of a murder-suicide.

Table 12: **Children whose deaths (2010 and 2011) were the result of, or suspicious of, family or other homicide by age**

	<1	1-4	5-9	10-14	15-17	All
Familial homicide	2	7	4	2	-	**15**
Peer homicide	-	-	-	-	9	**9**
Unrelated/ unknown	1				2	**3**
All abuse-related deaths	**3**	**7**	**4**	**2**	**11**	**27**

Table 13: **Abuse-related deaths (2003-2011) by abuse category and age**

	<1	1-4	5-9	10-14	15-17	Total
Familial homicide	**25**	**37**	**15**	**10**	**2**	**89**
(murder-suicide)	-	(9)	(7)	(3)	-	**(19)**
Peer homicide	-	-	-	1	17	**18**
Unrelated/ unknown	2	2	1	2	4	**11**
Total	**27**	**39**	**16**	**13**	**23**	**118**

2.6 Deaths due to neglect, or suspicious of, neglect

Table 14 shows that most children who died in neglect-related circumstances in 2010 and 2011 were either sudden and unexpected deaths (8) or drowning deaths (7). This is generally consistent with previous years (table 15).

Table 14: **Deaths related to neglect, (2010 and 2011)**

	Neglect and suspicious of neglect
Drowning	7
SUDI	8
Transport	2
Fire	1
Other	3
Total	**21**

Table 15: **Deaths related to neglect, (2003-2011)**

	All neglect and suspicious of neglect deaths	SUDI
External causes		
– Drowning	57	-
– Transport	20	-
– Fire	8	-
– Poison	3	-
– Other	13	6
Natural causes		
– Med. neglect	12	2
– Natural	3	2
– Ill-defined	20	20
Other		
– Not determined	1	1
– Un-ascertained	4	3
– Not finalised	3	2
Total	**144**	**36**

2.7 Children who died while in care

Twenty nine children died while they were in care. Table 16 illustrates the circumstances in which the children died. Half of the children died as a result of natural causes, and eight as a result of external injury.

Table 16: **Deaths of children in care – 2010 and 2011**

	Deaths of children in care
Natural	15
SUDI	4
Drowning	3
Poisoning	3
Transport	1
Suicide	1
Unknown / pending	2
Total	**29**

2.8 Coronial and criminal status

As shown in table 17, at the time of writing, inquests had been held by the State Coroner for five of the children who died in 2010 or 2011. In 33 cases, an inquest was dispensed. The Coroner suspended inquests into the deaths of 13 children, predominantly because criminal charges were laid in relation to these cases.

Table 17: **Coronial status reviewable child deaths (2010 and 2011)**

Coronial status	Number of deaths
Inquest held	5
Dispensed	33
Suspended	13
Open not finalised	26
Total	**77**

Criminal status

In relation to the 27 children who died as a result of abuse, or in circumstances suspicious of abuse:

- Five offenders have been convicted in relation to the deaths of four children. Two perpetrators were convicted of murder and three of manslaughter. One offender was found not guilty of murder by reason of mental illness.
- Two alleged offenders were deemed unfit to be tried due to mental illness or intellectual disability, and were referred to the Mental Health Review Tribunal.
- Two children died in two murder-suicide incidents. Both murder-suicides were subject to a Coronial inquest; one in NSW and one in Queensland.
- A further 26 people have been charged in relation to 14 deaths.

In relation to the 21 children who died in neglect-related circumstances, three persons have been convicted of negligent driving occasioning death.

3. Abuse-related deaths of children

Between 1 January 2010 and 31 December 2011, 27 children died as a result of abuse (24), or in circumstances suspicious of abuse (3). Sixteen of the children were aged 12 years or less, and most of these children were under six years. Eleven were teenagers.

In the nine years from 2003 to 2011, 118 children in NSW died in circumstances of fatal abuse. This represents two percent of the 5,505 children who died in NSW over that period.

There is no universally accepted way of classifying different types of child homicide. Researchers generally consider these deaths against a range of scenarios. The NSW Child Death Review Team (CDRT) developed a typology of 'common characteristics' that classified fatal assault into four categories: fatal non-accidental injury; parents affected by mental illness; family breakdown; and killings of teenagers.[23] Neilssen et al recently adapted this typology to consider categories of child homicide during psychotic illness, deaths arising from child abuse, retaliatory killings (replacing the CDRT 'family breakdown' and including murder-suicides), fatal sexual assault and teenage homicide.[24]

Classifying deaths by circumstance and primary reason or motive is an important consideration in a prevention context. While typologies such as those above are not easily accommodating of multiple and interacting factors that may contribute to the fatal assault of a child, they clearly identify the features that are often associated with such deaths. Taking this into account, this chapter considers:

- The age of the child and the relationship of the child to the offender or alleged offender. [25]
- The circumstances of the incident that resulted in the death of a child.
- The characteristics of the offender, particularly those that may have contributed to risk to the child.

We also consider any previous contact the child and/or their family had with government and non-government agencies, particularly those agencies with child protection responsibilities.

In relation to younger children who died in 2010 and 2011, the offender was either a parent or a person in a parental or caring role through their relationship with the child's parent. These deaths occurred either in a context of intentional harm to a child, sexual abuse of a child; or parental psychotic illness.

The majority of teenagers (9) were killed in incidents of confrontational violence involving a peer or peers. Seven of these deaths occurred in 2010, representing a marked increase in peer-related homicides from previous years. In order to identify whether any particular trends were emerging, we conducted a further focused review of peer homicides from 2002. The findings of this review are detailed in chapter 4.

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

3.1 The children who died in 2010 and 2011

The 27 children died in separate incidents. Two children died in incidents where the offender subsequently committed suicide.

Most of the children who died were either very young, or were teenagers. National and international trends also evidence a decrease in the frequency of child homicides with age. Australian research indicates that the decrease continues until the teenage years, with particular risk of fatal abuse relating to children under 12 months, followed by children aged one to four years.[26]

The majority of the children (17) were male, although this was concentrated in the older age groups; twice as many children under 10 years who died were female.

Table 18: **Age and gender of children who died in abuse-related circumstances (2010 and 2011)**

	<1	1-4	5-9	10-14	15-17	Total
Male	1	2	1	2	11	**17**
Female	2	5	3	-	-	**10**
All	**3**	**7**	**4**	**2**	**11**	**27**

The age of the children was reflected in the circumstances of their deaths; all of the children aged 12 and under died in abuse-related circumstances within the family, and all teenagers died in community–level incidents of violence.

23. NSW Child Death Review Team 2003, *Fatal assault and neglect of children and young people*, NSW Commission for Children and Young People, Sydney, p 5.
24. Nielssen, N., Large, M., Westmore, B. & Lackersteen, S. 2009, 'Child homicide in New South Wales from 1991 to 2005' *Medical Journal Australia,* vol.190, no. 1, pp. 7-11.
25. In this section, the term 'offender' includes persons who have been charged or convicted or identified by police as persons of interest.
26. Dixon, D. 2011, *Children who die of abuse: an examination of the effects of perpetrator characteristics on fatal versus non-fatal child abuse,* PhD Social Work Thesis*,* University of South Florida, p. 3; Strang, H. 1996, 'Children as victims of homicide', *Trends and Issues in Crime and Criminal Justice*, no.53, p. 2; UNICEF 2003, 'A league table of child maltreatment deaths in rich nations,' *Innocenti Report Card*, no. 5, viewed 21 December 2012, <http://www.unicef-irc.org/publications/pdf/repcard5e.pdf>.

Nine of the children who died as a result of abuse or in circumstances suspicious of abuse were identified as Aboriginal.

Child protection history

Chapter 1 described recent changes to the NSW child protection system, and different thresholds for reporting risk of harm to children.

In NSW, children who die in circumstances of abuse have consistently been more likely to have been the subject of a child protection report prior to their death. In 2010 and 2011, the families of half (13) of these children had been the subject of a report of risk of harm or risk of significant harm to Community Services or a Child Wellbeing Unit in the three years prior to their death. An additional five families had been the subject of a report that was made outside of that period.

Cause of death and related charges and convictions

The children died as a result of blunt force injury, sharp force injury, gunshot, drowning or asphyxiation. Six of the 11 teenagers died in the context of an affray or fight. In most of these cases, fatal wounds were inflicted by weapons, including knives and in two cases, guns.

Offenders and relationship to the child

Police have laid charges against persons, or have identified persons of interest in relation to 25 of the 27 deaths. At the time of writing only nine cases had been finalised through court processes. Of the 25 cases:

- fifteen of the children were in a familial relationship with the offender(s);[27]
- nine children, all of whom were teenagers, were killed in incidents involving peers;
- one alleged offender was an adult unrelated to the child.

In two cases, there is either no identified offender, or no information is available about offender status.[28]

The following sections focus separately on abuse related deaths that occurred in a family context, and teenage homicides that did not occur within the family.

3.2 Abuse-related deaths within the family in 2010 and 2011

Across Australia, most child homicides are perpetrated by parents, with approximately 27 children killed by their parents each year.[29]

Research indicates that where women kill their children, it is often in the context of their own mental illness; in particular postpartum, major or psychotic depression.[30] Women are also more likely to commit neo-naticide (killing an infant aged 28 days or less). In contrast, men are more likely to perpetrate fatal child abuse, where the killing of a child is not planned but takes place in the context of child abuse. Men are also more likely to be the perpetrators of 'retaliatory' killing of a child, typically in the context of a relationship breakdown.[31]

For the 15 children who died in abuse related circumstances within the family in 2010 and 2011, offender(s) were identified as:

- Birth parents (nine mothers and four fathers) in relation to 12 deaths.
- Stepfathers or male partners of birth mothers in relation to six deaths. In a number of cases, the partner was a relatively new presence in the family.
- A close family associate.

In NSW over the period 2003 to 2011, 89 child homicides or suspected homicides – 75% of all child abuse related deaths –- occurred within the family. Of the 88 offenders who have been identified in relation to these deaths, the vast majority (81) were in a parental relationship with the child, and seven were other relatives. More offenders were male (52) than female (36).

Circumstances in which children died

The two predominant circumstances in which the 15 children died were intentional harm inflicted in the context of child abuse, and harm inflicted in the context of the offender's psychotic illness:

- Seven children died following an injury sustained at their own home or the home of the alleged offender. The alleged offender(s) presented the child to hospital or called an ambulance, and most reported that the child had suffered accidental injuries as a result of misadventure on the child's part. Subsequent investigation found this unlikely to be the case.

27. This includes persons who were not residing with the child's family, but had a familial type relationship with them.
28. The death of one child is subject to investigation in another state and information about this case is therefore limited.
29. Domestic Violence Resource Centre 2012, *Just say goodbye: parents who kill their children in the context of separation*, cat. no. 8 2012, DVRC, Melbourne.
30. Kauppi, A., Kumpulainen, K., Vanamo, T., Merikanto, J., Karkola, K 2008, 'Maternal depression and filicide — case study of ten mothers', *Achive of Women's Mental Health,* vol. 11.
31. Byard, R. *et al.* 1999, Murder suicides involving children: A 29 year study, *American Journalof Forensic Medicine & Pathology,* vol. 20; Marleau, J., Poulin, B., Webanck, T., Roy, R. & Laporte, L. 1999, 'Paternal filicide: a study of 10 men', *Canadian Journal of Psychiatry*, no. 44; Liem, M. & Koenraadt, F. 2008, 'Filicide: a comparative study of maternal versus paternal child homicide', *Criminal Behaviour and Mental Health*, vol. 18, no. 3.

- Five children died during what appears to be, or has been identified as, parental psychotic illness. In most cases, the child died at home.
- Family breakdown and estrangement was identified through a Coronial inquest as the primary circumstance for the death of one child.
- The circumstances of the deaths of two children are at this stage unclear.

Family involvement with agencies

We considered whether the families of children who died had been involved with key agencies, particularly those agencies with child protection responsibilities. This included Police, Health services and Community Services. This information was available for fourteen children.[32]

Generally, where the deaths of children occurred in the context of intentional harm / child abuse, families were more likely to be known to police and to have had a child protection history. Families of children who died in the context of parental psychotic illness were more likely to have had prior involvement with mental health and drug and alcohol services.

Involvement with police

Nine of the families had, at some point, come to the attention of police. In six families, either or both parents had extensive histories, with charges, convictions or intelligence relating to a range of offences, including assault, domestic violence, sexual offending, break and enter, malicious damage and drug use and/or supply. Three families had one or two earlier contacts with police, including police attending for incidents of verbal (2) and physical (1) domestic violence.

Six families had had contact with police within the 12 months prior to the child's death, including three of those who were well known to police. However, police contact in this period was not extensive, nor was the involvement with police usually related to safety risks associated with the behaviour of the offender toward the child. In these incidents, police:

- Attended incidents of verbal domestic violence regarding two different families.
- Were contacted and attended in relation to concerns about the welfare of the offender in a context of mental health issues or drug misuse.
- Responded to concerns about two children, one in relation to child abandonment and the other raising concerns about a parent who was not the subsequent offender.

Police made risk of harm or risk of significant harm reports to Community Services about six of the children who died, with the main issue of concern being domestic violence and parental drug and alcohol use.

Involvement with health services

Some of the families were involved, or had episodic contact with, health service providers within the 12 months prior to the child's death. Services included family general practitioners, early childhood nurses, mental health services and hospital emergency departments.

All of the five families whose child died in the context of parental mental illness had had some previous involvement with public or private health services in relation to mental health concerns.

At least two families had recent contact with drug and alcohol treatment services, or had presented to emergency departments due to the effects of drug use.

Two children who died in circumstances of abuse had been presented to hospitals within days or weeks prior to their death. Another child had two presentations to a local medical centre for physical injury in the months prior to the child's death. In one case, physical injury was assessed as being possibly intentional; however medical advice provided to Community Services indicted the injuries were not the result of abuse.

Two of the children who died were noted to have disabilities, and the families were involved with relevant health services, including specialist paediatric services. The services identified no issues of concern for the children.

Overall, health services made reports to Community Services about five of the children who died, primarily in regard to parental drug and alcohol use, physical harm and mental health issues.

Community Services

Within the three years prior to the child's death, nine of the families had been the subject of a report of risk of harm or risk of significant harm; and most of these (7) were reported within the 12 months prior to the child's death.[33] Some reports to Community Services were made through Child Wellbeing Units (CWU), but we identified no report having been made to a CWU that was not also referred to Community Services as a report of risk of significant harm. Two other families had been the subject of a report or reports between three and four years prior to the child's death.

Some families had a limited child protection history; for three families the history was extensive.

One child protection report

Including one family that was reported just over three years prior to the child's death, four of the 14 families had been the subject of only one previous report:

32. The family of one child resided in another state.
33. This does not include any report made in relation to the incident in which a child died.

- In two cases, the report related to domestic violence. For one, the issues of concern about a verbal altercation were not considered to present risks to the child. In the second case, concerns about physical domestic violence resulted in the family being referred to early intervention services. The family declined to participate in the voluntary service.
- One family was reported in relation to the physical abuse of a child. The report was determined to meet the threshold for risk of significant harm, but was closed without any action due to 'current competing priorities' at the Community Services Centre.
- One child was reported prenatally due to concerns about the mother's mental health issues and drug and alcohol use. The report was not allocated to a caseworker and was subsequently closed.

In three of the four families, the persons reported as allegedly causing harm or risk were confirmed through court processes as the persons responsible for the death of the child.

Two child protection reports

Two children were the subject of two reports of risk of significant harm within three months of their death. In both cases, the reports indicated concerns about physical abuse. Both children received a child protection response. For one child, the case was open and allocated to a child protection caseworker at the time they died. For the other child, the reported concerns were not actively assessed and the case was closed prior to the child's death.

Extensive child protection histories

Three families had extensive child protection histories, with multiple reports for the child and/or the child's sibling(s). The child protection history was intergenerational in all three families, with the mothers themselves having had a child protection history. In two of these families, the child, or a sibling of the child, had previously been removed and temporarily placed in care by Community Services.

In relation to the reports in connection with the three families:

- One family, while having an extensive history, had not come to the attention of Community Services for over a year, but had been involved with a number of non-government agencies. Our investigation into this matter found that there were recent concerns about the child that related to significant absenteeism from school, and that these concerns should have been the subject of a report.
- One family had been the subject of reports of risk of significant harm in the year prior to the child's death relating to family violence and a carers' prior history of sexual offending. The reports were not in relation to the subsequent offender. Reports were either not considered to meet the threshold of risk of significant harm, or were closed because of 'current competing priorities'.
- One family had been the subject of a number of reports in the months prior to the child's death raising concerns about exposure to domestic violence, risk of physical harm, and neglect-related issues. While most reports were assessed as not meeting the risk of significant harm threshold, the family was referred to and engaged with a non government service.

In two of the three families, the person(s) identified as causing harm or risk of harm to the child in a child protection report was subsequently identified as the homicide offender.

Education

Six of the children were of school age. For three children, significant absenteeism was a noted concern. For two of the three children this was a recent concern, and the home school liaison program had been involved with both families.

Other government and non-government agencies

Six families had been in contact with, or were engaged with, a number of other agencies providing social and/or health support. This included childcare services, early intervention services and disability services such as respite care. Some of these agencies identified vulnerability within the family, such as social isolation and parental depression. In some cases, agencies identified risk to the child and made reports to Community Services.

A number of families, especially those with extensive child protection histories, were involved with a range of government and non-government agencies. Our reviews and investigations identified that effective information exchange and coordination between agencies at times presented a challenge.

Offender characteristics

As part of our reviews, we sought to identify any particular offender characteristics or issues that may have contributed to the circumstances leading to the child's death, or indicated some risk to the child. Information was available for 19 offenders, in relation to the deaths of 14 children. We focused particularly on issues that have been identified as common child protection risks: domestic violence, mental health issues and substance misuse. These factors are not predictors of fatal abuse, but rather are recognised risk factors for significant harm.[34] We also considered whether offenders had been involved

34. Mayes, 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; NSW Ombudsman 2011, *Report of reviewable deaths in 2008 and 2009: volume 1,* NSW Ombudsman, Sydney, p. 22.

in a recent family breakdown, as retaliatory homicide post separation is a recognised form of child homicide.[35]

History of domestic violence and other violence

Twelve of the 19 offenders were known to police, through charges, convictions or intelligence. In all of the cases where a child died as a result of intentional harm in the context of child abuse, the offender had a previous recorded history of violence.

In some cases, involvement with police was extensive and covered a range of offences including domestic violence, common assault, sexual assault, drug related offences, and malicious damage. Three offenders had been previously incarcerated for violent offences.

All of the 12 offenders had come to the attention of police at some stage for domestic violence. In three cases, within the 12 months prior to the child's death, police attended a domestic violence incident involving the offender and the child's family. Police reported two incidents to Community Services. Police, through the JIRT, were already involved with the other family in relation to concerns about a child. Another homicide offender was subject to an Apprehended Violence Order in the year prior to the child's death, but not in relation to the child's family.

Mental health issues

There is some debate regarding mental illness, especially psychotic illness, and the perpetration of violence. Evidence suggests that people with a mental illness are more likely than the general population to perpetrate violence, although this increased risk is not to the extent commonly feared in the community.[36]

Mental health issues were noted in the history of ten offenders. Four offenders had been diagnosed with mental illness and/or personality disorders, including schizophrenic illnesses, post natal depression; and anti-social personality disorder. In addition, a Coronial Inquest found that one offender was suffering an undiagnosed mental illness at the time of the death. For the other five, mental health concerns related to self-reported depression, or treatment for issues such as anxiety and depression.

In two cases, mental health treatment or assessment was being actively provided around the time of the incident. In another, treatment was episodic.

In three cases where murder charges were laid; one offender was found by the Court to be unfit for trial and referred to the Mental Health Tribunal, one offender was found not guilty by reason of mental illness, and one mother was found guilty of manslaughter 'in satisfaction of an indictment for murder', noting the child was killed during a psychotic episode. Records for one of the three offenders did not indicate a history of mental illness.

Child protection: person causing harm

International research indicates that children who have been reported to child protection authorities for physical abuse are up to four times more likely to die from fatal abuse than the general population.[37]

The majority (12) of the 19 offenders had been previously identified in reports to Community Services as being a person causing harm or posing a risk to children. Apart from one case, concerns related to the child who died.

Commonly reported issues for the children were exposure to domestic violence, parental drug and alcohol misuse, risk of physical harm and neglect related issues. For some of the children, the reports were made over twelve months before the child died; for two, the reports had been made more than three years prior to the incident that resulted in their death.

For four children, the concerns identified in reports were recent and related to the physical abuse of the child.

Drug and alcohol issues

Nine offenders had reported problems related to alcohol and other drug use, with six noted to have a chronic problem. Two offenders were identified as receiving opioid replacement therapy in addition to using other drugs at the time, and a number of offenders were suspected of involvement in drug supply. Other offenders had long term poly-substance abuse issues, or chronic cannabis and alcohol misuse.

Child protection reports in relation to four children who died included the offender's drug use as a risk concern.

Family breakdown

In two cases, the offender's relationship with the child's mother had recently broken down.

For one, relationship breakdown and estrangement was identified as the primary motive for the offender killing his daughter, the child's mother and the mother's friend, and the offender's subsequent suicide. The case was subject to Coronial Inquest in Queensland[38], and the Coroner

35. Domestic Violence Resource Centre 2012, *Just say goodbye: parents who kill their children in the context of separation*, cat. no. 8 2012, DVRC, Melbourne; Johnson, C. 2005, *Come with daddy: child murder-suicide after family breakdown,* University of Western Australia Press, Perth.
36. Mullen, P. 2006, 'Schizophrenia and violence: from correlations to preventive strategies', *Advances in Psychiatric Treatment,* vol. 12, p. 240.
37. Dixon, D. 2011, *Children who die of abuse: an examination of the effects of perpetrator characteristics on fatal versus non-fatal child abuse,* PhD Social Work Thesis, University of South Florida, p. 44.
38. The child's death is reviewable because it occurred in NSW.

noted in his findings the connection between domestic and family violence and homicide, and that *'extremely controlling perpetrators are particularly dangerous under conditions of estrangement.'*

3.3 Themes and issues: abuse-related deaths of children within the family

Chapter 7 details the themes and issues arising from our reviews of child deaths. For children who died in abuse-related circumstances within the family, our reviews identified:

- Issues related to Community Services' capacity to respond to children who were determined to be at risk of significant harm. This included reports closed because of competing priorities, risk assessment that was not fully informed, and risk assessment that did not include interviewing children where the child was capable. In some cases where families were involved with Community Services and other agencies, coordination was an identified problem.
- The adequacy of agency identification of, and response to, risks including responses to chronic school absenteeism; support and a coordinated intervention for parents with mental illness; and health services' response to injury in young children.
- Where families were involved with different agencies, there was not always effective information exchange and/or effective coordination.

3.4 Teenage homicides

In 2010 and 2011, 11 teenagers were killed in fatal assaults. Nine of these young people died in incidents involving their peers. In relation to the 11 teenagers:

- The relationship between the offender(s) and five of the victims is not known or unclear. All of the deaths occurred in a context of confrontational violence. In three cases, records indicate the possibility of the victim and alleged offender belonging to rival gangs. In one additional case, this was confirmed to be the case following criminal proceedings.
- Three victims were friends or associates of the offender.
- In three cases, police established there was no personal relationship between the offender(s) and the victim. For example, the murder of one young person occurred during an incident described by police as 'random and totally unprovoked'.

As noted, most of the deaths of young people in peer-related homicides are currently the subject of police investigation. In broad terms, most of the fatal assaults of teenagers (6) resulted from confrontational violence involving groups of young men. Records indicate that some of these confrontations may have been a 'payback' for earlier fights or disagreements between different groups or individuals. In at least three cases, the young people who died, and/or the alleged offenders, appear to have belonged to a gang, and the incident that led to their death may have been linked to gang rivalry.

The seven peer-related homicides in 2010 represent a substantial increase to previous years, where on average two young people have died each year in these circumstances.

This increase was noted in the CDRT's 2010 Annual Report[39] and we committed to examining peer-related homicides in more detail in our next report of reviewable deaths. The following chapter outlines the results of this review.

39. NSW Child Death Review Team 2011, *NSW Child Death Review Team annual report 2010*, NSW Ombudsman, Sydney.

4. Peer-related homicides 2002 - 2011

This chapter considers the deaths of 19 young people aged between 14 and 17 years who died in circumstances of fatal assault and who were killed by a peer, or young person of similar age and/or social standing to themselves. The 19 deaths include all peer-related homicides identified during the period that the Ombudsman has had responsibility for reviewable child deaths, December 2002 – December 2011.

As noted previously, in 2010 there was a significant spike in apparent homicides perpetrated by young people against other young people, with seven teenagers dying in these circumstances. Since December 2002, 28 teenagers have died in circumstances of abuse, and the majority of these young people (19) were killed in incidents involving a peer.

Criminal proceedings have been finalised in relation to 12 of the 19 homicides reviewed. For the remaining seven deaths, police have laid charges against one or more offenders in each case.[40] As proceedings in these matters have not yet concluded, we have exercised caution in providing details that could be identifying.

Typical scenarios in which the fatal incidents occurred include fights at parties or other social events, affray between groups of young people and seemingly random attacks by people of similar age.[41]

The young people died as a result of sharp piercing injury, gunshot, blunt force injury, and asphyxiation. In almost all cases (17), fatal wounds were inflicted by weapons, including knives (7) and firearms (5). In a number of cases, weapons were improvised from available objects such as pieces of wood, metal poles or glass bottles.

The following case studies describe two of the peer-related homicides considered in this review that illustrate the types of incidents in which the teenagers died. Criminal proceedings have been finalised in both cases.

Case study 1

A group of friends hired a community hall in which to hold a large party. One of the guests, a young man, brought whisky, beer and several 'ecstasy' tablets, which he consumed during the evening. He also brought a firearm and some bullets to the party, which he intended to show his friends. Over the course of the evening, two separate groups of uninvited youths arrived, resulting in short verbal exchanges and a degree of tension between some party guests and the uninvited arrivals. Shortly after midnight, and while affected by drugs and alcohol, the young man who brought the gun retrieved it from the boot of his car, and in a reported state of anger, approached a group of uninvited youths standing outside the hall. A verbal confrontation took place, and the young man fired his gun, fatally injuring one of the group. The offender was subsequently convicted of murder.

Case study 2

The victim was with a group of teenagers at an informal gathering held one evening. Some of the young people present were consuming alcohol. The offender arrived at the party and whilst there, used a glass pipe to smoke amphetamine. There was a recent history of animosity between the victim and offender. The victim asked the offender to leave the area and then pushed or punched the offender. The two engaged in a fight in which other teenagers became involved, and when the young people were pulled apart, it became apparent that the victim had been stabbed. It was later discovered that he had been stabbed with the broken glass pipe used by the offender for smoking drugs. The offender was convicted of manslaughter in relation to the death.

Most of teenagers considered in this review (12 of 19) were killed in public places – primarily on the streets – but also in other public locations such as parkland, bush or forest settings, on trains or train stations, riverbanks and outdoor car parks. The remaining seven deaths occurred in private homes – either that of the offender, an associate or friend of the victim, or in one case, the home of the victim.

All 19 fatal incidents occurred in the same area, or very near to, where the young people lived. Analysis of residential postcodes indicates that the majority (12) of victims resided in the south-western or western areas of Sydney, with these locations generally identified as among the more socio-economically disadvantaged in the Sydney metropolitan area. The seven assaults that occurred outside the Sydney area were widely spread across the state.

4.1 About the young people who died

Table 19 shows the number of peer-related homicides over the nine-year period in comparison to other circumstances of abuse-related deaths. Although some fluctuations are apparent from year to year, most notably the spike in 2010, the number of peer homicides remains relatively small when compared to other types of child homicide, particularly deaths that occur in the context of familial abuse.

40. For ease of reading, the term 'offender' refers to both convicted offenders and alleged offenders who have been charged in relation to a peer homicide death.
41. Deaths of teenagers that did not involve peers were excluded from the analysis. Some examples of excluded cases include teenagers killed by immediate family members (parents or siblings) or other unrelated adults over 25 years of age.

Table 19: **Trends in peer homicide deaths compared to other offender relationships, December 2002-2011**

	Dec 02 - 2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Peer	4	-	1	1	1	3	-	7	2	**19**
Familial	15	7	13	11	6	11	11	6	10	**90**
Other	3	2	1	1	1	-	1	1	1	**11**
Total abuse	**22**	**9**	**15**	**13**	**8**	**14**	**12**	**14**	**13**	**120**

Age, gender and Aboriginal and Torres Strait Islander status

Of the 19 teenagers who died in peer homicide incidents, 16 were male and 3 were female. The predominance of male homicide victims is well-recognised in research literature.[42] Previous Australian research has shown 75% of young (10-24 years) Australian homicide victims are male.[43]

As illustrated in table 20, most of the victims were 17 years old. This finding is consistent with research indicating that, for older children and young people, the rate of homicide victimisation increases with age, peaking between 21 and 24 years.[44]

Table 20: **Age and gender, peer homicide victims, December 2002-2011**

	14 years	15 years	16 years	17 years
Male	1	2	3	10
Female	-	3	-	-

Aboriginal children are generally over-represented in deaths resulting from assault, and this trend is also apparent in peer-related fatalities. Records indicated four victims were Aboriginal.

In addition, nearly one-third (6) of the victims were identified as coming from culturally and/or linguistically diverse backgrounds, including Pacific Islander, Asian, Middle-Eastern, and Italian.

Occupation

Most of the young people who died (14) were students at school or TAFE, including two young people who were enrolled, but not attending. The remaining five young people had left school, three of whom were in employment.

4.2 The offenders

Police have identified 31 persons as responsible for, or associated with, the deaths of the 19 teenagers identified for this review. Charges have been laid against all 31 offenders, including for murder, manslaughter, affray and other assault related offences. At the time of writing, convictions have been recorded for 14 offenders in relation to 12 deaths, including murder (6), manslaughter (7) and other malicious assault and driving offences (1). Criminal proceedings are continuing for the 17 identified offenders allegedly responsible for the seven remaining deaths.

Age, gender and Aboriginal and Torres Strait Islander status

Offenders ranged in age from early teens to young adults in their twenties. Just over half (16) were aged 14 to 17 years at the time of the fatal incident; the remaining 15 offenders were adults at the time of the offence.

Over the nine year period, all but one offender was male. This finding is consistent with both national and international data, which shows the vast majority of violent crime is committed by males.[45]

Records indicate that six of the 31 offenders were Aboriginal, and seven were from culturally and/or linguistically diverse backgrounds.

Occupation and education

Research has found that educational or learning difficulties and discipline problems are common amongst juvenile homicide and attempted-homicide offenders.[46] In this regard we considered education levels and occupation of offenders. Although this information was not available for all, we found that:

42. Finkelhor, D. & Ormrod, R. 2001, 'Homicides of children and youth', *Justice Bulletin*, US Department of Justice, Washington, pp.2-4; Muftić, L. & Moreno, R. 2010, 'Juvenile homicide victimization: differences and similarities by gender', *Youth Violence and Juvenile Justice,* vol. 8, no. 4, pp.386, 388.
43. Carcach, C. 1997, 'Youth as victims and offenders of homicide', *Trends and Issues in Crime and Criminal Justice*, no. 73, Australian Institute of Criminology, Canberra, p.3.
44. Carcach, C. 1997, 'Youth as victims and offenders of homicide', *Trends and Issues in Crime and Criminal Justice*, no. 73, Australian Institute of Criminology, Canberra, p.2.
45. Carrington, K. & Pereira, M. 2009, *Offending youth : crime, sex and justice*, Federation Press, Sydney, p. 4; Carcach, C. 1997, 'Youth as victims and offenders of homicide', *Trends and Issues in Crime and Criminal Justice*, no. 73, Australian Institute of Criminology, Canberra, p.2.
46. Rodway, C. et al. 2011, 'A population-based study of juvenile perpetrators of homicide in England and Wales', *Journal of Adolescence,* vol. 34, no. 1; Britvic, D., Urli, I., & Definis-Gojanovic, M. 2006, 'Juvenile perpetrators of homicides and attempted homicides - a case control study', Collegium Antropologicum, vol. 30, no. 1, pp. 146-147.

- Seven young people aged between 15 and 17 years were no longer attending school. Nine offenders aged between 14 and 16 years were enrolled at and attending school.
- For the 12 young people who had left school and for whom we had information about highest education level achieved:
  - None had completed Year 12.
  - One offender was educated to Year 11, and was employed at the time of the offence.
  - Five were educated to Year 10. Four of these young people were unemployed at the time of the offence.
  - Six were educated to Year 8-9; five of these young people were unemployed at the time of the offence.

From 1 January 2010, the school-leaving age in NSW was raised from 15 to 17 years, with all students now required to complete Year 10 and either continue their education or be in paid work (or a combination of these activities) until they turn 17. This initiative was based on the findings of studies that showed teenagers who left school early were more likely to be unemployed, earn lower wages, have poorer health, and be involved in criminal activities.[47]

4.3 Relationship between victim and offender

Just over half of the victims were friends or social acquaintances of the offender. In most cases where the victim and offender knew each other, there was no known history of animosity. However in four cases, records indicate problems between the victim and offender/s that were relevant to the fatal assault.

For the nine cases where there was no previous relationship between the victim and offender. In three, the victim and offender were members of rival 'gangs' or groups of young men, with the deaths occurring in the context of an affray. In another three cases, the victim and offender were present at the same social event as either an invited guest or 'gatecrasher', and their contact and hostilities arose as a result of an incident at the social event. The final three cases involved young people being at the 'wrong' place at the 'wrong' time, either as victims of unprovoked attacks while out late at night, or as a victim in an armed robbery.

4.4 Circumstances of peer homicides

As noted, some of the homicides considered in this review are currently the subject of police investigations. However, for the purpose of this review, we considered the broad context in which deaths occurred.

Affray and confrontational violence

The most common scenario identified involved young males engaged in altercations with other young males, escalating to physical violence. Ten teenagers died in situations of this type, with many of the confrontations involving groups of youths. In most cases, offenders responsible for the deaths reportedly did not intend to kill the young people who died.

Our review found that victims sometimes played a role in situations of affray or confrontation. In five of the ten affray-related deaths the victim was identified as either the initiator of the incident, or an equally active participant in the conflict. The following case highlights this issue:

> By chance, two groups of teenage youths, some of who knew and disliked members of the other group, boarded separate carriages of the same train one afternoon. The victim's group began to walk through the carriage towards the offender's group, who attempted to avoid a confrontation, firstly by moving away in the opposite direction, and then by temporarily disembarking from the train. When the victim's group reached the offender's carriage, an altercation occurred; the victim rushed at the offender with his fists raised, and began to grab and punch the offender. As he did so, the offender took a knife from his pocket and stabbed the victim. The offender reportedly carried the knife for protection after having been assaulted and robbed on a train one month prior to the fatal incident. The offender was subsequently convicted of manslaughter on the basis of excessive self-defence.

Gang-related violence

Research indicates that in Australia, the criminality of young people is predominantly non-violent, petty and spontaneous rather than organised, and is often linked to substance abuse or drinking binges. Young people, including those from visible ethnic minorities, rarely form organised gangs, and very few participate in outlaw gangs committed to crime and violence as a way of life.[48] These findings are generally supported by the cases considered in our review. While a number of homicides involved informal social groups of young people or multiple offenders, only two of the 19 deaths reviewed were identified as specifically related to gang conflicts. One of these cases is described below:

> One evening, animosities arose between two groups of young men from different graffiti gangs. Members of one group gathered at the home of a member of the rival group, with the intention of engaging in a fight. A meeting place for a fight was arranged, and a confrontation took place. The subsequent affray involved the use of improvised weapons, such as sticks and wooden posts. During the course of the fight, the victim and offender – one armed with a broken bottle,

47. NSW Auditor-General 2012, *The impact of the raised school leaving age,* The Audit Office of New South Wales, Sydney.
48. Carrington, K. & Pereira, M. 2009, *Offending youth : crime, sex and justice,* Federation Press, Sydney, p. 6.

the other with a knife – swung at each other, resulting in fatal injuries to the victim. Toxicology revealed the victim had a blood alcohol level nearly three times greater than the adult limit for driving, as well as the presence of an ecstasy-like stimulant drug. The offender was subsequently convicted of manslaughter, with the magistrate commenting on both the immaturity of participants, and the opportunistic nature of the offence in the context of a planned confrontation between the two gangs.

A study of serious case reviews in the United Kingdom which considered a small number of gang-related incidents[49] notes that young people in gangs are often '*vulnerable individuals who can be both perpetrators and victims of harm*', and identified that '*a range of overlapping factors*' contribute to young people becoming involved in gang related activity, including '*community and social factors like poverty and high rates of local unemployment. Lack of appropriate leisure and social facilities also play their part…*'

Other circumstances

The circumstances and contexts in which the other nine deaths occurred are varied:

- Two young people were killed by offenders seeking a 'thrill', or 'just to see what it felt like'. Sentencing remarks in these cases refer to the anti-social personality, lack of empathy, and gratuitous cruelty of offenders in these deaths.
- Two young people were killed in separate attacks described by police or the courts as 'senseless' and 'unprovoked' by offenders who were reportedly 'spoiling for a fight'. Neither victim knew their assailants; the attacks appeared to be random and primarily a case of the victim being in the 'wrong place at the wrong time'.
- Two victims were fatally injured while handling guns. Both cases involved young people who accessed inadequately secured firearms.
- One victim was killed in the context of ongoing and extreme domestic violence perpetrated by the offender.
- The circumstances around the deaths of two teenagers are unclear. In one case, the magistrate commented that 'something must have snapped' to cause the offender to behave in the manner described.

4.5 Risk factors and involvement with agencies: victims

More than one-third (7) of the victims were known to multiple agencies as vulnerable or 'at risk' adolescents. Typically, these agencies included police, Community Services, Health, Juvenile Justice and Education, as well as other services such as refuges, Centrelink, Aboriginal support services, and local youth services.

Police and Juvenile Justice

The majority of young people (15 of the 19 victims) had some history of adverse contact with police prior to their death. For some, this history involved relatively few contacts for relatively minor incidents such as public transport fare evasion offences or graffiti. Other teenagers had longer histories of contact with police, or were involved in more serious incidents related to violence and anti-social behaviour.

Ten teenagers who died had numerous adverse contacts with police; three had been supervised by Juvenile Justice in relation to their offending behaviour. Of the ten teenagers, all were known for risk taking. Five had been charged with offences. In other cases, police response to risk-taking and offending behaviour by these young people was largely consistent with the alternatives provided by the *Young Offenders Act*, including the issuing of warnings or cautions and referral to diversionary programs.

Five of the young people who were well-known to police for their offending behaviour were also identified by police as being at risk of harm, and were the subject of police reports to Community Services. Concerns raised by police related to physical harm from a carer or other person, parental drug and/or alcohol use, parental mental health issues, neglect, inadequate supervision, sexual harm, and family violence.

Community Services

Just over one-third (7) of the 19 young people who died in circumstances of peer homicide had been the subject of a risk of harm or risk of significant harm report within the three years prior to their death. Collectively, reports raised concerns about the young person's own behaviour, such as risk-taking, school refusal, violence, or issues within the young person's family, including physical violence with the young person as a victim.

Four of the seven young people reported to be at risk did not receive any casework or other contact from Community Services. The three young people who received a Community Services response all had extensive and recent child protection histories prior to their death. For two of the young people, intervention was minimal. In one case where a child protection response was comprehensive, caseworkers encountered significant difficulties in attempting to engage with the young person.

In addition, a further four young people had been the subject of child protection reports at some time earlier in their lives. In two cases, this history involved multiple reports or protective intervention.

49. Brandon, M., Bailey, S. & Belderson, P. 2010, *Building on the learning from serious case reviews: a two year analysis of child protection database notifications 2007-2009*, cat. no. DFE-RR040, Department for Education, London.

NSW Health

Records indicated that few of the young people who died had contact with public health services during the year prior to their death; we identified only four teenagers who did.

Two of these young people presented to health services on several occasions in relation to instances of physical harm, homelessness or neglect; and health professionals made corresponding risk of harm reports to Community Services in relation to identified issues. In both cases, presentations were prior to *Keep Them Safe*.

Another young person presented to hospital emergency departments twice in the months prior to his death for injuries sustained. On the first occasion the young person reported having been assaulted by unknown offenders; on the second, the teenager presented with accidental injuries, in the context of other apparent injuries reportedly sustained during a fight earlier in the evening. The fourth young person was known to mental health services working with the young person's mother.

Drug and alcohol use

Drug and alcohol use by teenagers who were victims of homicide was common. Available records showed a high proportion had a history of drug and/or alcohol use. In addition, post-mortem toxicology results indicated that just over half the young people who died (10) had alcohol and/or other drugs in their system at the time of the fatal assault, some to the level of intoxication. Research indicates that intoxication is common in homicide victims, and that intoxication is a risk-factor for becoming a victim of homicide.[50]

4.6 Risk factors and involvement with agencies: offenders

Police

Overall, we found offenders had a high level of prior involvement with police, with most (26 of the 31) having some history of adverse contact with police. This contact ranged from relatively minor to significant contact comprising multiple arrests and charges, serious violence, and concerning anti-social behaviour. Five offenders were known to police for gang-related activity.

Most offenders had come to the attention of police on multiple occasions, and half were well known to police with an extensive history of adverse contact.

Of the 15 offenders with extensive police contact, most had been charged on multiple occasions in relation to an array of offences. More serious charges involved offences such as aggravated break and enter, armed robbery, assault causing harm, and shooting to resist apprehension. Eight offenders had convictions recorded in relation to these charges.

Sixteen offenders – and nearly all of those with extensive police histories – were known to police for previous violence towards others. In most cases, violence was an ongoing issue that bought the offender to the attention of police. Nine offenders had been identified as the 'person of interest' (offender) in an Apprehended Violence Order taken out against them.

Police reported seven offenders to Community Services as being children at risk of harm or risk of significant harm in relation to concerns about familial violence, inadequate supervision, underage alcohol consumption, and unsuitable home environments.

Community Services

Some research has found that physical abuse and family rejection are notable risk factors for a young person attempting or committing a murder.[51]

Half (15) of the 31 offenders had, at some point in their lives, been identified as children or young people at risk. Ten had been the subject of a report of risk of harm or risk of significant harm to Community Services during the three years prior to the offence, and five had earlier histories.

As younger children, three offenders had experienced removal from their families; two were placed under the parental responsibility of the Minister and another was placed with family. All three were also the subject of more recent child protection reports.

For the ten young people for whom child protection concerns had been reported within the three years prior to the offence, most (8) were the subject of three or less reports. In the main, concerns related to the young person's behaviour – for example, involvement in incidents of assault and alcohol misuse - or exposure to harm from others, including family. Only one offender had contact with caseworkers in relation to reported concerns, with most reports closed due to 'current competing priorities'.

Two offenders were the subject of multiple risk of harm and risk of significant harm reports during the three years prior to the offence. For both, reports raised concerns about risk taking behaviour including drug and/or alcohol misuse, and homelessness. One young person had noted risk-taking and behaviour management issues, and the other was reported to be a suicide risk. One of the young people had an open and allocated case and was also involved with Juvenile Justice. The other young person, although previously involved with health and non-

50. Tardiff, K. et al. 2005, 'Drug and alcohol use as determinants of New York City homicide trends from 1990 to 1998', *Journal of Forensic Science*, vol. 50, no. 2, p. 2; Ezell, M. & Tanner-Smith, E. 2009, 'Examining the role of lifestyle and criminal history variables on the risk of homicide victimization', *Homicide Studies*, vol. 13, no. 2, pp. 144-173.
51. Britvic, D., Urli, I., & Definis-Gojanovic, M. 2006, 'Juvenile perpetrators of homicides and attempted homicides - a case control study', Collegium Antropologicum, vol. 30, no. 1, pp. 145-146.

government services, was not engaged with any agencies at the time of the offence. Neither young person received a comprehensive or coordinated response to child protection, health or behavioural issues.

Drug and alcohol issues

Research indicates that substance misuse is common in juvenile homicide offenders, and that use appears to have increased in the last 30 years.[52]

Seventeen of the 31 offenders had a documented history of alcohol and/or other drug use. For ten, records indicate significant and chronic substance abuse. Based on available records, it does not appear that any were involved in treatment programs to address their drug and alcohol misuse in the period prior to the offence. Eleven offenders with a history of alcohol and/or other drug misuse were also found to be substance affected at the time of the fatal incident.

Of the 14 offenders with no recorded history of alcohol or other drug use, half (7) were still at school.

Mental health

Previous studies have found that juvenile homicide offenders are rarely psychotic, but do present with characteristics commonly associated with deteriorating mental health, such as suicide ideation and psychotic-like symptoms.[53] Overall, although we found little evidence of mental illness amongst offenders, many (12) exhibited signs of poor mental health.

Three offenders had been diagnosed with a conduct disorder, oppositional defiance disorder or depression, prior to the offence; and one offender had previously received treatment, including prescribed medication, from mental health professionals for aggression and 'mood', but had not been diagnosed with a specific disorder or condition.

A range of other mental health-related issues were identified for nine offenders, although none had been assessed as having a mental illness. For some offenders, these issues only became apparent after the homicide. Identified issues primarily involved anger management problems and untreated or suspected conditions such as depression, post traumatic stress disorder, anti-social personality disorder or other personality difficulties. In one case where there was differing psychiatric opinion about the offender's mental status, the magistrate concluded it '*probable*' the offender was acting under the influence of some psychosis at the time of the offence, while acknowledging that there was no evidence of psychosis either before or after the fatal incident.

For nine of the 12 offenders where we identified mental health issues, records indicate a history of illicit drug and/or alcohol misuse. Records also refer to difficult or disrupted childhoods, and adverse social circumstances or experiences, including a family history of mental illness or mistreatment, in describing the offender's background.

Two offenders had disabilities – in one case a learning disability, and in the other, a suspected mild intellectual disability.

4.7 Observations arising from our review of peer homicides

Based on our review of the deaths of 19 teenagers killed by peers, and the 31 offenders identified as responsible for these deaths, broad observations are:

- Victims and offenders often have similar profiles. We found a significant number of young people, whether victims or offenders, were involved in risky or dangerous behaviour, including drug and alcohol misuse, offending and other anti-social behaviour. This observation has been made elsewhere in the context of child death reviews. A recent study in the United Kingdom found young people involved in dangerous behaviour and street level violence often '*shared a similar profile to the young people who died or were seriously harmed* (and that) *most had experienced neglect and or abuse and had grown up living with the 'toxic trio' of family violence, parental substance misuse and parental mental ill health.*'[54]
- Alcohol and/or drug use was common amongst victims and offenders – both in terms of a documented history of misuse, and as a possible factor relevant to the circumstances of the fatal incident. Given that nearly three-quarters (35 of the 50) of the young people considered in this review – all 19 victims and 16 of the 31 offenders – were aged 17 years or less, this issue is particularly concerning. Previous Australian research has considered the prevalence and role of alcohol in homicides, but has not focused specifically on teenage deaths or young offenders.[55] Consistent with our review,

52. Britvic, D., Urli, I., & Definis-Gojanovic, M. 2006, 'Juvenile perpetrators of homicides and attempted homicides - a case control study', Collegium Antropologicum, vol. 30, no. 1, pp. 146-147; Heide, K. 2003, 'Youth homicide: a review of the literature and a blueprint for action,' *International Journal of Offender Therapy and Comparative Criminology*, vol. 47,pp. 6-36.
53. Heide, K. 2003, 'Youth homicide: a review of the literature and a blueprint for action,' *International Journal of Offender Therapy and Comparative Criminology*, vol. 47,pp. 6-36.
54. Brandon, M., Bailey, S. & Belderson, P. 2010, *Building on the learning from serious case reviews: A two year analysis of child protection database notifications 2007-2009*, cat. no. DFE-RR040, Department for Education, London, pp. 31-33.
55. Dearden, J. & Payne, J. 2009, 'Alcohol and homicide in Australia,' *Trends and Issues in Crime and Criminal Justice*, no. 372, Australian Institute of Criminology, Canberra.

however, is the finding from one study that victims whose death resulted from a physical altercation were more likely to have had alcohol and cannabis present in their system.[56]

- Many young people – again, both victims and offenders – had previously come to the attention of police for risk-taking, and violent or anti-social behaviour, highlighting the critical role of police in providing a coordinated interagency response to this cohort.
- Offenders frequently left school early, and before completing high school. The importance of this issue is emphasised by recent legislative change to expand the statutory grounds for reporting risk of significant harm to include educational neglect and cumulative harm, as well as a government initiative to raise the school-leaving age in the NSW.
- The link between child protection and subsequent offending in the lives of some young people was clearly highlighted, and that for most young people, reports of risk of harm did not elicit a comprehensive response. This was generally because of competing priorities, but also because of the challenges of effectively engaging young people. In this context, recent Australian research has noted that '*early intervention has largely focused on interventions "early in life" rather than "early in the pathway"*', and that maltreated adolescents need early intervention and support.[57]

Chapter 7 details the themes and issues arising from our reviews of child deaths.

56. Darke, S. & Duflou, J. 2008, 'Toxicology and circumstances of death of homicide victims in New South Wales, Australia 1996-2005', *Journal of Forensic Sciences*, vol. 53, no. 2, pp. 447-451.
57. Cashmore, J. 2011, 'The link between child maltreatment and adolescent offending: systems neglect of adolescents', *Family Matters,* no. 89, Australian Institute of Family Studies, pp. 31-41.

5. Neglect-related deaths of children

Between 1 January 2010 and 31 December 2011, 21 children in NSW died as a result of neglect (14), or in circumstances suspicious of neglect (7). The large majority of the children were very young; 17 were under four years of age.

In the nine years from 2003 to 2011, 144 children in NSW died in circumstances of neglect. This represents 2.6 percent of the 5,505 children who died in NSW over that period.

There is no standard definition of neglect. Generally, neglect is understood to be a failure by parents or carers to provide for the physical, psychological, medical and developmental needs of a child.[58] Definitions of neglect often incorporate more specific reference to carer responsibilities to adequately supervise, and to anticipate harm to a child. However, determining what constitutes adequate care or supervision, or to what degree carers should anticipate harm, is highly contested. These considerations are underpinned by, and subject to, a range of political, cultural and moral factors.[59] There are few standards to guide decisions about the adequacy of supervision, and the needs of children vary with age, developmental level and behaviour.[60] The concept of neglect is further complicated when considering families affected by poverty who, despite a desire to provide for their children, do not have the resources to do so.

Defining fatal neglect is equally complex. The definition used here focuses on those cases where the actions – or inactions – of the child's carer indicated a failure to provide for the child's basic needs, or represented a significantly careless act, or an intentional or reckless failure to adequately supervise the child. We also consider information relating to cause of death, and whether police consider the death to be suspicious.

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.

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.[61] 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.

5.1 The children who died in 2010 and 2011

Most of the 21 children who died were less than five years of age, and over a third of the children were infants less than one year old. Since 2003, close to 80 percent of children who died in neglect-related circumstances were aged under five. This reflects the vulnerability of very young children, and their strong reliance on carers to meet their basic needs and to keep them safe.

Table 21 shows the age and gender of children who died in neglect-related circumstances. The majority of the children (16) were male; five were female. While the association between gender and fatal neglect has been identified previously,[62] the over-representation of male children in 2010 and 2011 is not reflective of trends since 2003; overall, our work has identified a slight majority of males (52%) in neglect-related deaths.

Table 21: **Neglect related deaths of children 2010 and 2011 – age and gender**

	<1	1-4	5-9	10-14	15-17	Total
Male	5	8	1	1	1	**16**
Female	3	1	-	1	-	**5**
All	**8**	**9**	**1**	**2**	**1**	**21**

Over one-third of the children (8) who died in circumstances of neglect were identified as Aboriginal. This is slightly higher than in previous years, where on average, a quarter of children have identified as Indigenous. A range of factors have been identified as contributing to child abuse and neglect in relation to Aboriginal children, including the legacy of historical practices of forced removal of children, cultural differences in child-rearing practices, and entrenched social and economic disadvantage.[63]

Child protection history

In 2010 and 2011, 15 of the families of children who died in neglect-related circumstances had a child protection

58. Scott, D, Higgins, D & Franklin, R. 2012, 'The role of supervisory neglect in childhood injury', *CFCA Paper*, no. 8, Australian Institute of Family Studies, viewed 21 December 2012, <https://aifs.govspace.gov.au/2012/09/05/the-role-of-supervisory-neglect-in-childhood-injury/>.
59. Corby, B. 2007, *Child Abuse*, Open University Press, Maidenhead.
60. Alexander, R. 2007, *Child fatality review: an interdisciplinary guide and photographic reference*, GW Medical Publishing, St Louis, p. 182.
61. Liller, K. 2001, 'The importance of integrating approaches in child abuse/neglect and unintentional injury prevention efforts: implications for health educators', *International Electronic Journal of Health Education*, vol. 4, pp. 283-289.
62. Margolin, L. 1990, 'Fatal child neglect', *Child Welfare*, vol. 49, no. 4; Victorian Child Death Review Committee 2006, *Child death group analysis: effective responses to chronic neglect*, Office of the Child Safety Commissioner, Melbourne, p. 9.
63. Frances, K., Hutchins, T., Saggers, S. & Gray, D. 2008, *Group analysis of Aboriginal child death review: cases in which chronic neglect is present*, Western Australia Department for Communities, Perth; Berlyn, C. & Bromfield, L. 2010, *Child protection and Aboriginal and Torres Strait Islander children,* NCPC Resource Sheet, National Child Protection Clearinghouse, Melbourne.

history. While in some cases this history was extensive and indicated chronic neglect in the family, this was not always the case. In comparison with previous years, the proportion of children with a child protection history has remained stable in relation to fatal neglect.

5.2 Cause and circumstances of neglect-related deaths in 2010 and 2011

The children died as a result of drowning, in motor vehicle crashes, as a result of brain injury, from exposure to excessive heat or smoke, or were determined to be Sudden Unexpected Death in Infancy (SUDI) or sudden unexpected death of a child.[64] In almost all cases, parents were responsible for the care and supervision of the child at the time the child died. Eighteen of the 21 children were in the direct care of their parent(s) – in 10 cases both parents – and three children were being cared for by extended family.

As noted, we classify neglect-related deaths according to the context in which they occurred. In 2010 and 2011, the 21 deaths of children occurred in the context of:

- an intentional or reckless failure by the child's carer to adequately supervise the child, or
- a significantly careless act on the part of a carer, or
- a refusal or delay in providing medical care.

Significantly careless act

The majority of the children (14) died in the context of a significantly careless act on the part of a carer. This included seven cases where the cause of the child's death was undetermined by autopsy, or has yet to be determined, but there is evidence that the actions of the carer may have been 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.

Sleep related deaths

Nine of the 14 children died suddenly and unexpectedly in sleep environments that were unsafe. Almost all (8) of the children were aged less than 12 months and their deaths determined to be SUDI. One child was aged just over 12 months. Five infants died while co-sleeping with adults, and four were placed for sleep in inappropriate bedding and environments.

Most of the SUDI remained unexplained after investigation.[65] In those cases where a cause of death has been determined by a Coroner, the causes were Sudden Infant Death Syndrome (Category II)[66], and presumed suffocation.

In half of the 14 cases, the neglect classification was in part due to the carer(s) being, or suspected of being, affected by drugs and/or alcohol at the time the child died. This was indicated in all of the deaths of infants who were co-sleeping with carers.

In cases where infants were placed for sleep in inappropriate bedding, 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.

The CDRT has noted that the annual variability of the number and rate of SUDI has not been significant over the past 10 years. The Team found that in both 2010 and 2011, there was at least one modifiable risk factor present in almost all SUDI. The Team has made a number of recommendations to the Ministry of Health focused on improved responses to SUDI investigation and promotion of safe sleeping messages. The CDRT has also recommended that Community Services conduct a cohort review of SUDI where the infant's family had a child protection history, noting the high number of infants who dies suddenly and unexpectedly whose families were known to the agency.[67]

Physical injury

Five deaths that occurred in the context of a significantly careless act by a carer resulted in direct physical injury to the child. Two children died in motor vehicle crashes. One child drowned and two other deaths were caused by heat exposure and smoke inhalation.

Over the past nine years, a common scenario in reviews of deaths resulting from 'a significantly careless act' on the part of a carer has been the death of a child in a transport incident where protective devices were not used. This includes motor vehicle crashes where the child was not restrained, or not restrained appropriately; and incidents where the child was not equipped with a lifejacket in a boat on open water. Other cases include smoke alarms being disabled in circumstances where fire was a known possibility.

64. One child was just older than 12 months and was therefore not an infant. For the purposes of reporting, we have included this case in the discussion relating to SUDI.
65. Unexplained SUDI is where a cause is unable to be identified following investigation, including post mortem.
66. SIDS (Category II) is a classification of Sudden Infant Death Syndrome. The classification includes cases where the infant was premature, or where there have been similar deaths in a family, or where certain other factors cannot be ruled out, including overlaying.
67. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney, p. 72.

Responsible carers are required by law to provide a certain level of protection from harm, and some of these requirements have been recently upgraded. For example, new rules introduced in NSW in 2010 require children to be placed in age-graduated restraints in vehicles.[68] 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.[69]

The CDRT has noted the critical importance of promoting appropriate safety measures to parents and carers.[70]

Intentional or reckless failure to adequately supervise

Six children died in circumstances where there was an intentional or reckless failure on the part of a carer to adequately supervise the child. All six children drowned. A common scenario – both in this reporting period and over the nine years of reviewing neglect related deaths – is the drowning death of a very young child unsupervised for a relatively long period of time, *and* where carers were aware of defects in barrier fencing and the capacity of the child to access water. Notably, the CDRT has identified that the large majority of drowning deaths of children over a five year period (2007 to 2011) occurred in pools where there was a defect in pool barrier fencing, accompanied by a lack of adult supervision.[71]

In 2010 and 2011, 30 children drowned in NSW, 11 in private swimming pools.[72] In 2012, the NSW government announced legislative changes to address the safety of very young children around swimming pools. The changes focus on the implementation of a state-wide and compulsory pool registration program, and pool inspection programs run by local councils. The CDRT has proposed a range of measures to enhance the effectiveness of these changes.[73]

Refusal or delay in providing medical care

One child died as a result of a failure on the part of carers to provide adequate medical care and assistance. The child's death was in the context of long term concerns about a condition, and medical advice that if untreated, the condition could result in significant complications or death.

5.3 Family and carer characteristics and involvement with agencies

We considered whether the families of children who died had been involved with key agencies, particularly those with child protection responsibilities. This included Community Services and health services.

Family and carer characteristics

For five of the 21 families, agency records did not indicate concerns in relation to the care of the child or other children. These children died in what appear to be one-off incidents. For a sixth family, health service records stated that two reports about child protection concerns were made to Community Services, however, no reports were identified on Community Services' system.[74]

For the other fifteen families, the nature and extent of issues related to child neglect varied, but in all, there was some recorded concerns or issues often associated with neglect:

- Low income was an identified issue for at least half of the families. Employment and income status was known for ten of the families, and of these, eight were not employed and were in receipt of social security benefits. Three of these families were living in social housing, and three were caring for more than five children. Low income and unemployment, and larger families, are factors that have been associated with child neglect because of the fewer resources available to meet the basic needs of children.[75]
- Four families comprised young parents, and/or parents who had been the subject of child protection concerns themselves. Community Services has noted the vulnerability of young parent families, *'especially when the family is living with disadvantage; the young parents have experienced abuse, neglect and/or have left care; or there are poor family and professional support networks available.'*[76]
- For some families, reports made about risk to children and police contacts with the family indicated extremely poor physical environments. Homes were described as being in appalling or uninhabitable condition, and children as presenting poorly clothed and dirty, sometimes with inadequate food.

68. *Road Rules,* 2008, NSW.
69. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney.
70. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney.
71. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney, p.96
72. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney, p. 98 - 99
73. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney, p. 98.
74. We provided this advice to Community Services.
75. Connell-Carrick, K. 2003, 'A critical review of the empirical literature: identifying correlates of child neglect', *Child and Adolescent Social Work Journal*, vol. 20, no. 5, pp. 411 – 412.
76. NSW Department of Family and Community Services 2012, *Child deaths 2011 annual report: learning to improve services,* NSWDFCS, Sydney, p.8.

A common issue identified within the 15 families was carer substance abuse. Drug or alcohol misuse was a noted issue in 11 of the families. The degree of misuse ranged from regular or habitual cannabis use to poly drug use, and for some, substance abuse was a chronic and significant problem. Carers in five families were involved in, or had been involved in, opioid replacement therapy programs. Domestic and other violence was also a noted issue in most of these families. Concerns about the impact of substance use and violence on children formed a large part of relevant reports about children in these families.

Where previous concerns had been raised to, or noted by agencies, the most likely agency to have had contact with the family about concerns for children was Community Services.

Family involvement with Community Services

The families most likely to be known to Community Services were those where the child died in the context of a significantly careless act on the part of a carer, particularly sleep-related incidents.

Within three years prior to the child's death, 15 of the 21 families had been the subject of a risk of harm or risk of significant harm report to Community Services or a Child Wellbeing Unit. One of the families had been the subject of a report to a Child Wellbeing Unit only.

Twelve of the families had been the subject of a report to Community Services within the 12 months prior to the child's death, although one of these reports did not reach the risk of significant harm threshold. Two additional families had been the subject of a report to a Child Wellbeing Unit within the 12 months prior to the child's death. One of the 14 families received a face-to-face response to the concerns raised. The family was referred to and accepted by an early intervention service, and had an open and allocated case when the child died.

The issues of concern raised in reports included child neglect, such as sub-standard home environments, inadequate supervision, and families failing to engage with needed services. Reports for families commonly raised concerns about parental drug abuse and domestic violence.

Infrequent reporting

Seven of the families had been the subject of between one and four reports to Community Services and/or a Child Wellbeing Unit.

- One of the main reported issues for four of the families was parental drug and alcohol misuse. In two of these cases, additional identified child neglect issues included overcrowding in the home, inadequate food and inappropriate clothing for the weather. Two of the cases were closed by Community Services without a response because of 'current competing priorities'. One family was unable to be located for follow-up, and one case was closed at the Child Wellbeing Unit after checks were completed and the report was determined to not meet the risk of significant harm threshold.
- For one family, the primary reported issue was in relation to a lack of adequate supervision. Community Services received two reports in relation to the family in the 12 months prior to the child's death, one of these met the threshold for significant harm and the other did not. Community Services closed the case without assessment due to 'current competing priorities'.
- One family had been the subject of a report about the child being exposed to domestic violence. The report was closed by Community Services without a response because of 'current competing priorities'.
- Community Services received four reports in relation to one family; two prior to the child's birth and two following birth. The reported concerns included the young age of the mother in addition to parental mental health. One month prior to the child's death, a report was made to Community Services in relation to risk of physical harm, after the child was observed with bruising. Community Services phoned services that were involved with the family and closed the matter based on advice received.

Families with a more significant child protection history

Six of the families had been the subject of between five and 11 reports to Community Services and/or a Child Wellbeing Unit.

- For five families, the predominant reported issues of concerns were domestic violence and parental drug and/or alcohol misuse. For all five families, the last report received prior to the child's death was screened as not meeting the threshold of significant harm.
- One family was the subject of four risk of significant harm reports, as well as six additional reports that did not meet the threshold for significant harm. The identified issues included inadequate supervision, concerns relating to poor nutrition and hygiene and the children being at risk of physical harm. In response to the first of the four reports, Community Services assessed the family to be suitable for early intervention and the case was open and allocated with a caseworker at the time of the child's death.

Families with an extensive child protection history

Two of the families had extensive child protection histories, with multiple reports for the child and/or the child's sibling(s). Both families had been the subject of 20 or more reports. The histories for both of these families pre-dated the birth of the child that died and one family had previously had children removed from their care.

- In the first family, the child's parents had a significant history of illicit drug use which was reported to Community Services on numerous occasions.

Additional concerns identified in the family included inadequate supervision of the children, risk of psychological harm and medical treatment not being provided. The last report for the family was received by Community Services less than one month prior to the death of the child. The report was screened as meeting the risk of significant harm threshold but was closed by Community Services without a response due to 'current competing priorities'.

- In the second family, the child's parents also had a significant history of substance abuse. In addition to parental substance use, the primary reported issue for the child prior to their death was in relation to the carers not complying with medical treatment for the child. In the 18 months prior to the child's death, Community Services' received four risk of harm reports and one risk of significant harm report in relation to the family. In response to three of the four reports, Community Services completed follow up tasks in the form of phone calls to the family and service providers, but no face-to-face contact with the family occurred. All four reports were closed under 'current competing priorities'.

Family involvement with Early Intervention services

Three families were involved at some stage with early intervention services, either through Community Services or a non-government Brighter Futures agency. Services were withdrawn from two of the families; in one case because of limited progress and entrenched issues within the family, and in the other, because the family failed to participate in the voluntary program. One family was engaged with Brighter Futures at the time the child died, with active casework being provided.

Another three families were referred to Brighter Futures, but none of the three were accepted. One family were deemed not eligible one on the basis of a previous child protection history including removal of children from their care; one family was considered too young; and one case was closed due to the family being difficult to locate.

Family involvement with police

Seven families had some involvement with police, relating to offending behaviour. Five of these families had an extensive history, primarily for drug and/or alcohol related offences and domestic and other violence.

In four families, both parents were known to police because of chronic drug and alcohol problems. Two of these families had existing Apprehended Violence Orders in place at the time the child died. The parents of another two children were incarcerated at the time the child died.

Police reported child protection concerns to Community Services about seven children in the three years prior to their death, including four children from families that were known to police for offending behaviour. The reports related to domestic violence, substance abuse and child neglect.

Family involvement with health and other support services

Most families had episodic contact with health services, including public facilities such as hospitals and community health centres, and private general practitioners. In the main, this contact did not raise concerns about the welfare or wellbeing of children.

Apart from standard contacts, some of the families were also involved with services focused on children, and/or with specific responsibilities to identify child protection issues. These were primarily ante natal services, early childhood services, and drug and alcohol treatment services.

In two cases, health services identified and reported as a child protection concern a lack of willingness on the part of mothers to engage with antenatal or post natal support. In one case, the Child Wellbeing Unit referred the family to Brighter Futures. The family was determined to be ineligible for the service, because of their extensive child protection history, and no further action was taken.

Some of the families were involved with drug and alcohol services, including opioid replacement therapy, and drugs in pregnancy services. While a number of agencies did make risk or harm or risk of significant harm reports, in the main, agencies did not raise child protection concerns during their involvement with families.

Families with extensive child protection histories were most likely to be involved with a number of government and non-government agencies. This included schools, pre-schools, and child care centres. As identified in the previous section, our reviews indicated challenges to effective coordination between agencies.

Health services reported child protection concerns about six of the children who died within the three years prior to their death. In three cases, the issues related to parental drug use. Other reports referred to general concerns about the need for support in the family, or medical treatment for a child not being provided.

5.4 Themes and issues: neglect-related deaths of children

Chapter 7 details the themes and issues arising from our reviews of child deaths. Some of the notable issues for the families of children who died in neglect-related circumstances are:

- Where child protection reports relating to neglect reached the threshold of significant harm, they were often unable to be assessed due to more urgent demand for statutory intervention at the local level.
- While early intervention services were involved with, or considered to be a potential support for families, lack of engagement and /or ineligibility for the program were identified issues.
- The most commonly identified issue of concern in families where a child died in circumstances of fatal neglect was parental alcohol or drug misuse.
- Families were mostly involved with health services related to antenatal and early childhood services, and drug and alcohol treatment. These services in the main did not consistently identify child protection concerns.

6. Children who died while in care

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* has a broad definition of a 'child in care'. The definition includes children placed voluntarily in out-of-home care or disability accommodation services, children in supported relative or kinship care placements, and children who are the subject of a statutory care order.

Between January 2010 and December 2011, 29 children died in NSW while in care. Twenty-one of the children were in out-of-home care because of child protection issues, and eight of the children were placed in disability accommodation services.

Over the nine years from 2003, we have reviewed the deaths of 79 children in care. This represents 1.4 percent of all children who died in NSW over the same period, and 23 percent of all reviewable child deaths. Since 2003, the number of children in out-of-home care has increased by 78 percent from 10,059 children at 30 June 2003 to 17,896 children at 30 June 2011.[77, 78] This rise in the number of children living in care may in part explain the increase in the number of deaths of children in care in recent years.

Children in care are likely to have higher health and developmental needs than the general population. It is well recognised that many children enter out-of-home care with a physical, developmental, emotional or mental health issues, some of which may not have been previously identified or attended to. It is also known that children in out-of-home care have poorer health outcomes than other children. A NSW Health study based on an audit of over three thousand case files for children in out-of-home care found that over one third had health problems recorded, including medical conditions such as asthma, diabetes, epilepsy and severe allergies (13%); dental problems (38%); and mental health or behavioural problems (39%).[79] Mental health or behavioural problems were particularly concentrated in the 12-17 year age group.[80]

6.1 Children in care who died during 2010 and 2011

Age, gender and cultural background

Most of the children in care who died in 2010 and 2011 were either very young or were adolescents. The majority (16) were children under 10 years of age, and 11 were aged 15-17 years. As table 22 shows, this is consistent with the age distribution in previous years.

Two thirds of the children (20) were male. The proportion of deaths of male children in care since 2003 is higher than the proportion of male children in the NSW out-of-home care population. At 30 June 2011, 52 percent of the children in out-of-home care were male[81], whereas males account for 70 percent (55) of the deaths of children in care from 2003 to 2011.

Eight children were Aboriginal and one child was Aboriginal and Torres Strait Islander. This is consistent with the number of Indigenous children in care who have died since 2003 (22; 28%) and with the proportion of Aboriginal and Torres Strait Islander children in the NSW out-of-home care population (34%).[82]

Table 22: **Deaths of children in care by age and Indigenous status 2003 to 2011**

	<1	1-4	5-9	10-14	15-17	Total
ATSI	5	8	4	2	3	**22 (28%)**
Non - ATSI	11	9	7	11	19	**57 (72%)**
Total	**16**	**17**	**11**	**13**	**22**	**79 (100%)**

Two children in care who died in 2010-2011 were identified as being from a culturally and linguistically diverse background.

Child protection history

The majority (23) of the 29 children also had a child protection history within the three years prior to their death, including five children who were in voluntary care. For some children, the child protection history preceded, and was the reason for, their entry into care; however 12 of the 23 children were the subject of one or more child protection report while they were in care. In some cases, these reports concerned the child's behaviour and/or mental health problems, including drug and alcohol use, self-harm and risk taking behaviours. For other children, concerns that led to a report of risk of harm were varied, and included the behaviour of a natural parent who was in contact with the child; concerns about a carer's capacity to cope; and allegations of reportable conduct. In regard to the latter, allegations were managed by supervising agencies as required.

77. NSW Department of Community Services 2005, *Trends in the numbers of children and young people in out-of-home care in NSW*, NSWDCS, Sydney, p.13.
78. NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, p.46.
79. NSW Department of Health 2011, *Keep them safe 2009-2014: prevalence study on the health care of children in out-of-home care in NSW*, NSWDP, Sydney, p.10.
80. NSW Department of Health 2011, *Keep them safe 2009-2014: prevalence study on the health care of children in out-of-home care in NSW*, NSWDP, Sydney, p.11.
81. NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, p.79.
82. NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, p.48.

Parental responsibility and care status

The majority of children in out-of-home care are subject to a Children's Court order allocating parental responsibility to the Minister.[83]

Fifteen children in care who died in 2010 and 2011 were subject to final orders of the Children's Court:

- Parental responsibility for eleven children was allocated to the Minister for Community Services until 18 years of age.
- Parental responsibility for three children was shared between the Minister and a relative of the child until 18 years of age.
- One child was the subject of a short term (three year) care order allocating parental responsibility to the Minister.

Five children were subject to interim Children's Court orders, with care proceedings underway when the child died. Eight children were in voluntary care, and one child was subject to an order of the Family Court.

Where the children were living

Placement types in NSW

Around half of all children in out-of-home care in NSW live in relative/kinship care, and almost 40 percent in foster care. A small number of children are in residential care or other care arrangements, and some children are placed with their parents.

Families of children with a disability may arrange voluntary out-of home care, including disability respite services, through Ageing, Disability and Home Care or a registered voluntary out-of-home care agency. Since January 2012, the Children's Guardian has had a framework in place to monitor the provision of voluntary out-of-home care and agency compliance with voluntary out-of-home care procedures. In 2010-2011, more than two thousand children accessed voluntary out-of-home care. [84]

Children in out-of-home care placements provided or funded by Community Services

Most (19) of the children in care who died in 2010 and 2011 were residing in placements provided or funded by Community Services; most of these children were living in foster care provided by Community Services (5) or a non government organisation (4); or were living in relative/kinship care supported by Community Services (8), including five children who were placed with their grandparents. The other two children were being cared for in a shared care arrangement between the child's grandparents and foster care provided by a non government organisation, or by a non government residential service for children with complex needs.

Children placed in a disability accommodation services

Eight children were placed in, or were temporarily absent from, a disability accommodation service provided or funded by Ageing, Disability and Home Care.[85] Four children were living full-time in disability group homes. Two children who usually lived with their family died while in respite care and two children were living in alternate family care placements under the *Family Choices* program.[86]

The children placed in disability accommodation services were aged nine to 17 years; the majority (6) were 15 to 17 years of age. All of the children were in voluntary care. Two of the children died while in hospital.

Other placements arrangements

One infant died in hospital without ever being discharged following birth.

One young person was homeless, having left a semi-independent supported placement some months prior to death.

6.2 Causes of death

In 2010 and 2011, half (15) of the children in care died as a result of diseases or morbid conditions (natural causes). Eight children died as a result of external causes (injury) and four children died from ill-defined causes. In two cases, information was not available about cause of death.

Table 23 shows that for the nine year period from 2003 to 2011, the majority of deaths of children in care were due to natural causes. Many of these children had significant disabilities and related health issues.

83. NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, pp. 51, 53.
84. NSW Children's Guardian 2012, *Annual Report 2011-2012*, NSW Office of Communities, Sydney, p. 17.
85. The deaths of these eight children will also be included in the report of reviewable disability deaths.
86. The Family Choices program is funded by Ageing, Disability and Home Care and provides voluntary alternative family based care for children with disabilities who cannot be cared for in their own home. Placement options include foster, shared or relative care.

Table 23: **Broad cause of death - children in care - 2003-2011**[87]

Cause of death	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Natural	6	4	2	1	3	4	13	12	3	**48 (61%)**
External	1	4	1	1	2	-	3	3	5	**20 (25%)**
Ill-defined & unknown causes	1	-	1	2	1	-	-	3	1	**9 (11%)**
Information not available	-	-	-	-	-	-	-	1	1	**2 (3%)**
Total	**8**	**8**	**4**	**4**	**6**	**4**	**16**	**19**	**10**	**79 (100%)**

Natural cause deaths

Eleven of the 15 children who died in 2010 and 2011 as a result of natural causes had significant disabilities or congenital or degenerative disorders, including four children who had cerebral palsy. The children died as a result of the disorder or condition, or related health complications. Seven of these children were living in disability accommodation services when they died.

One child died as a result of cancer. Two children who had pre-existing medical conditions died suddenly and unexpectedly and one other child died following a sudden illness.

Deaths due to external (injury related) causes

Eight children in care died as a result of external causes. Six of the children were male and four were Aboriginal.

Seven of the children died from unintentional injuries, including drowning (3), poisoning (3), and a transport incident (1). One child committed suicide.

Five of the eight children were residing in foster or relative care placements and two children were in residential care. One child was homeless.

From 2003 to 2011, one quarter (20) of the deaths of children in care were due to external injury. The most common external cause of death for children in care, as shown in table 24 below, is suicide, followed by drowning, then poisoning and transport incidents. The majority (14) of the children in care who died from external injury were male and eight were Aboriginal.

Table 24: **External causes of death for children in care - 2003-2011**

Cause of death	Male	Female	Total
Suicide	4	2	**6**
Drowning	5	-	**5**
Poisoning	2	1	**3**
Transport	1	2	**3**
Assault	1	1	**2**
Other external cause	1	-	**1**

Drowning

The three children who drowned were all less than five years of age. Two drowned in swimming pools located at their carer's home. In both cases, the child gained access to the pool at a time when they were not directly supervised. Both pools were required by law to have child resistant barriers; however one pool had fencing that was found to be defective after the child's death, and the other had no barrier fence between the pool and the house. The agencies responsible for authorising and supervising each child's placement were aware that the pools existed; however, our reviews identified that neither pool had been inspected or approved by the local Council.

One child drowned in a dam on a rural property that neighboured the carer's home. The child was last seen playing in an outside area of the home that the carer thought was adequately fenced from neighbouring properties. The child managed to leave the property unnoticed.

Since these drowning deaths, Community Services has introduced measures to improve carer and frontline staff knowledge about pool and water safety. These measures include an updated Home Inspection Checklist, which now includes details of the requirements of the *Swimming Pools Act 1992*, discussions on water safety at Regional Foster Carer Advisory Group meetings, and publication of feature articles on water safety in carer and staff resources. The Connecting Carers NSW education package for carers on child safety and first aid has been updated to incorporate more detail on pool safety, including legislative requirements.

A non-government agency supervising the placement of one child who drowned has reviewed and improved caseworker training, updated tools for caseworkers to assess home safety and has implemented the Home Inspection Checklist as part of foster care assessments.

87. Ill-defined and unknown causes include Sudden Infant Death Syndrome (SIDS) and other sudden and unexpected deaths where the cause is unknown. The category includes open coronial cases where information on the cause of death was not available at the time of writing. The cause of death was not available for two children who died suddenly and unexpectedly in 2010-2011.

Medication safety

A child in foster care died as a result of poisoning after accessing and ingesting prescription medication without the carer's knowledge. The medication did not have a child resistant cap and was within the child's reach.

Our review considered issues relating to the safe storage of medications. The agency supervising the child's placement advised us that it had requirements about safe storage of medication, and that the medication was not out of reach on this occasion due to a series of unusual circumstances. Following the child's death, the agency revised its policies and procedures to better address the safe storage of medications.

We also looked at why the child's medication was not dispensed in a child resistant container. Although very toxic, the medication was not included on the Therapeutic Goods Order No. 80 *Child resistant packaging for medicines* (TGO 80), a Commonwealth Order that sets out requirements for the packaging of medicines that may present a significant risk of toxicity to children if accidentally ingested. We found that in 2010, a review by the Therapeutic Good Administration (TGA) had recommended the particular medication be added to the order. At the time of our review, the changes were still pending. In 2012, we made representations to the TGA and the relevant Commonwealth Minister about the lengthy delay in this process. In October 2012, the TGA advised that amendments to the Order have now been approved, extending requirements for child resistant packaging to an additional 30 substances, including the medication prescribed to this child.[88] The changes will take legal effect on 1 October 2013, following a transitional period.

Young people with complex needs

Young people in care often have complex needs in relation to their behaviour, development, emotional well-being and mental health. Some may present with extremely challenging and self-harming behaviours that may place them at serious risk. Typically, young people with complex needs require a range of coordinated services and intensive supports delivered by multiple agencies.

In 2010 and 2011, two young people in care died following accidental drug overdose. Both of the young people had entered care during adolescence and each had complex needs which placed them at high risk, including intellectual disability, substance abuse, and extremely challenging behaviour. Both young people had experienced ongoing placement instability and periods of transience. One young person had mental health issues and one young person had chronic offending behaviour. In each case, the young person had received extensive casework and was involved with support services, but with limited positive outcomes.

One young person committed suicide. The young person 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 Community Services 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 identifying that cooperation between relevant agencies could have been improved.[89]

Our reviews of young people in care who have complex needs have consistently identified the challenges for agencies working with adolescents who have complex needs, mental health problems and behaviours that place them at serious risk. We have noted in previous reports of reviewable child deaths the need for earlier intervention in the lives of young people in care, and for effective interagency coordination in this regard.[90]

SUDI and other sudden or unexpected deaths

In 2010 and 2011, four children in care died suddenly and unexpectedly in infancy (SUDI) after being placed for sleep. An additional child aged over 12 months also died suddenly and unexpectedly after being placed for sleep. Three of the children were placed in foster care and two were in relative/kinship care.

Three of the five children were born premature and two had been treated for symptoms of neonatal abstinence syndrome after their birth. One child also had additional health problems. SIDS is more common in babies exposed to opioids in pregnancy; and prematurity is also a known risk factor.[91] [92] Modifiable risk factors for SUDI were also present in the sleep environment for all five children, including non infant-specific bedding and loose or excessive bedding.

88. Australian Department of Health and Ageing 2012, *Therapeutic Goods Order 80A - Amendments to Therapeutic Goods Order No. 80 - Child-Resistant Packaging Requirements for Medicines*, ComLaw, Canberra.
89. At the time of writing, we had not received full information about action taken as a result of the reviews.
90. NSW Ombudsman 2007, *Report of reviewable deaths in 2006: volume 2: child deaths*, NSW Ombudsman Sydney, p. 30; NSW Ombudsman 2006, *Report of reviewable deaths in 2005: volume 2: child deaths*, NSW Ombudsman Sydney, p. 28.
91. Kuschel, C. 2007,'Managing drug withdrawal in the newborn infant', *Seminars in Fetal and Neonatal Medicine,* vol. 12, no. 2, pp.127-33.
92. Sullivan, F. & Barlow, S. 2001, 'Review of risk factors for Sudden Unexpected Death Syndrome', *Paediatric Perinatal Epidemiology*, vol. 15, no. 2, pp.144-200.

The cause of death for three infants has been attributed to SIDS or SIDS Category II.[93] For one child, the cause of death could not be determined and one case is still under investigation by the Coroner.

In relation to the death of one child, we asked Community Services about any policy changes or training implemented or planned as a result of the agency's internal review of the child's death. Community Services advised us that a revised home inspection checklist had been distributed to all Community Services staff that now includes information about unsafe sleeping practices and SIDS. Community Services staff are required to complete an assessment of the safety of any cot used by a foster carer, and to provide information to the foster carer about safe sleeping practices.

Community Services also advised us that Connecting Carers NSW has developed a component for their existing training package for carers called 'Special Babies' which includes information about safe sleeping practices to reduce the risk of SIDS.[94] Community Services has also published an article about safe sleeping in the agency carers newsletter and foster care guide.[95]

6.3 Themes and issues: deaths of children in care

Chapter 7 details the themes and issues arising from our reviews of child deaths. For children who died in care, our reviews identified:

- The significant challenges for agencies in engaging and responding effectively to children with complex needs, and the need for:
  - early assessment and intervention both before and following entry into care; and
  - effective coordination and collaboration between agencies working with these young people.
- In the context of the number of children who died as a result of preventable injury, the need for agencies to have robust policy and practice and education initiatives for staff and carers that enhance child safety in foster and relative/kinship care placements.
- In the context of infants coming into care with high needs, the need for effective education strategies that promote carer and caseworker knowledge and understanding about safe sleep practices for infants and modifiable risk factors for SUDI.

93. Sudden Infant Death Syndrome (SIDS) is the sudden unexpected death of an infant less than one year of age that remains unexplained after a thorough investigation. SIDS Category II is a classification of Sudden Infant Death Syndrome. The classification includes cases where the infant was premature, or where there have been similar deaths in a family, or where certain other factors cannot be ruled out, including overlaying.
94. Connecting Carers provides support, advocacy and training to carers across NSW.
95. Advice provided by Community Services, correspondence dated 15 February 2013.

7. Themes and issues: reviewable child deaths in 2010 and 2011

Most of the families of children whose deaths were reviewable had some previous contact with agencies providing health, education or community support, and/or with police. This chapter considers the issues and themes identified through our reviews in relation to the identification of, and response to, possible risk to a child.

7.1 Agency responsibilities

All government agencies have responsibilities for the welfare and wellbeing of children. Persons who are employed to deliver services wholly or partly to children in a range of areas – from education and health to legal and residential services – are mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998*. Since 2010 and the introduction of *Keep Them Safe*, NSW government agencies have also been given more direct responsibilities for the protection of children.

In considering agency involvement with families, it is important to note that there is no direct link between a family being 'known' to an agency and the death of a child. The majority of children who died in circumstances of abuse or neglect were from families who had contact with agencies because of problems that are child protection risk factors; a history of violence, drug and alcohol misuse or mental illness. However, it is important to acknowledge these issues exist in many families who access community and health services, and who have contact with police. For example:

- In 2011, NSW police responded to 26,808 domestic violence-related assaults.[96] Police are the highest reporting group to Community Services, and in 2010/11 made over 20,000 reports of risk of significant harm to Community Services. [97]
- In the same period, Community Services received 215,272 child and young person concern reports, of which 98,845 were determined to be risk of significant harm. Physical abuse, neglect, emotional abuse and domestic violence are the top four reported issues.[98]
- A recent federal government report estimated that almost 64,000 people aged 18 to 64 years have a psychotic illness and are in contact with public mental health services.[99]
- In NSW in 2008–09, government-funded alcohol and other drug treatment agencies and outlets provided 34,893 treatment episodes. The most common principal drug of concern was alcohol (17,476 episodes), followed by cannabis (6,316 episodes) and heroin (3,706 episodes). The median age of persons receiving treatment for their own drug use was 35 years.[100] In 2010, there were over 19,000 people in NSW receiving pharmacotherapy for opioid dependence.[101]

Many of the factors that may present a risk of harm to children – for example, domestic violence, drug misuse and mental illness – are not factors that predict death or serious injury. 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.*[102]

The following sections describe the main themes and issues arising from reviews in 2010 and 2011, and our consideration of peer homicides since 2002:

- Responding to risk of significant harm
- Assessing risk of significant harm
- Identifying and responding to children at risk: health and education
- Managing risk through early intervention
- Providing appropriate intervention and support for young people at risk, including young people engaging in risk taking and anti-social behaviour.

In considering the issues it is important to note the context of reform and rapid and continuing change in the child protection system.

7.2 Responding to risk of significant harm

Over the time that we have been reviewing the deaths of children, we have consistently raised concerns about reports of risk of harm being closed without further assessment due to lack of capacity within Community Services.[103] A key consideration in limiting Community

96. Goh, D. & Moffat, S. 2012, *NSW recorded crime statistics 2011*, NSW Bureau of Crime Statistics and Research, Sydney, p. 16.
97. NSW Family and Community Services 2012, *Annual statistical report 2010/11*, NSWDFCS, Sydney, p.31.
98. Ibid
99. Morgan, V. et al 2011, *People living with psychotic illness: report on the second Australian national survey*, National Mental Health Strategy, Commonwealth Government, Canberra.
100. Australian Institute of Health and Welfare 2011, *Alcohol and other drug treatment services in New South Wales 2008–09: findings from the National Minimum Data Set,* cat. no. HSE 97. AIHW, Canberra.
101. Australian Institute of Health and Welfare 2011, *National opioid pharmacotherapy statistics annual data collection: 2010 report,* cat. No. HSE 109, AIHW, Canberra, p. 11.
102. Brandon, M. et al. 2009, *Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005 – 2007*, University of East Anglia, Norwich, p. 118.
103. Prior to 2009, the Ombudsman was responsible for reviewing the deaths of all children or siblings of children who had been the subject of a report to Community Services within the three years prior to the child's death. See reports at http://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths-vol-1.

Services' responsibilities to risk of significant harm under *Keep Them Safe* was to enable the agency to respond promptly where there is immediate risk.[104]

The Community Services' Helpline makes an initial determination of whether a report of risk for a child meets the threshold of risk of significant harm. If it does, the Helpline refers the report to a Community Services Centre for assessment, along with a recommended response timeframe. Community Services Centres 'triage' reports, and may determine that on available information, reports about other children may present a higher likelihood of risk or harm. If resources are unable to meet demand, the report will not be allocated to a caseworker for assessment. After a period of time, and if resources do not become available, the report may be closed without further action.

A lack of capacity within Community Services to respond to children at risk of significant harm was evident in our reviews of children who died as a result of abuse or neglect in 2010 and 2011. Seventeen families were the subject of at least one risk of significant harm report to Community Services within the 12 month period prior to the child's death. Less than one-third of these families (5) received a face-to-face response from Community Services in that twelve month period.[105] For the other 12 families, the case was closed because of current competing priorities (9 families), because initial assessment by phone or through history searches indicated the risk was not significant (2 families); or because the family could not be located (1 family).

Families with no significant history

Some families who did not receive a child protection response were not well-known to Community Services; a number had been the subject of one or two reports. In these cases, it was not possible to judge the level of risk against prior history. On the basis of presenting information, Community Services identified a risk of significant harm and formed an initial view that a response was required. However, resources at the local level did not enable a child protection response.

Case study 3

Community Services received a report that a child's mother had hit her three year-old child, and had been disciplining her child in this way for some time. The report was the only report received about the family, and was considered by the Helpline to meet the threshold of risk of significant harm. Initial assessment noted concerns that '*the frequency of this form of discipline is unknown and may escalate without appropriate supports and possibly education.*' The report was transferred to a Community Services Centre for further assessment within 10 days. The CSC was not able to allocate the report for assessment, and the report was closed due to 'current competing priorities' two weeks later. The child died in circumstances of abuse some months later.

Case study 4

A child who died in neglect-related circumstances had been the subject of one previous report to Community Services. The report alleged chronic neglect and concerns about parental alcohol and other drug use. The report indicated living conditions for the family were 'disgusting', with dog faeces observed in a dining area, along with broken bottles and drug paraphernalia. The fridge had rotting food, and the bathtub was reported to be black and unfit to bathe children. The Helpline assessed the report as reaching the risk of significant harm threshold, and determined it required a response within 24 hours. The report was closed at the Community Services Centre due to current competing priorities.

Frequently reported families

Community Services did not have capacity to respond to a number of families where they had been the subject of frequent reports to the agency. In these cases, we found that risk at times was not assessed, or not assessed adequately because of competing priorities and gaps in casework:

Case study 5

A two-year old child died in circumstances of abuse. In the 18 months prior to the child's death, the family were the subject of 14 reports that met the threshold of risk of significant harm. Many of the reports, including those related to exposure to domestic violence and risk of physical harm, were closed due to 'current competing priorities'.

We investigated Community Services response to the family, and found the number of reports of risk of significant harm for the child and siblings that received little or no response was very concerning, and that *'insufficient numbers of well-trained staff at [the Community Services Centre] created the context in which the agency provided a limited response to concerns about the safety and wellbeing of these siblings'*. We also noted that at critical points, the agency did not review its own holdings about the family to inform cumulative risk assessment, the children were not interviewed, and concerns received from non-mandatory reporters were not clarified.

104. NSW Department of Premier and Cabinet 2009, *Keep Them safe*: *a shared approach to child wellbeing 2009 - 2014*, NSWDPC, Sydney, p. 11.
105. One of the four responses was provided by a child protection agency in another state.

In this case, Community Services' internal review also identified staff shortages, a high volume of court work in the Community Services Centre, limited caseworker experience, staff turnover and newly implemented assessment tools as impacting on the level of work conducted with this family.

As Community services has noted, a decision to close a case because of competing priorities '*does not mean the child is not at risk of significant harm. Rather, it means there are other cases where the reported risks are considered to be more serious.*'[106]

Community Services' internal reviews of five reviewable deaths identified that in all five cases, staff vacancies, staff leave, and inexperienced and untrained staff impacted on capacity and subsequently, the way each case was handled. In one case, the agency's internal review found that for one Community Services Centre, retention of staff had been an ongoing challenge, with vacancy rates as high as 50 percent across child protection teams. The review also identified staff inexperience as a factor; at the Community Services Centre in August 2011, only two full-time and one part-time caseworkers of around 20 establishment positions had completed the foundation skills program for new caseworkers, and two were skilled in interviewing children. Only five caseworkers had more than 12 months casework experience, not all of whom were available for fieldwork.

These issues have been consistently identified in our previous work. Our *Report of reviewable deaths in 2006*, for example, noted that resource issues, particularly related to staff vacancies, staff absences due to leave and training, and new and inexperienced or untrained staff, and had been consistently cited as the basis for the inability of the (then) Department of Community Services inability to respond to reports of risk of harm.[107]

In late 2011, this office released a special report to Parliament; *Keep Them Safe?.* The report outlined emerging concerns with the implementation of the new system, including Community Services' capacity to respond to reports of risk of significant harm. The report demonstrated that while there had been a substantial drop in the number of reports referred by the Community Services Helpline to Community Service Centres or Joint Investigation Response Teams, a substantial number of children reported as being at risk of significant harm were still not receiving a child protection response.[108]

As noted previously, 2010 and 2011 were the first two years of *Keep them Safe*. Reforms are also ongoing, and a number of initiatives are currently being rolled out that are targeted to improving the agency's capacity to respond effectively and fully to risk of significant harm. Specific strategies are detailed below. Of particular note, recent data provided to this office in response to our *Keep Them Safe?* report shows an increase in the number of face-to-face assessments; from 16 per cent of children reported in 2009/10 to 27 per cent of children reported in 2011/12.[109]

7.3 Assessing risk of significant harm

Linked in part to demand on resources, our reviews identified at times inadequate assessment for children reported as being at risk of harm and risk of significant harm. In some cases, our reviews identified shortcomings in assessing cumulative harm and gathering adequate information to make an informed assessment of risk, including the failure to interview children. Community Services has identified similar issues, and has noted that assessing cumulative and changing risk is one of the 'enduring challenges of child protection'.[110]

Case study 6

Community Services received ten risk of harm reports and one risk of significant harm report in relation to a child prior to their death in neglect-related circumstances. The child's siblings had an extensive child protection history, and identified risk issues for the family included domestic violence, parental substance abuse and risk of psychological harm. While various health professionals provided information to Community Services over a 12 month period that the child was at risk of significant harm if the child's specific needs were not addressed, no comprehensive assessment of risk was undertaken. Our investigation found that Community Services responded to risk of harm reports on an incident basis and there was little evidence of caseworkers adequately analysing the information they had, or considering this information against what they were told. We noted the need for the agency in such circumstances to focus on analysing the information already held, and identifying and gathering quality information that it needed.

106. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p. 38.
107. NSW Ombudsman 2007, *Report of reviewable deaths in 2006: volume 2: child deaths*, NSW Ombudsman Sydney, p. 49.
108. NSW Ombudsman 2011, *Keep them safe? A special report to Parliament under s31 of the Ombudsman Act 1974*. NSW Ombudsman, Sydney.
109. Advice received by the NSW Ombudsman from Department of Family and Community Services in response to *Keep Them Safe?,* December 2012.
110. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p. 40.

Coordinated responses

A system that relies on child protection being 'everybody's business' needs robust measures in place to ensure effective coordination in identifying children at risk, and providing effective joint responses to families. From our reviews, this was not always the case, and at times, poor information exchange and lack of coordination presented barriers to effective intervention with families.

Case study 7

A child died as a result of suspicious injuries. Three months prior, the child and siblings had been the subject of a report of risk of physical harm related to an injury, in addition to concerns that the children were malnourished and dehydrated.

The family had no significant child protection history. The Helpline determined that the report met the threshold for risk of significant harm, and forwarded the reports to different units for each child, for a response within 24 hours. One of the siblings was referred to a Joint Investigation Response Team for assessment.

We investigated the Team's response and found that there had been a number of breakdowns in communication between police and Community Services staff within the unit. We found that there was key information that had not been shared between the two agencies, and the nature and scope of the information that was provided was conflicting. The lack of information sharing resulted in some significant information not being considered in the sibling's risk assessment by Community Services, and subsequently this information was not available for consideration in determining the safety of the other children. Our investigation found that this case highlighted *'the importance of both agencies working in a seamless fashion to complement each others' work through sharing of appropriate information'*. Following our investigation, JIRT, Community Services and Police held an interagency review of the case. Community Services advised us that the JIRT partner agencies are working to improve policy and practice in this area.

Case study 8

An infant died in circumstances suspicious of neglect. In the two years prior to the child's death, the child and siblings had been reported to Community Services on numerous occasions. Issues identified in the reports related to chronic neglect, domestic violence and allegations of sexual harm.

The family had contact with police on a number of occasions prior to the child's death. Our investigation examined whether all relevant information obtained by police was reported to Community Services. We examined one occasion where police possessed pertinent information that was not provided to Community Services; and another occasion where police obtained information regarding a number of risk factors, but provided only partial information to Community Services. Our investigation determined that some of the issues with information exchange could be attributed to a new electronic process of reporting that was being utilised by police, while other issues were attributed to miscommunication between police and Community Services. Our investigation found that the case highlighted *'the importance of rigour when agencies exchange information in relation to serious child protection matters'*.

The need for effective and coordinated interagency intervention for vulnerable adolescents – particularly those with complex needs – was also highlighted in our review of peer-related homicides. We found little evidence of liaison between, and integrated support provided by, agencies to young people including those involved with multiple services due to their risk taking or challenging behaviour.

Community Services' 'enduring challenges'

Community Services has clearly outlined critical issues arising from child death reviews, including those above, and recurring themes in assessing risk.[111] The agency's *Child Deaths 2010* report articulates the *'enduring challenges'* of child protection, and the need for:

- Risk assessment to be informed and holistic rather than incident focused; to engage effectively with families while retaining a focus on the child; to balance safety and cultural sensitivity; and to prioritise professional supervision that *'promotes critical reflection on cases and supports every aspect of child protection work, including the capacity of staff to address the enduring challenges and predictable errors inherent in this work.'*
- Assessing cumulative harm, using new information to revise judgements and decisions, and to sight children: *'the unwavering truth about child protection is that children and young people need to be seen by caseworkers, and seen often.'*
- Working with intergenerational risk factors, and the importance of conducting a clear analysis of the underlying issues in families with complex histories of abuse and neglect.
- More, and more focused engagement with parents, caregivers and children during assessment and intervention, including those families who may be reluctant to engage. Male partners – including those who have become recently involved with families – and extended family members need to be considered in assessing risk.

111. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services*, NSWDFCS, Sydney, p. 38.

Our reviews and investigations have identified similar challenges. These issues are not new, and in the main have been well documented. The critical issue is how improvement strategies as outlined by Community Services are managed and implemented at the local level.

7.4 Measures to address responses to risk of significant harm

A range of strategies that build on *Keep Them Safe* are currently being implemented or are planned that target capacity and related issues within statutory child protection.

In progress reports in response to our *Keep Them Safe?* report and other reports[112], Family and Community Services has also advised that Community Services:

- Is trialling *Practice First*, a new model of child protection service delivery that prioritises *'direct work with families and relationship based practice, group supervision, reduced administration and strong interagency partnerships.'*
- Has completed the state-wide rollout of new *Safety and Risk Assessment* tools to streamline and structure assessment of child safety and risk. Community Services' casework practice procedures require that all subject children should be sighted and where the child is capable, interviewed.
- Is implementing a number of initiatives to monitor productivity and to provide support in managing caseloads. Performance measures have been developed to monitor regional performance; a caseload management tool is in development, and modelling is being undertaken to consider resourcing levels required by individual Community Services Centre, in the context of demand and operational characteristics for each Centre.
- Has initiated information management and technology projects to improve productivity, including immediate changes to the agency's data system, the Key Information Directory System. Proposed changes in the medium to longer term are focused on increasing information management capability, simplifying processes and improving ease of access to critical information.
- Is implementing a range of strategies to address educational neglect.
- Is considering approaches to young people with complex needs; and as part of this, has facilitated an Expert Panel Workshop to inform a framework for working with this group.
- Is developing strategies to improve child protection responses to Aboriginal children and families living in rural and remote communities.
- Is progressing consideration of 'intelligence driven child protection' through an interagency sub-committee of the *Keep Them Safe* Senior Officers Group.

Community Services has also advised that a new chapter of its annual Statistical report will provide a 'child-centric' view of child protection intervention data, including summary information on all children reported to Community Services at risk of significant harm and subsequent action or intervention. Greater clarity and transparency in Community Services' reporting on the capacity in Community Services have been key recommendations in our *Keep Them Safe?* report, and previous reports of reviewable child deaths. We have also emphasised the need to increase efficiency, coupled with a greater capacity to measure and drive productivity.

The NSW government is currently consulting on additional legislative reforms focused on strengthening parental capacity, accountability and outcomes for children in state care. Specific measures relevant to the issues identified above include proposals to strengthen the Parent Responsibility Contract scheme.[113] Proposed legislative reforms also provide for a greater focus on permanency for children in out-of-home care through open adoption or long term guardianship to relatives or kin.[114]

7.5 Identifying and responding to children at risk: health and education

Reviewable deaths of children in 2010 and 2011 raised specific issues about support for children of parents with mental illness, dealing with physical injury, recognising risk in an education context, responding to young people with complex needs, and effectively managing early intervention.

Parents with mental illness

We noted in chapter 3 that just over half the offenders in abuse-related deaths of children in 2010 and 2011 evidenced some level of mental health concern. Mental illness has been identified through court processes as a directly contributing factor in the fatal assault deaths of

112. NSW Ombudsman 2011, *Addressing Aboriginal disadvantage: the need to do things differently. A special report to Parliament under s31 of the Ombudsman Act 1974*, NSW Ombudsman, Sydney; NSW Ombudsman 2012 (unpublished review), *Investigation by the Ombudsman into NSW Community Services' conduct in responding to reports of habitual school non-attendance: final report*, NSW Ombudsman, Sydney.
113. Parent Responsibility Contracts are formal contracts between Community Services and parents that detail goals and actions for parents that will resolve identified child protection concerns.
114. Goward, P. 2012, *Discussion paper: child protection: legislative reform, legislative proposals*, NSW Minister for Family and Community Services, Sydney.

four children, and was a likely contributing factor in the death of a fifth child.

Between 2003 and 2011, we reviewed the deaths of 89 children in domestic homicides. Psychotic[115] or mental illness has been identified through criminal investigations and proceedings as a primary or contributing factor in one-fifth (18) of these deaths. In the large majority of cases, the offender was the child's parent or carer:

- Eight offenders were tried in court and found not guilty of murder by reason of mental illness.
- Seven offenders were found by the court to be impaired due to mental illness, and were subsequently convicted with a reduction in liability. Generally this meant a reduction to a conviction of manslaughter.
- Two offenders were found unfit to be tried in court, and were referred to the Mental Health Review Tribunal for assessment.
- At the time of writing, the death of one child is still subject to current criminal proceedings; however records indicate a history of diagnosed mental illness for the alleged offender.

The majority of offenders (14 of the 18) were diagnosed with a mental illness prior to committing the offence; with some offenders suffering from long-term and significant mental illness including schizophrenia, severe depression and bi-polar disorder. Five offenders had previously experienced auditory hallucinations and/or delusions.

In addition to mental illness identified through criminal investigation, another 19 children died in 12 murder-suicide incidents; all of which involved a biological or step parent. In at least four subsequent inquests, the Coroner identified undiagnosed or unmanaged mental illness. In three additional cases, the biological or step-parent had previously been diagnosed with a mental illness.

Abuse-related deaths in 2010 and 2011

In 2010 and 2011, three offenders had previously been diagnosed with a mental illness, including schizophrenic illnesses and post natal depression and associated concerns. All three had had recent contact with health services.

In one case, the offender's contact with mental health services in the year prior to the incident was episodic, against a background of long term chronic schizophrenic illness and substance abuse. In two cases, parents were involved with the health system in regard to mental health issues around the time the child died. One had a long term history of mental illness, including admissions to mental health facilities and Community Treatment Orders. For the other, illness was more recently diagnosed and contact with health services included a number of private and public practitioners and facilities.

In all three cases, NSW Health conducted a 'root cause analysis' or review. The NSW Patient Safety and Clinical Quality Program requires *'that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system'*. Serious incidents, including suspected homicide by a person who has received care or treatment for mental illness, undergo a root cause analysis.

Systemic issues identified in two reviews related to screening and assessment in the antenatal and post natal period, follow-up of missed psychiatric appointments, and exchange of information and coordination between services.

- For one mother, the review identified a failure to apply psychosocial and depression screening in either the antenatal or postnatal period. This meant that psychosocial risks, and the need to manage these risks in pregnancy, were not identified. This was seen to relate in part to a lack of transfer of information between private providers and public health, and also within the public health system. The review indicated the importance of identifying antecedents of postnatal depression in pregnancy, in order to mobilise support for pregnant women and families to reduce risk and plan for treatment and care.
- For one parent, failure to follow-up on a missed psychiatric appointment was identified as a contributory factor insofar as it was a missed opportunity to assess the parent's mental state shortly prior to the child's death. The review also identified a lack of communication between mental health services and other support services, resulting in patchy information being available about possible support needs. Review recommendations included an improved system for tracking appointments and prompt investigation of non-attendance, and timely case conferences involving early childhood services.

In the third case, the agency's root cause analysis found no root cause or contributory factor, no gaps in service delivery or no systems improvement opportunities. In this case, two months prior to the incident in which the child died, the parent presented to emergency indicating mental health issues. The man had a history of mental illness and chronic substance abuse, and advised treating staff he had recommenced using heroin and was under stress from relationship issues. His status as a parent was identified. The Emergency department undertook a mental health review that found no evidence of psychosis of risk of self harm or harm to others. Health staff identified the

115. Morgan, V. et al 2011, *People living with psychotic illness: report on the second Australian national survey*, National Mental Health Strategy, Commonwealth Government, Canberra. The report defines psychotic disorders as a 'diverse group of illnesses that have their origins in abnormal brain function and are characterised by fundamental distortions of thinking, perception and emotional response. These disorders include, among others, schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder. The most common of these is schizophrenia' (p.14).

primary issue as being substance abuse. The man was discharged after drug and alcohol counselling and no further follow-up occurred.

Current responses to parents with mental illness

Many people with psychotic illness are parents. As noted by the National Mental Health Strategy:

> *This is of considerable consequence from a service perspective, creating an imperative for services to identify the needs of these families and ensure that affected parents and their children are well supported.*[116]

In regard to capacity to provide care to dependent children, the National Mental Health Strategy identified that three quarters of parents interviewed for its survey were assessed as functioning very well, however 21.3% of mothers and 28.3% of fathers had an obvious or severe impairment in their ability to care for dependent children.[117]

NSW Health policy notes that:

> *The higher risk associated with having a mentally ill parent needs to be assessed through appropriate supports and ongoing evidence based assessment and monitoring of parenting capacity.*[118]

The NSW Health framework for responding to parents with mental illness includes:

- The *Safe Start guidelines: Improving mental health outcomes for parents and infants*, which relates to infancy and the provision of psychosocial assessment and depression screening for women expecting or caring for an infant, with 'integrated care pathways for vulnerable families identified through the universal assessment and depression screening process.'[119]
- The *NSW Children of parents with a mental illness (COPMI) framework for mental health services 2010 – 2015*. The framework has four strategic directions, including:
  - promoting the wellbeing of, and reducing the risks associated with, mental illness for children, parents/ carers and families;
  - identifying and providing responsive services for families where a parent has a mental illness;
  - strengthening capacity of interagency partners to recognise and respond to the needs of children of parents with mental illness; and
  - supporting the workforce to provide appropriate family focused interventions and care to parents with a mental illness and their children.

Local Health Districts are required to provide services consistent with these strategic directions.

While the policies described above underscore the importance of a focus on children and the identification of risks and need for family support, a significant issue identified through one root cause analysis process was *'the focus of care by the mental health service was on the mother as a mental health patient and that the interests of the child were not fully explored.'* In our reviews in 2010 and 2011, and also in previous years, it was apparent that mental health services were not always cognisant of the support needs of patients as parents, or of the possible impact of the parent's mental health concerns on children.

The 2012 *National Report Card on Mental Health and Suicide Prevention* notes that mental health promotion and prevention must be an essential focus for families at risk, proposing action to:

> *'increase enhanced and personalised support for parenting through culturally relevant forms of home-based visiting (ante-natal and in the first few years of life). These must be provided at a local or regional level. There must also be active follow-up where a family is under stress or experiencing tough financial or social difficulties'*[120].

This highlights the need for mental health services to understand and support the needs of patients and provide treatment within their parenting and family contexts.

116. Morgan, V. et al 2011, *People living with psychotic illness: report on the second Australian national survey*, National Mental Health Strategy, Commonwealth Government, Canberra, p. 101.
117. Morgan, V. et al 2011, *People living with psychotic illness: report on the second Australian national survey*, National Mental Health Strategy, Commonwealth Government, Canberra, p. 58.
118. NSW Health 2009, *Improving mental health outcomes for parents and infants: Safe Start guidelines*, NSWH, Sydney, p.4.
119. NSW Health 2010, *NSW Children of parents with a mental illness (COPMI) framework for mental health services 2010 – 2015*, NSWH, Sydney, p.14.
120. National Mental Health Commission 2012, *A contributing life: the 2012 national report card on mental health and suicide prevention*, NMHC, Sydney, p.12.

Recommendation 1:

The Ministry of Health

The Ministry of Health should consider the issues raised above, and provide advice regarding current or proposed strategies to:

- **Equip frontline staff in both mental health services and other health facilities, including emergency departments, with an understanding of potential risks to, and needs of, children of a parent with a mental illness.**
- **Ensure that a history of a patient's children and child caring responsibilities is identified and considered in psychiatric assessment or review.**
- **Promote and monitor adherence within Local Health Districts to the Children of Parents with Mental Illness (COPMI) and Safe Start guidelines and principles, particularly in relation to linking parents and families to appropriate supports and services.**
- **Apply and share lessons learnt from root cause analysis to inform practice and responses to parents with mental illness across NSW health facilities.**

Dealing with physical injury

In 2010 and 2011, three children who were fatally assaulted had been presented to NSW hospitals or private medical services for treatment of physical injury in the months or days prior to their death. The three children were aged six years or younger.

Two of the children were presented by their parents for treatment of a head or facial injury, and no concerns were identified by treating practitioners. A third child was presented to a local hospital following a direction from Community Services that the child required a medical examination.

Case study 9

Community Services presented a child and sibling to a local hospital by for a medical assessment. The medical assessment was requested by Community Services, following caseworkers sighting bruising on the children. The purpose of the assessment was to ascertain whether the cause of the injuries was consistent with explanations that had been provided by the children's carers. The assessment by medical staff concluded that there was no evidence to suggest that the injuries were 'deliberately inflicted'. On this basis, the report relating to physical harm was not substantiated by Community Services. The child died of deliberately inflicted head injuries two weeks later.

In another of these three cases, we asked the Local Health District if a root cause analysis had been conducted in relation to the response to the presenting head injury. We were advised that this had not happened because the injuries to the child matched the scenario provided at the time.

Since 2003, we have identified that ten other children who subsequently died in abuse-related circumstances were presented to a NSW public hospital in relation to relevant injuries within the months prior to their death. All of the children were aged six years or less; nine were under three years of ages, including three infants.

Three of these children were presented within one month, two within two months, three within six months and two within nine months of their death. On initial presentation, the children's injuries included multiple bruises, swelling, bleeding, petechiae and abrasions.

Hospital staff made reports of risk of harm or risk of significant harm to Community Services for six of the children, due to concerns regarding either the nature of the injuries sustained or the inconsistent explanation provided by the carer. Two additional children had open and allocated cases with Community Services at the time and hospital staff informed Community Services of the children's injuries.

In two of the six cases, medical opinions about the nature of the injuries were subsequently revised. In one case, medical staff revised their initial opinion and stated that the child's injury 'may have been consistent' with the carers' version of events. In another, an earlier opinion that the child's presenting symptoms were caused by 'suspicious non-accidental injuries' was revised to 'suspicious not conclusive'.

In a number of the cases where the child's hospital presentation and injuries were reported to Community Services, our reviews or investigations indicated a lack of effective interagency communication and liaison.

Health services deal with many presentations of children with a range of injuries. Even where there is some suspicion of physical abuse, formulation of forensic opinion can be difficult.[121] However, the importance of accurate assessment or identification of abusive injury when children are presented for treatment is a serious issue.[122]

In a prevention context, and noting the increased responsibility health services have under *Keep Them Safe*, valuable insight and learning could be gained from close review of cases where children who present with injury subsequently die in suspicious circumstances. This would complement existing processes across NSW Health relating to *Serious Severity Assessments Code* (SAC1)

121. Skellern, C. & Donald, S. 2011, 'Suspicious childhood injury: formulation of forensic opinion', *Journal of Paediatrics and Child Health,* vol. 47 pp. 771 – 775.
122. Chadwick, D., Castillo, E., Kuelbs, C., Cox, S. & Lindsay, S. 2010, 'Missed and missing cases of abusive injuries: the magnitude and the measurement of the problem, *Child Abuse & Neglect,* vol. 34, no. 12, p.943.

clinical incidents; all of which undergo root cause analysis to identify any contributing factors, gaps in service delivery and/or other systems improvement opportunities.[123]

Recommendation 2:

The Ministry of Health

Noting that processes will need to be put in place to advise the Ministry of Health and Local Health Districts of the suspicious death or injury of a child:

- **If a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility, the child's death should be the subject of internal review. The purpose of review would be to assess whether the interaction of the child and their family with the facility raises any systems issues that should inform future practice and service improvement at a local level and across the NSW health system.**
- **In addition, the Ministry of Health should consider whether this process of review could be applied to circumstances in which a child is seriously injured in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility.**

Identifying risk in an education context

As part of the *Keep Them Safe* reforms, the grounds for reporting risk of significant harm were expanded to include where parents or other caregivers *'have not arranged and are unable or unwilling to arrange for the child or young person to receive an education'* in accordance with the *Education Act 1990.*

In 2010 and 2011, three children who died in circumstances of abuse or neglect had a recorded history of chronic school absenteeism. In all three cases, absences warranted a referral to the Department of Education's Home School Liaison program.[124] Our reviews – and in two cases investigations – indicated that school absenteeism was present with other concerns relating to the child's welfare or wellbeing. Our investigations identified that education staff did not respond adequately to school absenteeism as a child protection concern.

Case Study 10

We investigated one case where a child was from a family well known to Community Services and, on turning school age, attended school for a short period only. The school appropriately maintained contact with the family and involved the Home School Liaison program to assist the child's return to school. However, while having some concerns about the child's welfare, no contact was made with the Education Child Wellbeing Unit to determine whether a child protection response was warranted. The Department of Education eventually referred the case for legal action because of the family's ongoing failure to have their child attend school. Our investigation found that a mandatory report was warranted at this point, but was not made. We noted: *'That no such report was made is particularly concerning and raises a question about the effectiveness of the implementation of KTS reforms within DET'.*

In response to our investigation findings, the Department of Education conducted an internal review of the case and introduced steps to strengthen the process or improving school attendance. Proposed strategies included work with schools to improve knowledge of *Keep Them Safe* and the role of the Child Wellbeing Unit, advice to Home School Liaison officers about the importance of sighting children where risk of harm is a potential issue, and explicit clarification of responsibility for making risk of significant harm reports.

Current responses to educational neglect

Over the past four years, this office's work in a number of areas has raised issues relating to agency responses to chronic school absenteeism. We have previously noted that children who experience significant interruptions to their schooling are not only being deprived of a fundamental right relating to their development, they also lose the social support network and structure that the school community can provide and are often exposed to other significant child protection risks.[125] [126] In 2010, legislative amendments were introduced to include habitual non-attendance as a risk circumstance to ensure that Community Services directed its attention to children identified as being at risk of significant harm because they were being deprived of education. In our 2011 *Keep Them Safe?* report, however, we noted that data subsequently received from Community Services indicated that almost half of all reports made to the Helpline about educational

123. NSW Health 2007, *Incident management: policy directive 2007_061*, NSW Health, Sydney, p.12.
124. The NSW Home School Liaison program provides support to schools by working with students of compulsory school age and their families when regular attendance is an issue.
125. NSW Ombudsman 2008, 'Part 4: mandatory reporting', *Submission to the Special Commission of Inquiry into Child Protection Services in NSW*, NSW Ombudsman, Sydney.
126. NSW Ombudsman 2011, *Keep them safe? A special report to Parliament under s31 of the Ombudsman Act 1974*. NSW Ombudsman, Sydney. This issue has also been the subject of further inquiry in relation to the Ombudsman's work in two towns in Western NSW (unpublished 2012).

neglect were assessed as not meeting the risk of significant harm threshold, and that less than 10 percent of educational neglect reports that are assessed as meeting the threshold result in a comprehensive face-to-face assessment.

We have continued to focus our attention on this issue in work conducted more broadly across our office.[127] This work has consistently highlighted the need for a strong interagency approach in a child protection context, and holistic assessment of children who have significant school attendance issues.[128]

In July 2012, in response to our report *Keep Them Safe?,* the Department of Premier and Cabinet advised that a number of strategies were under way to address responses to educational neglect, including:

- Work to develop an online resource to assist service providers to identify and respond to educational neglect. The resource will *'provide a multi-agency practice framework for responding to educational neglect and/or other child protection concerns that may have an impact on a child or young person's school attendance.'*
- The piloting of an early intervention program for students below the risk of significant harm threshold who may be at risk of educational neglect. The pilot will run for 12 months, and is based on a family case management model to assist families through appropriate referrals.
- An action research project '*Schoolzin: getting kids back to school'*. The project will consider risk of significant harm reports where educational neglect is an issue. The research will consider responses to these reports, while providing an augmented service where Community Services will assess the risk and safety of children, and convene interagency case planning as required.

In addition, a cross agency *Keep Them Safe* Senior Officers Group is currently working to develop systems for improved agency responses to educational neglect.

The report of our audit of the Interagency Plan relating to child sexual assault in Aboriginal communities will comprehensively discuss the issue of school attendance, particularly in the context of improving place-based service responses. An important strategy in this area will be the Department of Education and Communities' *Connected Communities strategy*.[129] The strategy proposes to make schools the hub of local service delivery, encouraging children and families to access the kinds of services they need in order to thrive, from birth, through school, to further training and employment.

7.6 Managing risk through early intervention

We reviewed the deaths of four children who died in circumstances of abuse or neglect who were involved with, or had recently been involved with, early intervention services through Brighter Futures or Community Services. Another four families were referred to early intervention services, but were not engaged with the program.

The broad aim of early intervention strategies is to *'influence children's, parents' or families' behaviours in order to reduce the risk or ameliorate the effect of, less than optimal social and physical environments'.*'[130]

Referral and interaction with child protection

Four families were considered to be candidates for early intervention services, and were referred to them, but the families either declined a service, or were deemed ineligible for one. In all cases, this meant that there was no further assessment or other action in relation to child protection concerns at that time. In one case, a referral to *Brighter Futures* following a serious incident of domestic violence was the only contact the family had with services around the child's welfare and wellbeing, however the family did not wish to be involved, and on this basis, the case was closed.

In one case we identified concerns about the gap created where early intervention was not a feasible option for a family because child protection concerns were too serious.

Case study 11

Concerns were raised by a service to a Child Wellbeing Unit about an unborn child. The child was to be born into a family with a number of young children. The family had previously been the subject of child protection concerns, and the parents had a history of substance abuse and were currently receiving opioid treatment therapy. The Child Wellbeing Unit and the reporting service agreed that a referral to Brighter Futures would be appropriate. In the meantime, the child's birth was reported to Community Services. Following liaison between the three parties, the Brighter Futures service indicated the family did not meet the eligibility criteria because of their extensive child protection history, including previous removal of children. Community Services also advised that it would be closing the case due to 'current competing priorities'.

The Child Wellbeing Unit did not advise the reporting service of these decisions and no further action was taken

127. For example, our report, NSW Ombudsman 2011, *Addressing Aboriginal disadvantage: the need to do things differently. A special report to Parliament under s31 of the Ombudsman Act 1974*, NSW Ombudsman, Sydney.
128. NSW Ombudsman 2012 (unpublished review), *Investigation by the Ombudsman into NSW Community Services' conduct in responding to reports of habitual school non-attendance: final report*, NSW Ombudsman, Sydney.
129. NSW Department of Education and Communities 2012, *Connected Communities – discussion paper*, NSEDEC, Sydney.
130. NSW Department of Community Services 2005, *Prevention and early intervention literature review,* NSWDCS, Sydney, p. 5.

in relation to the concerns that had been raised. The Child Wellbeing Unit advised us that a follow-up call to mandatory reporters is standard practice, and in this case, failure to do so was either oversight or a decision made on the basis that the family were engaged with services.

In our broader work in monitoring we have previously raised the issue of families being too high a risk for early intervention, but unable to be provided with a child protection response because of competing priorities.[131] Community Services has also noted a gap between early intervention and statutory intervention.[132]

Engagement of families

The voluntary nature of early intervention may result in families declining participation, or failing to engage effectively with the services. This was the case in some of the families of children who died in 2010 and 2011.

For three of the four families who did engage with early intervention, caseworkers encountered challenges in working work with the families to address the problems that could lead to statutory intervention. Early intervention services were withdrawn from two families – one after 18 months, and the other after six months – because of limited progress in addressing entrenched issues within the family, or failure to participate effectively in the program.

A key feature in another case was that the family was engaged with *Brighter Futures* due, in part, to a lack of capacity in child protection. The voluntary nature of the program was noted to present significant challenges for caseworkers attempting to engage with this family. Over a period of nine months, four risk of harm reports were received about the child. Brighter Futures determined that the case should remain with early intervention, with a referral to child protection should the family withdraw from the program. The family withdrew, but no referral was made.

Current responses to service gaps in early intervention

In response to the issue of the 'service gap' between early intervention and child protection, Community Services has introduced the *Strengthening Families* program, which provides for Community Services' early intervention teams to work with families with more complex needs in an early intervention context.

The NSW government has also proposed the introduction of stand-alone orders in the *Children and Young Persons (Care and Protection) Act* requiring a parent or primary caregiver to attend a parenting capacity program or other treatment or program. In an early intervention context, the intent of the orders is to enable appropriate intervention where risks within a family engaged in early intervention escalate.[133]

Proposed changes to parent responsibility contracts, described above, will include modifications to enable the use of these contracts in early intervention programs:

> *to address escalating risk where a parent/s has become disengaged in early intervention support and a child protection response is likely to be needed in the near future.*[134]

These measures have the potential to deliver a more seamless approach to responding to changing risk within families.

7.7 Appropriate support and intervention for young people

Our review of nine years of peer-related homicides and the deaths young people in care who had complex needs highlights two recurring themes:

- The need for targeted, timely and coordinated intervention and support for young people at risk, including young people engaging in risk-taking and anti-social behaviour.
- The importance of early intervention, both early in life and 'early in the pathway'.[135] Our reviews provide a clear illustration of young people – both victims and offenders – who had child protection histories early in their lives, and/or whose behaviour indicated their psycho-social needs were not being met as adolescents.

These themes are not new. This office's work has highlighted concerns about the adequacy of service provision to vulnerable older children and young people, including young people in care, over a number of years:

- Annual reports of reviewable child deaths have previously identified the need for models of casework practice within a child protection context that effectively meet the needs of adolescents at risk, including adolescents with mental health issues.[136]

131. NSW Ombudsman 2008, 'Part 6: assessment and early intervention / prevention', *Submission to the Special Commission of Inquiry into child protection services in NSW*, NSW Ombudsman, Sydney, p 14; NSW Ombudsman 2009, *Special report to Parliament: the death of Dean Shillingsworth – critical challenges in the context of reforms to the child protection system,* NSW Ombudsman, Sydney.
132. Goward, P. 2012, *Discussion paper: child protection: legislative reform, legislative proposals*, NSW Minister for Family and Community Services, Sydney, p. 9.
133. Goward, P. 2012, *Discussion paper: child protection: legislative reform, legislative proposals*, NSW Minister for Family and Community Services, Sydney, p. 12.
134. Goward, P. 2012, *Discussion paper: child protection: legislative reform, legislative proposals*, NSW Minister for Family and Community Services, Sydney, p. 15.
135. Cashmore, J. 2011, 'The link between child maltreatment and adolescent offending, systems neglect of adolescents', *Family Matters*, no. 89, Australian Institute of Family Studies.
136. NSW Ombudsman 2007, *Report of reviewable deaths in 2006: volume 2: child deaths*, NSW Ombudsman, Sydney, p. 30.

- Our 2011 report, *Addressing Aboriginal disadvantage: the need to do things differently*, raised issues about older children and young people who were at risk engaging in offending behaviours and becoming caught up in the criminal justice system. In particular, we noted that a consequence of failing to address the needs of older children and young adolescents can be high levels of offending.
- Work undertaken by this office in relation to Aboriginal children has noted that children who frequently engage in risky, anti-social behaviour are generally regarded by police as children at risk. As children get older and their patterns of offending behaviour escalate, incidents of risk-taking behaviour are more likely to be regarded as criminal offences. The shift from a child protection to a criminal justice focus is explained by police as partly attributable to the '*failure or inability of the child protection system to curb escalating patterns …behaviour can also influence decisions on whether to charge…*'[137]
- Our *Keep Them Safe?* report outlined the inadequacy of service provision for vulnerable older children and young people. The report identified the need for urgent debate about how agencies might provide a more effective and coordinated child protection response to high risk older children and young people.
- Our 2012 discussion paper *Service provision challenges in responding to very vulnerable older children and young people* illustrated the policy and service provision challenges in providing an effective and timely child protection response to vulnerable older children and young people, particularly those with extremely complex needs.[138]

In 2008, and in the context of the Special Commission of Inquiry into Child Protection Services in NSW, Justice James Wood raised concerns about the services available to very vulnerable adolescents.[139] At that time, Justice Wood described gaps in services to assist and accommodate young people who were at risk of significant harm.

Current responses to young people at risk

There is a broad acknowledgement across agencies of the pressing need to improve responses to adolescents at high risk, and several initiatives have been put in place that indicate a commitment to doing so. Since the tabling of our *Keep Them Safe? report:*[140]

- During 2012, Community Services led a review of Family and Community Services' policies and programs for highly vulnerable adolescents *'to identify reforms that will better support these young people.'*[141] As part of this, Community Services facilitated an Expert Panel Workshop to consider how service systems and supports for at risk older children and young people and their families can be strengthened and improved. This process and its outcomes, along with this office's discussion paper (noted above), and our other work relating to school aged children, will be key inputs into the development of FACS' approach to vulnerable adolescents.[142]
- Community Services are implementing a Child Protection Adolescent Response across all regions that aims to improve child protection responses to adolescents aged 12 to 17 years who are at risk of significant harm.
- The non-government sector will receive $10 million early intervention funding per year to trial innovative services for nine to 15 year old children and young people who are reported to Community Services as being at risk of significant harm.

7.8 Children in care

Our reviews of children in foster or relative/kinship who died due to injury or were SUDI have identified critical issues about agency assessment, training and support to carers around swimming pool safety, safe storage of medication, and safe sleep practices for infants.

In relation to swimming pools and water safety, agencies need to have in place procedures and practices that ensure pools on carer properties meet the requirements of the *Swimming Pool Act 1992,* and that carers understand their responsibilities to maintain an effective pool barrier. As detailed in chapter 6, Community Services has put in place new training initiatives and resources to this end.

Education strategies that promote carer and caseworker knowledge and understanding about safe sleep practices for infants are particularly important in the context of the increased risk of SIDS or SUDI for infants in care who were born premature or with neonatal abstinence syndrome.

The NSW Child Death Review Team has also recommended that Community Services conduct a cohort review of SUDI where the family had a child protection history. The purpose of the review – to develop targeted strategies and training resources to assist caseworkers to assess risk for infants and to provide casework services to at-risk families – will also be of benefit to foster, relative and kinship carers.

137. NSW Ombudsman 2012 (unpublished), *Review of a group of school-aged children from Bourke and Brewarrina: towards an intelligence-driven approach to child protection practice,* NSW Ombudsman, Sydney.
138. NSW Ombudsman 2012 (unpublished), *Discussion paper: service provision challenges in responding to very vulnerable older children and young people,* NSW Ombudsman, Sydney.
139. Wood, J. 2008, 'Oversight agencies', *Wood Inquiry Forum, Transcript of proceedings*, Sydney, p. 33.
140. NSW Ombudsman 2011, *Keep them safe? A special report to Parliament under s31 of the Ombudsman Act 1974.* NSW Ombudsman, Sydney.
141. NSW Department of Family and Community Services 2011, *Child deaths 2010 annual report: learning to improve services,* NSWDFCS, Sydney, p.63.
142. Advice received by the NSW Ombudsman from Department of Family and Community Services, November 2012.

8. Monitoring recommendations

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* requires that the biennial report of reviewable deaths contain information about the implementation (or otherwise) of previous recommendations.

The period of time covered in our previous *Report of reviewable deaths in 2008 and 2009, volume 1 child deaths* (published August 2011) pre-dated the commencement of *Keep Them Safe*, and in the context of rapid and far-reaching change for all agencies in relation to the protection of children, we made no recommendations. We did, however, provide this report to all agencies that have child protection responsibilities. We also sought specific feedback from relevant agencies on key issues raised, including:

- Capacity and service improvement through *Keep Them Safe*, in particular:
  - Capacity to undertake comprehensive assessment of risk to children, either through Community Services or agencies with child protection responsibilities.
  - Enhancement of the role of early intervention services and community support services for vulnerable families, particularly in relation to neglect.
  - Support for young mothers, particularly those who are homeless or in marginal housing.
  - Support for high needs adolescents living in care, particularly in relation to mental health concerns.
- Developments in swimming pool safety measures, particularly consideration of Coronial and Child Death Review Team recommendations.

Previous chapters of this report provide some detail about agency actions that go to these issues.

The following sections provide in full detail the additional information provided to us by the Department of Family and Community Services (Community Services and Housing NSW) and the Ministry of Health.[143] We sought information in addition to that already provided to our office, as reflected in the contents of this current report.

Information relating to developments in swimming pool safety has been drawn from information previously provided to the CDRT.

8.1 Child protection services

Community Services

Community Services provided the following overview of current reforms in child protection:

Table 25: **Children and young people receiving a selected child protection related service or assessment, NSW**

Service or assessment received	2010/11	2011/12
Entered or in OOHC	20,887	21,248
Intensive Family Support/ Preservation or Short Term Court Orders	..	747
Strengthening Families	..	2,881
Brighter Futures	14,057	13,120
Face-to-face child protection assessment (SARA/SAS2) completed	12,702	16,409
Total children and young people receiving a service/ assessment	**42,716**	**47,148**

Notes:

1. '..' not applicable (programs were not operational in 2010/11).
2. Children and young people are counted against each type of service or assessment received at any time during 2011/12 – therefore the rows do not add to the total. The "total" row is a unique count of children and young people.

Source: Unpublished Annual Statistical Report 2011-12.

Community Services is currently engaged in a series of reforms designed to achieve better outcomes for children, young people and families in NSW. The reforms promote shared responsibility for children's wellbeing and protection, and a coordinated and collaborative government and non-government system working together to ensure all children receive the best possible opportunities in life. *Keep Them Safe* is a key aspect of this work.

Chapter 4 of Family and Community Services' Child Deaths 2011 Annual Report summarises key aspects of the reform program which relate to the learning from child death reviews. Previous responses provided to the Ombudsman in relation to various reports, inquiries and reviews undertaken during the period also comment on the reform program. In that context [*the additional information below*] focuses on additional information relevant to the four areas of practice noted by the Ombudsman.

143. Housing NSW also provided detail on services at area and local level that has not been included above.

8.2 Comprehensive assessment of risk

Community Services

Community Services provided the following information:

Community Services' capacity to undertake comprehensive assessments for children has been enhanced through the introduction of Structured Decision Making (SDM).

SDM has been progressively introduced into Community Services from 2010 as part of the *Keep Them Safe* reforms. The SDM system aims to improve capacity to respond to child protection reports while enhancing the consistency of child protection assessments.

The SDM system consists of a set of assessment tools that guide each critical decision in the life of a child protection case. The SDM system is designed to ensure that every caseworker is assessing the same items in each case and that responses to these items lead to specific decisions. Professional judgement is augmented by the SDM assessments, which are customised for use in each jurisdiction to reflect local conditions and legislative parameters. In addition to achieving consistency in decision making, SDM helps to improve the targeting of resources to families who are most in need.

The following SDM tools have been introduced in NSW to assist the agency to make key decisions about child protection assessments:

- The *Mandatory Reporter Guide (MRG),* introduced in January 2010, helps mandatory reporters make decisions about whether to report their child protection concerns to the Child Protection Helpline. The MRG is used widely by mandatory reporters such as police officers, teachers, nurses, social workers and other government and non-government workers. The United States based Children's Research Centre (CRC) conducted case readings during March to May 2012 on the use of the MRG by mandatory reporters in the Health, Education, Police and Family & Community Services Child Wellbeing Units (CWUs). In summary, the correct decision was reached in 78% of cases read by CRC. CRC is providing support and expertise to these four CWUs to improve the use of the MRG and to strengthen fidelity. The MRG contributes to efficiency at the Helpline by minimising the number of reports it must process that do not result in meeting the threshold of risk of significant harm. The process to refine the MRG is ongoing in working towards a shared understanding among mandatory reporters of what should be reported and what should not.
- The Child Protection Helpline introduced the SDM screening and response priority tools in January 2010. Caseworkers use the Screening Assessment to determine if a report meets the risk of significant harm threshold and should be investigated. If the report meets the risk of significant harm threshold, the Response Priority Assessment helps caseworkers to determine how quickly Community Services should respond. The use of SDM at the Helpline ensures that Community Services is dealing with reports that require a statutory child protection response.
- The SDM safety and risk assessments were gradually implemented by caseworkers in Community Services Centres and Joint Investigative Response Teams during 2011, with full implementation achieved by October 2011. Caseworkers use the Safety Assessment at the time of the first contact to determine whether there are any immediate indicators of significant harm to a child and to consider in a structured way what interventions should be put in place to provide immediate protection. There were 16,409 children and young people who were the subject of a ROSH report and received a face-to-face child protection assessment (Safety and Risk Assessment or Secondary Assessment Stage 2 - SARA/SAS2) during 2011/12, a substantial increase from the previous year.
- The Risk Assessment is used by caseworkers to classify families into low, moderate, high and very high risk groups to determine the likelihood of future abuse or neglect to a child. The SDM Risk Assessment is an actuarial tool, which is based on research of abuse and neglect cases and the relationship between family characteristics and outcomes of confirmed abuse and neglect.
- The Risk Assessment items highly correlate with higher risk of future abuse and neglect. By completing the Risk Assessment, the caseworker obtains an objective appraisal of the likelihood that a family will mistreat their child in the next 12 to 18 months. When risk level is clearly established, agency resources can be targeted to higher risk families because of the greater potential to reduce subsequent ill-treatment. This information is used by caseworkers to guide their decisions about whether cases should be opened for ongoing services or not.
- For open cases that are receiving continuing services, the SDM Risk Reassessment is used periodically to assess any changes to the family's risk level in order to guide caseworkers' decisions about whether the case can be closed or if services should continue.
- The SDM assessments are now a vital part of the NSW child protection system.

Practice First

Practice First was developed in late 2011 and a decision was made to trial it at Bathurst/Mudgee CSC starting 5 March 2012. Following strong early indicators of a positive change in the culture and the skills of that workforce and in the ways of working with families, a commitment was given to extend the trial of the *Practice First* model across

all regions into 14 additional CSCs and one regional Adolescent Team[144].

The focus of *Practice First* is to impact on the practice culture across the spectrum of work with families – assessment, intervention and collaboration with partner agencies. The model has been crafted to be a pragmatic fit with the current resourcing, legislative and policy framework in NSW. Principles of practice guide the model – they are evidenced based, reflect contemporary research about what works in child protection and provide a solid framework for improved outcomes.

There are three essential components of *Practice First* that set it apart from child protection practices that have become the norm:

- **Culture**: a child protection culture founded on principles of practice rather than one that seeks compliance with tools and adherence to structure.
- **People**: casework is delivered by teams, not individuals. Skill development is ongoing and requires practitioners to have insight into the impact of their own practice on families, and to strengthen their skills in working with families to change. It relies on clear role definition and positions practice leadership as the most important aspect of management.
- **Systems**: built on a clear mandate giving legitimacy to family work, freeing casework time from administration, and sharing risk and decision making across teams.

There are early indications from Bathurst and Mudgee CSCs about the positive impact of *Practice First.* For example, between March 2012 and January 2013 there has been a:

- 15% decrease in staff sick leave at Bathurst and Mudgee CSCs
- 26% increase in direct client contact at Mudgee CSC
- 182% increase in direct client contact at Bathurst CSC
- 47% decrease in entries into care at Mudgee CSC
- 60% decrease into entries into care at Bathurst CSC.

The 15 other sites commenced trialling *Practice First* on 3 December 2012. The initial anecdotal feedback from these sites has been very positive.

Professor Eileen Munro from the London School of Economics and Political Science will undertake a review of the implementation of *Practice First* in April 2013. Her review will focus on early results, both qualitative and quantitative, and providing advice about the potential for further roll out.

Practice Framework

The *Care and Protection Practice Framework* (the *Framework*) is the first of its kind in New South Wales and was designed by members of the Community Services' Practitioner Advisory Group which is made up of a broad range of Community Services' staff from all regions as well as Head Office.

The Framework provides a clear mandate for respectful family work and recognises that relationship based casework is the key to quality child protection service provision. It also outlines the values and principles that underlie our approach to working with children and families and describes specific skills and knowledge that are fundamental to achieving the agency purpose of '*Improving children's lives every day.*'

The Framework was launched by Maree Walk, Chief Executive Community Services, on 5 December 2012.

Ministry of Health

The Ministry of Health provided the following information:

The capacity of all NSW Health and its workers to identify and assess risk to children and young people, and to provide an appropriate service response has been enhanced through the following KTS initiatives:

NSW Health Child Wellbeing Units

- To advise, support and educate NSW Health workers to help them assess and determine the level of suspected risk to a child or young person, including whether matters should be reported to the Child Protection Helpline.
- Do risk appraisals as required based on cumulative factors.
- To provide advice to workers about possible responses by their service or other services to assist vulnerable children, young people and families.
- Over time, drive better alignment and coordination of agency service systems.
- Operating since January 2010 in Dubbo (Western NSW LHD), Wallsend (Hunter New England LHD) and Sydney Children's Hospital Network.
- Provide a state-wide service for NSW Health mandatory reporters.
- 4,200 preliminary risk appraisals of reported child protection concerns in 2011 (out of a total of 7832 inbound communications from Health staff).
- Nous Review, Aug 2011 – CWUs have successfully established an alternate reporting pathway for child protection concerns.

144. Clarence Valley CSC, Coffs Harbour CSC, Ulladulla CSC, Batemans Bay CSC, Bathurst/Mudgee CSC, Albury/Deniliquin CSC, Sutherland CSC, Eastern Sydney CSC, Ingleburn CSC, Liverpool CSC, Muswellbrook CSC Gosford CSC, Penrith CSC, Hawkesbury CSC and Met West Child Protection Adolescent Unit.

- A further evaluation of CWUs is currently being developed.
- The Ministry of Health shares the concerns of KTS partner agencies about the issue of ROSH unallocated cases. The Ministry is participating in interagency discussions with Community Services and other Keep Them Safe partner agencies on this issue and on the Ombudsman's recommendations about intelligence driven child protection.
- Local Health Districts are participating in Community Services' led interagency case discussions in relation to ROSH unallocated cases.

Mandatory reporter guide (MRG)

This guide was developed to assist front-line mandatory reporters such as health workers and non-government agency staff to determine whether a case meets the new risk of significant harm threshold for reporting children and young people at risk in NSW and to prevent too many calls that do not meet this threshold going through to the Helpline.

A Mandatory Reporter's Workforce Survey has been conducted which will provide NSW Health with information on the uptake of the MRG and Chapter 16A by NSW Health MR.

Promotional Material is currently being developed to refresh NSW Health and Aboriginal Support Services Workers on their child protection responsibilities and where to find the MRG.

Chapter 16A Information sharing

Chapter 16A allows government agencies and non-government agencies who are prescribed bodies to exchange information that relates to a child's or young person's safety, or wellbeing, whether or not the child or young person consents to the information exchange.

NSW Health has been consulting on the issue of broadening the definition of 'prescribed bodies' under Chapter 16A to include GPs and other Private Health Professionals.

Child Wellbeing and Child Protection – NSW Interagency Guidelines (Mandatory reporter guide)

- Promote best practice service delivery to vulnerable children, young people, and families
- Support collaborative practice and are applicable to both government and non-government agencies.
- NSW Health draft Frontline Policies and Procedures for Child Protection and Wellbeing incorporating the KTS changes and providing cross-references to the interagency guidelines are currently being finalised.

NSW Health Child Wellbeing Coordinators

- Each Local Health District has access to a Child Wellbeing Coordinator to support health staff with their responsibilities in relation to the safety, welfare or wellbeing of children and young people and to link staff to appropriate services
- Provide local advice on mandatory reporter responsibilities and the Health CWUs.
- Coordinate improved responses to children and young people where concerns are raised by mandatory reporters via the CWU.
- Assess the referral pathways to appropriate services for children, young people and families in the Local Health Districts.
- Child Wellbeing Coordinators also provide information on resources such as the details of Information Exchange Consultants in Local Health Districts, Justice Health and the NSW Ambulance Service.

Assessment of broad service needs for vulnerable children and young people below the ROSH threshold and their families has been enhanced through the establishment of Family Referral Services.

Family Referral Services

- FRS are funded under KTS.
- Assessment and referral to local services for vulnerable families whose children are below the risk of significant harm (ROSH) child protection reporting threshold.
- State-wide rollout expected to be completed by June 2013 (Current Request for Tender HAC 12/63 will complete this process).
- A Pilot Evaluation report has been completed.
- The next phase of evaluation of FRS is currently being developed.
- NSW Health is contract manager for these non-government operated services.

Health assessment of families expecting or caring for an infant has been enhanced through the staged implementation of the SAFE START program as referenced in the *KTS Action Plan*. This initiative involves psychosocial assessment and depression screening in all public hospitals and community based child and family health services.

Safe Start

- The aim of assessing women/families during the antenatal and postnatal periods is to identify and provide care to those parents and their infants who are most at risk of adverse physical, social and mental health outcomes. Infants are very sensitive to the emotional states of their caregivers. Parenting style, the quality of attachment relationships and family context during the first few years of life have long lasting effects on neurobiological and socio-emotional development.

- Health workers are guided to determine the level of care needed by a family considering both risk and protective factors.
- There are three levels of care: Level 1 – no specific vulnerabilities detected. Universal services sufficient. Level 2 – factors that may impact on ability to parent requiring ongoing early intervention and prevention services and active follow up are indicated. Level 3 – complex risk factors including; mental illness, drug and alcohol misuse, domestic violence, current/history of child protection. Coordinated team management and review by needs specific services as indicated.
- Under the NSW Health Supporting Families Early SAFE START strategic policy all LHDs are required to provide comprehensive psychosocial assessment and depression screening during pregnancy, and in the first 12 months after birth through their maternity and early childhood health services and to provide appropriate levels of care according to vulnerabilities identified. See the policy at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html.
- Additional funding was provided through Families NSW for child and family health nursing positions. From 2009-10 eight new positions were funded through Families NSW Mental Health to provide strategic coordination across SAFE START processes for families identified as needing coordinated case management and support for multiple and complex issues.
- More than 3,000 NSW Health employees have successfully completed the SAFE START online training program since release in 2010-11. An online training package targeting the Mental Health and Drug & Alcohol Workforce will soon be released.
- The Ministry of Health (MHKids, Mental Health, Drug and Alcohol Office) has engaged ARTD Consultants for an evaluation of perinatal depression screening (i.e. SAFE START). The evaluation is due to conclude June 2013.
- Infancy is a crucial developmental phase with implications for later health, mental health, social, relational and employment functioning. Providing infants with opportunities for healthy development is a key strategy in building resilience and reducing health, mental health and social problems across the life span.

Complex health assessments for families with mental health and drug and alcohol problems requiring tertiary intervention have been enhanced through the implementation of Whole Family Teams (WFT).

Whole Family Teams

- KTS-WFTs provide specialist comprehensive assessments of families where parental or carer mental health and/or drug and alcohol problems co-exist with child protection concerns.
- Case management of these complex needs families involves a six-month, intensive therapeutic intervention, to ensure that clients are treated in a way that recognises the whole family problem.
- WFT are funded under KTS.
- Whole Family Teams are established in: Lismore - Northern New South Wales LHD, Newcastle - Hunter New England LHD, Gosford - Central Coast LHD and Nowra – Illawarra Shoalhaven LHD.
- An independent 4 year evaluation is underway and incorporates a mix of qualitative and quantitative measures to determine the effectiveness of interventions and outcomes for families. An economic analysis has been factored into the evaluation.
- A range of outcome data is collected with the recent addition of the North Carolina Family Assessment Scale (NCFAS). The NCFAS is a family-focussed assessment tool administered by a family's case worker which will enable a comprehensive assessment of family functioning and includes a specific domain on child wellbeing.

8.3 Enhancement of early intervention and community support services for vulnerable families

Community Services

Community Services provided the following information:

Pre-natal reports

In late 2011, the Minister for Family and Community Services, the Hon Pru Goward, advised that Community Services had implemented its *Responding to Prenatal Reports Policy* and related procedures across the state in response to recommendations made in previous reviewable death reports.[145] In addition to providing guidance about how staff should respond, the policy identifies strategies to support and assist vulnerable pregnant women, including liaising with NSW Health, in order to maximise the success of preventative and early intervention support to reduce the risk of harm to the child when born.

145. NSW Ombudsman 2006, 'Recommendation 19', *Report of reviewable deaths in 2005: volume 2: child deaths,* NSW Ombudsman, Sydney; NSW Ombudsman 2007, 'Recommendation 30', *Report of reviewable deaths in 2006: volume 2: child deaths,* NSW Ombudsman, Sydney; Advice received by the NSW Ombudsman from Minister Goward, Department of Family and Community Services, October 2011.

Programs and initiatives

Community Services introduced new programs in 2012 that fall within the Early Intervention and Placement Prevention spectrum. Specific details of each of the programs are provided below:

- The Strengthening Families program targets families where a report meeting the Risk of Significant Harm threshold has been received concerning an unborn child or a child under nine years of age and where certain vulnerabilities are present. The vulnerabilities relate to parenting capacity and would therefore contribute to any neglect. It is expected that, with a safety plan in place, families will remain in the program for an average of 12 months. Support is provided by Community Services' Caseworkers or through purchased services and may include quality child care, structured home visiting, parenting programs and casework focused on parent vulnerabilities. There were 2,881 children and young people whose families were receiving Strengthening Families services during 2011/12.
- The Intensive Family Support (IFS) and Intensive Family Preservation (IFP) programs target families whose children or young people up to the age of 15 years, are at risk, or at imminent risk, of removal. Intensive casework is provided to address the immediate situation and includes on-call support 24 hours a day, seven days a week for an initial period of 12 weeks. Following this, the family receives up to 40 weeks of continuous, multi-faceted and individually tailored assistance consistent with their needs. The support services include intensive in-home crisis intervention, practical assistance, counselling, skill development and referral to other specialist services. IFS and IFP services are provided and generally case managed by contracted NGOs. There were 747 children and young people whose families received Intensive Family Support or Preservation Services or were involved in the Short Term Court Orders pilot program during 2011/12.
- The pilot Innovative Early Intervention Service Programs project for 9-15 year olds is currently undergoing the final phase of a tender process. The agencies who are successful in the tender process will assume responsibility for working with 9-15 year olds who are at risk of entering Out of Home Care (OOHC). Five districts have been chosen for the pilot; Metro West; Metro South West; Hunter / Central Coast; Northern; and Western. The client group for this tender is; children and young people aged 9 - 15 years who are reported to Community Services as at ROSH but who are not prioritised to receive a Community Services statutory response (this will be at least 90% of the client cohort); children and young people aged 9 - 15 years who are not currently the subject of a ROSH report but are at high risk of escalation into the child protection system; and families of the children and young people aged 9 - 15 years outlined above, including siblings aged under 16 years. The central expected outcomes of service provision are for children to be safer in the family home so they can grow up in a stable and supportive environment. The pilot also aims to reduce offending behaviour, increase school attendances, and improve the child or young person's mental health. These piloted programs will be evaluated 18 months after the commencement of service against a range of measurable indicators.
- The Project Air Strategy for Young People with Complex Needs and High-Risk Challenging Behaviours includes those in care as well as other young people with high needs.
- The Adolescents with Complex Needs State-wide Panel (ACNSP) operated between June 2011 and June 2012. ACNSP was established as a part of the complex case management process implemented by Family and Community Services (FACS) to improve service delivery to all FACS clients with complex needs. It aimed to provide an integrated high level response to adolescents (aged 12-18 years) with complex needs who have not been able to have their needs met at local and regional levels. ACNSP sought to build the capacity of government agencies and the non-government sector to support young people with multiple and complex needs. This incorporated workforce development, development of clinical practice guidelines and referral and access pathways and provision of services to key stakeholders. It also included facilitating transitions from child to adult services and educational and employment opportunities as well as promoting active and meaningful community participation for young people. In the first nine months of operation, 10 young people were reviewed by the panel. Most have experienced early exposure to DV, substance abuse in utero, parental mental health problems or all of these. All had harmed themselves in the past and most were at current risk of self harm. The Panel has successfully reviewed each of the cases and provided expert input and advice to the referrers. It has applied brokerage funding to support additional services, drawn on services not usually provided to the client group and drawn on the agency representatives to better enable service provision within their agency. Community Services is developing a Framework for a Co-ordinated Approach for Complex Clients. ACNSP will reconvene aligning with the draft framework and new FACS districts.
- Ageing, Disability and Home Care (ADHC) has entered into an agreement with the University of Wollongong to work with the agencies/representatives of the ACNSP to provide: service model development and guidelines (for young people with complex needs and high risk challenging behaviours); capacity building through training; case consultation and supervision; and report on project outcomes and recommendations to further build operational capacity. A steering committee has been established and is chaired by the Acting Executive Director, State-wide Services, Community Services.

- Sherwood House is a Community Services' therapeutic secure residential program. The approved capacity of Sherwood House is six young people at any given time. Sherwood Cottage, the community based residential program, currently has capacity for three young people. Overall, 11 young people are residing in, or have completed the program at Sherwood House. In 2011, an external review of Sherwood House was undertaken and an implementation plan was developed to address the key recommendations arising from the review. This reform will assist to support the care needs of young people in care with high and complex needs.
- The Vulnerable Teen Review is a FACS wide review concerning vulnerable teenagers. The steering committee consists of FACS Strategic Policy, Community Services, Housing NSW, ADHC and four non-government peak agencies. The Review aims to achieve better outcomes for young people in care. A report about responding to vulnerable teenagers is currently being drafted. The report will be submitted shortly for Ministerial consideration.

Ministry of Health

The Ministry of Health provided the following information:

The availability of early intervention services has been expanded under KTS through its Getting on Track in Time (Got It!) program.

Got It!

- Got It! is a new primary school-based mental health early intervention service being implemented by NSW Health (Child and Adolescent Mental Health Services) in partnership with the Department of Education and Communities (DEC), which provides a combination of universal and early intervention specialist clinical services for vulnerable children and families who may otherwise never access support.
- It is a multi level program delivered in schools over two consecutive terms. Screening and assessment is completed in the first term and specific interventions are provided in the second term.
- The program aims to reduce the frequency and prevent the development of severe behaviour problems such as conduct disorder in children at selected schools from Kindergarten to Grade 2. It also aims to improve schools capacity to respond to children with conduct disorders.
- It is operating in three pilot districts of Mount Druitt, Newcastle and Dubbo and is rolling out into new schools each term.
- NSW Health has provided KTS funding to support teacher release to implement the programs for the remaining three years to 2014 of the pilot so that classroom teachers can be involved in the management and planning of the parent and student sessions.
- Implementation is supported by the state-wide coordinator for Got It! And an implementation committee with representation from NSW Health and DEC at regional and State levels.
- All pilot sites, Dubbo, Mt Druitt and Newcastle, are now fully operational and working collaboratively with local staff from Department of Education and Communities (DEC) to deliver the program in schools.
- A detailed, evidence based model of care guides implementation and outlines nine mental health promotion, primary prevention and secondary prevention intervention components, including; universal screening, professional development for teachers, targeted interventions for children and parents.
- A two-year evaluation commenced in June 2012 which will examine the effectiveness of the program in terms of outcomes for children, parents and teachers, level of implementation and cost-benefits of the program.
- Providing mental health services, information and support to both education staff and parents in a school setting which is familiar and neutral, helps overcome some of the barriers that can discourage vulnerable families from seeking help, such as; stigma, accessibility and availability of suitable local services.
- Got It! builds the confidence and capacity of parents and teachers to respond to a child's challenging behaviour while strengthening their relationship with the child and providing a consistent response across school and home settings.
- Early reports have been extremely positive and the program has had high acceptability with schools and parents alike.
- The Mt Druitt site has created a short film to promote and encourage participation. It showcases real, positive, first-hand experiences of the program, including interviews with parents, teachers and a school principal.
- One of the strengths underpinning the success of the program to date is the strong partnership between NSW Health and DEC both at state-wide and local levels.

The role of early intervention services has been substantially enhanced through the Sustaining NSW Families, Sustained Health Home Visiting program.

Sustaining NSW Families – a NSW Health sustained health home visiting program

- Sustaining NSW Families (SNF) is an integrated, high-intensity sustained health home visiting service that strengthens relationships between children, parents, and/or carers; builds parenting capacity; and enhances child development, wellbeing, and health in vulnerable families. All families provided with the Program are significantly socially and economically disadvantaged and face a number of risk factors which may impede effective parenting.

- The program ideally commences in early pregnancy and continues until the child's second birthday. The program seeks to support strong family relationships, optimal child development and wellbeing, and meeting parents' aspirations for themselves and their child. Structured positive parenting interventions are provided regularly in the home by specially trained child and family health nurses supported by a range of other disciplines.
- Three Sustaining NSW Families programs were established in 2009–10 in the Fairfield/Liverpool, Cessnock/Kurri Kurri/Maitland, and Wyong Local Government Areas.
- From March 2011, two further sites commenced: a rural site in the Northern NSW Local Health District servicing Kyogle, Lismore, and Richmond Valley Local Government Areas; and in the South Eastern Sydney Local Health District at Arncliffe with includes bilingual nursing staff who work with vulnerable Arabic and Chinese families who would normally require an interpreter. Families in Arncliffe who meet eligibility criteria but who speak English are also offered the program.
- Aboriginal families are accessing the program, and the Northern NSW program has a particular focus on seeking to engage with rural Aboriginal families and as such participation of Aboriginal families will increase over time.
- An evaluation of the Sustaining NSW Families program will seek to refine the model for SNF and describe the population that will benefit most from sustained health home visiting programs in the context of the NSW health system.

Housing NSW

Housing NSW provided the following information:

The National Partnership Agreement on Homelessness funds a number of initiatives that focus on providing housing assistance and support to people who are homeless or at risk, including women and their children escaping domestic violence, and young people. For example, the *Young Aboriginal Parents Project* provides appropriate long-term accommodation and support in Dubbo to young Aboriginal parents, and supports young parents to maintain existing tenancies.

In addition, there are a number of specialist non-government homelessness services that specifically focus on families, including single parent families and pregnant teenagers.

In July 2012, the *Going Home Staying Home* reform program was announced, which aims to improve access for homeless people to appropriate housing and support. The program is currently being developed in consultation with the homelessness service sector.

8.4 Support for young mothers, particularly those who are homeless or in marginal housing

Housing NSW

Housing NSW provided the following information:

Housing NSW has two roles in the provision of housing assistance and support for young single mothers:

- the direct provision of housing assistance services and products; and
- as lead agency for homelessness in NSW, oversighting the NSW Homelessness Action Plan and National Partnership Agreement on Homelessness (NPAH).

In 2010-2011, Housing NSW:

- Newly housed 370 young single mothers in public or Aboriginal housing properties;
- Provided 958 young single mothers with assistance via Rentstart – as either bond loans, assistance with rental arrears or advance rent – and 36 young single mothers with private rental subsidies;
- Secured temporary accommodation for 677 young single mothers facing homelessness.

Community Services

Community Services provided the following information:

Community Services is working closely with Housing NSW to enhance coordination of support and target services to the most vulnerable members of the community.

Families NSW is the NSW Government's population based prevention and early intervention strategy for families expecting a baby or with children aged 0 to 8. The whole-of-government strategy is implemented through service models that are focused on supporting parents to be confident, connected to their community and its services and equipped to support their children's development.

To achieve its key objectives and ultimately outcomes for all children, Families NSW regions fund organisations and agencies to deliver a range of prevention and early intervention initiatives in order to support children's development and influence lifelong health and wellbeing outcomes.

Service delivery aims to incorporate strategies to engage the most vulnerable children and families through soft entry points. Families NSW service models include supported playgroups, family worker projects, and parenting skills development and education programs.

Families NSW is provided jointly by FACS, the Ministry of Health and the Department of Education and Communities together with local government and community organisations.

Ministry of Health

The Ministry of Health provided the following information:

The Sustaining NSW Families, Sustained Health Home Visiting program includes support for young mothers who meet the eligibility criteria for this program.

Support for Aboriginal families expecting or caring for an infant has been enhanced through the state-wide implementation under KTS of the NSW Aboriginal Maternal and Infant Health Strategy (AMIHS).

Aboriginal Maternal and Infant Health Strategy

- Aims to improve the health of Aboriginal women during pregnancy and reduce mortality rates for Aboriginal babies.
- The services includes antenatal and postnatal care, education about the effects of smoking, drugs and alcohol during pregnancy and the benefits of breastfeeding, home visits and transport of appointments.
- A direct referral pathway has been established from AMIHS into Brighter Futures.
- From 2011/12, there was an enhancement of the AMIHS service delivery model in the form of 28 new positions recruited across NSW: 10 mental health clinicians, 10 drug and alcohol clinicians and 8 Aboriginal trainees. These positions have been funded under the Closing the Gap Indigenous Early Childhood Development National Partnership Agreement Element 2 (antenatal care component) to provide prevention and early intervention for AMIHS families where there is a risk of or current drug and alcohol and/or mental health issues. These workers are collocated with AMIHS teams across 9 LHDs.
- The AMIHS service model supports young mothers to understand the importance of their own health on their baby during pregnancy and postnatal. It does this by linking these young mothers to services that will improve their health and wellbeing.
- AMIHS was evaluated in 2005. The evaluation showed that AMIHS was improving maternity services and outcomes for Aboriginal women and that Aboriginal women trusted and supported the service provided. The evaluation also showed that AMIHS had achieved the following outcomes for Aboriginal mothers and babies:
  - increased proportion of women who attended their first antenatal visit before 20 weeks gestation,
  - decreased rate of low birth weight babies (13% versus 12% after the Service) although the difference is not statistically significant,
  - decreased proportion of preterm births,
  - decrease in perinatal mortality from 1996–2000 (20.4 per 1000 births) compared to 2001–2003 (14.4 per 1000 births) in Local Government Areas where AMIHS was located. The difference is not statistically significant owing to small numbers, and
  - improved breastfeeding rates from 67% initiating breastfeeding and 59% still breastfeeding at 6 weeks in 2003, to 70% initiating breastfeeding and 62% still breastfeeding at 6 weeks in 2004.

8.5 Support for high needs adolescents living in care, particularly in relation to mental health concerns

The Ministry of Health

The Ministry of Health provided the following information:

One aspect of improving support for high needs adolescents has been the introduction under KTS of coordinated primary and/or comprehensive multi-disciplinary health screening, assessments, reviews and interventions for all children and young people entering Out Of Home Care in NSW. This is being facilitated through the state-wide implementation of the Health Screening, Assessment, Review and Intervention for Children and Young People in OOHC Program.

Health Screening, Assessment, Review and Intervention for Children and Young People in OOHC Program

- A Memorandum of Understanding between Department of Family and Community Services, Community Services division and NSW Health supports the facilitation of the Health Screening, Assessment, Intervention and Review for children and young people in statutory Out-of-Home Care. A model pathway has been developed to articulate the journey of the child or young person who has entered OOHC, through the process of health assessment, intervention and reviews. The Pathway promotes close collaboration between NSW Health, Community Services, and OOHC service providers. The role of health professionals, other government agencies, non-government agencies and carers is also articulated and the flow of information exchange is mapped.
- This Program aims to support the early identification of health, development and wellbeing needs, and ensure access to timely health interventions for children and young people in statutory OOHC. The development and communication of a health management plan outlining required health interventions is a key outcome of this process.

- The program is an outcome of the Justice Wood Special Commission of Inquiry into Child Protection in NSW and funded under KTS to address the health needs of children and young people in statutory OOHC Health Pathway
- Local Health Districts are responsible for coordinating health screening and assessment, reviews and the development of the Health Management Plan.
- The assessments should be commenced within the first 30 days of a child entering OOHC. This timeframe is critical to their success.
- The timeframe for conducting these assessments is monitored through LHDs performance indicators.
- The Program is being implemented in phases with the first phase being all children and young people entering statutory out of home care and who are expected to remain in care for 90 days or more. NSW Health continues to work closely with Community Services, Non Government Agencies and other stakeholders to identify the next phases of implementation.

OOHC Coordinators also support high needs adolescents as they are responsible for:

- Local implementation of health assessments to children and young people entering statutory OOHC and facilitating access to primary and comprehensive health assessments, interventions and reviews. OOHC Co-ordinators have been appointed in all Local Health Districts across NSW
- Under KTS funding, Health OOHC Coordinators, Community Services Interagency Pathway Coordinators, and OOHC Education Coordinator positions have been established to support health assessments for children and young people in OOHC. This is particularly important for children and young people with complex health development and wellbeing issues
- OOHC Coordinators work together with Community Services Interagency Pathway Coordinators to support timely provision and coordination of primary and comprehensive health and developmental screening, assessment, intervention and review for children and young people entering OOHC.
- These positions have been critical to the change management process underway regionally, to ensure Community Service's Regions and Local Health Districts continue to maintain the capacity to deliver the Pathway.

Community Services

Community Services provided the following information:

Community Services offers specialised psychological services and supports to assist our caseworkers to case manage adolescents with mental health concerns.

Psychological services:

- Community Services psychologists operate within and across Community Service Centres as professional practitioners offering specialised assistance to caseworker staff. The types of problems that psychologists address are typically complex and often require individually tailored solutions. Psychologists may undertake specialised assessment of Community Services clients, and may deliver brief, evidence based therapeutic interventions. They may also provide clinical advice and offer consultation and liaison, and training. Through their use of reliable and valid psychometric assessment instruments and in drawing on the best available scientific evidence, psychologists make significant contributions to casework planning and practice.
- The Psychological Services Intensive Clinical Services team (ICS), part of Specialist Psychological Services, is a small team that provides clinical services to clients with complex needs. It has also developed experience in providing psychological services to Regional Psychology Teams, to other service streams within Community Services and across Agencies. The ICS team complements the Regional Psychological Teams. It works directly with Metro ISS to support Metro ISS Casework staff and clients, and supports other operational activities that require specialised psychological input. Psychologists working with ISS clients have a specific role in developing behaviour plans and providing interventions for children and young people with high needs. Children and young people are described as having high needs when they display challenging and/or risk taking behaviours of such intensity, frequency or duration that they place themselves or others at risk, for example risk of illness/injury/death due to high level alcohol and other substance use; self harming behaviour or suicide; or may involve causing harm or injury towards others through aggression or assault.
- Two Community Services Psychologists are also seconded to work at the Alternate Care Clinic (ACC), Redbank House, Western Sydney LHD. The ACC is a joint program between Community Services and NSW Health which provides therapeutic services for children and young people in long term OOHC with high levels of complex needs. It provides flexible and comprehensive interventions with open time frames and seeks to co-ordinate and support services involved with the client to ensure the highest possible standard of care. It works within a systemic, attachment based framework. There are currently 90 children who are active clients of the clinic. Anecdotal evidence indicates that significant presenting problems such as placement breakdown, emergency department admission and school suspensions/expulsion are stabilised during the children and young people's involvement with the ACC. A small but significant part of the clinic's work also involves very high engagement with residential care

for 6-18 year olds with non-acute but significant mental health and trauma related problems (an area not well covered by other services). The clinic provides clinical case management and psychiatric review.

- The ACC has also developed a nine session fortnightly reparative parenting program for foster carers of children in long term out-of-home care. This group program has been developed with the understanding that children in care present with specific and complex needs that present significant challenges to caregivers and caseworkers. Over the last 18 months in partnership with staff from Health and NGOs, 14 Community Services psychologists have participated in the training and running groups, with 72 foster carers. Course material is grounded in an extensive review of the literature, the clinical experience of ACC staff and information provided by a large number of kinship and foster carers. Evaluation indicates that there is a reduction in carer stress and increased optimism. There is a positive response to the program from foster carers; they are well engaged and find the group very useful and practical. They appreciate the specialist training that addresses attachment and trauma issues that the children and young people in their care present with which is different to other types of parenting programs. Carers find the groups more accessible, with good networking.

This client group is also supported by a number of the strategies mentioned above:

- The Adolescents with Complex Needs Statewide Panel - almost all of the children reviewed in the first 12 months were in care.
- Project Air Strategy for Young People with Complex Needs and High-Risk Challenging Behaviours.

In addition, the *Reflection, Resilience and Relationships (RRR) Program (Pilot)* was designed for residential care staff working in the complex context of a youth residential setting – a setting that is often characterised by high ambiguity, emotionally laden situations, and by strong public and political pressure. In the midst of this context, staff's ability to make sound decisions and think reflectively are critical to supporting young people to keep safe and achieve their own personal goals.

Better supporting young people to keep safe was a key driver of the development of this joint initiative (with Marist). This partnership was formed in response to the challenging and complex shared experiences in working with young people who have experienced serious abuse, neglect and other forms of trauma and in particular, the ramifications associated with the experience of young people attempting to suicide or who have died as the result of a suicide.

The pilot program was designed to achieve the following goals:

- Introduce residential care staff to the concept and language of reflective practice;
- Increase residential care staff confidence in decision making;
- Increase residential care staff sense of team cohesion;
- Decrease residential care staff feelings of stress in relation to their work;
- Improve residential care staff skills in managing work related stress; and
- Increase residential care staff confidence in their ability to undertake the functions of their role.

Housing NSW

Housing NSW provided the following information:

Housing NSW reports there are a number of state-wide and locally-based program initiatives funded under NPAH to support young people leaving out-of-home care. Examples include:

- NSW North Coast *SWITCH program*, which provides intensive case management and advocacy to help young people access adequate, safe and affordable housing, and includes services such as assistance with community mental health and access to medication.
- *Assisting Aboriginal Young People Leaving Care project*, which operates in the Wollongong, Shellharbour, Kiama, Shoalhaven and Eurobodalla areas.
- Expanded '*Out of Home Care Leaving Care / Aftercare*' and '*Out of Home Care Supported Independent Living*' programs, which assist young people transition to, and maintain, independent living and self-reliance.

In addition, NPAH funds other programs that support high needs adolescents, including:

- the *Bail Assistance Line* – a service that coordinates a range of supports to enable young people to successfully complete bail periods and re-integrate into the community after leaving custody;
- the *Youth Hub Project*, which incorporates both on-site accommodation support and outreach support services to young people in Western Sydney and the Illawarra; and
- the *Inner City Youth At Risk* project, which works with homeless young people on the streets in inner Sydney.

Other NPAH-funded projects have been established to provide intensive support and accommodation to young people with complex needs who are exiting Juvenile Justice custody, or at risk or entering custody, or on community-based orders. These programs operate on the North Coast, in South-Western Sydney, and the Riverina Murray areas. Priority is given to Aboriginal young people and those from culturally and linguistically diverse communities.

8.6 Swimming pool safety

Since our last report, there have been significant developments in promoting the safety of young children around private swimming pools.

In January 2012, the Division of Local Government (Department of Premier and Cabinet) released a discussion paper on a review of the *Swimming Pools Act 1992*. The discussion paper sought views about proposed amendments to the Swimming Pools Act to increase the safety of very young children around backyard swimming pools.

Following a consultation period, on 13 September 2012, the Minister for Local Government, the Hon Don Page, announced that the NSW government would introduce new legislation relating to private swimming pools. The main proposed amendments to the Swimming Pools Act are to:

- Require pool owners to self-register at no cost on a State-wide, online register and assess to the best of their knowledge that their pool barrier complies with the legislation. Failure to register a swimming pool will be an offence.
- Require councils to develop a locally appropriate and affordable inspection program in consultation with communities.
- Require that any property with a swimming pool must be inspected and registered as compliant before that property can be sold or leased.
- Clarify that, where an existing swimming pool that is exempt from the Act's fencing requirements is fenced voluntarily, the new fencing must meet the Act's requirements for a compliant, four-sided barrier and the exemption will be removed.

The NSW Child Death Review Team has recommended a range of supporting strategies be implemented to enhance the new legislation. These include that government develop model policies for council inspection programs, pool inspections be targeted to premises where children live or regularly visit, local councils report annually on swimming pool compliance and that a comprehensive education and that a awareness program accompany the changes.[146]

146. NSW Child Death Review Team 2012, *NSW Child Death Review Team annual report 2011*, NSW Ombudsman, Sydney, p. 99.

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