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Child protection in NSW – two reports

NSW Ombudsman Bruce Barbour tabled two special reports in Parliament today.

The first is the Ombudsman's report, *Review of the NSW Child Protection System: Are Things Improving?*

As Convenor of the NSW Child Death Review Team, the Ombudsman also tabled a report on the Team's research into the causes of death of children with a child protection history over a 10-year period 2002-2011.

'These two reports together show the strong link between my office's community services responsibilities and the work of the Child Death Review Team' said the Ombudsman. **'However, it is important when reading the reports not to assume a causal relationship between the operation and effectiveness of the child protection system and the deaths of children.'**

Review of the NSW Child Protection System: Are things improving?

This is the Ombudsman's second report following the introduction of the *Keep Them Safe* reforms. The first report was released in August 2011, and can be accessed at the Ombudsman's website.

'We have seen a great deal of change as part of the *Keep Them Safe* reforms' the Ombudsman said. **'Despite some encouraging developments, including more face-to-face contact, increased caseworker numbers in some areas and improvements to practice and reporting, there is still more that needs to be done.'**

In 2011 the Ombudsman reported that 21% of all risk of significant harm reports were receiving a face-to-face response. Two and a half years later, Community Services has lifted its rate of face-to-face responses to 28%.

'I recognise that Community Services continues to make changes to the way it records information, but it is still challenging to assess the response to all risk of significant harm reports' the Ombudsman said. **'Better, clearer information will need to be collected and reported to allow for greater accountability and community understanding.'**

The Ombudsman has again stressed the need for improvements to interagency cooperation and involvement. **'The children and families the subject of reports rarely come into contact solely with Community Services'** Mr Barbour said.

While Community Services has increased its capacity to respond to reports, improvements to productivity and responsiveness within Community Services alone

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are unlikely to meet reporting demand. **'Non government service providers, the NSW Police Force, the Department of Education and NSW Health all have a part to play. It is vital they identify when they need to share information and do so swiftly, recognise when a child protection response is required and take appropriate action.'**

One of the key issues highlighted in the report is the need for more efficient and integrated service systems in local communities**. 'Systems need to be developed and tailored to suit the place they are being delivered and the people receiving them'** Mr Barbour said. **'This is particularly important in high-need communities.'**

The report can be accessed at the Ombudsman's website (www.ombo.nsw.gov.au) after 10:30am.

Causes of death of children with a child protection history 2002-2011

A key function of the NSW Child Death Review Team is to undertake research that aims to prevent or reduce the likelihood of child deaths.

In this context, the Team contracted the Australian Institute of Health and Welfare (AIHW) to analyse the causes of death of children with a child protection history between 2002 and 2011.

The Team's report on the results of this research identifies that children with a child protection history:

- comprised almost 20% of all deaths of children in NSW in the 10-year period
- had a higher mortality rate overall (1.4 times the rate) than children without a child protection history, and
- had a much higher mortality rate for particular causes of death, including sudden unexpected deaths in infancy (SUDI), fire, assault, accidental poisoning and suicide.

'The research underscores the importance of the Team's focus on the need to reduce the sudden and unexpected deaths of infants in families with a child protection history,' said Mr Barbour. **'The analysis found that the SUDI mortality rate of these infants was almost 10 times the rate of children without a child protection history.'**

'More broadly, the research provides a useful foundation for the Team's further prevention work' the Ombudsman said. **'Reducing child deaths relies on the ability to effectively identify and target relevant prevention strategies to those who are most at-risk. The research has helped the Team to distinguish where further work is needed to identify where, and how, prevention strategies ought to be targeted.'**

The report can be accessed at the Ombudsman's website (www.ombo.nsw.gov.au) after 10:30am.

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