NSW Ombudsman

Report of Reviewable Deaths in 2005

Volume 2: Child Deaths

November 2006

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November 2006

The Hon Meredith Burgmann MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon John Aqualina MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Madam President and Mr Speaker

I am pleased to present the NSW Parliament with volume two of our third report on reviewable deaths. This volume concerns the deaths of certain children.

The report contains an account of our work and activities and is made pursuant to s43 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. The report includes data collected, and information relating to, reviewable deaths that occurred in the period ending December 2005; our recommendations; and information with respect to the implementation or otherwise of previous recommendations. The report includes material on developments and issues current at the time of writing.

I recommend that this report be made public forthwith.

Yours faithfully

Bruce Barbour
Ombudsman

Ombudsman's message

Bruce Barbour
NSW Ombudsman

This is our third reviewable deaths annual report. It differs from previous years in that we have decided to release the report in two volumes: the first on the deaths of people with disabilities in care and the second on the deaths of certain children. Separation of the report in two volumes recognises the unique yet diverse issues, challenges and priorities of the disability and child protection sectors, and reflects the specialised work undertaken by my officers in each area.

This volume concerns the deaths in 2005 of 117 children.

The definition of reviewable deaths includes children, or siblings of children, who were reported to the Department of Community Services in the three years before they died. Because of this, most children whose deaths are reviewable will be those with a child protection history.

DoCS is now half way through its $1.2 billion reform program and as part of this, has been recruiting extra staff and working to improve its performance and the quality of its services. Over the next four years, DoCS intends to conduct a quality review of each of the Community Service Centres in NSW. This is a critical strategy for identifying developments at the local level and implementing remedial action where it is needed.

However, we also continue to see recurring problems in the child protection system. Some of these problems rest with DoCS, some rest with other agencies that also have child protection responsibilities, such as NSW Health and NSW Police. Our report aims to clearly articulate these problems and propose solutions, while acknowledging the current work agencies are doing to improve their capacity to respond effectively to children at risk.

This year we chose to look more closely at cases where the families of children who died were affected by one or both parents' drug or alcohol abuse, an issue that has featured in many of the deaths we have reviewed over the past three years. In almost half of all the deaths we reviewed in 2005, we found evidence of parental substance abuse. A parent's substance abuse was directly linked to the deaths of eight children.

Responding effectively to child protection concerns in families where there are drug and alcohol issues is a challenge for agencies. Our report recognises this, but highlights the critical need to improve how risk is assessed for these children and how services and supports are put in place to protect them and to assist their parents.

Bruce Barbour
Ombudsman

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Executive summary

Reviewable child deaths in 2005

In 2005, the deaths of 117 children were reviewable. In 109 cases, the child's death was reviewable because they, or their sibling, had been the subject of a report to DoCS in the three years before the child died. For the remaining eight children, there had been no such report to DoCS. Their deaths were reviewable because the children died as a result of abuse or neglect, or in suspicious circumstances. Of the children who were known to DoCS, the deaths of 25 were attributed to abuse or neglect, or occurred in suspicious circumstances.

Most of the 117 children were very young, with close to three quarters of them aged less than four when they died. Sixty were aged under 12 months.

Indigenous children continued to feature disproportionately in reviewable deaths, with 20 deaths of indigenous children and young people representing 17% of reviewable child deaths. In NSW last year, 44 children were identified as being of indigenous background when their deaths were registered. This means that nearly half of all indigenous child deaths in 2005 were reviewable deaths. In comparison, 20% of all child deaths in NSW in 2005 were reviewable.

Our reviews aim to identify shortcomings in agency systems or practice that may have directly or indirectly contributed to the death of a child or lead to children being exposed to risk in future. Our focus is on all agencies involved with the child and their family.

As a result of our reviews and related work we have made a total of 34 recommendations to DoCS, NSW Health and NSW Police. A summary of our findings and related recommendations is outlined below.

In part our findings and recommendations reflect a focus this year on parental substance abuse. DoCS has noted that drug and alcohol abuse is one of the most common concerns in risk of harm reports about children.

Risk of harm and agency responses

Our reviews of deaths that occurred in 2005 showed that the level of risk was not always adequately recognised or reported by agencies in contact with the family, that when reported, concerns were not always fully assessed or responded to, and that measures taken by agencies — alone or jointly — to protect children at risk were not consistently effective.

Parental substance abuse

In almost half of our reviews there were indications that parental substance abuse was present in the child's life. We decided to pay particular attention to this issue in order to highlight specific challenges for agencies that have contact with children who may be at risk because of parental substance abuse.

Among the children who died, we identified 54 for whom records indicated a history of parental substance abuse. Most of these children were under five when they died, and almost two thirds of them were babies aged less than one year. In 53 of the 54 cases, the child or their sibling was known to DoCS.

Parental substance abuse was rarely the only risk factor in the matters we reviewed. Often drug or alcohol misuse was present with domestic violence, physical abuse, neglect and, sometimes, mental health issues. In many families, one or both parents had criminal records or were known to police. In some cases, a parent's chaotic lifestyle led to other problems, such as homelessness.

Our work confirmed that agencies may encounter difficulties in dealing with drug-dependent parents in a child protection context. Parents may seek to conceal or minimise their drug use or, conversely, agree to changes that they may be unable to sustain. Unpredictable behaviour linked to substance use and the high rate of relapse can make assessment a complex task. In many of the cases we reviewed, the parents were chronic and/or poly-drug users. In some cases, parents were involved with drug treatment programs at the time their child died.

Identification of, and initial response to, risk

DoCS is unable to respond to concerns that children may be at risk unless it is made aware of such risk. A number of our reviews raised questions about whether agencies had given adequate consideration to making

a risk of harm report when responding to incidents affecting the safety and welfare of children. In these cases, mandatory reporters did not inform DoCS about incidents that, in our view, warranted a risk of harm report. We also identified the need for safeguards to ensure that information about children at risk that is conveyed to DoCS in written form, such as fax, is received and can be followed up by DoCS staff.

As with our two previous reports, we found that DoCS sometimes did not adequately review child protection histories when it received reports. Understanding the available history of a family is a critical step in determining current risk for a child. We also continued to see problems relating to the way DoCS and police handled some risk of harm reports that indicated criminal offences.

Among our recommendations we have asked DoCS and NSW Police to advise us of the progress of their joint work to improve risk assessment procedures for child protection reports from police. We have also asked DoCS about the status of a process to review the quality of work at its central intake point, the Helpline.

Responses to maternal substance abuse

In at least 14 cases, there was evidence that the child's mother used illicit drugs or alcohol during pregnancy. Our work showed that there is a particular challenge for agencies in effectively engaging and supporting women who use drugs in pregnancy, in order to minimise subsequent risk to their children.

NSW Health provides specialist antenatal health care services for pregnant women who misuse alcohol and other drugs. There appears to be no central co-ordination, monitoring or review of these services. We have recommended that NSW Health consider addressing these issues.

Our work raised questions about the adequacy of responses by health services in the post-natal period for some children whose mothers used substances during pregnancy, or who had a history of substance abuse. In some cases, we questioned whether there was sufficient assessment of child protection concerns to determine if a report to DoCS was warranted. We identified that in some cases, there was a lack of discharge planning and questions about whether comprehensive drug and alcohol assessment was undertaken. We have asked NSW Health to tell us what it is doing or proposing to do to ensure compliance with procedures relating to maternal substance abuse.

Responses to pre-natal reports

Pre-natal reporting is not mandatory but may provide an opportunity to support pregnant women. The goal is to reduce the likelihood of risk of harm after the child is born.

Most pre-natal reports that we reviewed were prompted by concerns about maternal substance abuse or included such a concern. We found that DoCS often gave pre-natal reports a low priority for allocation for assessment. The records we reviewed indicated that in many cases, local DoCS offices did not contact the woman during her pregnancy or assess what might be required to reduce risk of harm to the baby after the birth.

DoCS has advised us that it is developing a policy on pre-natal reports.

Child deaths and methadone

Among reviewable child deaths in 2005, we identified three deaths relating to methadone poisoning.

NSW Health has advised us that it is reviewing its systems relating to the reporting of fatal and non-fatal child methadone overdoses. NSW Health said that data from 30 hospital emergency departments showed that in these hospitals, there were 12 non-fatal presentations of children due to methadone poisoning in the two years to 1 June 2006. We have asked NSW Health to consider the establishment of a consistent state-wide system for the collection and monitoring of data about children presenting to health services as a result of methadone ingestion.

We have also recommended that NSW Health implement a policy requiring emergency department staff to identify and inform the relevant methadone prescriber of the admission of a child as a result of methadone ingestion. In addition, we have asked NSW Health and DoCS to advise us of the outcomes of a joint review of methadone-related child deaths that they are undertaking.

Responding to risk of harm reports

When the DoCS Helpline determines that a report requires further response, it refers the report to a local office or a Joint Investigation Response Team of police and DoCS staff, where more assessment may be done to substantiate risk of harm or confirm a child's safety. However, cases may be closed for reasons including competing priorities and lack of resources.

We continue to be concerned that some cases are closed without assessment, despite reports indicating the possibility that children were at risk. In some cases, we found that closure without assessment occurred where DoCS records indicated a significant child protection history.

DoCS told us that with the roll out of additional resources, more cases are being allocated for assessment at Community Service Centres. While noting this as a positive indicator, DoCS capacity to respond to reports remains a significant concern.

We have recommended that DoCS develop the capacity in its computer system to collect and report

on data which details the reasons for case closure, including cases closed due to competing priorities. We have also asked DoCS to tell us how it intends to measure the impact of reform initiatives on its capacity to fully assess risk of harm reports and to provide protective intervention.

Quality of assessment

Our reviews also raised questions about the quality of DoCS secondary risk of harm assessment. At times, our reviews identified that assessments were not holistic and not informed by adequate information gathering and analysis. In some cases, assessment was suspended or ceased before a final decision was made about a child's need for care and protection.

In relation to parental substance abuse, we identified cases where a lack of relevant expertise on the part of DoCS staff hampered effective risk assessment. Sometimes there was an over-reliance on parents' advice about their own substance use. Sometimes DoCS staff did not fully consider parental capacity to fulfil agreements that were intended to minimise risks to a child.

DoCS has told us that it intends to conduct a quality review of each Community Service Centre in NSW. It is also releasing a new policy on neglect and a revised secondary assessment procedure.

We have asked DoCS to provide an update on progress in the implementation of the proposed quality reviews, and to consider the issues we have identified about parental substance abuse in the ongoing development of the department's training initiatives. We have also asked DoCS and NSW Health to work together to develop arrangements to ensure that expert drug and alcohol assessments are used where appropriate in cases where parental substance abuse is a child protection concern.

Protective intervention

When DoCS assesses that a child is in need of care and protection, the department has various options for intervention. We identified some concerns about the types of intervention utilised, and the way that protective strategies were implemented.

In particular, our reviews raised concerns about the use of undertakings where parents had either long histories of drug abuse, repeated relapses from drug treatment, or both. In some cases, there appeared to be inadequate consideration of the likelihood that parents would — or could — fulfil the terms of agreements. We have asked DoCS to inform us of its progress in reviewing policies on the use of undertakings.

Our reviews raised some questions about the timeliness of intervention to protect children, and how DoCS monitors the provision of support services. In some cases where a child was assessed as being in need of care and protection, we found that a relatively significant amount of time elapsed between the need for support being determined, and the provision of that support.

In our previous report, and in reviews of deaths in 2005, we raised some questions about how effectively police were utilising their powers to take out Apprehended Violence Orders on behalf of children, and whether police officers had adequate procedural guidance to determine the circumstances that warrant application for an AVO on behalf of a child. We have asked NSW Police to report on progress with a project they are undertaking on AVO compliance with legislation.

Interagency responses

Our work in 2005 again showed the importance of good interagency cooperation and co-ordination. Our work also indicated that this is not consistently being achieved.

In some cases, we found that different agencies had information that, when combined, provided a clear picture of risk to a child or children. However, this was not identified at the time because the agencies did not communicate effectively or adequately coordinate their work.

A revised version of the *NSW Interagency guidelines for child protection intervention* was released in 2006. We have asked the department to give us more advice about plans for an evaluation of the effectiveness and take-up of the guidelines.

In circumstances where a baby is subject to pre-natal reports of risk of harm, we found that arrangements between hospitals and DoCS for notifying DoCS of a baby's birth appeared to be inconsistent across different areas. We have recommended that NSW Health and DoCS develop a state-wide policy on this issue.

Our previous report raised particular interagency issues about adolescents, particularly for young people with mental health issues. We have asked DoCS and NSW Health to discuss the issues raised in that report and to identify clear strategies to jointly assist these young people.

Our previous report highlighted some concerns with agency responses to Aboriginal children reported to be at risk of harm. We have asked Human Services CEOs to provide us with an update of initiatives to strengthen joint responses to Aboriginal families and children.

Recommendations

The recommendations below reflect the findings of our reviews of child deaths in 2005, and our assessment of the progress toward implementation of the recommendations we made in our *Report of reviewable deaths in 2004*. In regard to the latter, we have modified some of the previous recommendations to take into account developments in the past year.

Agency identification and reporting of risk of harm

In some of the matters we reviewed, we questioned whether agencies had given adequate consideration to making a risk of harm report to DoCS when responding to incidents affecting the safety and welfare of children. Our reviews indicated that agency staff may not fully appreciate the extent of their obligation as mandatory reporters, and highlighted the need for clarity in guidance provided to staff about identifying possible risks to children.

1. **NSW Police should prioritise completion of the *Child protection standard operating procedures*, and ensure that the revised SOPS and where relevant, *Domestic violence operating procedures*:**
   a) **Give adequate advice to police about circumstances where a risk of harm report to DoCS may be appropriate in cases where the child is not present with the adult and police are aware of a child protection history.**
   b) **Give adequate guidance to police about circumstances where it may be appropriate for police to themselves seek further information about the safety of children.**
   c) **Ensure that the procedures encourage full and relevant reporting to DoCS on the type and level of risk posed to children who are present at a domestic violence incident.**
2. **NSW Police should advise this office of plans for releasing the revised procedures, including associated information and training strategies.**
3. **DoCS and NSW Police should provide advice to this office on the progress of their joint work to improve risk assessment procedures for child protection reports from NSW Police, and details of any actions arising from this work.**

Determination of child protection history

In the *Reviewable Deaths Annual Report 2003–2004*, we said that DoCS should develop strategies to ensure staff adhered to policies regarding consideration of the child protection history of a child and their family. DoCS told us in 2005 that the department had emphasised child protection history in training and that the Helpline would be implementing a 'rolling quality review process'.

4. **DoCS should provide advice to this office of the current status of the Helpline quality review process, including the regularity and future focus of quality reviews.**

Reports indicating criminal offences

In our *Report of reviewable deaths in 2004*, we raised questions about referral of reports indicating possible criminal offences to JIRT or police, and noted some apparent confusion within DoCS' policies and procedures about which matters should be referred to JIRT and/or Police. Our reviews of deaths in 2005 continued to identify issues relating to reports not being referred to JIRT when they appeared to meet JIRT criteria, and inadequate responses to reports unable to be taken up by JIRT. DoCS, NSW Police and NSW Health have recently initiated a review of JIRT.

5. **DoCS and NSW Police should provide advice to this office regarding the progress of, and timelines for, the DoCS, NSW Police and NSW Health review of JIRT systems, policies and procedures.**
6. **In conducting the review of JIRT, DoCS and NSW Police should consider relevant issues raised in this report and our *Report of reviewable deaths in 2004*, in particular:**
   a) **That in those cases where JIRT rejects referrals, JIRT should clearly document the reasons for this decision, including details about any information that would be required to enable JIRT to take up the matter.**
   b) **The need for clarity about the type of reports that DoCS should refer to JIRT and/or police.**
   c) **The need to ensure appropriate child protection responses to children who are the subject of reports referred to, but rejected by, JIRT.**
7. **DoCS should provide advice to this office regarding the findings of the proposed analysis of a sample of JIRT declined referrals, and how DoCS will act on those findings.**

Response to maternal substance use

Specialist antenatal health care services for pregnant women who misuse alcohol and other drugs are available in all Area Health Services in NSW. However, it appears that there is no central coordination, monitoring or review of the various drugs in pregnancy services across NSW, and, beyond the *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* and the *Neo-natal abstinence syndrome guidelines*, no common standards or benchmarks for service delivery. We are unaware of any state-wide evaluation having been undertaken of the services.

8. **NSW Health should consider strategies to:**
   a) **Facilitate common benchmarks and standards for the provision of drugs in pregnancy services in NSW.**
   b) **Provide ongoing state-wide coordination and development of drugs in pregnancy services in NSW.**
   c) **Evaluate the effectiveness of drugs in pregnancy services in NSW.**

   NSW Health should provide advice to this office of the outcomes of this consideration.

Our reviews raised some questions about the adequacy of the level of coordination, assessment and planning by health services in the post-natal period for some children born to mothers who had a history of substance abuse or who were known to have used substances during pregnancy. We raised concerns about lack of risk assessment to determine whether a risk of harm report to DoCS was warranted, lack of discharge planning and questions as to whether comprehensive drug and alcohol assessment occurred in some cases.

9. **NSW Health should advise this office of strategies in place, or planned, to promote and ensure compliance with relevant procedures relating to maternal substance use, particularly the *Neonatal abstinence syndrome guidelines* and *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*.**

Response to pre-natal reports

We found that pre-natal reports often received a low priority for allocation for assessment by DoCS. Records we reviewed indicated that, in many cases, the CSC did not initiate any contact with the mother during the pregnancy and did not assess what supports might be required to reduce risk of harm to the baby after the birth. DoCS is currently completing a policy on pre-natal reports.

10. **DoCS should provide advice regarding progress in the development and roll out of a policy on responding to pre-natal reports, including a copy of the policy when completed.**

Child deaths resulting from methadone toxicity

Among reviewable child deaths in 2005, we identified three deaths related to methadone poisoning. In 2003, we reviewed two cases where methadone contributed to, or resulted in, the child's death.

11. **NSW Health should provide advice to this office on the progress of the review into the systems related to reporting fatal and non-fatal child methadone overdoses.**
12. **As part of the review into the systems related to reporting fatal and non-fatal child methadone overdoses, NSW Health should consider the establishment of a consistent state-wide system for the collection and monitoring of data about children presenting to health services as a result of ingestion of methadone. Data collection should include the number and age of children presenting, and the circumstances in which methadone was ingested.**
13. **NSW Health should implement a policy requiring emergency department staff to identify and inform the relevant methadone prescriber of the admission of a child to an emergency department as a result of ingestion of methadone. This policy should be incorporated into relevant NSW Health policies and procedures relating to child protection and to opioid treatment.**
14. **NSW Health should provide this office with a copy of the *NSW Clinical guidelines for methadone and buprenorphine treatment of opioid dependence (2006)*, and advice regarding:**
    a) **Strategies by which NSW Health will monitor compliance with the guidelines, particularly in regard to contraindications for clients with children in their care.**
    b) **The current status of the *Guidelines for prescribing methadone for unsupervised administration 'takeaway doses'* in the context of the revised guidelines.**
15. **NSW Health and DoCS should provide this office with advice about the outcomes of the joint review of methadone-related child deaths, including a copy of the review report, and details of plans to respond to the review findings.**

Closure of reports without assessment

Capacity to respond fully to reports indicating that a child is at risk of harm is a significant and ongoing concern.

For deaths in 2005, we continued to see reports of risk of harm being closed without assessment. Closure was often due to competing priorities, despite reports indicating the possibility that children were at risk. In both previous reports of reviewable deaths, we made recommendations based on our view that DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention. According to DoCS, there has been an increase in the proportion of reports allocated for further assessment by local offices. DoCS has been trialling *Intake assessment guidelines*, which will replace the 'priority one' case closure procedure. The guidelines provide criteria for prioritisation of reports for secondary assessment stage one. We also asked DoCS to advise whether information about risk of harm reports closed without assessment, and the reason for closure, was being drawn from DoCS data and if it would be reported. DoCS told us that *'there are no coded fields in KIDS that allow recording of detailed case closure reasons or the circumstances of the case.'*

Closure of reports without assessment *(continued)*

16. **A key principle in child protection intervention should be that where a report raises issues of safety of a child, or failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to assess the level of risk and resolve identified risk. In this context, DoCS should:**
    a) **Develop capacity within KIDS to enable collection of, and reporting on, data which details the reasons for case closure, including the number of cases closed due to competing priorities.**
    b) **Provide advice to this office regarding how the department intends to measure the degree to which reform initiatives have improved its capacity to assess risk of harm reports to the appropriate stage, and to provide necessary intervention where a child is assessed to be in need of care and protection.**
17. **DoCS should provide advice to this office regarding progress toward the finalisation and implementation of the *Intake Assessment Guidelines*, including provision of a copy of the current draft guidelines.**

In responding to previous recommendations about case closure, DoCS told us that a key issue was the monitoring of allocation rates for high-risk cases, and reporting of these annually. In 2004/05, 140,184 reports were referred to a CSC or JIRT for further assessment. DoCS' Annual Statistical Report for 2004/05 indicates that there was no secondary assessment outcome recorded for 65,975 (47.1%) of these reports.

18. **DoCS should provide advice to this office about the department's capacity, and any plans, to enhance data reporting to identify the status and outcomes of all reports referred to CSCs and JIRTs for further assessment, with particular reference to the category of reports indicated in DoCS annual data as having *'no secondary assessment outcome recorded.'***

Quality of risk of harm assessment

Our reviews of deaths in 2005 raised questions about the effectiveness of secondary assessment. We found that secondary assessment was at times not holistic and not informed by adequate information gathering and analysis, and that where DoCS assessed risk without full and relevant information, assessments did not always adequately reflect the possible risks to a child. We also reviewed cases where secondary assessment was suspended or ceased before a final determination was made about the child's need for care and protection. DoCS has plans to undertake quality reviews in all CSCs, and is rolling out a new neglect policy and a revised secondary assessment procedure.

19. **DoCS should provide advice to this office regarding:**
    a) **An update of progress in implementing the proposed quality review of each CSC in NSW, including details of the quantitative and qualitative information that will be sought about priority systems, processes and practice.**
    b) **Progress of the roll out of the neglect policy and revised *Secondary assessment — risk of harm procedure,* and implementation of the *Secondary assessment — risk of harm practice review tool.***

Our reviews identified particular issues about the quality of risk assessment in cases where substance abuse was a concern. We found that risk assessment was at times adversely affected by limited caseworker and supervisor expertise in the area of substance abuse; that information used to inform risk assessment was not always comprehensive and at times there was an over-reliance on parent's own advice about their substance use; and that parental capacity to meet agreements to minimise risks to a child was at times not fully considered.

20. **In the ongoing development of alcohol and other drugs training and professional development strategies for caseworkers and managers, including the revision of the *Alcohol and other drugs* module of the Caseworker Development Course, DoCS should consider and incorporate the issues raised in this report, in particular:**

Quality of risk of harm assessment *(continued)*

a) **The challenges for DoCS staff in effectively engaging drug dependent parents, particularly where parents seek to avoid contact with agencies and/or conceal or minimise substance use.**

b) **The challenges in effectively engaging with, and responding to, women using drugs in pregnancy, in order to minimise the subsequent risk to their child.**

c) **The need for caseworkers to have a solid understanding of the nature of drug dependence, the range of illicit and legal substances that may be used and the range of their effects, and guidance to apply this information in assessing risk to children.**

d) **The high vulnerability of infants and very young children in an environment of parental substance abuse.**

e) **The importance of obtaining critical information from relevant agencies to inform risk assessment.**

21. **DoCS and NSW Health should work together to develop arrangements between the two agencies to ensure expert drug and alcohol assessments are appropriately sought by DoCS and provided by NSW Health in cases where parental substance abuse is identified as a child protection concern.**

22. **DoCS should provide advice to this office of:**

    a) **The outcomes of the trial of the Hearth Safety Assessment Tool and any proposals for broader application of the tool across DoCS.**

    b) **Progress in the roll out of the protocol between NSW Health and DoCS on exchange of information concerning DoCS' clients on opioid treatment, and provision of a copy of the protocol.**

    c) **Progress in the development and trial of the policy on drug testing in a child protection context, including provision of a copy of the policy and key findings to date.**

Aboriginal children and young people

Our reviews of deaths in 2004 found that some of the children had no, or a limited, response to reports that they were at risk of harm, and that when risk assessments did occur, these often did not comply with standards required by DoCS. In the matters we reviewed in 2005, these issues remained apparent. DoCS advised us of a number of initiatives in relation to its work with Aboriginal children and families.

23. **DoCS should provide a copy of the *Aboriginal strategic commitment* to this office, and advice on the progress of major commitments to improve outcomes for Aboriginal clients.**

Adolescents

Our reviews of 22 adolescents who died in 2004 identified a range of challenges for DoCS in responding effectively to young people. Our recommendation to DoCS included a proposal that the department give consideration to the issues raised in the report, including whether existing procedures and models of casework and current practice were effectively meeting the needs of adolescents. DoCS advised us of a number of initiatives in relation to its work with adolescents.

24. **DoCS should provide advice to this office regarding:**

    a) **Progress of work with relevant community sector representatives on the issue of youth in Supported Accommodation Assistance Program (SAAP) services.**

    b) **Progress of, and findings arising from, the Child Deaths and Critical Reports Unit research paper on matters arising from the Unit's reviews of deaths of young people by suicide or risk taking behaviour.**

    c) **Progress of DoCS' Centre for Parenting and Research projects to inform policy and practice relating to effective strategies and interventions for adolescents at risk, any findings to date and DoCS' plans to respond to those findings.**

Protective intervention

Our reviews raised concerns about DoCS' decisions to use undertakings where parents had long histories of drug abuse and/or repeated relapses from drug treatment or drug-related mental health issues. In some cases there appeared to be inadequate consideration of the likelihood that parents could fulfil the terms of agreements. DoCS is reviewing its policies on undertakings.

25. **DoCS should provide advice to this office on progress with the review of policies on the use of undertakings, including a copy of relevant revised policies when completed.**

26. **DoCS should provide details about the department's policy regarding the circumstances where case plans and unregistered care plans alone will be considered to be adequate protective measures.**

Timeliness of intervention and monitoring of support services

Our reviews raised some questions about the timeliness of intervention that risk assessment determined to be necessary to protect children, and how DoCS monitors the provision of support services deemed necessary to ensure the safety of children. In some cases, we found that a relatively significant amount of time elapsed between a determination that support was needed, and the provision of that support.

27. **The proposed DoCS quality reviews of CSCs should include review of CSC systems and practice in relation to timely implementation of case plans, and the efficacy of systems in place for monitoring the implementation of case plans.**

Apprehended Violence Orders

Last year and in reviews of deaths in 2005, we raised some questions about how effectively police were utilising their powers to take out AVOs on behalf of children, and whether police officers had adequate procedural guidance to determine the circumstances that warrant application for an AVO on behalf of a child.

28. **NSW Police should provide advice to this office of progress with the AVO Compliance with Legislation project.**

Interagency response to children at risk of harm

Our reviews and other work in 2005 again showed both the importance of good interagency cooperation and coordination, and that this is not consistently being achieved. Our reviews identified examples of ineffective communication between agencies, inadequate liaison between agencies to ensure full information was available to accurately assess risks to children, and concerns about effective use of section 248 of the *Children and Young Persons (Care and Protection) Act 1998.*

We note that the *NSW Interagency guidelines for child protection intervention* have been the subject of review, and revised guidelines have recently been released. *In our Report of reviewable deaths in 2004*, we recommended that the guidelines should be released with an evaluation framework. DoCS indicated an evaluation would commence in June 2007, and would incorporate an assessment of agency take-up, and overall effectiveness, of the guidelines.

29. **DoCS should advise this office of the progress of the review of evaluation frameworks for interagency practice, and timelines and method for the proposed evaluation of the *NSW Interagency Guidelines for Child Protection Intervention.***

Pre-natal reports

In regard to planning for effective intervention following the birth of a child, it appears that there are inconsistent systems and arrangements across different CSCs and Area Health Services for alerting DoCS that a baby the subject of a pre-natal report has been born.

30. **NSW Health and DoCS should, through an appropriate joint forum, develop a state-wide policy by which hospitals can alert DoCS about the birth of a baby, and through which a coordinated response to any concerns about risk to the baby can be initiated.**

Interagency response to children at risk of harm *(continued)*

Adolescents

Of the 22 young people whose deaths we reviewed in 2004, six committed suicide. Five of these young people had been reported to DoCS as being at risk of harm in the six months prior to their death. In three of these cases, the reports indicated that the young person was suicidal, or raised concerns about the young person's mental health. Overall, we found that most of the young people who had committed suicide had had contact with a number of agencies, but in some of these cases, there was limited communication or coordination between services, including between mental health services and DoCS. We recommended that DoCS consider how current responses to adolescents with mental health issues, or who have been reported to be at risk of suicide, could be enhanced through cooperation with relevant interagency partners. With advice from Human Services CEOs, DoCS advised us that this recommendation was a matter primarily for NSW Health. The Centre for Mental Health, however, advised us that implementation of this recommendation was more appropriately led by DoCS.

31. DoCS and NSW Health should discuss, at an appropriate joint forum, the issues raised in the *Report of reviewable deaths in 2004* concerning adolescents. In particular, the agencies should consider strategies to promote effective and coordinated child protection and health responses to adolescents who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

Aboriginal children and young people

Recommendations from our *Report of reviewable deaths in 2004* included a proposal that DoCS consider strategies to improve interagency coordination and collaboration in the care and protection of Aboriginal children and young people. DoCS advised that Human Services CEOs had agreed to their agencies investigating options with a view to '*strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed.'* DoCS also said that the Child Protection Senior Officers' Group will identify and map *'legal, policy, procedural and practice issues from recent reports on child protection for interagency action'*, also considering options for strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed. In our view, and given the number of reports of risk that do not result in assessment or confirmation of risk, there is a need for improved joint responses, particularly in regard to information exchange and consultation by DoCS with relevant agencies in assessing risk of harm.

32. Human Service CEOs should provide advice to this office on the progress of:

- **a) Human Services CEOs' initiatives in regard to strengthening joint responses to Aboriginal children and young people once a secondary risk of harm assessment has been conducted and risk of harm confirmed.**
- **b) Child Protection Senior Officers' Group identification and mapping of legal, policy, procedural and practice issues from recent reports on child protection for interagency action.**

33. In progressing the above initiatives, Human Services CEOs should consider strategies to strengthen joint responses to Aboriginal children and families more broadly, particularly in relation to:

- **a) exchange of information and consultation between DoCS and relevant agencies when assessing risk of harm, and**
- **b) coordination of support services to families where need is identified prior to confirmation of risk of harm.**

Human Services CEOs should provide advice to this office on the outcome of these considerations.

Interagency response to children at risk of harm *(continued)*

Integrated case management projects

In our *Report of reviewable deaths in 2004*, and in the context of developing better models for interagency coordination, we recommended that DoCS consider the outcomes of the review of the Complex Case Management Response Team (Dubbo) for its potential broader application in NSW. DoCS advised us that it had commissioned a broader evaluation of integrated case management projects, and that the evaluation and further steps in evaluating service delivery models was under consideration.

34. **DoCS should provide advice to this office on the progress of evaluation of service delivery models of interagency cooperation, and how the department intends to apply the outcomes of evaluation.**

1. Introduction

1.1 Reviewable deaths

Since December 2002, the Ombudsman has had responsibility for reviewing the deaths of people with disabilities in care, and of certain children. This responsibility is legislated under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA). Specifically, the Ombudsman reviews the deaths of:

- a child[1] in care.
- a child in respect of whom a risk of harm report[2] was made to the Department of Community Services within the three years prior to the child's death.
- a child who is a sibling of a child in respect of whom a risk of harm report was made to the Department of Community Services within the three years prior to the child's death.
- a child whose death is, or may be, due to abuse or neglect or that occurs in suspicious circumstances. Our definitions of abuse, neglect and suspicious are detailed in *appendix 1*.
- a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place).
- a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider authorised or funded under the *Disability Services Act 1993* or a licensed boarding house.

In NSW in 2005, the deaths of 184 individuals were reviewable deaths.

CS CRAMA requires the Ombudsman to report to Parliament each year about reviewable deaths. In the report, we must include data about deaths that occurred during the previous calendar year, recommendations that have arisen from the reviews, and information about the implementation of previous recommendations we made.

This report is the third annual report we have prepared. It differs from previous years in that we have decided to release the report in two volumes: the first on disability deaths and the second on child deaths. The separation of the report into two volumes will allow for more focused consideration of the unique issues raised for the child protection and disability sectors.

This volume of the report is about reviewable child deaths in 2005.

1.2 The scope of our work

Under CS CRAMA, the functions of the Ombudsman are to monitor and review reviewable deaths, 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)).*

The brief to consider prevention or reduction of deaths of children identified above can be met in part by considering, in the broadest sense, how agencies and service providers have acted, and can act, to ensure the safety of children.

Our reviews therefore aim to identify shortcomings in agency systems or practice that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future. The work involves examination of relevant records and information relating to the child who died and their family. These include coronial records about the child's death, government and non-government agency records about the history of their contact with the child and their family, and incident reports or internal reviews of a child's death. We may also request specific information from agencies to assist in our reviews.

Information from reviews contributes to the register of reviewable deaths. The register holds data

about causes of death and the characteristics and circumstances of children who died. It provides the basis for our annual reporting, and allows us to monitor trends and issues over time.

1.3 Reviewing deaths

To assist in the identification of deaths that are reviewable, section 37 of CS CRAMA requires certain agencies to notify us of certain deaths:

(1) The Registrar of Births, Deaths and Marriages must provide the Ombudsman with a copy of death registration information relating to a child's death not later than 30 days after receiving the information.

(2) The Director-General of the Department of Ageing, Disability and Home Care must provide the Ombudsman with copies of any notification received by the Director-General relating to a reviewable death not later than 30 days after receiving the notification.

(3) It is the duty of the State Coroner to notify the Ombudsman of any reviewable death notified to the State Coroner not later than 30 days after receiving the notification.

In regard to identifying children whose deaths are reviewable, we have access to the client database of the NSW Department of Community Services (DoCS).

The Act also requires relevant government agencies and service providers to give us full and unrestricted access to records that are reasonably required to exercise our reviewable death functions. This means that we are able to draw on relevant documented information about the characteristics and circumstances of the person or child who died.

We have established two advisory committees to assist in our work in reviewing deaths. The committees provide us with valuable advice on complex child or disability death matters, and on relevant policy and practice issues.

Membership of the child death advisory committee is detailed in *appendix 2*. The committee participated in the preparation of this report through provision of advice and feedback.

1.4 Reviewable child deaths that occurred in 2005

Why the deaths of children were reviewable

In 2005, 598 children and young people died in NSW.[3] Of these deaths, 117 were reviewable child deaths:

- 69 (59%) child deaths were reviewable because the child had been the subject of a risk of harm report to DoCS in the three years prior to their death. For ease of reporting, we refer to this group of children as being 'known to DoCS'.
- 40 (34%) child deaths were reviewable because a sibling of the child had been the subject of a risk of harm report to DoCS in the three years prior to their death.
- 33 (28%) child deaths were reviewable because the child died in circumstances of abuse, neglect or in suspicious circumstances. These deaths include eight deaths where neither the child, nor their sibling were known to DoCS, and 25 deaths that were reviewable because the child or their sibling were known to DoCS.

Our focus in reviewing deaths is on all of the agencies involved with the child and their family. The definition of a reviewable death means that the majority of such deaths will be children known to DoCS.

As our reviews examine child protection history, they often related to DoCS and other agencies' handling of child protection matters in 2005 or earlier. 2005/2006 was the third full year of funding to DoCS under a five-year, $1.2 billion package for reform of child protection. The package incorporates staff recruitment and initiatives for service improvement, and DoCS is in the process of implementing significant reforms to the delivery of child protection services. We acknowledge that changes that have been made, or are planned, may address some of the problems we identified through our reviews.

The nature of our work relating to child deaths in 2005

As at July 2006, and in relation to the 117 children who died in 2005 and whose deaths were reviewable by this office, we initiated 117 reviews and completed 73. Forty-four matters are still under review, pending receipt and analysis of information from a range of sources.

In some cases, our review work may highlight issues that warrant further inquiries about the conduct of an agency. Under the *Ombudsman Act 1974*, 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 the conduct of an agency. This action may relate to the child who died, or their surviving siblings, or both. CS CRAMA enables us to provide information arising from our reviews to certain agencies or service providers, and allows us to make reports to agencies about matters related to a reviewable death, or that arise generally from our work.

Decisions to report to an agency about issues identified through an individual review, or to take further action under the *Ombudsman Act*, are based on a number of factors. Generally, we take these steps only where we identify concerns about practice, policy or procedure that we believe have currency and warrant relevant action. Particularly in relation to preliminary inquiries and investigations, we take into account the seriousness of the concerns raised and whether they

are of a systemic nature. We also take account of any current action that an agency may be taking to address the concerns. We may also defer any direct action where the matter is subject to inquest by the NSW Coroner, or subject to internal review by the relevant agency.

Of the deaths we have considered to date, we took additional action in relation to 23 matters:

- In eight cases, we commenced investigations under s.16 of the *Ombudsman Act*. The investigations were about the conduct of agencies dealing with the child, or the child and their sibling(s). One investigation was subsequently discontinued.[4] Investigations relating to the remaining seven child deaths considered the conduct of DoCS (all cases), NSW Police (five cases), and NSW Health (three cases). As at July 2006, we had finalised four of the eight matters.
- In six cases, we undertook preliminary inquiries under s.13AA of the *Ombudsman Act*, relating to our reviews of six children who died. Preliminary inquiries are for the purpose of deciding whether agency conduct should be the subject of investigation. Our inquiries were about the conduct of agencies dealing with the child, the child and their sibling(s), or the child's sibling(s) only. They were directed to DoCS (in five cases), and the Department of Ageing, Disability and Home Care (one case). As at July 2006, none of our inquiries had progressed to investigation. In one matter, our inquiries resulted in a determination that the matter was not in the jurisdiction of our reviewable death function. In two matters, agencies provided us with sufficient information to indicate they would resolve the issues we had identified. In two cases, our concerns were not sufficient to proceed to investigation, and we finalised these by providing relevant information or suggestions to the agencies involved. One preliminary inquiry was in progress.
- In nine matters, we made reports to agencies under s.43 (3) of CS CRAMA. The legislation provides for us to report to an agency or appropriate person about matters relating to a reviewable death, or arising from our work. In the main, we use these reports to draw agencies' attention to information to assist their work, or to issues we have identified that need to be considered. Our reports were made in relation to the child who died in two cases, and the siblings of the child who died in seven cases. The reports were directed to DoCS (in all cases), and NSW Health (in one case). In three of the nine matters, reports were made to DoCS to provide them with information only.

1.5 About this report

Our focus

This report focuses on child protection issues arising from our reviews of the 117 children who died in 2005, drawing particularly from those matters subject to investigation, preliminary inquiries or reports to agencies under s.43 of CS CRAMA.

As with our previous reports, we raise issues or concerns that have come to our attention through our work, and identify some challenges for agencies that have responsibilities in child protection. In this report, however, we also pay particular attention to agency responses to risk associated with parental substance abuse.[5]

In 2005, almost half of our reviews of child deaths indicated that parental substance abuse was a factor in the child's family. DoCS has noted that drug and alcohol abuse is one of the most prevalent issues in risk of harm reports about children.[6]

Our purpose in highlighting this issue is to draw attention to the particular challenges for agencies that have contact with children who may be at risk as a result of their parents' substance abuse.

In doing so, we note that parental substance abuse cannot be considered in isolation — our reviews showed that it was frequently associated with other risk factors or inextricably linked with them. For this reason, our approach has been to incorporate substance abuse in the broader discussion of our work, while drawing out specific concerns and challenges where relevant.

Report sections

The report is divided into the following sections:

Section 2 provides an overview of reviewable child deaths in 2005.

Section 3 provides an overview of the circumstances and characteristics of the children who lived in families affected by parental substance abuse, and discusses in broad terms some of the challenges where substance abuse is a risk factor.

Section 4 focuses on identification of, and initial response to, risk of harm.

Section 5 considers DoCS' response to risk of harm reports.

Section 6 considers protective intervention.

Section 7 looks at interagency responses to children at risk of harm.

Many of the themes and issues we have identified within these areas are similar to those we considered in our reviews of deaths in 2004. In this context, our discussion below incorporates comment on the

progress agencies have made in implementing relevant recommendations from our *Report of reviewable deaths in 2004. Appendix 3* provides a detailed analysis of agency implementation of all recommendations made in that report.

All the agencies whose work is referred to in this report were given an opportunity to comment on relevant sections prior to publication. All comments were considered and incorporated as appropriate in the final report.

Case studies and references

Throughout the report we refer to cases we have reviewed, and matters we have made inquiries about or investigated. The cases relate to children who died and/or their surviving siblings. In order to ensure that identities are protected and to reflect the range of issues identified through our work, we have used different aspects of cases in different parts of the report.

Endnotes

1 A child is defined as a person under the age of 18 years.
2 A report must be made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998*.
3 While this report refers to 598 child deaths, we note that the NSW Child Death Review Team Annual Report January to December 2005 states there was a total of 599 child deaths in NSW. The difference is related to legislative requirements. The CDRT considers deaths that were *registered* in NSW in the given year. The Ombudsman reviews deaths that *occurred* in NSW in the given year. Deaths may not be registered in the year they occur.
4 In one case, we discontinued our investigation into DoCS' handling of risk of harm reports for the sibling of a child who died, as there were not sufficient grounds for reaching a formal finding under section 26 of the *Ombudsman Act*.
5 For the purposes of this report, we have used the term 'parental substance abuse' to describe substance use by parents or carers that has resulted in impaired parenting capacity and subsequent risk to a child. For consistency, we use the term 'parental' to refer to carers who have responsibility for the day-to-day care of the child, including birth parents, step-parents and de-facto parents.
6 DoCS (2006) *Annual statistical report 2004/05*, p.15.

2. Overview of reviewable child deaths in 2005

This section focuses on the key observations and broad trends arising from the data we collected about the children who died in 2005.[7] It provides an overview of the demographic background, family characteristics, circumstances of death and agency response to risk of harm factors for these children.

The data used in this report is drawn from agency and client files, with the primary data sources being the DoCS database, the Key Information Directory System (KIDS); DoCS and NSW Health client files; NSW Police Computer-operated Policing System (CoPS) database; coronial information; and information supplied by the Registry of Births, Deaths and Marriages (BDM).

2.1 Why the deaths were reviewable

BDM notified us of the deaths of 598 children and young people in NSW in 2005. The deaths of 117 (20%) of these children were reviewable under Section 35 (1) of the *Community Services (Complaints, Reviews and Monitoring) Act* 1993 (CS-CRAMA). In cases where a child is not known to DoCS, we rely on coronial cause of death information to make decisions about whether a death is within our jurisdiction. At the time of writing we were unable to determine the reviewable status of a further 37 deaths, as coronial information was outstanding.

Due to the nature of the legislation a child's death may be reviewable for more than one reason. The following table outlines the reasons why these deaths were reviewable across the last three years.

Table 1: Reviewable Status

Reason for reviewable status	Number of children, percent and additional information		
	2003 reviewable deaths[8] (128 children)	2004 reviewable deaths (104 children)	2005 reviewable deaths (117 children)
Death resulted from abuse	17 (13%)	7 (7%)	11 (9%)
Death resulted from neglect	18 (14%)	6 (6%)	12 (10%)
Death occurred in circumstances suspicious of abuse or neglect	8 (6%)	11 (11%)	10 (9%)
The child, or the child's sibling, was reported to DoCS in the three years prior to the child's death	103 (81%) reviewable deaths: • 84 of the children were themselves reported to DoCS. These children were the subject of a total of 286 reports to DoCS • 19 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 143 reports of risk of harm.	96 (92%) reviewable deaths: • 72 of the children were themselves reported to DoCS. These children were the subject of a total of 310 reports of risk of harm. • 24 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 96 reports of risk of harm.	109 (93%) reviewable deaths: • 69 of the children were themselves reported to DoCS. These children were the subject of a total of 246 reports of risk of harm. • 40 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 194 reports of risk of harm.
The child died while in care[9]	10 (8%)	8 (8%)	4 (3%)

Note: As a child's death may be reviewable for more than one reason, percentages for any one year will not total 100%.

2.2 Demographic details

Age

This year just over half of the children (51%) whose deaths were reviewable were less than 12 months of age. This is an increase on last year's figures where we reported that 34% of children were under 12 months of age when they died. In 2005, a further 26 (22%) children were toddlers aged between one and four years at the time of their death. In total, close to three-quarters of children (73%) were less than four years of age when they died.

Last year we reported on 22 (21%) adolescent deaths. This year there were fewer adolescent deaths 11 (9%).

The relatively high proportion of young infant deaths that we observed in our reviews this year was also reflected in the data we received from BDM regarding child deaths in the general population. In 2005, 61% of all child deaths in NSW were of infants aged less than 12 months.

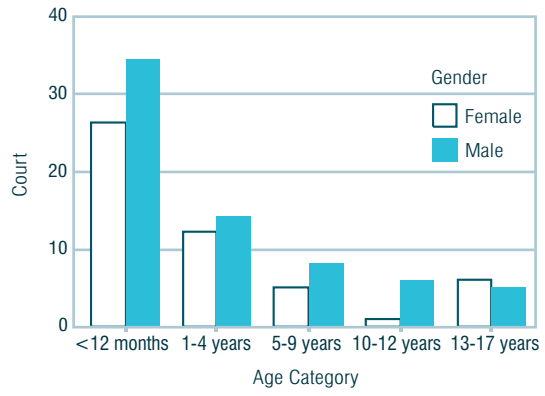
Age category of children — Table 2

	All Child Deaths in NSW	All Reviewable Deaths
< 12 months	365 (61%)	60 (51%)
1–4 years	81 (14%)	26 (22%)
5–9 years	47 (8%)	13 (11%)
10–12 years	21 (4%)	7 (6%)
13–17 years	84 (14%)	11 (9%)
Total	598 (100%)	117 (100%)

Gender

Consistent with data from previous years, and with child deaths in general, there were more male (57%) than female deaths. This was the case in all age categories, except adolescents, where we saw a slightly higher proportion of female deaths.

Age by Gender of Reviewable Child Deaths — fig 1



Aboriginality

Indigenous children and young people continue to be over-represented in both the deaths of all children in NSW, and in the reviewable child death population.

According to information we received from BDM, 44 children who died in 2005 were identified as being of Aboriginal or Torres Strait Islander (ATSI) background. The deaths of 20 of these children were reviewable, representing 17% of all reviewable deaths.

Close to half (45%) of deaths of ATSI children in NSW last year were reviewable. In comparison, 20% of all child deaths in NSW were reviewable. The proportion of reviewable deaths of ATSI children and young people has remained fairly constant over the last three years. In 2003, 20% of the deaths of ATSI children were reviewable, whilst in 2004, 19% of ATSI children's deaths were reviewable.

Aboriginal and Torres Strait Islander status — Table 3

	All Child Deaths in NSW	All Reviewable Deaths
ATSI	44 (7%)	20 (17%)
Non-ATSI	554 (93%)	97 (83%)
Total	598 (100%)	117 (100%)

Child and family circumstances

The majority (91, 78%) of children usually resided with their families — 89 children resided with at least one biological parent and two children with another family member. One young person was living independently, whilst 23 babies died shortly after birth prior to discharge from hospital.

Four deaths were reviewable because the children died whilst in statutory care. Two of the children were under care orders that allocated parental responsibility to the Minister, but were placed with their birth parents. One child was living with departmental foster carers at the time of his death. The fourth child was placed with extended family by virtue of a temporary care arrangement, and the carer was receiving ongoing financial support from DoCS in the form of a care allowance.

Twenty-seven (23%) children were recorded as having had either an intellectual and/or a physical disability. A number of these children required a high level of ongoing support to manage the impact of problems associated with their disability, for example, challenging behaviours. Last year we reported that two children died whist in the care of a disability support service as defined by the CS-CRAMA legislation, and therefore also came within our reviewable disability death jurisdiction. This year, although a number of children

were recorded as having had disabilities, none died whilst in the care of a supported disability accommodation service, or other type of disability service.

2.3 Children known to DoCS

In line with previously reported upward trends in the number of risk of harm reports to the department, DoCS recently published figures showing that they received 216,386 reports in 2004/05, up 16.8% from 2003/04.[10] DoCS also reports that the number of children and young people involved in child protection reports has increased by 21% over the last five years, from 84,965 in 2001/02 to 102,349 in 2004/05.

Sixty-nine of the 109 children known to DoCS were themselves the subject of a report. For these children, the status of their case with DoCS at the time of their death was as follows:

- open and allocated to a caseworker for 29 children
- open and unallocated for seven children. This means that a report or case plan may be open at a DoCS Community Service Centre (CSC), but is not allocated to a caseworker for active casework.
- open but insufficient information to determine allocation status for two children
- closed for 31 children.

Forty of the children who died were not themselves the subject of a report to DoCS, but their sibling(s) had been. Most of these children (30, 75%) were under the age of 12 months when they died. Five children were identified as being of Aboriginal or Torres Strait Islander background.

During the reporting period there were eight children who were not known to DoCS. These deaths are reviewable because the children died as a result of abuse (four children) or neglect (four children).

2.4 Children who died from abuse, neglect, or in suspicious circumstances

Our definitions of abuse, neglect and suspicious deaths are detailed in *appendix one*.

Of the 117 reviewable child deaths, 11 (9%) children died as a result of abuse, 12 (10%) died as a result of neglect and 10 (9%) children died in suspicious circumstances. The following table presents a breakdown of the abuse, neglect and suspicious deaths.

Abuse, neglect or suspicious circumstance deaths **Table 4**

	All children (117)	Children known to DoCS (109)	Children with siblings known to DoCS (40)	Children not known to DoCS (8)
Abuse	11 (9%)	6 (7%)	1 (3%)	4 (50%)
Neglect	12 (10%)	7 (10%)	1 (3%)	4 (50%)
Suspicious	10 (9%)	8 (12%)	2 (5%)	0 (0%)
Total	33 (28%)	21 (30%)	4 (10%)	8 (100%)

Of the group of 33 children who died as a result of abuse or neglect, or whose deaths occurred in suspicious circumstances:

- Twenty-five children and/or their sibling(s) had been reported to DoCS within three years of their deaths. Twenty-one of these children were themselves known to DoCS and the remaining four children had one or more of their siblings known to DoCS.
- Eight children were not known to DoCS. Four of these children died of abuse, and four died of neglect.
- Twenty-six were four years of age or younger when they died.
- Fourteen of the children were male and 19 were female.
- Five of the children were identified as Aboriginal.
- Criminal charges have been laid in relation to 13 of the deaths, including nine murder and two manslaughter charges. NSW Police have informed us that inquiries are continuing into a number of deaths.

2.5 Manner and circumstances of death

Full coronial information was not available at the time of writing for 40 (34%) of the 117 deaths in 2005. These matters will be carried over for comment in next year's annual report.

Most of the deaths occurred in the family home (63, 54%) or in hospital (39, 33%). There were a small number of deaths that happened in public places, for example, on the road as the result of motor vehicle accidents, or in one instance, a public swimming pool.

The manner of death determined by the Coroner is as follows:

Manner of death **Table 5**

	All Reviewable Deaths
Natural manner	50 (43%)
Homicidal manner	12 (10%)
Accidental manner	7 (6%)
Undetermined/unascertained	5 (4%)
Suicidal manner	3 (3%)
Coronial process is open (manner not yet determined)	40 (34%)
Total	117 (100%)

The Coroner determined a natural manner of death for close to half of the children (50, 43%). Within this category, the most commonly occurring causes of death included the following: extreme prematurity, congenital abnormalities, infection, respiratory conditions and Sudden Infant Death Syndrome.

2.6 Coronial and criminal status

Reviewable deaths are also Coronial deaths under section 13AB of the *Coroners Act 1980.* This legislation requires reviewable deaths to be referred to the Coroner. The Coroner will examine, and may hold an inquest into, these deaths.

In 2005, the Coroner held an inquest into three (3%) deaths, dispensed with an inquest in 63 (54%) cases and terminated the inquest process in relation to 11 (9%) deaths. Coronial processes for the remaining 40 (34%) deaths are still open, with no decision made as to whether an inquest will be held.

An autopsy was performed in 66 (56%) cases. Of the remaining 51 deaths, 44 deaths were not referred to the Coroner at the time they were registered with BDM, thus preventing an autopsy from being carried out, and in two cases, next of kin did not wish an autopsy to be performed.

Criminal charges have been laid in relation to 13 (11%) of the deaths. Police are still making inquiries into a further five deaths.

Endnotes

7 Throughout this section, we have rounded figures to the nearest whole percent.

8 In 2005 we modified our definitions of abuse, neglect and suspicious deaths. To provide a comparative base we re-assessed the deaths that occurred during the 2003 reporting period according to our new definitions. In our 2005 *Report of Reviewable Deaths in 2004,* we reported on the changes that would result had we applied the new definitions. The figures in table 1 are based on an application of the definitions adopted in our 2005 report.

9 As defined in CS CRAMA.

10 DoCS (May 2006) *Annual Statistical Report 2004/05.*

3. Parental substance abuse

As noted above, this report gives particular consideration to issues we identified for children whose parents had a history of substance abuse. The following provides an overview of the characteristics and circumstances of these children, and of the issues and challenges that arise for agencies working with families where substance abuse is a concern.

3.1 Parental substance abuse and children who died in 2005

From our examination of agency files relating to the 117 children who died in 2005 and whose deaths were reviewable, we identified 54 cases in which records indicated a history of parental substance abuse.[11] Of these cases:

- The families of nearly all of the children (53 of the 54) were known to DoCS.
  - In 39 cases, the child who died had been reported to DoCS in the three years prior to death.
  - In the remaining 14 cases, the deceased child had a sibling who was the subject of a report to DoCS during the three-year period. Most of this latter group were infants, some of whom died soon after birth.
- We considered that for 24 children, parental substance abuse was a significant risk factor in their lives.[12]
- Parental substance abuse was directly linked to the circumstances of death for eight children. All of these children were known to DoCS. Six of the deaths occurred in suspicious circumstances, one death resulted from abuse and one death was due to neglect.

Thirty-two of the children were the subject of risk of harm report(s) that included concerns about drug or alcohol use by a carer in the 12 months before their deaths. More than half of these children were the subject of two or more such reports. In addition to drug or alcohol related concerns, the reports frequently identified risk of harm from other issues, such as domestic violence, mental health, physical abuse and neglect. Many reports also included concerns about siblings.

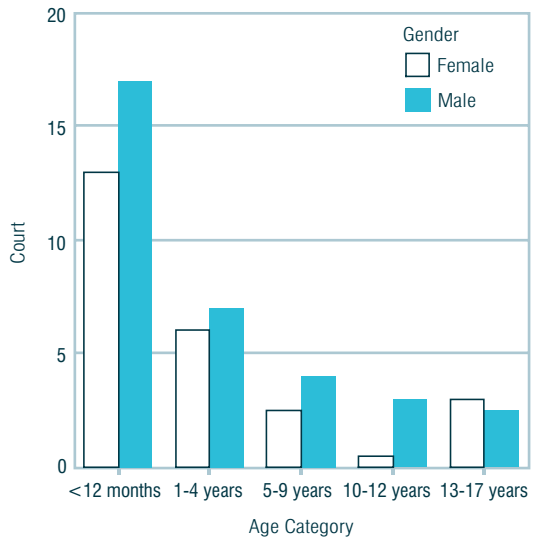
3.2 Characteristics and circumstances of the children who died

Age and gender of the children

The 54 children ranged in age from one day to 17 years. The large majority (47) were less than five years of age. Nearly two-thirds of the children (34) were less than 12 months old. Three children were teenagers.

Thirty of the children were male and 24 were female.

Age by gender — children in families with a history of parental substance abuse Fig 2



Family circumstances

Twelve of the 54 children were identified as being of ATSI background.

Almost three-quarters of the children resided with at least one birth parent (39). However, close to one-quarter of the children (13), were never discharged from hospital, and died shortly after birth. Many of these children were born prematurely.

The majority of the children who lived in families where parental substance abuse was apparent had siblings (46). Generally, family size for these children appeared to be relatively large, with close to one third of the children (18) having four or more siblings.

One child was subject to an interim care order allocating parental responsibility to the Minister, but was placed with his mother at the time of his death. Another three children had previously been in a temporary care placement arranged by DoCS, but they were not in care when they died.

Five of the children had sibling(s) who lived in long term out-of-home care. In all five cases, DoCS initiated the sibling(s) placements in response to risk of harm report(s) and took action in the Children's Court that led to final care orders being made.

Circumstances and cause of death

Deaths due to abuse or neglect, or occurring in suspicious circumstances

Twenty of the 54 children died in circumstances related to abuse or neglect, or their deaths occurred in suspicious circumstances. Nineteen of these 20 children were known to DoCS. The one child who was not known to DoCS was, however, known to child protection services in another state.

- Four children died as a result of abuse.
- Seven children died as a result of neglect.
- The deaths of nine children were considered suspicious.

Criminal charges have been laid in relation to seven of these deaths.

Deaths due to other causes

Thirty-four of the 54 children died from causes that were not due to, or suspicious of, abuse or neglect.

The most common causes of death in these cases were:

- Complications linked to extremely premature births (nine deaths).
- Congenital abnormalities (six deaths).
- Infections or communicable diseases (six deaths).
- Sudden Infant Death Syndrome (three deaths).
- Accidents (two deaths).

The cause of death for six children could not be determined. Two of these deaths occurred in the context of co-sleeping or bed-sharing. In the other four cases, the cause was listed as 'undetermined — SIDS category II', indicating that certain other explanations for the death (such as mechanical asphyxia) could not be completely ruled out.[13]

Coronial and Criminal proceedings

At the time of writing, the Coroner had dispensed with an inquest in almost half (25) of the 54 cases where we identified parental substance abuse as an issue in the family. For 21 deaths, the Coroner's decision as to whether an inquest will be held was pending. In seven cases, the Coroner had terminated the inquest because criminal charges had been laid. In one matter, an inquest was held, however no coronial recommendations were made.

Charges have been laid in relation to seven of the 54 child deaths where parental substance abuse was identified as an issue in the family. These seven include four deaths where we determined that parental substance abuse was directly relevant to the circumstances of the child's death.

3.3 Issues and challenges where parental substance abuse is a risk factor

There are no reliable measures of the extent of substance abuse among people who have children in their care. Over the past decade, Australian researchers have noted a dearth of relevant data.[14] National data sets that survey household drug and alcohol use or illicit drug use do not provide detailed information about users who are also parents.

In NSW, data collected by DoCS in 2004/05 shows that concerns about drugs and alcohol often featured in risk of harm reports. The DoCS Helpline received a total of 216,386 reports in that year. Carer drug or alcohol use was the main reported concern in nine per cent of these reports. When considering all of the concerns raised in reports, over 42,000 reports (19%) included a concern about drug and alcohol use.[15]

In relation to this data, DoCS told us that the prevalence of carer alcohol, drug, domestic violence and mental health issues in child protection cases is greater than that identified through its client database, and the percentage of reports that involved carer drug and/or alcohol abuse in 2004/05 was likely to be between 42 and 56 per cent.[16,17]

Issues and challenges identified through our reviews

In the main, the issues and challenges we identified in reviewing these cases largely replicated those we identified for all children who died in 2005. That is,

we found that the level of risk to the children was not always adequately recognised or reported; that when reported, concerns were not always fully assessed or responded to; and that measures taken by agencies — alone or jointly — to protect children at risk were not consistently effective.

However, we also identified some significant additional issues and concerns that present specific challenges for caseworkers and others dealing with families where substance abuse is an issue.[18] For instance:

- Substance abuse was rarely a sole risk factor, and was often present in conjunction with domestic violence, physical abuse, neglect and in some cases, mental health issues. In many of the families, one or both parents had criminal records or were otherwise known to police. In some cases, risk to the child was exacerbated by chaotic family lifestyle and ensuing problems such as homelessness. In this context, it is a challenge for agencies to address the multiplicity of issues while retaining a clear focus on the child.
- Our reviews confirmed that parents who are drug dependent may be difficult to engage, may avoid contact with agencies and seek to conceal or minimise drug or alcohol use. Conversely, they may be compliant, and agree to make changes that may not be sustainable for them. The high rate of relapse and the unpredictability of behaviour when using substances make assessment a complex task.
- In many cases, we found evidence that parents were chronic and/or poly-drug users.[19] The types of drugs used by parents included heroin, amphetamines, cocaine, cannabis and prescription drugs such as benzodiazepines. A number of parents had been using illicit drugs since their early teens, and in some families, siblings had been born with symptoms of Neonatal Abstinence Syndrome. In some cases, we identified that parents were involved in drug treatment programs at the time their child died. Adequate identification of a parent's substance use as a risk to children requires knowledge about illicit and legal drugs and alcohol, how they are used and the range of their effects. The amounts, frequency and context of use may all be relevant in determining risk. It was not always evident in the cases we reviewed that caseworkers had the necessary level of knowledge and training to inform their assessment of, and responses to, risk.
- In 10 cases we reviewed, pre-natal reports indicated that the child's mother used illicit drugs during pregnancy. While there is provision in the *Children and Young Persons (Care and Protection) Act 1998* for responding to pre-natal reports of risk of harm, our reviews indicated a particular challenge for agencies in effectively engaging and supporting women using drugs in pregnancy, in order to minimise the subsequent risk to her child.
- Common in many of the cases where parental substance abuse was an issue in the families of children who died was their young age. In all reviewable deaths, one half of the children who died were under 12 months of age. In cases where parental substance abuse was evident, however, nearly two-thirds of the children were under 12 months of age when they died.

Determining the level of risk posed to a child in circumstances where parental substance use or abuse is evident is a significant challenge for agencies that have contact with the child and their family.

It cannot be assumed that all people who misuse substances are unable to adequately care for their children.[20] For instance, parents may limit substance misuse to times where children are not in their care, or the children may have significant support from other members of the family. Assessing risk also needs to take account of factors such as measures being taken by the parent to overcome their dependence or misuse, and whether these measures are sufficient to ensure a child's immediate and longer-term safety.

However, where parenting capacity is affected, the results for children can be significant.[21] The effects of substance abuse may render parents unable to identify or meet the basic needs of their children, including adequate food and medical care. Parents' ability to supervise children or to drive safely may be compromised. Certain drugs or alcohol may trigger violent or psychotic episodes that directly endanger children. Being drug or alcohol affected and co-sleeping with children significantly raises the risk of overlaying and suffocation of the child. Substance abuse in pregnancy is associated with premature birth and a range of harmful effects on the developing foetus and newborn baby.[22] Substance abuse may also result in circumstantial problems arising from the cost of drugs — the family may, for example, experience homelessness, resulting in children's welfare being further compromised.[23]

Previous work on child deaths and parental substance abuse

The NSW Child Death Review Team (CDRT) 1998/99 annual report incorporated a review of 86 child deaths that occurred between January 1996 and June 1999 and where a history of parental substance use was evidenced.[24] Seventy of the 86 families had had previous involvement with DoCS.[25]

The CDRT found that children of substance using parents were significantly over-represented among

children whose deaths were a result of SIDS, non-accidental injury, acute toxicity and bed sharing. There were also a disproportionately high number of deaths where the cause was undermined and/or occurred in suspicious circumstances.

Significant issues identified in the report included:

- In relation to pregnant women, lack of implementation of appropriate antenatal detection and management of parental drug dependence.
- In relation to children born to drug dependent parents, a failure, at times, of hospital staff and general medical services to report 'high-risk' cases involving parental substance abuse to DoCS. The Team also raised concerns about DoCS, at times, classifying notifications as 'information only' with no requirement for follow-up.
- In the perinatal period, lack of specialised drug and alcohol assessment when parental drug use was suspected, inadequate or no discharge planning for substance dependent parents and their babies, and concerns about the practice of discharging babies experiencing withdrawal symptoms.

The work of the CDRT included a range of recommendations to government agencies, particularly DoCS and NSW Health. Among other responses to the recommendations, NSW Health developed and published the *Neonatal Abstinence Syndrome Guidelines (2002)*.

As outlined below, a number of the concerns raised by the CDRT remain evident in reviews of child deaths in 2005.

Endnotes

[11] Records we reviewed included DoCS, NSW Police and NSW Health records. We included cases where the records indicated that substance use by parents or carers resulted in impaired parenting capacity and subsequent risk to a child.

[12] 'Significant risk' was indicated by factors including: more than one report being made to DoCS in the 12 months prior to the child's death that indicated the parent had a severely compromised capacity to care for their child(ren); a documented history of violence associated with the parent's substance use; records indicating a hazardous level of drug or alcohol use in pregnancy and/or the child being born with neonatal abstinence syndrome; parental substance abuse being directly relevant to the circumstances of the child's death.

[13] SIDS category II is defined in Coronial documentation as 'the sudden and unexplained death of an infant under one year of age, and apparently occurring during sleep, and which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history, but where age range outside IA/IB (i.e. outside of > 21 days but < 9 months), where there is a history of deaths in siblings or other infants under the same caregiver, where mechanical asphyxia is considered but not determined with certainty and/or where abnormal growth, or more marked pathological abnormalities are identified at autopsy'.

[14] Tomison, A.M., (1996) 'Child maltreatment and substance abuse', *National Child Protection Clearinghouse Discussion Paper Number 2*, p.4.

[15] DoCS (May 2006) *Annual Statistical Report 2004/05,* p.14.

[16] DoCS' response to a draft copy of this report, in correspondence dated 17 October 2006.

[17] DoCS arrived at this estimate though analysis of a sample of client records. The reasons for under-enumeration of these issues in the DoCS Key Information Directory System (KIDS) records include that coded fields only record the circumstances of the current report and not the carer's history, and that concerns may be present but not associated with the current report and therefore not recorded.

[18] These findings are consistent with other research on the topic. See for example Tunnard, Jo, (2002) *Parental drug misuse — a review of impact and interventions studies*, p.3, accessed via www.rip.org.uk.

[19] For the purpose of this report, we defined poly-drug use as evidence of the use of two or more psychotropic drugs. We included alcohol, and all illicit drugs, such as cannabis, heroin and amphetamines. We also included prescription drugs such as benzodiazepines, analgesics and methadone, where there was evidence that the drug was used for non-medical purposes.

[20] NSW Health (2005) *Interagency guidelines for the early intervention, response and management of drug and alcohol misuse.* P.24 see also, Tunnard, Jo, (2002) *Parental drug misuse — a review of impact and interventions studies*, accessed 5/10/06 via www.rip.org.uk.

[21] See for example, Patton, N (2003) *Parental drug use — the bigger picture. A review of the literature,* The Mirabel Foundation, Melbourne.

[22] Barth, Richard. P, (2001) 'Research outcomes of prenatal substance exposure and the need to review policies and procedures regarding child abuse reporting' in *Childwelfare League of America,* 80; 2; pp.278.

[23] Tunnard, Jo, (2002) *Parental drug misuse — a review of impact and interventions studies,* p.10, via www.rip.org.uk

[24] NSW Child Death Review Team (2000) *1998–99 Annual Report.*

[25] Until December 2002, when the reviewable deaths function was established within the office of the NSW Ombudsman, the NSW Child Death Review Team reviewed the deaths of all children in NSW.

4. Identification of, and initial response to, risk

DoCS has lead responsibility for responding to concerns that children may be at risk of harm. However, DoCS is only able to respond if it is aware of the risk. Anyone who has reasonable grounds to suspect that a child or young person may be at risk of harm can make a report to DoCS. Any person who, as part of their paid work, delivers health, welfare, education, children's or residential services or law enforcement to children, is a mandatory reporter under the *Children and Young Persons (Care and Protection) Act 1998*. Police, health care workers and providers of non-government community services are mandatory reporters, and as such have a responsibility to recognise and report risk of harm to DoCS.

Reports can also be made about an unborn child where a person believes the child will be at risk after birth. These pre-natal reports are not mandatory.

Reports of risk of harm are made to a central intake point, the DoCS Helpline. The Helpline undertakes an assessment of reports to determine the nature of any initial response by DoCS. In doing so, the Helpline considers the reported information and any available history and determines the level of risk posed to a child. If the Helpline assesses that a child may be in need of care and protection, the report will be referred to a DoCS Community Service Centre (CSC) or a Joint Investigation and Response Team (JIRT).[26]

Our reviews of child deaths in 2005 raised some particular concerns about how agencies identified and reported risk of harm, including how information was communicated to DoCS, the adequacy of history checks to inform accurate risk assessment, and the handling of matters indicating criminal offences. Our reviews also revealed issues relating to identification, and provision of an initial response to, risk associated with parental substance abuse. These included health services' response to maternal substance use, the handling of pre-natal reports, and child deaths related to methadone toxicity. These issues are discussed below.

4.1 Agency identification and reporting of risk of harm

In some of the matters we reviewed, we questioned whether agencies had given adequate consideration to making a risk of harm report to DoCS when responding to incidents affecting the safety and welfare of children. Our reviews indicated that agency staff may not fully appreciate the extent of their obligation as mandatory reporters, and highlighted the need for clarity in guidance provided to staff about identifying possible risks to children.

In one case, for example, domestic violence was a key factor in the family of a child who died. In investigating this case, we found a community service did not make a risk of harm report to DoCS after they had been approached by the children's mother for assistance. The mother told the service that her young children were in the sole care of her partner, who had assaulted her and had been drinking throughout the day. The service's view was that they were correct to take *'at face value'* the mother's assurance that her partner would never harm the children. The service told us it was not its function to do *'investigative work of possible breaches of the law'*. We disagreed with this view. Mandatory reporters must reasonably assess information in order to determine whether there are reasonable grounds to suspect that a child is at risk of harm. We advised the service that in our view, this is not investigative work related to illegal activity, but the core work of professionals working in welfare services. We have asked the service to review its policies, procedures and staff training strategies in regard to identifying and reporting risk of harm.

In the same case, we also identified a concern with NSW Health procedures relating to domestic violence. In this instance, the woman presented to an emergency department following a serious assault by her partner. Health records we examined provided no evidence that the hospital made enquiries about the existence, whereabouts and safety of any children in her care. We found that the NSW Health *Policy and procedures for identifying and responding to domestic violence* was not clear as to whether staff are required to make such enquiries, and only make specific reference

to staff being required to act where they are aware a client presenting as a result of domestic violence has children. We asked the department to review policy and procedural guidelines to ensure they give sufficient direction to health staff. NSW Health agreed to address our finding without delay: they told us they would prepare a policy directive aimed at clarifying the responsibility of NSW Health staff to make enquiries regarding the existence, whereabouts and safety of any children in the full time or part time care of victims and perpetrators of domestic violence.

A significant challenge for people working in human services is to identify when drug or alcohol use constitutes risk to a child. In some cases we reviewed where parental substance abuse was an issue, it appeared that agencies did not consider risk holistically and failed to make use of relevant information to inform reporting decisions.

The recently released 2006 *Interagency guidelines for child protection intervention* provide more explicit information about making a report, and increased guidance in relation to mandatory reporting.

DoCS has also advised us that as part of the current review of the *Children and Young Persons (Care and Protection) Act 1998*, consideration is being given to the operation of mandatory reporting:

> *'Specifically, consideration is being given to whether the criteria for establishing that a child or young person is at risk of harm should be more explicit, to both ensure reporting where it is necessary and to prevent reporting where there is no real risk to a child.'*[27]

4.2 Effective communication of information to DoCS

A particular issue that arose in a number of cases related to reporting of risk of harm by fax. For example, in two cases we investigated, police records indicated

CaseStudy

We investigated a case where a young baby died. The mother had a history of chronic drug use and was sleeping with the baby and another adult when the baby died. Police reported that both adults appeared to be drug affected. An autopsy failed to determine the cause of the baby's death and the matter remains open with the Coroner.

A fortnight before the baby's death, police observed the mother *'passed out'* in the lap of another woman on the kerb of a road. On rousing her, the woman told police she had used marijuana and methadone earlier in the day, and refused their offer of medical assistance. Police officers noted in their records that the woman appeared drug affected, that her companions were known to police for a variety of drug and other offences, that she had given birth in recent months and that DoCS was supervising her interactions with the baby. Police did not report this incident to DoCS.

Police records showed that some days earlier, an agency had requested police to conduct a 'welfare check' on the baby, because of concerns for the baby's safety, the mother's mental health and possible substance abuse. Police had located the mother and baby and taken them to the police station, where DoCS caseworkers attended to assess the mother's ability to care for the baby and to ensure the baby was medically examined. The caseworkers took the baby and the mother to hospital, and the baby was admitted overnight for medical review.

We asked NSW Police to consider whether it was reasonable that police officers did not make a child protection report. Police advised us that the mother told attending officers that the baby was in the care of other persons, and that there was therefore no reason to suspect that the baby may have been at risk of harm. Police acknowledged, however, that it may have been preferable for the officers to make inquiries about who was caring for the child and confirm the child's whereabouts. Police told us that they would develop an article for publication to provide information to officers about identifying risk in relation to children at risk of harm.

In our view, given the mother's presentation and police awareness of her drug history and DoCS involvement, this incident warranted reporting to DoCS.

that reports of risk of harm had been faxed to DoCS. This was not supported by DoCS records. In neither case did police have a reference number for the report. NSW Police *Child Protection Standard Operating Procedures,* which are currently under review, require police to obtain a call reference number from the Helpline when making a report.

Our reviews also highlighted the importance of information provided being sufficiently comprehensive to assist DoCS caseworkers to make an accurate assessment of risk. For example, in a case that we investigated, police faxed a report of a serious domestic incident involving a woman and her children. The fax advised that the woman had made a statement to police and wanted the perpetrator charged and an ADVO taken out. During initial assessment, the information provided in the fax was interpreted to indicate that the mother was acting protectively. What the police did not include in the report was that the woman was reluctant to make a complaint and had to be persuaded to make a statement. If DoCS had had this information, their assessment of the mother's protective capacity may have been different.

Fax may be a timely and convenient way for mandatory reporters to lodge risk of harm reports. However, failure to ensure receipt of faxed reports of risk of harm to the Helpline, and delays in agencies making risk of harm reports, can hamper the possibility or effectiveness of a subsequent response. DoCS told us that it views the use of fax to make risk of harm reports as a last resort, and noted that responses may be delayed if a fax does not include sufficiently comprehensive information and the reporter cannot be contacted.[28] Nonetheless, fax will continue to be an avenue to make reports and similar issues are likely to arise with the proposed introduction of electronic or 'e-reporting'.[29] It is therefore critical that there are appropriate safeguards to ensure that information about risk of harm that is conveyed in written form is received and can be followed-up by DoCS.

In response to a draft copy of this report, DoCS told us that it and NSW Police have commenced a joint project to improve risk assessment procedures for child protection reports from NSW Police. The project will *'examine the characteristics of incidents reported to DoCS by Police and the outcomes for these reports'*, and *'develop some options for improved reporting mechanisms and risk assessment in police reports.'*[30]

Our previous recommendations about effective communication of information to DoCS

Last year, we recommended that NSW Police, in reviewing their domestic violence and child protection standard operating procedures, ensure that the procedures encourage full and relevant reporting to DoCS on the type and level of risk posed to children who are present at a domestic violence incident.

NSW Police told us that telephone reporting has been mandatory since October 2005.[31] Police officers may still report by fax, but must telephone and wait on a Helpline phone queue for five minutes before fax may be used. NSW Police told us that this had improved the quality of information being provided to DoCS. Police also said that the review of the *Child Protection Standard Operating Procedures* will fully address the issue of full and relevant reporting to DoCS of all children living in a household where there has been an incident of domestic violence and the children are considered to be at risk.

4.3 Determination of child protection history

In both our previous reports of reviewable deaths, we have noted the critical importance of understanding the child protection history of a family, in order to holistically assess the likelihood of current risk. In our reviews of deaths in 2005, we found that, at times, inadequate history checks were conducted in the initial assessment of risk of harm reports, resulting in an incomplete basis for determining current probability of risk within a family. We raised concerns with DoCS about history checks in a number of cases.

These concerns focused on the failure of the Helpline to identify all relevant child protection history for the family at the time of initial assessment, resulting in decisions being made about a child's safety without full knowledge of previous risks identified within the family. In two separate cases that we investigated where the children died, reports about substance abuse were closed without assessment for children where DoCS had previously taken protective action for older siblings. In neither case did DoCS' initial assessment identify this history. In both cases, the siblings had been placed in long term care as a result of proceedings in the Children's Court, and parental substance abuse had been a significant factor in the decision to remove the older children. In relation to the two children who died, both died in circumstances directly related to parental substance abuse.

We also found that discrepancies in information held by DoCS at times made determination of a family's child protection history difficult for DoCS staff. For instance, in two matters we reviewed and reported to DoCS, we found different or multiple reference numbers for the child subject to a report or for relevant persons. Different numbers can result in a failure to link reports and children in searches of the DoCS database.

Our previous recommendations about determining child protection history

In our first *Reviewable Deaths Annual Report 2003–2004*, we said that DoCS should develop strategies to ensure staff adhered to policies regarding

consideration of the child protection history of a child and their family.

DoCS told us in 2005 that the department had emphasised child protection history in training, the Helpline would be implementing a 'rolling quality review process', and that following new procedures for history and person searches being introduced, the Helpline would implement a compliance monitoring system. We noted these to be clear indicators of progress.

DoCS advised us that procedures for searching and recording child protection histories have been updated and now contain minimum requirements, and that training for new caseworkers in 'history' and 'person' searches has been updated. DoCS said that the Helpline is using a compliance checklist to monitor caseworker adherence to the procedures.[32]

4.4. Reports indicating criminal offences

In our *Report of reviewable deaths in 2004*, we raised questions about referral of reports indicating possible criminal offences to JIRT or police. We noted some apparent confusion within DoCS' policies and procedures about which matters should be referred to JIRT and/or police.

We have continued to identify issues regarding referrals to, and handling of matters by, JIRT, and the relationship between JIRT, DoCS and NSW Police.

This year, we completed an investigation about the handling of risk of harm reports for a teenage girl who died in 2004. The investigation found significant problems with coordination between DoCS and JIRT in the handling of reports that indicated possible sexual offences. Among other issues, we raised concerns about the information used to determine whether or not JIRT can act on referrals from the Helpline.

Three of four reports referred to JIRT about possible sexual offences against the girl were determined to not meet the JIRT criteria, and were rejected. Two reports were rejected because of an assessment that the child had not disclosed sexual abuse. In our view, this assessment appeared to have been made in the absence of fulsome information. In one instance, the report related to concerns that the girl, then 14 years of age, was at risk because of her involvement with adult males and that she had been involved in a relationship with one of the men. In another report, the reporter alleged that the girl was being 'groomed' by adult men. We raised concerns with police that the reports had been rejected without making inquiries to clarify the information at hand. It was our view that there had not been sufficient opportunity for the girl to disclose abuse.

We proposed that NSW Police consider whether reasonable inquiries were made to inform JIRT's intake decisions. NSW Police advised us that *'the decisions to accept or reject a notification is made solely on the information contained in the notification.'*[33] The rationale given for this was firstly, the perception that once inquiries are made *'it could be deemed they commence an investigation'*, and secondly, JIRT staff have a limited capacity to follow up on Helpline information where that information is insufficient.

We also found that in two of the instances where JIRT referred the reports back to DoCS, the reasons provided for the decision were minimal and misleading.

In our final report on this matter, we told NSW Police that JIRT should, when advising CSCs of JIRT rejection decisions, clearly document what information is needed for proper assessment of the available evidence to be made. That is, if there are gaps in the information provided to JIRT, this should be spelt out and some indication of what would be required for JIRT to take up the matter should be given.

Our reviews of deaths in 2005 also raised issues relating to reports not being referred to JIRT when they appeared to meet JIRT criteria, and inadequate responses to reports unable to be taken up by JIRT.

In one case we investigated, we raised concerns about two risk of harm reports made to DoCS that alleged serious physical abuse, including a baby being rendered 'half unconscious'. While DoCS responded to the reports, neither was referred to JIRT or Police.

As part of our investigation into another matter, we considered agency responses to a report alleging that an adult had written sexually explicit words and images on the bodies of two young children. The report was referred by the Helpline to JIRT, but JIRT rejected the report on the grounds that it did not constitute a sexual offence. JIRT referred the report to a CSC and to a local area police command (LAC). However, DoCS was reportedly given incorrect advice by the LAC that police were unable to interview children under 14 years. The report was subsequently closed by DoCS due to 'current competing priorities'. Our primary concern in investigating the matter was the lack of priority given to the report, and that the issues it raised were not addressed in an assessment of the matter by DoCS that commenced some months later.

Our previous recommendations about JIRT

In our report last year, we asked DoCS to advise us of its progress in achieving its stated priority of *'improving accuracy of referrals to JIRTs and monitoring compliance with JIRT criteria'*.[34]

In relation to JIRT, DoCS told us:

- A working group of DoCS, Police and NSW Health is developing 'improved physical abuse criteria' for JIRT referrals;

- a 2004 procedure requires CSCs to review case plans rejected by JIRT to ensure they receive a response commensurate with risk and safety issues, and
- a memorandum of understanding between DoCS and Police, inclusive of a section relating to JIRT, will be completed by 2007.

DoCS also advised us that the Helpline had undertaken an analysis of a sample of declined JIRT referrals, and found a degree of inconsistency regarding acceptance of referrals. DoCS said this information was provided to JIRT coordinators, and a further analysis of a more representative sample of JIRT declined referrals would occur in October 2006.[35]

In response to a recent investigation by this office, DoCS advised us in August 2006 that DoCS, NSW Police and NSW Health will now undertake a review of JIRT systems, policies and processes. The review will consider referral processes, and *'improvements in the provision of protective action and support to victims and families where a criminal justice response is not appropriate.*[36]

The decision to undertake a comprehensive review of JIRT is timely and positive.

4.5 Health response to maternal substance use

Risk of harm from maternal substance abuse is high during pregnancy and infancy. Maternal substance abuse pre-natally is associated with increased health problems for the baby, including prematurity, developmental delay, growth retardation and Neonatal Abstinence Syndrome.[37, 38] Babies with high needs born to mothers with a history of substance abuse may be particularly vulnerable if the mother is still using a hazardous level of drugs and/or alcohol at the time of birth; has recently entered drug treatment, when the risk of relapse is high; or has a chaotic lifestyle.[39] Babies born to substance using mothers may be more vulnerable to Sudden Infant Death Syndrome or suffocation while sleeping with an affected parent.[40]

Records we reviewed provided evidence that the mothers of 14 children who died in 2005, and were aged less than 12 months when they died, used hazardous levels of alcohol or other drugs during their pregnancy with the child. The causes of death for these children were:

- SIDS (four children, including three determined as SIDS Category II)[41]
- extreme prematurity (three children)
- drug toxicity (one child)
- effects on the unborn child of assault on the mother (one child)
- natural causes (one child)

For a further three children, the cause of death was undetermined, and the Coroner is yet to determine the cause of death for one child. Three of these children died during sleep, two of whom were sleeping with an adult.

Drugs-in-pregnancy services

Specialist antenatal health care services for pregnant women who misuse alcohol and other drugs are available in Area Health Services in NSW. These operate under different models of service provision. In some areas, there are dedicated drug use in pregnancy programs that feature collaborative work with non-government organisations. In other areas, services are provided as required by combinations of midwives, drug and alcohol nurses and other health professionals. The services include the Chemical Use In Pregnancy Service (CUPS), Substance Use in Pregnancy and Parenting Service (SUPPS), Drugs in Pregnancy Teams (DIPT) and Drugs in Pregnancy Services (DIPS). The teams '*provide support to pregnant women and their families throughout the pregnancy, during the birth and in the weeks and months following delivery'*.[42]

Health workers in these services are well positioned to identify and assess risk of harm from parental substance abuse. However, it appears that there is no central coordination, monitoring or review of the various drugs in pregnancy services across NSW, and no common standards or benchmarks for service delivery. In this regard, NSW Health advised us that it had distributed the *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* to key stakeholders, and further, that the *Neo-natal abstinence syndrome guidelines* apply to all health workers involved with the management of pregnant women who are dependent on drugs or alcohol.[43] We are unaware of any state-wide evaluation having been undertaken of drugs-in-pregnancy services.

Responding to child protection concerns

Various NSW Health policy, procedures and guidelines direct health care workers in identifying and reporting child protection concerns arising from parental substance abuse.[44] Where drug or alcohol concerns are identified, including in cases where a baby is born affected by drugs, health staff are required to consult with a health worker with expertise in child protection in order to make an initial assessment of risk to the infant. Where child protection concerns are identified, health care workers are directed to make a report to DoCS and a protection planning meeting should be held prior to the baby's discharge from hospital.[45] NSW Health *Neonatal Abstinence Syndrome Guidelines* require a formal discharge plan to be developed for a baby who displays signs or symptoms of Neonatal Abstinence Syndrome.

The basic aim of procedural guidance for responding to substance abuse concerns prior to, or after, a child's birth is to ensure that a child is discharged from the care of health services to a safe environment with appropriate health and social support to the baby and family.[46] Our reviews raised some questions about the adequacy of the level of coordination, assessment and planning by health services in the post-natal period for some children born to mothers who had a history of substance abuse or were known to have used substances during pregnancy.

- For some babies, we did not find evidence that health workers had made an initial assessment of risk to determine whether a report to DoCS was required.
- Formal, multi-disciplinary discharge planning did not occur for some babies who were born with Neonatal Abstinence Syndrome and/or whose mother was known to have used concerning levels of alcohol or other drugs during pregnancy. This was the case even when health workers had recognised concerns prenatally and made reports to DoCS.
- The mothers of some babies who were born with Neonatal Abstinence Syndrome were receiving methadone treatment at the time of the birth, but had also used other drugs during the pregnancy, or had only commenced methadone during the pregnancy. In these cases, it was unclear whether comprehensive drug and alcohol assessment occurred.
- In some cases, we found that the responsibility for coordinating services and support to the family was unclear. We also found that at times, there were no clear plans to monitor or review the progress of the mother and baby following discharge from hospital.

For example, in one case we investigated, we were concerned about whether hospital staff followed NSW Health procedures in planning for the baby's discharge from hospital. We found no evidence that staff recognised risk of harm for the newborn baby, or that a child protection expert within the health system was consulted so that a preliminary assessment of risk could occur. This was despite the fact that two pre-natal reports had been made by the hospital about the unborn baby, in relation to the impact of domestic violence in the family, the mother's hazardous use of alcohol, and poor antenatal care. At the time of discharge, the mother was itinerant and had no permanent accommodation. No discharge planning meeting was held, and it was unclear whether the various health services provided to the mother and baby after discharge were sufficiently integrated. In conducting its own review of the case, the Area Health Service identified the challenge for health services across the area to be able to effectively share information for transient families.

4.6 Response to pre-natal reports

Under section 25 of the *Children and Young Persons (Care and Protection) Act 1998*, a person who has reasonable grounds to suspect that an unborn child may be at risk of harm after his or her birth can make a risk of harm report to DoCS. While not mandatory, pre-natal reporting provides an opportunity for early support and assistance to pregnant women. Its purpose is to reduce the likelihood of risk of harm after the child is born.

Most pre-natal reports we reviewed were made by reporters as a result of, or included, concerns about maternal substance abuse.

NSW Health, as a key provider of antenatal care, plays an important role in identifying women whose babies may be at risk of harm because of parental substance abuse. NSW Health policies support health workers making a pre-natal report where there are indicators that an infant may be at risk of harm.[47]

DoCS does not publish data on the number of pre-natal reports it receives, or on how the department has responded to them. Last year, we reported that our work in relation to children who died in 2004 indicated that pre-natal reports may not be providing the opportunity for support and intervention envisaged by the Act.

Ten children who died were the subject of pre-natal reports that raised concerns about the mother's use of alcohol or other drugs during pregnancy, or her known history of substance abuse.

The Helpline forwarded most of these reports to a CSC for further assessment. However, once received at a CSC, we found that the reports received a low priority for allocation. Records we reviewed indicated that, in most cases, the CSC did not initiate any contact with the mother during the pregnancy and did not assess what supports might be required to reduce risk of harm to the baby after the birth. We identified only two cases where a Stage two secondary assessment was initiated as a result of a pre-natal report about substance abuse.

Our previous recommendations about pre-natal reports

In our *Report of reviewable deaths in 2004*, we recommended that DoCS should give priority to risk of harm reports or pre-natal reports for a child or unborn baby living in a family where a child has been previously removed by an order of the Children's Court. We told DoCS that at the least, implementation of this recommendation should be the inclusion of previous sibling removal as a criterion for priority assessment in the department's *Intake Assessment Guidelines*. DoCS has told us that it has done so, and that previous removal of a sibling will be a criterion to prioritise certain reports for secondary assessment stage one.

CaseStudy

We investigated the conduct of DoCS and an Area Health Service in relation to two children who were in the mother's care.

The baby was the subject of five pre-natal reports in 2005 that also concerned risk of harm to the sibling. Care proceedings for two older children had led to their placement in long-term care some years earlier because of ongoing domestic violence, neglect and the mother's substance abuse. The first three pre-natal reports concerned the mother's heavy abuse of alcohol and other drugs, domestic violence and lack of antenatal care. These reports were referred to a CSC but were closed without assessment under the department's case closure policy. The CSC allocated the case after receiving a fourth pre-natal report concerning domestic violence and physical abuse that occurred in the context of parental substance abuse. Caseworkers assisted the mother and her child to move to another town. DoCS completed an assessment but it was not comprehensive. It did not consider the child protection history for her two children who had been removed from her care, the mother's substance abuse and her capacity to care for the child who remained with her, or future risk of harm to the unborn baby. DoCS substantiated risk of harm from domestic violence, physical abuse and psychological harm for the child, but concluded that future risk was low because the mother had moved from her violent partner. The child was not considered to be in need of care and protection and the case was closed.

A fifth pre-natal report was received within a fortnight, and indicated that the mother was using drugs intravenously and was not receiving antenatal care. She was said to be neglecting the needs of her child and unborn baby. The mother had moved again and was itinerant, and DoCS caseworkers could not locate the family to assess this report. The case remained open but unallocated.

Health workers contacted the CSC when the baby was born to notify the family's whereabouts. Although there was still an open risk of harm report for the baby and child, the CSC did not allocate the case for assessment of current risk. No interagency discharge planning occurred prior to the baby leaving hospital, although the CSC and the hospital knew of the mother's history of transience and substance abuse. The DoCS case remained open but unallocated until the baby's death, in suspicious circumstances, five weeks later. DoCS subsequently assumed the care of the older child.

We also recommended that DoCS develop clear policy and procedural guidance for DoCS staff in relation to handling pre-natal reports.

DoCS has advised us that it is currently developing a draft policy on responding to pre-natal reports. This will include consultation with NSW Health. The policy will describe the actions required at the Helpline and at CSCs in response to pre-natal reports, and set down criteria to indicate whether an early intervention response or a child protection response would be appropriate. DoCS told us that the policy will also specify the need for joint planning with NSW Health, to ensure that a protective response is in place for 'high risk' cases when the child is born.[48]

In addition, as part of the review of the *Children and Young Persons (Care and Protection) Act 1998*, consideration is being given to whether there is a need for amendment to section 248 of the Act to enable exchange of information regarding pre-natal reports.[49] In our view, a change to this effect would be desirable. The cases we have reviewed have highlighted the importance of responding appropriately to pre-natal reports, and availability of comprehensive information is an essential part of effective risk assessment.

4.7 Child deaths resulting from methadone toxicity

Since 2004, workers in NSW Health drug and alcohol services have had a centralised intake system that requires staff to ask clients about any children in their care and about their safety.[50] More broadly, NSW Health policy on child protection requires all staff to consider the parenting capacities of clients in the context of medical or health conditions.[51]

Among reviewable child deaths in 2005, we identified three deaths related to methadone poisoning. There were no such deaths identified in 2004. In 2003, one child died as a result of methadone poisoning and in another case, ingested methadone was identified as a 'significant contributing factor' in the child's death. Of the three methadone-related deaths of children in 2005, one involved takeaway methadone and one involved street methadone.[52,53] Takeaway methadone also featured in the methadone-related deaths in 2003.

Methadone is a synthetic opiate used in the treatment of heroin addiction. Treatment is commonly provided through public or private sector outpatient clinics or via selected GPs who prescribe the drug. The *NSW Drug Treatment Services Plan 2000–05* states that 13,500 clients were involved in methadone maintenance treatment in NSW, with most (70%) receiving treatment from a private medical practitioner.[54] Some methadone is dispensed as takeaway doses. NSW Health guidelines note the benefits in giving selected patients access to takeaway doses. These benefits include promoting rehabilitation, improving retention in treatment and improving access to treatment.[55]

Previous reviews of child deaths related to methadone ingestion

In 2000, the NSW Child Death Review Team (CDRT) reported on reviews of child deaths resulting from the ingestion of parental methadone. The CDRT reviewed the deaths of three infants and one young person who died between January 1996 and June 1999, after ingesting methadone. In three of the cases, the methadone was administered to the child by an adult.[56] The CDRT noted that a parent who was prescribed takeaway methadone could be at any one time in possession of a quantity of methadone that could be fatal to a child, and that drug using parents were more likely to use 'medications' to comfort or subdue children.

The CDRT subsequently recommended that the Drug Treatment Services Plan include a re-evaluation of policy of providing take-home methadone to homes where children are living. This recommendation was not supported by NSW Health, which stated in 2000:

> *A number of changes have been made to the operation of the methadone program in the last two years. Further restrictions in the application of the current take-away policy will not result in improved outcomes or reduced risk for children.*[57]

In 2001, NSW Health advised the CDRT that information about the responsibilities of clients with children in their care had been completed and distributed to all prescribers, methadone clinics and clients, and Client Treatment Agreements had been implemented that set out client rights and responsibilities around such issues as drug use, behaviour, appointments, takeaway doses, urine tests and treatment plans for methadone maintenance treatment.[58] NSW Health also advised the CDRT that the Drug Programs Bureau would conduct an audit of methadone takeaway prescription, with the aim of *'enforcing stringent methadone take-away policies'.*

We note that an audit of prescribing undertaken in 2002 revealed poor compliance by some practitioners with takeaway guidelines.[59]

NSW Health data collection and monitoring

NSW Health advised us in October 2006 that it is currently undertaking a review into the systems related to reporting fatal and non-fatal child methadone overdoses.[60]

NSW Health indicated that where methadone or any other drug of addiction is involved in a child's admission to hospital, Area Health Services should report the incident via the Statewide Incident Information Management System. Once reported, NSW Health would *'receive a Reportable Incident brief which would contain a description of the incident, the actions taken and highlight any further actions / investigations that may be undertaken by the facility as a result of the incident.'* Data is also collected through hospital data collection systems.

From a preliminary examination of data from 30 of some 140 hospital emergency departments, the Centre for Drug and Alcohol found that in the two years from 1 July 2004 to 1 July 2006, there were 12 non-fatal emergency department presentations of children due to methadone poisoning. Nine of the cases resulted in admission, with two children being admitted to a critical care unit. The children were aged between one and four years, with the median age being one year.

NSW Health told us that further to statutory requirements and general child protection policies, there is no policy regarding hospital staff informing prescribers of child methadone poisoning. However, the NSW Health policy directive on *Discharge planning responsive standards* requires *'communication with the general practitioner and/or appropriate health professionals'*, and local hospitals have policies and protocols relating to paediatric non-accidental injury and toxicology admissions.

NSW Health policies and initiatives related to opioid treatment and child protection

NSW Health reported to the CDRT in 2003 that a revised policy had been drafted *'to make explicit the circumstances under which prescribing takeaway pharmacotherapy treatment is contraindicated, the process by which prescribing decisions are reached, and the way of monitoring the risks and benefits of giving unsupervised doses.'*[61]

NSW Health subsequently introduced revised guidelines on takeaway methadone: *Guidelines for prescribing methadone for unsupervised administration 'takeaway' doses.* These guidelines are not incorporated in, but are supplementary to, the 1999 *Methadone maintenance treatment clinical practice guidelines*.

Together, the guidelines require methadone prescribers to assess the suitability of clients for takeaway dosing, to review this regularly, and also to review eligibility for takeaways if there are certain indicators of instability

or unreliability. The clinical guidelines also set weekly limits on the number of doses available for takeaways and require prescribers to ensure that clients are aware of the dangers that methadone poses to other people, including children.

While emphasising the important therapeutic role of takeaway methadone, the *Guidelines for prescribing methadone for unsupervised administration "takeaway' doses* note that there is substantial evidence for risk and actual harm associated with takeaway doses, including diverted methadone being sold onto the black market, and that deaths of children have been associated with takeaway methadone. The guidelines criteria cover 'contraindications' to the provision of takeaway doses, including '*children <4 in* (a patient's) *care about whom there is DoCS involvement, and where in case conference with DoCS staff concern about takeaway doses is expressed.'*[62]

In October 2006, NSW Health advised us that a review of the *Methadone maintenance treatment clinical practice guidelines* had been completed. Revised guidelines — *NSW clinical guidelines for methadone and buprenorphine treatment of opioid dependence* — will be published later in 2006 and will replace the earlier guidelines. According to NSW Health:

> *'These revised guidelines highlight children at risk issues and state that negative DoCS involvement is a contraindication to providing takeaway medication. The guidelines also require prescriber cooperation with DoCS information requests, this will become a condition of all prescribers' authority to prescribe (including private practitioners) when in full effect'*.[63]

NSW Health also advised that a 'take-safe' time release security device for the storage and administration of takeaway methadone has been developed and trialled in some pharmacotherapy clinics and community pharmacies. NSW Health noted the trials had indicated, among other benefits, that *'temptation to 'overdose' or 'divert' is minimised as dose is only accessible when it is needed'*, and children would find it difficult to open.

DoCS / NSW Health initiatives relating to opioid treatment and child protection concerns

In recent initiatives, DoCS and NSW Health have recently signed off on a protocol for *Information sharing — assessing potential risk of harm to children less than 16 years of age under the Children and Young Persons (Care and Protection) Act 1998 who are in the care of persons participating in opioid treatment (methadone or buprenorphine)*. NSW Health noted that the protocol will provide for a clear process in which DoCS caseworkers will be able to obtain the name and contact details of a prescriber who is prescribing opioid treatment to a parent or carer of a child that may be at risk. DoCS told us the protocol will apply '*in situations where DoCS is assessing a risk of harm report involving opioid use* (and also) *where an opioid treatment prescriber has concerns about a child'*. [64]

The two agencies have also established a joint review of methadone-related child deaths. The agencies intend to produce a joint paper by the end of 2006 that *'considers the systemic issues for each agency'* and the agencies will develop a pilot interagency training program on issues arising from the joint work.[65]

We intend to undertake further examination of child deaths related to drug toxicity, and will monitor the progress of the NSW Health/DoCS reviews.

Endnotes

26 A Joint Investigation Response Team (JIRT) is a team of DoCS and police officers formed to conduct joint investigations of child abuse. JIRT deals with reports that may be subject to criminal charges, such as child sexual abuse and serious physical abuse.

27 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.

28 Ibid.

29 NSW Government (2006) *Interagency guidelines for child protection Intervention*, p.31.

30 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.

31 NSW Police response to recommendations from the *Report of reviewable deaths in 2004,* drawn from correspondence dated 8 March 2006 and 4 July 2006.

32 Correspondence from DoCS, 27 July 2006 (op cit) and 29 June 2006, responding to a provisional investigation report; also DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.

33 Correspondence from NSW Police, 27 March 2006, in relation to the investigation's statement of preliminary findings and recommendations.

34 DoCS (2005) *Corporate Directions 2005/06.*

35 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.

36 DoCS response to recommendations in a final investigation report, in correspondence dated 8 August 2006.

37 Barth, Richard. P, (2001) 'Research Outcomes of Prenatal Substance Exposure and the Need to Review Policies and Procedures Regarding Child Abuse Reporting' in *Child Welfare League Of America* 80;2; p.278.

38 NSW Health (2002) *Neonatal Abstinence Syndrome Guidelines* describe NAS as 'occur(ing) in newborns going through withdrawal as a result of the mother's dependence on drugs during pregnancy. It is characterised by signs and symptoms of central nervous system hyperirritability, gastrointestinal dysfunction and respiratory distress, and by vague autonomic symptoms that include yawning, sneezing, mottling and fever.' Note that infants whose mothers were involved in a methadone treatment program and did not use illicit drugs during pregnancy may also exhibit symptoms of NAS.

39 Tomison, A.M. (1996) 'Child Maltreatment and Substance Abuse', *National Child Protection Clearinghouse Discussion Paper Number 2*, p.4.

40 Child Death Review Team (2000) *Annual Report 1998-1999*, NSW Commission for Children and Young People.

41 Refer to endnote13 for the definition of SIDS Category II.

42 NSW Health response to a draft copy of this report, in correspondence dated 19 October 2006.

43 ibid.

44 See for example, *Protecting children and young people circular, National clinical guidelines for the management of drug use during pregnancy, birth and early development years of the Newborn, Frontline Procedures for the protection of children and young people and Interagency guidelines for the early intervention, response and management of drug and alcohol misuse.*

[45] NSW Health (January 2005) *Protecting children and young people* policy directive.
[46] National clinical guidelines for the management of drug use during pregnancy, birth and the early development years.
[47] NSW Health (2000) *Frontline procedures for the protection of children and young people*; (2002) *Neo-natal abstinence syndrome guidelines;* (January 2005) *Protecting children and young people*.
[48] DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
[49] DoCS response to the recommendations from the *Report of Reviewable Deaths in 2004*, in correspondence dated 27 July 2006.
[50] NSW Health (2004) *Drug and alcohol program centralised intake guidelines*.
[51] NSW Health (2003) *Protecting children and young people* staff circular, p.3.
[52] For one child, the source of the methadone was not clear on the information available to us.
[53] Legally prescribed methadone that has been diverted for illicit sale or use is known by names including street methadone.
[54] NSW Health (2000) *Drug treatment services plan* p.35.
[55] NSW Health (2003) *Guidelines for prescribing methadone for unsupervised administration 'take-away' doses*.
[56] NSW Child Death Review Team (2000) *Annual Report 1998–1999*. NSW Commission for Children and Young People. Pp.122–125.
[57] NSW Child Death Review Team (2000) *Annual Report 1999–2000*. NSW Commission for Children and Young People. p. 83.
[58] NSW Child Death Review Team (2001) *Annual Report 2000–2001*. NSW Commission for Children and Young People. p.111.
[59] NSW Health *Guidelines for prescribing methadone for unsupervised administration 'take-away' doses*.
[60] NSW Health response to a draft copy of this report, in correspondence dated 19 October 2006.
[61] NSW Child Death Review Team (2003) *Annual Report July — December 2002*. NSW Commission for Children and Young People. p.83.
[62] ibid.
[63] NSW Health response to a draft copy of this report, in correspondence dated 19 October 2006.
[64] DoCS response to the recommendations of the *Report of reviewable deaths in 2004*, correspondence dated 27 July 2006, and DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
[65] Ibid.

5. Responding to risk of harm reports

Where the DoCS Helpline determines that a report requires further response, it refers the report to a CSC or JIRT. The referral includes the Helpline's assessment of level of risk, and a recommended time within which the report should be responded to. The CSC or JIRT may undertake further — or secondary — assessment of the report. The aim of secondary assessment is to substantiate risk of harm to a child, or confirm a child's safety. If risk is substantiated, assessment identifies the level of risk and the protective strategies required to ensure a child's safety. Secondary assessment is divided into two stages:

- Stage 1 (SAS 1). This precedes any field action and is the process of gathering additional information and making inquiries to determine whether further assessment is required. Stage 1 assessment may include consideration of the child protection history of the family, gathering information by phone, and requesting information from other agencies.
- Stage 2 (SAS 2). Consists of a home visit or other field action to assess the child's need for care and protection and the action required of DoCS.

At either stage, cases may be closed for a number of reasons, including competing priorities and lack of resources. We note that DoCS is currently rolling out a new policy on neglect, which incorporates a revised *Secondary assessment — risk of harm* procedure.

Many of the issues we identified in our reviews and raised through reports, inquiries and investigations related to the assessment process. In particular, key areas of concern about risk assessment were the closure of risk of harm reports without assessment, and the quality of the assessment undertaken by DoCS. In discussing these areas below, we also identify specific concerns about closure of reports and risk assessment where parental substance abuse was an identified issue.

5.1 Closure of reports without assessment

In our *Report of reviewable deaths in 2004*, we raised concerns that high-risk cases were, at times, being closed without allocation to a caseworker for a risk assessment, largely due to lack of resources and relative urgency of other cases being handled by CSCs. Our view was that the practice of determining whether a response to a report can be provided based on relative, rather than actual, risks to a child is a critical public policy issue.

For deaths in 2005, we continued to see reports of risk of harm being closed without assessment, despite indicating the possibility that children were at risk. Many of the reports, inquiries and investigations arising from child deaths in 2005 that we have directed to DoCS include concerns about reports that have been closed without assessment, often due to 'current competing priorities'.

For example, in one review, we examined DoCS' response to a report of risk of harm about five children aged between one and nine years. The children were reported to be living in squalid and unhygienic conditions in a premises that the reporter deemed to be uninhabitable and a serious fire hazard, with the family facing eviction. The family was known to DoCS, and one child had been previously placed in short-term foster care as a result of physical abuse. The DoCS Helpline assessed the risk to the children as being high, and recommended a prompt response by the CSC. The CSC closed the report without any assessment. The family subsequently moved. We reported our concerns about the closure of the report to DoCS, noting that house fires had resulted in the deaths of a number of children in the previous year. DoCS advised us that no further reports had been received about the family since they moved from the area, and as there were no open reports, it was not appropriate to start a secondary assessment. DoCS told us that should a further report be received, *'the family's history would be considered and an appropriate assessment will occur.'*[66]

Cases closed without assessment where parental substance abuse was an identified concern

Of the 54 deaths we reviewed where we found evidence of parental substance abuse, 32 children

were the subject of a report to DoCS that included concerns about parental substance abuse in the 12 months before they died. The records we reviewed indicated that the Helpline referred 69 of the 70 reports made about these children to a CSC for further assessment. However, records indicated there was no secondary assessment for 26 of the 69 reports. For eight children, secondary assessment was not commenced on any of the reports made about them. Reports for six of the eight children were closed without assessment, and for two children, reports were open but not allocated when the child died.

We found that closure of reports without assessment occurred for some children where DoCS records indicated a significant child protection history.

CaseStudy

Two months before a child died, two reports were referred to a CSC by the Helpline for further assessment. Together, the reports indicated that the mother was using illicit and prescription drugs in combination with alcohol, and that her drug use appeared to be escalating. One reporter said that the older sibling, aged nine, was missing school to care for the younger child when their mother was substance affected. Another reporter told DoCS that the mother had overdosed at home while caring for the children. Ambulance officers had found the mother unconscious and the children in a distressed state. Neither report progressed to secondary assessment.

DoCS history for the family indicated that the mother had poor mental health, had previously attempted suicide, and had overdosed several times in previous years. Five months earlier, DoCS had commenced secondary assessment following risk of harm reports about the mother's overuse of prescription drugs and alcohol, and bruising to one of the children. At that time, the mother denied that she used drugs and indicated she was not interested in receiving support. That assessment was not finalised, and no judgements or decisions had been recorded, but the case had been inactive and unallocated for three months. DoCS re-commenced secondary assessment after the death of the younger child, in suspicious circumstances.

In another case that we reviewed, a report was made to DoCS about two young children who had both been previously reported as being at risk of harm. DoCS had conducted secondary assessment for these children in the prior 12 months and determined, without sighting them, that they were not at risk. The mother had an extensive history of amphetamine use. The new report contained information that identified risk of harm on many levels. The reporter said the mother was using speed and heroin, was aggressive and incapable of providing appropriate care for the children, leaving them often with relatives, sometimes for weeks at a time. The reporter told DoCS that the mother brought other people to the house to use drugs, and left needles in reach of the children. One of the children displayed inappropriate sexual behaviour. The Helpline referred the report to a CSC, where it was closed without assessment. Some months later, one of the children, a toddler, died from a bacterial infection. An autopsy found that the child also had significant injuries suggestive of non-accidental cause.

Our previous recommendations about case closure

In both previous reports of reviewable deaths, we made recommendations based on our view that DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention. We said that this threshold should be based on a key principle in child protection intervention that where a report raises issues of safety of a child, or failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to resolve the issues.

In response to our most recent recommendation, DoCS told us:[67] *'We do not accept that there can ever be an arbitrary risk threshold beyond which a case cannot be closed'*, and that *'The alternative is a non-transparent system in which cases above a threshold may remain open, but resource constraints mean that no work may ever be done on them.'*

DoCS advised us of the progress of the trial of the *Intake Assessment Guidelines*. The guidelines specify certain criteria that indicate high risk, and require reports meeting these criteria to be prioritised for secondary assessment stage 1. These criteria include:

- reports given a 24 hour response rating by the Helpline.
- reports where the Helpline recommends a response within 72 hours and the child is under two years of age and certain other factors are present. Examples of these factors include impaired parenting capacity due to alcohol or drug misuse, unmanaged mental illness or intellectual disability, neglect, or domestic violence involving injury or weapons.

DoCS said that the guidelines have been tested in CSCs, and that in those CSCs with additional caseworker resources, the guidelines have targeted children under five years of age. The intention is for the

guidelines to be implemented across the department by early 2007.

DoCS told us that a key issue was the monitoring of allocation rates for high-risk cases, and reporting of these annually.

In 2004/05, DoCS received 216,386 child protection reports. Of these, 140,184 (64.7%) were referred to a CSC for further assessment. DoCS data indicates that the outcome of referral for these reports was:

- Secondary assessment (stage 1 or 2) was concluded for 55,775 reports (39.8%)
- Secondary assessment or investigation was ongoing for 18,434 reports (13.1%), and
- There was no secondary assessment outcome recorded for 65,975 reports (47.1%).[68]

In DoCS' published data, therefore, information is not reported about secondary assessment outcomes of almost half (47 per cent) of reports referred to a CSC or JIRT, including whether or to what degree they were subject to assessment. For these reports, DoCS is unable to report in aggregate what happened once reports were referred to a CSC.

In response to a draft of this report, DoCS told us that for these 65,975 reports the information is held on the hard copy of the file, and *'if DoCS needed it, it could be extracted. It is not on the computerised system in a uniform format and is therefore not easily extractable and not in the published data.'*[69] In our view, accurate and full data about the outcomes of secondary assessment, as well as allocation rates, is critical to informing the progress of reform initiatives in DoCS.

In other recommendations, we also asked DoCS to advise whether information about risk of harm reports closed without assessment, and the reason for closure, was being drawn from DoCS data and if it would be reported. DoCS told us that *'there are no coded fields in KIDS that allow recording of detailed case closure reasons or the circumstances of the case.'*[70]

While we agree the *Intake Assessment Guidelines* provide consistency and a degree of transparency in decisions to allocate reports for secondary assessment stage 1, the basis for DoCS' decisions about case closure remains relative priority, measured against the urgency and risk of other presenting cases. The policy enables closure of cases at a range of points, including where assessment has indicated a child is in need of care and protection.

Closure of cases without assessment is predominantly a result of high demand against limited resources. As noted earlier, DoCS is now more than half-way through a $1.2 billion program to reform child protection in NSW. Additional resources are likely to result in fewer cases being closed in the longer term. DoCS provided us with data that indicates that in CSCs where additional child protection resources have been allocated, there has been *'a significant increase in the proportion of referred reports allocated to a caseworker at a CSC for further assessment.'* In other CSCs, DoCS has seen a *'significant improvement'* in allocation rates.[71]

However, demand for DoCS services is also continuing to grow. DoCS data indicates that over the last five years, risk of harm reports received by the department have more than doubled.[72] DoCS notes that this increase is not uniform, with most increases being in 'level three' reports. DoCS told us this indicates that for 'high priority' cases, *'the increase in resources is unlikely to be outstripped by increasing demand in the short-medium term'*.[73]

While noting these positive indicators, and based on the findings of our work, DoCS' capacity to respond to reports indicating a child is at risk of harm remains a significant concern.

5.2 Quality of risk of harm assessment

Our *Report of reviewable deaths in 2004* raised some concerns about the quality of DoCS casework where reports were allocated for assessment. In some cases we reviewed, we found that at times, assessment was not holistic, or was based on inadequate analysis of risk, or the strategies used to address identified risk were not effective.

While our reviews in 2005 identified examples of effective assessment leading to sound decisions and responses to children at risk, we also continued to review cases that raised questions about the effectiveness of secondary assessment.

In cases we reviewed or where we took further action, these concerns included:

- Secondary assessment being limited in scope. In a number of cases, we found that secondary assessment focused on a specific event or issue, rather than considering the circumstances of the child and family in a holistic way. In some cases, we found that actions taken by the department resolved immediate issues of homelessness or safety in the context of domestic violence, but failed to holistically address child protection concerns in the family, particularly in relation to chronic parental substance abuse.
- Inadequate information gathering and analysis to inform assessment. Sometimes, essential questions were not asked, or necessary information was either not sought or not taken into account.
- Children not being sighted, or persons alleged to have caused harm not being interviewed, despite the serious nature of allegations made in some reports.

- In some cases, secondary assessment was suspended or ceased before a final determination was made about the child's need for care and protection.

We found that, in cases where DoCS assessed risk without full and relevant information, the results of the assessments in these cases did not adequately reflect the possible risks to a child.

CaseStudy

We raised concerns with DoCS about their handling of risk of harm reports for two children and an unborn baby. There were 21 reports for the family over a six-year period, including nine reports following the death of a new-born baby.

Reports related to parental drug use and domestic violence and the children living in a deprived environment. Later reports indicated risk resulting from chronic homelessness and itinerancy, including poor school attendance for one of the children.

Two secondary assessments were initiated by DoCS in 2005 in relation to the family's six-year-old child. The first assessment commenced within a month of the death of a new-born baby in the family. The baby's death was due to extreme prematurity. The medical certificate linked this to the mother's intravenous drug use. Reports leading to the assessment indicated risk arising from the family's homelessness and non-attendance of the six-year-old at school, with added concerns about drug dealing in the family. The assessment was limited to obtaining information about the baby's death and a call to the Department of Housing, which advised that it had provided the family with emergency accommodation in a caravan park. No further action was taken by DoCS.

Some months later, the family sought assistance from DoCS as a result of homelessness. The Helpline organised overnight accommodation, and advised the parents to attend a CSC the next morning. The Helpline advised the mother to again approach Housing for assistance, given that *'if the family continue to be homeless they face the risk of (subject child) being placed in care'*. The CSC commenced assessment by phoning the Department of Housing, which advised that emergency accommodation could not be provided to the family. The parents did not attend the CSC, and the report was closed as the family were 'no longer receiving a service'.

Some weeks later, the mother contacted DoCS to seek further assistance as she was unable to access either private or public housing, and had no money and no clothes. The Helpline determined that for the child, *'the likelihood of harm re-occurring without intervention is high'*, and assessed the child as being at high risk, with a response required from a CSC within 24 hours. No action was taken by the CSC and the report was closed due to 'current competing priorities'.

In our report to DoCS, we raised our concerns about the welfare and wellbeing of the six-year-old child and proposed that the department make inquiries to establish the child's current welfare, living situation and school attendance. DoCS subsequently advised us that it had contacted a number of agencies and determined that homelessness was not a current issue for the family, that the family now had a new baby and no concerns had been raised in this regard, and that it had been unable to ascertain the child's school attendance. DoCS did not contact or visit the family, but told us that there had been no risk of harm reports since late 2005.

Our own separate inquires found that the child was enrolled in school, but that in an eight month period, had had more than 70 partial and whole day absences.

While DoCS has undertaken some assessment for this child, we were concerned as to whether the assessment demonstrates a holistic consideration of the risks posed to the child by the family's lifestyle, and whether the parents' domestic violence issues and drug use have been resolved. Our inquiries in this matter are continuing.

Quality of assessment in the context of parental substance abuse

As noted above, for over half (32) of the 54 children who died where we identified parental substance abuse as an issue, at least one report was made about them to DoCS concerning parental substance abuse in the 12 months before they died. We found that for 18 of these 32 children, at least one of these reports progressed to secondary assessment stage 2. For 11 of the 18 children, the secondary assessment led to judgements and decisions about the child's safety and welfare. In the majority of cases — nine — DoCS did not substantiate risk of harm.

Our work in relation to these deaths, and also cases we reviewed or investigated in the previous two years identified concerns about the adequacy of DoCS' secondary assessment. In general, these concerns related to lack of holistic assessment, inadequate information gathering and analysis to inform assessment, and a lack of focus on the child. These concerns are not specific to DoCS' handling of matters involving parental substance abuse, but are critical to effective risk assessment in a substance abuse context. We also identified issues that were more evident in cases where substance abuse was a concern. These issues include:

- Limited caseworker and supervisor expertise in the area of substance abuse, which at times led to an assessment that risk to a child was minimal, or premature decisions that child protection concerns had been resolved.
- An overly optimistic expectation of an individual's capacity to effectively parent once they engaged in a drug treatment program, and lack of acknowledgement of the time needed to stabilise or the possibility of relapse.
- An over-reliance on parents as key informants about whether they were using or the extent of their substance use, and failure to seek and/or use relevant information or professional advice in the assessment process. In some cases, it appeared that parents avoided contact with DoCS, or attempted to minimise the extent, and impact, of their drug use.
- Accepting parental undertakings to take certain actions to minimise risks to a child as a reasonable indicator of safety, without adequate consideration of the parent's capacity to meet the undertakings, or the impact on the child's safety if the parent failed to comply.
- Not adequately taking into account the additional risk posed by the effect of parental substance abuse on very young and vulnerable babies.

DoCS recently noted that this is a *'complex and imprecise'* area of work, and that:

> *The challenge for DoCS workers is to differentiate between those cases where the risks or potential risks to children from parental substance use can be tolerated and those which require protective action.*[74]

In our view, the fundamental challenge is for DoCS staff to undertake timely risk assessment that is comprehensive and considers the cumulative impact of all risk factors to the child, in order to inform critical decisions about the child's safety and welfare.

Our previous recommendations about DoCS risk of harm assessment

In our *Report of reviewable deaths in 2004*, we made a number of recommendations that related to risk of harm assessment. These are listed in detail in *appendix 3*. We are pleased to note that a number of our recommendations are being implemented.

For example, we made a recommendation that DoCS undertake a systematic performance audit of each CSC in NSW. We proposed the audits should specifically consider key areas of practice, including the basis for case closure decisions, the scope and adequacy of secondary assessment processes, and the adequacy of case plans and their implementation. In responding to this recommendation, DoCS advised us that *'improving quality of practice is the next key area of the reform program to be implemented commencing in 2006.'* DoCS said that a comprehensive framework for service improvement would cover a range of strategies, including-but not limited to-audit. DoCS advised us that it was starting a quality assurance program that has a core component of a *'quality review'* in each CSC in the state. Reviews will take place over the next four years and will *'collect quantitative and qualitative information about priority systems, processes and practice.'* Following review, DoCS said that each CSC will develop a 'quality improvement plan' to improve performance, in line with review outcomes.

In regard to initial assessment, we asked DoCS to provide advice about how it was implementing a stated corporate priority to improve initial assessment processes. DoCS advised us that it had considered different approaches to assessment, but has decided to maintain its current model. DoCS said it is, however, working to improve the tools that DoCS staff use in this assessment.

Other recommendations that DoCS is acting on include prioritisation of reports for children in families where a child has been previously removed, and implementation of a policy on neglect and practice guidance for case workers. DoCS is now publishing data about reports referred for, and reports receiving, secondary assessment, and is in the process of developing clearer policies about requirements to observe children and interview parents as part of a secondary assessment.

We also made specific recommendations about parental substance abuse, and recommendations targeted to work with Aboriginal children and adolescents, that focused to some degree on secondary assessment practices.

Recommendations about parental substance abuse

We made a recommendation that drew on proposals made in the department's own internal reviews of child deaths. These proposals focused on enhanced provision of drug and alcohol advice to field staff and quality assurance in cases where parental substance abuse was a concern. We asked DoCS to advise us of its progress in implementing some of these proposals. Of relevance to secondary assessment, the department advised us that:

- The Helpline is undertaking a 'Quality Review' of the assessment of risk of harm reports for children under 12 months of age where the presenting problem is parental substance abuse. DoCS has told us that the outcomes of the review will be used to refine training and supervision for Helpline staff and to develop assessment tools.
- DoCS has re-developed an intranet site to assist staff deal with drug and alcohol issues and has revised staff training to include materials about specific drug and alcohol issues, such as methadone use and drugs in pregnancy. Alcohol and other drug forums were undertaken in 2006 as part of an action research project, and will inform future training strategies.
- A number of resources have been developed for DoCS staff and community workers to assist in their management of families where substance abuse is a concern, such as the *Dual Diagnosis Support Kit.*
- DoCS has trialled a new tool — the Hearth Assessment Tool — for assessing risk in a drug and alcohol context and is considering the outcomes of this.

Recommendations about Aboriginal children and young people

Our reviews of Aboriginal child deaths in 2004 found that some of the children had no, or a limited, response to reports that they were at risk of harm, and that when risk assessments did occur, these often did not comply with standards required by the department. These problems were particularly evident in regional areas. We asked DoCS to consider the issues we had raised in our report, including enhancing capacity to respond to reports of risk of harm for Aboriginal children, and ensuring compliance with the secondary risk of harm assessment framework in assessing risk for Aboriginal children. In responding to our recommendations, DoCS told us that *'the problems of social and community breakdown in Aboriginal communities are not new and there are no simple answers.'* DoCS outlined a number of initiatives in train to improve services, including recruiting Aboriginal caseworkers, developing Intensive Family Based Services, and incorporating specific elements in policies and strategies that relate to work with Aboriginal families, including the DoCS neglect policy and revised secondary assessment procedures.

While we acknowledge the work in train, we are keen to see DoCS implement an encompassing strategy to respond to the ongoing problems for which DoCS recognises there are no simple answers. DoCS' corporate priorities for 2005/06 included an improved commitment and service to Indigenous communities. As part of this, DoCS noted the department would develop a *'whole-of-DoCS Strategic Plan that outlines and integrates the organisation's major priorities for work to improve outcomes for Aboriginal clients and staff.'*[75] DoCS has advised us that it has finalised and is preparing for publication the *DoCS Aboriginal Strategic Commitment*, which outlines how DoCS will work to provide better services for Aboriginal people over the next five years.[76]

Recommendations about adolescents

Our reviews of 22 adolescents who died in 2004 identified issues of mental health, risk-taking behaviour and, in almost half the cases, a child protection history prior to the young person reaching adolescence. We noted the challenges for DoCS in responding effectively to young people.

Our recommendation to DoCS included a proposal that the department give consideration to the issues raised in the report, including whether existing procedures and models of casework and current practice are effectively meeting the needs of adolescents.

In this context, DoCS told us that it had been working with relevant community sector representatives on the issue of youth in Supported Accommodation Assistance Program (SAAP) services, and that the department's Child Deaths and Critical Reports Unit is intending to develop a research paper on matters arising from the Unit's reviews of the deaths of young people by suicide or risk taking behaviour. The project will use internal and external expertise and *'look at issues for practice in engaging with young people and to identify, where possible, serious suicide and self-harm patterns in vulnerable young people and promote successful practice*'.

DoCS also advised us that the Centre for Parenting and Research is undertaking several pieces of work focusing on adolescents. Broadly, these are a literature review of effective strategies and interventions for adolescents in a child protection context, a study

examining the nature of effective casework practice with adolescents from the perspective of DoCS staff, and a review of models of service delivery and interventions for children and young people with high needs.[77]

We are keen to see the extent to which these initiatives result in enhancements to existing procedures and models of casework for working with young people.

Endnotes

66 DoCS response to a report under s.43(3) CS CRAMA about this matter, in correspondence dated 15 August 2005.
67 DoCS' response to recommendations from the *Report of reviewable deaths in 2004* are drawn from correspondence from DoCS, 1 March 2006 and 27 July 2006.
68 DoCS (May 2006) *Annual Statistical Report 2004/05.*
69 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
70 DoCS' response to recommendations from the *Report of reviewable deaths in 2004,* 27 July 2006.
71 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
72 DoCS (May 2006) *Annual Statistical Report 2004/05.* p6.
73 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006. 'Level three' reports indicate a less urgent risk, with responses required within 10 days.
74 DoCS response to a statement of provisional findings and recommendations following an investigation, in correspondence dated 29 August 2006.
75 DoCS *Corporate Directions 2005/06*.
76 DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
77 Ibid.

6. Protective intervention

When a child is assessed to be in need of care and protection, a range of intervention options are available to DoCS within the *Children and Young Persons (Care and Protection) Act 1998.* Under the Act, all actions and decisions must give paramount consideration to the safety, welfare and wellbeing of the child.

In addition to our reviews and investigations identifying concerns with the process of assessing risk of harm, in some cases they also raised questions about the adequacy of DoCS' response to children where assessment confirmed risk of harm or required action during the assessment process.

In some of the cases where we took further action, we raised issues with DoCS about the type of interventions used, and the way they were, or were not, implemented. Interventions that we particularly identified in our reviews, and are discussed below, are undertakings and informal agreements with parents — which has a particular relevance to issues relating to parental substance abuse; timeliness of intervention and monitoring of support services; and the use of Apprehended Violence Orders.

6.1 Undertakings and informal agreements with parents

When a child is determined to be in need of care and protection, caseworkers develop a case plan. The case plan identifies what all parties are required to do to ensure a child is safe and details their responsibilities for implementing it. DoCS caseworkers are required to monitor case plans to ensure that the tasks are undertaken and the goals remain relevant.[78]

Case plans may involve general or specific agreements — or undertakings — from parents. Parents may agree to do — or not to do — certain things. According to DoCS policy, undertakings may form part of a case plan but it is not policy to use informal undertakings. Care plans, registered or unregistered, or orders accepting undertakings, are preferred.[79]

In our report of reviewable deaths in 2004, we raised concerns about the use of undertakings as a protective measure.

Included in the matters we reviewed for children who died in 2005 were some that featured undertakings or agreements. Many of these related specifically to parental use of drugs and drug testing. Aspects of the agreements included:

- Abstaining from illicit drug use
- Continuing drug treatment
- Undergoing drug testing
- Accepting drug and alcohol counselling
- Undergoing mental health assessment and accepting treatment
- Ensuring medical care for an infant
- Maintaining involvement with health or other services
- Receiving a parenting or home help service
- Accepting supervision from DoCS

In some cases, these agreements appropriately formed part of an integrated protective response by DoCS and other agencies. In others, however, we continued to see problems in the use and monitoring of agreements, and in responses to breaches.

In some cases, our reviews raised concerns about DoCS' decisions to use undertakings where parents had long histories of drug abuse and/or repeated relapses from drug treatment or drug-related mental health issues. Sometimes, these histories included the parents' own contradictory accounts of drug use, or unsubstantiated claims that they had stopped using. In our view, such histories raised questions about the capacity of individual parents to comply with agreements that required them to abstain from drug use, or to maintain relationships with various services. Although DoCS staff are required to assess the consequences and probability of future harm, in some cases there appeared to be inadequate consideration of the likelihood that parents could — or would — fulfil the terms of agreements.

As noted above, DoCS staff are required to monitor aspects of case plans — including agreements — to ensure that these are implemented. We identified cases where monitoring of undertakings either did not occur or, where it did, the monitoring was inadequate.

In one case, private providers of methadone to a mother advised DoCS they would undertake a mental health assessment and weekly urinalysis. The results were neither provided to DoCS by the provider, or sought from the provider by DoCS.

Because agreements often also involve responsibilities on the part of DoCS or other agencies, we also noted cases where services failed to act as agreed. There were agreements for intensive supervision, including home visits, but at times these were done on an erratic or only partial basis.

We also saw monitoring of agreements that identified, in one case, repeated and escalating failures to comply with various undertakings. These included refraining from illicit drug use, keeping paediatric appointments and undergoing a mental health assessment. These informal undertakings included a note that they had no legal force but breaches might lead to further action by DoCS. Despite this, there were no consequences as a result of the breaches. Although DoCS continued to receive information from different sources, including the mother herself, that indicated she continually breached the undertakings by using a range of drugs, DoCS took no action to review the case plan or the baby's safety. The baby died in suspicious circumstances at seven months of age.

In other cases, informal arrangements based on an agreement with a parent contained no provisions relating to action in the event of non-compliance.

Our previous recommendations on undertakings

In our report of reviewable deaths in 2004, we raised concerns about the use of undertakings as a protective measure, and made a number of recommendations to address this and to clarify DoCS' position on the use of undertakings. Our recommendations contained specific proposals that DoCS:

- Identify the circumstances under which undertakings may be an appropriate protective measure, and the circumstances under which they may not be.
- Require a monitoring component in relation to reviewing compliance with undertakings.
- Require the inclusion of agreed consequences should parents/carers breach undertakings.
- Require that a case — including cases where undertakings are part of unregistered care plans, and the child is not subject to a current order of the Children's Court — not be closed on the basis that undertakings have been signed.

DoCS told us it agreed that current policies on the use of undertakings would be reviewed to ensure consistency and make instructions to staff more explicit. As part of this:

- References to 'informal undertakings' will be removed from relevant procedures.[80]
- Procedures will address central issues of when case plans and unregistered care plans alone are adequate protective measures, and will provide guidance as to when additional measures — including court orders — would be required.
- Procedures on case planning, care plans and orders accepting undertakings will include specific guidance about monitoring arrangements and consequences of breaching agreements.
- Procedures on case planning and care plans will state that parents/carers will need to demonstrate compliance with agreements for 12–24 months before the agreements could be considered to be a sufficient protective measure.

DoCS advised that the NSW government intends to introduce parent responsibility contracts. According to DoCS, the contracts will be legislated, and will provide an additional tool for caseworkers. The contracts will:

> *'establish a means for parents of children and young people assessed by DoCS to be in need of care and protection to improve parenting skills and accept greater responsibility for their children. The contracts will do this by specifying attendance at a range of programs including parental programs for behaviour management, parenting, reduction of substance abuse and rehabilitation services. Parental Responsibility Contracts will be voluntarily entered into by parents and DoCS and, in the first instance, registered with the Children's Court.'*

The Bill relating to Parent Responsibility Contracts, which was assented to on 5 October 2006, requires that the parental responsibility contract must specify which terms, if breached by the parent or carer, will enable DoCS to file a contract breach notice with the Children's Court. The filing of a contract breach notice will initiate an application for care orders in regard to the child concerned, and there is a rebuttable presumption that the child is in need of care and protection. [81, 82]

DoCS also told us that is has developed a draft policy on drug testing, which provides for a more structured approach to applying drug testing, with a focus on cases where there are plans to restore a child to his or her parent/carer and where persistent or serious drug use was the reason the child was removed. Parent Responsibility Contracts will provide a formal process through which drug testing can be applied. Formal arrangements for drug testing may also apply in cases where removal of a child is being considered, where

parental drug use is a serious and persistent concern.[83] Under this regime:

> *Unless parents are able to demonstrate to the department that they have stopped using drugs in a timely manner, DoCS will use the evidence provided by drug testing to place their children in care permanently.*[84]

The drug testing policy will be trialled for 12 months in four CSCs from November 2006.

6.2 Timeliness of intervention and monitoring of support services

Our reviews raised some questions about the timeliness of intervention assessed as being necessary to protect children, and how DoCS monitors the provision of support services deemed necessary to ensure the safety of children. In some cases where there were identified child protection concerns, we found that a relatively significant amount of time elapsed between a determination that support was needed, and the provision of that support.

In one matter, DoCS completed a secondary risk assessment for three children that recommended Children' Court proceedings be initiated and an Order for Supervision be sought. There was a lengthy history regarding parental substance abuse. Two months after the assessment recommendation was made, when DoCS attempted to visit the family, it was found that the family had vacated the premises. DoCS was advised of the family's new address some days later, but did not take action until advised by the children's father that he had left the family home due to the mother's drug use. DoCS subsequently commenced proceedings in the Children's Court and the children were placed in care. DoCS advised that the three-month delay between the secondary assessment and Children's Court action was due to workload from other cases: *'a number of matters already before the Court, and new matters initiated from unplanned removals'*.[85]

In another case we reviewed, an 18-month-old child was reported to DoCS due to concerns about the child's health and the parents' failure to access essential medical attention for an illness the child had acquired. The DoCS Helpline recommended an immediate response by the CSC. The CSC did not respond to the report urgently, and it took the CSC some days to locate an address for the family. Six days following the report, DoCS spoke with the family and issued a notice to the parents requiring them to present the child for medical examination. The child was presented to hospital some hours later, but died the following day due to the illness. This case has been the subject of DoCS internal review.

In regard to cases where intervention is primarily to address risk to a child as a result of parental substance abuse, monitoring how required services were provided is critical. As noted earlier, substance dependent parents may avoid contact with agencies in order to conceal drug or alcohol use, and the possibility of relapse is a concern where there has been a commitment to rehabilitation.

In some of the cases we reviewed, we saw a number of examples where support services were a clear part of a case plan, but failed to eventuate.

Our previous recommendations about implementation of case plans

In recommending that DoCS conduct a systematic audit of CSCs in NSW, we asked DoCS to consider the overall adequacy of case plans, and their implementation, where risk of harm is substantiated. As noted above, DoCS will be commencing 'quality reviews' in CSCs over the next four years.

6.3 Apprehended Violence Orders

As a protective intervention, NSW Police may apply for Apprehended Violence Orders (AVOs) where certain offences have been committed, or are likely to be committed. Circumstances under which police must apply for an AVO include where children have witnessed or been directly assaulted as a result of domestic violence.[86] Police procedures note that only police officers can apply for an AVO for the protection of children under 16. Last year, in considering responses to domestic violence, we raised some questions about how effectively police were utilising their powers to take out AVOs on behalf of children.

In 2005, we investigated one matter that raised questions about whether police should have applied for an AVO to protect children. In this case, the family were known to police due to domestic violence. In responding to a domestic violence incident, attending police noted injuries to an infant, that the mother claimed were accidental. However, a family member subsequently raised concerns about the safety of the children to police, and indicated that the children had been subject to abuse. Police did not apply for an AVO for the children in this case. While our investigation noted that there would have been some evidentiary and practical obstacles to obtaining an AVO for the children, our view was that this option should have been fully explored.

Our previous recommendations about Apprehended Violence Orders

In our *Report of reviewable deaths in 2004*, we asked NSW Police to review whether Apprehended Domestic Violence Orders (ADVOs) for children were being utilised effectively, and whether police officers had adequate procedural guidance to determine the circumstances that warrant application for an ADVO on behalf of a child.

NSW Police told us that informants for AVOs on behalf of children are mostly investigators with the Child Protection and Sex Crimes Squad, particularly JIRT. Police said that in regard to data, it is difficult to identify how many AVOs were applied for on behalf of children, but that there is a major program enhancement underway — the AVO Compliance with Legislation project — which among other things is aiming to develop and upgrade data collection and recording processes.

NSW Police also indicated that the review of *Domestic Violence Standard Operating Procedures* and *Child Protection Standard Operating Procedures* will take into consideration the issue of guidance to police dealing with children present at, or affected by domestic violence, where there is no JIRT referral or involvement.

The Ombudsman is currently conducting an investigation regarding the effectiveness of policing strategies targeting domestic and family violence.

Endnotes

[78] DoCS *Business Help Topic — Care Planning.*

[79] Under section 38 of the *Children and Young Person's (Care and Protection) Act 1998*, care plans can be registered in the Children's Court; under section 73, the Court may make an order accepting undertakings from a parent with respect to the care and protection of a child.

[80] On 20 December 2005, DoCS deleted a reference to 'informal undertakings' from a list of practice bulletins for caseworkers.

[81] *Children and Young Persons (Care and Protection) Amendment (Parent Responsibility Contracts) Bill 2006.*

[82] A rebuttable presumption that a child is in need of care and protection means that it will be presumed (or taken as fact) that a child is in need of care and protection unless evidence is submitted by a party to the contrary.

[83] DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.

[84] Hon. Reba Meagher, Minister for Community Services, 4 September 2006. Statement to General Purpose Standing Committee No. 2, *Transcript of Committee Proceedings*, p.27.

[85] DoCS response to preliminary inquiries, in correspondence dated 31 May 2006.

[86] NSW Police (April 2000) *Domestic Violence Policy and Standard Operating Procedures,* p.29.

7. Interagency response to children at risk of harm

No one agency has a complete capacity to protect children from harm. Protecting children and supporting families requires collaboration between various public and community sector agencies. Effective collaboration requires that agency staff understand their responsibilities to identify and report risk of harm, appropriately seek and provide information to inform risk assessment, and work co-operatively to resolve identified risks.

In our *Report of reviewable deaths in 2004* we noted cases where there was limited evidence of coordination between agencies resulting in a comprehensive approach to protecting children and supporting their families.

In the interim, the *NSW Interagency guidelines for child protection intervention* have been the subject of review, and revised guidelines have now been released.

The guidelines note that DoCS is responsible for coordinating the response where intervention is necessary for the care and protection of children. Where DoCS is not involved with a family or has not identified a child as in need of care and protection, the key common responsibility of agencies such as NSW Police and NSW Health, and non-government organisations, is to recognise and report child abuse and neglect. The revised guidelines also state that *'reporting is just the beginning of the child protection process and is not necessarily the end of a reporter's role or responsibility in a matter'*.[87] The guidelines say that reporters who were providing services to a child and family should continue to do so, and consider the possibility of linking the family to appropriate services.

DoCs advised us that information packages about the guidelines have been provided to all DoCS' 'partner agencies', and that DoCS is training/briefing individuals who will subsequently roll out training within individual agencies.[88]

Below, we discuss interagency issues generally and also identify specific issues in relation to substance abuse. Where parental substance abuse is an issue in a family, it is likely that there will be contact by the family with, and intervention by, a number of agencies. Substance abuse by parents can involve a health issue, a legal issue and a child protection issue, and our reviews highlighted the critical importance of effective information exchange and collaborative work in these cases.

7.1 Interagency responses to children who died in 2005

Our reviews and other work in 2005 again showed both the importance of good interagency cooperation and coordination, and that this is not consistently being achieved.

In some cases we investigated, we found that different agencies had information that, when combined, provided a clear picture of risk to a child or children. However, this was not identified at the time because the agencies did not communicate effectively or adequately coordinate their work.

For example, in one case we noted that within twelve months of the fatal assault of a child, there were ten occasions when escalating domestic violence in the family was brought to the attention of one of the four agencies whose conduct we investigated. Due to decisions not to report risk of harm to DoCS, administrative errors that led to a failure to communicate concerns of risk, and decisions not to assess possible risk of harm, on only one of the occasions was information regarding possible risks to the children arising from domestic violence effectively identified and exchanged.

We saw inadequate liaison between agencies to ensure full information was available to accurately assess risks to children. We also had concerns about effective use of section 248 of the *Children and Young Persons (Care and Protection) Act 1998*, which allows for exchange of information between DoCS and other agencies. In one case, for example, DoCS sought information from the Department of Corrective Services (DCS) but failed to pursue its request when a correctional facility advised that it did not have the relevant documents as they had been transferred out of the facility. For its part, the correctional facility also failed to act to obtain the information. As a result, critical information relating to the safety of a newborn baby was not exchanged.[89]

In relation to this matter, DCS advised us that since the time this exchange took place, it has initiated changes to improve the department's response to section 248 requests. DCS has centralised responses to section 248 requests from DoCS by establishing the Child Protection Coordination and Support Unit, which has *'greatly improved interagency liaison and collaboration'*.[90] The Unit manages section 248 requests and liaises with DoCS. The unit has also provided information for the DoCS intranet about DCS, the types of information held by DCS and the role of the unit.

Interagency responses where parental substance abuse was a significant issue

As well as the shortcomings detailed above, we identified concerns about interagency work that related specifically to some of the cases we reviewed that featured parental substance abuse.

As noted elsewhere, parental substance abuse may pose particular challenges to agencies charged with identifying or responding to concerns about children. In a number of cases we examined, parents had extensive histories of substance abuse and also involvement with a number of different agencies, including DoCS, NSW Health, NSW Police and Corrective Services.

A parent's involvement with multiple agencies may be a complicating factor in child protection terms because the agencies may be dealing simultaneously with the needs of the parent and those of the child. The parent may have long-term needs, for example, as a client of a drug treatment program, while the child may be at immediate risk of harm. The challenge this presents to agencies is acknowledged in some policy documents. The interagency guidelines for dealing with drug and alcohol misuse note that drug and alcohol interventions focus on the adult as the primary client. The goal is harm minimisation and the client's participation is voluntary. By contrast, child protection is aimed at ensuring the child's safety, welfare and well-being and intervention may be on a compulsory basis. The guidelines also say that for substance dependent parents, the possible removal of their children is '*a powerful sanction that is widely feared, and may underpin reluctance to seek help.*'[91]

Interagency response to pre-natal reports

In regard to planning for effective intervention following the birth of a child, it appears that there are inconsistent systems and arrangements across different CSCs and area health services for alerting DoCS that a baby the subject of a pre-natal report has been born.

In one matter that we investigated, we found that one CSC and a major hospital had a different understanding of the procedures in place where DoCS required an alert following a baby's birth. In the case we examined, DoCS records indicated that a departmental caseworker had made a telephone request to the hospital's senior social worker to be alerted on the birth of the baby. The hospital had no record of the referral and subsequently did not alert DoCS to the baby's birth. The Area Health Service told us that DoCS must make referrals for a birth alert in writing through the area's Prevention of Physical Abuse and Neglect of Children (PANOC) service. In response to our recommendation that written procedures should be developed in relation to birth alerts, the area health service told us that PANOC services are currently unable to develop written procedures in relation to birth alerts, and that:

> *Previous advice from NSW Health was not to have a statewide policy regarding this as the concern would be that AHS's would be overwhelmed by birth alerts …… Current NSW Health advice is that the issue has been taken up at the Health/DoCS Child Protection SOG* [Senior Officers Group] *and are waiting for further legal advice before the PANOC service can progress any policy further.*[92]

The area health service told us that this issue has been raised at NSW Health Child Protection Statewide meetings since 2004.

In our view, it is imperative that clear processes are in place in all areas to facilitate the appropriate referral of, and response to, concerns that an unborn baby may be at risk following their birth.

Effective information exchange

Our work demonstrated the critical importance of effective collaboration between agencies when substance abuse was a risk factor. In some cases this did not occur because agencies failed to maintain an appropriate focus on the needs of children or failed to effectively implement plans that were intended to ensure their safety.

In one case, for example, a drug treatment service was involved in interagency planning for a baby who was born with symptoms of drug dependence. The interagency meeting included discussion of drug use by both parents. Hospital drug screening had shown that the mother was using amphetamines and cannabis. The meeting agreed that DoCS would be notified if the mother failed to keep appointments at her methadone clinic. However there was no plan for a response if drug screening continued to reveal illicit drug use. In fact, urinalysis on three occasions did show that the mother was continuing to use drugs, but the methadone clinic did not pass this information on to DoCS. The baby died while sleeping with the mother, and the cause of death was attributed to SIDS.

In some cases, we found that relevant information about parental substance abuse, held by DoCS and by other agencies and professionals, was either not gathered or not adequately considered during secondary assessment.

CaseStudy

Seventeen reports were made about a baby and a sibling over a 13-month period. Parental substance abuse was identified as a significant issue in nine of the reports. These indicated that the mother had a lengthy history of poly-drug use, and that drug use continued during the pregnancy and after the baby's birth. The baby tested positive for amphetamines and cannabis following the birth.

After the baby's discharge from hospital, a number of services, including DoCS, undertook home visits. DoCS also undertook a secondary assessment (SAS2) one month before the baby's death. The mother denied significant drug use, acknowledging occasional cannabis and alcohol use. We found no evidence that DoCS liaised with the other services providing support to the family when undertaking the secondary assessment, despite services raising concerns about parental substance use with the department. No planning meeting was convened to coordinate services to the family.

Ten days before the baby died, the mother was treated in hospital for an opiate overdose. This incident was reported to DoCS, and the department was again advised of the mother's long-term drug use. DoCS attempted a home visit, but found no-one at home. There was no further contact between the family and the department before the baby's death, which was attributed to SIDS Category II.[93]

Our previous recommendations about interagency coordination

In our *Report of reviewable deaths in 2004*, we made a number of recommendations to DoCS, the NSW Government and the Child Protection Senior Officer's Group (CPSOG) about interagency coordination. DoCS, with the input of the Human Services Chief Executive Officer's forum (HSCEOs), responded to these recommendations. *Appendix 3* discusses in more detail our recommendations, DoCS' response to them, and our comments about progress in their implementation.

An over-arching recommendation we made proposed that the CPSOG, in revising the *NSW Interagency guidelines for child protection intervention*, consider the issues raised in our report. In particular, we drew attention to the need to establish appropriate triggers for interagency protection planning, identify the circumstances that would warrant an interagency response at any stage of the assessment process, and the need to articulate the nature of such responses. We also proposed the guidelines should state when interagency responses should be mandatory.

DoCS told us that in the guidelines:

- Agencies would have an ongoing service role with families and children that they report.
- DoCS will support agencies through general 'consultative advice' in agencies' work with families where a case is unallocated.
- Case meetings are described as a core component of case management, and a sample of triggers will be provided that may cause DoCS to convene a case meeting.

The guidelines do not propose circumstances in which a mandatory interagency response is warranted.

In the context of higher expectations on agencies other than DoCS maintaining involvement with families where there are child protection concerns — especially where these cases are not allocated by DoCS — we recommended that section 248 of the *Children and Young Persons (Care and Protection) Act 1998* should be amended to allow agencies other than DoCS to share relevant information about care and protection concerns. DoCS told us that this matter would need to be considered within the current review of the Act.

Our recommendations about adolescents and Aboriginal children also went to improving interagency collaboration in responding to these particular client groups.

Recommendations about adolescents

In our *Report of reviewable deaths in 2004*, we noted that of 22 young people who died and whose deaths were reviewable, six committed suicide. Five of these young people had been reported to DoCS as being at risk of harm in the six months prior to their death. In three of these cases, the reports indicated that the young person was suicidal, or raised concerns about the young person's mental health. Two of the young people were the subject of Children's Court orders placing them under the parental responsibility of the Minister, and one of the young people was in the process of being restored to their parents, following a period of temporary foster care. Overall, we found that most of the young people who had committed suicide had had contact with a number of agencies, but in some of these cases, there was limited communication or coordination between services, including between mental health services and DoCS.

Our reviews identified the need for better joint work to address the needs of adolescents who are identified as being at risk of harm and have mental health issues. We recommended that DoCS consider how current responses to adolescents with mental health problems or who have been reported to be at risk of suicide, could be enhanced through cooperation with relevant interagency partners.

DoCS' response noted the *New South Wales Interagency action plan for better mental health*, and a clinical services implementation plan, being developed by NSW Health, but indicated that *'this section of the recommendation is a matter primarily for NSW Health. The Ombudsman should pursue further discussions with that agency.'*[94]

We sought and received advice from NSW Health in this regard. NSW Health outlined some current initiatives relevant to assisting adolescents with mental health problems, but they told us that:

> *'the Centre for Mental Health acknowledges that children and adolescents with mental health problems lie within its responsibility, however, implementation of recommendation 22 is more appropriately led by DoCS based on the issues raised in the Ombudsman's report.'*

DoCS told us in response to a draft copy of this report that there is no disagreement between DoCS and NSW Health about responsibilities for the provision of services to adolescents with mental health issues, and that there are three DoCS/NSW Health interagency partnerships related to adolescent health. These projects include a state-wide jointly-funded position to develop a coordinated approach to support better mental health outcomes for children and young people in DoCS Intensive Support Services, and two initiatives in specific areas to provide and/or link mental health services to DoCS clients.[95]

While noting these initiatives, our work indicates there is a need for close consideration of further strategies to improve coordinated responses to adolescents with mental health issues who are the subject of reports of risk of harm or protective intervention by DoCS.

Recommendations about Aboriginal children and young people

Recommendations from our *Report of reviewable deaths in 2004* included a proposal that DoCS consider strategies to improve interagency coordination and collaboration in the care and protection of Aboriginal children and young people.

DoCS' response referred to current cross-government initiatives, such as the finalisation of the Aboriginal Child Sexual Assault task force, forums linked with the NSW Aboriginal Affairs Plan *Two Ways Together*, and place-based mechanisms focusing on specific child protection or family support issues. In regard to DoCS initiatives, the department told us it has introduced a pilot traineeship program — a Diploma of Community Services (Protection and Intervention) — for existing Aboriginal caseworkers, and will be implementing a cultural awareness training program to increase awareness of Aboriginal issues and examine ways to improve service quality. Enhancements have also been made to the Caseworker Development program in regard to awareness of Aboriginal issues and 'practical ways to improve services for Aboriginal clients'.[96]

In regard to future strategies, DoCS advised that:

> *'HSCEOs have agreed to their agencies investigating other options with a view to strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed.'*

DoCS also said that the Child Protection Senior Officer's Group will identify and map *'legal, policy, procedural and practice issues from recent reports on child protection for interagency action'*. As part of this work, CPSOG will consider *'the investigation of options for strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed.'*

Our *Report of reviewable deaths in 2004* reported on 18 Aboriginal children who were known to DoCS before they died. We found that of 52 risk of harm reports made about these children that were referred to a CSC for further assessment, just over half (30) were allocated to a caseworker at a CSC. Of these, 11 reports resulted in the child being sighted or interviewed.

We said that the issues we saw indicated a need for better information exchange and more consultation by DoCS with relevant agencies when assessing risks. We said that *'Some risk of harm assessments failed to identify risks because they were not informed by adequate consultation with other professionals working with the family.'*[97]

In two of our investigations relating to Aboriginal children who died in 2005, we raised concerns about the adequacy of coordination between agencies, and in both cases linked this to inadequacies in DoCS' risk assessment. In both cases, we found that DoCS' assessment did not identify the children as being in need of care and protection. This in turn adversely impacted on opportunities for relevant agencies to work together to plan and provide services.

In this context, we believe DoCS and relevant agencies should consider strategies to strengthen joint responses more broadly, particularly beyond only those cases where risk of harm is confirmed.

Endnotes

[87] NSW Government (2006) *NSW Interagency guidelines for child protection intervention*, p.42.
[88] DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
[89] In May 2006, the Department of Corrective Services advised us that it had no record of the section 248 request from DoCS.
[90] Department of Corrective Services response to a draft copy of this case study, in correspondence dated 12 October 2006.
[91] NSW Government (2005) *Interagency guidelines for the early intervention, response and management of drug and alcohol misuse* p.25.
[92] Area Health Service response to the Ombudsman's statement of provisional findings and recommendations arising from an investigation, dated 5 September 2006.
[93] For a definition of SIDS category II see endnote 13.
[94] DoCS response to recommendations from the *Report of reviewable deaths in 2004,* 27 July 2006.
[95] DoCS response to a draft copy of this report, in correspondence dated 17 October 2006.
[96] Ibid.
[97] NSW Ombudsman (2005) *Report of reviewable deaths in 2004*, p.89.

Appendices

Appendix 1

Definitions

Definitions we have adopted to determine whether deaths are due to abuse or neglect or occurred in suspicious circumstances are:

Deaths due to abuse:

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

Deaths due to 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 reckless failure to adequately supervise
- a reckless act.

Suspicious deaths:

Deaths where there is some evidence or information that indicates the death may have been a result of abuse or neglect. Deaths would be considered suspicious if:

- 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)
- 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.

We note that this definition of suspicious is broader than that used by the NSW Coroner. In the Coronial context, suspicious is generally attributed to a death that is a possible homicide.

Appendix 2

Reviewable child death advisory committee — membership

Mr Bruce Barbour: NSW Ombudsman (Chair)

Mr Steve Kinmond: Deputy Ombudsman and Disability Services Commissioner

Dr Ian Cameron: CEO, NSW Rural Doctors Network

Dr Judy Cashmore: Associate Professor, Faculty of Law, University of Sydney and Honorary Research Associate, Social Policy Research Centre, University of New South Wales

Dr Michael Fairley: Consultant Psychiatrist, Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital.

Dr Jonathan Gillis: Senior Staff Specialist in Intensive Care, The Children's Hospital at Westmead

Dr Bronwyn Gould: Child protection consultant and medical practitioner

Ms Pam Greer: Community worker, trainer and consultant

Dr Ferry Grunseit: Consultant paediatrician, former Chair of the NSW Child Protection Council and NSW Child Advocate

Assoc Prof Jude Irwin: Associate Professor, Faculty of Education and Social Work, University of Sydney

Ms Toni Single: Clinical psychologist and child protection consultant

Ms Tracy Sheedy: Children's Registrar, Children's Court of NSW

Appendix 3

Agency responses to our recommendations

Section 43 (2) (c) of *CS CRAMA* requires us to provide information in our reviewable deaths annual report with respect to the implementation or otherwise of previous recommendations. In our *Report of reviewable deaths in 2004*, in relation to child deaths, we made 22 recommendations:

- Seventeen recommendations were directed to DoCS
- Two recommendations were directed to the Child Protection Senior Officer's Group (CPSOG)
- Two recommendations were directed to NSW Police
- One recommendations was directed to the NSW government.

Shortly after we released our report, the Minister for Community Services, the Hon. Reba Meagher, stated that *'the NSW government would accept all recommendations in the NSW Ombudsman's report into reviewable child deaths in 2004'*.[98]

In March 2006, DoCS provided a response to all recommendations, with the exception of those directed to NSW Police. DoCS told us that it had *'accepted all the recommendations specifically directed to the department'*. Further, DoCS had referred the recommendations that we made to the CPSOG and the NSW government to the Human Services Chief Executive Officers' Forum (HSCEOs). DoCS told us that the responses it provided to these recommendations had been endorsed by HSCEOs in February.

In May 2006, we asked DoCS for clarification and further advice on a number of the recommendations. DoCS provided this in July, along with a general report on progress in implementing the recommendations. In relation to recommendation 22, we also sought and received additional information from NSW Health.

NSW Police provided us with an initial response to the two recommendations we made to them in March 2006. We sought further clarification from NSW Police, and received this in July.

The following provides an overview of what agencies told us they were doing to implement our recommendations, and our assessment of progress in this regard. Our assessment is based on the advice provided by agencies and, where appropriate, additional information from our work.

Recommendations directed to DoCS, the Child Protection Senior Officers' Group and NSW government

Note: DoCS' response is our summary of the relevant information provided by the department.

Recommendation 1

Quality assurance and compliance

DoCS practice improvement strategies should incorporate a systematic performance audit of each CSC in NSW. Specific areas of consideration should include:

- efficiency of resource allocation
- whether responses to Helpline recommendations adequately consider both recommended response time and initial assessment of risk level
- whether secondary risk assessment practices reflect the requirement for holistic assessment
- whether other agencies are being effectively engaged in risk assessment and response to confirmed risk of harm
- the degree to which secondary assessments result in judgements and decisions[99]
- the overall adequacy of secondary assessment reports and judgements and decisions
- the overall adequacy of case plans, and their implementation, where risk of harm is substantiated
- case closure decisions, including the basis for decisions.

DoCS should report the results of the audits to this office.

DoCS response

DoCS told us that *'improving quality of practice is the next key area of the reform program to be implemented commencing in 2006.'* The department advised that a comprehensive framework for service improvement would cover a range of strategies, including — but not limited to — audit. DoCS advised us that it was starting a quality assurance program that has a core component of a 'quality review' in each CSC in the state. Reviews will take place over the next four years and will *'collect quantitative and qualitative information about priority systems, processes and practice.'*

DoCS said that the quality reviews will be supported by the establishment of a head office unit to work on professional development and quality assurance, and by additional resources at regional level. The reviews will be undertaken by regionally-based teams and committees. Each CSC will also develop a 'quality improvement plan' to improve performance, in line with review outcomes. DoCS also told us that there will be systems in place to enable analysis of, and response to, 'common themes' identified through this process at a regional and/or central level.

Our comments

The intent of our recommendation was for DoCS to be able to systematically identify and address, at both CSC and state-wide levels, some of the most critical issues arising from our reviews. This includes how CSCs make decisions about the nature of their response to risk of harm reports, and how they subsequently respond to children at risk.

DoCS' response indicates clearly that the department's intention is for all CSCs to be subject to a level of review that will identify local practice issues and result in the development of plans to address them. There is also a clear intention to use the outcomes from these reviews to inform a response to common issues across the state.

The proposed quality improvement process is a significant commitment for DoCS that provides an opportunity to improve frontline responses to children at risk. We will continue to monitor developments in the quality assurance program.

Recommendation 2

Initial risk of harm assessment

DoCS should provide advice to this office about progress in achieving the stated *2005/06 DoCS Corporate Directions* priority to *'implement an improved initial assessment process.'*

DoCS response

DoCS told us that it had undertaken some review of various assessment models that had resulted in a decision to maintain the current model of initial assessment. DoCS said it would also monitor the implementation of a different assessment model in Queensland — Structured Decision Making. The main message in DoCS' response is that while the current system will be maintained, the department is currently reviewing assessment tools with a view to improving these.

DoCS' stated view is that prior to any change in assessment processes, it will undertake research into the profile of reports coming in and reports referred to CSCs for further investigation, in order to better understand *'the links between the operation of mandatory reporting, the tools used for assessment and Helpline processes.'*

Our comments

We recognise the need for thorough consideration of the range of options and the costs and benefits of change prior to any moves to adopt new systems of assessment. We will continue to monitor DoCS' progress in improving initial assessment processes.

Recommendation 3

Initial risk of harm assessment

DoCS should provide advice to this office about progress in achieving the stated *2005/06 DoCS Corporate Directions* priority to *'improving accuracy of referrals to JIRTs and monitoring compliance with JIRT criteria'.*

DoCS response

In response to this recommendation, DoCS told us that in relation to JIRT:

- A review indicated that inappropriate referrals to JIRTs are mostly 'non sexual abuse matters'.
- A working group of DoCS, Police and NSW Health is developing 'improved physical abuse criteria' for JIRT referrals.
- A 2004 procedure requires CSCs to review case plans rejected by JIRT to ensure they receive a response commensurate with risk and safety issues.
- A memorandum of understanding between DoCS and Police, inclusive of a section relating to JIRT, will be completed by 2007.

In response to a recent investigation by this office, DoCS advised us in August 2006 that DoCS, NSW Police and NSW Health will undertake a review of JIRT systems, policies and processes. The review will consider referral processes, and *'improvements in the provision of protective action and support to victims and families where a criminal justice response is not appropriate.'*[100]

Our comments

The Police/DoCS MOU and proposed JIRT review provides an opportunity to closely consider a number of issues identified through our reviews in relation to JIRT and the relationship between JIRT and CSCs. We will monitor the progress of these initiatives.

Recommendation 4

Secondary risk of harm assessment

DoCS should give priority for allocation for secondary assessment to reports referred to a CSC or JIRT for further assessment, where

- A risk of harm report is made for a child living in a family where a sibling has been previously removed by an order of the Children's Court.

Recommendation 4 *(continued)*

- A pre-natal report is made concerning an unborn baby and the baby is born into a family where a child has been previously removed by an order of the Children's Court.

The purpose of giving priority to these cases is to assess whether previously identified risk is still present.

DoCS response

DoCS advised us that it has added the previous removal of a sibling to criteria set out in the department's *Intake Assessment Guidelines*. The guidelines provide criteria that ensure reports containing certain risk indicators are prioritised for secondary assessment stage 1, before closure of the report can be considered.

Our comments

Our advice to DoCS was that implementation of the recommendation would require inclusion of previous sibling removal as a criterion for priority within *Intake Assessment Guidelines*, and DoCS has progressed this.

We consider secondary assessment stage 1 to be a minimal response to reports of risk of harm for families where there have been previous serious child protection issues. We will monitor the implementation of the guidelines.

Recommendation 5

Secondary risk of harm assessment

In 2004, we made a number of recommendations related to the reporting of information about DoCS' work. DoCS has indicated its capacity to report certain types of information from its client information database is improving. DoCS should advise this office whether the following state-wide information is being drawn from KiDS, and if so, how the information will be reported:

- Reports referred by the Helpline to CSCs and JIRTs for secondary risk of harm assessment.
- Reports that received a secondary risk of harm assessment, including actions taken and outcomes of that assessment.
- Risk of harm reports closed without assessment and the reason for closure.

DoCS response

In May 2006, DoCS published an annual statistical report for 2004/05. The data provides information about reports referred to a CSC or JIRT: how many had a secondary assessment concluded and outcome recorded (SAS 1 or secondary assessment stage 2 — SAS 2), how many were subject to ongoing secondary assessment or investigation, and reports where no secondary assessment was recorded. Other information is available about reports where secondary assessment was concluded, including type of harm, whether risk of harm or harm was determined and what type of harm this was, and age, gender and indigenous status of children reported.

The data does not include risk of harm reports closed without assessment or the reason for closure. DoCS told us that in relation to these reports *'there are no coded fields in KiDS that allow recording of detailed case closure reasons or the circumstances of the case.'*

Our comments

Lack of capacity to fully report on the outcomes of the department's work has been raised as a concern in the previous two reviewable deaths reports.

DoCS has progressed its data reporting significantly since 2005. However, the department's inability to report more fully on cases closed without assessment remains a concern. We note that in DoCS' 2004/05 data, almost half of the reports referred to a CSC or JIRT (65,975, or 47.1% of all reports referred) had *'no secondary assessment recorded'*. That is, no aggregate information is available on whether, or how, these reports were responded to, whether they are open or closed, and if closed, the reason for closure.

Recommendation 6

Secondary risk of harm assessment

In 2004, we recommended that DoCS should institute a system to review decisions at a CSC to override Helpline recommendations. DoCS advised us that this would be considered. DoCS should advise this office of the outcome of its consideration to incorporate regular review of decisions at CSCs to overturn recommendations from the Helpline, as an initiative within the Practice Improvement Process.

DoCS response

DoCs told us that the overall rates of change by CSCs are low. In the March 2005 quarter, CSCs overrode Helpline decisions in only 4% of cases. In a quarter of these, the rating was upgraded. DoCS initially told us that it would monitor the rate and direction of change each year. However, in response to our further queries, DoCS told us that the information is difficult to extract and given the low rates identified, annual review is not warranted. DoCS told us it would look at possible modifications to its system to enable easier extracting of the information. If this is not possible, the department will use the current intensive system of extracting the data for the March 2007 quarter to enable review of any further change to the degree to which CSCs are changing Helpline recommendations. This will inform decisions about any future monitoring.

Our comments

The strategy proposed by DoCS appears reasonable, particularly in the context of broader initiatives to review and monitor practice at CSCs (see recommendation 1).

Recommendation 7

Secondary risk of harm assessment

In 2004, we recommended that DoCS clarify its policies about sighting children and interviewing and sighting families. DoCS has advised that guidance for sighting and interviewing children will be covered in the revised Business Help topic on secondary assessment. DoCS should provide advice to this office about changes to the Business Help topic on secondary assessment that provide guidance about the circumstances in which:

- children should be sighted
- children should be interviewed
- families/carers should be interviewed.

DoCS response

DoCS advised that the new *Secondary Assessment — Risk of Harm* procedure will include specific practice instructions about observing children as part of an assessment. A checklist for secondary assessment stage 2 will include a requirement to observe and engage with the subject child. Where this is not possible, reasons must be recorded. The procedures will also require that the pre-assessment consultation should include interviews with parents/carers. Where this does not occur, reasons must be provided.

Our comments

The intent of this recommendation was for DoCS to address a lack of clarity about requirements for caseworkers to sight or interview a child and interview parents/carers. From the information provided by DoCS, it appears that this intent will be met by the new procedures. We will review the new procedures when finalised.

Recommendation 8

Case closure

DoCS should regularly assess its capacity and provide reports to the NSW government, and to this office, on its ability to meet the objective of our 2004 recommendation that:

A key principle in child protection intervention should be that where a report raises issues of safety of a child, or failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to resolve the issues. In this context, DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention.

DoCS response

DoCS told us: *'We do not accept that there can ever be an arbitrary risk threshold beyond which a case cannot be closed'*. DoCS said that the alternative would be a 'non-transparent' system where cases would remain open if they are above the threshold, but no work may be done on them.

DoCS advised us of the progress of the trial of the *Intake Assessment Guidelines*. The guidelines specify certain criteria that indicate high risk, and require these reports to be prioritised for secondary assessment stage 1. SAS 1 involves an analysis of child protection history, in some cases contact with the reporter and other agencies, and potentially referral to other agencies. SAS 1 does not involve face-to-face contact with the family or child. SAS 1 may result in the report being prioritised for field-based assessment through secondary assessment stage 2.

The specified criteria by which reports are prioritised for SAS 1 include:

- reports given a 24 hour response rating by the Helpline
- reports where the Helpline recommends a response within 72 hours and the child is under two years of age and certain other criteria are present. Examples of criteria include impaired parenting capacity due to alcohol or drug misuse, unmanaged mental illness or intellectual disability, neglect, or domestic violence involving injury or weapons.

DoCS said that the guidelines have been tested in CSCs, and that in those CSCs with additional caseworker resources, the guidelines have targeted children under five years of age. The intention is for the guidelines to be implemented across the department by early 2007. DoCS told us that:

> *'the key issue is the monitoring of allocation rates for high risk cases and reporting of these annually. This will provide trend data that will make it clear whether changes in demand (or other operating conditions) are outstripping the capacity of currently available resources.'*

DoCS cited its 2004/05 Annual Statistics report and the publication of *'allocation activity for all reports referred to CSCs for assessment'*. DoCS also told us that in its 2006/07 report, additional information will be provided on allocation rates by Helpline-assigned level.

DoCS told us that reports are made to government in a variety of ways, including its annual report, reports to Treasury, reports via the Minister for Community Services and regular reports to Parliamentary Committees.

Our comments

Since our first reviewable deaths report, and while accepting the recommendation in principle, DoCS has taken some issue with our view that there should be a risk threshold above which a case should not be closed without the department taking protective intervention. The department refers in its response to the key issue being to monitor allocation rates for high-risk cases and reporting of these annually, and cited its 2004/05 Annual Statistics report and the publication of *'allocation activity for all reports referred to CSCs for assessment'*.

Recommendation 8 *(continued)*

Our comments ***(Continued)***

However, as noted in recommendation 5 above, DoCS told us in that context that in relation to reports closed without assessment *'there are no coded fields in KiDS that allow recording of detailed case closure reasons or the circumstances of the case.'* In DoCS' published data therefore, information is not reported about secondary assessment outcomes of almost half (47%) of reports referred to a CSC or JIRT, including whether or to what degree they were subject to assessment. For these reports, DoCS is unable report in aggregate what happened once reports were referred to a CSC.

In our view, accurate and full data about the outcomes of secondary assessment, as well as allocation rates, is critical to informing the progress of reform initiatives in DoCS.

Capacity to respond to reports indicating a child is at risk of harm remains a significant concern.

Recommendation 9

Interagency coordination

In the context of the current review of the *Interagency Guidelines for Child Protection Intervention*, the Child Protection Senior Officers Group should consider the issues raised in this report. The Senior Officers Group should give particular consideration to:

- the number of cases that are currently not able to be assessed by DoCS to the point of substantiation of risk of harm, and the implications of this for determining a reasonable trigger for interagency protection planning.
- the need to identify the types of circumstances that might warrant an interagency response at any stage of the assessment process, and the need to articulate the nature of such responses. Specific consideration should be given to timely interagency responses to reports involving:
  - substance abusing parents/carers
  - adolescents
  - unborn children (pre-natal reports)
- the need to clearly articulate in the guidelines the types of circumstances where an interagency response should be mandatory.

DoCS response

DoCS advised us that its initial response to this had been endorsed by HSCEOs. This response drew on the procedures in the revised guidelines that state DoCS may convene an interagency case meeting where a matter has been allocated for secondary risk of harm assessment, and will convene such a meeting or teleconference where a child has been found to be in need of care and protection. The initial response also stated that:

> *'It is not appropriate to use the guidelines as the mechanism for mandating action. The ability of an agency to act is a product of the scope of its statutory powers and the budget allocation received through the appropriations process.'*

In a later response from DoCS (July 2006) following a further inquiry from us, the department said that the new guidelines were in penultimate draft and that they were likely to contain *'strategies for improving interagency collaboration and revised information on key agency roles and responsibilities, both before and after reporting.'*

DoCS told us that in the guidelines:

- Agencies would often have an ongoing service role with families and children that they report, and DoCS feedback on reports made will facilitate this.
- DoCS will improve support of interagency partners through general 'consultative advice' in agencies' work with families where a case is unallocated.

Recommendation 9 *(continued)*

DoCS response ***(Continued)***

- Case meetings are described as a core component of case management, *'to be convened at a range of points in the intervention process'*, and a sample of triggers will be provided that may cause DoCS to convene a case meeting.

DoCS said that the question of whether the guidelines should prescribe circumstances in which an interagency response is warranted has received a significant amount of consideration. DoCS advised that *'The better solution is seen to be strengthening of the understanding of reporters on those cases where the risk warrants a report, more effective assessment of reports and focused joint work when this is warranted on the basis of the assessment of risk'*

Our comments

We made this recommendation in light of our finding that few protection planning meetings had been identified in our reviews in 2004. We also noted that given the number of cases DoCS is unable to allocate for secondary assessment, it is essential that interagency planning be initiated at any point, where appropriate to the case.

While we acknowledge DoCS' view that improved processes around risk assessment would lead to more effective joint work, our reviews over time have clearly identified that interagency responses are often lacking in cases where joint work is clearly warranted. We will monitor the outcomes of the revision of the interagency guidelines.

Recommendation 10

Interagency coordination

The NSW government should consider the amendment of section 248 (provision and exchange of information) of the *Children and Young Persons (Care and Protection) Act 1998* to allow for an agency that is a 'prescribed body' under the Act to furnish or request information relating to the safety, welfare and wellbeing of a child or young person, or class of children or young persons, to another prescribed body.

DoCS response

While we provided our recommendation to the Cabinet Office, DoCS provided the response. The department advised us that its initial response had been endorsed by HSCEOs, and that this Forum had decided to undertake a project to develop tools, procedures and standards that *'create a culture emphasising the value of information management and sharing at an individual and statistical level.'*

The HSCEOs response and DoCS later response both reiterated the view that the appropriate avenue for considering our recommendation was through the review of the *Children and Young Persons (Care and Protection) Act 1998*. Further, DoCS told us that there is a need for government to consider the best approach to balancing *'freer disclosure'* with the need to *'preserve the integrity of mandatory reporting'*.

DoCS told us that a key issue to consider is the need to ensure protection of a reporter's identify. *'The key issue is to resolve the means of ensuring that information sharing occurs only for the purposes of child protection and not for other purposes which may never have been intended or foreseen by the reporter.'*

Our comments

The intent of this recommendation was for the NSW government to consider gaps in the system where agencies other than DoCS seek to exchange such information relevant to their work with families and children in a child protection context. Section 248 does not enable a prescribed body to furnish information relating to the safety, welfare and wellbeing of a child or young person to a body other than DoCS.

While we acknowledge DoCS' concerns about the need to preserve the integrity of mandatory reporting, the revised guidelines place increased onus on the responsibility of individual agencies to work directly with families, particularly where DoCS is not able to allocate a case.

Recommendation 10 *(continued)*

Given this, it remains essential that close consideration be given to the capacity of agencies to access and provide important information related to protecting children.

We will consider progress in this regard once the review of the Act has been completed.

Recommendation 11

Interagency coordination

The Child Protection Senior Officer's group should ensure that the revised *NSW Interagency Guidelines on Child Protection Intervention* are released with an evaluation framework. The evaluation should focus on assessment of agency take-up and overall effectiveness of the guidelines.

DoCS response

DoCS advised us that its initial response to this had been endorsed by HSCEOs. DoCS told us that HSCEOs will undertake a review of evaluation frameworks for interagency practice, with proposals to be submitted by February 2007 for consideration of the *'best approaches for ensuring the ongoing effectiveness of the guidelines.'* DoCS said that assessment of agency take-up and overall effectiveness of the guidelines will be incorporated in the development of an evaluation framework.

In a later response, DoCS advised that the Centre for Parenting Research is undertaking a literature review on methodologies for evaluating interagency agreements and guidelines, and that simultaneously with this, a framework for the evaluation is being developed. Further *'once the literature review and the development of the framework is completed, the evaluation will be commissioned.'*

Our comments

We will monitor progress with evaluation of the guidelines.

Recommendation 12

Interagency coordination

DoCS, in consultation with other interagency partners, should consider the outcomes of the review of the Complex Case Management Response Team operating in the DoCS Western Region and consider the potential for application of the model in other regions of NSW.

DoCS response

DoCS told us that the proposed review of the Complex Case Management Response Team was replaced by an evaluation of the range of integrated case management projects. We asked DoCS about this process and whether the report would be publicly available. In July, DoCS said that the evaluation report and further steps in evaluating these models is under consideration through Cabinet processes, and that *'release of evaluation materials will be considered in that process'.*

Our comments

We will monitor developments in the outcomes arising from the evaluation of integrated case management projects.

Recommendation 13

Substance abuse

We support recommendations made in internal departmental reviews relating to substance abuse, as described in section 6.1 (*Report of Reviewable Deaths in 2004*). DoCS should provide advice on the progress it has made in implementing these recommendations:

- Enhancement of availability of in-house expert drug and alcohol advice to field staff, possibly including regular case practice review discussions led by expert drug and alcohol professionals.
- A Helpline quality assurance project over a two year period reviewing the adequacy of DoCS' response to cases of children under one where the primary presenting problem is parental substance abuse and the priority rating level is 2 or 3.
- Monitoring of child deaths over a two year period where there are concerns regarding parental substance abuse, with a project around this sample group to identify common systemic and practice issues and formulate recommendations.
- Provision of information about parental methadone use via the department's intranet and a review of the methadone component of drug and alcohol training provided to departmental staff so that it includes contemporary research regarding risk factors.

DoCS response

In summary, DoCS advised us that:

- The redeveloped DrugNet resource site for DoCS staff was launched in May 2006. The site provides research and information to assist staff working with families with drug and alcohol issues, and is monitored and reviewed.
- The Hearth Assessment tool — a strengths-based tool for assessing the safety of children in the care of a person presenting with drug or alcohol issues — was trialled in a number of areas and is now being considered for further in-depth trial.
- The alcohol and other drugs program (training) has been reviewed to include materials about specific issues including methadone use, drugs in pregnancy, children ingesting a sedative drug, supervision and neglect. The training is mandatory and forms part of the Caseworker Development Course. DoCS also advised that the training module will be revised to include findings from the *Report of reviewable deaths in 2005*.
- Regional training about dual diagnosis will be offered in DoCS' training calendar for 2007.
- An action research project was undertaken in April 2006 that consisted of Alcohol and Other Drug forums being held in all regions. Key findings of the project will be incorporated into training strategies.
- NSW Health and DoCS have developed a protocol on exchange of information about DoCS clients on opioid treatment: *Information sharing — assessing potential risk of harm to children less than 16 years of age under the Children and Young Persons (Care and Protection) Act 1998 who are in the care of persons participating in opioid treatment (methadone or buprenorphine).* The protocol focuses on improved procedures for information sharing between DoCS and opioid treatment prescribers where DoCS is assessing a risk of harm report relating to opioid use, and where a prescriber has concerns about a child's safety, welfare or wellbeing.
- DoCS has developed and will trial a policy on drug testing in a child protection context. DoCS indicated this will involve a more structured approach to application of drug testing in child protection, with the use of formal parental undertakings about refraining from drug use and undergoing a testing regime.
- The Helpline conducted a 'Quality Review' on assessing risk of harm reports for children under 12 months of age, who resided with a substance using parent or carer. This resulted in the development of a 'practice solution session' for DoCS staff to improve caseworker knowledge on substance abuse and its effect on parenting.
- DoCS and NSW Health have commenced a joint review of methadone-related child deaths. The intention is to examine systemic issues regarding child deaths from methadone poisoning and develop a pilot interagency training program on the issues arising.

Recommendation 13 *(continued)*

DoCS also provided advice about a number of other relevant initiatives, including development and launch of the *Dual Diagnosis Support Kit* to assist workers, carers and parents; development of the *Family and Carers Training Resource Kit*, to assist workers in the community who do not specialise in drugs and alcohol but work with affected families; current work to develop a DoCS policy response to the *Interagency Guidelines for Early Intervention, Response and Management of Drug and Alcohol Misuse*; and work on literature reviews by the Centre for Parenting and Research on parental alcohol misuse and parental drug misuse.

Our comments

We asked DoCS to provide advice only. The issue of substance abuse, and current DoCS strategies to deal with this issue, is discussed throughout this report.

Recommendations 14, 15 and 16

Substance abuse: Undertakings

DoCS should clarify and consolidate departmental policy on the use of undertakings as a protective measure. In particular, policy should clearly identify the circumstances under which undertakings may be an appropriate protective measure, and circumstances under which they may not be.

DoCS should require that where undertakings with parents or carers are used in case plans or unregistered care plans, the plan should include a monitoring component to review compliance with undertakings. Consequences of breaching undertakings should be agreed as part of the plan.

DoCS should require that a case should not be closed on the basis that undertakings have been signed. The signing of a case plan or care plan including undertakings should not be considered a protective measure for children until parents/carers have demonstrated a reasonable period of compliance.

DoCS response

DoCS told us it agreed that current policies on the use of undertakings as a protective measure were confusing and required clarification. DoCS said its Business Help topics in this regard would be reviewed to ensure consistency and make instructions more explicit. In its latest response in July 2006, DoCS provided further information about its work to address concerns with policies about undertakings. The amendments are expected to be completed by December 2006. In summary:

- References to 'informal undertakings' will be removed from Business Help topics on case planning, care planning and undertakings.
- Procedures will address central issues of when case plans and unregistered care plans alone are adequate protective measures, and will provide guidance as to when additional measures — including court orders — would be required.
- Procedures on case planning, care plans and orders accepting undertakings will include specific guidance about monitoring arrangements and consequences of breaching agreements.
- Procedures on case planning and care plans will state that parents/carers will need to demonstrate compliance with agreements for 12–24 months before the agreements could be considered to be a sufficient protective measure.

DoCS also advised that the NSW government intends to introduce parental responsibility contracts. The contracts will be legislated, and will provide an additional tool for caseworkers. The contracts will:

> *'establish a means for parents of children and young people assessed by DoCS to be in need of care and protection to improve parenting skills and accept greater responsibility for their children. The contracts will do this by specifying attendance at a range of programs including parental programs for behaviour management, parenting, reduction of substance abuse and rehabilitation services. Parental Responsibility Contracts will be voluntarily entered into by parents and DoCS and, in the first instance, registered with the Children's Court.'*

Recommendation 14, 15 and 16 *(continued)*

DoCS said that a breach of the contract would ultimately result in children being determined to be in need of care and protection.

Our comments From the advice provided by DoCS, the revision of procedures relating to undertakings will provide the opportunity to address the concerns leading to our recommendations. We will monitor this recommendation through review of the procedures on completion and through our ongoing reviews.

Recommendation 19

Pre-natal reports

DoCS should develop clear policy and procedural guidance for DoCS staff in relation to handling pre-natal reports and reports of risk of harm that include unborn children. Guidance should:

- identify strategies to support and assist pregnant women and the circumstances in which such strategies should be used.
- clarify the circumstances that would give rise to risk assessment and intervention following the birth of the child.

DoCS response DoCS advised us that it is preparing a draft policy on responding to pre-natal reports. This will include consultation with NSW Health. DoCS said the policy would clearly delineate the respective roles of DoCS and NSW Health, and the timing and type of DoCS intervention in responding to pre-natal reports. This will include approaches to supporting pregnant women and actions following the birth of a child.

DoCS also advised that as part of the review of the *Children and Young Persons (Care and Protection) Act 1998*, consideration is being given to changes to section 248 of the Act to allow for exchange of information regarding pre-natal reports.

Our comments From the advice provided by DoCS, the drafting of a pre-natal reports policy will provide the opportunity to address the concerns leading to our recommendations. We will monitor this recommendation through review of the policy on completion and through our ongoing reviews.

Recommendation 20

Neglect

We support recommendations made in internal DoCS reviews relating to neglect, as described in section 6.4 *[of the Report of reviewable deaths in 2004]*. DoCS should provide advice as to the progress it has made in implementing these recommendations:

- the DoCS neglect policy be released with accompanying training that includes a strong emphasis on assessment of the relationship issues between the parent and the child.
- development of learning strategies aimed at raising the clinical skills of casework managers in undertaking and supervising holistic assessments.
- an increased focus on the integration of history in the training provided to caseworkers.

DoCS response DoCS advised that it is currently rolling out its neglect policy, which includes a revised *Secondary assessment — risk of harm procedure*. The roll out will occur in phases from July 2006 — August 2007.

Release of both will involve 'practice solutions sessions' for all direct child and family staff between July and October 2006. A separate practice session will be developed for Managers Casework and Managers Client Services, and a separate strategy will be designed for Helpline staff. A one-day session on neglect will be included in the Caseworker Development Course.

Recommendation 20 *(continued)*

DoCS response ***(Continued)***

DoCS also noted the relevance of the department's broader professional development strategy in promoting increased staff skills and capabilities, and strategies to improve assessment practice overall.

Our comments

We will review the neglect policy and revised *Secondary Assessment — Risk of Harm* procedure and continue to monitor responses to neglect through our ongoing work.

Recommendation 21

Aboriginal children and young people

DoCS should consider the issues raised in this report in relation to Aboriginal children and young people, and report on proposed strategies to address these issues. Particular consideration should be given to:

- Enhancing capacity to respond to reports of risk of harm for Aboriginal children that require secondary risk assessment, particularly in regional NSW.
- Ensuring compliance with the secondary risk of harm assessment framework in assessing reports for Aboriginal children and young people, particularly in regional NSW.
- Improving interagency coordination and collaboration in the care and protection of Aboriginal children, particularly in regional NSW.
- Clarifying appropriate circumstances for the use of temporary care agreements as a protective measure for Aboriginal children at risk.

DoCS response

DoCS initially advised that part of this recommendation was referred to HSCEOs for advice. DoCS told us that *'the problems of social and community breakdown in Aboriginal communities are not new and there are no simple answers.'* In regard to relevant strategies, DoCS noted:

- The recruitment of additional caseworkers, particularly Aboriginal caseworkers for which DoCS has a targeted recruitment strategy, will enhance DoCS capacity to respond to risk of harm reports for Aboriginal children.
- The development of Intensive Family Based Services to work with Aboriginal families in Bourke, Dapto, Casino, Redfern and Campbelltown. These services aim to *'reduce the number of Aboriginal children being placed in out-of-home care; to reunite families where possible; and to build positive strengths and resilience with families where child protection is an issue.'*
- Review of the procedure for the use of Temporary Care Agreements, with a key practice issue being the appropriate circumstances in which TCAs should be used.
- The new DoCS policy and practice guidance on neglect and revised secondary assessment procedures *'provide practice guidance for caseworkers in managing risk assessment for Aboriginal children and young people'.* Development of practice standards will also have as a key element assessment of Aboriginal children and families, and one of the terms of reference for the JIRT review is to improve effectiveness of the JIRT model with Aboriginal communities.
- DoCS has introduced a pilot traineeship program — a Diploma of Community Services (Protection and Intervention) — for existing Aboriginal caseworkers, and will be implementing a cultural awareness training program to increase awareness of Aboriginal issues and examine ways to improve service quality. Enhancements have also been made to the Caseworker Development program in regard to awareness of Aboriginal issues and 'practical ways to improve services for Aboriginal clients'.

HSCEOs noted other initiatives relating to child protection concerns in Aboriginal communities:

- The finalisation of, and reporting by, the Aboriginal Child Sexual Assault Taskforce.
- The Families and Communities Cluster linked with the NSW Aboriginal Affairs plan *Two Ways Together* provides a forum for discussion and advice on the prevention of harm to children in Aboriginal communities.

Recommendation 21 *(continued)*

- Place-based mechanisms *'focusing on specific child protection and family support issues'*, such as the Toomelah/Bogabilla project.

The response noted that *'HSCEOs have agreed to their agencies investigating other options with a view to strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed.'* DoCS' later response noted that the CPSOG will identify and map *'legal, policy, procedural and practice issues from recent reports on child protection for interagency action'*. As part of this work, CPSOG will consider *'the investigation of options for strengthening joint responses once a secondary risk of harm assessment has been conducted and risk of harm confirmed.'*

DoCS has advised us that it has finalised and is preparing for publication the 'DoCS Aboriginal Strategic Commitment', which outlines how DoCS will work to provide better services for Aboriginal people over the next five years.

Our comments

Our recommendation was informed by our reviews of deaths in 2004 that found that some of the children had no, or a limited, response to reports that they were at risk of harm, and that when risk assessments did occur, these often did not comply with standards required by the department. In the matters we reviewed in 2005, these issues remained apparent.

DoCS' corporate priorities for 2005/06 included an improved commitment and service to Indigenous communities. As part of this, DoCS noted the department, through the Aboriginal Services Branch, would develop a *'whole-of-DoCS Strategic Plan that outlines and integrates the organisation's major priorities for work to improve outcomes for Aboriginal clients and staff*[101]*.'*

We will consider the Aboriginal Strategic Commitment, in the context of the need for an encompassing strategy to address problems, the nature of which DoCS notes are not new and are complex.

We note also that the future strategies referred to in relation to CPSOG and HSCEOs relate only to responses following secondary assessment by DoCS and a confirmation of risk of harm.

Recommendation 22

Adolescents

DoCS should consider the issues raised in this report in relation to adolescents, and report on proposed strategies to address these issues. Particular consideration should be given to:

- Whether existing procedures and models of casework and current practice are effectively meeting the needs of adolescents at risk.
- How current responses to adolescents with mental health problems, or who have been reported to be at risk of suicide, could be enhanced through cooperation with relevant interagency partners.

DoCS response

DoCS initially advised that part of this recommendation was referred to HSCEOs for advice. DoCS told us that:

- The department had been working with relevant community sector representatives on the issue of youth in Supported Accommodation Assistance Program (SAAP) services.
- The Child Deaths and Critical Reports Unit is intending to develop a research paper and case study based on issues arising from the Unit's reviews of deaths of young people by suicide or risk taking behaviour. The project will use internal and external expertise and 'look at issues for practice in engaging with young people and to identify, where possible, serious suicide and self-harm patterns in vulnerable young people and promote successful practice'.

Recommendation 22 *(continued)*

- DoCS' Centre for Parenting and Research is undertaking a project to inform *'policy and practice relating to effective strategies and interventions for adolescents at risk.'* The project will consider evidence relating to effective services and interventions for young people, and will identify the knowledge of DoCS' staff about child protection strategies and interventions that are effective with young people.
- DoCS also contributes to the Chair in Adolescent Medicine at the University of Sydney, in order to gain agreement for research in out of home care and adolescent mental health.
- DoCS advised that the response regarding mental health (point 2 of the recommendation) had been endorsed by Human Services CEOs.

The response identifies initiatives to reform mental health services, principally the New South Wales Interagency Action Plan for Better Mental Health, and a clinical services implementation plan, being developed by NSW Health. The response further notes that *'this section of the recommendation is a matter primarily for NSW Health. The Ombudsman should pursue further discussions with that agency.'*

We sought and received advice from NSW Health in this regard. They told us that:

> *'the Centre for Mental Health acknowledges that children and adolescents with mental health problems lie within its responsibility, however, implementation of recommendation 22 is more appropriately led by DoCS based on the issues raised in the Ombudsman's report'.*

NSW Health clarified that the NSW Cabinet Office, not the Centre for Mental Health, is directing implementation of the *NSW Interagency action plan for better mental health*. NSW Health advised that the Centre for Mental Health and NSW Child and Adolescent Mental Health Services are committed to working cooperatively with DoCS and other agencies to improve access and service delivery for children, adolescents and families. NSW Health identified a number of relevant joint initiatives:

- Development, led by DoCS, of a memorandum of understanding on prioritising access to health services for children and young people for whom the Minister for Community Services has parental responsibility relating to, or the Director-General of DoCS has responsibility relating to residence and/or medical issues.
- Development by the CMH and network of Child and Adolescent Mental Health Services of a NSW Mental Health Service Plan for children, adolescents and their families. The aim of the plan is to provide a strategy for service development and a secure base for child and adolescent mental health services.
- Collaborative partnership through the NSW School-Link initiative between NSW Health and the NSW Department of Education and Training to support collaborative work between adolescent mental health services, schools and TAFE.
- Piloting and evaluation of a youth mental health service, with the aim of strengthening mental health service delivery and focusing on early intervention and prevention for young people with mental health problems (CMH and Northern Sydney/Central Coast Area Health Service). The intention is to progressively implement this model in the Area Health Services from 2007–2008.

Our comments

The recommendation was made in the context of our reviews of 22 adolescents who died in 2004 and whose deaths were reviewable. Of these 22 young people, six committed suicide. Five of these young people had been reported to DoCS as being at risk of harm in the six months prior to their death. In three of these cases, the reports indicated that the young person was suicidal, or raised concerns about the young person's mental health. Two of the young people were the subject of Children's Court orders placing them under the parental responsibility of the Minister for Community Services, and one of the young people was in the process of being restored to their parents, following a period of temporary foster care. Overall, we found that most of the young people who had committed suicide had had contact with a number of agencies, but in some of these cases, there was limited communication or coordination between services, including between mental health services and DoCS.

Recommendation 22 *(continued)*

Our reviews identified the need for better joint work to address the needs of adolescents who are identified as being at risk of harm and have mental health issues. We believe it is essential in the first instance that DoCS and NSW Health determine which of these two agencies should take the lead for ensuring that there is ongoing improvement to the level of service provided to at-risk young people who are the focus of our recommendation.

Recommendations directed to NSW Police

Note: NSW Police' response is our summary of the relevant information provided by the department.

Recommendation 17

Domestic violence

NSW Police should review whether Apprehended Domestic Violence Orders (ADVOs) for children are being utilised effectively and whether police officers have adequate procedural guidance to determine the circumstances that warrant application for an ADVO on behalf of a child.

NSW Police response

NSW Police told us that informants for AVOs on behalf of children are mostly investigators with the Child Protection and Sex Crimes Squad, particularly JIRT. Police said that in regard to data, it is difficult to identify how many AVOs were applied for on behalf of children, but that there is a major program enhancement underway — the AVO Compliance with Legislation project — which among other things is aiming to develop and upgrade data collection and recording processes.

In 2005, a total of 26,548 final AVOs were issued. There were 13,416 children aged 0–17 years named in final AVOs as 'victims', the majority of whom were included as a result of domestic violence investigations.

In response to our further queries, NSW Police indicated that the review of *Domestic Violence* and *Child Protection Standard Operating Procedures* will take into consideration the issue of guidance to police dealing with children present at, or affected by domestic violence, where there is no JIRT referral or involvement.

Our comments

This office is currently conducting an investigation regarding the effectiveness of policing strategies targeting domestic and family violence.

Our primary concern with AVOs was that there be adequate guidance for police in determining when AVOs should be taken out on behalf of children. We will review guidance provided in the revised *Standard Operating Procedures* and monitor outcomes of the AVO Compliance with Legislation project.

Recommendation 18

Domestic violence

NSW Police have advised this office that they are reviewing their domestic violence and child protection standard operating procedures. In this context, NSW Police should ensure the procedures encourage full and relevant reporting to DoCS on the type and level of risk posed to children who are present at a domestic violence incident.

NSW Police response

NSW Police initially advised us that reporting risk of harm via telephone, rather than fax, has been mandatory since October 2005. Police said that this has improved the quality of information being provided by police to DoCS. Following our further queries, police advised that the directive to police in relation to fax reporting indicates that *'if after five minutes of waiting for a response from the DoCS Helpline, police are able to make a report by fax'*.

NSW Police told us that the review of the *Child Protection Standard Operating Procedures* will fully address the issue of full and relevant reporting to DoCS of all children living in a household where there has been an incident of domestic violence and the children are considered to be at risk.

Recommendation 18 *(continued)*

Our comments

This office is currently conducting an investigation regarding the effectiveness of policing strategies targeting domestic and family violence.

We note that reporting by fax is an efficient method for police to convey concerns to DoCS. Our concern was that police reporting of risk of harm in relation to children being present at domestic violence incidents must provide comprehensive information upon which DoCS can make judgements about risk and required response. We note that the Helpline's average in answering calls was less than five minutes in 2004/05.[102] The Auditor-General's performance audit of the Helpline in 2005 noted that the caseworker queue standard was an average waiting time of three minutes, and a maximum time of 15 minutes,[103] which indicates that faxed reports will likely remain a significant avenue for police reporting to DoCS.

We will review guidance provided to police in the revised *Standard Operating Procedures* regarding reporting on the type and level of risk posed to children who are present at domestic violence incidents.

Appendix 4

Data: Child deaths in 2005

Jurisdiction

For the period 1 January 2005 to 31 December 2005 there were 598 children and young people who died in NSW, and 117 (20%) of these child deaths were reviewable under the Ombudsman's reviewable deaths function. Table A4.1 below presents the number of child deaths in each group that determines a child's death as reviewable under section 35 (1) of the *Community Services (Complaints, Reviews, and Monitoring) Act 1993.* Note that the groupings are not exclusive as a child's death may be reviewable for more than one reason.

Reasons for reviewable status — Table A4.1

	Reviewable Child Deaths (117)
Child report < 3 years prior to the child's death	69
Sibling report < 3 years prior to the child's death	83
Fatal abuse	11
Fatal neglect	12
Suspicious circumstances	10
In care	4
In detention	0
In correction	0

The table below provides a comparison of reasons for reviewable status over the last three years.

Comparison of reasons for reviewable status — Table A4.2

	2003 deaths 2004 definitions	2003 deaths 2005 definitions	2004 deaths 2005 definitions	2005 deaths 2005 definitions
Total deaths in NSW	605	605	540	598
Reviewable child deaths	148	128	104	117
Deaths due to abuse	17 (11%)	17 (13%)	7 (7%)	11 (9%)
Deaths due to neglect	26 (18%)	18 (14%)	6 (6%)	12 (10%)
Deaths in suspicious circumstances	43 (29%)	8 (6%)	11 (11%)	10 (9%)
Children where the child or the child's sibling(s) were known to DoCS — number of deaths as a result of abuse or neglect, or in suspicious circumstances	54 (47%) of 114	32 (28%) of 114	17 (18%) of 96	25 (23%) of 109

Demographic information

Age and gender

Age category of children — Table A4.3

	All Child Deaths in NSW	All Reviewable Deaths
< 12 months	365 (61%)	60 (51%)
1-4 years	81 (14%)	26 (22%)
5-9 years	47 (8%)	13 (11%)
10-12 years	21 (4%)	7 (6%)
13-17 years	84 (14%)	11 (9%)
Total	598 (100%)	117 (100%)

Gender of children — Table A4.4

	All Child Deaths in NSW	All Reviewable Deaths
Male	343 (57%)	67 (57%)
Female	255 (43%)	50 (43%)
Total	598 (100%)	117 (100%)

Aboriginal and Torres Strait Islander children and young people

The deaths of 20 Aboriginal children of the 44 Aboriginal and Torres Strait Islander children who died in 2005 were reviewable. Aboriginal child deaths constitute 20% of all reviewable deaths in 2005.

Reasons for the reviewable status of child deaths by Aboriginal identity

Table A4.5

	All Reviewable Child Deaths (117)	Non-Indigenous Reviewable Child Deaths (97)	Indigenous Reviewable Child Deaths (20)
Child report < 3 years prior to the child's death	69	54	15
Sibling report < 3 years prior to the child's death	82	70	13
Fatal abuse	11	9	2
Fatal neglect	12	12	0
Suspicious circumstances	10	7	3
In care	4	4	0
In detention	0	0	0
In correction	0	0	0

Family characteristics, living arrangements and place of death

Person who the child normally resided with

Table A4.6

	All Reviewable Deaths (117)
Biological parent(s)	89 (76%)
Other family member(s)	2 (2%)
Non-related person(s)	2 (2%)
Young person living independently	1 (1%)
Child never discharged from hospital	23 (20%)
Total	117 (100%)

The place of the child's death

Table A4.7

	All Reviewable Deaths
Child's family home	63 (54%)
Other private home	4 (3%)
Residential service	1 (1%)
Hospital or health facility	39 (33%)
Public place	8 (7%)
Other location	2 (2%)
Total	117 (100%)

Person responsible for the supervision of the child at the time of the death incident

Table A4.8

	All Reviewable Deaths
Biological parent(s)	83 (71%)
Other family member(s)	2 (2%)
Non-related person(s)	19 (16%)
Child/ young person self-supervising	8 (7%)
Hospital staff	5 (4%)
Total	117 (100%)

Circumstances of death

Coronial inquests

At the time of writing, the coronial process had not been finalised for 40 (34%) reviewable child deaths that occurred in 2005.

Status of the coronial process

Table A4.9

	All Reviewable Deaths
Closed — inquest held	3 (3%)
Closed — inquest dispensed	63 (54%)
Closed — inquest terminated	11 (9%)
Open — coronial process not finalised	40 (34%)
Total	117 (100%)

For the 77 children where the coronial process has been finalised the manner of death determined by the Coroner is as follows:

Manner of child deaths

Table A4.10

	All Reviewable Deaths
Natural manner	53 (45%)
Coronial process is open	32 (27%)
Homicidal manner	13 (11%)
Accidental manner	10 (9%)
Undetermined/unascertained	5 (4%)
Suicidal manner	4 (3%)
Total	117 (100%)

The following table identifies the primary cause of death, according to ICD-10 codes. Note that the table only includes categories in which deaths of this group of children were coded.

ICD-10 Primary cause of death

Table A4.12

	All Reviewable Deaths
External causes of morbidity and mortality (U50–Y98)	30 (26%)
Conditions originating in the perinatal period (P00–P96)	23 (20%)
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)	12 (10%)
Diseases of the respiratory system (J00–J99)	6 (5%)
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	6 (5%)
Diseases of the circulatory system (I00–I99)	4 (3%)
Infectious and parasitic diseases (A00–B99)	4 (3%)
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanisms (D50-D89)	2 (2%)
Endocrine, nutritional and metabolic diseases (E00–E89)	2 (2%)
Diseases of the nervous system (G00–G99)	1 (1%)
Neoplasms (C00–C96)	1 (1%)
Diseases of the digestive system (K00–K93)	1 (1%)
Diseases of the genitourinary system (N00–N99)	1 (1%)
Insufficient information to code	24 (21%)
Total	117 (100%)

Children whose deaths resulted from abuse or neglect or that occurred in suspicious circumstances

Of the 117 reviewable child deaths, 11 (9%) children died as a result of abuse, 12 (10%) as a result of neglect and 10 (9%) children died in suspicious circumstances.

Abuse, neglect or suspicious deaths by children known to DoCS

Table A4.13

	All Reviewable Child Deaths (117)	Children Known to DoCS (109)	Children with Siblings Known to DoCS (40)	Children Not Known to DoCS (8)
Abuse	11 (9%)	6 (7%)	1 (3%)	4 (50%)
Neglect	12 (10%)	7 (6%)	1 (3%)	4 (50%)
Suspicious	10 (9%)	8 (7%)	2 (5%)	0 (0%)
Total	33 (28%)	22 (20%)	4 (10%)	8 (100%)

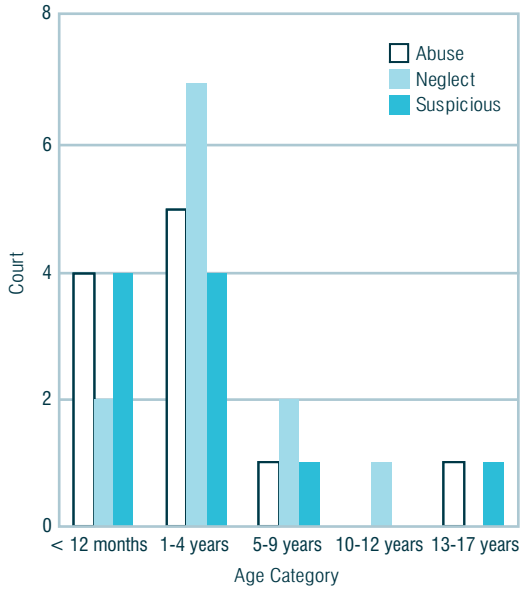
Criminal charges by abuse, neglect, suspicious deaths

Table A4.14

	Criminal Charges Laid		
	Yes	No	Total
Abuse	8	3	11
Neglect	2	10	12
Suspicious	3	7	10
Total	13	20	33

Age category of children by abuse, neglect & suspicious deaths

Fig A4.15



Appendix 5

Updated data: Child deaths in 2004

Jurisdiction

In the NSW Ombudsman's (2005) *Report of Reviewable Deaths in 2004,* we reported that for the period 1 January 2004 to 31 December 2004 there were 540 children and young people who died in NSW and that 104 (19%) of these deaths were reviewable. During the year we received further notifications from the NSW Registry of Births, Deaths and Marriages and information from the Coroner regarding child deaths that occurred in this period. This new information allows us to update our child death register and amend the figures we reported in last year's Annual Report as follows:

- There were 544 child deaths in NSW in 2004.
- One hundred and seven (20%) of these 544 deaths were reviewable.
- We are still unable to determine the status of a further 11 deaths as at the time of writing the coronial process for these deaths is still open.

Table A5.1 below presents the revised number of child deaths in each group that determines whether a child's death is reviewable under section 35(1) of CS CRAMA. Note that the definitions of abuse, neglect and suspicious circumstances are those used in our 2004 report.

Reasons for reviewable status — Table A5.1

	Reviewable Child Deaths (107)
Child report < 3 years prior to the child's death	76
Sibling report < 3 years prior to the child's death	74
Fatal abuse	7
Fatal neglect	8
Suspicious circumstances	10
In care	8
In detention	0
In correction	0

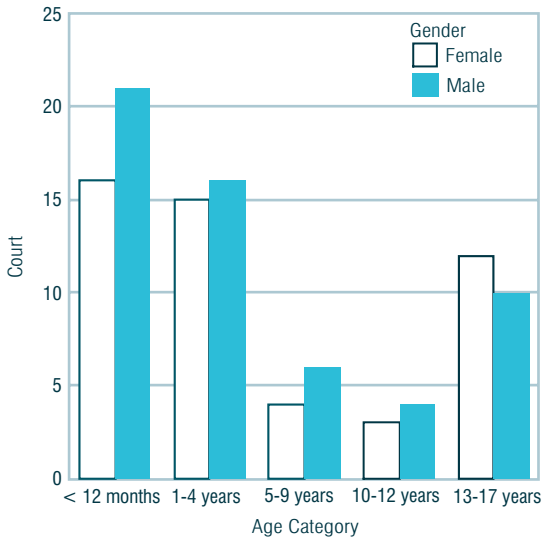
Demographic information

Age and gender

More than half of the children (68, 64%) were aged four years or less at the time of their deaths, while just under a quarter (22, 21%) were adolescents. Fifty-seven children were male and 50 were female.

Consistent with child deaths in general, slightly more male than female children's deaths were reviewable. See the figure below.

Age by gender for all reviewable deaths — Fig A5.2



Aboriginality

Of the 34 Aboriginal and Torres Strait Islander (ATSI) children who died in NSW in 2004, the deaths of 22 were reviewable. This constitutes 21% of all reviewable deaths in 2004.

Deaths due to abuse or neglect or that occurred in suspicious circumstances

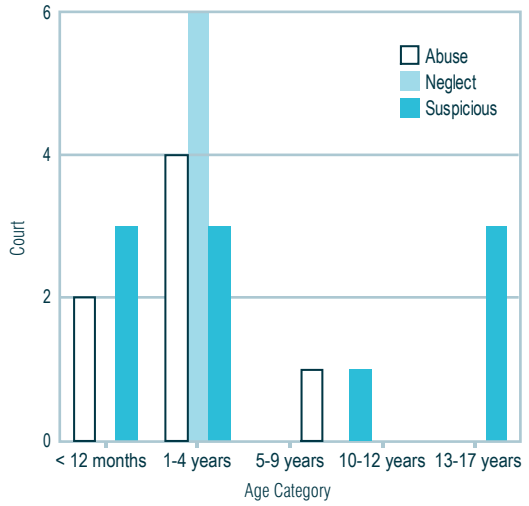
Previously, we reported that in 2004 there were seven deaths due to abuse, six deaths due to neglect and 11 deaths that occurred in suspicious circumstances. See the table below for the amended classifications.

Abuse, neglect or suspicious deaths by children known to DoCS — Table A5.3

	All Children (107)	Children Known to DoCS (76)	Children with Siblings Known to DoCS (23)	Children Not Known to DoCS (8)
Abuse	7 (7%)	2 (3%)	0 (0%)	5 (63%)
Neglect	8 (8%)	6 (8%)	1 (4%)	1 (13%)
Suspicious	10 (9%)	6 (8%)	3 (13%)	1 (13%)
Total	25 (23%)	14 (18%)	4 (17%)	7 (88%)

Age category by abuse, neglect or suspicious deaths for all reviewable deaths

Fig A5.4



Status of the Coronial Process

In 2004, we reported that the coronial process had not been finalised for 58 of the 104 reviewable child deaths reported on last year. At the time of writing, the coronial process remains open for 26 (24%) of the 107 reviewable child deaths.

Status of the coronial process

Table A5.5

	All Reviewable Deaths
Closed — inquest held	13 (12%)
Closed — inquest dispensed	59 (55%)
Closed — inquest terminated	9 (8%)
Open — coronial process not finalised	26 (24%)
Total	107 (100%)

Endnotes

[98] The Hon. Reba Meagher, MP Media Release: '2nd Report on Reviewable Deaths by the NSW Ombudsman, 7 December 2005.

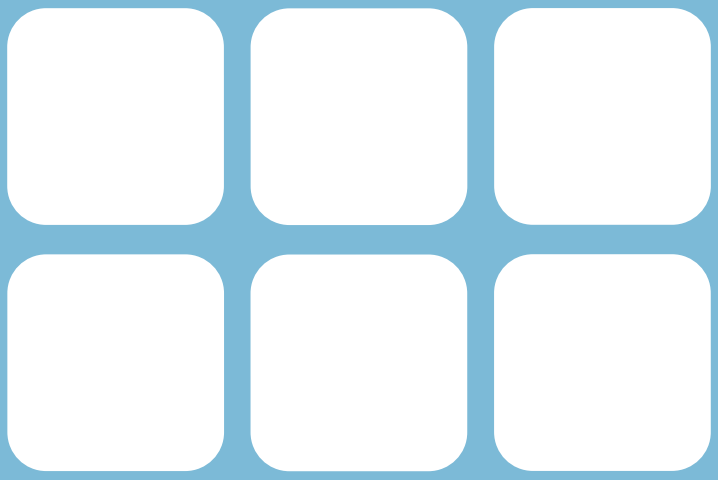
[99] Judgements and decisions' is DoCS' term for decisions made following secondary assessment about whether a child is at risk and whether protective intervention is required.

[100] DoCS response to recommendations in a final investigation report, in correspondence dated 8 August 2006.

[101] DoCS *Corporate Directions 2005/06.*

[102] DoCS *Annual Report 2004/05*, p.41.

[103] Audit Office of NSW (2005) *Performance Audit: The Department of Community Services Helpline.*



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