NSW Ombudsman

Report of Reviewable Deaths in 2006

Volume 2: Child Deaths

December 2007

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December 2007

The Hon Peter Primrose MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon Richard Torbay MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

I am pleased to present the NSW Parliament with volume two of our fourth 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 2006; 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

This report concerns the deaths in 2006 of 123 children.

It is the fourth report I have released on reviewable deaths, and the fifth year of this work since my office took responsibility for reviewing certain deaths in late 2002. Over that time, we have reviewed the deaths of almost 500 children.

The death of a child is reviewable for a number of reasons, including that they, or their sibling, were reported to the Department of Community Services as being at possible risk of harm at some time in the three years before they died. This means that the majority of deaths we review involve families who have had some involvement with the child protection system, minimally with DoCS, and in many cases, also with agencies such as NSW Police and NSW Health.

It is important to recognise that in the majority of cases, the child protection concerns that were raised with DoCS bore no direct connection to the circumstances in which these children died.

In scrutinising these cases over the years, however, we have identified a range of issues relating to the capacity of DoCS and other agencies to respond effectively to children at risk of harm. In highlighting these concerns, our aim is to alert agencies to areas of child protection practice that, if unaddressed, may lead to children being exposed to risk in the future.

Over the past five years, there has been a great deal of effort aimed at reforming and increasing the capacity of the child protection system. The roll-out of DoCS' $1.2 billion reform program will be completed by mid-2008. It is timely, therefore, to consider the changes that have taken place over the past five years. This report does so, and also considers the role my office plays in highlighting areas for systems improvement through reviewing child deaths.

The report recognises the work being undertaken in a number of areas that are critical to effective child protection. But we have also identified some recurring challenges. Broadly, these challenges reflect the limited capacity of child protection services to respond to high and growing demand, and some specific failings that can result in less than optimal practice. But they also reflect broader societal problems. It concerns me greatly, for instance, that Aboriginal children feature so disproportionately in reviewable child deaths, and that we continue to see young people who die who have a long history of contact with the child protection system coupled with mental health problems. Many of our reviews continue to identify significant underlying problems within families where a child has died, including parental substance abuse, parental mental health problems, and domestic violence.

In the report, I have included the outcomes of work undertaken for my office by the National Centre for Classification in Health. This work considers the causes of death for children whose deaths were reviewable over the four years to 2006. While statistically the numbers on which the work focused are small, it has raised some important questions about the differences in the cause of death for these children against the broader population. My office will consider the Centre's findings closely in our future work.

Bruce Barbour
Ombudsman

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Executive summary

Reviewing child deaths

The NSW Ombudsman reviews the deaths of children who die:

- while in care
- within three years of being the subject of, or having a sibling who was the subject of, a risk of harm report to the Department of Community Services (DoCS) ('known to DoCS').
- as a result of abuse or neglect
- in suspicious circumstances
- while in detention.

This definition means that the majority of reviewable deaths will be children who were known to DoCS. In most cases, the circumstances of the child's death had no connection to reported child protection concerns.

Our reviews aim to identify any 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.

In 2006, the deaths of 123 children were reviewable.

- Most — 114 — of the children were known to DoCS. They included 81 children whose deaths were reviewable because they had been the subject of a report to DoCS in the three years before they died. Another 33 children who died had a sibling who had been reported to DoCS.
- In 40 cases, the children's deaths were reviewable because they resulted from abuse or neglect, or happened in suspicious circumstances. This included 31 children who were known to DoCS and nine who were not.
- The majority of children — 73 of 123 — were aged under 12 months old when they died. Almost half of these children were under four weeks old.
- Indigenous children continued to be over-represented in reviewable deaths. The deaths of 25 children of indigenous background were reviewable, representing 20 per cent of all reviewable deaths in 2006.

Results of our work 2002 — 2006

In the four years to the end of 2006, we reviewed the deaths of 496 children.

The child protection system was entering a period of significant change when the Ombudsman began reviewing child deaths, with the implementation of a five-year $1.2 billion DoCS reform program. The broad plan of the program is to improve and extend child protection services, while reducing demand by

expanding early intervention and prevention services.

Since 2003, agencies have provided detailed responses to recommendations arising from our work, and have implemented a range of strategies to meet them.

Significant factors in child death reviews

Since 2003, our reviews have consistently identified parental substance abuse, parental mental health problems, domestic violence and neglect in the child protection histories of the children who died. These factors often co-exist and present significant risks to children, and challenges to the agencies in contact with them and their families.

As noted above, Aboriginal children feature disproportionately in reviewable deaths. There are also relatively high numbers of adolescents with a child protection history and mental health problems.

All these underlying factors were again prevalent in reviews of child deaths in 2006:

- We identified a history of parental substance abuse in 63 of the families of the children who died. Of these families, 51 children (or their siblings) were the subject of at least one risk of harm report to DoCS in the year preceding their deaths.
- Parental mental health problems were indicated in the records for 49 families. Of these, there were 14 families for whom risk of harm reports raised carer mental health issues as a primary or secondary concern. In 11 of these families, records also indicated a history of parental substance abuse.
- At least one risk of harm report was made in relation to 85 children and/or their sibling(s) in the year before they died. In just under half of the reports, domestic violence was the main issue reported.
- Nine children died as a result of neglect.

Aboriginal children and young people

From 2003 to 2006, 19 per cent of all child deaths in NSW were reviewable. In the same period, 42 per cent of the deaths of indigenous children were reviewable.

Over the past four years, we have identified a range of issues and subsequent challenges for agencies working with Aboriginal children who may be at risk and their families, including:

- gaps in effective interagency coordination and collaboration and the need to improve interagency approaches,
- at times, limited responses to issues of neglect, parental substance abuse and domestic violence in Aboriginal communities. We identified the need for DoCS to enhance capacity to respond to reports requiring assessment, particularly in regional NSW.

In 2006 we reviewed the deaths of 25 Aboriginal children and young people. Almost three quarters of these children were aged less than 12 months when they died. One third of the children had been the subject of a prenatal report to DoCS.

Since our last reviewable deaths report, the NSW government has released an *Interagency plan to tackle child sexual assault in Aboriginal communities*. DoCS has finalised, and commenced implementation of, its *Aboriginal Strategic Commitment 2006–2011*. While these are important initiatives, we are keen to see a significant improvement in the ability of agencies to deliver early intervention and child protection services to Aboriginal communities, particularly in more remote areas of the state.

Adolescents

In the four years from 2003 to 2006, we reviewed the deaths of 87 young people aged between 13 and 17. Suicide was the manner of death for a quarter — 22 — of these young

people. We identified risk taking behaviour as a likely contributing factor in another 22 deaths.

Some of the young people who died had contact with various agencies since childhood. This raised questions about the adequacy of earlier intervention in their lives. In many cases, we also noted a lack of effective interagency coordination.

In 2006 we reviewed the deaths of 17 young people. Fifteen of them had been the subject of reports to DoCS and the other two adolescents had siblings who had been reported to the department. In two thirds of the cases, the young person had been known to DoCS since childhood and nine cases included evidence of mental health problems and/or risk taking behaviour. Five of the 17 adolescents whose deaths we reviewed committed suicide. A number of these young people were engaging in anti social or criminal behaviour, and some had also had recent contact with the health system.

Our reviews highlight the importance of providing holistic responses to young people who are at risk and who have mental health issues and/or are engaging in risk taking behaviour. We have asked DoCS and NSW Health to advise us of strategies to promote an effective and coordinated response to these young people.

Systems for responding to children at risk of harm

Our reviews of deaths in 2006 focused on how the child protection system responded to the risk factors identified above. We focused on:

- How agencies identified and reported risk of harm.
- How reported risk was assessed.
- How agencies acted to protect children at risk.

Identifying and reporting risk of harm

Our reviews in 2006 found that in most cases, agencies appropriately identified children at risk and made reports to DoCS. However, in some cases, we found that risk was either not identified by agencies, or was identified but not reported.

NSW Police Force (NSWPF) is the agency that makes the most reports to DoCS. We found cases where police had not effectively identified risk to children, and cases where police recorded that a report had been made to DoCS, but DoCS had no record of receiving the report. Police have recently established a working party to improve police reporting of, and response to, children at risk of harm.

In a number of our reviews involving NSW Health, we found that records indicated some level of risk to children, but we found no corresponding risk of harm report to DoCS, or a delay in reporting. NSW Health has amended its domestic violence policy to ensure certain incidents are reported to DoCS, and has developed new requirements around prenatal reporting.

Our reviews may incorporate examination of education records. In one review, we identified that education staff did not report identified risk of harm. We have asked the department of Education and Training to consider the issues raised by the case in the context of departmental procedure and information strategies.

Assessing risk of harm

Initial assessment

In 2005–06, the DoCS Helpline received over 241,000 reports of risk of harm. This represents an 11.4 per cent increase since the previous year, and a 51 per cent increase in the five years since 2000–01.

When reports are made, the DoCS Helpline decides whether they require secondary assessment and how urgently this should be done. The Helpline refers reports that require further assessment to local DoCS' Community Service Centres (CSCs) or Joint Investigation and Response Teams (JIRTs).

Our work in 2006 identified issues concerning Helpline initial assessments that were similar to those in previous years. These included concerns about:

- whether urgency ratings adequately reflected the reported risks, and delays in providing relevant information to CSCs.
- whether certain reports that indicated a criminal offence should have been referred to JIRTs.
- the adequacy of Helpline consideration of child protection histories to inform initial risk assessment, and the effectiveness of assessment in some cases where a child's family had previously had children removed.

The Helpline is also able to refer reports to the department's early intervention program — Brighter Futures. Our reviews identified that where a referral to the program is rejected because the risk is too high for early intervention, there is no requirement for the case to be subject to a comprehensive risk assessment by child protection staff. We have recommended that DoCS review this issue in its evaluation of the child protection program.

DoCS, NSWPF and NSW Health have recently completed a review of JIRT, the outcomes of which will include new referral criteria. The Helpline has developed new procedures for searching and recording child protection histories.

Competing priorities

One of the predominant issues identified in our reviews of child deaths is the number of reports that do not receive the level of assessment that is recommended by the Helpline, and are closed at a CSC due to the relative urgency of other cases.

In 2006, around two-thirds of our investigations of, and reports to, DoCS included significant concerns about CSC failure to undertake comprehensive secondary assessment of children at risk. This was predominantly due to limited CSC resources, resulting from staff shortages.

DoCS has indicated that improved outcomes — that is, more reports being assessed — will flow from the additional funds and caseworkers through the DoCS reform process. The department is continuing to roll-out new resources, and is engaging with the Premier's Department and other agencies on a whole-of-government approach to rural and remote incentive programs.

It is critical that DoCS' capacity to respond to children reported to be at risk of harm is able to be closely monitored. DoCS told us that it has been working with the NSW Treasury on key performance indicators, and an indicator to measure allocation capacity is under development as part of that process. We have recommended that DoCS develop the capacity to report fully on cases where assessments and inquiries are not able to be commenced or completed due to resource constraints.

Secondary assessment

Secondary assessment is undertaken in two stages. Stage 1 (SAS 1) provides for limited information gathering and analysis to determine whether stage 2 (SAS 2) — or more comprehensive — assessment should be conducted.

Stage 1 secondary assessment

Eighty-six children who died in 2006 were the subject of a risk of harm report in the twelve months prior to their death. For over half (45) of these children, at least one report was the subject of a completed SAS1. We found in many cases that this assessment was effective. However, in some cases we found the information gathering too limited to make a well-informed decision, and in others we found the information gathered did not appear to inform decisions to close a case.

We also identified some cases where secondary assessment records appear to have been created

for purposes other than assessment, including as a tool to close a case, without any apparent gathering or assessment of information.

Intake assessment guidelines are intended to provide guidance to caseworkers about reports that should be prioritised for SAS2. Implementation of the guidelines is pending finalisation by DoCS.

Stage 2 secondary assessment

Our review of children who died in 2006 identified that a SAS2 had commenced for a quarter (26) of the 86 children who were reported to the department in the twelve months prior to their deaths. Five of these children had been the subject of more than one SAS2. For 21 of the 26 children, the SAS2 was completed.

In our reviews, we identified some cases that showed a timely and comprehensive approach to risk assessment. However, we continued to identify cases that raised concerns about the scope and nature of assessment. We found that:

- SAS2 was sometimes limited in scope, and it did not appear that adequate information was gathered to inform the assessment.
- In some cases, assessment appeared to be incident-focused, with inadequate consideration of factors beyond the immediate concerns facing the child and their family.
- In some reviews we found that the practice of assessing a number of different reports together did not ensure that all the issues of concern were considered effectively.

We also saw examples where there did not appear to be a good understanding of, or adequate guidance to caseworkers about, the factors leading to risk.

DoCS' primary initiative to ensure quality in delivery of services involves the implementation of quality reviews of all CSCs over four years, commencing in November 2007. The reviews will lead to the development of quality improvement plans. In 2006, DoCS revised the department's secondary assessment procedures and completed a policy on neglect.

Protecting children at risk of harm

Our reviews in 2006 found that, in many cases, agencies responded with appropriate strategies to promote the safety and wellbeing of children at risk.

At times, however, we found less than optimum practice. In these cases, some of the issues we identified have been raised in our previous reports, and include:

- Inadequate responses by agencies to promote the safety of children. We found that where this was the case, it was often linked to inadequate risk assessment. Narrow, incident-based secondary assessment did not provide a sound basis to determine the best protective measures, and mostly resulted in strategies that addressed only some of the risk factors present.
- Lack of effective liaison and information exchange between agencies. At times, we saw that agencies operated on incorrect information about the level of involvement of DoCS. Having a clear understanding of the level of involvement of other agencies, particularly DoCS, is essential in order for agencies to make informed decisions about their appropriate role with the family.
- In particular, in some reviews, we identified a lack of effective planning around the discharge of babies from hospital who had been born to substance-using mothers. In some cases, we saw no evidence of planning meetings being held prior to the baby's discharge. We also found instances where there was ineffective liaison between NSW Health and DoCS, even where both agencies were aware of the other's involvement with the family.

In relation to DoCS' role as lead agency, we found that at times, services were not effectively coordinated or monitored. In some cases we found that DoCS did not deliver the services it had planned to provide. Our reviews also noted early closure of cases without monitoring the outcome of referrals to other agencies.

DoCS is working to implement new procedures associated with the recently legislated parent responsibility contracts. It is also trialling a new parental drug testing policy, which is a tool to guide the use of drug testing in cases where serious and persistent drug use is a concern, and the department is considering removing the child from the family, or restoring the child following earlier removal.

In November 2006, NSW Health released *Opioid treatment program — clinical guidelines for methadone and buprenorphine treatment*, which demonstrate a greater emphasis on identifying, reporting and responding to possible risk of harm to children of patients in their care.

We have previously raised concerns about information exchange between agencies, and this issue is currently the subject of further consideration through the review of the *Children and Young Persons (Care and Protection) Act 1998*.

Apprehended Violence Orders

Only police have powers to apply for an AVO for the protection of children under 16 years. Previously, we have raised concerns about police use of AVOs to protect children. In some cases in 2006, police applied separately for an AVO for a child, or for an order to include a child. In some cases, such applications did not occur, although our reviews indicated this would have been appropriate.

NSWPF advised us that the issue of children having separate AVOs is under consideration by Parliament.

Causes of death 2003–2006

In 2007 we commissioned an analysis from the National Centre for Classification in Health of the underlying causes of death of the 496 children whose deaths we reviewed in the four years from 2003 to 2006. We sought the analysis to better understand the range of factors that may contribute to particular causes of death.

Among other findings, the analysis identified:

- A greater proportion of Indigenous children (23%) died as a result of sudden or unexpected causes than did non-Indigenous children (17%). In contrast, a greater proportion of children who were non-Indigenous (16%) died due to intentional causes (assault or intentional self-harm) than did Indigenous children (5%).
- Most infants (76%) aged between one day and one month died of natural causes, while the majority of infants (58%) aged between 1 month and 6 months died as a result of sudden or unexpected causes.
- When examining natural causes of death only, children whose deaths are reviewable are more likely than non-reviewable children to die as a result of meningococcal disease, epilepsy and pneumonia than children whose deaths were not reviewable.
- When examining unnatural causes of death only, and excluding assault, children whose deaths are reviewable are more likely to die as a result of accidental poisoning; accidental exposure to smoke, fire or flames; other sudden death, (cause unknown); and accidental drowning and submersion than children whose deaths were not reviewable.

While the analysis is based on very small numbers and is indicative only, it has identified areas that may warrant further scrutiny through our reviews.

Recommendations

NSW Police Force

Progress on previous recommendations

In our reports in 2005 and 2006, we made a number of recommendations to NSWPF concerning aspects of the child protection and domestic violence standard operating procedures, particularly in relation to reporting risk of harm to DoCS. We also made recommendations about particular JIRT procedures. In response to concerns we raised this year, NSWPF advised that a working party had been established to address a range of issues about police identification and reporting of children at risk of harm.

Section 43(2)(c) of CS CRAMA requires us to provide information in our annual reports to NSW Parliament about the implementation or otherwise of recommendations made previously. In this context, we recommend that:

1. NSWPF provide this office with progress reports in February 2008 and July 2008 in relation to:
    a. The outcome of targeted project work with DoCS on developing strategies to enhance the quality of information communicated between NSWPF and DoCS in relation to children at risk of harm.
    b. Outcomes of the NSWPF working party to address reporting issues, in particular, strategies to:
        - Improve compliance with risk of harm reporting requirements
        - Improve the quality of the police response to children at risk of harm
        - Provide police with better information and support in relation to managing children and young people at risk of harm and working with other agencies
        - Implement a more systematic, focused approach in Local Area Commands relating to children at risk of harm.
    c. Implementation of the JIRT review recommendations.

Department of Community Services

Progress on previous recommendations

Since our first report in 2004, we have made a range of recommendations to DoCS relating to child protection policy and practice, and quality assurance processes. The department has responded to the recommendations in the context of the ongoing DoCS reform process.

Section 43(2)(c) of CS CRAMA requires us to provide information in our annual reports to NSW Parliament about the implementation or otherwise of recommendations made previously. In this context, we recommend that:

2. DoCS provide this office with progress reports in February 2008 and July 2008 in relation to:

   a. The roll-out of quality reviews of CSCs in NSW.

   b. The outcome of targeted project work with NSWPF on developing strategies to enhance the quality of information communicated between NSWPF and DoCS in relation to children at risk of harm.

   c. Implementation of the JIRT review recommendations.

   d. Completion of the review of policies and procedures for managing case plans rejected by JIRT, including a copy of revised procedures.

   e. Outcomes of the pilot of the drug testing policy and parent responsibility contracts, and finalisation of the case planning and care plan policies.

   f. Implementation of recommendations arising from the joint review of methadone-related child deaths with NSW Health.

   g. Completion and implementation of the Intake Assessment Guidelines.

   h. Completion and implementation of the pre natal policy.

   i. Implementation and outcomes of the Aboriginal Strategic Commitment, particularly specific initiatives identified in relation to:

   - Development of a consultation model for use by CSC staff
   - Establishment of a regional Aboriginal advisory group
   - Strengthening the capacity of mainstream early intervention services to better meet the needs of Aboriginal children, families and communities
   - Increased resources to better support Aboriginal foster carer recruitment
   - Development of guiding principles and protocols to inform engagement with isolated communities.

Competing priorities

Closure of reports due to competing priorities is a critical benchmark of system capacity. Our report of reviewable child deaths in 2005 raised concerns about the inability of DoCS to report in aggregate on the outcome of almost half of the reports referred to CSCs for further assessment, or on the reasons for cases closed at a CSC. DoCS advised us that improving and increasing DoCS capacity to report and analyse data through its client database (KiDS) will form part of the major project to reform the child protection program, and that the department is working with NSW Treasury on a final set of key performance indicators for the child protection system, including an indicator to measure allocation capacity.

3. DoCS should develop the capacity to report on the number and proportion of child protection reports in which assessments and inquiries are not able to be commenced or completed due to resource constraints (as opposed to the evidence not warranting further action).

Early intervention

This year, we identified an issue about DoCS management of risk of harm reports where they are referred to an early intervention team but not accepted on the basis that the risk is too high. In these cases, there is no requirement for the matter to be allocated for further risk assessment.

4. The DoCS evaluation of the child protection program under the Child Protection Major Project should include a component to consider referrals to the Brighter Futures program that are subsequently deemed ineligible due to

risk being too high. The evaluation should consider:

- The nature of reports referred to Brighter Futures that are subsequently deemed ineligible due to high risk, and
- the nature of response by DoCS to these reports and outcomes for the child and family.

Recommendations: NSW Health

Progress on previous recommendations

Our report of reviewable child deaths in 2005 included a special focus on parental substance abuse. We made a number of recommendations to NSW Health that focused on improving responses to mothers using drugs during pregnancy, and to children born into families with substance abuse issues. We also made recommendations about responding to children presenting at hospital as a result of methadone poisoning. NSW Health proposed a range of initiatives to address the recommendations.

Section 43(2)(c) of CS CRAMA requires us to provide information in our annual reports to NSW Parliament about the implementation or otherwise of recommendations made previously. In this context, we recommend that:

5. NSW Health provide this office with progress reports in February 2008 and July 2008 in relation to:
   a. Terms of reference and timeframes of, and methodology for, the audit of drugs-in-pregnancy services in NSW. On completion, please provide a copy of the audit report.
   b. Outcomes of NSW Health's approach to the Intergovernmental Committee on Drugs regarding the issue of ensuring compliance with the National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn.
   c. Development of a state-wide system for the reporting of fatal and non-fatal methadone poisoning of children.
   d. Establishment of the proposed Compliance and Quality Control Program for the NSW Opioid Treatment Program.
   e. Outcome of the proposed one-week census of take-away methadone doses.
   f. Implementation of the recommendations of the joint review of methadone-related child deaths with DoCS.

NSW Health and Department of Community Services

Advising prescribers of child methadone poisoning

Last year, we recommended that NSW Health implement a policy to enable staff to inform the relevant methadone prescriber of the admission of a child to an emergency department as a result of ingestion of methadone. NSW Health accepted this recommendation. However, the department later advised that while the information sharing protocol with DoCS enables DoCS to obtain details about a prescriber and contact that prescriber to gather information to inform risk assessment, *'Currently however there is no provision for DoCS to advise prescribers that a child of their patient was presented to hospital with methadone poisoning'*. NSW health said it would negotiate specific roles and responsibilities of each department when a report is made regarding child methadone poisoning.

6. NSW Health and DoCS should prioritise the development of a clear process for

providing prompt advice to a methadone prescriber when their patient's child is admitted to an emergency department as a result of ingestion of methadone.

Responding to adolescents

Over a number of years, we have raised concerns about interagency responses to young people at risk of harm, particularly where child protection concerns are coupled with mental health issues and/or risk-taking behaviour. DoCS and NSW Health advised us of initiatives relating to young people in statutory care, a number of regional initiatives and the review and development of tools to assist risk assessment for adolescents.

7. The DoCS / Health Senior Officers Group provide advice about any specific strategies planned to promote effective and coordinated child protection and health responses to adolescents reported to be at risk of harm, where reported concerns include suicide risk and mental health.

Department of Education and Training

DET procedures are based on centralised reporting. Staff are required to inform the principal where they consider a risk of harm report should be made, the principal is required to make the report, and the staff member must ensure that the report is made. In a case we reviewed, we found that these requirements were not followed.

8. The NSW Department of Education should consider the issues raised in this report and ensure that departmental procedure and associated information strategies reinforce individual mandatory reporting obligations and the need for a report where there are reasonable grounds to suspect risk of harm.

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 and young people.[1] 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[2] in care.
- a child in respect of whom a risk of harm report[3] 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.

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 fourth annual report we have prepared. The report is released in two volumes: the first on disability deaths and the second on child deaths.

In NSW in 2006, the deaths of 221 individuals were reviewable deaths. In one case, the death was that of a child with a disability who lived in care. The review of this child's death is therefore included in both volumes of this report.

This volume of the report is about reviewable child deaths in 2006.

1 In this report, reference to 'child' and 'children' includes young people unless otherwise stated.

2 A child is defined as a person under the age of 18 years.

3 A report must be made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998*.

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 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 comments.

1.4 Reviewable child deaths that occurred in 2006

Why the deaths of children were reviewable

In 2006, 622 children and young people died in NSW.[4] Of these deaths, 123 (20%) were reviewable child deaths. The following outlines why these deaths were reviewable, noting that a death may be reviewable for more than one reason.

- 81 (66%) 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'.
- 33 (27%) 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.
- 40 (33%) child deaths were reviewable because the child died in circumstances of abuse, neglect or in suspicious circumstances. These deaths include nine deaths where neither the child, nor their sibling were known to DoCS, and 31 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. In most cases, the child's death had no connection to reported child protection concerns.

The nature of our work relating to child deaths in 2006

We initiated reviews of all 123 children who died in 2006 and whose deaths were reviewable. Fourteen matters are still under review, pending receipt and analysis of further information sought by us.

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 also 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.[5]

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 consideration or 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

[4] While this report refers to 622 child deaths, this may differ from the figure reported by the NSW Child Death Review Team (CDRT). 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.

[5] Sections 39 and 43(3).

any direct action where the matter is subject to inquest by the NSW Coroner, or subject to internal review by the relevant agency.

For child deaths in 2006, we took additional action in relation to 38 matters:

- In 10 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). Investigations considered the conduct of DoCS (all cases), Sydney South West Area Health Service (three cases) and South Eastern Sydney and Illawarra Area Health Service (one case). As at July 2007, we had finalised four of the nine matters and in one matter, we ceased our investigation following review of additional files[6].
- In eight 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 six cases), and one case to each of the Department of Ageing, Disability and Home Care, the Department of Education, and the NSW Police Force (NSWPF). As at July 2007, none of our inquiries had progressed to investigation. In four matters, agencies provided us with sufficient information to indicate they would resolve the issues we had identified. In one case, our concerns were not sufficient to proceed to investigation, and we finalised this matter by providing relevant suggestions to the agencies involved. Three preliminary inquiries were in progress at the time of writing.
- In relation to 25 matters, we made 27 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 three cases, the child who died and their sibling(s) in 13 cases, and the siblings only in seven cases. The other two reports were in relation to the 15 year-old mother of a child who died, and an unrelated child. In 22 cases, the reports were directed to DoCS. This included two cases where the purpose of the report was to provide DoCS with relevant information only. We directed a further four reports to the NSW Police Force (NSWPF), and one to Sydney South West Area Health Service. In addition to these individual matters, we made a s.43 (3) report to NSWPF relating to 18 child death reviews. The report concerned issues about police reporting and recording of risk of harm reports. This matter is still under consideration.

1.5 Other agencies' child death reviews

DoCS Child Deaths and Critical Reports Unit

DoCS conducts internal reviews of children, or siblings of children, who die and who are known to the department.

The purpose of DoCS' internal reviews is to *'examine the case history and action taken prior to the child's death, and identify ways in which existing policies, procedure and practice might be improved.'*[7]

[6] In this case, we identified practice issues but not sufficient grounds for reaching a formal finding under section 26 of the Ombudsman Act, and we were confident that the practice issues would be identified through DoCS' internal review of the case.

[7] Department of Community Services (March 2006) factsheet *Investigating child fatalities from abuse or neglect.*

DoCS advises this office where it intends to conduct an internal review of the death of a child, and provides us with a copy of the review report.

In order to avoid duplication, we take into account DoCS' decision to review a case when determining the action we may take. In general, we defer decisions to undertake further work- as outlined in section 1.4 above—on those matters until we have examined the outcome of the department's review. We may, however, make exceptions to this where our work would involve consideration of the actions of a number of agencies and/or how agencies worked together, or where matters raise particularly serious issues and timeliness is a paramount consideration.

The NSW Child Death Review Team

The role of the NSW Child Death Review Team (CDRT) is to prevent or reduce the number of child deaths in NSW. Under the *Commission for Children and Young People Act 1998*, the functions of the Team include to:

- Maintain a child death register
- classify deaths according to cause, demographic criteria and other relevant factors
- identify patterns and trends
- undertake research to prevent or reduce the likelihood of child deaths
- formulate and monitor recommendations for the prevention of child deaths.[8]

Responsibility for reviewing the deaths of children described in section 1.1 above was transferred to the Ombudsman in December 2002. The CDRT does not undertake reviews of the deaths of these children, but may include reviewable deaths in research.

1.6 About this report

This report focuses on child protection issues arising from our reviews of the 123 children who died in 2006, drawing particularly from those matters subject to investigation, preliminary inquiries or reports to agencies under section 43(3) of CS CRAMA.

As with our previous reports, we highlight issues or concerns that have come to our attention through our work, and identify challenges for agencies that have responsibilities in child protection.

In doing so, it is important to note that our reviews examine child protection history. Our observations may therefore relate to the handling of child protection matters in 2006 or earlier.

2006–07 was the fourth 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. DoCS is in the process of implementing significant reforms to the delivery of child protection services. In 2005–06, DoCS received 241,000 reports of risk of harm concerning 109,500 children.[9] Other agencies, including NSW Health and NSWPF have also set in train a number of service improvement initiatives in relation to child protection.

We acknowledge that changes made, or planned, by agencies may address some of the problems we have identified through our reviews. Where appropriate, we provide details about these initiatives. We are also continuing to monitor responses to issues raised in our *Report of reviewable deaths in 2005*.

In this report, we also include a focus on the cause of death for 496 children who died between 2003 and 2006, and whose deaths

[8] NSW Child Death Review Team (2006) *Annual Report 2005*. NSW Commission for Children and Young People. Page 8.

[9] Department of Community Services (2007) *Community Services Budget 2007/08.*

were reviewable by this office. The majority of children whose deaths were reviewable died as a result of natural causes, followed by accidents and then sudden or unexpected causes, such as Sudden Unexplained Deaths in Infancy (SUDI). One of the reasons for considering these causes in more detail was to identify any notable differences between children who died and whose deaths were reviewable, and other children whose deaths were not. In particular, we sought to identify whether the causes of death could be linked to any specific environmental factors that could direct us to broader preventative strategies.

Report sections

The report is divided into the following sections:

- *Section 2* considers the contribution the reviewable child death function has made to the child protection system since commencing within this office in 2002.
- *Section 3* provides an overview of reviewable child deaths in 2006.
- *Section 4* provides an overview of significant factors identified through our reviews, and some of the challenges presented by specific risk factors.
- *Section 5* focuses on systems for responding to risk of harm. The section examines agency identification and reporting of risk of harm, the assessment of risk, and protective strategies put in place to address risks to children.
- *Section 6* presents an analysis of cause of death for children who died between 2003 and 2006, and whose deaths were reviewable.

Many of the themes and issues we have identified through our reviews of child deaths in 2006 mirror, or relate to, those we considered in our previous reports of reviewable deaths. 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 2005*.

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, data 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 some of the cases, matters are before the Court. 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.

When reporting data throughout this report, we have rounded figures to the nearest whole percent.

DoCS data

At the time of writing, the department had not released its annual statistical report for 2005–06. In this report, we have drawn 2005–06 data where available from a number of published DoCS sources. In other cases, we have used 2004–05 data, published by DoCS in 2006.

In this report, we do not make any comparison of DoCS and our own data. However, it should be noted that our counting of numbers of reports differs from DoCS. We relate each instance of a child or children being reported to DoCS as a single risk of harm report, while for reasons of national conventions and to enable comparison across states, DoCS counts each individual child who is the subject of a report as a separate report. For example, if a person makes a risk of harm report to DoCS about three children in a family and the report is subject to initial assessment[10], DoCS would count this as three reports. We would refer to this as one report.

[10] See description on page 41.

2. Results of our work 2002–2006

It is some five years since we started reviewing child deaths. When we assumed responsibility for this work in late 2002, the child protection system was entering a period of significant change, based on a five-year reform program.

Although implementation of that program is continuing, it is timely to consider the contribution of the reviewable death function to child protection in NSW, the changes that have come about as a result of our recommendations, and more broadly, progress that has been made in the context of agency reform. In preparing this section we have taken account of the views of the main agencies that are subject to scrutiny under our work and the recommendations resulting from it.

It should be noted from the outset that child death reviews are by no means the only catalyst for change in the State's child protection system. Apart from their own reform initiatives, DoCS and other human services agencies are involved in interagency projects, protocols and committees that focus on the continuous task of improving child protection policy and practice.

That said, our work does allow us to gain both an independent overview and detailed insights into the operations of a complex system that deals — on a daily basis — with daunting and challenging issues. The complexities of the task are evident in the way that various agencies and systems intersect in the child protection nexus. Although DoCS is the central child protection agency, other agencies and systems are invariably in play. Police, for example, are required to implement criminal justice responses to perpetrators and victims of domestic violence and also to inform DoCS of risks to any child present at a domestic violence incident. Similarly, both the police and the health system must address the problems of adult substance abusers or people with mental illness, while also responding appropriately to risks to children in these circumstances.

Together with community sector organisations, DoCS and other state agencies have a crucial role in protecting children. It is important we ensure that our work supports them by identifying flaws in agency policy or practice and by recommending ways to address these and improve responses to children at risk of harm. This is in line with the legislature's requirement that we make recommendations to prevent or reduce deaths of certain children, and formulate strategies to reduce or remove risk factors associated with reviewable deaths that are preventable.

When the state government introduced legislation to change oversight arrangements for community service providers in mid-2002, it said the new arrangements would provide a means for influencing changes to child protection systems and practices. In particular, the government said the reviewable death function

would provide '*a powerful tool for focusing investigations and improving services*'[11].

At around the same time, the government was initiating broad changes to child protection. Central to these changes was a $1.2 billion reform plan to be implemented by DoCS from 2003 to 2008. DoCS published its own *Blueprint for change* in mid-2003. That document outlined plans to improve primary child protection responses but also foreshadowed a stronger focus on early intervention and prevention to '*decrease demand for child protection services*'.

In 2006 the NSW Government published a 10-year State Plan. Priorities in the plan include reducing rates of child abuse and neglect. DoCS has lead agency responsibility for this priority during the life of the plan.

In the four years to the end of 2006, we reviewed the deaths of 496 children. Each year around 90 per cent of these children and/or their siblings had been the subject of a risk of harm report to DoCS. This is not surprising as the definition of reviewable deaths means that the majority of the children we review will have had some involvement with the child protection system before they died.

Our first report: Child deaths in 2003

In our initial annual report, all of our recommendations were directed to DoCS. We took the view that it was important to begin by focusing on the agency with the central role in the child protection system. In broad terms, the recommendations addressed practice issues including the quality of risk assessment and responses to indigenous children, policy matters including the closure of cases due to competing priorities, and the department's engagement with other agencies in child protection work. We also proposed changes in relation to DoCS' capacity to report comprehensively on its own child protection performance.

Along with our annual report, we released a special report to Parliament arising from our review of the death of a child. The report, *Improving outcomes for children at risk of harm — a case study*, raised particular issues about DoCS' response to reports about neglect.

The department's initial response to our recommendations was provided in the context of the work DoCS was doing to progress the five-year reform program. DoCS' initiatives included development of a new procedure to prioritise those cases that should be allocated for risk assessment, and a new policy on neglect. The department also put in place strategies to improve services to indigenous children and families, arrangements to improve DoCS' record keeping, and agreements on co-operation with other state agencies. In addition, DoCS foreshadowed arrangements to monitor and audit the quality of its child protection work. In particular, it pointed to a proposed *compliance reporting regime and an operational consistency major project* and ongoing plans to improve data collection and reporting.

Our second report: Child deaths in 2004

Because of its status as lead agency in child protection, most of the recommendations in our second report were made to DoCS. We also made recommendations to the Child Protection Senior Officer's Group and the NSW Police Force (NSWPF). Our recommendations reflected concerns about police recognition and reporting of risks to children, as well as the adequacy of assessment and response to identified risk, particularly in the context of domestic violence.

We found some problems with the clarity of DoCS procedures for referring matters to JIRT, which could impede caseworker's actions in

[11] The Hon Carmel Tebbutt, Minister for Juvenile Justice, Community Services Amendment Bill second reading speech, 18 June 2002.

cases where a criminal offence may have been committed.[12] We raised specific concerns in relation to the quality of assessment of risk of harm reports. We identified issues with prenatal reports, with our reviews indicating that these reports were often treated as a low response priority. We highlighted the need to consider child protection history when assessing reports, including prenatal reports, noting particularly the need to fully assess cases where the child's siblings had been removed from the family. We noted some shortcomings with agencies' response to parental substance abuse, and again raised the need for better co-operation and communication between agencies. For the second year, our reviews also raised questions about how effectively DoCS and other agencies were responding to the specific needs of Aboriginal children at risk.

Our work also enabled us to provide pertinent input to the draft *Interagency Guidelines for Child Protection Intervention*, and to the to the evaluation framework to be used in assessing the effectiveness of the guidelines. We also contributed to the review of the *Children and Young Persons (Care and Protection) Act 1998*.

The State Government initiated legislative changes in late 2006 in response to issues identified in the second report. The amendments included the introduction of Parent Responsibility Contracts to formalise agreements made between DoCS and parents to address risk of harm concerns, and to clarify actions where agreements are breached. Other legislative amendments included:

- A child being specifically identified as at risk of harm if they were the subject of a pre-natal report and the birth mother of the child did not engage successfully with support services to eliminate, or minimise, the risk factors that gave rise to the report.
- Allowance for information exchange between DoCS and other agencies relating to unborn children subject to a pre-natal report.
- The admissibility of evidence that a parent or primary care-giver of a child subject to care proceedings had a child previously removed from them by an order of the Court, and the child has not been restored. The Act identifies this as prima facie evidence that the child is in need of care and protection.

At the same time, DoCS rolled out a revised secondary assessment procedure and neglect policy to its staff. The procedure includes an emphasis on holistic risk assessment that takes account of previous child protection history. Other work was initiated to reform the way the department used undertakings given by parents as a strategy to protect children, and new guidelines for prioritising the cases that should be subject of assessment were trialled in some CSCs. DoCS also advised that it was drafting a prenatal policy in consultation with NSW Health.

More broadly, DoCS reported that it was undertaking work to prepare and implement strategies to monitor and improve child protection practices at the local and state-wide level. A major part of this work includes a proposed quality review of every DoCS CSC in NSW.

In regard to issues we raised about the need for full and relevant reporting when police make reports about children present at domestic violence incidents, NSWPF told us that this would be incorporated in the Force's review of child protection and domestic violence standard operating procedures.

In an interagency context, DoCS, NSWPF and NSW Health finalised a review of JIRT. The review proposed new, more expansive criteria for referring matters to JIRT, and significant changes to the structure and processes of the teams.

[12] 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.

Additionally, Integrated Case Management projects, which were centred in Dubbo and Bourke and had been the subject of a number of our recommendations, were expanded into the Anti Social Behaviour Pilot Strategy. The strategy promotes a coordinated response to high risk vulnerable families, and an anti social case coordination framework is being rolled out in a number of areas across the state.

Our third report: Child deaths in 2005

In addition to identifying recurring concerns about agency identification and reporting of risk of harm and the quality of risk of harm assessment, our third report focused on agency responses to risks posed by parental substance abuse. Most of our recommendations were again made to DoCS, with many focused on monitoring the implementation of earlier proposals. We also directed a number of recommendations to NSW Health and the NSWPF. Our recommendations included that NSW Health consider changes relating to its responses to maternal substance abuse and child methadone poisonings, and that DoCS and NSW Health establish a consistent state-wide birth alert system linked to prenatal reports.

NSW Health committed to an audit of drugs-in-pregnancy services to consider models of and access to services, and minimum service standards. Other NSW Health initiatives include a review into systems related to collecting information about, and reporting, fatal and non-fatal methadone poisoning in children. The Drug Budget 2007–2011 also provides funding for NSW Health to establish a unit specifically to investigate fatal and non-fatal methadone poisonings involving children. NSW Health also released new policy guidelines for opioid treatment, which include greater emphasis on recognising and responding to child protection concerns for the children of parents undergoing treatment, and NSW Health and DoCS released a joint protocol to allow information sharing between the two agencies and opioid treatment prescribers.

Responses by DoCS to our third report included revised training for caseworkers on alcohol and drugs and trial of a policy on parental drug testing in conjunction with new parent responsibility contracts. DoCS also finalised a corporate strategy to improve services for Aboriginal children and families, and indicated to us that the department would be undertaking a detailed review of Aboriginal child deaths. The department invited us to participate in a broader joint project in this regard.

Shortly after the release of our third report, we tabled *Policing domestic violence: Improving police practice* in Parliament. In response to the 44 recommendations made to improve the way in which police respond to domestic violence, NSWPF committed to a range of strategies, including revised training for officers, better procedures for assessing risk associated with domestic violence, and a good practice framework for responding to domestic violence.

Agencies views about our work

We asked DoCS, NSW Health and the NSW Police Force for their views on our work in reviewing the deaths of children since 2002. In particular, we wanted to know agency views of how our work had contributed to improvements in the agencies' capacity to respond effectively to children at risk of harm.

DoCS considered the recommendations arising from our work, and noted that the department had accepted the vast majority of provisional recommendations made through investigations of individual deaths. DoCS said that these recommendations can serve to reinforce the need for improved performance by individual CSCs in particular areas of work, and can be a useful management resource.

In regard to recommendations contained in the reviewable deaths annual reports, DoCS considered that many of the recommendations made related to action already contemplated, or

underway, by the department, indicating that our work at times serves to confirm what DoCS already knows. DoCS however acknowledged that this outcome is inevitable in the context of a $1.2 billion reform program.

The NSWPF said they had responded to our findings by issuing guidance to police regarding identifying and reporting risk of harm, including risk associated with parental substance abuse. They said their reviews of standard operating procedures relating to domestic violence and child protection would take account of our recommendations.

NSW Health told us that it strongly endorsed the work of this office, and noted the '*improvement in both internal collaboration within NSW Health and interagency collaboration in child protection responses*.' NSW Health noted our work had been effective as a catalyst, in areas such as examining the intersection between child protection and other areas, such as drug and alcohol abuse. It had also contributed to initiating reviews into important issues, such as methadone-related child deaths. NSW Health also noted policy change to help ensure child safety when working with victims of domestic violence, and legislative change, particularly relating to pre-natal reports.

We also asked agencies to comment on any areas of our work that may be worthy of further consideration.

DoCS suggested that this office and its Child Deaths and Critical Reports unit work to consider collaborative approaches to child death reviews. DoCS expressed the view that the Ombudsman could make greater use of powers to gather information on interagency practice.

DoCS questioned the value of recommendations that reflect existing work or directions, noting that confirming statements could be made where warranted. DoCS also indicated the desire to have the opportunity to respond to draft recommendations of the reviewable deaths annual reports, and we note that this has been the case for recommendations made in our last and current reports.

NSWPF suggested that our future work include consideration of any inhibitors to interagency cooperation on child protection, and that we work with agencies, interagency committees and Government, to remove or reduce the effect of those inhibitors.

NSW Health suggested that the over-representation of Aboriginal children amongst reviewable child deaths is a matter of significance and therefore an important issue for further consideration by this office.

We will take these suggestions into account when determining our future priorities.

The following table provides a broad summary of issues we have raised through our recommendations over the past five years, and some of the relevant changes and improvements that we have seen in agency approaches to child protection.

Concerns underlying recommendations	Relevant agency developments and achievements
Improving the quality of DoCS child protection work	DoCS has implemented a quality assurance project that will include an audit of each of its local offices over a four-year period to 2010.
Improving initial risk assessment	DoCS reviews the quality of work done at the central intake Helpline.
Improving secondary risk of harm assessment	DoCS has implemented a revised policy on secondary risk of harm assessment and provided relevant training to staff.
Improving responses to risk arising from neglect	DoCS has implemented a new neglect policy and provided relevant training to staff.

Concerns underlying recommendations	Relevant agency developments and achievements
Decreasing numbers of cases closed without comprehensive assessment due to competing priorities	DoCS has endorsed intake assessment guidelines that require the prioritising of high risk cases for secondary assessment.[13]
Improving responses to child protection reports from police	NSWPF are reviewing operating procedures for responding to domestic violence and child protection.[14] DoCS and NSWPF are working on a joint project to improve risk assessment procedures.
Improving responses to cases involving parental substance abuse	Child protection legislation has been amended to include Parent Responsibility Contracts. These are being used in selected DoCS offices that are also piloting a Parental Drug Testing policy. DoCS is revising training to improve staff expertise on carer substance abuse. NSW Health is working to improve services to women who use drugs during pregnancy. DoCS and NSW Health have established a protocol on information exchange regarding DoCS clients on opioid treatment. The agencies are jointly reviewing methadone-related child deaths. NSW Health has upgraded its systemic response to children presenting with methadone poisoning.
Better response to prenatal reports	Child protection legislation has been amended to allow exchange of information regarding an unborn child, and to expand the definition of a child at risk to include prenatal reports in certain circumstances. DoCS has consulted NSW Health and developed a draft policy on responding to prenatal reports.
Improving responses to Aboriginal children and young people	DoCS has published its *Aboriginal Strategic Commitment 2006-2011* outlining plans to provide better services to Aboriginal clients.
Improving responses to adolescents	DoCS is establishing an internal panel to review the suicide and risk-taking deaths of young people known to DoCS.
Better interagency child protection responses	A new edition of the *Interagency Guidelines for Child Protection Intervention* was published in 2006. The effectiveness of interagency practice under the guidelines is to be evaluated during 2007 and 2008. DoCS, NSWPF and NSW Health have reviewed the work of Joint Investigation Response Teams and revised criteria for reports of physical abuse. DoCS has memoranda of understanding with agencies including police, NSW Health and the Department of Education. An Anti Social Behaviour Case Coordination Framework is being rolled out as part of an Anti Social Behaviour Pilot Strategy, with a focus on partnerships for improving and coordinating strategies to '*reduce risks to, and anti social behaviours of, children and young people requiring multi agency intervention*.'
Improving DoCS data collection and reporting	DoCS resumed quarterly data reporting in 2005.[15]

[13] The intake assessment guidelines are finalised and implementation in discussion.

[14] Police have foreshadowed a December 2007 launch of child protection policy.

[15] We have raised concerns about lack of capacity to fully report outcomes of DoCS work in the first three reports. The absence of aggregate information about the outcome of 47.1% of reports referred to CSC/JIRT in 2004-05 is notable.

3. Overview of reviewable child deaths in 2006

This section focuses on the broad trends arising from the data we collected about the children who died in 2006. It provides an overview of the demographic background, family characteristics and circumstances of death for these children.

In the fourth year of this report we are able to compare the characteristics and circumstances of reviewable child deaths in 2006 with those from previous years (2003–2005) and where noteworthy, report the differences.

3.1 Why the deaths were reviewable

The Registry of Births, Deaths and Marriages (BDM) notified us of the deaths of 622 children and young people in NSW in 2006. The deaths of 123 (20%) of these children were reviewable under Section 35(1) of the *Community Services (Complaints, Reviews and Monitoring) Act* 1993 (CS-CRAMA).

The reviewable status of a further 84 of the 622 child deaths has not been determined as coronial information was outstanding. These children were not known to DoCS, and therefore, their deaths will only be reviewable if suspicious or related to abuse or neglect.

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, over the last three years.

In considering the number of deaths each year that were reviewable because the child was known to DoCS, it should be noted that the number of children reported — and therefore known — to the department has increased significantly in each year of review. This will have a direct bearing on the number of child deaths that are reviewable.

Table 1a: Reviewable status

	Number of children, percent and additional information			
	2003 deaths	2004 deaths	2005 deaths	2006 deaths
Total deaths in NSW	605	540	598	622
Reviewable child deaths	128 (21%)[16]	104 (19%)	117 (20%)	123 (20%)

[16] 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 this table are based on an application of the definitions adopted in our 2005 report.

Table 1b: Reviewable status

Reason for reviewable status	Number of children, percent and additional information			
	2003 deaths	2004 deaths	2005 deaths	2006 deaths
Death resulted from abuse	17 (13%)	7 (7%)	11 (9%)	12 (10%)
Death resulted from neglect	18 (14%)	6 (6%)	12 (10%)	9 (7%)
Death occurred in circumstances suspicious of abuse or neglect	8 (6%)	11 (11%)	10 (9%)	19 (15%)
The child, or the child's sibling, was reported to DoCS in the three years prior to the child's death	103 (80%): • 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%): • 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%): • 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.	114 (93%): • 81 of these children were themselves reported to DoCS. These children were the subject of a total of 296 reports of risk of harm. • 33 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 201 reports of risk of harm.
The child died while in statutory care	10 (8%)	8 (8%)	4 (3%)	4 (3%)
The child died in a detention or correctional facility	0 (0%)	0 (0%)	0 (0%)	0 (0%)

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

3.2 Demographic details

Age

This year, the majority of children whose deaths were reviewable (73, 59%) were less than 12 months of age when they died. Close to half of these children (35, 48%) were babies under the age of four weeks, many of whom (26) were never discharged from hospital.

Since 2004, we have observed a 36 per cent increase in the proportion of children who were aged less than 12 months when they died.

Table 2: Reviewable child deaths: infants aged less than 12 months

	2003 (128 deaths)	2004 (104 deaths)	2005 (117 deaths)	2006 (123 deaths)
Number	54	36	61	73
Percent	42	35	52	59

In 2006, a further 17 (14%) children were toddlers aged between one and four years. In total, close to three-quarters (73%) of reviewable deaths in 2006 were of children aged four years or less.

The relatively high proportion of young infant deaths that were reviewable in 2006 was also reflected in the data we received from BDM regarding child deaths in the general population. In 2006, 64% of all child deaths in NSW were of infants aged less than 12 months.

Seventeen (14%) of reviewable deaths in 2006 were of young people aged 13 to 17. The proportion of adolescent deaths has fluctuated to a certain degree over the past four years. (See table 3, bottom).

The deaths of adolescents are discussed further in *section 4*.

Gender

Over the last four years there has been very little variation between the proportion of male and female reviewable deaths. In 2006, there were more male (63%) than female deaths. This was the case across all age categories, but was most pronounced in the 0-12 month and 13-17 year age groups. This is consistent with data from previous years and with child deaths in general. The Australian Bureau of Statistics found over a 15 year period, infant mortality rates were higher among males than females. The gender difference is thought to be largely biological in origin.[17]

Table 4: Gender of children who died in NSW in 2006

	Reviewable Deaths	Non-reviewable Deaths
Male	77 (63%)	304 (61%)
Female	46 (37%)	195 (39%)
Total	**123 (100%)**	**499 (100%)**

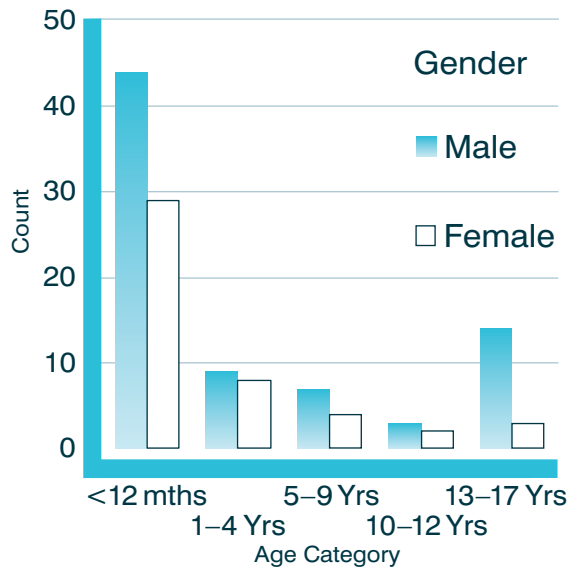
The age and gender distribution of the children is presented in figure 1 (over page).

Table 3: Reviewable child deaths: young people aged 13–17 years

	2003 (128 deaths)	2004 (104 deaths)	2005 (117 deaths)	2006 (123 deaths)
Number	37	22	11	17
Percent	29	21	9	14

[17] Australian Bureau of Statistics (1998) '*Causes of infant and child deaths — Australia'* ABS, Canberra, Cat No. 4398.0. Page 4.

Figure 1: Reviewable deaths: age and gender



Aboriginality

Indigenous children and young people continue to be overrepresented in reviewable deaths, and more broadly, they also feature disproportionately in the deaths of all children in NSW. The deaths of 25 children who were of Indigenous background were reviewable. This represents 20 per cent of all reviewable deaths in 2006.

According to information we received from BDM, across the state last year, 58 children were identified as being of Aboriginal and Torres Strait Islander (ATSI) background at the time their death was registered. This means that nearly half (43%) of deaths of ATSI children in NSW last year were reviewable. By contrast, 20 per cent of all child deaths in NSW were reviewable.

The proportion of reviewable deaths of ATSI children and young people has remained relatively constant over the last four years.

Table 5: Indigenous status for child deaths in NSW in 2006

	Reviewable Deaths		Non-reviewable Deaths	
Indigenous	25	(20%)	33	(7%)
Non-Indigenous	98	(80%)	466	(93%)
Total	**123**	**(100%)**	**499**	**(100%)**

Child and Family Circumstances

The majority of children (87, 71%) resided with at least one biological parent. A further four children lived with other extended family members, primarily grandparents. Twenty-six (21%) children died in hospital shortly after birth, having never been discharged. The deaths of this group of children were largely attributed to pregnancy complications and prematurity. Half of the children (61, 50%) died at the family home, and a third (40, 33%) died in a hospital or health facility.

Most of the children and young people came from mid to large size families, with an average of 2.38 children in each household. Twenty-five children (20%) were being raised in a single-child household at the time of their deaths.

In 2006, four children whose deaths were reviewable died whilst in statutory care:

- Three of the children were under care orders that allocated parental responsibility to the Minister, and were placed with carers.
- One child with significant disabilities was living in a residential supported accommodation service.

Table 6: Reasons for the reviewable status of child deaths by Indigenous status

	All Reviewable Child Deaths (123)	Non-indigenous Reviewable Child Deaths (98)	Indigenous Reviewable Child Deaths (25)
Child report < 3 years prior to the child's death	81	64	17
Sibling report < 3 years prior to the child's death	33	26	7
Fatal abuse	12	12	0
Fatal neglect	9	7	2
Suspicious circumstances	19	14	5
In care	4	3	1
In detention	0	0	0
In correction	0	0	0

Twenty-seven children were recorded as having had either an intellectual and/or physical disability.[18] A number of these children required a high level of ongoing support to manage the impact of problems associated with their disabilities.

Table 7: Usual place of residence

	All Reviewable Deaths	
Biological parent(s)	87	(71%)
Child never discharged from hospital	26	(21%)
Other family member (s)	4	(3%)
Non-related person (s)	4	(3%)
Young person living independently	2	(2%)
Total	**123**	**(100%)**

Table 8: Place of the child's death

	All Reviewable Deaths	
Child's family home	61	(50%)
Hospital or health facility	40	(33%)
Public place	10	(8%)
Other private home	7	(6%)
Residential service	1	(1%)
Other location	4	(3%)
Total	**123**	**(100%)**

[18] This is a conservative estimate and likely understates the number of children who had disabilities because the types of records we review would not necessarily convey this information.

3.3 Children who died from abuse, neglect, or in suspicious (ANS) circumstances.

Our definitions of abuse, neglect and suspicious deaths are detailed in appendix 1.

Of the 123 reviewable deaths, 12 (10%) children died as a result of abuse, nine (7%) as a result of neglect and 19 (15%) children died in suspicious circumstances. The following table provides details of why deaths were reviewable.

(Table 9, below).

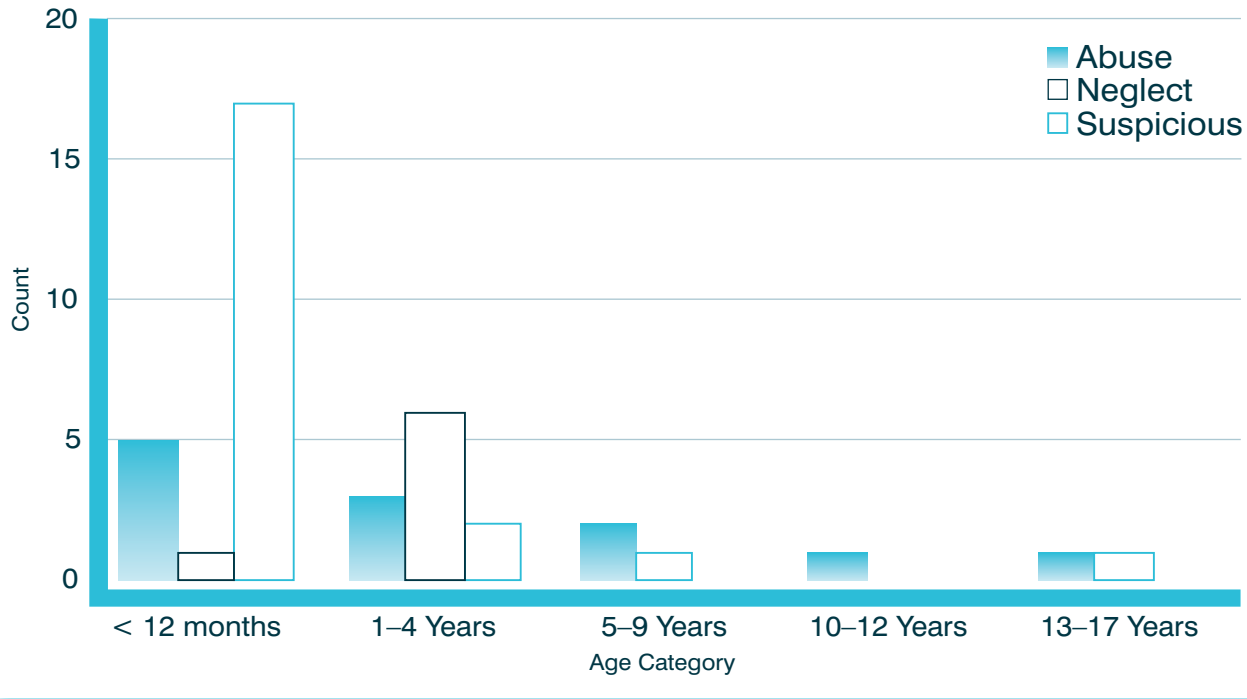
Of the group of 40 children who died as a result of abuse or neglect, or whose deaths occurred in suspicious circumstances:

- Thirty-one children had been reported to DoCS within three years of their deaths.
- Almost one quarter (9) were not known to DoCS. Three of these children died of abuse, and two died of neglect.
- Twice as many male (21) than female children (10) died.
- Six of the children were identified as Aboriginal.
- Criminal charges have been laid in relation to 10 of the deaths. Police inquiries are continuing into a number of deaths.

Table 9: Abuse, neglect or suspicious circumstance deaths

	All Children (123)	Children Known to DoCS (81)	Children with Siblings Known to DoCS (33)	Children not Known to DoCS (9)
Abuse	12	9	0	3
Neglect	9	7	0	2
Suspicious	19	15	0	4

Figure 2: Age category by abuse, neglect or suspicious deaths



3.4 Children known to DoCS

Most children who were the subject of a report had two or more reports to DoCS in the three years prior to their death, with the average number of reports being 2.41.

Eighty-one of the 114 children known to DoCS were themselves the subject of a report to DoCS. 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 27 children.
- Open and unallocated for eight children. This means that a report or case plan may be open at a CSC, but is not allocated to a caseworker for active casework.
- Closed for 46 children.

Thirty-three of the children who died were not themselves the subject of a report to DoCS, but their sibling(s) had been reported. The majority of these children (28, 85%) were under the age of 12-months when they died. Seven (21%) of the children were Aboriginal.

3.5 Children not known to DoCS

During the reporting period, there were nine children who were not known to DoCS (7% of all reviewable deaths). This number is consistent with the proportion of children not known to DoCS in previous years.

(See table 10, below).

These nine deaths were reviewable because the children died as a result of abuse in three cases and neglect in two cases. The remaining four children died in circumstances considered suspicious. One child died in a murder suicide incident and criminal charges have been laid in relation to the two other deaths. In terms of a demographic profile, the age distribution of these nine children was spread fairly evenly across all age groups. One child was Aboriginal.

In both deaths resulting from neglect, the children drowned in swimming pools. In these cases, there were known risks relating to the potential for the children to gain unsupervised access to the pool.

Of the four deaths considered suspicious, three were sudden, unexplained deaths that occurred in the context of bed sharing with some evidence that the parents were also substance affected. In the other case, there was evidence of unreasonable delay in seeking medical treatment for illness.

Table 10: Reviewable child deaths: number of children not known to DoCS[19]

	2004 (104 deaths)	2005 (117 deaths)	2006 (123 deaths)
Number	8	8	9
Percent	8	7	7

[19] We have not included figures from 2002/03, as definitional changes do not provide a consistent comparative basis in this context.

In some cases, although the child had not been reported to DoCS, there was evidence that the family had contact with other services, primarily NSW Health and NSWPF.

3.6 Coronial and criminal status

At the time of writing, our review of available records indicate that criminal charges have been laid in relation to 10 of the children. All reviewable deaths are examinable by the NSW Coroner, pursuant to section 13AB of the *Coroners Act 1980*. The Coroner determines which deaths are subject to a full inquest. At the time of writing, the coronial process had not been finalised for 82 (67%) of reviewable deaths that occurred in 2006.

Table 11: Status of the coronial process

	All Reviewable Deaths	
Closed – Inquest held	2	(2%)
Closed – Inquest dispensed	33	(27%)
Closed – Inquest terminated	6	(5%)
Open – Inquest decision pending	82	(67%)
Total	**123**	**(100%)**

Table 12: Manner of child deaths

	All Reviewable Deaths	
Natural manner	31	(25%)
Accidental manner	6	(5%)
Suicidal manner	5	(4%)
Homicidal manner	7	(6%)
Undetermined/unascertained	3	(2%)
Coronial process not finalised	71	(58%)
Total	**123**	**(100%)**

4. Significant factors identified in child death reviews

Over the past four years, the child protection histories we have reviewed have consistently identified issues related to parental substance abuse, parental mental health problems, domestic violence and neglect.[20] Moreover, and in line with contemporary research, our work has clearly shown that these factors often co-exist, presenting significant risks to children and challenges to agencies working with them and their families. We have also noted the over-representation of Aboriginal children in reviewable deaths, and the relatively high numbers of adolescents with both child protection histories and mental health issues.

These significant underlying factors were again prevalent in our reviews of child deaths in 2006.

This section provides an overview of the issues arising from parental substance abuse, parental mental health problems, domestic violence and neglect, and the particular issues arising for adolescents and Aboriginal children. We consider the challenges these issues present for agencies in a child protection context, and outline the work agencies have told us they are doing to improve their responses in these areas.

Appendix 3, which provides an update on agency progress with our previous recommendations, provides a more detailed outline of the initiatives agencies have, or intend to, put in place to address key child protection issues.

In section 5 we examine more closely the capacity of the child protection system to respond to children living in families in which these and other high risk issues exist.

4.1 Parental substance abuse

Substance abuse can seriously affect parenting capacity and place children at significant risk of harm. Parents affected by drugs or alcohol may not be able to identify or meet the basic needs of their children, including food, essential care and supervision. Drug or alcohol misuse has the potential to result in violent or psychotic episodes, and the effects of drugs and/or alcohol where parents share a bed with children can significantly increase risks of overlaying and suffocation.[21]

[20] The period of review referred to in this section is December 2002 to December 2006 inclusive.

[21] Blair, P.S., Platt, M.W., Smith, I.J., Fleming, P.J., (2006) 'Sudden infant death syndrome and sleeping position in pre-term and low birth weight infants: an opportunity for targeted intervention.' *Arch Dis Child,* 91 (2): 101–6.

Our previous work on parental substance abuse

Our *Report of reviewable child deaths in 2005* included a focus on parental substance abuse. Our reviews illustrated the challenges facing agencies in dealing with substance abusing parents in a child protection context, including that they may:

- Be difficult to engage, seek to conceal or minimise their drug use, and behave inconsistently, making risk assessment a difficult task.
- Agree to changes and make undertakings about their substance use that they may be unable to sustain.
- Be prone to relapse, making ongoing case monitoring and follow up critical.[22]

DoCS has estimated that, in 2004–05, between 42 and 56 per cent of risk of harm reports made to the department involved carer drug and/or alcohol abuse.[23]

Agency responses to parental substance abuse

Through our reviews, we identified concerns about the effectiveness of DoCS' risk assessment for children whose parents misused drugs and/or alcohol, and about how DoCS monitored and responded to breaches of undertakings that parents made with the department.

Since our report, DoCS has initiated or progressed a number of strategies for improving responses to child protection concerns arising from parental substance abuse. DoCS told us it has:

- Revised caseworker training on drugs and alcohol.
- Established an Alcohol and Other Drug Expertise Unit.
- Finalised an information sharing protocol with NSW Health in relation to DoCS' clients participating in opioid treatment.
- Is trialling a new Parental Drug Testing Policy.

The NSW government has also legislated Parent Responsibility Contracts, which will formalise agreements with parents whose children are at risk, particularly around agreements to address drug and alcohol issues.[24]

Our report also considered the role of NSW Health in responding to drug and alcohol use in pregnancy, and in managing take-away methadone for parents with children.

In 2005, 14 children who died before the age of 12 months were born to mothers who used hazardous levels of drugs or alcohol in pregnancy. Three child deaths in 2005 were related to methadone poisoning. We raised some issues about the management of take away methadone for parents, and the capacity of NSW Health to identify and respond to children who are presented to hospital as a result of ingestion of methadone. We also raised concerns about the apparent lack of coordination, monitoring and review of the state's various drugs-in-pregnancy services, which operate through Area Health Services.

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[22] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths.* NSW Ombudsman November 2006.

[23] DoCS' published statistical data is derived from specific fields in KiDS that relate to the dominant aspects of the reported incident, not the underlying problems of the family. This data indicates that in 2004/05, drug and alcohol use by the carer was the primary reported issue in one in ten risk of harm reports made, and was included as a concern in 19 per cent of reports. However, DoCS advised us that a more in-depth research study was undertaken which looked at the underlying problems of the family, represented by all reported issues related to that family. This study found that the prevalence of carer drug and alcohol issues was much greater than that indicated by the incident based published statistics.

[24] Following the proclamation of the *Children and Young Persons (Care and Protection) Amendment (Parent Responsibility Contracts) Act 2007* in March 2007, DoCS announced in the May/June 2007 edition of *Inside Out* that the new contracts are currently being piloted across eight Community Service Centres.

Since our report, NSW Health:

- Has proposed to audit drugs-in-pregnancy services.
- Released new clinical guidelines for methadone and buprenorphine treatment, that includes guidance on the identification and reporting of risk of harm to children of patients receiving treatment.
- Is examining opportunities to establish routine monitoring and surveillance of data related to child methadone poisoning.
- Will require all child methadone poisonings to be reported to NSW Health, and will establish a unit to investigate these matters.
- Will notify prescribers of cases of child methadone poisonings.
- Finalised an information sharing protocol with DoCS, as noted above.
- Developed an Advanced Prescribers Course aimed at providing further training to existing methadone prescribers about assessing patient stability and the appropriate use of Buprenorphine/Naloxone.
- Is piloting the use of a secure storage container, which includes a controlled time-release dosage mechanism for patients receiving take-away methadone.

Child deaths in 2006

For deaths in 2006, we identified a history of parental substance abuse in 63 of the families (51%) of the children who died. This is slightly higher than we found in deaths in 2005, where we identified a history in 46 per cent of reviewable deaths. A risk of harm report was made in relation to 51 of the 63 families in the twelve months prior to the child's death.

Our reviews identified that in four of these 51 cases (8%), a comprehensive secondary risk of harm assessment was completed by DoCS in relation to one or more reports about parental substance abuse.[25]

Most of the 63 children were very young when they died. Forty-five of the children (71%) were aged less than 12 months, and in 18 of these cases, the child was aged less than one month.

Pre-natal reports to DoCS were made for 21 of the children, the majority of which raised concerns about the mother's drug or alcohol use. Eighteen children were identified as having been born to a mother who used illicit substances or hazardous levels of alcohol during pregnancy. In these cases, it was common that they had not received ante-natal care prior to the child's birth. Eight of the mothers were linked to drugs-in-pregnancy services at some time in the 12 months prior to the child's death, and seven were on a methadone treatment program during their pregnancy.

In some of the 63 cases, the coronial process has not been completed, and so it is difficult to provide any extensive analysis of the number of deaths linked to parental substance abuse.

However, we observed that:

- In one death where the coroner has determined cause of death, methadone toxicity was identified as a contributing cause.
- In a number of cases, evidence of recent parental alcohol and/or drug use was noted at the time of the child's death. For example, in one in which a baby died in a bed sharing incident, attending police found heroin and cocaine in the room, and the baby's mother acknowledged her use of drugs the previous day.
- In four cases, the child displayed symptoms of neo-natal abstinence syndrome.

[25] Secondary risk of harm assessment is a guided assessment to determine risk of harm or safety of a child and results in decisions about the need for care and protection. See section 5.2 for a detailed description. Secondary risk of harm assessment is completed when assessment results in judgements and decisions about the risks to, or safety of, a child.

4.2 Parental mental health problems

Not all children who have a parent with a mental health problem will experience difficulties as a result of their parent's ill health, and there are a range of factors, such as genetic inheritance, relationship factors and 'psychosocial adversities' that appear to increase risks to children.[26] Depending on these factors, the nature of their parent's mental health problem and engagement with appropriate treatment, children who have a parent affected by a mental health problem can experience the effects of social isolation and financial hardship, inconsistent parenting, low levels of expressed affection, neglect, and an increased longer-term risk of developing mental health problems themselves.[27]

While there is no detailed data about the number of children in NSW living with parents affected by mental health problems, it is estimated that 29 to 35 per cent of female clients of mental health services in Australia have dependent children under the age of 18 years, and further, that post-natal depression affects 10 to 15 per cent of mothers.[28]

DoCS data indicates that in almost eight per cent of child protection reports in 2004-05, the carer's emotional state, psychiatric disability and/or suicide risk/attempt was the primary, or main, reported issue.[29]

In our reviews over the past four years, we have noted the prevalence of recorded mental health problems for the parents of children who died and whose deaths were reviewable. Agency records have indicated the presence of various mental health problems linked to parental substance abuse, such as clinical depression, personality disorders, and diagnosed psychiatric disorders, including psychotic episodes. Notably, we have most often identified mental health issues in tandem with other child protection concerns, particularly substance abuse and neglect.

We have previously highlighted concerns about the level of interagency coordination between DoCS and mental health professionals in responding to child protection concerns in the context of parental mental health problems.[30] The need to ensure that frontline caseworkers engage with relevant agencies to ensure accurate assessment of, and support to, families where children may be at risk is an ongoing challenge for DoCS and NSW Health.

NSW Health response to parents with mental health problems

In 2005, the NSW Mental Health Sentinel Events Review Committee recommended that NSW Health develop clinical guidance for the management of risk to children of a parent with a major psychiatric disorder.[31]

NSW Health has indicated a number of initiatives in this context, including:

- The development of *Integrated perinatal and infant care clinical pathways and guidelines*, which includes a focus on child protection issues in the context of working with mentally ill parents.

[26] Australian Infant, Child, Adolescent and Family Mental Health Association (2004) *Principles and actions for services and people working with children of parents with a mental illness*. Australian Government, Department of Health and Ageing, Canberra.

[27] For example, Maybery, D, Ling, L, Szakacs, E and Reupert, A (2005) Children of a parent with a mental illness: perspectives on need. *Australian e-Journal for the Advancement of Mental Health*. Volume 4, Issue 2.

[28] NSW Health (2003) *Children of parents with mental illness*. (brochure), drawing from Cowling, V (ed) 1999, Children of parents with mental illness. Australian Council for Education Research, Melbourne.

[29] Department of Community Services (2006) *Annual statistical report* 2004/05.

[30] For example, NSW Ombudsman (2004) *Reviewable deaths annual report 2003 – 2004*. NSW Ombudsman, Sydney. Page 62.

[31] NSW Mental Health Sentinel Events Review Committee (2005) *Tracking Tragedy 2004*. Second report of the Committee. Page 60.

- The development of a strategic framework in relation to children of parents with mental illness.[32]

Parental mental health and child homicide

According to the NSW Sentinel Events Review Committee, only 10 per cent of people suffering mental illness have a history of violence. The committee also notes that the ability of clinicians to identify who will be violent in a group of people is difficult, and that:

> *There is a myriad of unpredictable events that can change a person's level of risk; sometimes violence can be foreseen, but sometimes events change and foresight is difficult or impossible.*[33]

Over the four years to December 2006, we reviewed the abuse deaths of 53 children. In 23 cases, the alleged perpetrator had a recorded history of mental health problems. In 13 of these cases, records we reviewed provided evidence that the alleged perpetrator was mentally unwell at the time the homicide was committed.

In 19 of the 23 deaths, the alleged perpetrator was the child's biological parent, and in three further cases, was either a relative or resided with the family. Neither the child nor the family were known to DoCS in seven, or one-third, of these cases.

Some of these cases are still before the Courts. Of the matters we identified as being finalised:

- In relation to the deaths of four children, the person charged was found not guilty on the grounds of mental illness.
- In seven deaths, the perpetrator was convicted of manslaughter.
- In two deaths, the perpetrator was convicted of murder.
- Six of the children died in three murder-suicide incidents.[34]

Child deaths in 2006

Parental mental health problems were indicated in the records of 49 families of children who died in 2006. In 14 of the families (29%), risk of harm reports raised carer mental health issues as a primary or secondary concern. In 11 of the families, file records also indicated a history of parental substance abuse.

To date, we have identified four cases in which mental health issues appeared to be a contributing factor in the child's death.

4.3 Domestic violence

Domestic violence has a significant impact on children. Children can be directly physically harmed by violence, and they can be subject to serious emotional harm by witnessing, and living with the effects of, violence within their household.

One study has estimated that in 30 to 60 per cent of families affected by domestic violence, domestic violence co-exists with child abuse.

The Australian Bureau of Statistics found that 57 per cent of women who experienced violence by a current partner reported that they had children in their care, and 34 per cent of these women reported that the children had witnessed the violence.[35]

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[32] NSW Health (2005) NSW Government *Response to Tracking Tragedy 2004*. NSW Department of Health, Sydney.

[33] NSW Mental Health Sentinel Events Review Committee (2005) *Tracking Tragedy 2004*. Second report of the Committee. Page 21.

[34] In the period 2002-2006 inclusive, 11 children died in murder-suicide incidents. In five of these cases, our review did not identify any recorded history of mental health problems.

[35] As reported in NSW Ombudsman (2006) *Domestic violence: Improving police practice*. A special report to parliament under s31 of the Ombudsman Act 1974. NSW Ombudsman, Sydney. Page 41.

Each year, police in NSW respond to approximately 120,000 calls for assistance in relation to domestic violence.[36] The latest figures published by the NSW Bureau of Crime Statistics and Research (BOSCAR) note that there were 27 521 domestic violence related assaults across NSW in the 12 months ending 30 June 2007.[37]

In addition to mandatory reporting requirements, current police operating procedures require police to make a risk of harm report to DoCS when children are present at a domestic violence incident.[38]

According to DoCS' data, domestic violence is the most prevalent issue raised in risk of harm reports to the department. In 2004/05, approximately one in four child protection reports (27.2%) involved domestic violence as the primary, or main, reported issue. Just under one-third (32.2%) of all reports included the issue of domestic violence. DoCS has previously indicated to us that the prevalence of domestic violence as an issue in reports is, in reality, likely to be greater than identified through reported data.[39]

In December 2006, this office tabled a special report in the NSW Parliament detailing the findings and recommendations of an investigation into the effectiveness of policing strategies to address domestic violence. The investigation found that some police commands are meeting the challenges associated with responding to domestic violence better than others and there is inconsistent application of good practices across the state.[40]

In our reviews of child deaths, domestic violence has been evident in many child protection histories. For example, for deaths in 2004, we identified that almost half of the children known to DoCS (46%) had been the subject of a report where domestic violence was a reported issue. As noted previously, we have found domestic violence concerns are often present with concerns about parental substance abuse and neglect.

In 37 of the 53 cases we have reviewed in the past four years where children died as a result of abuse, the alleged perpetrator was a family member or a parent's current partner. In a further two cases, the young person who died was, or had been, in a relationship with the alleged perpetrator.

Through our work in child deaths, and also through our scrutiny of NSWPF response to domestic violence, we have identified a range of challenges for agencies in dealing with child protection concerns arising from domestic violence, including:

- The need for good exchange of information and referral between agencies, particularly NSW Health, NSWPF and DoCS, about children identified at risk because of domestic violence. We found the identification, reporting and exchange of information about risk arising from domestic violence to be, at times, inconsistent.
- In the context of the high volume of reports of risk arising from domestic violence, the need for reports made by police to DoCS to provide meaningful information about the level of risk posed to a child. We identified this as a critical challenge, particularly given our observations that domestic violence reports appeared to be given a typically lower priority for DoCS' risk of harm assessment.

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[36] Ibid. Page 1. The NSWPF operate under a broad definition of domestic violence as contained in Part 15A of the *Crimes Act 1900*.The Act defines domestic violence as a 'personal violence offence'.

[37] NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics Quarterly Update,* June 2007, page 4.

[38] NSW Police domestic violence standard operating procedures and child protection procedures are currently under revision.

[39] Department of Community Services' response to a draft copy of *Report of reviewable deaths in 2005*, in correspondence dated 17 October 2006.

[40] NSW Ombudsman (2006) *Domestic violence: Improving police practice*. A special report to parliament under s31 of the Ombudsman Act 1974. NSW Ombudsman, Sydney.

- The importance of good guidance for police in ensuring children are covered by apprehended domestic violence orders (ADVO), and for determining when to take out an ADVO specifically on behalf of a child.
- The need to develop a risk assessment tool to guide the decision making of police when responding to individual domestic violence incidents and a shared risk assessment model with DoCS to improve the quality of information police provide to DoCS in risk of harm reports.[41]

Agency responses to children exposed to domestic violence

In relation to improving responses to children at risk in a domestic violence context, NSWPF is currently revising both domestic violence and child protection operating procedures, and progressing an Apprehended Violence Order (AVO) Legislation alignment project, in line with recent amendments to part 15A of the *Crimes Act 1900*. NSWPF recently advised us that through this project, automatic electronic faxing of orders will commence in February 2008, supported by a training strategy. NSWPF also noted that the issue of children having separate AVOs is under consideration by Parliament.[42]

NSWPF's *Aboriginal Strategic Direction 2003-2006* incorporates an objective aimed at targeting Aboriginal family violence and sexual abuse. An identified strategy to support this objective is to establish and expand programs that address family violence and sexual abuse.[43]

In recent years, NSWPF, DoCS and other relevant agencies have developed and trialled a number of locally initiated pilot projects. These include domestic violence response teams and programs to provide integrated case management to families experiencing domestic violence and child protection issues.[44]

NSW Health, NSWPF, DoCS and the Attorney General's Department are jointly developing a cross agency risk assessment tool, and NSWPF and DoCS have undertaken some joint work analysing child protection reports made, in order to inform recommendations for improvements in reporting.

DoCS has also initiated the *Staying Home, Leaving Violence* program, which assists women to stay at home while the perpetrator moves to alternative accommodation.

Child deaths in 2006

In 2006, at least one risk of harm report was made in relation to 85 children and/or their sibling(s) in the 12 months prior to the death. In just under half of the reports made (41), domestic violence was the main issue reported.

Twelve children died as a result of abuse or in circumstances suspicious of abuse. In 10 of these cases, the alleged perpetrator or the person responsible for caring for the child at the time the incident occurred was a parent or step-parent.

4.4 Neglect

Neglect is a broadly encompassing term, which can complicate an understanding of its effects on children.[45] Neglect can range from poor supervision of children, to failure to provide basic necessities such as food, hygiene and

41 NSW Ombudsman (2006) *Domestic violence: Improving police practice*. A special report to parliament under s31 of the Ombudsman Act 1974. NSW Ombudsman, Sydney. Recommendations 34 and 23.

42 NSWPF response to a draft copy of this report. Correspondence dated 12 October 2007.

43 NSW Police, *Aboriginal Strategic Direction 2003-2006,* pg 23.

44 NSW Ombudsman (2006) *Domestic violence: Improving police practice*. *A special report to parliament under s31 of the Ombudsman Act 1974.* NSW Ombudsman, Sydney. Pages 37, 48-50.

45 Department of Community Services (2005) *Child neglect, literature review*. Dr Johanna Watson, Centre for Parenting and Research. Page 20.

medical care, to a parent being emotionally unavailable to a child.[46] As noted above, neglect is often present with other risk factors, including substance abuse and parental mental health problems.

DoCS' data indicates that neglect is a prominent issue in child protection reports. In 2004-05, neglect was the main issue raised in 14.8 per cent of risk of harm reports, with inadequate supervision for the child's age and inadequate shelter or homelessness being the main concerns.[47]

Our reviews have found that almost half of all risk of harm reports made about children who died included neglect-related issues as a reason for the report being made.[48]

In our previous reports of child deaths, we have consistently raised concerns about responses to child protection reports related to neglect. For example, we identified a relatively low level of assessment of neglect-related risk of harm reports made to DoCS, and we raised questions about how adequately child protection histories were used to assess escalation of neglect and subsequent risk where there were multiple reports made.[49]

Fatal neglect

Neglect is a significant contributing factor in child deaths. A chronic failure to provide basic food or care, including medical care, can cause or contribute to a child's death. Fatalities can also result from one-off instances of inadequate supervision, where parents or carers are at a point in time unavailable to protect their children from danger.[50,51]

Our definition for determining whether a child's death was a result of neglect is:

> Conduct by a parent or carer that results in the death of a child or young person, and that involves:
>
> - failure to provide for basic needs such as food, liquid, clothing or shelter;
> - refusal or delay in providing medical care;
> - intentional or reckless failure to adequately supervise; or
> - a reckless act.

In the four years to December 2006, we attributed 46 child deaths to neglect.[52] This represents approximately 10 per cent of all reviewable child deaths over the period. A further 28 deaths during this period were considered suspicious of neglect.

Most of the children who died as a result of neglect were very young. Close to three-quarters of these children were less than four years of age when they died (32, 70%). Six of these infants (13%) were under 12 months of age at the time of death. This is consistent with research findings, which show that infants up to the age of four years of age are at highest risk of dying from neglect. This is largely a reflection of their dependence on carers and heightened vulnerability. Since 2003, seven (15%) children whose deaths were related to neglect were Aboriginal.

46 Dubowitz, H (2005). Examination of a conceptual model of child neglect. *Child Maltreatment,* 10 (2), pp 190-206.

47 Department of Community Services (2006) *Annual statistical report* 2004/05.

48 NSW Ombudsman (2005) *Report of reviewable deaths in 2004*. page 85. Of the 310 risk of harm reports made about 48 children who died in 2004, 140 (45%) included neglect as an issue.

49 NSW Ombudsman ((2004) *Reviewable deaths annual report 2003 – 2004*. Page 54. (2006) Report of reviewable deaths in 2005. Page 85.

50 Margolin (2001) Acts of omission: An overview of child neglect 'in *National Clearinghouse on Child Abuse and Neglect Information* .

51 The CDRT reported that 26 (84%) of the total 31 neglect deaths were due to 'inadequate supervision' and a further four deaths (13%) were transport fatalities involving negligent driving. Page 64.

52 This includes revised figures for deaths in December 2002 – December 2003, following definitional changes adopted by this office in 2004. See NSW Ombudsman (2005) Report of reviewable deaths in 2004. Page 58.

In 2006, there were nine deaths due to neglect. These children were aged between 6 weeks and 17 years, with most (6) aged between one and four years.

DoCS response to neglect

DoCS has recently completed a number of initiatives focused on neglect. The department has finalised a policy and literature review on neglect, produced guidelines for caseworkers[53], and has rolled out this policy with a revised *Secondary assessment — risk of harm procedure*. The neglect/secondary assessment implementation project includes a range of sessions to develop caseworker and manager understanding of, and skills to respond to, neglect. In a broader context, DoCS has continued to develop the early intervention program, *Brighter Futures*, which provides for support to vulnerable families, including those where neglect may be a concern.

More broadly, DoCS has released a revised secondary risk of harm assessment framework, and as part of a major project to reform the child protection program, DoCS will undertake a quality review of all Community Service Centres (CSCs) over the next four years.

4.5 Aboriginal children and young people

According to the NSW Child Death Review Team, while Aboriginal and Torres Strait Islander children make up 3.5 per cent of the population of children and young people in New South Wales, 11 per cent of all children who died in the state in 2005 were identified as Aboriginal or Torres Strait Islander children. This represents three times the overall child death rate.[54]

In reviewable child deaths, Aboriginal children are also over-represented. Approximately 20 per cent of all reviewable deaths are Aboriginal children.[55] Between 2003 and 2006, while 19 per cent of all child deaths in NSW were reviewable, 42 per cent of the deaths of indigenous children were reviewable.[56]

Similarly, the number of Aboriginal children who are the subject of a risk of harm report to DoCS is disproportionate. Drawing from DoCS published quarterly data, Aboriginal children were the subject of approximately 15 per cent of all risk of harm reports made to the department in 2006.[57]

This year, as detailed in section 6, we examined the causes of all reviewable child deaths to December 2006. This work found a greater proportion of deaths for indigenous children were due to sudden or unexplained causes than for non-indigenous children (23% compared to 17%), and in contrast, a greater proportion of deaths were due to intentional causes such as assault and intentional self-harm for non-indigenous children than indigenous children (16% compared to 5%).

Our previous work on Aboriginal child deaths

Over the past four years, we have identified a range of issues and subsequent challenges for agencies working with Aboriginal children who may be at risk and their families, including:

- Gaps in effective interagency coordination and collaboration in the assessment of, and response to, child protection concerns in

[53] Department of Community Services (2006) *Practice Guidelines for Caseworkers on Child Neglect,* July 2006.

[54] NSW Child Death Review Team (2006) *Annual Report 2005*. NSW Commission for Children and Young People. Page 32.

[55] We identify a child as Aboriginal if any of the records or files we review from any source indicate that the child or their family identify as Aboriginal.

[56] National Centre for Classification in Health (2007) *Causes of death of reviewable children in New South Wales from 2003–2006: A report for the NSW Ombudsman*. NCCH, Queensland University of Technology.

[57] Department of Community Services (2007) *Child protection quarterly data July 2005 – December 2006.* Page 7. In the March 2006 quarter, 14% of reports were for Indigenous children; in the June 06 quarters, 15%; in the September 06 quarter, 15% and in the December 06 quarter, 16%.

Aboriginal families, and the need to improve interagency approaches.

- At times, limited responses to issues of neglect, parental substance abuse and domestic violence in Aboriginal communities, and the need for DoCS to enhance the department's capacity to respond to reports requiring assessment, particularly in regional NSW.
- The use of temporary care agreements for Aboriginal children, and the need to clarify appropriate circumstances for the temporary placement of children in care as a protective measure.

Agency responses to Aboriginal children and families

Since our last reviewable deaths report, the NSW government has released an *Interagency plan to tackle child sexual assault in Aboriginal communities*. Actions under this plan are designed to improve the exchange of information and coordination between agencies.

DoCS *Corporate Directions 2006–2007* include progressing their work with indigenous communities as a key priority, and the department has finalised, and commenced implementation of, *DoCS Aboriginal Strategic Commitment 2006–2011*. The Commitment links to DoCS' business planning and resource allocation, and requires regular progress reporting from the department's regions and Directorates.

Aboriginal child deaths in 2006

In 2006, we reviewed the deaths of 25 Aboriginal children and young people, representing 20 per cent of all reviewable deaths in 2006. Almost three-quarters of these children (18) were aged less than 12 months when they died, and one-third (six) of the 18 had been the subject of a pre-natal report to DoCS. Over a quarter (29%) of the children who died who were subject to a pre-natal risk of harm report were Aboriginal**.** Twenty-three (92%) of the Aboriginal children and young people who died were known to DoCS.

As outlined in section 1, we took further action in relation to 36 children who died in 2006 because our reviews raised issues or concerns about the response of agencies to the child and/or their siblings. In 10 of these matters, the child who died was identified as Aboriginal.

4.6 Adolescents

For agencies working with adolescents, there can be particular challenges in identifying and responding to child protection issues. While young people remain at risk from issues such as family violence, neglect, and parental substance abuse, additional risks can be posed by their own mental health and their behaviour.[58] Young people may also decline the assistance offered by agencies, making it difficult for agencies to respond to risk.

In the four years between 2003 and 2006, we reviewed the deaths of 87 young people aged between 13 and 17 years. This represents approximately 18 per cent of all reviewable deaths. In half of the 87 deaths of adolescents we reviewed, suicide or risk-taking was evident. Suicide was the manner of death in 22 of the 87 cases,[59] and we identified risk-taking behaviour as a likely contributing factor in a further 22 deaths.

DoCS' data indicates that in 2006, approximately 29 per cent of risk of harm reports were made in relation to young people

[58] McDonald, J., & Hayes, L. (2001) 'Strengthening welfare services for young people,' *Youth Studies Australia,* 20 (1); Australian Institute of Criminology (2002) 'Pathways from child maltreatment to juvenile offending,' *Trends and Issues,* No. 241.

[59] Not all youth suicides are reviewable deaths. All suicide deaths are, however, reviewed by the NSW Child Death Review Team. Refer the CDRT report (2003) *Suicide and risk-taking deaths of children and young people*. NSW Commission for Children and Young People.

aged between 12 and 17 years.[60] It appears that younger adolescents aged 12 to 15 years are more likely to be the subject of reports.[61] Under the *Children and Young Persons (Care and Protection) Act 1998*, mandatory reporting is not required for young people aged over 16 years and under 18 years.

Over the past four years, we have identified a number of key issues and subsequent challenges for agencies working with young people at risk, particularly those engaging in risk-taking behaviour, or with mental health problems. These included:

- Some of the young people who died having had contact with various agencies since childhood — from DoCS and police to mental health services, refuges, foster care agencies and education services — raising issues about the adequacy of earlier intervention in their lives.
- In many of the cases where young people were reported to be at risk and were engaging in risk taking behaviour, there did not appear to be effective interagency coordination, including cases where mental health problems or risk of suicide was known or documented. We identified the need for clear strategies to jointly assist these young people.

Agency responses to adolescents

Since our last reviewable deaths report, DoCS has finalised research relating to effective strategies for adolescents in a child protection context, and on models for delivering services to young people in care. DoCS has also established a panel to meet on a quarterly basis to focus on the suicide/risk taking deaths of young people known to DoCS.[62]

Last year, we asked DoCS and NSW Health to discuss the issues raised about adolescents in our *Report of reviewable deaths in 2004*. In that report, we found that in cases of suicide, there had been limited communication or coordination between agencies where mental health and child protection issues had been apparent.

DoCS and NSW Health both advised us that they have continued to work at an interagency level to improve strategies and responses for adolescents at risk of harm requiring mental health services.

NSW Health advised us that the DoCS/Health Senior Officers group would identify strategies to promote effective and coordinated child protection and health responses to adolescents reported to be at risk of harm where concerns include suicide risk and/or mental health. DoCS noted the Senior Officers group as an avenue for promoting appropriate joint responses to risk of harm concerns for this group. DoCS also indicated a number of specific interagency partnerships, including a position funded to support better mental health outcomes for young people in intensive support services.

NSW Health and DoCS have also signed a Memorandum of Understanding (MOU) to ensure priority access to health services for children and young people for whom the Community Services Minister or DoCS Director-General have parental or care responsibility. NSW Health stated that '*An addendum to this MOU is being developed to improve linkages between NSW Health and DoCS in the care of adolescents and young people*' with a key consideration being risk management and suicide prevention.[63] The addendum will apply to young people in care only.

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60 Department of Community Services (2007) *Child protection quarterly data July 2005 – December 2006.* Page 5. Data indicates reports by age group for 12 to 17 years was 28% in the March 06 quarter, 29% in the June 06 quarter, 29% in the September 06 quarter and 28% in the December 06 quarter.

61 Department of Community Services (2006) *Annual Statistical Report 2004 – 2005*. Page 21, figure 8.

62 DoCS progress report on implementation of recommendations from the Report of reviewable deaths in 2005. Dated 31 July 2007.

63 NSW Health progress report on implementation of recommendations from the Report of reviewable deaths in 2005. Dated 26 July 2007.

While the MOU is a positive development, neither agency has indicated any specific state-wide strategies that are being considered to address the broader issues relating to young people who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

The *NSW Youth Action Plan* states that the NSW government will focus on delivering mental health services that are accessible and relevant to young people. The plan proposes the development of an early intervention '*Youth Mental Health Service Model*' to provide one-stop shop services for young people with mental health problems and disorders. The plan also envisages youth-specific initiatives under the NSW Suicide Prevention Strategy.[64]

NSWPF also has a range of diversionary programs for adolescents at risk of offending or re-offending. NSWPF in partnership with Mission Australia have been trialling an integrated case management framework in several Local Area Commands (LACs). Currently this project specifically targets the Arabic and Pacific Islander communities. NSWPF advised us that due to the success of the program in addressing social, environmental, economic and familial issues, a generic model targeting the general community is intended to be rolled out across selected metropolitan and regional areas.

In the Macquarie Fields LAC, strategies include mentoring and case management of young people at risk of offending, and a range of residential camps for targeted young people to build relationships between them and local police, and to develop self esteem and motivation.[65]

Another example is Tirkandi Innaburra, a cultural outstation for Aboriginal boys aged between 12 and 15 years. This program is situated in the Griffith LAC, and serves the Riverina and southern border areas. The aim of the program is to assist young people at risk before they become involved in offending behaviour by providing them with training opportunities to develop the skills and confidence to make positive life choices.

Additionally, in September 2006, the NSW Premier announced the implementation of an Anti Social Behaviour Pilot Strategy. An anti social case coordination framework is being rolled out in a number of areas across the state.[66] The framework provides for government agencies involved with high-risk vulnerable families to coordinate responses and promote integrated case planning for high risk children and young people and their families.

Deaths of young people in 2006

In 2006, we reviewed the deaths of 17 young people. This represents 14 per cent of all reviewable deaths in 2006. Fifteen of these young people had been the subject of reports to DoCS. The other two young people had siblings who had been reported to DoCS. In 10 of the 15 cases, we found the young person had been known to the department since childhood. For nine of the 17 young people, we found some evidence of mental health problems, and/or engagement in risk-taking behaviour.

The factors described above do not present new issues for agencies with child protection responsibilities. As noted, key agencies, particularly DoCS, NSWPF and NSW Health have identified a range of strategies that have

64 NSW Government (2006) *NSW Youth Action Plan — The way forward: Supporting young people in NSW*. Action 19.

65 Correspondence from NSWPF, dated 17 August 2007.

66 Department of Community Services progress report on implementation of recommendations of the Report of reviewable deaths in 2004. Dated 27 March 2006.

been put in place, or are planned, to address these and other child protection issues, and to improve agency responses to children at risk of harm. It is critical that these commitments are achieved and built upon.

In the next section, we draw from our reviews of child deaths in 2006 to examine how the child protection system was able to respond to the challenges.

5. Systems for responding to children at risk of harm

The risk factors discussed in the previous section are present in most cases we review. Often they are present as combined and chronic risks impacting on children over a long period of time. This section of the report considers our review findings about systems in place in NSW for responding to children at risk of harm. Our focus is on three key areas:

- How agencies identified and reported risk of harm.
- How reported risk was assessed.
- How agencies acted to protect children at risk.

5.1 Identifying and reporting risk of harm

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. Staff employed in health, welfare, education, children's or residential services and in law enforcement that provide services to children, are mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998*. Mandatory reporters must notify the DoCS Helpline, a centralised intake point, if they have reasonable grounds to suspect that a child is at risk of harm.

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. In late 2006, the Act was amended to specify that a newborn child is at risk of harm if he or she was the subject of a pre-natal report and the birth mother did not successfully engage with support services to eliminate, or minimise, the risk factors that led to the pre-natal report.[67]

In our previous reports of child deaths, we raised concerns that reporting obligations were not always effectively met. In the majority of cases, our reviews of child deaths in 2006 found that agencies had appropriately identified children at risk and made risk of harm reports. For some children however, we again identified that risk was either not identified or was identified but not reported.

NSW Police Force

NSWPF is the agency that makes the most reports to DoCS. Police make more than one in every three reports to the department.[68] In addition to being mandatory reporters, NSWPF policy requires police officers to make a report for any child who has been '*present at a domestic violence incident*'.[69] The reports police

[67] *Children and Young Persons (Care and Protection) Act 1998*. s.23 (f).

[68] Department of Community Services (2006) *Annual Statistical Report 2004/05*. Page 13.

make primarily raise concerns about domestic violence. In 2004–05, domestic violence was the main concern reported in almost 60 per cent of reports made by police.[70]

In our report of deaths in 2005, we noted a number of instances where police records documented that a report had been faxed to DoCS, but we had found no evidence of a report being received.

This year, we conducted a targeted review of NSWPF and DoCS records for a sample of children who died and their families. The review, which we have provided to the NSWPF, identified 29 events involving 18 families where police reporting of risk of harm did not appear to meet requirements. The events occurred between January 2005 and April 2007. Of particular note, we found:

- In nine events, a mandatory risk of harm report and/or a risk of harm report as required by NSWPF procedures may have been warranted, but we found no evidence that police considered making a report.
- In 10 events, a mandatory risk of harm report and/or a risk of harm report as required by NSWPF procedures may have been warranted, and police records indicate that a report was made to DoCS, but we could locate no evidence that a report was received by DoCS.
- In the remaining 10 events, it appeared that a report may not have been necessary, but police records stated that a report was made. However, we could locate no evidence that a report was received by DoCS.

Notably, over three-quarters of the reports in the last two categories were recorded as being made by fax.

As noted above, most of the reports made by police are about domestic violence. Domestic violence events entered onto the police Computerised Operational Policing System (COPS) are reviewed at Local Area Commands by either a Domestic Violence Liaison Officer (DVLO) or a supervisor.

Our findings raised concerns about:

- The reasons why police officers may not be consistently meeting their reporting obligations for children at risk of harm.
- Whether police are adequately recording verifying information about reports to DoCS, and how supervisors are monitoring reporting.
- Why, in some cases, reports are recorded as being made, but there is no record of this on the DoCS KiDS system.

While we note the challenges facing police in terms of the numbers of reports to DoCS, at present it appears difficult for NSWPF to verify or audit risk of harm reports to ensure they are made.

In response to our report, NSWPF advised us that they have established a working party to consider the issues we raised. The working party comprises officers from the Youth, Domestic and Family Violence, Child Protection, and Organisational Review and Support areas of the Commissioner's Inspectorate, and a representative of the Child Protection and Sex Crimes Squad. NSWPF told us the working party is discussing strategies to:

- Improve compliance with risk of harm reporting requirements
- Improve the quality of the police response to children at risk of harm
- Provide police with better information and support in relation to managing children and young people at risk of harm and working with other agencies

[69] NSW Police (2000) *Domestic violence policy and standard operating procedures*. Page 31.

[70] Department of Community Services (2006) *Annual statistical report 2004/05.* Page 16.

- Implement a more systematic, focused approach in Local Area Commands relating to children at risk of harm.

We note also that an electronic reporting process is presently being explored by NSWPF and DoCS.[71] Electronic reporting will provide an easier avenue for reporting and address some issues around verification of reports. Such a capacity will need to be supported by greater clarity about what should be reported by police officers, and improved quality in the information provided when reports are made. The working party provides a solid basis for this work.

Relevant developments since our last report

As of July 2007, NSWPF is continuing to review both domestic violence and child protection standard operating procedures (SOPs). We have been advised that the issues raised through our reviews will be addressed through the revised SOPS and accompanying policy. While this is clearly a positive development, the SOPS have been under review for some time. It is critical for good practice that front line police have clear guidance about identifying children at risk, and their reporting obligations. In response to a draft copy of this report, NSWPF noted that the Domestic and Family Violence SOPs are due for endorsement by the Commissioner in December 2007, and implementation in February 2008. Implementation will be in conjunction with new domestic violence training for police.

The SOPs will link to the new child protection procedures, which are currently being drafted. The Domestic and Family Violence SOPs contain a section on children and domestic violence and provide advice to police on best practice for completing a risk of harm report for children involved in domestic violence incidents. In response to a recommendation made in our report *Policing domestic violence: Improving police practice,* NSWPF has advised us that their domestic violence training package will be comprehensively reviewed.

We have previously raised issues about the quality of reporting by police and the imperative, given the volume of reports made, to ensure that the DoCS Helpline has adequate information with which to determine an appropriate response. We have noted that police routinely report by faxing copies of COPS events, rather than notification forms that may better articulate specific concerns about children.[72] From January 2007, police and all mandatory reporters have been required to complete a standardised DoCS Helpline form when faxing risk of harm reports. NSWPF further advised that the DoCS Helpline has agreed to provide a checklist for inclusion in the Domestic and Family Violence SOPs to assist police in making a determination about when to report children in these incidents, and the type of information that police need to include when reporting to DoCS.

DoCS and NSWPF are also continuing a joint project to improve risk assessment procedures through an analysis of reports received by DoCS from police.

NSW Health

Along with NSWPF and school/education reporters, NSW Health is one of the three largest reporting groups to DoCS. In each quarter of 2006, NSW Health made between 10,000 and 11,000 child protection reports.[73] The main issues reported by health professionals involve parental mental health issues, domestic violence, physical abuse, parental drug or alcohol use and neglect.[74]

[71] NSW government (2006) *NSW Interagency guidelines for child protection intervention*. Page 31.

[72] NSW Ombudsman (2006) *Policing domestic violence: improving police practice*. Page 43.

[73] Department of Community Services (2007) *Child protection quarterly data July 2005 – December 2006.* Page 8.

[74] Department of Community Services (2006) *Annual statistical report 2004/05.* Page 17.

In the majority of our reviews, we found that NSW Health staff had effectively identified and reported risk of harm, including where concerns were about unborn babies. In a number of cases, however, our reviews of NSW Health and DoCS records indicated that the circumstances in which a health professional had contact with a child may have warranted closer consideration of possible risk to a child.

Identifying risk

In our reviews, obstetric departments and early childhood visiting services were often the first agency to alert DoCS to possible risk to babies. In a number of cases, the records we reviewed indicated some level of risk to children, but we found no corresponding risk of harm report to DoCS, or a delay in reporting.

In reporting risk of harm, a mandatory reporter needs to have reasonable grounds to suspect that a child is at risk of harm, and sometimes professionals will judge that the circumstances do not warrant a report to DoCS. NSW Health policy notes that reporting is complex, and it will not always be clear that a report is required. The policy indicates staff should consult with supervisors if there are indicators of risk but a report is not considered necessary, and consider what additional supports should be put in place for the child and their family. The policy requires clear documentation of decisions not to report to DoCS.[75] In some cases we reviewed, we found there was no clear rationale provided for such decisions.

In some cases, our reviews also raised questions about the degree to which possible risk had been fully considered by health professionals. Our concerns included a case where health staff neither verified the circumstances of a child's presentation at emergency with a physical injury, nor made a report about the injury. In another case, we have raised questions about the degree to which risks associated with a patient's threats to harm a child were consistently reviewed during the person's ongoing treatment.

One case also raised concerns about lack of notification to police where there was evidence of serious domestic violence:

Case study

A woman presented to an emergency department with injuries resulting from domestic violence, including a broken bone. The mother informed hospital staff that her child was safe with relatives. NSW Health policy requires health workers to report certain incidents of domestic violence to police, such as where the victim sustains broken bones.[76] We found no evidence in the records we reviewed that police were notified or further enquiries made about the children.

Reporting to NSWPF has important child protection considerations, as police can issue AVOs and clarify the wellbeing of children where there has been domestic violence.

Relevant developments since our last report

NSW Health advised us that it has:

- Amended its domestic violence policy to clarify 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.[77]

[75] NSW Health (2000) NSW Health frontline procedures for the protection of children and young people. Page 23, 24.

[76] NSW Health (2003) Policy for identifying and responding to domestic violence. Section 4.2.

[77] NSW Health (2006) Policy directive – *domestic violence – identifying and responding*. Document number PD2006_084. October 2006.

- Is the lead agency in a cross-agency domestic and family violence risk assessment framework project, with DoCS, NSWPF and the Attorney General's Department. The aim of the project is to *'develop a more integrated and consistent service response to domestic/family violence, for earlier, more effective and targeted services to those affected by violence including children'*.[78]
- Has published a policy directive on pre-natal reports. The directive clarifies health workers' obligations under recent changes to the *Children and Young Persons (Care and Protection) Act 1998*, particularly in relation to reporting children who were subject to a pre-natal report and where risk factors remain after the child's birth.

Education

Schools and child care services make up a significant proportion of mandatory reports to DoCS. In 2004/05, physical abuse was the most common reported concern in reports from schools and child care services. Other common concerns were neglect, sexual abuse, psychological issues and domestic violence.[79]

Our reviews may incorporate examination of education or child care records, but we do not review these records in every case. In relation to mandatory reporting from schools and child care services, we identified only one matter where it appeared that education staff did not report identified risk of harm.

Case study

Our review of the death of a young child indicated that there may be current neglect issues for the child's siblings. Following the child's death, the children's school had reported concerns about inadequate supervision and neglect. As part of our review, we examined education records for the family. We found that school personnel had held concerns about the family since the children's enrolment two years earlier, and that a referral to DoCS had been considered, but not made, on at least five occasions. The school's concerns included the children's psychological and behavioural problems, 'chronic, severe problems' at home, and difficulties in the parent's capacity to cope.

We found that a staff member had advised the school principal on several occasions that a report should be made to DoCS about the family. However, the principal's view was that the family was being appropriately supported through the school's efforts. Consequently, neither the staff member nor principal made a report.

While there was no question that the school was actively working to provide support and assistance to the family, the school held serious concerns and information that should have informed DoCS' work. We identified that in the same period, police had made reports on a number of occasions and DoCS had assessed the family, substantiated neglect of the children, and provided immediate assistance. The case was then closed.

DoCS has advised us that the department and school personnel have since met and planned a collaborative approach to ongoing service delivery.

78 Correspondence from NSW Health dated 28 March 2007.

79 Department of Community Services (2006) *Annual statistical report 2004/05*.

In regard to schools, Department of Education and Training (DET) reporting to DoCS is centralised. DET procedures require principals to make a report to DoCS when informed by a staff member of the need to do so. Staff members are required to:

- Inform their principal when they have reasonable grounds to suspect risk of harm to a child or young person;
- provide relevant information to the principal to assist in making the report; and
- ensure that a report has been made to DoCS, including reporting to the Helpline directly if there are reasons precluding the report being made by the principal.[80]

In response to a draft copy of this report, DET confirmed that in this centralised reporting procedure ' *there is no option for opinions to be provided or considered by the principal or the staff member in the making of a report where there are reasonable grounds to suspect risk of harm.*'

The case illustrates the importance of clear guidance for staff in their reporting obligations, and the need to ensure effective supporting policy and information strategies.

Identifying and reporting young people at risk of harm

Reports for young people aged over 16 and under 18 years are not mandatory.

As was the case in previous years, we found that the majority of young people who died were known to DoCS, and of these, most had been known to DoCS since childhood. Many of the young people were engaging in risky behaviour, and for some there was evidence of mental health problems. However, we found little evidence that the risks for these young people was consistently identified.

Review of the records of many of the young people who died indicated there were ongoing risks in their lives that were not being comprehensively addressed. As noted earlier, 15 of the 17 young people who died in 2006 had been the subject of reports to DoCS. However, our reviews identified that for these young people, only five had been the subject of a report in the 12 months prior to their deaths. There were no reports made in this period for the four young people who committed suicide.

We found that risk resulting from self-harming or risk-taking behaviour was not always reported as a child protection concern.

In situations where young people engaged in anti social or criminal behaviour, it was not common for police to identify this behaviour as placing a young person at risk, even where this behaviour involved levels of risk-taking. In most of the cases we reviewed where anti social behaviour was emerging, there were also abuse and neglect issues. The link between anti social behaviour in adolescence and child abuse and neglect has been clearly documented.[81] This is a difficult area particularly for police, who have child protection obligations while also needing to address anti social behaviour in a crime prevention context.

There are complexities in identifying risk of harm in adolescents. In an environment of competing priorities, agencies have noted to us that adolescents tend to be accorded a low priority by DoCS. This is evidenced through our reviews. When linked to the low response to risk identified for some young people who died in 2006, our reviews highlight an ongoing challenge for agencies in ensuring that young people are provided with appropriate protective intervention.

[80] NSW Department of Education and Training (2000) *Protecting and supporting children and young people*. Pages 8 – 9.

[81] For example, Smith, C et al (2005) Adolescent maltreatment and its impact on young adult antisocial behaviour. In *Child abuse and neglect* vol.29, no. 10. Also, Stewart et al (2002) Pathways from child maltreatment to juvenile offending. In *Trends and issues in crime and criminal justice*. No 241. Australian Institute of Criminology.

5.2 Assessing risk of harm

Reports of risk of harm are made to a central intake point, the DoCS Helpline. The Helpline undertakes an initial assessment that includes consideration of the information provided by the reporter and any available history. If the Helpline assesses that a child may be in need of care and protection, a case plan is generated. This case plan details the main issues of concern, a timeframe for a required response, and an assessed level of risk. The case plan is then transferred to a DoCS Community Service Centre (CSC) or a Joint Investigation and Response Team (JIRT) for secondary assessment. If an urgent response is required after business hours, the case plan is transferred to the Helpline Crisis Response Team, which undertakes a secondary assessment.

The CSC or JIRT may conduct a secondary risk of harm assessment. The aim of this assessment is to substantiate harm or risk of harm to a child, or to confirm the child's safety. The assessment forms the basis for decisions about the need for, and strategies to provide, care and protection.

In 2006, DoCS revised its secondary risk of harm assessment procedure.

Secondary risk of harm assessment is comprised of two stages:

- **Secondary Assessment Stage 1 (SAS1).** DoCS procedures describe SAS1 as providing for *'limited additional enquiries and the gathering, recording, processing and consideration of 'other information'* about the child, young person and/or family to determine whether further assessment is required or whether the case can be closed.' This includes phone calls, review of DoCS paper files and information obtained from other agencies through s.248 of the *Children and Young Persons (Care and Protection) Act 1998*.[82] Following consideration of this information and within 28 days, the case must proceed to Secondary Assessment Stage 2, or be closed.
- **Secondary Assessment Stage 2 (SAS2).** This is a comprehensive assessment of the risk to a child that includes further information gathering, including from the family, and observation and where possible interviewing of the child. SAS2 considers all aspects of harm or possible harm, parenting capacity and supports and services in place for the child and/or family. The result of a SAS2 is a judgement about safety, the probability of harm, and the consequences of harm for the child. The assessment informs a decision about whether or not harm or risk of harm is substantiated, and in either case, whether DoCS should take protective action. The procedure notes that as a guide, SAS2 assessment is to be completed within 28 days of the case being allocated if harm or risk is not substantiated, and within 90 days of the case being allocated if harm or risk is substantiated.

There is also a role for other agencies in the process of risk assessment. In December 2006, changes to the *Children and Young Persons (Care and Protection) Act 1998* amended s.29 of the Act to clarify mandatory reporters' obligations to a child and/or family following the making of a report to DoCS. Section 29A confirms that reporters should continue to provide support and assistance to the family, and that making a report does not discharge their other obligations in respect of the child.

[82] Section 248 enables DoCS to exchange information relating to the safety, welfare and well-being of a child or children, with a 'prescribed body'. Prescribed bodies include, among other agencies, police, hospitals and schools.

Initial assessment: Issues identified through our reviews

In 2005–06, the DoCS Helpline received 241,003 reports of risk of harm. This represents an 11.4 per cent increase since 2004–05, and a 51 per cent increase in the five years since 2000–01. The proportion of reports that the Helpline determines require further assessment by a CSC or JIRT is around 67 percent. It appears that this proportion has not significantly changed since 1999–2000.[83]

Our reviews of child protection records relating to children who died in 2006 and their families found some issues with the Helpline's initial response to risk of harm reports. Similar issues have been identified in our earlier work, and relate predominantly to the appropriateness of the response rating given to some reports at the Helpline, the way in which information was transferred to CSCs, and the consideration of previous child protection history when determining the need for further assessment.

In a number of cases we also identified, and raised with DoCS, issues about errors in recording information on the KiDS system, and delays in providing relevant information to CSCs.

Rating the urgency of risk of harm reports

The Helpline assesses urgency and recommends a corresponding response time to the relevant CSC or JIRT. The recommended response times are:

- Within 24 hours
- Within 72 hours
- Within 10 days
- Information only (no need for CSC or JIRT to intervene, or assess in conjunction with work ongoing).

Reports are referred to a JIRT for investigation and assessment where a report involves allegations of physical or sexual abuse or neglect that may constitute a criminal offence.

While information received in reports from the Helpline is reviewed by CSCs, our work indicates that it is not usual for a CSC to prioritise a report that has a response time of 10 days, or in some cases where there is high demand, a 72 hour response. Intake assessment guidelines — a tool to prioritise reports for secondary assessment — are being trialled by DoCS. The guidelines focus on prioritising reports with a 24 hour response time, with consideration of cases with a recommended response time of 72 hours that meet certain other criteria.

In the main, our reviews found that the Helpline ratings were consistent and accorded due urgency to cases where available information indicated serious concerns.

In some cases however, we questioned whether the Helpline's recommendation adequately reflected the risks to the child indicated in the information at hand, or in information that could be ascertained from records held by DoCS about the family. The timeliness of the Helpline assessment also appeared to have some impact on the recommended response time.

[83] Department of Community Services (2006) *Statutory child protection in NSW – issues and options for reform.* DoCS discussion paper. October 2006.

Case study

The birth of a child was reported to DoCS, on the basis that the mother had not received any ante-natal care and concealed her pregnancy, had a history of depression and had used intravenous drugs during pregnancy. In addition, the mother refused support services following the baby's birth. The mother also had a number of other children at home. The reporter advised that the mother and child would be discharged from hospital within a fortnight. The report was entered onto the client database by the Helpline some three weeks later.

The outcome was a recommendation that the CSC undertake further assessment to determine the mother's capacity to care for the new baby and her other children, and to determine supports she may require. While it was likely the mother and child had already been discharged from hospital, the Helpline recommended a response time of 10 days and determined risk to the child as medium. When received by the CSC, the report was 'unallocated' and some days later, closed without further assessment due to current competing priorities.[84]

Referrals to JIRT

In our previous reports, we have raised concerns about reports not being referred to JIRT when appropriate, and an apparent lack of consistency in DoCS' procedures and practices for referring reports to JIRT or NSWPF.[85]

Focusing on the 12 months prior to the child's death, our reviews found that in 15 cases relating to the child who died or a sibling, the information provided by a reporter warranted a referral to JIRT. In most cases (13) the Helpline referred the report. In two of these cases, the referral related to the incident that resulted in the child's death. Five of the 13 cases referred were rejected by JIRT. Reasons for rejection included sexual behaviour not providing evidence of an offence, and the level of physical injury not meeting JIRT criteria.

In two cases, we raised concerns to DoCS about reports not being referred where there was evidence of under-age sex with a minor, and allegations of sexual abuse.

The JIRT Policy and Procedures Manual and DoCS procedures state that the referral criteria for sexual abuse reports includes:

- *'disclosure and/or evidence of sexual assault', and*
- *'any reports of sexual abuse of a child under the age of 18 years where the alleged offender is over the age of criminal responsibility ie. 10 years.'*

[84] On receiving a report from the Helpline, a CSC may allocate the report to a caseworker for secondary assessment. Some reports may require assessment but cannot be allocated due to inadequate casework resources. These reports do not receive assessment and are 'unallocated' at the CSC.

[85] NSW Ombudsman (2005) *Report of reviewable deaths in 2004*. Page 63.

Case study

In one case, a reporter raised concerns that children in a household were at risk of sexual abuse. These concerns were linked to allegations made by a third party that the partner of the children's mother had previously sexually assaulted children. The reporter also stated that a family member had apparently raised concerns about the person inappropriately touching one of the children.

The Helpline noted the allegations were serious, and indicated high risk of harm for the child and her sibling. The report was referred to the CSC for response within 72 hours.

About a month later, the CSC sent a letter to the reporter advising that the report was currently unallocated and that this decision would be reviewed in one month. The letter stated the case was unallocated because there were no immediate safety concerns identified, that there were higher priorities at the CSC and that *'No disclosure from child, not enough information provided.'* The letter invited the reporter to contact the manager to discuss the matter. There was no indication that the CSC sought to either clarify information contained in the report or obtain further information, and the reporter made no further contact.

The report remained unallocated at the CSC and was closed without further assessment due to competing priorities just over a month later.

We raised concerns with DoCS that, in our view, the report met JIRT criteria and the Helpline should have referred the report to JIRT. Leaving aside the fact that the JIRT manual does not define 'disclosure', our view was that an allegation of sexual abuse was implicit in the reporter's statement that the man had been '*caught touching*' the child '*inappropriately*'.

DoCS, NSWPF and NSW Health have recently completed a review of JIRT. Among other significant changes to the structure and processes of JIRT, the review:

- Has established new physical abuse criteria. The criteria provide a greater clarity about the types of injuries that should be referred to JIRT.
- Has proposed changes to sexual abuse referral criteria, with less emphasis on disclosure as a basis for acceptance and investigation of the matter by JIRT.
- Proposes the capacity for provisional acceptance of cases to allow further information gathering by DoCS and NSW Health.

In its response to a draft copy of this report, DoCS advised that the review of JIRT aims to ensure that the revised criteria will better identify JIRT clients. Matters accepted for a JIRT response will be expected to require a *'high likelihood of criminality'*, but *'all JIRT referrals that are not accepted for a JIRT response, due to not meeting the criteria, will be referred to the relevant DoCS CSC'*. Information gathered by JIRT will be provided to the CSC.

'Information only' reports

Some reports may raise issues about cases that are open at a CSC and that DoCS has already been made aware of. For example, one incident may be reported by a number of different people, and ongoing issues in a family may already be the subject of assessment by a CSC. The Helpline may refer these reports to a CSC as 'information only', with the recommendation that the CSC assess the current information in conjunction with current open case plans that relate to similar concerns. Other reports may be closed at the Helpline if there are no open plans

at the CSC, and Helpline team leaders assess there are no risk issues or the concerns have been previously reported.

In some reviews, we found that:

- Reports sent as information only contained, at least in part, additional information that raised new concerns not previously identified to DoCS. This meant that new information was not subject to analysis by the CSC. At times however, CSCs did review, and subsequently act on, information only reports containing new concerns.
- Some reports considered information only were closed at the Helpline. In some of these cases, our reviews found the information provided by the reporter indicated a level of risk, and for some children, there was also a recent child protection history.

The role of the Helpline is critical in ensuring that a CSC is alerted where there is likelihood a child is at risk, and in providing essential information upon which a CSC can act. While acknowledging the volume of reports handled by the Helpline, there is an imperative to ensure that decisions are based on accurate information, as errors can have significant consequences.

Case study

We made preliminary inquiries of DoCS about the Helpline's response to a report for a child with a disability. The report related to concerns about whether the child was receiving necessary medical care. In assessing the report, the Helpline noted that the *'family whereabouts appears to be unknown'*. The report was closed at the Helpline. There was no attempt to contact or locate the family beyond a search of the DoCS database, which located no previous DoCS history.

In responding to our inquiries, DoCS advised us that this was in fact the second report about this child. The first report raised similar concerns about the parent's compliance with a medical regime necessary for the child's wellbeing, but the child's name had been incorrectly spelt when entered onto the database. Also, the entry did not include the child's address, which had been provided. This first report was transferred to the CSC with a recommendation for a response within 10 days, to be re-evaluated in case of further concerns.

Some weeks later, the CSC did some intake work on this report. Information was sought, and received, including the family's address. Following receipt of this information however, no further work was undertaken and the case was closed.

On consideration of the matter, DoCS confirmed that the data entry for the first report did not meet the Helpline's accuracy standards. DoCS acknowledged that the report should have received a higher priority than the recommended 10 day response.

In regard to the second report and the issues we raised, because of errors in recording the first report, the child's history was not identified. DoCS noted that had the Helpline linked the second report to the first, it is likely that it would have been assigned a higher response rating. DoCS advised that a standard type of search, a 'wildcard' search, using the child's birth date and the first letter in their name, would have accurately linked the reports.[86]

[86] Department of Community Services response to s.43(3) report, dated 19 June 2006.

History checks

Our previous work has consistently highlighted the need for an accurate and comprehensive analysis of child protection history in the Helpline's assessment of risk. The adequacy of history checks can have a direct impact on a caseworker's judgements about the level of risk to a child, and can subsequently determine whether and how the CSC is alerted to the risks. Our reviews of deaths in 2006 identified some ongoing issues in this regard.

- We found at times that history checks did not sufficiently capture relevant family background, including long-term parental substance abuse, or mental health issues. Sometimes history checks did not establish significant links to previous incidents or relationships, including where children of a previous relationship had been removed. Where history gathering was not sufficient, we saw significant barriers to holistic assessment of a reported incident or concern.
- Errors in an assessment of a report were sometimes carried over either wholly or in part, resulting in assessments for subsequent reports replicating an inaccurate child protection history. Decisions were therefore based on information that was either not relevant, or did not reflect the full reality of the child's circumstances.
- Multiple reports at times appeared to be assessed on an incident basis, although our review of records indicated escalating risk.

Case study

A child died in circumstances of inadequate supervision. Fifteen risk of harm reports had been made to DoCS about children in the family in the last year of the child's life. While initial assessments noted complex family issues, three of the reports were closed at the Helpline with 'no response required', and most other reports were transferred to the CSC with a recommended response time of 10 days. The reports remained unassessed until after the child's death.

Previous removal of siblings

Our reviews found that the parents of 16 children who died in 2006 had previously had children removed from their care, either temporarily or permanently. In most cases, removal of the sibling(s) had occurred in recent years. In six of these cases, parental responsibility for the siblings had been allocated to the Minister until the children reached adulthood.[87]

Seven of the 16 children died as a result of abuse or neglect, or in suspicious circumstances. In a number of these cases, information provided to DoCS in risk of harm reports mirrored the concerns that led to the previous removal of siblings, and we identified concerns about the degree to which the history of previous reports was adequately considered in DoCS' response to risk of harm reports for the children. In four of the seven cases, we identified that reports had been closed without further assessment, and in two cases we raised concerns about this action with DoCS.

[87] In four cases, the deceased child's sibling had previously been removed from their parent's care, and subsequently restored. In two cases, the children remained in the care of extended family members, in one case, the deceased child and siblings had been restored to their parent's care, and in one case, the deceased child was in the care of the Minister, while the siblings remained in their parent's care.

In our report of reviewable deaths in 2004, we identified three children who died whose siblings had been removed from the family and had not been restored prior to the child's death. We recommended that DoCS 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.

In 2006, DoCS advised us that it had added the previous removal of a sibling to criteria set out in the department's *intake assessment guidelines*.[88] This would give priority to reports for SAS1. We noted this was a minimal response in these cases.[89] As noted above, *intake assessment guidelines* are still under consideration. Secondary assessment procedure also includes reference to previous removal of a sibling as a factor that may signal high risk.

In late 2006, the NSW government introduced changes to the *Children and Young Persons (Care and Protection) Act 1998* (s.106A) in relation to previous removal of siblings. For matters that are taken to court by DoCS, the change allows the Children's Court to admit evidence that the person subject to a care application had a child previously removed from them by an order of the Court, and the child has not been restored. This evidence is deemed to provide prima facie evidence that the child who is subject to a care application is in need of care and protection.

While noting these recent changes, our reviews of children who died in 2006 again raise concerns about the effectiveness of responses to children living in families with a significant history of carers causing harm, or risk, to children.

Reports referred to early intervention

DoCS early intervention program — Brighter Futures — is an initiative to provide early assistance to vulnerable families, with the aim of improving family functioning and preventing children entering or becoming entrenched in the child protection system. It is a voluntary program that targets families who have children eight years or younger, or are expecting a child, and where certain vulnerabilities are present, including low-level domestic violence, drug and alcohol issues and parental mental health concerns. The program provides a range of services through DoCS and non-government agencies, such as child care, parenting programs and home visiting.

Risk of harm reports received at the Helpline that do not require an immediate response and where there is low or medium risk, can be streamed to early intervention teams based in DoCS CSCs. A family can choose at the outset not to take part in the program. According to the Brighter Futures caseworker manual,

> *If the family decline to participate in the Brighter Futures program, the [early intervention] caseworker should consider whether the child/ren in the family are at increased risk of harm. The additional information gained during the suitability assessment, including the family's reason for declining to participate, will inform this decision. However, a decision not to participate is not a sufficient reason to make a Risk of Harm report.*[90]

In our reviews of deaths in 2006, we identified three cases where the family had been referred to an early intervention team at some point. Two of the referrals were appropriate to the circumstances, although in both, the parents refused to participate in the program. In both

[88] Department of Community Services progress report on implementation of recommendations from the *Report of reviewable deaths in 2004*. Dated 27 July 2006.

[89] NSW Ombudsman (2006) Report of reviewable deaths in 2005. Page 45.

[90] Department of Community Services *Brighter Futures Caseworker Manual Abridged Version*, April 2007. Page 32.

cases, the parents' refusal did not result in further consideration of a child protection response and reports were subsequently closed for these two children. One of the children died in circumstances of abuse and the other in suspicious circumstances.

In reviewing the third case in which a report was referred to Brighter Futures, we identified issues about the management of reports where they do not meet the criteria for early intervention on the basis that risk is too high. In this case, DoCS Early Intervention Team sought additional information about the family from police prior to accepting a referral. Police indicated that the children's father was wanted by police in relation to domestic violence and had a current AVO and a history of AVOs against him. The referral to early intervention was appropriately rejected. However, the child protection team then closed the case under current competing priorities. This child's death was a result of abuse.

While there are procedures to refer cases back to child protection should a case be assessed as unsuitable for early intervention due to high risk, there is no requirement for these cases to be allocated for further secondary assessment by the child protection team. The Manager, Casework manages these matters in the same way as other child protection cases. We raised concerns with DoCS about this issue. In response to our concerns about the above case, DoCS advised us that their internal review of this case would be provided to the appropriate Directors responsible for Brighter Futures to consider this issue.[91]

Relevant developments at the Helpline

The Helpline has developed procedures for locating children at risk of harm, and for searching and recording child protection histories. Recruitment of additional team leaders has also reduced the supervision load of supervisors, providing for additional quality review.[92]

In March 2007, DoCS advised us that the Helpline had conducted a quality review of how effectively caseworkers were conducting person searches on KiDS. The Helpline has also planned a series of '*rolling quality reviews*' in 2007, with topics ranging from how changes in addresses or relationships are being updated, to how Helpline caseworkers are recording their analysis of reported concerns.[93]

DoCS has also previously advised us that, as part of an *Assessment Pathways Major Project*, the department would undertake research into the profile of reports and the relationship between reports coming in and reports referred to CSCs for further investigation. DoCS noted that this work would be needed prior to considering any changes to improve assessment tools.[94]

Competing priorities

When a case plan is received by a CSC, the CSC makes a further decision about whether the matter will be allocated to a caseworker for comprehensive, or stage 2 secondary assessment (SAS 2).

One of the predominant and ongoing issues identified in our reviews of child deaths is the number of reports closed due to current competing priorities once they reach a CSC. As we have noted previously, this includes high-

91 Department of Community Services response to s.43 (3) report, dated January 2007.

92 Department of Community Services response to preliminary inquiry. Dated 20 June 2006.

93 Department of Community Services progress report on implementation of recommendations from the *Report of reviewable deaths in 2005*. Dated 31 July 2007.

94 Department of Community Services progress report on implementation of recommendations of the *Report of reviewable deaths in 2004*. Dated 27 July 2006.

risk cases that are unable to be allocated to a caseworker due to the relative urgency of other cases.[95]

DoCS has consistently advised us that it is not possible to identify a risk threshold beyond which a case can be closed. The department has indicated that improved outcomes — that is, more reports being allocated and fully assessed — will flow from the roll-out of additional funds and caseworkers through the DoCS reform process. As we noted above, DoCS has also continued work on developing *intake assessment guidelines*, to assist caseworkers and managers in prioritising cases that should be subject to secondary assessment.[96] We understand the guidelines have been finalised, but are subject to further discussion with the Public Service Association prior to being implemented.

Cases closed without comprehensive assessment in 2006

In some cases reports are referred to a CSC by the Helpline for further assessment but do not receive this assessment. This is predominantly because of 'current competing priorities'. This term acknowledges that CSCs do not have the resources to respond to all reports transferred by the Helpline, and must therefore prioritise the most urgent cases.

Closure of cases due to current competing priorities remained a critical issue identified through our reviews of child deaths in 2006.

We identified five children for whom the issues that had previously been reported to DoCS were directly relevant to the circumstances of their death. In these five cases, the report was received within six months prior to their death. In two of these cases, that report was unallocated and closed without further assessment under current competing priorities.

Around two-thirds of our investigations of, and reports to, DoCS included significant concerns about CSCs not undertaking comprehensive assessment of children at risk. Our concerns focused on:

- Reports raising serious and immediate concerns being closed without comprehensive assessment, and
- multiple reports and concerns about families, often involving neglect, being given a low priority and ultimately being closed without comprehensive assessment of cumulative risk.

We note that DoCS' revised secondary assessment procedure notes a range of factors that may signal high risk and relative priority for SAS 2. Factors noted include:

- A report of serious injury, and
- a pattern of multiple reports for a child under five years closed following initial assessment that may suggest chronic neglect.[97]

CSC resources

In responses to our inquiries and investigations, and in the department's own internal reviews, DoCS has consistently cited resource issues as the basis for the inability of CSCs to respond effectively to reports requiring comprehensive assessment. Generally, resource issues appear to fall into four broad categories:

- Difficulties in filling staff vacancies, particularly in regional areas.
- Difficulties in managing caseloads where there are staff absences, including sick leave and internal training.

[95] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths*. Pages 23 – 25.

[96] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths*. Pages 23 – 25.

[97] Department of Community Services (2006) Secondary assessment – risk of harm. DoCS business Help procedures.

- Staff shortages and high turnover of staff in temporary positions resulting in inadequate supervision for casework staff.
- New and inexperienced staff, or staff not being trained in particular areas or issues, including staff not having completed caseworker development course training.

As noted above, DoCS is in the latter stages of implementing a $1.2 billion reform package. In total, the reforms will result in an increase of over 1,000 caseworkers since 2002 in key areas of child protection, early intervention and out-of-home care.[98] Enhancements have been rolled-out by CSC, with many now being 'Enhanced Service Delivery Sites'. In response to a draft copy of this report, DoCS noted that the enhancement funding was based on 2001-02 levels of demand, and that risk of harm reports to the department have increased by almost 80 per cent since that time. DoCS also noted however, that despite this increase, its capacity to allocate cases is 'significantly higher' than it was in 2001-02.

DoCS is engaging with the Premier's Department and other agencies on a whole-of-government approach to rural and remote incentive programs. DoCS has advised us that the department has put in place a range of strategies to address staffing issues in regional areas, particularly the Western Region, including:

- Offering short term secondment programs with full travel compensation to encourage staff in metropolitan areas to work in regional areas.
- Rolling caseworker recruitment using assessment centres.
- Relocating more experienced staff throughout the Western region as required to balance the mix of experienced and inexperienced staff. [99]

DoCS has previously advised that where additional resources have been provided, there has been a significant increase in the proportion of reports allocated for further assessment, and data provided supports this.[100] Increased resources should increase capacity and enable reports, particularly those of a high priority, to be assessed to the appropriate level. However, the number of reports *allocated* at a CSC will not always be commensurate with the number of reports that are subsequently subject to SAS 2. Reports can be unallocated or closed by a CSC prior to secondary assessment commencing.

Case study

In one case we are investigating, a family had been the subject of two previous risk of harm reports concerning inappropriate parenting with a newborn baby, possible maternal drug use, and domestic violence. One report received stage 1 secondary assessment.

Three years later, a report was received by the CSC about another newborn baby in the family. The reporter raised concerns that the mother had had no ante-natal care and was presenting as anxious, agitated and not coping. The reporter noted the mother's history of poor parenting skills and possible drug use. In an update, the reporter informed the CSC that the mother was requesting discharge against medical advice. A further report was made that the family's house was unhygienic, matted with dirt and smelly. The baby's toddler sibling had been dressed in a 'filthy' t-shirt and according to the mother, "looks after himself'. We found no evidence of any casework in response to these reports.

At the time of the reports, the CSC was an enhanced service delivery site.

[98] Department of Community Services (2007) NSW State Budget 2007/08

[99] DoCS response to investigation final report dated 23 March 2007

[100] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths*. Page 25

Data on cases closed due to competing priorities

It is critical that DoCS' capacity to respond to children reported to be at risk of harm is able to be closely monitored.

At the time of writing, DoCS had not released an annual statistical report for 2005–06. The previous report released in May 2006 relates to data for the 2004/05 period.

Last year, we raised concerns about limitations with DoCS' data.[101] DoCS' published data includes information on the number of reports referred to a CSC for secondary assessment that either:

- Had a secondary assessment stage 1 or stage 2 concluded, or
- were subject to ongoing secondary assessment or investigation.

However, for almost half of the reports referred to CSCs for further assessment (47.1%), the data identified only that '*no secondary assessment outcome recorded*'. DoCS did not identify the outcome of these reports, including whether or to what degree these reports were subject to assessment.[102] Further, DoCS also told us that there are no fields in the client database that allow recording of reasons for case closure.

Through our recommendations, we asked DoCS whether it intended to collect this type of data, and increase its capacity to report more fully on cases referred to CSCs for further assessment.

DoCS did not respond directly to these specific queries, but told us that work in quality reviews of CSCs will include review of case closure decision making. DoCS also noted the initiation of a '*major project to reform the child protection program*', and that '*improving and increasing DoCS' capacity to report and analyse data through KiDS will be part of the process*'.[103]

Closure of reports due to competing priorities must be considered a critical benchmark of system capacity. A comprehensive picture of capacity would require the ability to report on the number and proportion of reports in which assessments and inquiries are unable to be commenced or completed due to resource constraints and competing priorities.

In response to a draft copy of this report, DoCS told us that it has been working with the NSW Treasury on key performance indicators, and an indicator to measure allocation capacity is under development as part of that process.

DoCS told us that it is '*desirable to measure reports assessed as warranting further investigation, whether these reports were investigated and, where not investigated, whether the reason was current competing priorities*', and that technical work and modifications to the KiDS system would be undertaken as part of the Child Protection Major Project to develop a valid set of indicators.

DoCS was not supportive of measures proposed by us that linked directly to the outcomes of stage 2 secondary assessments, as these '*are process steps that occur only if the individual case warrants their occurrence*'.

The development of indicators to measure allocation capacity is positive. However, it is also important to have an understanding of overall outcomes of comprehensive secondary assessment. DoCS policy on secondary assessment states a general principle that once SAS 2 is commenced, it should be completed. SAS 2 allows for decisions, and approval of decisions, about whether a child is in need of care and protection and if so, the basis for a case plan to provide that protection.[104]

[101] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths*. Page 25.

[102] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2: Child deaths*. Page 25.

[103] Department of Community Services progress report on implementation of recommendations from the *Report of reviewable deaths in 2005*. Dated 31 July 2007.

[104] Department of Community Services *Secondary assessment — risk of harm procedure*, Business Help.

Stage 1 secondary assessment: Issues identified through our reviews

Since we commenced our reviews of child deaths in 2002, we have noted a general increase in the number of matters coming to our attention that have been subject to some secondary assessment, mainly the first stage of this assessment. For 45 of the 86 children who died in 2006 and for whom a report was made in the 12 months prior to their death, at least one report was the subject of a completed SAS1.

As noted above, SAS1 is limited in scope, and is primarily focused on determining whether more comprehensive assessment is warranted. Our reviews of the records of children who died in 2006 and their families found that in many cases, SAS1 resulted in an effective analysis of risk and safety and an adequate basis for a decision on the need for further assessment. Nevertheless, in some cases, we noted:

- SAS1 was very limited in the information gathered, leading to a poorly informed decision not to proceed to comprehensive assessment.
- SAS 1 information gathering was adequate, but the information gained appeared not to inform decisions about case closure:

Case study

A report was made to DoCS about a child with a disability, raising concerns about parenting capacity, neglect and parental substance use. The family had been previously involved with DoCS. The SAS1 comprised two phone calls. One was to a community health service, and the call established the child had not been seen by the service for over two years. The other was to the Department of Ageing, Disability and Home Care, which advised they had closed the child's case a year earlier. While the manager casework recommended re-contacting the reporter, our review identified no further assessment activity until the case was unallocated and closed two months later. We note that the child in this case study was a half sibling of, and did not reside with, a child whose death was reviewable.

We also identified some cases where secondary assessment records appear to have been created for purposes other than assessment. This included '*data remediation purposes only*', that appear in the child's history as completed assessments, although there is no information to indicate assessment of risk. In other cases we saw SAS1 records that appear to have been created as a tool to close a case, without any apparent gathering or assessment of information. In one record, the only information documented in the record of assessment is '*CSC will not be responding due to workload and other cases having a higher priority*'.

DoCS procedure requires reports that have been subject to SAS1 to be either allocated for further assessment (SAS2) or be closed within 28 days.[105]

Intake assessment guidelines are intended to provide guidance to caseworkers about reports that should be prioritised for comprehensive assessment. As noted above, implementation of the guidelines is pending.

Stage 2 secondary assessment: Issues identified through our reviews

DoCS' policy notes that:

> *When a case proceeds to SAS2 this means that a decision has been made to initiate*

[105] Department of Community Services (2006) *Secondary assessment – risk of harm*. DoCS business Help procedures. Page 6.

> *face-to-face contact with the child, young person and the family to assess welfare and wellbeing and determine the need for protective action by DoCS.*[106]

Over the past four years, we have raised a range of issues about the quality of secondary assessments identified in our reviews. In the main, our concerns have related to the limited scope of secondary assessments, and whether assessments were comprehensive and adequately considered the range of factors in the child's life that resulted in harm or risk of harm. We also raised concerns about the number of assessments that were not completed.[107]

Our review of the records of children who died in 2006 identified that a SAS2 had commenced for a quarter (26) of the 86 children who were reported to DoCS in the 12 months prior to their deaths. Five of these children had been the subject of more than one SAS2. For 21 of the 26 children, the SAS2 was finalised to the point of judgements and decisions. In 10 cases, risk of harm was substantiated.

Quality of secondary assessment

Effective risk assessment has been summarised as requiring:

> *Workers gaining a holistic, ecological and empirically based assessment of the family. This includes an understanding of the conditions that brought the family into the child protection system, each individual family member's history, the systems of which the family is a part, and the strengths and resources the family already possesses.*[108]

In our reviews of deaths in 2006, we identified some cases that showed a timely and comprehensive approach to risk assessment. While the baby in the following case died prior to discharge from hospital, the assessment conducted by DoCS and the department's plans for interagency coordination provided the basis for an effective casework response:

Case study

A NSW Health facility made a risk of harm report to DoCS raising concerns about a new-born baby. The report indicated that the baby had been born very prematurely, the mother had used heroin during the pregnancy and had received no ante-natal care. DoCS commenced secondary assessment activities the following day.

Information gathering was broad, and included requests for information under s. 248 of the *Children and Young Persons (Care and Protection) Act 1998* from three agencies that had had contact with the mother. The SAS2 comprehensively analysed all gathered information and identified a range of risk factors, including the mother's drug use and criminal history, lack of preparation for the baby, the baby's extensive medical needs and environmental factors, such as the illness of a family member, that could contribute to risk.

DoCS continued to liaise with various agencies involved with the mother and organised for the mother to undergo regular urinalysis. As part of the assessment, there were plans for a Protection Planning Meeting with all relevant agencies to coordinate support, and plans for home visits by DoCS and referrals to relevant support agencies.

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[106] Department of Community Services (2006) *Secondary assessment – risk of harm*. DoCS Business Help procedures.

[107] NSW Ombudsman (2006) *Report of reviewable deaths in 2005*, page 26; and (2005) *Report of reviewable deaths in 2004*, page 75.

[108] Department of Community Services (2006) *Risk assessment in child welfare*. Centre for Parenting and Research. September 2006. Referring to Cash, SJ (2001) Risk assessment in child welfare: the art and science.

While some of our reviews in 2006 identified good practice in secondary assessment, we continued to identify cases that raised concerns about the scope and nature of assessment. We found that:

- SAS2 was sometimes limited in scope, and it did not appear that adequate information was gathered to inform the assessment. This included a lack of communication with other agencies that were working with families, or had previously worked with them.
- In some cases, assessment appeared to be incident-focused, with inadequate consideration of factors beyond the immediate concerns facing the child and their family. Sometimes, analysis of risk did not take account of all the relevant information available about the child and their family.
- In some reviews we found that the practice of assessing a number of different reports together did not ensure that all the issues of concern were considered effectively. When a report is open at a CSC, subsequent reports are frequently 'merged' together, to allow full consideration of all concerns raised about the safety and wellbeing of a child. But sometimes assessment of these merged reports focused on one concern — such as whether an incident of alleged neglect occurred — rather than on other underlying issues, such as parental substance abuse or inappropriate parenting.

Understanding of risk factors

One of the issues we raised last year was the need for caseworkers to have a good understanding of the factors that are likely to be the cause of harm. Last year, this was raised particularly in relation to parental substance abuse. For children who died in 2006, we saw examples where there did not appear to be a good understanding of, or adequate guidance to caseworkers about, the factors leading to risk.

Case study

DoCS received numerous reports over several years about the mother's mental health, including anxiety, depression and possible psychotic episodes. Reports were also received that the mother was using drugs, refusing to seek treatment for her mental health problems, and was having difficulties coping with the care of her children.

DoCS commenced a secondary assessment, and worked to help the mother link in with early childhood services. The secondary assessment substantiated risk of harm for the child, but did not identify a need for care and protection as long as the mother monitored the child and engaged with services.

The case remained open to enable monitoring of the family, and a case meeting was held at which it was noted that the mother, who did not attend the meeting, was not engaging with services.

DoCS continued to receive reports concerning the mother's mental health and substance use. While DoCS remained involved and casework was undertaken, the records we reviewed provided no evidence that the impact of the mother's mental health issues on her capacity to parent were at any point comprehensively assessed.

Relevant developments in secondary assessment

DoCS' primary initiative to ensure quality in delivery of services involves the implementation of quality reviews of all CSCs over four years, commencing in November 2007. The reviews will focus on CSC performance in a range of areas, including risk assessments and protective intervention. The reviews will lead to the development of quality improvement plans.

In 2006, DoCS revised its secondary assessment procedures and completed a policy on neglect. These have been implemented through 'practice solutions sessions' for DoCS staff in all regions across the state, which are continuing.

A drug and alcohol expertise unit has also been established within DoCS to provide direct advice to staff, and develop resources to assist staff improve practice in regard to families affected by drug and alcohol issues. Alcohol and other drug training has also been delivered to all CSCs.

5.3 Protecting children at risk of harm

DoCS is the lead agency in child protection, and management of child protection cases is the primary responsibility of the department.[109] According to the interagency guidelines:

> *Case management in child protection is the process of assessment, planning, implementation, monitoring and review that aims to strengthen families and decrease risks to children and young persons in order to optimise their outcomes through integrated and coordinated service delivery.*[110]

When a child is assessed as being in need of care and protection, a case plan is developed. DoCS' policy states that:

> *A case plan is an up-to-date record of the plan for DoCS action to address the needs of a child or young person identified through assessment. Case planning ensures that all parties are clear about the goals and objectives of DoCS involvement, the issues to be addressed and responsibilities of all parties for the tasks involved.*[111]

DoCS can also register a Care Plan with the Children's Court. This involves all parties, including parents or carers, developing an agreed plan and registering this plan with the Court.

In the process of assessing risk, DoCS can also put in train immediate protective strategies. These may range from organising money for food or accommodation for a homeless family, to removing the children from the family and placing them in emergency care.

For other agencies, the legislation now makes it clear that they should continue to provide services and respond to the needs of a child following the making of a mandatory risk of harm report.[112] Further, effective intervention relies on good interagency coordination and cooperation:

> *No single agency, service, program or professional discipline has the knowledge, skill or mandate for the entire spectrum of interventions to protect children from harm.*[113]

Our reviews in 2006 found that, in many cases, agencies responded with appropriate strategies to promote the safety and wellbeing of children at risk.

At times, however, we found less than optimum practice. In these cases, some of the issues we identified have been raised in our previous reports, and include inadequate responses by agencies to promote the safety of children, and lack of effective liaison and information exchange between agencies.[114]

In relation to DoCS' role as lead agency, we found that in some cases protective intervention did not fully address the range of risk factors present in a child's life, and at times, services were not effectively coordinated or monitored.

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[109] NSW government (2006) NSW Interagency guidelines for child protection intervention. Page 59.

[110] NSW government (2006) NSW Interagency guidelines for child protection intervention. Page 58.

[111] Department of Community Services *Case planning*. Business Help procedures.

[112] *Children and Young Persons (Care and Protection) Act 1998,* s.29A.

[113] NSW government (2006) NSW Interagency guidelines for child protection intervention. Page 6.

[114] For example, NSW Ombudsman (2006) *Report of reviewable deaths in 2005, volume 2: child deaths*. November 2006. Page 35.

Determining protective strategies

DoCS' policy is to promote a '*strengths-based, partnership approach*' to engaging families, and to take action that is least intrusive to the family while giving paramount importance to the safety and wellbeing of the child.[115]

Protective strategies put in place for those children where harm or risk of harm was substantiated, and for those children who required some intervention in the immediate assessment period, were diverse, and included:

- Encouragement and support to parents to engage with services, such as drug rehabilitation.
- Entering into agreements or undertakings, both court-ordered and informal, with parents to gain their commitment to change the actions or circumstances presenting risks to their children.
- Referrals to, and/or coordination of, support services, such as home visits from early childhood nurses.
- Assistance with addressing immediate concerns, such as homelessness or insecure housing.
- Requiring parents to present their child for medical assessment.
- Requirements for parents to undergo drug testing.

Some children were removed from their family and placed in temporary care, and we identified that two cases were before the Children's Court at the time the child died.

These measures alone, or in combination, were often appropriate for the child and their family. In some cases however, protective measures did not address all of the risk factors, or did not address them effectively.

We found that where this was the case, it was often linked to inadequate risk assessment. Narrow, incident-based secondary assessment did not provide a sound basis to determine the best protective measures, and mostly resulted in strategies that addressed only some of the risk factors present. For instance, protective intervention might focus on locating accommodation for a homeless family, but not on the underlying issues that led to homelessness and child protection concerns.

Sometimes, assessments that did not effectively consider the history of a child and their family resulted in a decision that the child was facing no, or low, risk, and case plans that followed did not address entrenched and long-term issues such as neglect, parental mental health issues or parental substance abuse.

Case study

We investigated a matter arising from our review of the death of a baby. The baby's siblings had an extensive child protection history, largely related to their mother's poor parenting capacity, alcohol abuse and mental health problems. The siblings were placed in care prior to the baby's birth.

The baby was subject to a pre-natal report about lack of ante-natal care, and following the baby's birth and prior to discharge from hospital, another three reports. These reports raised concerns about the mother not adequately caring for the baby, lack of bonding with the baby, and lack of preparation for the baby's discharge from hospital.

[115] Department of Community Services *Engaging families*. Business Help procedures.

DoCS undertook a secondary assessment and liaised with key services by teleconference. An outcome of this meeting was that the department would monitor and liaise with health and support services that would be put in place for the family.

The assessment concluded that risk of harm to the baby was low, because support services were in place and DoCS would monitor services' involvement with the family.

The assessment, and the case plan, did not consider in any detail how the mother's mental health and history of alcohol abuse and child neglect, which resulted in the removal of her other children, would affect her capacity to parent the new baby. In particular, the assessment did not appear to consider that the provision of support services had previously failed to address these risk factors.

It was agreed that case meetings between all agencies would be held regularly to monitor the family's progress.

Shortly after the initial meeting, however, the allocated DoCS caseworker left the CSC, and the case was not reallocated due to staff shortages and competing priorities.

The services organised to support the family were subsequently provided to a lesser degree than planned, with one service ceasing visiting due to the mother refusing them entry. Case files indicated very limited active monitoring by DoCS, and no further case meetings occurred.

Some children we reviewed had a lengthy DoCS history, including a number of completed assessments and case plans. However, it did not appear that intervention significantly improved the child's long-term safety and wellbeing where these underlying concerns remained unaddressed.

We also found that decisions about protective measures did not always take into account all relevant information. In some cases, our reviews found that the strategies put in place by DoCS, particularly in response to immediate crises, exposed children to possible other risks.

This concern was apparent in a number of cases where the child was removed and placed with a carer, without proper assessment of the suitability of the carer. In two cases children were left or placed with their fathers following crises involving their mothers, despite the department having previous concerns about the fathers' parenting capacity**.** We also identified concerns where children were restored to their parents without clear evidence that the risk factors within the family had been resolved.

Case study

In one case we investigated, a child was removed from their parents and placed in temporary care, due to risks presented by domestic violence, homelessness, substance abuse and poor parenting capacity. After some months, the child was restored to the parents following DoCS advice to the Children's Court that the family had demonstrated significant changes in the circumstances that had led to the child's removal, and that the parents would continue counselling and had agreed to random drug testing. However, our review found there was inadequate assessment or verification of these changes. Records indicate the parents disengaged with support services following restoration of the child and closure of the case by DoCS.

Decisions about protection that did not appear to reflect history were also apparent in relation to measures that relied on parents engaging with required services, or actively refraining from certain behaviour, particularly in cases where parents had previously failed to demonstrate a capacity to change. In a number of cases, case plans included expectations that parents would take up certain services, even where previous experience did not support the likelihood that their involvement would be sustained. Similarly, some reviews identified unrealistic commitments made by parents and accepted by caseworkers, for example, commitments not to expose children to domestic violence, where there was a significant history of violence.

Undertakings

We have previously identified concerns with the use of undertakings, or informal agreements with parents, as a protective measure. DoCS has told us that it does not support the use of informal undertakings, and is revising case planning procedures, which will *'iterate that undertakings are not a casework option unless they form part of an order accepting undertakings'* (under section 73 of the *Children and Young Persons (Care and Protection) Act 1998)*. The recent amendments to the Act relating to Parent Responsibility Contracts also provides for monitored agreements with parents.[116]

A critical component of agreements with parents is the monitoring of compliance, and clarity about DoCS' response when agreements are not upheld. While DoCS has noted that its procedures include specific guidance on monitoring and review arrangements, our reviews continue to raise questions about the adequacy of monitoring of undertakings and case plans.

Coordination and monitoring of protective strategies

Agencies involved with a child at risk of harm or in need of protection generally provide services or supports that can promote the safety of the child and/or assist their family. NSW Health, for example, has early childhood nurses able to visit new babies in their homes and drugs-in-pregnancy services, along with a range of counselling services for children. Police can take out AVOs on behalf of children where there are concerns about the potential for harm, particularly in families affected by domestic violence, and NSWPF has also developed some specific strategies for diverting young people at risk of harm and at risk of offending. School counsellors can provide an initial avenue for support and assistance for children who are identified at risk in schools.

There are also a number of case coordination pilot projects across the state. As noted earlier, as part of the NSW government Anti Social Behaviour Pilot Strategy, an anti social case coordination framework is being rolled out in a number of areas across the state.[117] The framework provides for government agencies to coordinate responses and promote integrated case planning for high risk children and young people and their families.

When well-coordinated and monitored, the range of services available can provide significant assistance to children at risk and vulnerable families.

In some of the matters we reviewed, we did not find an adequate level of coordination or monitoring. Key issues we identified concern clarity of agency involvement and poor implementation of case plans.

[116] Section 38A. A Parent Responsibility Contract 'is an agreement between the Director-General and one or more primary care-givers for a child or young person that contains provisions aimed at improving the parenting skills of the primary care-givers and encouraging them to accept greater responsibility for the child or young person'.

[117] Department of Community Services progress report on implementation of recommendations of the Report of reviewable deaths in 2004. Dated 27 March 2006.

Clarity of agency involvement

At times, we saw that agencies operated on incorrect information about the level of involvement of DoCS, and assumed that DoCS was involved when this was not the case. Having a clear understanding of the level of involvement of other agencies, particularly DoCS, is essential in order for agencies to make informed decisions about their appropriate role with the family.

Discharge planning and follow-up of new-born babies

Our reviews highlighted the importance of agencies being clear about the level of involvement of other services in a case, and well-coordinated planning where babies are born and child protection concerns are apparent.

We discussed this issue in some detail in our previous report, along with a need to improve responses to pre-natal reports to ensure a capacity to respond effectively once a child is born.[118]

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 *'documented, multidisciplinary protection planning meeting'* should be held prior to the baby's discharge from hospital.[119] 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. They also state there should be a continuum of care for pregnant women with a history of opioid use, and that this should occur from *'ante natal care through discharge and follow-up.'*[120]

In 2006, 22 children we reviewed were the subject of pre-natal reports, the majority of which (60%) concerned the mother's substance abuse.

In some reviews, we again identified a lack of effective planning around the discharge of babies from hospital who had been born to substance-using mothers. In some cases, we saw no evidence of planning meetings being held prior to the baby's discharge. We also found instances where there was ineffective liaison between NSW Health and DoCS, even where both agencies were aware of the other's involvement with the family.

A number of these issues are the subject of consideration within NSW Health and DoCS. NSW Health is conducting a review of drugs-in-pregnancy services that will consider compliance with relevant procedures, including the neonatal abstinence syndrome guidelines.[121] DoCS and NSW Health are working on the development of a system whereby health may alert DoCS to the birth of a baby for whom pre-natal reports have been made and risk is still apparent.[122] DoCS is also finalising a policy on responding to pre-natal reports.

Implementing case plans

Sometimes, our reviews noted that change in the status of cases or the progress of the family were not effectively communicated. This clearly has an effect on overall coordination of cases, particularly where there a number of agencies involved with the child and family.

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[118] NSW Ombudsman (2006) *Report of reviewable deaths in 2005: Volume 2, Child deaths*. Page 17.

[119] NSW Health (January 2005) *Protecting children and young people* policy directive. Page 7.

[120] NSW Health (2006) *Neonatal Abstinence Syndrome Guidelines*. Page 4.

[121] NSW Health progress report on the implementation of recommendations of the *Report of reviewable deaths in 2005*. Dated 26 July 2007.

[122] Department of Community Services progress report on the implementation of recommendations of the *Report of reviewable deaths in 2005*. Dated 31 July 2007.

Some of our reviews highlighted limited monitoring by DoCS, and at times, we found that DoCS did not deliver the services it had planned to provide. Our reviews also noted early closure of cases without monitoring the outcome of referrals to other agencies.

Case study

Twenty-three risk of harm reports were made in relation to a family in a two and-a-half year period. Reports primarily concerned the mother's mental health and substance abuse, and the impact this had on her capacity to parent her children. Prior to the birth of a new baby, a secondary assessment was completed and a case conference held.

DoCS made a number of referrals to support services, and risk was assessed as 'low' as the family were receiving support services. In the two months following the baby's birth, three reports were made to DoCS about the mother being intoxicated and depressed, and about an incident of domestic violence. A mental health worker also contacted DoCS to request a case conference due to the complexity of the family's needs. Our review of records indicated that DoCS did not respond to these events.

At times, where there was monitoring of case plans there was an inadequate response when strategies developed to protect the child were not being delivered as agreed, or when parents failed to meet their commitments.

We also saw some problems with the follow-up of cases where families moved to a different area, and the DoCS files were transferred to a different CSC. In a number of matters, our review raised questions about the level of involvement of DoCS following the case being transferred. In one of these cases, risk was substantiated for a family, including a new born baby. When the family moved, the CSC transferred the file and recommended the case plan remain open for three months and that fortnightly home visits be undertaken. Our review found that two months later, the matter was unallocated because of a lack of available casework hours and on the fact that no further reports had been received by the new CSC.

Current developments relevant to protective intervention: DoCS and NSW Health

In addition to the specific strategies referred to above, relating to pre-natal reports and new born babies at risk, DoCS' case planning Business Help topic is currently being reviewed and a best practice guide to case planning, monitoring and review was due for completion by August 2007.

DoCS is also working to implement new procedures associated with the recently legislated parent responsibility contracts. The department is also trialling a new parental drug testing policy, which is a tool to guide the use of drug testing in cases where serious and persistent drug use is a concern, and the department is considering removing the child from the family, or restoring the child following earlier removal.[123]

In November 2006, NSW Health released *Opioid treatment program- clinical guidelines for methadone and buprenorphine treatment*, which replaces earlier policies governing opioid treatment. The guidelines demonstrate a greater emphasis on the role of NSW Health staff, opioid treatment prescribers and dispensers in identifying, reporting and responding to possible risk of harm to children of patients in their care.

[123] Department of Community Services (2007) *Parental drug testing in cases of serious and persistent drug use where the child has already been removed or is at immediate risk of removal*

We have previously raised concerns about information exchange between agencies because of the number of cases we have reviewed that have demonstrated information was not always shared in an effective or timely way.[124] This issue is currently the subject of further consideration, through the review of the *Children and Young Persons (Care and Protection) Act 1998*.[125]

Apprehended Violence Orders

Apprehended Violence Orders (AVOs) may be made for the protection of a person or persons against another person and are intended to prevent or apprehend violent behaviour. Only police have powers to apply for an AVO for the protection of children under 16 years.

In our *Report of reviewable deaths in 2004* we raised questions about how effectively police were utilising their powers in regard to AVOs for 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 recommended that NSWPF review these issues. Consultations held by this office to inform a special report to Parliament — *Domestic Violence: Improving Police Practice* — identified similar concerns regarding AVOs in relation to children. Focus groups indicated that it is unusual for police to initiate separate AVOs for children, and consultations indicated that police officers appeared to mistakenly believe that children are automatically protected by AVOs taken out on behalf of their mother.[126]

NSWPF told us that it was difficult to identify the number of AVO applications made on behalf of children, but that a project underway - the AVO Legislation Amendment (ALA) project[127] — was aiming to develop and upgrade data collection and recording processes.

NSWPF told us that the issue of guidance to police dealing with children present at, or affected by, domestic violence would be considered during the review of the *Domestic Violence* and *Child Protection Standard Operating Procedures*.[128] *Domestic violence standard operating procedures* are scheduled for completion by December 2007, and the *Child protection policy and standard operating procedures* by March 2008.[129]

Changes to part 15A of the *Crimes Act* also expands relevant definitions relating to domestic violence, increases the focus on children involved in domestic violence and allows for greater scope in making an application for orders, particularly in relation to telephone interim orders.

In our reviews of deaths in 2006, we saw some examples of police officers seeking AVOs for a parent that included the child or children, and one example of a separate AVO application for a child. In some other cases, police applications for AVOs did not include the child or children, although our reviews indicated that it would have been be appropriate in the circumstances to do so.

For example, in one case, an AVO that was taken out to protect a mother from her former partner did not include her children, even though the

[124] NSW Ombudsman (2006) *Report of reviewable deaths in 2005, volume 2: child deaths*. Page 36; (2005) *Report of reviewable deaths in 2004*. Page 95. We also raised issues about section 248 requests for information in a submission to the review of the *Children and Young Persons (Care and Protection) Act 1998*. This, and other submissions, re available at http://www.community.nsw.gov.au/html/about/act_review.htm

[125] See http://www.community.nsw.gov.au/html/about/act_review.htm

[126] NSW Ombudsman (2006) *Domestic Violence: Improving Police Practice,* December 2006. Page 42.

[127] Previously known as the AVO Compliance with Legislation project.

[128] In 2005, NSW Police Force advised this office that they were reviewing standard operating procedures for child protection and domestic violence.

[129] NSW Police Force response to the recommendations of the *Report of reviewable deaths in 2005 Volume 2: Child Deaths*, dated March 2007.

children were often present during incidents of domestic violence and previous incidents included threats to kill, threats to harm an unborn child and threats to set fire to the house. Police had also previously identified that the children were at risk due to domestic violence.

Protective intervention for young people

Our review of the deaths of adolescents in 2006 indicated that only five of the 17 young people known to DoCS were the subject of a risk of harm report in the 12 months prior to their death. Of the seven reports made for these young people, one progressed to a stage 1 secondary assessment, and was then closed.

In 2006, five of the 17 adolescents whose deaths we reviewed committed suicide. A number of these young people were engaging in anti social or criminal behaviour. Some of these young people also had recent contact with the health system.

In many of the deaths of young people we have reviewed, we have identified a combination of risks involving a child protection history from childhood, mental health problems, and anti social and risk-taking behaviour. The link between abuse and neglect of children leading to anti social or criminal behaviour in adolescence is well documented.[130] Some studies have indicated the link is even more pronounced when abuse or neglect is experienced in adolescence.[131]

Case study

We reviewed the suicide death of a young person. In the two years prior to his death, the young person was reported to DoCS on more than 10 occasions. He had been diagnosed with a mild disability and some mental health problems, and records indicated a history of thoughts of self-harm and suicide. He also began engaging in risky behaviour and had no stable accommodation.

The young person was at times linked to mental health services and a number of reports to DoCS were allocated prior to being closed. Some of the reports indicated serious concerns, including one where the young person was threatening to jump to his death. Some reports were closed without further assessment at a CSC due to current competing priorities. Some were closed after DoCS provided immediate assistance, such as securing accommodation, or after the department identified that the young person was receiving current support from counsellors or health services.

In the year prior to his death, police records indicated seven instances where the young person, then 16, was found intoxicated and in a possibly drug affected state. On one of these occasions, he disclosed consuming large quantities of over-the-counter and illicit drugs, and inhaling gas and drinking alcohol on a regular basis. Health records document one incident where the young man was presented to a hospital in an incoherent state, with his clothes soaked in petrol. We found no evidence of these events being reported to DoCS.

[130] For example, Stewart A, et al (2002) Pathways from child maltreatment to juvenile offending. In Australian Institute of Criminology *Trends and issues in crime and criminal justice*. No 241, October 2002.

[131] As above, and also Smith C, Ireland T, Thornberry T (2005) Adolescent maltreatment and its impact on young adult antisocial behaviour. In *Child abuse and neglect* Vol 29, No 10. October 2005.

As we noted in section 3, agencies can face particular challenges in responding to adolescents who are at risk of harm. *The Children and Young Persons (Care and Protection) Act 1998* does not require mandatory reports for young people aged over 16 years. Young people may also decline intervention, and this was apparent in some of the cases we examined.

In section 3, we noted a number of initiatives in place or planned that are aimed at assisting young people at risk.

Our reviews highlight the importance of holistic responses to young people who are at risk and who have mental health issues and/or are engaging in risk taking behaviour.

We note that as part of the Anti Social Behaviour Pilot Strategy, the Anti Social Behaviour Case Coordination Framework is being rolled out in a number of areas across NSW. The framework focuses on *'..... partnerships to improve and coordinate supportive and preventative strategies to reduce the risks to, and anti social behaviours of, children and young people requiring multi agency intervention.'* DoCS advised us that the pilot project will be reviewed and evaluated by the project steering committee, which is chaired by the Premier's department.[132]

[132] Department of Community Services progress report on the implementation of recommendations of the *Report of reviewable deaths in 2005*. Dated 31 July 2007.

6. Causes of death 2003–2006

6.1 Introduction

In March 2007, we engaged the National Centre for Classification in Health (NCCH), based at Queensland University of Technology, to analyse underlying causes of death for the 496 children whose deaths had been reviewed by this office between 2003 and 2006.

For the period 1 January 2003 to 31 December 2006, there were 2,309 child deaths in NSW. Of these, 496 (21%) were reviewable.

We asked the NCCH to consider the information we held about causes of death, and data provided by the NSW Child Death Review Team for all child deaths in NSW over the same period.[133] We specifically sought:

- An analysis of causes of death and contributory causes of death for all reviewable child deaths.
- An analysis of the rates of different causes of death for children whose deaths were reviewable, compared to children whose deaths were not reviewable.
- A systematic literature review relating to risk factors that may contribute to these causes of death.

The main reason we sought the analysis was to gain a better understanding of the range of factors that may contribute to particular causes of death, in order for us to be aware of areas that may warrant detailed focus in the course of our reviews.

In this chapter we provide a summary of the NCCH's work.

In considering the information below, it is important to note that:

- the size of the group of children is relatively small for comparative purposes, and where groups comprise a very small number of cases, this should be interpreted with caution as very small fluctuations over time will significantly affect these results.
- because the definition of reviewable deaths includes all children who die as a result of abuse or neglect or in suspicious circumstances, comparison of reviewable and non-reviewable deaths can be complex. For example, children whose deaths are reviewable will clearly be at a much greater risk of deaths as a result of assault, by the nature of definition.

[133] The NSW Child Death Review Team is responsible for reviewing all child deaths in NSW. Under part 7A of the *Commission for Children and Young People Act 1998,* the Team maintains a register of all child deaths; classifies deaths according to cause, demographic criteria and other relevant factors; identifies patterns and trends relating to those deaths; and undertakes research focused on prevention or reduction of child deaths. The team does not undertake reviews of reviewable deaths, but may include a reviewable death in research.

6.2 Background

Number of children who died

Data on causes of death for all children who died in NSW between 2003 and 2006 was provided to us by the NSW Child Death Review Team. As some deaths were not coded, the NCCH was able to analyse data for 2263 children and young people who died.

Underlying cause of death

Nationally and internationally, morbidity and mortality data are coded and tabulated according to the International Statistical Classification of Diseases and Related Health Problems (ICD) system. The ICD is the international standard health classification published by World Health Organisation (WHO) for coding diseases for statistical aggregation and reporting purposes.

The underlying cause of death (UCOD) is used principally for tabulation of causes of death. The UCOD is defined by the WHO as:

> *(a) the disease or injury which initiated the train of events leading directly to death, or*
>
> *(b) the circumstances of the accident or violence which produced the fatal injury* (WHO, 2005).

Categories

The NCCH grouped causes of death based on particular sets of ICD-10 codes. These groups were:

- Natural causes.
- Sudden or unexpected causes, which are largely comprised of Sudden Infant Death Syndrome (SIDS) and sudden death, cause unknown.
- Unintentional unnatural causes, where there is an unintentional or unknown cause of injury, for example, accidents.
- Intentional unnatural causes, generally resulting from assault or intentional self-harm.

6.3 Demographic information: reviewable child deaths

Almost half (45%, 225 children) of all of the children who died and whose deaths were reviewable were aged less than 12 months.

For Indigenous children, the proportion of children who were very young was even greater, with 55% of reviewable Indigenous child deaths being aged less than 12 months.

Overall, the deaths of almost one in two Indigenous children (42%) were reviewable. In contrast, the deaths of one in five children (19%) who were not Indigenous were reviewable.

Table 13 and 14 provide further detail.

Table 13: Age and Gender of Reviewable Child Deaths 2003–2006

Reviewable: Age Groups	Male		Female		Total	
	n	%	n	%	n	%
0 days	20	7.19	17	7.8	37	7.46
1 day–<1mth	27	9.71	29	13.3	56	11.29
1mth–6mths	51	18.35	40	18.35	91	18.35
6mths–1yr	23	8.27	18	8.26	41	8.27
1–4yrs	54	19.42	49	22.48	103	20.77
5–9yrs	35	12.59	18	8.26	53	10.69
10–12yrs	18	6.47	10	4.59	28	5.65
13–17yrs	50	17.99	37	16.97	87	17.54
Total	**278**	**100.00**	**218**	**100.00**	**496.00**	**100.00**

Table 14: Age and Indigenous Status of Reviewable Child Deaths 2003–2006

Reviewable: Age Groups	Non-Indigenous		Indigenous		Total	
	n	%	n	%	n	%
0 days	26	6.62	11	10.68	37	7.46
1 day–<1mth	41	10.43	15	14.56	56	11.29
1mth–6mths	68	17.3	23	22.33	91	18.35
6mths–1yr	33	8.4	8	7.77	41	8.27
1–4yrs	82	20.87	21	20.39	103	20.77
5–9yrs	44	11.2	9	8.74	53	10.69
10–12yrs	26	6.62	2	1.94	28	5.65
13–17yrs	73	18.58	14	13.59	87	17.54
Total	**393**	**100.00**	**103**	**100.00**	**496**	**100.00**

6.4 Broad Underlying Causes of Death: reviewable child deaths

Table 15 describes the broad UCOD for children whose deaths were reviewable.

Over 40% of reviewable child deaths were due to natural causes, and 14% were due to intentional causes (assault or intentional self harm).

Tables 16 and 17 report these broad UCOD by gender, indigenous status and age groups.

Table 15: Broad UCOD of Reviewable Child Deaths 2003–2006

Broad causes of death	n	%
Natural causes of death	198	41.77
Sudden or unexpected causes of death	86	18.14
Unintentional causes of death	124	26.16
Intentional causes of death	66	13.92
Total	**474**	**100.00**

Gender

Comparing males and females, almost half of the deaths of females were due to natural causes, while for males, similar proportions of deaths were due to natural causes as due to unintentional causes.

Table 16: Broad UCOD of Reviewable Child Deaths 2003–2006 by Gender

Broad causes of death	Male		Female	
	n	%	n	%
Natural causes of death	99	37.08	99	47.83
Sudden or unexpected causes of death	47	17.6	39	18.84
Unintentional causes of death	82	30.71	42	20.29
Intentional causes of death	39	14.61	27	13.04
Total	**267**	**100.00**	**207**	**100.00**

Table 17: Broad UCOD of Reviewable Child Deaths 2003–2006 by Indigenous Status

Broad causes of death	Non-Indigenous		Indigenous	
	n	%	n	%
Natural causes of death	154	40.85	44	45.36
Sudden or unexpected causes of death	64	16.98	22	22.68
Unintentional causes of death	98	25.99	26	26.8
Intentional causes of death	61	16.18	5	5.15
Total	**377**	**100.00**	**97**	**100.00**

Indigenous status

A greater proportion of Indigenous children (23%) died as a result of sudden or unexpected causes than did non-indigenous children (17%).

In contrast, a greater proportion of children who were non-Indigenous (16%) died due to intentional causes (assault or intentional self-harm) than did non-Indigenous children (5%).

(See table 17, above).

Age

Different patterns of underlying causes of death are evident across age groups.

For example, most infants (76%) aged between one day and one month died of natural causes, while the majority of infants (58%) aged between 1 month and 6 months died as a result of sudden or unexpected causes.

(See table 18, below).

(See table 19, over page).

For most age groups over one year of age, the major causes of death were largely unintentional causes, followed by intentional causes of death.

Table 18: Broad UCOD of Reviewable Child Deaths 2003–2006 by Age Group for Under 1 year olds

Broad causes of death	0 days		1 day–1 mth		1mth–6mths		6mths–1yr	
	n	%	n	%	n	%	n	%
Natural causes of death	32	100	41	75.93	23	26.74	16	41.03
Sudden or unexpected causes	0	0	11	20.37	50	58.14	10	25.64
Unintentional causes of death	0	0	2	3.7	8	9.3	6	15.38
Intentional causes of death	0	0	0	0	5	5.81	7	17.95
Total	**32**	**100.00**	**54**	**100.00**	**86**	**100.00**	**39**	**100.00**

Table 19: Broad UCOD of Reviewable Child Deaths 2003–2006 by Age Group for Children Aged 1–17

Broad causes of death	1–4yrs		5–9yrs		10–12yrs		13–17yrs	
	n	%	n	%	n	%	n	%
Natural causes of death	31	31	20	38.46	14	50	21	25.3
Sudden or unexpected causes	7	7	2	3.85	0	0	6	7.23
Unintentional causes of death	46	46	24	46.15	7	25	31	37.35
Intentional causes of death	16	16	6	11.54	7	25	25	30.12
Total	**100**	**100**	**52**	**100.00**	**28**	**100**	**83**	**100.00**

6.5 Specific underlying cause of death by reviewable status

The following table describes key differences between the most common specific underlying causes of death for children whose deaths were reviewable and those who were not.

Table 20: Most common specific underlying causes of death

Reviewable deaths (n = 496)	Non-reviewable deaths (n = 1831)
Transport accidents (10%)	Disorders related to length of gestation and fetal growth (19%)
Assault (9%)	Transport accidents (10%)
Sudden death, cause unknown (9%)	Fetus and newborn affected by maternal factors and complications (10%)

6.6 Comparison of key natural causes of death

Children whose deaths were reviewable were more likely to die from certain natural causes of death than children whose deaths were not reviewable.[134]

When examining natural causes of death only, children whose deaths are reviewable are:

- 4.40 times (1.43-13.59) more likely than non-reviewable children to die as a result of Meningococcal Disease.
- 4.02 times (1.75-9.23) more likely than non-reviewable children to die as a result of Epilepsy.
- 2.86 times (1.64-4.96) more likely than non-reviewable children to die as a result of Pneumonia.

[134] These identified causes included adequate numbers > 5 per cell for some degree of confidence in the odds ratio estimates.

The following tables provide further detail.

Table 21: A39 Meningococcal Disease

	Non-Reviewable (n=8)	Reviewable (n=5)
Specific UCOD	A39.2 Acute Meningococcaemia (5)	A39.2 Acute Meningococcaemia (All)
	A39.0 Meningococcal meningitis (3)	
	A39.9 Meningococcaemia, Unspec (1)	
Contributory Causes	No contributory causes reported (8)	No contributory causes reported (4)
Gender	Male (4)	Male (5)
	Females (4)	Females (0)
Age	< 1 year old (5)	All cases < 1 year old
	> 1year old (3)	
Indigenous	Indigenous (2)	Indigenous (3)
	Non-indigenous (6)	Non-indigenous (2)

Table 22: G40 Epilepsy

	Non-Reviewable (n=16)	Reviewable (n=9)
Contributory Causes	G80–G83 Cerebral Palsy & Paralytic Synd (2)	G80-G83 Cerebral Palsy & Paralytic Synd (3)
	Q00–Q99 Congenital malformation (3)	Q00-Q99 Congenital malformation (3)
	T75.1 Drowning nonfatal submersion (1)	T75.1 Drowning nonfatal submersion (2)
	T71 Asphyxiation or R09.0 Asphyxia (3)	T71 Asphyxiation or R09.0 Asphyxia (2)
Gender	Male (13)	Male (3)
	Females (3)	Females (6)
Age	1–9 years old (7)	1–9 years old (4)
	10–17 years old (9)	10–17 years old (5)
Indigenous	Non-indigenous(All)	Indigenous (3)
		Non-indigenous (6)

Table 23: J12–J18 Pneumonia

	Non-Reviewable (n=49)	Reviewable (n=19)
Contributory Causes	Q00-Q99 Congenital malformations (23)	Q00-Q99 Congenital malformations (5)
	Other Diseases of Nervous System (15)	Other Diseases of Nervous System (5)
	Other Respiratory System Diseases (12)	Other Respiratory System Diseases (4)
	G40 Epilepsy (10)	G40 Epilepsy (2)
	A40-A41 Septicaemia (3)	Septicaemia (2)
Gender	Male (27)	Male (13)
	Females (22)	Females (6)
Age	< 1 year old (13)	< 1 year old (5)
	1–9 years old (24)	1–9 years old (9)
	10–17 years old (12)	10–17 years old (5)
Indigenous	Indigenous (8)	Indigenous (6)
	Non-indigenous (41)	Non-indigenous (13)

6.7 Comparison of key unnatural/unknown causes of death

When examining unnatural causes of death only, and excluding assault[135], children whose deaths are reviewable children are:

- 7.77 times (0.9-66.85) more likely than children whose deaths are not reviewable to die as a result of Accidental Poisoning.
- 5.47 times (2.00-15.02) more likely than children whose deaths are not reviewable to die as a result of Accidental Exposure to Smoke, Fire or Flames.
- 2.60 times (1.57-4.29) more likely than children whose deaths are not reviewable to die as a result of Other Sudden Death, Cause Unknown.
- 2.07 times (1.21-3.54) more likely than children whose deaths are not reviewable to die as a result of Accidental Drowning and Submersion.

The following tables provide further detail.

Table 24: R96.1 Other Sudden Death, Cause Unknown

	Non-Reviewable (n=28)	Reviewable (n=43)
Contributory Causes	No contributory causes reported (26)	No contributory causes reported (42)
Gender	Male (15)	Male (21)
	Females (13)	Females (22)
Age	< 1 year old (17)	< 1 year old (34)
	> 1 year old (11)	> 1year old (9)
Indigenous	Indigenous (3)	Indigenous (10)
	Non-indigenous (25)	Non-indigenous (33)

[135] The definition of reviewable deaths will capture the vast majority of children who die as a result of assault. The ratio identified by the NCCH was 39.83 times (9.57-165.78) more likely than children whose deaths were non-reviewable.

Table 25: W65–74 Accidental Drowning and Submersion

	Non-Reviewable (n=26)	Reviewable (n=33)
Specific UCOD	W65 In Bathtub (1)	W65 In Bathtub (10)
	W67-W68 In Swimming Pool (12)	W67-W68 In Swimming Pool (17)
	W69-W70 In Natural Water (12)	W69-W70 In Natural Water (6)
	W74 Unspecified Drowning (1)	
Contributory Causes	T75.1 Drowning (24)	T75.1 Drowning (32)
	Other Disorders of the Brain (2)	Other Disorders of the Brain (3)
	J96 Respiratory failure (1)	J96 Respiratory failure (2)
Gender	Male (18)	Male (23)
	Females (8)	Females (10)
Age	< 1 year old (1)	< 1 year old (6)
	1–9 years old (18)	1–9 years old (25)
	10–17 years old (7)	10–17 years old (2)
Indigenous	Indigenous (0)	Indigenous (8)
	Non-indigenous (26)	Non-indigenous (35)

Table 26: X40–X49 Accidental Poisoning by Noxious Substances

	Non-Reviewable (n=1)	Reviewable (n=5)
Specific UCOD	X49 Other and unspecified substance (1)	X49 Other and unspecified substance (2)
		X42 Narcotics and Hallucinogens (2)
		X41 Antiepilep, Sedative, Psychotrop (1)
Contributory Causes	T78.2 Anaphylactic shock (1)	T40.1 Heroin (1)
		T40.2 Other Opioids (1)
		T42.4 Benzodiazepines (1)
		T43.6 Psychostimulants (1)
Gender	Male (0)	Male (3)
	Females (1)	Females (2)
Age	10–17 years old (1)	1–9 years old (1)
		10–17 years old (5)
Indigenous	Indigenous (0)	Indigenous (0)
	Non-indigenous(1)	Non-indigenous (5)

Table 27: X00–X09 Exposure to Smoke, Fire, and Flames

	Non-Reviewable (n=5)	Reviewable (n=17)
Specific UCOD	X00 Uncontrolled fire in building (5)	X00 Uncontrolled fire in building (16)
		X06 Ignition or melting cloths (1)
Contributory Causes		T14.9 Injury unspecified (3)
		T29.3 Burns of multiple regions (1)
	T30.0 Burns of unspecified regions (3)	T30.0 Burns of unspecified regions (3)
		T31.8 Burns to 80-89% body (1)
	T58 Toxic effect carbon monoxide (0)	T58 Toxic effect carbon monoxide (7)
	T59.8 Toxic effect other specified gas (2)	T59.8 Toxic effect other specified gas (2)
Gender	Male (3)	Male (13)
	Females (2)	Females (4)
Age	< 1 year old (1)	< 1 year old (0)
	1–9 years old (2)	1–9 years old (15)
	10–17 years old (2)	10–17 years old (2)
Indigenous	Indigenous (2)	Indigenous (5)
	Non-Indigenous (3)	Non-indigenous (12)

6.8 Cause of death analysis and prevention of child deaths

The analysis undertaken by the NCCH is indicative only, but does provide us with a basis for advancing our understanding of risk factors for children whose deaths are reviewable. It has identified some key areas that may warrant further consideration through our reviews.

Of particular significance is the higher likelihood of children whose deaths are reviewable dying from certain causes, both natural and unnatural.

For a number of the causes of death that are more prevalent for children whose deaths are reviewable, the literature identifies low socio-economic status or social deprivation as risk factors, including for example, meningococcal and sudden death, cause unknown.[136] Our reviews have also identified some particular issues in relation these causes of death.[137] For example:

- In deaths related to epilepsy, issues about non-compliance with medication were evident in four of 12 cases we reviewed. In two cases, adolescents did not take their own medication, and in two, there was some history that parents had not administered medication.
- In deaths related to pneumonia, we identified that in almost half of the cases (10 of 22), there was a history of neglect, including in most cases, some history of failure to seek, or delay in seeking medical treatment.

[136] National Centre for Classification in Health (2007) *Causes of death of reviewable children in New South Wales from 2003 – 2006: A report for the New South Wales Ombudsman*. June 2007. Section 5 Risk factors for key causes of death.

[137] The number of deaths under each cause referred to here may not concur with the NCCH figures as we have considered all variables of cause of death, not only UCOD.

- In cases where children died from meningococcal, parental substance abuse was an identified factor in four cases, and a history of neglect was identified in two.
- In deaths related to sudden death, cause unknown, a significant proportion have been attributed to SIDS category II, where a range of additional factors may be evident. For example, mechanical asphyxia is considered is considered in SIDS II deaths, but cannot be determined with certainty, or there may be abnormal growth or pathological abnormalities identified in autopsy.[138] In almost 40 per cent of the cases of SIDS II, there was evidence that the child's parent was substance-affected at the time the child died.

The potential links between natural cause deaths for children whose deaths are reviewable, and environmental factors linked to social deprivation and subsequent child protection concerns, will be an ongoing consideration in our reviews.

References

National Centre for Classification in Health (NCCH). The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). Fifth Edition. Sydney: University of Sydney; 2006

Pan American Health Organization (PAHO). International Classification of Diseases: Preparation of Short Lists for Data Tabulation. Epidemiological Bulletin, 2002 Dec; 23 (4): 3-6.

World Health Organisation (WHO). International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). 2nd edition, Geneva: WHO; 2005.

[138] 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 (ie 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.