

Reviewable Child Deaths in NSW 2022 and 2023

Biennial Report to Parliament

NSW Ombudsman

Level 24, 580 George Street Sydney NSW 2000

Phone: **(02) 9286 1000**

Toll free (outside Sydney Metro Area): **1800 451 524**

National Relay Service: **133 677**

Website: [**ombo.nsw.gov.au**](https://ombo.nsw.gov.au)

Email: [**info@ombo.nsw.gov.au**](mailto:info@ombo.nsw.gov.au)

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We acknowledge the traditional custodians of the land on which we work and pay our respects to all Elders past and present, and to the children of today who are the Elders of the future.

Artist: Jasmine Sarin, a proud Kamilaroi and Jerrinja woman.

ABN 76 325 886 267

Level 24, 580 George Street, Sydney NSW 2000

T 02 9286 1000 **Tollfree** 1800 451 524

www.ombo.nsw.gov.au



17 November 2025

The Hon Ben Franklin MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon Greg Piper MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

Pursuant to section 43(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (**CS CRAMA**), I present a report titled *Reviewable Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament*.

I draw your attention to the provisions of section 43(4) of CS CRAMA and section 31AA of the *Ombudsman Act 1974* in relation to the tabling of this report.

I recommend that this report be made public immediately.

Yours sincerely

A handwritten signature in black ink, appearing to read "Paul Miller".

Paul Miller
NSW Ombudsman



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Acknowledgements

The death of a child is a tragedy, and we wish to convey our sincere condolences to their families, friends, kin, carers and communities.

It is our foremost responsibility to learn from child deaths and use that knowledge to make a difference.

Caution: this report contains information about the deaths of children, including by suicide. Some people may find parts of this report confronting or distressing.

If you need help or support, please contact

Lifeline on 13 11 14

Beyond Blue on 1300 22 4636

Kids Helpline on 1800 55 1800.

Aboriginal and Torres Strait Islander readers should be aware that this report includes information about deceased children.

We use the Mindframe guidelines¹ on responsible, accurate and safe suicide and self-harm reporting.

Acknowledgement of Country

The NSW Ombudsman acknowledge the Gadigal people of the Eora nation, who are the traditional custodians of the land on which the NSW Ombudsman's office is located. We also respectfully acknowledge the traditional custodians of the land and waters across NSW, their cultural and spiritual customs and practices, and celebrate the diversity of First Nations people throughout NSW. We pay respect to all First Nations' Elders past, present and emerging, and to the children of today who are the Elders of the future.

Data considerations

Reviewable child death statistics exhibit significant variability. Year-on-year changes in numbers should be interpreted with caution and be considered in the context of longer-term trend data where available.

1. 'Mindframe guidelines: Communicating about suicide' *Mindframe* (Web Page, 2025) <<https://mindframe.org.au/suicide/communicating-about-suicide/mindframe-guidelines>>.

1. Introduction

This report concerns the reviewable deaths of children in NSW during 2022 and 2023. It also reports on our work and activities in relation to reviewable deaths since our last report in November 2023.

A death of a child is a ‘reviewable death’² if that child:

- died as a result of abuse or neglect, or in circumstances suspicious of abuse or neglect³
- was in care, or
- was an inmate of a children’s detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place).

The NSW Ombudsman is required to review and report on these deaths over 2-year periods.

The appendices to this report set out definitions of terms used in the report (**Appendix 1**), more information about our role (**Appendix 2**), our review processes (**Appendix 3**), and other reviews and investigations that may occur in relation to a child’s death and how these relate to our reviewable death reviews (**Appendix 4**).

2. Section 35 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (**CS CRAMA**).

3. We assess whether a child’s death was due to abuse or neglect, or suspicious of abuse or neglect using the definitions set out in this report.

2. Reviewable deaths in 2022–2023

In 2022–2023: 38 reviewable deaths	
Deaths as a result of abuse or neglect (or in circumstances suspicious of abuse or neglect) 22	Deaths of children who were in care (of which 1 resulted from neglect) 17

2.1 Overview

In 2022 and 2023, the deaths of 38 children aged 0–17 years were reviewable deaths (22 in 2022 and 16 in 2023).⁴

2.1.1 Deaths due to abuse or neglect

Twenty-two children died as a result of abuse (11) or neglect (7), or in circumstances suspicious of abuse or neglect (4). One child who died of neglect was in care.

Deaths due to abuse occurred in the context of:

- peer homicide (6)
- familial homicide (5).

Deaths due to neglect occurred in a range of circumstances, including suicide (1), drowning (1), dog attack (1), Sudden Unexpected Death in Infancy (**SUDI**) (1) and transport-related incident (3).

Four other children died in circumstances suspected of being a result of abuse (2) or neglect (2).

2.1.2 Deaths of children in care

Seventeen children died while living in care.

As noted above, 1 of these children died as a result of neglect. The other deaths were due to:

- natural causes (9)
- transport-related incidents (3)
- other unintentional external injury (1)
- suicide (3).

We are awaiting the final coronial outcome to confirm the circumstances of 1 death but the information to date indicates that they are not suspicious of abuse or neglect.

4. This number was correct at the time of writing. The number of children whose deaths are classified as reviewable can change over time as more information becomes available.

2.1.3 Deaths of children in detention

No child in detention died during 2022 and 2023.

2.2 Trends

Over the 10-year period (2014–2023), reviewable deaths each year have been a relatively small percentage of all child deaths (3.3%–4.8%).

While the total number of child deaths over the 10 years has decreased, the number of reviewable deaths has shown greater variability and no clear trend. Over the 10 years to 2023, the average number of reviewable deaths per year has been 21, with the lowest number of reviewable deaths in a year being 10 (2020) and the highest number being 25 (2015).

Table 1: Children whose deaths were reviewable in NSW in 2014–2023, number and percentage of all child deaths in 2-year intervals by reviewable status

		2014– 2015	2016– 2017	2018– 2019	2020– 2021	2022– 2023	2014– 2023
All child deaths in NSW		1,011	996	995	951	885	4,838
Reviewable child deaths ⁵	No	49	43	47	31	38	208
	% ⁶	4.8	4.3	4.7	3.3	4.3	4.3
Abuse	No	19 ⁷	11	17	13 ⁸	11	71
	%	1.9	1.1	1.7	1.4	1.2	1.5
Neglect	No	6	4	8	4	7 ⁹	29
	%	0.6	0.4	0.8	0.4	0.8	0.6
Suspicious	No	3	4	3	4 ¹⁰	4	18
	%	0.3	0.4	0.3	0.4	0.5	0.4
In care	No	23 ¹¹	24	19	13 ¹²	17 ¹³	96
	%	2.3	2.4	1.9	1.4	1.9	2.0

5. There were no deaths of children in detention between 2014 and 2023.

6. Of all child deaths in that reporting period.

7. Two of the children who died due to abuse were also in care.

8. Two of the children who died due to abuse were also in care.

9. One of the children who died due to neglect was also in care.

10. One of the children who died in suspicious circumstances was also in care.

11. Two of the children who died due to abuse were also in care.

12. Two of the children who died due to abuse were also in care; one of the children who died in suspicious circumstances was also in care.

13. One of the children who died due to neglect was also in care.

2.3 Abuse

A death due to abuse occurs when any act of violence by any person directly against a child or young person causes injury or harm leading to death. Abuse can refer to different types of maltreatment, including physical and sexual assault. Excluded from this definition are lawful acts of force that result in the death of a child or young person, for example, police discharge of a firearm to bring a dangerous individual under control.

In 2022 and 2023, the deaths of 11 children were identified as being a result of abuse (7 deaths in 2022 and 4 deaths in 2023). None of the children who died by abuse were living in care at the time of their death.

The 11 children died in 11 separate incidents:

- Six children aged 13–17 years were killed by unrelated individuals in the context of peer violence.
- Five children (3 aged under 5 years; 1 aged 9 years; and 1 aged 15 years) were killed in the context of familial abuse by a parent (3) or by a stepparent or partner of the child's parent (2).
- The 3 parents included 2 fathers and 1 mother. The stepparent and partner were both males.

Police investigations identified 18 males and 1 female responsible for, or allegedly responsible for, the deaths of the 11 children. In 3 cases, more than one person is implicated in the death. All 3 relate to instances of peer homicide.

Criminal charges against 8 individuals were finalised at the time of writing. Criminal proceedings are still underway for 10 persons of interest in relation to the deaths of 5 children. One case did not proceed to charges as the person of interest died by suicide at the time of the offence.

Further data and information about these abuse-related deaths is included in chapter 7 (Homicide) of the *Child Deaths in 2022 and 2023 Biennial Report to Parliament*.¹⁴

2.4 Neglect

A death due to neglect occurs if a reasonable person would conclude that the actions or inactions of a carer (in not meeting a child's basic needs such as supervision, medical care, nutrition, shelter) exposed the child to a high risk of death or serious injury, and the occurrence of that risk led to the death.

We categorise neglect-related deaths by the circumstances in which the child died:

- *A significantly careless act.* Deaths in this context are most often due to:
 - carer drug and alcohol abuse: for example, co-sleeping with a newborn while intoxicated
 - a carer placing a child in direct danger: for example, driving dangerously with a child unrestrained in the vehicle.
- *Intentional or reckless failure to adequately supervise.* Most commonly, this occurs when a child without developmental capability is left unsupervised by a carer in a potentially dangerous situation for an unreasonable amount of time.

14. Child Deaths Review Team, *Child Deaths in 2022 and 2023 Biennial Report to Parliament* (Biennial Report, 5 November 2025) <<https://cmsassets.ombo.nsw.gov.au/assets/CDRT/NSW-Child-Death-Review-Team-Biennial-Report-2022-2023.pdf>>.

- *Refusal or unjustified delay in providing medical care.* Examples of deaths in this context include when:
 - a child who has died due to acute illness, a chronic condition or an injury
 - was clearly unwell and deteriorating, and
 - the carer did not seek or refused to seek medical attention.
- *Failure to provide for basic needs such as food, clothing or shelter.* Deaths in this context usually involve significant and chronic neglect over a long period of time, a child being singled out for maltreatment, or a newborn baby being abandoned.

In 2022 and 2023, 7 children died as a result of carer neglect (5 deaths in 2022 and 2 deaths in 2023). The 7 children were aged 9 months to 13 years old. Five of the 7 children were being cared for by their parents at the time of death.

These 7 children died by various causes in a range of circumstances of neglect by a carer including:

- One child died by suicide (significantly careless act by a carer).
- One child died by drowning (intentional or reckless failure to adequately supervise).
- One child died from injuries sustained from a dog attack (significantly careless act).
- Three children died in transport related incidents (significantly careless act). Two of these children died in the same incident, 1 of the children was in care.
- The death of 1 infant was classified as SUDI (refusal or unjustified delay in providing medical care).

Of the 7 deaths, 4 were investigated by Police, and charges were laid in relation to the 3 transport deaths. Those criminal charges were as follows:

- One parent was convicted of manslaughter and dangerous and negligent driving offences in relation to the driving that caused the death of their child, with their sentence to be determined.¹⁵
- In relation to the transport incident that caused the death of 2 children, the children's relative driving the vehicle was charged with a range of dangerous driving offences, and received a sentence of 11 years 6 months' imprisonment with a non-parole period of 8 years.

The investigation of the SUDI death was finalised without charges.

Carer impairment due to potential alcohol or drug use was identified in 3 of the 7 deaths, impacting the ability of a parent or carer to adequately supervise in 2 of those deaths, and the ability to provide appropriate care for the third child (a SUDI death).

2.5 Suspicious of abuse or neglect

A child's death is considered suspicious (of abuse or neglect) where there is evidence that the death may have been due to abuse or neglect, but the evidence is insufficient for this to be reasonably determined.

15. As at September 2025.

A death is also classified as suspicious, even where it can reasonably be concluded that the death was due to abuse or neglect, if there are criminal proceedings on foot in relation to the death, and when those proceedings (including sentencing) are yet to be finalised.

In 2022 and 2023, 4 deaths occurred in circumstances that were suspicious of abuse or neglect (1 death in 2022 and 3 deaths in 2023).

These were the deaths of:

- 2 children (an infant aged 1 month and a 2-year-old) who each presented with multiple serious suspicious injuries at the time of their death. The 2-year-old's mother and her partner have been charged with manslaughter domestic violence in relation to the death. Police investigations into the infant's death are ongoing.
- an infant aged 1 month in circumstances suspicious of neglect. The infant's father has been charged with manslaughter in relation to the death.
- an infant aged 3 months where the Coroner was unable to determine a cause of death, but the circumstances were suspicious of abuse and/or neglect. The Police investigation into this matter is ongoing.

Carer use of alcohol and drugs has been identified as a factor in 2 of these deaths.

2.6 In care

Section 4(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (**CS CRAMA**) sets out the statutory and other arrangements for a child to be defined as 'in care', including various statutory care arrangements in the *Children and Young Persons (Care and Protection) Act 1998*.

In 2022 and 2023, 17 children died while living in care (9 in 2022 and 8 in 2023). The children were aged from 3 months to 17 years old.

As noted above, 1 of these children died as a result of neglect. The other deaths were due to natural causes (9), transport-related incidents (3), other unintentional external injury (1) and suicide (3). We are awaiting further information to confirm the circumstances of 1 death.

All the children (17) were in statutory care arrangements, including placements with authorised carers and relatives, and hospital and residential settings.

Seven of the children had lived with (and died because of) complex medical conditions, while 2 deaths were due to non-complex illness. Poor mental health against a background of trauma and abuse was a key factor in 4 deaths (3 suicides and 1 accidental overdose). Two of the 3 children who died by suicide had experienced a prior suicide attempt.

2.7 In detention

The death of a child who, at the time of their 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) is a reviewable death.¹⁶

There has been no reviewable death of a child in detention in NSW in the 10 years to 2023.

16. This does not include deaths in custody, or as a result of police operations as defined by s 23 of the *Coroners Act 2009*.

3. Significant 2022–2023 review outcomes

Our reviews are focused primarily on understanding service and agency interactions with the child who has died. We seek to identify agency practice and systems issues that may have contributed to reviewable deaths, or that may expose other children to risks in the future. As part of this work, we consider how agencies and service providers identified and responded to risks and vulnerabilities evident in the lives of the children and their families, as well as how relevant agencies communicated, consulted and collaborated with each other.

We may also consider how relevant agencies responded to the death, such as the quality of subsequent internal reviews or investigations.

3.1.1 Interagency issues of significance arising from reviews of deaths due to abuse and neglect

Two deaths during the 2022–2023 reporting period raised issues relating to post-death interagency collaboration and information sharing. These issues are discussed further in **section 4.4**, where these 2 deaths are included as case studies (alongside 8 others from earlier periods) that we have reviewed to inform our observations and recommendation to the NSW Government on these issues.

Given that some deaths in 2022–2023 continue to be the subject of police investigation, coronial inquiry and/or criminal proceedings, our reviews in many cases remain open.

3.1.2 Failure to maintain Health Management Plans

In 2022 and 2023, 13 of the 17 children in care who died did not have a current Health Management Plan (**HMP**) (reviewed in the 12 months prior to their death) when they died.

HMPs are required under the out-of-home care (**OOHC**) Health Pathway Program (**HPP**), which is a joint initiative of NSW Health and the Department of Communities and Justice (**DCJ**) that aims to contribute to improved health outcomes for children and young people in OOHC. HMPs record the health needs and recommended health services for the child or young person in care, identified through 2 assessments (the Primary Health Assessment and the Comprehensive Health Assessment).

They are required to be developed within 90 days of entering care. They must be reviewed every 6 months for children under 5 years, or annually for children 5 years and older. Implementation of the pathway relies on DCJ/OOHC non-government organisation (**NGO**) caseworkers, NSW Health staff including coordinators, clinicians, GPs and carers.¹⁷

The HPP was formally evaluated in December 2022 and the evaluation identified that the unclear roles, responsibilities and accountabilities of NSW Health, DCJ and OOHC NGO caseworkers and primary care providers was a barrier to the effective implementation of the HPP.¹⁸

17. Implementation of the HPP pathway relies on DCJ/OOHC NGO caseworkers, NSW Health staff including coordinators, clinicians, GPs and carers. DCJ caseworkers are responsible for completing the referral to NSW Health to place a child on the HPP within 14 days of their entry into care. It is then the responsibility of the OOHC Health Coordinator to gather relevant information about the child's health, organise the Primary Health Assessment to take place within 30 days of the child entering care, organise any follow-up assessments (Comprehensive Health Assessments) and develop a HMP within 90 days. For children case managed by DCJ, it is the caseworker's responsibility to ensure the HMP is included in the child's records, ensure it is incorporated into the child's case plan, ensure the HMP is implemented, and that any identified health issues are followed up. The caseworker is also responsible for ensuring the HMP is periodically reviewed by the OOHC Health Coordinator or a health practitioner.

18. NSW Ministry of Health, *Final Evaluation Report Executive Summary: OOHC Health Pathway Program enhancement funding* (Report, 2 December 2022) 5 <<https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Documents/exec-summary-2022-OOHC-HPP-eval.pdf>>.

Examples of unclear roles and accountabilities were evident in some of our reviews. In the review of a 2022 death, the child had commenced on the HPP but there was no communication between the OOHC Health Pathway coordinator and the OOHC NGO regarding progress of the child's health appointments and the need to develop a HMP, and referrals to specialists were not communicated to the OOHC Health Pathway coordinator. In another review of a 2023 death, the child's plan was last updated 2 years prior to their death, and there were no records that the child's HMP was provided to DCJ.

In their Serious Case Review (SCR) for a child who died by suicide in 2022 and was not on the HPP, DCJ acknowledged that enrolling the child in the program 'would have provided an opportunity to consider not only [their] general health needs but what additional support [they] may have required for [their] mental health'.¹⁹

The evaluation made 16 recommendations for improvements,²⁰ which were accepted by DCJ and the Ministry of Health and which we have been monitoring.²¹

In July 2024, we recommended in our report *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities* that DCJ and the Ministry of Health review and report on progress with the implementation of the evaluation recommendations, how that implementation is impacting trends, and any proposed actions to be taken to address identified issues.²²

DCJ and NSW Health accepted the recommendation and we are continuing to monitor its implementation, with further information expected in December 2025.

3.1.3 Other issues of significance

Our reviews of the deaths of children in care identified issues in some cases with the care and support they received. These issues – some of which have also been identified in DCJ's SCRs – provide opportunity for learning and systemic improvement in the provision of services to children in OOHC. The issues included:

- inappropriate placements resulting from a lack of available placements in an Aboriginal OOHC service, concerns regarding the exchange of information by DCJ with an external carer assessor, and the quality of carer assessments.
- a lack of support for carers to develop trauma-informed skills and capabilities and a lack of practice guidance for DCJ practitioners about carer support.²³
- casework standards not being met including decreasing home visits due to staffing limitations, not conducting regular and comprehensive risks assessments, inappropriate referrals and not tracking the outcomes of referrals (This issue of referrals is considered further in **section 4**).

19. NSW Department of Communities and Justice Office of the Senior Practitioner, *Internal Child Death Review BS* (March 2023) 52

20. NSW Ministry of Health, *Final Evaluation Report Executive Summary: OOHC Health Pathway Program enhancement funding* (Report, 2 December 2022) <<https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Documents/exec-summary-2022-OOHC-HPP-eval.pdf>>.

21. NSW Ombudsman, *Biennial report of the NSW Ombudsman under section 43 of the Community Services (Complaints, Reviews and Monitoring) Act 1993* (Report, 27 November 2023) 182 <<https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-children-in-NSW-2020-and-2021.pdf>>.

22. NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities* (Report, 5 July 2024) 61 <<https://cmsassets.ombo.nsw.gov.au/assets/Reports/Protecting-children-at-risk-report-2024.pdf>>.

23. The SCR stated that practitioner resources and support for carers is being developed as part of the placement stability project within the High Cost Emergency Strategy Unit.

- inadequate collaboration between multiple agencies and other service providers, typically a lack of coordinated care team response between DCJ, NSW Health and OOHC NGO providers. A number of examples identified missed opportunities to share information and adequately case plan. (Two of the deaths which involved inadequate interagency collaboration are considered further at **section 4.4.**)

3.1.4 Provision of review information to other inquiries and reviews

Since the last report in November 2023, we have provided 11 reviews concerning reviewable deaths to the Coroner to assist the coronial inquiries into those deaths (3 deaths occurred in 2022–2023).

In October 2025, we shared 2 reviews of deaths that occurred during 2022–2023 with the Clinical Excellence Commission (**CEC**) to inform the review of NSW Health's *Incident Management Policy*.²⁴

24. NSW Health, *Incident Management Policy* (Policy Directive, 14 December 2020) <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_047.pdf>.

4. Ongoing systemic work

In this section we provide information about ongoing and systemic work that has flowed from our reviews of reviewable deaths.

The information in this section may not relate specifically to deaths that occurred in this biennial reporting period (that is, 2022–2023), but includes issues that we have taken action on in 2022–2023 that arose from reviews of deaths in earlier periods as well as, in some cases, deaths that have occurred since 2023.

4.1 Investigations under the Ombudsman Act

In June 2023, we completed an investigation into a NSW Health local health district's (LHD) response (in 2018) to a child who presented to hospital with suspicious injuries, and who later died as a result of abuse.²⁵

At the time of issuing the investigation report, NSW Health's Child Wellbeing and Child Protection Policies and Procedures contained a requirement for all health services to establish a range of child protection procedures, including:

- intake and assessment procedures that consider the safety, welfare and wellbeing of children²⁶
- referral pathways facilitating access to clinicians with specialist/forensic child protection expertise²⁷
- local pathways for NSW Health workers to escalate child protection and wellbeing concerns and differences of opinion with other NSW Health workers and agencies²⁸
- a procedure to monitor 'best endeavours' requests for service, ensuring that service providers use their best endeavours to respond to requests from the Department of Communities and Justice (DCJ) when they meet agreed criteria, and that demand for and responses to those services are monitored.²⁹

We found that, while the LHD had identified child protection risks and made reports to the then Department of Family and Community Services (now the DCJ) at various points, the LHD's conduct overall had been unreasonable.

We made 4 recommendations to the Ministry of Health and 1 to the LHD. The recommendations focused on policy and practice improvements and review of child protection resources.

25. The *Ombudsman Act 1974* investigation followed our review of the death under pt 6 of *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)*. A summary of this investigation is included in NSW Ombudsman, *Formal investigations summary report 2022–23* (Report, 30 October 2023) <<https://cmsassets.ombo.nsw.gov.au/assets/Reports/Formal-Investigations-Summary-report-2022-23.pdf>>.

26. NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (Policy Directive, 15 April 2023) 11 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf>.

27. Ibid 13.

28. Ibid 13–14.

29. NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (Policy Directive, 15 April 2023) 13 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf>.

We recommended that the Ministry of Health:

- undertake a systematic review of state-wide resources to support the effective response to children at risk of harm
- establish a nominated child protection paediatric medical lead or case coordinator in each LHD and the Sydney Children's Hospitals Network
- address particular issues in a planned review of child protection policy, including clarifying escalation pathways for staff and improving information exchange processes
- include non-medical experts with child protection expertise in Serious Adverse Event Review (SAER) teams in cases of suspected homicide or serious crime involving the death of a child.

We recommended the LHD include a clear pathway for timely responses to requests relating to social (safety) admissions in its procedures that comply with 'best endeavours' requirements.³⁰ A safety admission refers to a person being admitted, or kept, in hospital for various reasons including their own safety, in circumstances when the admission is not required medically.

The Ministry provided updates in April 2024 and May 2025 advising that:

- It had funded a paediatric staff specialist role at the NSW Health Education Centre Against Violence. The role will lead specialist child physical abuse and neglect training, informed by a review of child protection resources to understand the learning and competency needs of the paediatric workforce, and develop resources specific to Emergency Departments.
- A child protection information hub³¹ has been established on the Sydney Children's Hospitals Network website.
- Child and adolescent safety paediatricians will be established in each LHD. The role will have responsibility for the case management of complex cases with child protection issues, oversight of local processes and pathways for interagency collaboration and discussion of medical and forensic cases, and development of local systems to monitor, review and audit child protection presentations.
- Clinical Guidelines for Responding to Child Physical Abuse and Neglect, providing guidance on best practice medical and forensic responses to child physical abuse and neglect, responses to specific clinical scenarios, and communication between interagency partners, are under development. The Child Wellbeing and Child Protection Policies and Procedures are also under review, with an interim review complete and a full review underway.
- Amendment of the Incident Management Policy to include non-medical experts with child protection expertise in SAER teams would be considered in the next review of the Policy, with the revised version due for publication in March 2026.

We continue to monitor the recommendations made to the Ministry.

The LHD provided an update in May 2025, and we met with them in September 2025. The LHD told us that it is developing new guidelines to implement our recommendation. It has also established internal and interagency meetings between the LHD and DCJ at the manager level, and the LHD, DCJ and NSW Police at the executive level to facilitate conversations on matters requiring close

30. Legislation and policy requires NSW Health to use its 'best endeavours' to comply with requests by DCJ for a child to be admitted, or to remain in hospital, where there are clear concerns about the child's safety, welfare and wellbeing.

31. 'Child protection', *NSW Government and The Sydney Children's Hospitals Network* (Web Page, 2025) <<https://www.schn.health.nsw.gov.au/child-protection>>.

collaboration between the agencies. The LHD says it is currently piloting a new pathway for analysis and review of significant incidents from a child protection perspective that would not otherwise be reviewed under NSW Health's Incident Management Policy.

We continue to monitor the recommendation made to the LHD.

4.2 Referrals to NSW Health for internal review

Since 2017, if a child dies in suspicious circumstances within 12 months of a presentation with a physical injury to a NSW Health facility, we may recommend that NSW Health, in conjunction with the Clinical Excellence Commission (CEC), conduct a comprehensive review of the interaction of that facility with the child and their family.

We have referred 3 deaths for review since 2017. All 3 referrals were accepted and reviews completed by either the CEC or SAER teams appointed by the CEC. The 3 reviews each considered key factors that may have contributed to the child's death and identified opportunities for practice or systems improvements to enhance child safety systems, build the capability of clinical personnel to identify and manage children at risk, and improve outcomes for children and their families.

Two reviews were completed in August 2020 and December 2021, and their outcomes were reported in our previous biennial report.³² The third review, referred to NSW Health in November 2023, was completed in August 2024 and is outlined below.

4.2.1 August 2024 review

The review considered NSW Health's response to a vulnerable parent and their infant, where the infant had later died in circumstances of abuse. The parent attended multiple hospitals in the year prior to the infant's death with concerns for the infant's health, including a serious physical injury, as well as for their own mental health concerns.

The review conducted by NSW Health noted a general failure to recognise the parent's vulnerabilities, and that presentations to the emergency department should have flagged escalating concerns for the infant's welfare and the parent's capacity to care for the infant. Record management and sharing, the utilisation of Pregnancy Family Conferencing,³³ reliance on DCJ to manage child protection concerns and failure to consider broader psycho-social circumstances were identified in the review.

The review was completed in consultation with DCJ representatives who provided information and input into the development of recommendations, including a joint recommendation to both agencies about statewide Pregnancy Family Conferencing guidance. Other recommendations related to general practitioner handover guidance, Mandatory Reporter Guide identification of cumulative risk, opportunities to extend an 'injury screen' state-wide as part of the development and roll-out of the Single Digital Patient Record, and "escalation processes within local services for identified risk of significant harm (ROSH)".

32. These reviews were reported on in our biennial report of reviewable deaths in 2020 and 2021: NSW Ombudsman, *Biennial report of the deaths of children in New South Wales: 2020 and 2021* (Biennial Report, 27 November 2023) 178–9 <<https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-children-in-NSW-2020-and-2021.pdf>>.

33. The NSW Government's Pregnancy Family Conferencing program supports expectant parents and their families where there are concerns about the safety and wellbeing of an unborn child. It provides early intervention to help families plan for a successful start in their parenting journey and keep mothers and their children together.

The recommendations were to be implemented within 12 months of the review, and we are engaging with NSW Health about their progress implementing the recommendations.

4.3 Reports to Community Corrections and NSW Police Force

Our review of the death of an infant in December 2019 in circumstances of abuse identified issues with Community Corrections' case management of the father while he was under an intensive correction order and a community corrections order, as well as with NSW Police attendance at incidents involving the family. The infant's father was subsequently convicted of manslaughter in relation to the death in August 2021.

Following review, we prepared reports to Community Corrections and NSW Police under s 43(3) of *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)*.

4.3.1 Community Corrections

We met with Community Corrections' Acting Assistant Commissioner in June 2024, and Director, Quality Assurance, Delivery Performance and Culture in August 2024.

Our report to Community Corrections, issued in November 2024, collated our observations from the infant's death, as well as 3 other deaths from 2019–2021 where Community Corrections was managing or had recently managed non-custodial sentences for individuals either responsible for, or named as a person of interest in, the deaths.

Our observations of Community Corrections' case management of the infant's father included:

- the need to corroborate information from family members and intimate partners about the father with information from other sources
- inadequate consideration of the father's non-compliance with his case plan when making case management decisions
- the impact of the first and second issues on the accurate assessment of the father's risk profile
- Community Corrections' focus in their post-death critical incident review on compliance with policy and procedure, without a holistic, critical evaluation of the quality of the supervision against best practice standards.

Community Corrections provided advice about their practices and processes for case management of offenders, including considering the offender's life and environment in addition to their offence/s and criminogenic risks in case management decisions. They advised about ongoing reform to improve offender compliance with case management requirements, promote critical thinking for their staff, and reform the Quality Assurance (reviews) function to improve the identification of opportunities for systemic improvement.

The report acknowledged the advice provided by Community Corrections in response to these observations.

4.3.2 NSW Police Force

Our observations of the NSW Police response to 2 domestic violence events involving the infant's family in January 2019 included:

- the response was not in accordance with the Domestic Violence Standard Operating Procedures (**DVSOPs**)
- their failure to apply to have children in the infant's family listed as persons in need of protection (**PINOPs**) on the Apprehended Domestic Violence Orders (**ADVOs**) that were obtained (protecting the infant's mother from the infant's father).

We also referred to an earlier coronial inquest into the death of 'CS', which identified similar and related issues.³⁴ The Coroner in that case recommended that NSW Police develop electronic prompts for officers on their obligations under the *Crimes (Domestic and Personal Violence) Act 2007*, review the DVSOPs and develop associated training including a case study featuring the circumstances of CS's death.

Police acknowledged their failure to comply with the DVSOPs. They advised that the children did not need to be named in the ADVOs because they were protected by virtue of being captured under the definition of 'domestic relationship' under the *Crimes (Domestic and Personal Violence) Act 2007*.

In our final report to NSW Police, we advised that, in our view, the ADVOs were not compliant with the *Crimes (Domestic and Personal Violence) Act 2007* because of the failure to name the children. We made 2 recommendations to NSW Police regarding the inclusion of guidance on the relevant sections of the *Crimes (Domestic and Personal Violence) Act 2007* in the DVSOPs, and the provision of training on those sections to staff.

NSW Police accepted that the ADVOs were not compliant and accepted the recommendations. NSW Police has since advised that:

- The DVSOPs are being revised to clearly communicate that any children of an adult aged 18 or over must be recorded as a PINOPs in an ADVO protecting that adult.
- The Code of Practice for the NSW Police Force response to Domestic and Family Violence (Code of Practice) is being revised into more user-friendly guidelines.
- Content on the requirements of the *Crimes (Domestic and Personal Violence) Act 2007* and a case study of the infant are included in their Domestic and Family Violence Fundamentals training course, delivered to current staff in face-to-face and online modules and included as a component of the Constable Development Program.
- Other relevant work is being done – including prompts in the Computerised Operational Policing System (**COPS**) platform to include known children on ADVOs, pre-population of children as PINOPs on ADVOs when they have been recorded as present at the scene, and revision of the Domestic Violence Safety Assessment Tool questions to improve their accuracy in predicting risk to children.

We are continuing to monitor NSW Police implementation of our recommendation.

34. Coroners Court of New South Wales, 'Inquest into the death of CS' (Coroner's Inquest, 15 July 2022) <[https://coroners.nsw.gov.au/documents/findings/2022/Inquest into the death of CS - Final Findings - Delivered 15 July 2022.pdf](https://coroners.nsw.gov.au/documents/findings/2022/Inquest%20into%20the%20death%20of%20CS%20-%20Final%20Findings%20-%20Delivered%2015%20July%202022.pdf)>.

4.4 Interagency collaboration and review

4.4.1 Previous reporting on the importance of interagency collaboration

Over the past 10 years, we have consistently called out a need for improved interagency collaboration across the spectrum of reviewable deaths, and specifically in relation to child protection and health services.

In 2017, we noted that ‘shared responsibility for protecting children has been the hallmark of the NSW child protection system since 2010’,³⁵ and how collaboration and information exchange across government and non-government agencies, and clarity regarding roles and responsibilities, were key challenges to address.³⁶ In relation to vulnerable children in care, we observed that when involved with multiple agencies, relevant information was not collated and analysed holistically at critical decision-making points, reducing the accuracy and effectiveness of that decision-making.³⁷

In 2019, we identified the importance for children in care of good communication between out-of-home care (OOHC) service providers, NSW Health and medical practitioners; and collaboration, information sharing and comprehensive planning between DCJ and non-government agencies that case manage children for whom medical decisions are required.³⁸

In 2021, we reported on ineffective interagency coordination, collaboration and information sharing in relation to deaths due to abuse and neglect.³⁹ We noted the need for coordinated service provision, clarification of roles and responsibilities, robust sharing of information, and the importance of intra-agency communication and interagency consultation.⁴⁰ We observed that more still needed to be done to improve case coordination, collaboration and information sharing for vulnerable families, and that we would continue to monitor agency practice in this area.⁴¹

In 2023, we noted that NSW Health reviews had identified a lack of interagency collaboration in relation to abuse-related deaths.⁴² We reported on the importance of coordination, communication and collaboration between service providers to prevent familial homicide.⁴³

4.4.2 Agency post-death reviews

Following the death of a child or young person aged under 18 years, some NSW Government agencies are required to complete a review of the death or of the agency’s involvement with a child and/or family in the period preceding the death.

35. NSW Ombudsman *Report of Reviewable Deaths 2014 and 2015* (Biennial Report, June 2017) 63 <https://cmsassets.ombo.nsw.gov.au/assets/Reports/Report-of-reviewable-deaths-2014-and-2105_Child-deaths_Vol1_June17.pdf>.

36. Ibid 9, 18, 63.

37. Ibid 64.

38. NSW Ombudsman, *Biennial report of the deaths of children in New South Wales: 2016 and 2017* (Biennial Report, 25 June 2019) 49 <https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-Children-in-NSW_2016-17.pdf>.

39. NSW Ombudsman, *Biennial report of the deaths of children in New South Wales: 2018 and 2019* (Biennial Report, 25 June 2019) 92 <https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-children-in-NSW_2018-and-2019.pdf>.

40. Ibid 98.

41. Ibid 99.

42. NSW Ombudsman, *Biennial report of the deaths of children in New South Wales: 2020 and 2021* (Biennial Report, 27 November 2023) 121 <<https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-children-in-NSW-2020-and-2021.pdf>>.

43. Ibid 122.

These various review mechanisms, summarised in **Appendix 4**, provide an opportunity for agencies to reflect on their practice and service provision to identify contributing factors and critical issues and make recommendations that support continuous improvement.

4.4.3 Need for interagency collaboration in death reviews

Generally, agencies complete post-death reviews independently of each other and rarely share their completed individual reviews.

In our view, collaborating on reviews, or sharing learnings following a review, would allow agencies to leverage review processes already in place to identify and develop a comprehensive shared understanding of any issues relating to interagency interaction prior to the death, and agree on and implement joint solutions. This includes identifying systemic improvements to reduce the likelihood of future child deaths.

Our reviews of 10 reviewable deaths between 2018–2023 identified opportunities for vital information sharing and cross-agency learning about systems reform to improve child safety and wellbeing that were missed in the separate agency reviews conducted about these deaths.

The 10 cases included 8 children aged under 2 years who died in circumstances of abuse (or suspicious of abuse) and the deaths of 2 young people aged 16 and 17 years who were in care, 1 of whom died due to an unintentional overdose and 1 of whom died by suicide. The cases highlighted a number of issues relating to interagency collaboration and information sharing in post-death review practice and highlighted a need for a robust cross-agency post-death review process.

These included:

- **Missed opportunities to share and resolve conflicting information held by agencies**

Single agency reviews may not consider critical information held by another agency that provides important context for the reviewing agency's information.

For example, in 2 cases we considered, the reviews of DCJ and NSW Health held conflicting contextual information about significant interactions between those agencies. Without an opportunity to share their reviews, neither agency was able to consider the information held and assessed by the other, resolve any conflicting views and reflect on the other agency's experiences of their practice.

In 1 case, the conflicting information held by the respective agencies led to different findings in each of their reviews and neither agency review making recommendations relating to cross-agency interaction. NSW Health did not make any recommendations, whereas DCJ made recommendations specific to their own internal systems.

In this same case, the agencies (as well as NSW Police) subsequently attempted to engage with each other to share the learnings from their own internal reviews. However, while the agencies shared the findings from their reviews, the meeting resulted in limited outcomes and many of the interagency issues raised either did not have a resulting recommendation or there was no clear commitment for action. This highlights the need for a robust process to assure that any interagency issues have been sufficiently addressed.

- **Missed opportunities to understand critical points of interaction and their impact on decision-making**

Effective agency interactions are critical to each agency's decision-making, including assessing the risks to a child or family and providing appropriate supports. Understanding the perspective of other agencies in the context of their role and responsibilities is crucial to recognising the impact of decisions and provides an opportunity for improved collaboration and consultation.

In 5 cases, agencies' decisions or actions impacted subsequent actions and/or decisions of other agencies. In 2 cases, it was apparent that a lack of understanding or incorrect assumptions made by 1 agency about the rationale for another's agency's decisions had influenced its actions (or decision not to act).

Currently a single agency review may identify where an agency's actions were influenced by the decisions of another agency. However, without the ability to share their learnings with other relevant agencies, there is a missed opportunity for agencies to properly understand the potential impact of their actions and decisions and improve future interagency interactions. The individual agency review which preceded the NSW Health review discussed at **section 4.2.1** identified that many NSW Health clinicians did not understand that if DCJ has closed a child protection case safety, welfare and wellbeing risks may continue to be present in a family. The review noted, "in practice this should trigger a heightened alert to risk for health services, as they then carry the responsibility of managing the risk without the support of DCJ".

- **Missed opportunities to consult or collaborate on recommendations**

The ability to identify issues and to suggest and implement improvements is enhanced (or in some cases only possible) when agencies can come together and share learnings.

In 4 cases we reviewed, individual agency reviews by DCJ and NSW Health identified similar and related issues about interagency collaboration and communication. However, the lack of cross-agency consultation about these interagency issues resulted in missed opportunities for jointly developing recommendations to address them. The outcome was that recommendations in the individual agency reviews either:

- only related to internal practice, or
- were intended to improve interagency issues but related only to the actions of a single agency and were made without consultation or collaboration with interagency stakeholders about their efficacy (noting 1 subsequent NSW Health review, referred to in **section 4.2.1** above, and conducted in consultation with DCJ, made a joint recommendation to NSW Health and DCJ).

- **Positive outcomes where cross-agency reviews and discussion have taken place**

Limited joint reviews and cross-agency discussions have occurred on an ad hoc basis, resulting in some positive outcomes. We identified circumstances where agencies conducted a joint review, or met to consider outcomes from their respective reviews, that resulted in recommendations to enhance and encourage information sharing and interagency management of child protection concerns.

In 1 case, referred to in **section 4.3.1**, DCJ and Community Corrections participated in a joint review process that recommended the establishment of a working group, with participants

from both agencies, to review current practice and consider issues relating to information sharing. The outcome was positive and resulted in the implementation of changed processes to enhance and encourage information sharing between the agencies.

In a more recent case, DCJ and NSW Health met to consider the outcomes from their respective reviews and discuss critical issues about interagency management of child protection issues. The agencies acknowledged the importance of interagency collaboration in the post-death review process to support cross-agency learning and systems improvement and welcomed the opportunity for similar consultations in the future.

In a separate case discussed in **section 4.2.1** of this report, DCJ participated in the August 2024 NSW Health review of an abuse-related death. DCJ provided NSW Health with information about current initiatives and reforms and NSW Health advised us that DCJ made significant input into the development of recommendations, resulting in recommendations that were both worthwhile and practical, including a joint recommendation to NSW Health and DCJ.

In the case of a 16-year-old who died by suicide and was in care, consultation and feedback from funded service providers to DCJ resulted in the identification of systemic concerns about the Intensive Therapeutic Care (ITC) program and recommendations for the review to be considered in any future work relating to reforms of the ITC model.

- **Barriers to sharing learnings**

In 5 of the cases we reviewed, agencies indicated that they would be willing to share their reviews and learn from the experience of other agencies. However, in 2 cases, agencies advised us that barriers, such as pending criminal and coronial proceedings, prevented full disclosure and limited the opportunity for robust learning and improvement.

In another case, after DCJ and NSW Health had undertaken internal reviews, DCJ participated, to some extent, in the finalisation of the NSW Health internal review. This was productive, although we were again advised there were limitations to the information DCJ felt able to provide to inform the review.

Both DCJ and NSW Health advised that any interagency process would need to be supported by a legislative framework and facilitated by whole-of-government oversight. NSW Health also noted the issue of privilege 'is one of the most significant impediments to cross-agency information sharing'.

Agencies have also cited resource constraints as a barrier to information sharing. In the case of a 17-year-old who died and was in care, the DCJ review recommended the development of a framework for a joint review function between DCJ and funded out-of-home care service providers. DCJ later decommissioned this recommendation for various reasons, including the significant resource investment required.

In the case of a 16-year-old who died by suicide and was in care, a joint review by DCJ and a non-government organisation was significantly delayed due to the need for ongoing consultation, although it has since been finalised. NSW Health also raised resourcing as a requirement for an effective interagency post-death review process during our consultation with them.

4.4.4 Our recommendation

We consulted with a range of agencies in preparing this report and recommend, pursuant to s 36(1)(b) of CS CRAMA, the following:

The NSW Government should convene a cross-agency working group to develop a legislative framework for a cross-agency, post-child death review process. The legislative framework should provide for:

- a. the objectives of the scheme, including the identification of opportunities for systemic improvements for improving child safety and wellbeing, both across and within agencies**
- b. the process for identifying which government agencies and funded service providers should participate in any joint reviews or consultation process for any particular death, and the process for mandating their participation**
- c. when and how information can and must be shared pre- and post-individual reviews and/or any joint review process, including when there are pending legal (criminal, coronial, civil) proceedings, and how information shared will be privileged from production or admission in proceedings**
- d. how the outcome of the joint review and/or information sharing should be recorded, including any inter-agency issues identified and resulting recommendations**
- e. obligations to report on the acceptance, implementation and progress of recommendations or agreed actions to a group of senior staff of the agencies involved**
- f. a process for accepting information or referrals from other authorities, who may hold relevant information about inter-agency interactions, such as the NSW Ombudsman**
- g. a process for providing advice on the outcomes of any joint review and/or information sharing to relevant authorities, such as the NSW Ombudsman and the NSW Coroner.**

5. Monitoring of Ombudsman recommendations

We are monitoring 2 recommendations made in relation to reviewable child deaths in previous biennial reporting. In the context of these 2 recommendations, we also note that we are currently undertaking an investigation under the *Ombudsman Act 1974* into the Department of Communities and Justice's (DCJ) response to children reported at risk of significant harm (ROSH), with findings expected to be tabled in early 2026.

Recommendation	When and why the recommendation was made	Agency response	Current status
In the context of its triage policy and process review, the Department of Communities and Justice undertake a thematic analysis of its Serious Case Reviews (SCRs) relating to triage policies and practices over at least the previous 5 years, and: a) ensure that this analysis informs the triage review, and b) advise us of the triage review's findings, recommendations, and outcomes by December 2024.	In our previous biennial report, we identified concerns regarding the rigour and transparency of triage assessments during the reporting period (2020–2021).⁴⁴ The concerns related to decisions about which children do or do not receive a child protection response (including an assessment and/or referral to another service), and how triage processes are assessing the needs and current supports for children reported at ROSH.	DCJ accepted the recommendation in principle in November 2023, noting that it had provided a number of SCRs to the Child Protection Policy team to assist with its current Prioritisation, Triage and Allocation Policy Review (Review). In December 2024 DCJ advised that it had conducted a thematic analysis of SCRs relating to triage policies and practices and that the analysis of those findings was also considered in the Review. DCJ confirmed in May 2025 that it would provide the final findings of the Review to the Ombudsman once ready.	Based on our review of DCJ's <i>Triage and Allocation Policy Review Discussion Paper</i> and advice provided by DCJ, we are satisfied that SCRs relating to triage policies and practices have been analysed and the findings of this analysis are being considered in the Review. We await receipt of the report of the Review's findings.

44. Ibid 185–7.

Recommendation	When and why the recommendation was made	Agency response	Current status
The NSW Department of Communities and Justice require that a [Community Services Centre] which has referred a child to an agency in response to a ROSH report: a) follow up with the agency if it does not receive notification that the referral has been accepted or declined, and b) where the agency declines the referral, review and re-assess its response to the child/ren reported at ROSH.	There is a significant gap in knowledge about what happens to children and young people reported at ROSH who are referred to other services, rather than being allocated for a child protection assessment. In our biennial report for the 2018–2019 period, we recommended that DCJ advise of its actions to record the outcome of any referrals when a ROSH report is not prioritised for comprehensive assessment, including so as to prompt a review of its response to a ROSH report where the referral outcome was that the service provider was not able to actually provide the referred service. Advice was provided by DCJ in 2023, and that recommendation was closed. However, the advice did not indicate that DCJ does review its response to children where a service referral has been declined, and so we have made this further recommendation.	DCJ accepted the recommendation in principle in November 2023. In December 2024 it advised that the referrals process at triage had been considered as part of the Review. DCJ confirmed in May 2025 that, while all services to which children and families are referred are being considered in the Review, the Review has particularly focused on family preservation services due to DCJ's greater capacity to track and influence these services, and their significance in addressing child protection risks. DCJ also advised that it is currently focusing on referrals made at triage. DCJ says it anticipates that additional guidance will be developed for caseworkers regarding when a matter should be held open to wait for a referral response, and when a declined referral will trigger further assessment of the information and a different response. It advised that it will consider strengthening guidance on responding to declined referrals during assessment and ongoing case planning in future.⁴⁵	It is unclear from the advice provided by DCJ if its proposed new guidance, or other initiatives described as likely to flow from the Review, will require staff to take the actions described in our recommendation. We await receipt of the Review's outcomes and the actions DCJ takes in response.

45. We note that DCJ's paper *Finalising the Family Preservation foundational elements* describes peak bodies and service providers supporting DCJ's proposed requirement that cases be held open for up to 3 months while a Family Preservation Service provider engages with the family: Department of Communities and Justice, *Finalising the Family Preservation foundational elements – Working together to design a more effective and more responsive system for children, young people, and families* (Paper, December 2024) 20 <<https://dcj.nsw.gov.au/documents/service-providers/deliver-services-to-children-and-families/family-preservation/finalising-the-family-preservation-foundational-elements-paper.pdf>>.

Appendix 1: Defined terms

Abuse – Any act of violence by any person directly against a child or young person that causes injury or harm leading to death. Abuse can refer to different types of maltreatment, including physical and sexual assault. Excluded from this definition are lawful acts of force that result in the death of a child or young person, for example, police discharge of a firearm to bring a dangerous individual under control.

Child – A person under the age of 18 years, as defined by section 34 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)*. Unless otherwise stated, the terms ‘child’ and ‘children’ include both infants and young people, as defined below.

Child in care – A child ‘in care’ is defined by various provisions in s 4(1) of CS CRAMA.

The provisions in CS CRAMA are directly linked to various statutory care arrangements, such as those set out in the *Children and Young Persons (Care and Protection) Act 1998*.⁴⁶

In 2022 and 2023, there were 3 main types of out-of-home care (OOHC):

- *statutory* OOHC
- *supported* OOHC
- *voluntary* OOHC (until 1 September 2022).⁴⁷

The definition also includes children who are otherwise in the care of a service provider.

Child in detention – A child or young person who was an inmate in, or was temporarily absent from, a detention centre, a correctional centre or a lock-up.⁴⁸

Child protection report - This is a term currently used by DCJ (which is not found in any legislation) to describe any report it receives that relates to a child’s safety, welfare and well-being.

Child Wellbeing Unit (CWU) – CWUs operate within NSW Health, the NSW Police Force and the Department of Education. CWUs assist staff in these agencies to meet their mandatory child protection reporting obligations.

Clinical Excellence Commission (CEC) – The CEC is the primary entity in NSW Health for system-wide leadership in clinical governance and safety assurance.

Community Services Centre (CSC) – DCJ locally-based community services offices. There are approximately 80 CSCs across NSW.

Computerised Operational Policing System (COPS) – COPS is the NSW Police Force’s core computer system for managing operation and administrative data.

Concerns report – This is a term currently used by DCJ (which is not found in any legislation) to describe any child protection report it receives that raises concerns about a child’s safety, welfare and well-being.

Concerns reports may include:

- mandatory (section 27) reports and voluntary (section 24) reports made under the *Children and Young Persons (Care and Protection) Act 1998* (that is, reports made by a person who

46. Section 135 of the *Children and Young Persons (Care and Protection) Act 1998*.

47. The definition of voluntary OOHC was repealed on 1 September 2022.

48. Section 35(1)(e) of CS CRAMA.

has reasonable grounds to suspect a child is at ROSH, and which trigger DCJ's statutory response duty)

- reports under ss 120 and 121 that a child may be homeless
- reports under s 25 of the *Children and Young Persons (Care and Protection) Act 1998* that a child not yet born may, once born, be at ROSH.

Co-sleeping – Where any person (including a child) is sleeping on the same surface as an infant, whether intended or not.

CS CRAMA – *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

Department of Communities and Justice (DCJ) – The lead agency in the NSW Government Communities and Justice portfolio, which aims to create safe, just, inclusive and resilient communities through its services.⁴⁹ DCJ is the statutory child protection agency in NSW.

Domestic and family violence – Any behaviour in an intimate or family relationship, which is violent, threatening, coercive or controlling and causing a person to live in fear for their own or someone else's safety. It is usually manifested as part of a pattern of ongoing controlling or coercive behaviour.⁵⁰

Family Preservation Services – DCJ-funded NGO voluntary programs for family preservation. These services typically support families with ROSH reports, who have undergone DCJ safety and risk assessments and/or who have a child at imminent risk of entering OOHc.

As at 2025, the Family Preservation programs are:

- Family Preservation (formerly Brighter Futures (including SafeCare) and Youth Hope)
- Intensive Family Preservation (IFP)
- Intensive Family Based Services (IFBS)
- Resilient Families (RF)
- Multisystemic Therapy for Child Abuse and Neglect (MST- CAN®)
- Functional Family Therapy – Child Welfare (FFT-CW®)
- Permanency Support Program – Family Preservation (PSP-FP)
- Nabu.

As at 2025, DCJ funded 4,500 places per year for up to 12,500 children,⁵¹ and was redesigning and recommissioning FPS services.

Child Protection HelpLine (HelpLine) – DCJ's central contact point for receiving, screening and prioritising reports about children who may be at risk of significant harm.

Infant – A child less than 1 year (12 months) of age.

Mandatory report (section 27 report) – A report made by a mandatory reporter who has reasonable grounds to suspect that a child is at ROSH (*Children and Young Persons (Care and Protection) Act 1998*, s 27).

49. 'About DCJ', *NSW Government, Communities and Justice* (Web Page, 21 March 2025) <<https://www.dcj.nsw.gov.au/about-us/who-we-are-and-what-we-do/about-dcj.html>>.

50. What is domestic and family violence?, *Department of Communities and Justice* (Web Page) <<https://dcj.nsw.gov.au/legal-and-justice/safer-pathway/what-is-domestic-and-family-violence.html>>

51. DCJ, *Redesigning Family Preservation in NSW – Discussion Paper* (2024), p.10; DCJ, *System review into out-of-home care (2024)*, 2.3.1.

Mandatory reporter - A person prescribed in s 27(1) of the *Children and Young Persons (Care and Protection) Act 1998*, who has a duty to report if they have reasonable grounds to suspect that a child is at ROSH.

This includes any person who, in the course of their professional work or other paid employment, delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children.

Ministry of Health – The Ministry supports the Secretary, the NSW Minister for Health and Minister for Regional Health, the Minister for Mental Health and the Minister for Medical Research to perform their executive government and statutory functions. The Ministry is also the system manager for the NSW public health system and consists of ministry branches, centres and offices.

Neglect – A death is classified as due to neglect if a reasonable person would conclude that the actions or inactions of a carer (in not meeting a child's basic needs – such as supervision, medical care, nutrition, shelter) exposed the child to a high risk of death or serious injury, and the occurrence of that risk led to the death.

Non-ROSH report – This is a term currently used by DCJ to describe concerns reports that have been screened in by the Helpline as not being a ROSH report.

NSW Police Force (NSWPF) – NSW's law enforcement agency whose role is to protect the community and property.

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

Register of Child Deaths (NSW) – Section 34D(1)(a) of CS CRAMA requires the CDRT to maintain a register of child deaths occurring in New South Wales since 1 January 1996.

ROSH – The definition of 'at ROSH' is in section 23 of the *Children and Young Persons (Care and Protection) Act 1998*.

A child or young person is at ROSH if 'current concerns exist for the safety, welfare or well-being of the child or young person because of the presence, to a significant extent, of any one or more of' the circumstances set out in that section. Circumstances include where the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated.

ROSH report – This is a term currently used by DCJ to describe concerns reports that have been screened in by the Helpline as a ROSH report. A concerns reports is screened in by the Helpline as a ROSH report if the Helpline considers that the report suggests the child may be at ROSH.

Screened in – This is a term currently used by DCJ to describe a process, after a concerns report is received by the Helpline, of the Helpline classifying that report as either a ROSH report or a non-ROSH report.

Serious Case Review (SCR) – A SCR is a review process conducted by the SCR Unit within the Department of Communities and Justice (**DCJ**) when a child known to DCJ (who was reported to DCJ as suspected of being at risk of significant harm (**ROSH**) within three years of their death, or who was in OOHC at the time of their death) dies. The reviews consider the local and organisational systems that impacted practice with the families of the child who died, and identify areas for practice improvement as well as positive practice to support organisational learning and inform system improvement.

Serious Adverse Event Review (SAER) – A SAER is a review of a patient safety event that results in or could have resulted in death, serious harm or a sentinel event, and is not an expected outcome of the patient’s illness. The review is conducted by a team of NSW Health staff with relevant knowledge who were not directly involved in the incident. The team prepares a report with findings and any recommendations aimed at preventing or mitigating any factors that caused or contributed to the incident, or unrelated system improvements, for the Ministry of Health to consider and implement.

Statutory response duty – Section 30 of the *Children and Young Persons (Care and Protection) Act 1998* requires that, on receipt of a voluntary (section 27) report or a mandatory (section 24) report:

- a) DCJ is to make such investigations and assessment as it considers necessary to determine whether the child or young person is at ROSH, or
- b) DCJ may decide to take no further action if, on the basis of the information provided, it considers that there is insufficient reason to believe that the child or young person is at ROSH.

(Note that s 30 does not apply to prenatal reports.)

Sudden Unexpected Death in Infancy (SUDI) – The death of an infant that is sudden and unexpected, where the cause was not immediately apparent at the time of death. SUDI is not a cause of death, but is a descriptive term applied at the point an infant is found deceased.

Suicide – includes deaths where:

- a Coroner found that the cause and manner of death was self-harm with fatal intent
- Police identified the death as suicide and the case remains open with the Coroner, or
- the Coroner dispensed with an inquest and has not made a finding about the manner of death, but Police identified the death as suicide and records examined provide evidence of self-harm with fatal intent.

Suspected ROSH – This is a term currently used by DCJ to describe a situation where a concerns report has been screened in as a ROSH report, but DCJ has not completed such investigations and assessment as it considers necessary to determine whether or not the child or young person is at ROSH.

Suspicious – A child’s death is classified as suspicious (of abuse or neglect) where there is evidence that the death may have been due to abuse or neglect, but the evidence is insufficient for this to be reasonably determined.

Triage – Process of prioritising and deciding actions for ROSH reports against resources at a local CSC.

Voluntary (section 24) report – A report made by any person who has reasonable grounds to suspect that a child or young person is at ROSH (*Children and Young Persons (Care and Protection) Act 1998*, s 24), and that is not a mandatory report.

World Health Organization (WHO) – A specialised agency of the United Nations responsible for international public health.⁵²

Year – unless otherwise stated, means calendar year.

Young person – a child aged 15–17 years (inclusive).

52. See <https://www.who.int/>

Appendix 2: Reviewable death functions of the NSW Ombudsman

Under part 6 of CS CRAMA, a death of a child is a 'reviewable death' if that child:

- was living in care or had been in detention at the time of death, and/or
- had died as a result of abuse or neglect, or in circumstances suspicious of abuse or neglect.

Section 36 of CS CRAMA requires the Ombudsman to monitor, review and maintain a register of reviewable deaths, and to:

- formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of the reviewable deaths of children
- undertake research or other projects for the purpose of formulating strategies to reduce or remove the risk factors associated with reviewable deaths that are preventable.

Section 43 of CS CRAMA requires the Ombudsman to report to the NSW Parliament on a biennial basis about:

- its work and activities in relation to reviewable deaths⁵³
- data collected and information relating to reviewable deaths
- any recommendations made
- the implementation or otherwise of previous recommendations.

53. This report covers work and activities undertaken since the last reviewable report was tabled (27 November 2023).

Appendix 3: Process and purpose of reviews

Our reviews involve seeking and examining relevant records and information relating to the children who died, and in particular their interactions with government agencies and government-funded community service providers.

A3.1 Process

We maintain the NSW Register of Child Deaths, which contains the register of reviewable deaths. Information for this report has been drawn from the Register of Child Deaths.

Under s 38 of CS CRAMA, a range of agencies and practitioners are required to provide our Office with ‘full and unrestricted access’ to records that it reasonably requires for the purpose of exercising its reviewable death function. We either specifically request information from agencies, or access information through direct access to relevant databases (such as ChildStory⁵⁴ and Justice Link⁵⁵).

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

- records from agencies – including government, private and non-government agencies – relating to children who died and associated persons
- agency reports or reviews relating to the death of a child, including SCRs conducted by DCJ and SAERs undertaken by LHDs
- coronial and police information relating to the death of a child (including briefs of evidence prepared by Police)
- judgement and sentencing information from NSW Courts
- for individual deaths that have been subject to inquiry or investigation by our Office under the *Ombudsman Act 1974*, information provided by agencies in response to statutory notices from our office.

A3.2 Purpose

The key focus of our reviews is to identify agency practice and systems issues that may have contributed to reviewable deaths, or that may expose other children to risks in the future. As part of this work, we consider how agencies and service providers identified and responded to risks and vulnerabilities evident in the lives of the children and their families.

We may also consider how relevant agencies responded to the death, such as the quality of subsequent critical incident investigations.

As well as considering individual agencies’ interactions with the children and their families, we also assess how relevant agencies communicated, consulted and collaborated with each other. This systems perspective can highlight issues that may not be evident or able to be addressed in an agency-specific review. In this regard, our reviewable death function can facilitate deeper understanding of interagency communication, process and practice issues to identify learnings and systemic improvements.

54. ChildStory is DCJ’s information management system for children and young people in OOHC and child protection.

55. JusticeLink is the information management system for the NSW Government justice system including the NSW State Coroner.

Much of our work in relation to reviewable deaths is necessarily out of the public view, in part to protect the privacy of the deceased children and their families. We work with agencies to address practice and systems issues to ensure protection of children and improved support to vulnerable families. This work involves a range of activities, including:

- making a report to a service provider or other appropriate person or body on a matter relating to a reviewable death
- consultation and discussion about specific cases or issues
- recommending certain cases to NSW Health for internal review
- taking action under the *Ombudsman Act 1974* where we identify there may have been maladministration by an agency – such as making preliminary inquiries and conducting investigations
- providing our reviews to the NSW Coroner to assist decision-making about inquests and determining lines of inquiry
- making recommendations to government and non-government agencies (service providers) about changes to policies and practices to assist in preventing or reducing the risk of deaths of children in care or detention, or due to abuse or neglect.

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

Appendix 4: Related reviews or investigation of child deaths

NSW has several related mechanisms for reviewing the deaths of children, which interact with our reviewable death function in various ways.

A4.1 NSW Child Death Review Team

In addition to having responsibility for reviewable deaths, the Ombudsman is the Convenor of the NSW Child Death Review Team (**CDRT**).

The CDRT reviews the deaths of all children in NSW, for the purpose of preventing and reducing the likelihood of deaths of children in NSW. The CDRT includes experts in healthcare, child development, child protection and research, as well as representatives of key government agencies. Ombudsman staff undertake work to assist the CDRT, including maintaining and analysing information contained in the Register of Child Deaths, preparing statutory reports, monitoring recommendations and performing secretariat functions. Our office has had this responsibility since 2011.

The CDRT reports biennially on data collected and analysed in relation to child deaths that occurred in a 2-year period. The CDRT's *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament*⁵⁶ is referenced in this report where relevant and provides further information about causes and classifications of deaths over the 2-year period and 15-year trends (2009–2023).

The CDRT launched its own website in early November 2025, which contains CDRT information, publications and reports.⁵⁷ Some CDRT information and reports are also available on the NSW Ombudsman website.⁵⁸

A4.2 Department of Communities and Justice

Under s 172A of the *Children and Young Persons (Care and Protection) Act 1998*, DCJ must review and report on the deaths of children known to them. This includes the death of a child if the child and/or a sibling were the subject of a report of suspected ROOSH in the 3 years prior to the child's death, or where the child was in OOHC at the time of their death.⁵⁹

These reviews are completed by the SCR Unit within DCJ and:

... consider how local and organisational systems impact on practice with the families of children who died. The reviews create learning opportunities for practitioners who work with families by not only identifying areas for practice improvement but also promoting positive practice. This in turn leads to broader system improvements. The findings from reviews are used to support organisational learning and system improvement.⁶⁰

56. Child Deaths Review Team, *Child Deaths in 2022 and 2023 Biennial Report to Parliament* (Biennial Report, 5 November 2025) <<https://cmsassets.ombo.nsw.gov.au/assets/CDRT/NSW-Child-Death-Review-Team-Biennial-Report-2022-2023.pdf>>.

57. See <<https://cdrt.ombo.nsw.gov.au>>.

58. See <<https://www.ombo.nsw.gov.au>>.

59. Department of Communities and Justice, 2023, *Child Deaths 2023 Annual Report: Learning to improve services* (Annual Report, November 2024) <<https://dcj.nsw.gov.au/documents/children-and-families/child-deaths-annual-reports/child-deaths-2023-annual-report.pdf>>.

60. Ibid 7.

When a child dies in a non-government OOHC setting, DCJ may work with the non-government OOHC provider as part of their review process, with some reviews being undertaken jointly.

DCJ's annual child death reports are tabled in Parliament and are available on DCJ's website.⁶¹

A4.3 NSW State Coroner

Reviewable deaths are also coronial deaths under the *Coroners Act 2009*. The role of the NSW Coroner is to investigate certain kinds of deaths in order to determine the identity of the deceased, and the date, place, circumstances and cause and of death. The Coroner may hold an inquest and can make recommendations to governments and other agencies with a view to improving public health and safety and preventing future deaths.⁶² Inquest decisions can be found at the Coroners Court website.⁶³

We regularly provide information (such as copies of reviews) on request to the Coroner to assist with their inquiries relating to inquests, as well as under our own initiative on occasion where we consider the information may assist.

A4.4 Domestic Violence Death Review Team

The NSW Coroner convenes the NSW Domestic Violence Death Review Team (DVDRT), which includes representatives of relevant government and non-government agencies. The Team reviews deaths that occurred in the context of domestic violence, including the deaths of children.

We provide information upon request to the DVDRT. Information about the DVDRT, including its reports, can be found at the Coroner's Court website.⁶⁴

A4.5 Health services

All NSW Health services are required to routinely review and report on the deaths of infants that occur within the first 28 days of life,⁶⁵ as well as all deaths that occur in hospitals.⁶⁶

Additionally, in accordance with s 21H of the *Health Administration Act 1982*, when serious patient harm occurs, NSW Health undertakes a SAER to find out what happened, why it happened and how to prevent a similar incident happening again.⁶⁷

These various reviews aim to identify system weaknesses that may have caused or contributed to the incident, learn from experiences, improve care and reduce the likelihood of future deaths.

In our Report of Reviewable Deaths 2014–15, we recommended that if a child dies in suspicious circumstance within 12 months of being presented to a NSW public health facility with a physical injury, and the NSW Ombudsman considers an internal review is warranted, NSW Health, in

61. See <<https://dcj.nsw.gov.au/children-and-families/child-deaths-annual-reports.html>>.

62. 'Role of the Coroner', *Coroners Court of New South Wales* (Web Page, 16 September 2025) <<https://coroners.nsw.gov.au/how-the-coroners-court-work/role-of-the-coroner.html>>.

63. See <<https://coroners.nsw.gov.au/coronial-findings-search.html>>.

64. See <<https://coroners.nsw.gov.au/resources/domestic-violence-death-review.html#Reports%3Cbr%3E2>>.

65. NSW Health, *Investigation, Review and Reporting of Perinatal Deaths* (Policy Directive, 26 September 2022) <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_046.pdf>.

66. See <<https://www.cec.health.nsw.gov.au/improve-quality/system-safety-culture/person-centred-care/end-of-life/death-screening-and-database-project>>

67. NSW Health, Clinical Excellence Commission, *Serious adverse event review: Information for staff affected by a serious incident* (Guidance, November 2020) <https://www.cec.health.nsw.gov.au/data/assets/pdf_file/0019/622027/SAER-information-for-staff.pdf>.

conjunction with the CEC, should establish a process for a comprehensive review of the interaction of that facility with the child and their family.

This recommendation was accepted by NSW Health and to date 3 deaths have been reviewed (discussed further at **section 4.2**).

A4.6 Other government agencies

Other government agencies may also complete an internal review following the death of a child. For example, when a serious incident occurs, Corrective Services NSW may complete a Critical Incident Review of their prior involvement with the family of a child who has died; or the NSW Department of Education may conduct their own follow-up in response to the death of a child that was enrolled in a NSW Government school at the time of their death by suicide.

Appendix 5: Technical notes

A5.1 Causes of death

In this report, underlying cause of death is reported using the World Health Organization (**WHO**) International Statistical Classification of Diseases and Related Health Problems ICD-10-AM.⁶⁸ This classification document has more than 12,000 unique codes in more than 2,000 categories. The highest-level classification is the chapter level (22 chapters).

Underlying cause of death is defined by the WHO as the 'disease or injury that initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury'. Unless otherwise indicated, in this report the cause of death relates to underlying cause. The underlying cause of death is recognised as the single most essential element to understanding causes of death.⁶⁹

A5.2 Identification of Aboriginal and Torres Strait Islander children

From 2013 onwards, and in line with recommendations by the Australian Institute of Health and Welfare, data that identifies Aboriginal and Torres Strait Islander children are obtained from all available sources for each case reviewed and recorded in the Register of Child Deaths:

- Individual children are identified as Aboriginal and/or Torres Strait Islander people if the child was identified as Aboriginal or Torres Strait Islander on the Registry of Births, Deaths and Marriages (**BDM**) death certificate.
- The child is identified as Aboriginal or Torres Strait Islander on their NSW BDM birth certificate.
- Agency records identify the child as Aboriginal or Torres Strait Islander through several records, which are corroborative. The DCJ *ChildStory* database often holds information that can support Aboriginal or Torres Strait Islander identity. NSW Health, NSW Police, Education, coronial and other agency records are also sources of family cultural background information. The sources of information requested for every child depend on several factors.

68. Independent Hospital Pricing Authority, *ICD-10-AM International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification*, Twelfth Edition, 1 July 2022.

69. National Centre for Health Information Research and Training, *Review and Recommendations for the Annual Reporting of Child Deaths in NSW* (NSW Ombudsman, Report, 2011, unpublished).

NSW Ombudsman
Level 24, 580 George Street, Sydney NSW 2000

Phone: **02 9286 1000**
Toll free (outside Sydney Metro Area): **1800 451 524**
National Relay Service: **133 677**

Website: www.ombo.nsw.gov.au
Email: info@ombo.nsw.gov.au

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