NSW GOVERNMENT

Child Deaths 2010 Annual Report

Learning to improve services

The purpose of Child Death Annual Reports is to increase accountability and transparency, and publicly share efforts to improve child protection practices in NSW. The reports are designed to better inform the public about Community Services, its role in protecting children and its limitations.

This report is not presented as an expert report and should not be treated as such in any Court or Tribunal. To comply with the Law and to protect the privacy of children and families, names or identifying details of individual cases have not been used.

Percentages listed in figures throughout this report may not add to 100% due to rounding.

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Minister's Foreword

No one can be unmoved by the death of a child. Understandably, the community as well as those involved in the child protection system seek to make sense of the sad loss of life. It is a critical government responsibility to report on the deaths of all children and young people and to find answers on behalf of the community.

This report, *Child Deaths 2010 Annual Report*, reviews the involvement of Community Services, a division of the Department of Family and Community Services, with the families of the 139 children and young people who died in 2010 who were known to Community Services.

The publication of this report provides, for the first time, the opportunity for a comprehensive examination of the role of the child protection system in the lives of these families, including the system's limitations.

The report analyses the response families and children received from Community Services, the lessons learned from reviewing the deaths, and the initiatives being put into place to improve both casework practice and the systems which support it. The report provides, for the first time, specific information about, and reflections upon, the way in which professional NSW child protection workers carry out their very difficult work. The report draws on the serious case reviews conducted internally to examine Community Services' work with the child and their family. These reviews seek to identify decisions made by Community Services about a case, and areas for improvement. This is the first time these existing rigorous internal reviews have ever been incorporated into a public report. Doing so is part of my commitment to greater transparency and accountability.

While families, like all of us, are responsible for our choices, child protection is a statutory responsibility of government. The people of NSW have a right to expect transparency and accountability. In particular, if a child death or critical incident occurs, the community is entitled to accurate information about the involvement of public services in the lives of children and young people who are known to be at risk of significant harm. The NSW Government already provides several public reporting mechanisms about the deaths of all children and young people, including the deaths of children known to be at risk, through the NSW Child

Death Review Team (CDRT) and the NSW Ombudsman. This report is a further and, I believe, a valuable addition to that examination and fulfils a core commitment of the NSW Liberals & Nationals Government to boost accountability and transparency. It is also the first annual report by a child protection agency in Australia to publicly report in this way on the deaths of children known to them. I hope this report encourages other states to follow NSW's lead.

It is also true that when a child's death comes to public attention, particularly a child known to be at risk of significant harm, confidence in the child protection system is often shaken. The community understandably looks for someone to blame and change is demanded. Governments are forced to respond swiftly. Governments responding to crisis will inevitably produce a crisis driven child protection system, delivering reactive reforms which may not always be planned, targeted, comprehensive or effective.

While each child's death is always an opportunity to learn and do better, reform also needs to be methodical and ongoing. Child protection systems must incorporate continuous reform to ensure they improve services in the face of ever-changing social pressures. Effective reform also relies upon informed public scrutiny of the deaths of children and young people who are part of the child protection system. This is another important function of this annual report.

Sharing and using our learning from child death and serious case reviews will not only improve services, boost transparency and drive reform, it will also, as it must, spur us all to do better to improve the lives of vulnerable children who are at risk.

Publication of this first *Child Deaths 2010 Annual Report* will not stop the deaths of children and young people, but the Government's increased transparency and reforms will help deliver a better child protection system with more caseworkers seeing more children more often. There are no easy answers. I am nonetheless confident this report and those to follow in years to come will make a unique contribution to ensuring the NSW child protection system is robust, critically aware and vigilant in serving the most vulnerable children and families in NSW.

Pru Goward MP
Minister for Family and Community Services
Minister for Women

Executive Summary

A new accountability

The *Child Deaths 2010 Annual Report* is the first NSW Government public report focusing exclusively on child deaths known to Community Services. It focuses on 139 children known to Community Services who died between 1 January and 31 December 2010.

Children known to Community Services are defined as those where a report was received about the child and/or his or her sibling/s in the three years preceding the death. It also includes children or young people who were in statutory care at the time of their death. Informed by Community Services' internal serious case reviews, this report presents information about these children, the responses they received from Community Services, the lessons that have been learned from review of these cases, the initiatives being implemented to improve casework practice and the systems that support best practice.

Objectives of this report

The *Child Deaths 2010 Annual Report* is part of a radically different approach by the NSW Government to transparency, accountability, partnership and public engagement. It has three objectives:

1. To publicly share efforts to improve child protection practices in the context of the Government's reform agenda and internal child death reviews.
2. To better inform the public about Community Services, its role in protecting children and its limitations.
3. To deliver on the Liberals & Nationals Government's commitment to use increased accountability and transparency to improve service delivery in NSW.

Child deaths: the context

At the election of the NSW Government in March 2011, the child protection system in NSW was part-way through a significant program of reform arising from the 2008 Wood Special Commission of Inquiry into Child Protection Services in NSW, led by Justice Wood. The inquiry's recommendations led to a shared whole of government approach to child welfare and wellbeing, where child protection is the collective responsibility of all areas of government and the community.

Wood recommended the threshold for mandatory reporting to Community Services be raised from '*risk of harm*' to '*risk of significant harm*' (ROSH), effective from 24 January 2010. The intention of this change was to allow Community Services to focus on children at the greatest risk; those children who may require statutory intervention by the state.

There remains significant work to be done to increase the capacity of the statutory child protection system so that Community Services can respond to all children reported to be at risk of significant harm.

The context of child deaths and background of child protection in NSW is discussed in Chapter 1.

2010 child death data

The Ombudsman-convened NSW Child Death Review Team (CDRT) reported in October 2011 that there were 589 deaths of children and young people registered in NSW between 1 January and 31 December 2010.

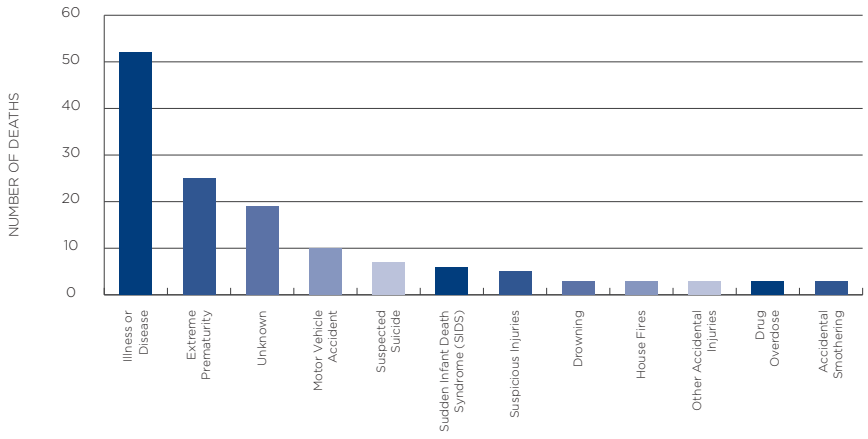
Many of the 139 children known to Community Services died from illness or disease and prematurity. Most often the causes of death are not related to the risks reported to Community Services.

65,041 children and young people were reported to Community Services in 2010.

Thorough investigation into the deaths of children inevitably takes time. However, based on past experience, it is likely that some of the other deaths involved a combination of physical illness or vulnerability in the child, and poor parenting capacity in the carers.

The data is discussed in detail in Chapter 2.

Figure 1: Circumstances of death of children and young people known to Community Services in 2010.



Source: Community Services, 2011.

Table 1: Circumstances of death of children and young people known to Community Services in 2010.

CIRCUMSTANCES OF DEATH	2010	%
Illness or Disease	52	37%
Extreme Prematurity	25	18%
Unknown*	19	14%
Motor Vehicle Accident	10	7%
Suspected Suicide	7	5%
Sudden Infant Death Syndrome (SIDS)	6	4%
Suspicious Injuries	5	4%
Drowning	3	2%
House Fires	3	2%
Other Accidental Injuries	3	2%
Drug Overdose	3	2%
Accidental Smothering	3	2%
Total Deaths	**139**	**100%**

Source: Community Services, 2011.

* The exact circumstance of death has not been determined for this group of children and young people. This could be because a cause of death could not be determined at autopsy or because the post mortem report is not yet available to Community Services.

Characteristics of the children and young people

This report identifies key characteristics about children and young people who died in 2010, including the following:

- Infants (under the age of one) are the most vulnerable age group. There were 65 children who were under the age of one at the time of their death. This accounts for 47% of all children known to Community Services who died.
- Male children were significantly more likely to be at risk of death than females. There were 86 male children and young people who died, accounting for 62% of all children known to Community Services who died.
- Aboriginal children continued to be significantly over-represented in child death data and child protection reports. There were 33 Aboriginal children and young people who died in 2010, accounting for 24% of all child deaths of children known to Community Services.
- 122 children (88%) were residing with their families at the time of their death, 11 children (8%) were under the Parental Responsibility of the Minister for Family and Community Services and a further six children were in other care arrangements, such as a disability residential service, or with extended family members.

Community Services' involvement with the children and families

- 106 (76%) children known to Community Services had been the subject of at least one individual report to the Community Services Helpline within three years of their death.
- Thirty-three children (24%) were not themselves the subject of an individual report to the Community Services Helpline, but their siblings had been reported within the preceding three years.
- Domestic violence was the most common reported risk factor in the families of children who died in 2010, evident in 64% of cases. Parental substance abuse was the second most common reported risk factor, evident in 51% of cases.
- Generational patterns of risk featured in 56 of the children's family histories. Further, 44 of the children who died had one or both parents (61 parents in total) who were known to Community Services as children.

Improving practice, improving systems

The review of Community Services' involvement with the families of children who died in 2010, identifies a number of practice and systemic issues.

Six key themes emerge from an analysis of 2010 case reviews, which cover the key issues and challenges facing Community Services, and lessons for improvement. These themes are:

1. Working with competing priorities.
2. Assessing cumulative and changing risk.
3. Engaging with parents, caregivers and children.
4. Working with intergenerational risk factors.
5. Working with risk in early intervention.
6. Assessing risk from new partners or adult household members.

These six themes provide crucial learnings in child protection practice and improvement opportunities for reform. They are discussed in full in Chapter 3.

Improving services through reform

The NSW Government, through the NSW State Plan *NSW 2021*, has committed to improve and better integrate social services to support and protect the people of NSW. This includes giving children the best possible start in life, helping vulnerable young people and their families to build resilience and plan for the future. We will work with government and non-government organisations across the sector to improve child protection services so they assist in preventing problems from escalating and becoming entrenched.

The NSW Government has started to respond to inadequate capacity within Community Services by transferring out-of-home care services and Brighter Futures, part of an early intervention program, to the non-government sector. This will help Community Services focus on improving child protection in NSW.

The Government will work to reform Community Services through improving casework performance and productivity. Early examples of this strong commitment include the trial of minimum monthly visits of children in out-of-home care, so that more caseworkers see more children more often.

Protecting children is the primary responsibility of parents. When this is not possible, it is a shared responsibility between families, the community, government and non-government organisations.

Chapter 1: Child Deaths – the Context

Chapter overview

This chapter outlines the objectives of the *Child Deaths 2010 Annual Report*, and the child protection context in NSW. The report shares with the public what Community Services knows about the deaths of children reported to Community Services. It sets out what rigorous internal reviews reveal about the critical practice and systemic issues facing Community Services. It outlines how the current reform agenda is addressing those issues, and identifies where Community Services needs to think creatively about new responses to the enduring challenges of child protection. It demonstrates that it is important to see child deaths in the context of overall demand for child protection services.

For example, in 2010 Community Services' received reports about 64,041 children and young people. This chapter also sets child death review in its systemic, social and public contexts. It explains NSW's oversight arrangements, and the contribution made by Community Services' internal reviews to learning and improvement.

1.1 Child Deaths 2010 Annual Report: objectives

The *Child Deaths 2010 Annual Report* is part of the NSW Government's radically different approach to transparency, accountability, partnership and public engagement. It has three objectives:

1. To publicly share efforts to improve child protection practices in the context of the Government's reform agenda and internal child death reviews.
2. To better inform the public about Community Services, its role in protecting children and its limitations.
3. To deliver on the Liberals & Nationals Government's commitment to use increased accountability and transparency to improve service delivery in NSW.

1.2 Child deaths: the context

The child protection system in NSW

The child protection system in NSW is part-way through a significant program of reform arising from the Wood Special Commission of Inquiry into Child Protection Services in NSW[1].

The key to Wood's vision is the transition to a genuinely shared approach to child welfare and wellbeing, where child protection is understood to be the collective responsibility of the whole of government and the community.

Following the Wood Inquiry recommendation, **Child Wellbeing Units** (CWUs) were established in NSW Health, NSW Police, the Department of Education and Communities and Family and Community Services. CWUs assist mandatory reporters in government agencies to determine whether child protection concerns meet the threshold of risk of significant harm. Concerns that do not meet the risk of significant harm threshold are referred to alternative services within that agency, or in other organisations, which could support the family.

The Wood Inquiry also recommended the establishment of **Family Referral Services** (FRS), which are intended to assist children, young people, and families who do not meet the statutory threshold for child protection intervention, but would benefit from accessing specific services to address current problems, prevent escalation, and foster a protective and nurturing environment. NSW Health has the lead for this initiative. FRS are intended to link vulnerable children, young people in need of assistance, and their families, with the most appropriate available support services in their local areas. There are five FRS pilot sites: Dubbo; Mt Druitt; Newcastle; Tamworth; and Wollongong. Staged statewide implementation is intended to be complete by 2014.

Another initiative was **Family Case Management** (FCM), an integrated case management response to families who frequently come into contact with multiple government and non-government agencies and have shown little improvement in their situations. FCM is led by Family and Community Services and focuses on those families with a child or young person at risk of harm, rather than risk of significant harm. The aims of FCM are to strengthen overall family functioning and reduce the risk of harm to children and young people. There is also a focus on improving agency collaboration so that procedural, policy, and system barriers do not prevent frontline staff from effectively helping families. FCM is running in eight sites in three regions: South West Sydney; South East NSW; and Western NSW.

1 Wood, J. (2008). *Report of the Special Commission of Inquiry into Child Protection Services in NSW*. State of NSW. (available at: www.dpc.nsw.gov.au).

The role of Community Services: the capacity challenge

The threshold for mandatory reporting to Community Services was raised from '*risk of harm*' to '*risk of significant harm*' (ROSH) on 24 January 2010. The intention of this change was to allow Community Services to focus on children at the greatest risk, those children who may require statutory intervention by the State.

Significant reform is needed to increase the capacity of the statutory child protection system for Community Services.

The enormous scale of the challenge was set out by the NSW Ombudsman on 30 August 2011 in *Keep Them Safe? A Special Report to Parliament under s31 of the Ombudsman Act 1974*[2]. In particular the Ombudsman expressed strong concern that in 2010, only 21% of risk of significant harm reports are recorded as having received a comprehensive assessment including face-to-face contact with the child, and 24% were closed without assessment.

As reported by the Ombudsman, this represents no improvement and even reduced performance by Community Services despite the Keep Them Safe reforms and significant additional resources.

Community Services' current initiatives aimed at improving productivity and increasing capacity are detailed in the Ombudsman's report, including:

- streamlining introductory training for caseworkers, reducing the time from entry on duty to being fully trained from up to 12 months to 16 weeks
- refocusing early intervention within Community Services to allow the program to focus on families where children are at risk of significant harm
- streamlining intake and assessment tools to improve the quality and consistency of decision-making, reduce the time spent on assessment and increase the time spent on intervention
- improvements to the KiDS casework database to reduce the proportion of casework hours spent on recording and increase the proportion of time available for direct work with families
- increasing recruitment to achieve a full complement of casework staff by early 2012
- continuing to work with the Department of Attorney General and Justice to reduce the resource intensity of court processes, to, again, increase the proportion of time available to see more children.

While the challenges are significant, they do not tell the whole story. Every year, thousands of children are safer as a result of support or intervention from Community Services caseworkers, whether their families are supported to make it safe for a child to remain at home, or whether a child needs to be removed from their family and placed in out-of-home care.

The social context

Demand for child protection services cannot be understood without an understanding of the social context in which risks to children's safety arise.

Families in which parents present with multiple risk factors are often families who experience wider societal disadvantage including housing instability, financial difficulties, low educational attainment and social marginalisation[3]. Common risk factors are domestic violence, parental alcohol and drug use and mental health issues. They are frequently reported to Community Services, and are families known to multiple agencies including Corrective Services, Education, Health, Police, Housing NSW, Centrelink and non-government services. Community Services' reviews have found family homelessness and poverty[4] are particular features of child death reviews where there are intergenerational family histories of involvement with child protection services.

2 NSW Ombudsman (2011). *Keep Them Safe? A special report to Parliament under s31 of the Ombudsman Act 1974*. (www.ombo.nsw.gov.au).

3 Bromfield, L., Lamont, A., Parker, R. & Horsfall, B. (2010). *Issues for the safety and wellbeing of children in families with multiple and complex problems – the co-occurrence of domestic violence, parental substance misuse, and mental health problems*, National Child Protection Clearinghouse, Australian Institute of Family Studies.

4 For the purposes of this report, family homelessness refers to the family having no accommodation or is living in short-term temporary accommodation; family poverty refers to children in the family who are significantly disadvantaged by the family's financial circumstances.

Increased awareness of child abuse and neglect also has a strong impact on the demand for child protection services. A 2011 report by the Australian Institute of Health and Welfare (AIHW)[5] identified two factors influencing a rise in reports to child protection services. These are:

- an actual increase in the number of children who require a child protection response
- an increased awareness of child protection issues in the wider community leading to a greater reporting of welfare concerns to child protection authorities.

Public understanding of child deaths

The public has two main sources of information about child deaths:

- formal Government and oversight agency reports
- media coverage.

In NSW to date the public has had access to the Child Death Review Team's (CDRT) annual statistical analysis of all child deaths in the State, and to the Ombudsman's Report into Reviewable Child Deaths, now published biennially. While these reports provide very valuable and reliable information, the public's attention is more likely to be focused on media coverage of individual child deaths. This leads to two key risks.

There is a risk that the public may overestimate the number of children who die as a result of abuse or neglect. As outlined in Chapter 2, five of the 139 children and young people who died in 2010 were injured in suspicious circumstances[6]. Two of these cases involved young people who were allegedly murdered by peers.

However, it is acknowledged that some other deaths may have involved a combination of physical illness or vulnerability in the child and poor parenting capacity in the carers, including lack of adequate supervision. These determinations are made by the NSW Ombudsman and the NSW Coroner, based n their review of records from all relevant agencies.

The NSW Ombudsman will report on this category of deaths for 2010 and 2011 next year. The most recent figures for this category for the two year period of 2008 and 2009, indicate that 57 children died as a result of abuse or neglect, or in suspicious circumstances. Of these children, 30 were known to Community Services.

There is also a risk that the public may overestimate the simplicity of child protection work and the ability of the child protection system to respond to very difficult circumstances. The reality is very complex. There are three likely reasons for this:

Firstly, Community Services may not be aware of the child or of the risks which led to the child's death. This limits the extent of child protection intervention that can be provided to these families prior to the death.

Secondly, working with vulnerable families is inherently challenging. Families reported to statutory child protection services face complex, multiple and often long-standing issues. Their circumstances are dynamic and unstable, making assessment and early intervention more difficult. Research allows us to identify the factors which are most likely to lead to abuse, neglect and death but it does not allow us to predict which children will actually be abused, neglected or die. As Professor Eileen Munro notes, the 'hindsight bias':

> *...distorts our judgment about the predictability of an adverse outcome. Once we know that the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement 'how could they not have seen x?' or 'how could they not have realised that x would lead to y[7]?'*

Finally, as the Ombudsman commented in his Report of Reviewable Deaths in 2008 and 2009, published in August 2011:

> *We also know from our work over the past eight years that identifying risk factors for the child and the characteristics of perpetrators or carers, does not in itself present simple answers to what could have been done to predict and prevent a death[8].*

5 Australian Institute of Health and Welfare (2011). *Child protection Australia 2009-10*. AIHW: Canberra.

6 These figures were current at the time of printing. The numbers may change due to the NSW Coroner and Ombudsman's ongoing work to determine or characterise which children died from abuse, neglect, or in suspicious circumstances. The NSW Ombudsman will not report on children who died in 2010 or 2011 until next year.

7 Munro, E. (2011). *The Munro review of child protection: Final report – a child-centred System* Department for Education: The Stationery Office, p18. (available online at: https://www.education.gov.uk/publications/eOrderingDownload/Munro-Review.pdf).

8 NSW Ombudsman (2011). *Report of Reviewable Deaths in 2008 and 2009*. NSW Ombudsman: Sydney. (www.ombo.nsw.gov.au) p12.

1.3 Oversight and review in NSW

New South Wales has a strong system of oversight and review of child deaths. As part of this system, Community Services works closely with other agencies responsible for child death review and the investigation of child deaths. The NSW Ombudsman, NSW Police Force, the NSW State Coroner and the Office of the Children's Guardian all have oversight, review or investigation responsibilities. Each of these agencies has their own criteria for which cases are examined.

The NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children which may be due to abuse or neglect or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which occur in a care setting[9]. These cases are known as 'reviewable deaths'.

The reviewable death functions of the Ombudsman changed in July 2009[10]. Under new reporting arrangements, the Ombudsman is required to report to Parliament on a biennial basis. In August 2011, the Ombudsman tabled his first report under these new arrangements[11].

The NSW Child Death Review Team

The Ombudsman is also the convenor of the NSW Child Death Review Team (CDRT). The team consists of the NSW Commissioner for Children and Young People, representatives from other government departments and individuals with expertise in relevant fields, such as health care, child development, child protection and research methodology. The CDRT reviews the deaths of all children and young people in NSW from all causes, and has a research focus that aims to prevent or reduce the likelihood of child deaths.

Between 2003 and 2010, the CDRT has considered an average of 614 child deaths per year. In 2010, the CDRT reported that the deaths of 589 children and young people were registered in NSW[12]. Of these cases, the team identified the deaths of 137 children who were known to Community Services.

The number of child deaths of children known to Community Services, as detailed in the CDRT annual report, differs slightly from Community Services' data. This reflects the important differences in the functions of CDRT and Community Services' annual reporting.

The CDRT reports on the deaths of children and young people that were *registered* in a calendar year with NSW Registry of Births, Deaths and Marriages. Community Services, however, reports on deaths that *occurred* in a calendar year. For example, a child who died in late 2010, but whose death was not registered until 2011, would not be included in the 2010 CDRT report. As the death occurred in 2010, Community Services has included it in the *Child Deaths 2010 Annual Report.*

Community Services also reports on NSW children, known to Community Services, who died in another state. CDRT reports child deaths registered in NSW. Further, Community Services will also undertake a review where a child was under the Parental Responsibility of the Minister for Family and Community Services but was not subject to a report to Community Services within three years. The CDRT has not previously reported on children in care.

Based on these differences in function, there are 16 cases in 2010 where either:

- Community Services has reviewed a case that was not included by CDRT in that year
- CDRT has included a case that was not reviewed by Community Services
- the death did not fit CDRT criteria due to the death occurring outside of NSW
- the death was not included in CDRT figures due to the death occurring outside of NSW unless the death was registered in NSW.

9 This includes children who died in an Ageing, Disability and Home Care funded, operated or licensed facility.

10 The NSW Ombudsman previously reviewed the deaths of children who had been reported to Community Services in the three years before the death (including siblings) or children in care.

11 NSW Ombudsman (2011), *Report of Reviewable Deaths in 2008 and 2009*. NSW Ombudsman: Sydney.

12 NSW Child Death Review Team (2011). *Annual Report 2010*. NSW Ombudsman: Sydney. (www.ombo.nsw.gov.au).

The NSW Coroner and NSW Police

The NSW Police investigate child deaths which are suspicious or where the cause or circumstances of the death are suspicious or undetermined.

Under section 24, *Coroners Act 2009*, a Coroner who is the State Coroner or a Deputy State Coroner, has the power to hold an inquest into a child's death where there is 'reasonable cause to suspect' that the child:

- was in care
- was reported to Community Services within a period of three years immediately preceding the child's death, or a child who is a sibling of a child reported to Community Services within three years preceding the child's death
- death is or may be due to abuse or neglect or that occurs in suspicious circumstances
- who at the time of their death was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for people with disabilities.

Community Services is responsible for reporting the deaths of children known to the division to the State Coroner, a Deputy State Coroner or a Police Officer. Community Services and the State Coroner's Office also regularly share information about child deaths.

Why does it take so long to report publicly?

Reviewing the deaths of children, or siblings of children who have been reported to Community Services, takes time. It often takes time for Community Services to first become aware of a death, to gather information, and to understand the circumstances and causes of a death. Community Services relies on information sharing and expert advice from NSW Police, NSW Health, the NSW Ombudsman, the NSW Coroner, and the Child Death Review Team (CDRT).

Generally, Community Services becomes aware of a child's death following a report by NSW Police or NSW Health to the Helpline. In addition, the NSW Ombudsman also advises Community Services of the deaths of children known to the agency.

Community Services also relies on the expert analysis of the CDRT. The CDRT Annual Report 2010 was published in October 2011.

Finally, the 2008 Special Commission of Inquiry into Child Protection Services in NSW commits Community Services to reviewing child deaths within six months of becoming aware of the death. This timeframe compares well with other Australian and international jurisdictions. Due to the six month timeframe, some reviews for child deaths that occur at the end of a calendar year are often not completed until the middle of the following year. To ensure that the data and themes in annual reports are reliable and accurate, all reviews for a calendar year must be completed prior to this annual report information being collated and analysed.

The Domestic Violence Death Review Team

On 16 July 2010 the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* commenced, amending the *Coroners Act 2009* by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team (the Team).

The Team is convened by the NSW State Coroner and includes representatives from 11 key government stakeholders, including law enforcement, justice, health and social services, as well as four representatives from non-government agencies[13].

The core functions of the Team are to:

- review and analyse individual closed cases of domestic violence deaths[14]
- establish and maintain a database to identify patterns and trends relating to such deaths
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths[15].

Where a child is killed in the context of domestic violence that death is subject to review by the Team.

The Children's Guardian

The primary functions of the NSW Children's Guardian are to:

- promote the best interests of all children and young people in out-of-home care
- ensure that the rights of all children and young people in out-of-home care are safeguarded and promoted
- accredit designated agencies and to monitor their responsibilities under the Act and the regulations.

To fulfil these functions, section 172(b), *Children and Young Persons (Care and Protection) Act 1998* requires Community Services to notify the Children's Guardian of the deaths of all children and young people in out-of-home care.

13 *Coroners Act 2009* (NSW) s101C.

14 A domestic violence death is defined as 'closed' if the Coroner has dispensed with or completed an inquest concerning the deaths, and any criminal proceedings (including appeals) concerning the death have been finally determined: *Coroners Act 2009* (NSW) s 101B(2).

15 *Coroners Act 2009* (NSW) s 101F(1).

1.4 Community Services' child death reviews

Community Services reviews its involvement with the families of children and young people where a report was received about the child who died and/or their sibling/s, in the three years preceding the death, or where a child or young person was in care at the time of their death.

Reviews are conducted using a rigorous and academically supported methodology by a central team independent of the Community Services' Region or Regions which provided services to the child. Reviews can make recommendations for practice and systemic improvement, and are used to support learning and professional development both with staff directly involved in the case and with staff across the division.

The Ombudsman and the Coroner consider Community Services' reviews as providing an important perspective that is closely considered in the conduct of their inquiries and responsibilities for oversight of the child protection system. This report represents the first time that the NSW Government has shared the findings from Community Services' internal reviews with the public.

A systems approach to child death reviews

> *The goal of a systems case review is not limited to understanding why specific cases developed in the way they did, for better or for worse. Instead, a case is made to act as a 'window' on the system. It provides the opportunity to study the whole system, learning not just of flaws but also about what is working well*[16].

Community Services' reviews draw on the systems approach to serious case reviews developed by United Kingdom academics Fish, Munro and Bairstow[17]. When a child dies, the systems approach emphasises the importance of understanding why decisions and actions in these cases appeared to make sense at the time that they were made, not just what happened. The systems approach seeks to identify factors in the work environment that promote good or problematic practice. When practice is analysed, this is done with consideration of the broader context of interrelated and contributory factors such as the working culture, operational environment, policy and procedures, interagency factors and available resources.

It's important to understand why decisions and actions in these cases appeared to make sense at the time they were made

Speaking with frontline staff about their role and experiences of the case provides invaluable information about the factors and thinking that influence their actions. The systems approach seeks to promote opportunities for organisations as a whole to learn from practice, not just the staff directly involved in the case.

16 Fish, S., Munro, E. & Bairstow, E. (2008). *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*, Children's and Families' Services Report 19, Social Care Institute for Excellence: London, p2.

17 Ibid.

Chapter 2: Child Deaths in 2010

Chapter overview

This chapter reports on the 139 children and young people known to Community Services who died in 2010. The chapter outlines the circumstances in which the children died, the characteristics of the children, in terms of age, gender and Aboriginality, and the extent of Community Services' involvement in their lives. It also considers the known risk factors associated with these children and their families.

As outlined in Chapter 1, Community Services reviews its involvement with the families of children and young people where a report was received about the child who died and/or their sibling/s in the three years preceding the death. Community Services also reviews cases where the child or young person was in care at the time of their death. The range of Community Services' involvement extends from families that Community Services was closely involved with, to children who may have had no involvement with Community Services but who had a sibling reported within three years of the death.

Of the 139 children known to Community Services who died, 122 children were residing with their families, and 17 children were in care at the time of their death.

106 (76%) children had been the subject of at least one report to the Community Services Child Protection Helpline within three years of their death. Thirty-three children (24%) had not been reported to the Helpline, but their siblings had been reported within the preceding three years.

Many of the children and young people died from illness, disease or prematurity. Causes of death are usually not related to the risks reported to Community Services.

To comply with the law and protect the privacy of the children and families, names or identifying details of individual cases have not been used.

2.1 Child deaths in NSW in 2010

The Ombudsman-convened NSW Child Death Review Team (CDRT) reported that the deaths of 589 children and young people were registered in NSW between 1 January and 31 December 2010.

The total number of children who died in NSW in 2010 increased slightly from 574 deaths in 2009, while the deaths of children known to Community Services decreased slightly from 147 in 2009. Figures are subject to fluctuation across years. Conclusions should not be drawn about these changes.

Figure 2 shows the comparison of deaths of children and young people in NSW against the deaths of children known to Community Services from 2006 to 2010. Considering this five-year average, in almost one quarter of all child deaths in NSW, the child or young person was known to Community Services.

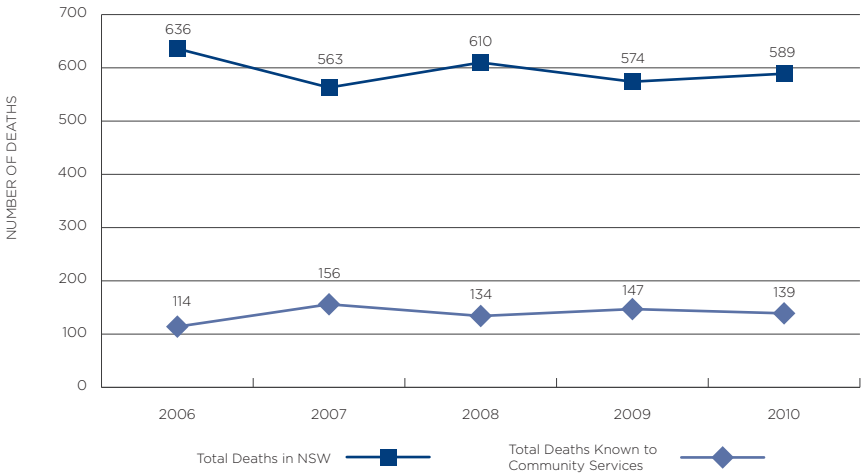
The challenges of comparing child deaths data across states

Child protection agencies across Australia have different criteria for child death reviews. NSW has broader criteria which include the deaths of children and young people:

- who had been reported to Community Services in the three years prior to their death
- whose sibling had been reported within three years of the death
- who were in care.

Unlike NSW, Victoria counts children who had been reported within the 12 months prior to the death – this does not include siblings. Queensland reviews cases where children were reported within three years of the death, but this does not include the child's siblings. Comparing figures is also problematic due to the variance of the child to adult population ratio in different states, differing thresholds for reporting and differences in the numbers of mandated reporters.

Figure 2: Comparison of total child deaths in NSW from 2006 to 2010 with the deaths of children and young people known to Community Services.



Source: CDRT and Community Services, 2011.

2.2 Circumstances of child deaths

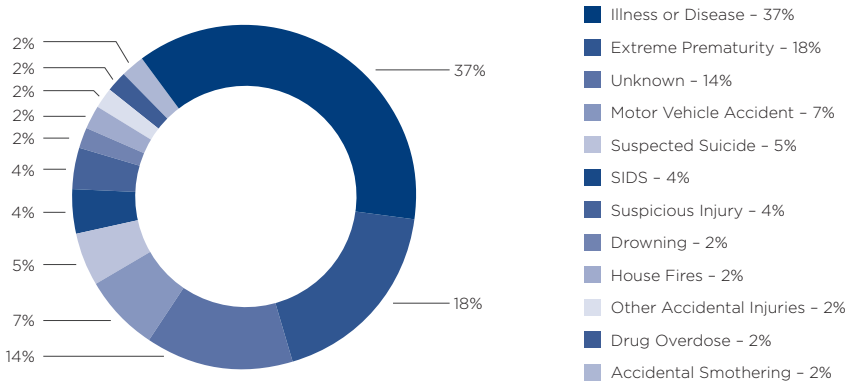
Community Services' reviews note circumstances of death, drawing on information from the NSW Coroner and the NSW Ombudsman. The circumstance of death is not necessarily the medical *cause* of death, but rather the primary circumstance in which the child or young person died. For example, the cause of death for a child could be head injuries, but the *circumstances* of the death could be a suspicious injury, a car accident or another type of accidental injury.

The circumstances of the deaths of children and young people vary. Most deaths are associated with illness, disease or extreme prematurity. Deaths can also be accidental, for example arising from motor vehicle or sporting related accidents. A very small number of deaths result directly from suspicious injuries. Thorough investigation into the deaths of children inevitably takes time, but, based on previous experience, it is likely that some of the other deaths involved a combination of physical illness or vulnerability in the child, and poor parenting capacity in the carers.

The medical cause of death is determined either by a medical practitioner or by the NSW Coroner. It is the role of the NSW Registry of Births, Deaths and Marriages to record cause of death information.

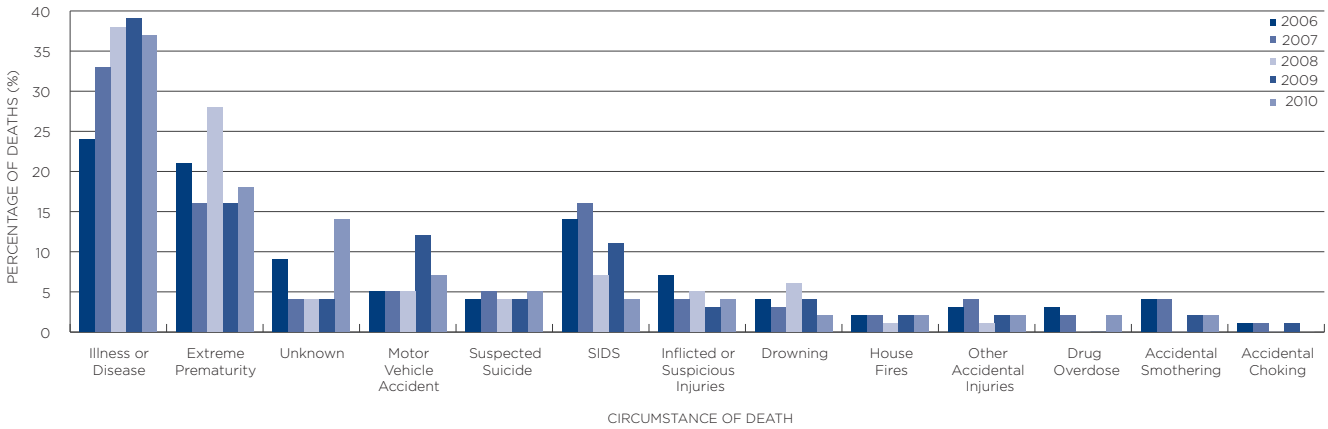
In some cases, the circumstances of death are unknown, or not available. This is usually due to post mortem results not being completed. As it can often take several months for post mortem reports to be completed, the circumstances of 19 deaths (14%) in 2010 were unknown, or unable to be determined, at the time of writing.

Figure 3: Circumstances of child deaths in 2010.



Source: Community Services, 2011.

Figure 4: Circumstances of the deaths of children and young people from 2006 to 2010.



Source: Community Services, 2011.

Death from illness and/or disease

52 Deaths

37% Of All Deaths

29 Males

23 Females

0-17yrs Age Range

Illness and/or disease was the most common circumstance of child deaths in 2010, and has consistently been the primary circumstance of death since 2006, as demonstrated in Figure 4 and Table 2.

Fifty-two children and young people died from illness and disease in 2010. This accounts for 37% of all deaths. The common illnesses and diseases vary, but include:

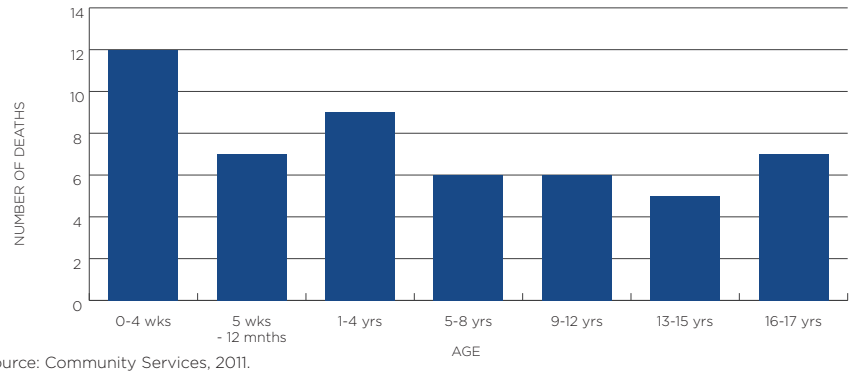
- congenital malformations
- disease of the respiratory system
- disease of the circulatory system
- neoplasms (cancers and tumours)
- diseases of the nervous system
- conditions originating in the perinatal period[18].

Table 2: Circumstances of deaths of children and young people from 2006 to 2010[19].

CIRCUMSTANCES OF DEATH	2006	2007	2008	2009	2010
Illness or Disease	27	52	51	57	52
Extreme Prematurity	24	25	37	24	25
Unknown[20]	10	7	5	6	19
Motor Vehicle Accident	6	8	7	18	10
Suspected Suicide	5	8	6	6	7
SIDS	16	25	10	16	6[21]
Inflicted or Suspicious Injuries[22]	8	7	7	4	5
Drowning	5	5	8	6	3
House Fires	2	3	2	3	3
Other Accidental Injuries[23]	3	6	1	3	3
Drug Overdose	3	3	-	-	3
Accidental Smothering	4	6	-	3	3
Accidental Choking	1	1	-	1	-
Total Deaths	**114**	**156**	**134**	**147**	**139**

Source: Community Services, 2011.

Figure 5: Age distribution of children and young people who died from illness and disease in 2010.



Source: Community Services, 2011.

As Community Services does not have specialist expertise in the classification of medical causes of death, a detailed breakdown of this category is not provided. The NSW *CDRT Annual Report 2010*[24] provides information about these categories.

Children under the age of one were most likely to die from illness or disease, particularly infants aged from birth to four weeks (see Figure 5).

18 **Congenital malformations** include congenital and chromosomal abnormalities which refer to a range of conditions. These include congenital heart disease, cardiac arrest and trisomy 13 and 21. **Diseases of the respiratory system** include pneumonia, influenza and asthma. **Diseases of the circulatory system** include deaths associated with cardiac and blood vessel malformations. **Neoplasms** include brain tumours and cancer. **Diseases of the nervous system** include deaths due to cerebral palsy, muscular dystrophy, inflammatory and degenerative conditions. **Infectious and parasitic diseases** include deaths caused by bacteria, or viruses, such as meningitis. **Conditions originating in perinatal period** include conditions arising within pregnancy or the first 28 days of life such as prematurity, complications of labour and disorders associated with foetal growth.

19 This data is likely to change in future years as new information is received by Community Services.

20 The exact circumstance of death has not been determined for this group of children and young people. This could be because a cause of death could not be determined at autopsy or because the post mortem report is not yet available to Community Services.

21 Conclusions should not be drawn about the lower rate of SIDS deaths in 2010. Delays in post mortem processes are common in suspected SIDS cases.

22 Includes confirmed, highly suspicious or alleged inflicted injuries. Category is based on information available to Community Services and should be used with caution.

23 Examples of deaths included in this category are a fall from a cliff, accidental head injuries, dog attacks, dehydration, snake bites, fatal sporting and recreation-associated injuries.

24 CDRT (2011).

Prematurity related deaths

25 Deaths

18% Of All Deaths

14 Males

10 Females

1 Unknown

Prematurity[25] was the second most common circumstance of death in 2010. It was the circumstance of death for 25 infants, and accounted for 18% of all child deaths.

Fourteen of the infants died in less than 24 hours from birth and 10 died within six weeks. One older child survived for a longer period but died of conditions relating to prematurity.

Ten of the infants were female and 14 were male. The gender of one child was not reported to Community Services.

Eight of the 25 cases included risk factors which may have contributed to the prematurity. The common risk factors can include:

- the mother being physically assaulted during pregnancy
- the mother's alleged substance abuse during pregnancy
- poor prenatal care leading to negative health outcomes.

These risk factors all have strong links in research to premature deaths and negative birth outcomes, as discussed further in the box, below.

No reported risk factors were evident from the available data of the other 17 cases.

Prenatal reporting to Community Services

Research shows that children exposed to substance abuse, domestic violence and/or maternal mental health concerns during pregnancy are at greater risk of adverse developmental outcomes. This includes premature labour, low birth weight, foetal distress and death[26, 27].

The *Children and Young Persons (Care and Protection) Act 1998* allows for prenatal reports to be made to Community Services where a person has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of significant harm when born. The intention of this is to allow assistance and support to be provided to an expectant mother to reduce the likelihood that the child will need significant Community Services intervention after the birth.

Some aspects of violence during pregnancy represent the most serious forms of child abuse and the risks posed from violent partners to both women and the unborn child need to be taken extremely seriously[28]. Further, women who experience violence during pregnancy are more likely to smoke, use drugs or be on antidepressants[29]. These women may also have poor prenatal care[30].

A study[31] showed women subject to domestic violence in pregnancy were four times more likely to miscarry than women who were not abused. Another study[32] of almost 15,000 young women between the ages of 18 and 23 years found that young women exposed to violence during pregnancy were more likely to have a miscarriage, stillbirth, premature birth or abortion than other young women.

Although conclusive links cannot be drawn between violence and premature births, the research about this issue points to strong vulnerabilities for unborn children exposed to violence.

25 The deaths of premature infants are reported as one group, where prematurity is mentioned as either an underlying or associated cause of death, or a contributory factor in the death.

26 McMahon, S., Huang, C., Boxer, P. & Postmus, J.L. (2011). The impact of emotional and physical violence during pregnancy on maternal and child death at one year post-partum. *Child and Youth Services Review*, doi:10.1016/j.childyouth.2011.06.001.

27 Yount, K., DiGirolamo, A.M., & Ramakrishnan, U. (2011). Impacts of domestic violence on child growth and nutrition: A conceptual review of the pathways of influence, *Social Science & Medicine*, 72(2011), pp1534-1554.

28 Humphreys, C., Houghton, C. & Ellis, J. (2008). *Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice*: The Scottish Government, p16.

29 Taft, A. (2002). *Violence against women in pregnancy and after childbirth: current knowledge*, Australian Domestic and Family Violence Clearinghouse, Issues Paper 6, UNSW: Sydney.

30 Huntsman, L. (2002). *Domestic violence and its impact on children's development*. Edited version of a presentation delivered at Community Services' fourth Domestic Violence forum September 2002: Sydney.

31 Taft (2002).

32 Taft, A., Watson, L. & Lee, C. (2004). Violence Against Young Australian Women and Association with Reproductive Events: A Cross-Sectional Analysis of a National Population Sample. *Australian and New Zealand Journal of Public Health*, 28, 324-329.

Motor vehicle related deaths

10 Deaths

7% Of All Deaths

7 Males

3 Females

2-17yrs Age Range

In 2010, 10 children and young people died from motor vehicle related incidents either as passengers in cars or as pedestrians. This accounts for 7% of all deaths.

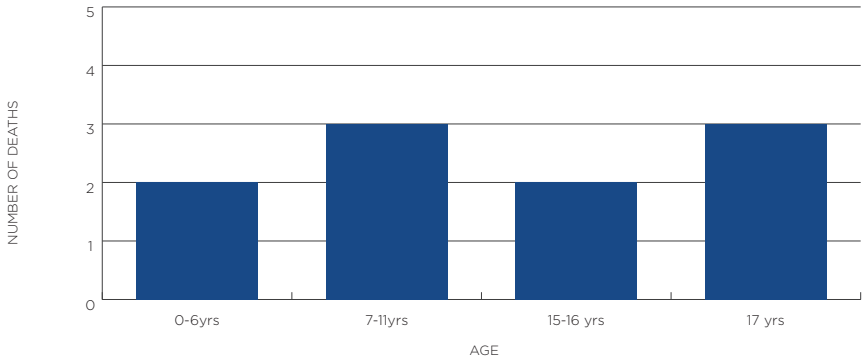
Four of the children and young people who died were Aboriginal.

In seven cases, the child or young person was a passenger in a car. In one of these cases the child was not wearing a seat belt before the accident. In another case a young person was a passenger in a stolen car being driven by a learner driver. The other cases were mostly accidents, and instances of the driver losing control of the vehicle.

Three children and young people died as pedestrians – all three were killed after being struck by cars or trucks on the road.

The ages of the children ranged between two and 17 years. Figure 6 shows a higher vulnerability in this category for young people aged over 15 years.

Figure 6: Ages of the children and young people who died in motor vehicle incidents in 2010.



Source: Community Services, 2011.

Suspected suicide deaths

7 Deaths

5% Of All Deaths

5 Males

2 Females

13-17yrs Age Range

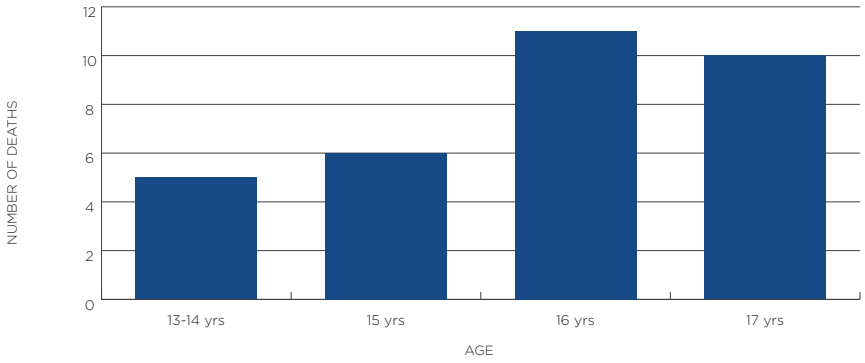
Suicide was the suspected circumstance of death of seven young people in 2010. This accounted for 5% of all deaths, which is a slight increase from 2009 deaths, where six children, or 4% died.

All seven young people who died of suspected suicide in 2010 were teenagers, aged between 13 and 17.

Three of the seven young people had allegedly previously expressed their intent to commit suicide and/or had previously made an unsuccessful suicide attempt.

An analysis of suspected suicides from 2006 to 2010 indicates 16 and 17 year olds are the highest risk group, as shown in Figure 7.

Figure 7: Suspected suicide deaths from 2006 to 2010 by age.



Source: Community Services, 2011.

Sudden and Unexplained Deaths in Infancy (SUDI)

6 Deaths

4% Of All Deaths

4 Males

2 Females

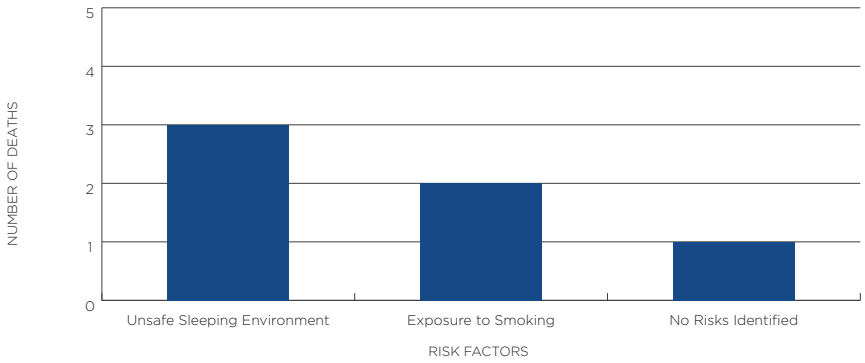
0-6mths Age Range

Six infants died in 2010 from Sudden Infant Death Syndrome (SIDS), as confirmed by the NSW State Coroner. This accounts for 4% of all deaths.

SIDS falls under the broader category of Sudden and Unexplained Deaths in Infancy (SUDI). SUDI includes the deaths of infants under one who died of:

- circumstances that were unexpected, or unexplained at autopsy (meeting the category of SIDS)
- an acute illness that was not recognised by carers and/ or health professionals as potentially life threatening
- an existing health condition that was not previously recognised by health professionals[33].

Figure 8: Identified risk factors for SIDS related deaths in 2010.



Source: Community Services, 2011.

Research shows that parental risk factors strongly linked to SUDI deaths include unsafe sleeping environments, exposure to tobacco smoke, and unsafe sleeping positions, that is, an infant placed in a position other than on their back[34].

In five of the six cases of infants who died from SIDS in 2010: three infants died in unsafe sleeping circumstances; and two infants had been exposed to smoking.

33 NSW Child Death Review Team (2010). *A Preliminary Investigation of Neonatal SUDI in NSW 1996 – 2008: opportunities for prevention*. NSW Commission for Children and Young People: Sydney. (www.kids.nsw.gov.au).

34 In 111 cases of unexpected infant deaths between 1996 and 2008, at least one of these factors was present in 87.4% of the cases, and 67% had evidence of more than one risk factor. NSW Child Death Review Team (2010).

Deaths associated with co-sleeping

Fourteen infants known to Community Services died in situations while co-sleeping with one or both parents in 2010. The term 'co-sleeping' describes an infant sharing a sleeping surface with another person.

In 11 cases the infant was sharing a bed or a mattress with another person. In three cases, the infants were co-sleeping with a parent on a lounge. Thirteen of the infants who died while co-sleeping were less than six months old. One child was one year old. Six of the children who died were Aboriginal.

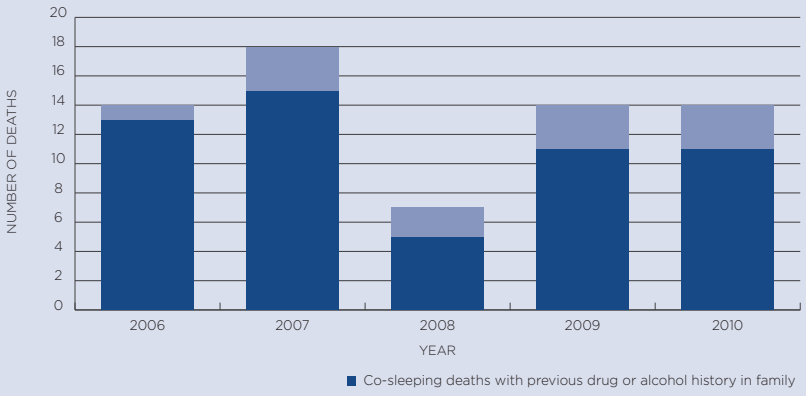
The causes of death for these 14 infants vary. In two cases the child died of a respiratory illness and in one case of congenital heart disease. SIDS was determined to be the cause of death in three cases and for the remaining eight cases, the exact cause of death has not yet been determined.

It is not the intention of Community Services to take a position on the practice of co-sleeping in itself. Co-sleeping is common and accepted across many cultures, and safe co-sleeping practice is outside the realms of comment from a child protection agency. However, what is relevant is that co-sleeping has been linked to increased risk of death, particularly when the parent or carer is under the influence of drugs or alcohol.

In 11 of the 14 cases of children who died while co-sleeping in 2010, concerns had previously been reported about parental substance abuse. Substance abuse is a significant factor in deaths associated with co-sleeping and is a consistent finding from Community Services' review work over the past five years.

Research shows that sharing a sleeping surface with an infant while drug and/or alcohol affected is an unsafe sleeping practice and places the infant at higher risk of death[35, 36]. Drug and/or alcohol use causes people to sleep in a much heavier state thus reducing the person's ability to appropriately respond to an infant sleeping close by on the same sleeping surface[37]. The person is less aware of the infant's presence, and under these circumstances, there is an increased risk of the infant suffocating or being accidentally smothered.

Figure 9: Co-sleeping deaths from 2006 to 2010, including the proportion of co-sleeping deaths with a previous drug or alcohol history in the child's family.



Source: Community Services, 2011.

35 NSW Department of Health (2005). *Babies – Safe Sleeping in NSW Health Maternity Facilities:* NSW Department of Health: Sydney.
36 Goldberg, W. & Keller, M. (2007). Parent-infant co-sleeping: why the interest and concern. *Infant and Child Development*, 16, 331-339.
37 Mesich, H. (2005). Mother-infant co-sleeping: Understanding the debate and maximising infant safety. *American Journal of Maternal Child Nursing*, 30(1), 30-37.

Suspicious injuries

5 Deaths

4% Of All Deaths

In 2010, five children and young people died from suspicious injuries. This accounts for 4% of all deaths.

This category includes children and young people who died from alleged assault, abuse or other types of injuries that were investigated by NSW Police as it was alleged that the injuries were inflicted by another person, or highly suspected to be non-accidental.

Three children died while in the care of a parent and/or adult known to the family. In two cases, charges have been laid against the parents or carers, with these cases currently subject to legal proceedings.

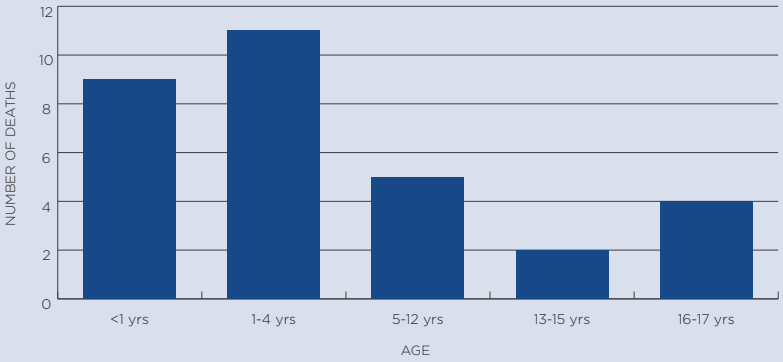
The other cases were young people who were allegedly assaulted by other young people. Charges have been laid in both cases, which are currently subject to legal proceedings.

Suspicious or inflicted injury cases since 2006

It is a common misperception that death from suspicious or inflicted injuries is the most common circumstance of death for children known to Community Services. It is these deaths which have the highest profile and which are most reported in the media.

Of 690 children known to Community Services who died between 2006 and 2010, 31 (4%) children and young people have died from suspicious or inflicted injuries. Twenty-three (74%) of these children were male, and eight (26%) were females. Nine (29%) of the children and young people were Aboriginal. Young children under the age of four are most vulnerable.

Figure 10: Deaths from suspicious or inflicted injuries from 2006 to 2010 by age.



Source: Community Services, 2011.

The CDRT study *'Trends in fatal Injuries Resulting from Parental Assault in NSW: 1996-2005'* examined deaths as a result of parental assault over a 10 year period. In examining the deaths over this period it was concluded that *'the number of deaths of vulnerable children*[38] *appears to vary by chance, and caution needs to be exercised in drawing any conclusion: the number of deaths is likely to swing up or down in what may be a random manner. A drop in numbers for any particular year need not indicate an improvement, just as an increase in numbers in any particular year need not indicate a worsening: rather they reflect the erratic nature of such deaths*[39]*'.*

38 The CDRT use the term vulnerable children to refer to all children and young persons 'where a child or their sibling had been reported as at risk of harm to the NSW Department of Community Services (DoCS) within the three years prior to the death', CDRT (2008) *Trends in Child Deaths in NSW: 1996-2005*: NSW Commission for Children and Young People, Sydney p467.

39 Ibid p10.

Other circumstances of death

In 2010, 15 children and young people died in other accidental circumstances including drowning, house fires, drug overdoses, accidental smothering, and other accidents:

- three children died of drowning
- three children died in house fires. These children were all under the age of four
- three children and young people died from an accidental drug overdose. Two of these young people, with a history of drug abuse, were aged over 16 years. One child died after accidentally overdosing on self-administered prescription medication
- three children died from accidental smothering, in unsafe sleeping environments, associated with co-sleeping and unsafe bedding
- three children died from other accidents associated with sporting and work activities.

2.3 Characteristics of the children and young people

This section outlines the characteristics of the children and young people known to Community Services who died in 2010 by age, gender and Aboriginality. Consistent with other research, a review of the 2010 cases found younger children under the age of one are most vulnerable, males are at greater risk, and Aboriginal children and young people are significantly over-represented in child deaths.

Age

Infants under the age of one are the most vulnerable group. In 2010, 65 children (47%) who died were under the age of one at the time of their death, and 47 of these infants were under 12 weeks old[40].

The vulnerability of children under one is well documented in international research[41] and is also reflected in CDRT data about all child deaths in NSW[42]. Infants under one are particularly vulnerable due to being entirely dependent on their carers to meet all of their basic needs, as well as being physiologically more fragile[43].

Of the 47 infants who died when they were less than three months old:

- 24 infants died from complications associated with being born premature;
- 15 infants died from natural causes;
- three infants died from SIDS; and
- five infants died from unknown causes.

In the eight cases where the cause of death was unknown or due to SIDS, the infants had been co-sleeping at the time of death or other unsafe sleeping practices were identified.

Community Services' reviews of 2010 deaths also highlighted key vulnerabilities for children aged between 13 and 15 years, and young people aged between 16 and 18 years. Unlike young infants, these children were more likely to die in circumstances linked to high risk behaviour. This is explained by the higher rates of motor vehicle accidents, drug overdose and suspected suicide for this age group, which is consistent with findings from the CDRT[44].

> Infants under the age of one are the most vulnerable group

40 Fifteen of these children died within the first 24 hours of life and 23 were under four weeks old. A further nine children were aged between five and 12 weeks.

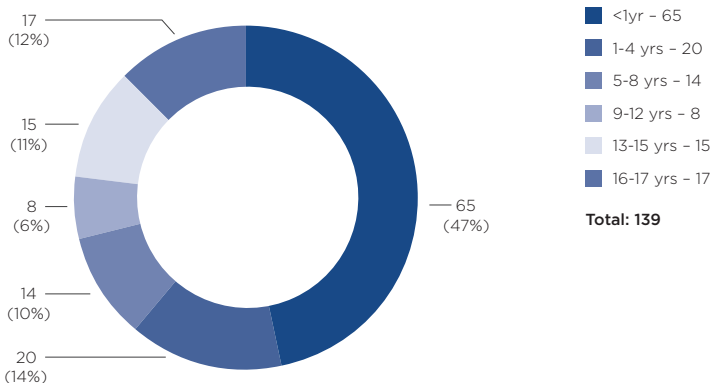
41 A review of child deaths in England found that in 2009/10, 65% of children who died were under the age of one. Department for Education (2010). *Preventable Child Deaths in England: Year Ending 31 March 2010*. Department for Education: London. (http://www.education.gov.uk/rsgateway/DB/STR/d000943/osr17-2010v6.pdf).

42 Of the 589 children who died in NSW in 2010, 62% were under the age of one year. CDRT (2011).

43 Dale, P., Green, R. & Fellows, R. (2005). *Child Protection Assessment Following Serious Injuries to Infants: Fine Judgements*. NSPCC/Wiley: West Sussex.

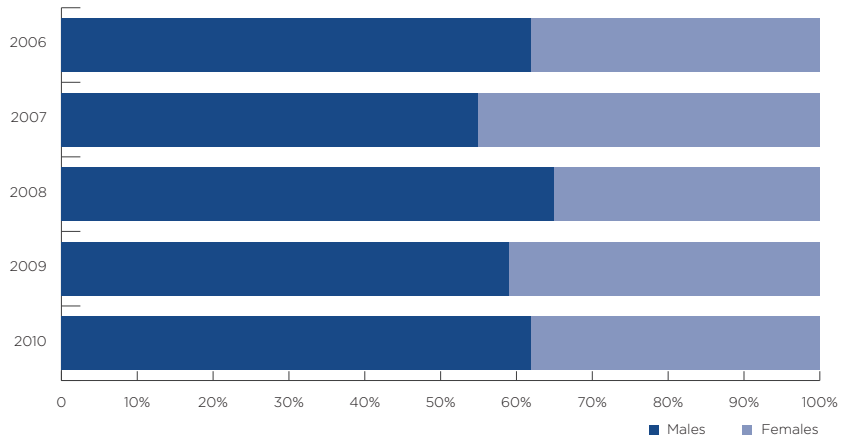
44 The CDRT found that in 2010 the most common cause of death for children over 15 years was injury. CDRT (2011).

Figure 11: Children and young people who died in 2010 by age.



Source: Community Services, 2011.

Figure 12: Deaths of children and young people from 2006 to 2010 by gender.



Source: Community Services, 2011.

Gender

86 Males

52 Females

1 Unknown

Male children and young people are almost twice as likely to be at risk of death as females. Eighty-six of the children and young people who died in 2010 were male and 52 were female. In one case, the gender of the infant was not known to Community Services, as this child's gender was not reported.

The over-representation of males has been consistently identified in NSW over the past five years (see Figure 12). This is consistent with international experience[45].

Research is limited and inconclusive about why a greater proportion of male than female children die. Research has found that male children are more likely to die as a result of an injury, possibly due to differences in behaviour, in the type of activities males and females engage in, and in the ways that girls and boys socialise from a young age[46]. Other research has found that male infants are at more risk of congenital abnormalities, such as heart malformations, an increased risk of SIDS and respiratory diseases[47].

45 CDRT reported that in 2010, 61% of children who died in NSW were male and 39% were female. Additionally, a finding in the UK was that the majority of child death reviews completed in 2009/10 were for male children (56%). HM Government (2009). *Public Service Agreement 13: improve children and young people's safety*. London, HR Treasury. (http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/d/pbr_csr07_psa13.pdf).

46 Australian Bureau of Statistics *Australian Social Trends*, 2005. ABS, Canberra, 2005.

47 Elsmen, E., Steen, M. & Hellstrom-Westas, L. (2004). Sex and gender differences in newborn infants: why are boys at increased risk?'. *The Journal of Men's Health and Gender*, 1(4), 301–311.

Aboriginality

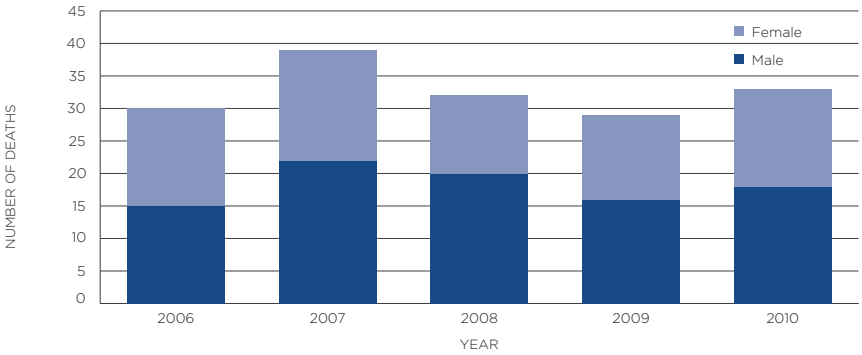
33 Deaths
24% Of All Deaths
18 Males
15 Females

In 2010, 33 of the children and young people known to Community Services who died were Aboriginal.

Aboriginal children are over-represented in child protection, out-of-home care and child death figures[48]. While Aboriginal children represent only 4% of the total population of children in NSW[49], Aboriginal children accounted for 17.5% of all child protection reports during 2009-2010 and 24% of all deaths in 2010[50]. Aboriginal children were also over-represented in suspicious injury deaths, house fires, motor vehicle accidents, SIDS and co-sleeping deaths in 2010.

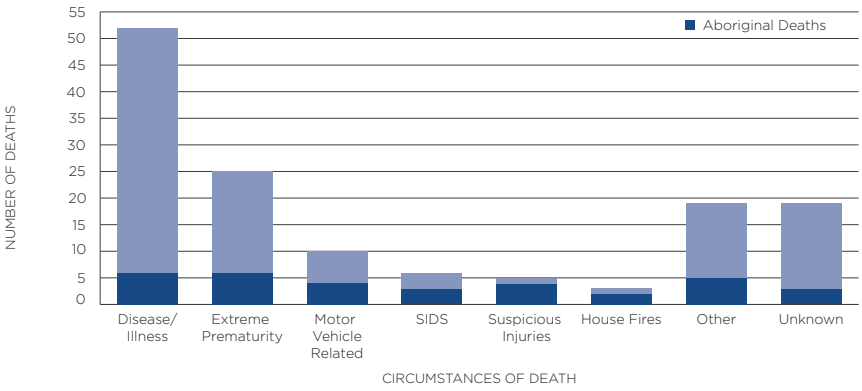
Aboriginal children are over-represented in child protection, out-of-home care and child deaths

Figure 13: Aboriginal children and young people who died between 2006 and 2010, including gender.



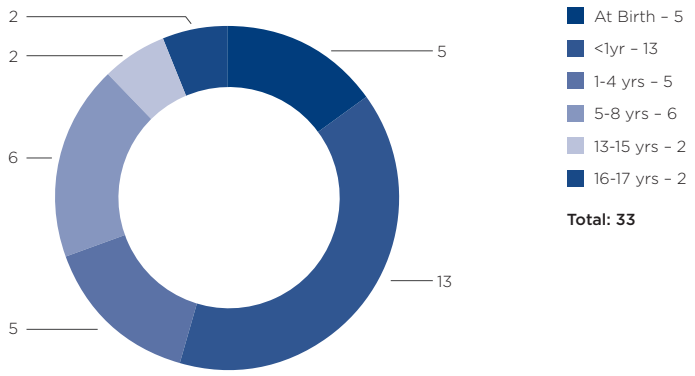
Source: Community Services, 2011.

Figure 14: Comparison of circumstances of 2010 deaths for Aboriginal and non-Aboriginal children and young people.



Source: Community Services, 2011.

Figure 15: Age of Aboriginal children and young people who died in 2010.



Source: Community Services, 2011.

48 Community Services recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. Community Services also acknowledges that Torres Strait Islander people are among the First Nations of Australia. This report acknowledges that it is possible that some families identified as Aboriginal could in fact be Torres Strait Islanders. However, as none of the 139 families were identified on Community Services' electronic KiDS database as Torres Strait Islander, this report uses the term Aboriginal.

49 NSW Commission for Children and Young People (2011). *A picture of children in NSW*. NSW Commission for Children and Young People and UNSW: Sydney. (http://picture.kids.nsw.gov.au/).

50 NSW Department of Family and Community Services (2010). *Annual report 2009/10*. NSW Department of Family and Community Services: Sydney. (www.community.nsw.gov.au).

2.4 Community Services' involvement with the families

Between 1 January 2010 and 31 December 2010, Community Services received 106,220 ROSH reports[51] relating to 65,041 children or young people[52].

Reports to Community Services

Of the 139 children who died in 2010, 106 (76%) children had been the subject of at least one report to the Community Services Child Protection Helpline prior to their death. Thirty-three children (24%) who died were not the subject of any reports to Community Services, but their sibling/s had been reported within three years of the death.

Eighty children were reported five times or less. However, five children had a very high level of reporting, and were the subjects of 20 reports or more.

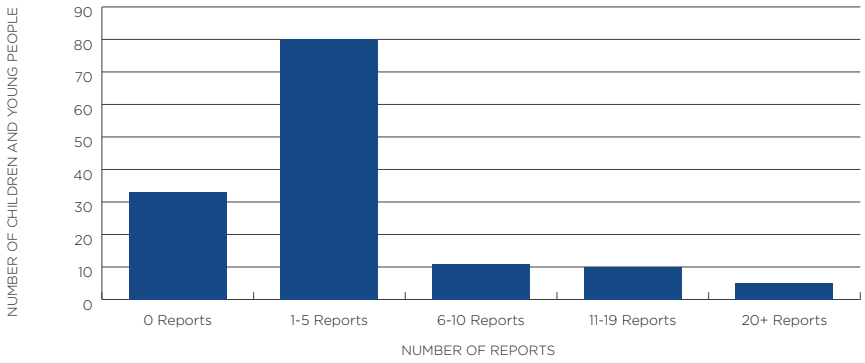
Prenatal reports

Of the 139 children who died in 2010, 23 children had been the subject of between one and five prenatal reports prior to their death.

Of these children, 18 were aged less than 12 months, including four infants who died shortly after birth, and five were aged between one and eight years when they died.

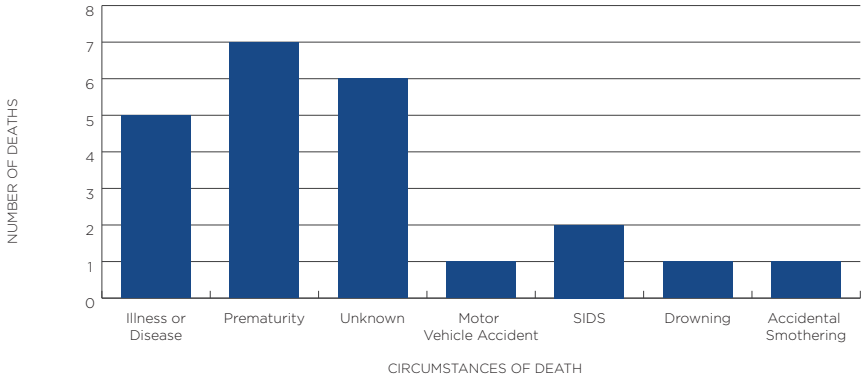
Eight of the 23 children reported prenatally were Aboriginal.

Figure 16: The total number of individual reports to the Community Services Child Protection Helpline for the children and young people who died in 2010[53].



Source: Community Services, 2011.

Figure 17: Circumstances of deaths of children and young people who were the subject of prenatal reports prior to their death.



Source: Community Services, 2011.

Of the 23 children reported prenatally:

- serious levels of domestic violence were reported in 11 cases. In one case, the pregnant mother required hospitalisation after a physical assault triggered preterm labour
- drug and/or alcohol abuse was reported in nine cases
- maternal mental health concerns were reported in eight cases
- poor ante-natal care was identified in six cases[54].

51 ROSH reports relate to the period from 24 January 2010 onwards. For 1 January to 23 January 2010, reports referred for further assessment are used.

52 Data are extracted from a production environment which is updated on a daily basis. Therefore, these data cannot be exactly reproduced.

53 This includes reports received for the child or young person at any time in their life. Reports received prior to the proclamation of the ROSH threshold are included in these figures.

54 Some reports contained a combination of these risk factors.

Children in out-of-home care

Of the 139 children who died in 2010, 11 children were under the Parental Responsibility of the Minister for Family and Community Services at the time of death. A further six children were in another form of care arrangement including being placed with extended family under a court order or living in a disability or respite care setting arranged through Ageing, Disability and Home Care (ADHC).

Of the 11 children and young people who died while under the Parental Responsibility of the Minister:

- three children died of an illness and/or disease
- two children died of a drug overdose
- one young person was fatally injured in an accident
- the cause of death for five children is yet to be determined by the Coroner, but unsafe sleeping practices had been identified in two cases and for the other three children illness and/or disease had been identified.

The ages of the children ranged from 0 to 17 years. Three infants were under one year, two children were aged between five and eight years and six children were aged over 13 years.

Brighter Futures

The Brighter Futures early intervention program provides families with services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing. Further information on the Brighter Futures program is available in Chapter 3. The Brighter Futures program has run as a partnership between Community Services and non-government agencies.

Of the 139 cases of children who died in 2010, 35 families, a quarter of all deaths, were determined to be eligible for Brighter Futures services. Of these cases:

- 12 were referred to a Brighter Futures service provided by the non-government sector
- 10 families received a Brighter Futures service from Community Services
- six were closed due to a lack of capacity to allocate a case to the Brighter Futures program
- six were closed due to the family declining the service.

As part of the Government's initial reforms to increase capacity, from 2012 early intervention services for families below the ROSH threshold will be fully provided by non-government organisations, freeing Community Services early intervention caseworkers to work with families above the ROSH threshold.

2.5 Reported risk factors

This section provides information on the reported risk factors for the children who died in 2010[55]. The information has been collected from the child protection histories of the children who died and those of their siblings. Domestic violence continued to be the most common risk factor in 2010.

Risk factors

In 2010, domestic violence was the most commonly reported risk factor in the child protection histories of the children who died and their siblings, followed by parental substance abuse and parental mental health concerns. As Figure 18 indicates, domestic violence has been the most common risk factor since 2006.

It is important to note that these risk factors were also present in similar proportions for children reported to be at risk of significant harm (ROSH), but who did not die.

Domestic violence was the most commonly reported risk factor in the child protection histories of the children who died and their siblings

55 Reported risk factors were not necessarily assessed or substantiated in all cases.

Reported abuse and neglect

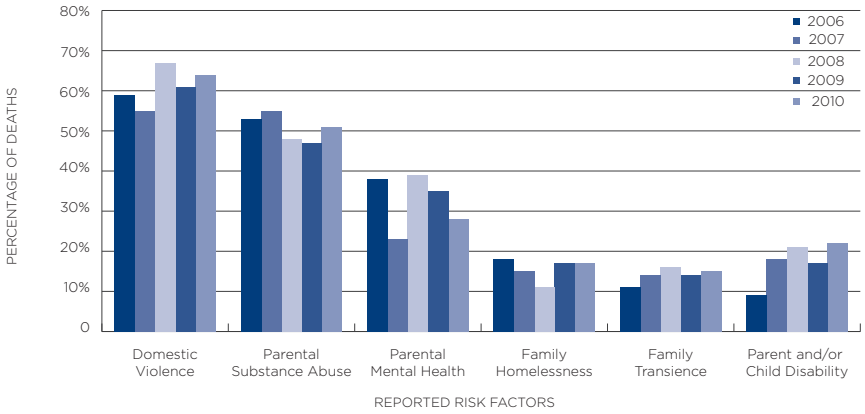
Of the 139 children who died in 2010, 66 children were reported to Community Services regarding some form of abuse or neglect[56]. This means that prior to the child's death, a risk of harm report had been made for the child who died, and/or their sibling/s concerning alleged neglect, physical abuse, sexual abuse and/or emotional abuse. These cases are shown in Figures 19 and 20.

Neglect featured in the child protection histories of 56 of the 139 children who died in 2010.

Intergenerational factors

Of the 139 children who died in 2010, generational patterns of risk featured in 56 of the children's family histories. For example, in many of these cases, parents who were alleged perpetrators or victims of domestic violence had also been exposed to domestic violence as children. Further, 44 of the children who died had one or both parents (61 parents in total) who were known to Community Services when they themselves were children.

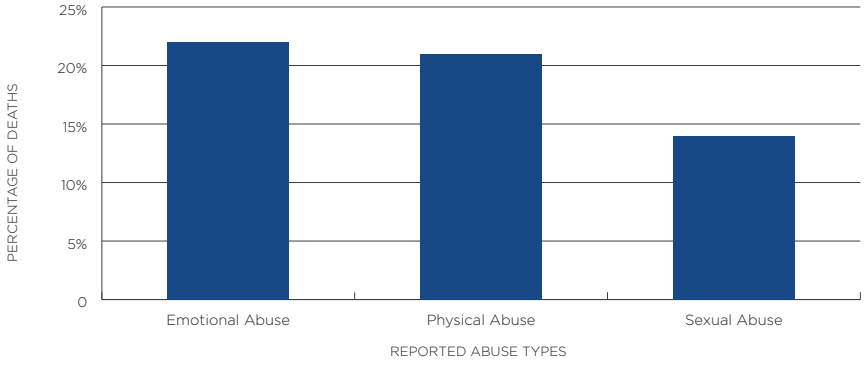
Figure 18: Reported risk factors from 2006 to 2010*.



* Please note that multiple risk factors may be reported in one case.

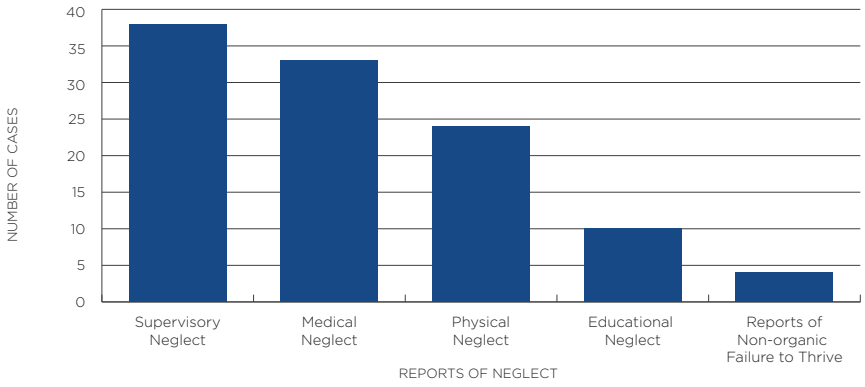
Source: Community Services, 2011.

Figure 19: Reported types of abuse for children and young people who died in 2010.



Source: Community Services, 2011.

Figure 20: Reported types of neglect for children and young people who died in 2010[57, 58].



Source: Community Services, 2011.

56 Reports about abuse or neglect were not necessarily assessed or substantiated.

57 Non-organic failure to thrive is a term used to describe when a baby is not receiving enough nutrients due to non-medically related factors including parental neglect.

58 As a child can have multiple reported issues, the categories are not mutually exclusive and do not add to a total percentage.

Chapter 3: Lessons for Improvement

Chapter overview

This chapter sets out the key themes and lessons for improvement that have emerged from Community Services' internal child death reviews in 2010. It also considers what has emerged from Community Services' reviews over the past five years and examines reports and literature from other jurisdictions. It starts by outlining the recurring challenges of child protection work faced by child protection workers globally: assessing risk holistically; asking the hard questions; focusing on the child; balancing safety and cultural sensitivity; and prioritising professional supervision.

This chapter then explores in more depth the key themes emerging from Community Services' reviews in 2010: working with competing priorities; assessing cumulative and changing risk; assessing risk from new partners or adult household members; working with intergenerational abuse; engagement with parents, caregivers and children; and working with risk in early intervention.

De-identified excerpts from review reports completed over the past five years are used to illustrate each theme, and present key findings from the reviews. Chapter 3 also outlines how current reforms are addressing the issues, what government can achieve and what is needed from parents, the community and agencies to support improved service delivery to children in NSW.

3.1 The enduring challenges of child protection

As discussed in Chapter 1, Community Services has been using a new approach to reviewing child deaths that is based on a UK model[59]. This approach has assisted Community Services to better understand how and why casework decisions are made in cases where children have died and what impacts on these decisions at the time. It also helps to understand the complexities of child protection work and what factors can assist or impede casework staff from doing their best work with families.

Common, enduring challenges are faced by child protection workers globally[60]. Child protection workers are often confronted with unique and complex issues and need to determine how to engage and deliver services to families who may not want these, are often reluctant and sometimes overly hostile about statutory child protection involvement. These challenges would be well known to most child protection practitioners and are outlined below.

Assessing risk holistically

A tendency to focus on 'incidents' (often the most recent reports) in risk assessments can obscure historical information and undermine the capacity of caseworkers to think holistically. Seeking and using information from our interagency partners and developing a broad, rather than a single-issue view of the cause of child protection problems is also a challenge in a high-volume environment, particularly where families have an extensive history and complex dynamics which need to be understood quickly. An example of this challenge was observed in the following review, which found:

> *...the children in this family were exposed to chronic and constant patterns of neglect, domestic violence and parental substance use over a number of years. However, the risk assessment completed by Community Services did not give consideration to this pattern. The assessment and subsequent case plan focused primarily on the immediate problems of homelessness for the family, without a holistic understanding of how domestic violence and substance abuse issues were contributing to the family's homelessness, as well as impacting on the care of the children.*

The children were exposed to chronic and constant patterns of neglect, domestic violence and parental substance abuse over a number of years

59 Fish et al. (2008).

60 Vincent, S. (2009). *An analysis of serious case reviews undertaken by Kent Safeguarding Children Board*. Kent Safeguarding Children Board: Kent.

Asking the hard questions

Effective engagement is critical when working with families. It can be challenging to engage parents while keeping a clear focus on the child. Workers need to be able to clearly discuss child protection concerns with parents and to state 'bottom lines' about 'good enough' care for their children. Working with reluctant families, asking hard or uncomfortable questions and challenging parents about practices that harm their children requires sensitivity, experience and courage.

These skills are critical in child protection work and underpin the capacity of staff to develop an accurate assessment of risk and the potential of families to change their behaviour. These challenges were observed in the review of a child who died in 2007. The review identified that the aggressive and controlling presentation of the mother's partner effectively deterred the caseworkers from challenging the mother and her partner about the cause of the child's injuries. The review found that:

> *...the mother's partner routinely showed hostile, threatening and aggressive behaviour towards professionals, including caseworkers. This behaviour and presentation may have influenced how challenging caseworkers were prepared to be with him. Caseworkers' fears about possible violence from families can negatively influence their capacity to carry out their work effectively, including decision making, assessments and intervention. Caseworkers did not appear to have challenged, or attempted to verify, the explanations provided about the child's injuries.*

Focusing on the child

Developing a case plan to address identified risks can be a significant challenge, as it takes time and relies on good risk assessment. A good case plan should clearly identify goals and tasks that will reduce risk and increase levels of care and protection for the child or young person. Once established, a case plan requires regular review to assess if the goals are being achieved and whether the risks to the child are being reduced. Reviewing the progress of a case plan and keeping a child focus in a high-volume environment can be extremely difficult. These issues were captured in a review in 2008.

The review found that:

> *...the risk assessment completed by the caseworker was successful in effectively drawing out and identifying key child protection issues and the underlying dynamics in the family that contributed to the increased vulnerability of [the child who died] and the siblings. The caseworker considered each child individually and, importantly, the children had an opportunity to talk about their concerns, fears and worries about their home situation. However, after the assessment, the case plan was not appropriately implemented. Casework focused on the family's accommodation issues and did not address the underlying drug and alcohol and mental health concerns in the family. Further, the children were not spoken to by caseworkers again, despite escalating risk issues in the family. As a result, the focus on the children was lost.*

The caseworker considered each child individually and the children had an opportunity to talk about their concerns, fears and worries

Balancing safety and cultural sensitivity

Providing culturally appropriate services to diverse communities in NSW is a major challenge for Community Services and a daily challenge for many child protection workers. The NSW Government is keenly focused on the over-representation of Aboriginal children in the deaths of children known to Community Services, and the difficulties faced by the workers across the sector who provide services to Aboriginal families. One key issue in this area is the challenge of balancing safety concerns for Aboriginal children with the importance of ensuring that ties to culture and kin are maintained. An example of this issue was observed in the 2010 critical case review of an Aboriginal child who was placed with family.

The review found that:

> *...Community Services did not identify, articulate or analyse critical information about the family member which should have questioned their capacity to care for the infant. It is positive that caseworkers tried to work within the legislative requirements of the Aboriginal Placement Principle*[61]*. However, the challenge is to balance these cultural considerations with the safety needs of a child. The Aboriginal Placement Principle was a major influence on the decision to approve the placement of the infant with the family member despite risks in the placement.*

Prioritising professional supervision

Professional supervision is a formal process that promotes critical reflection on cases and supports every aspect of child protection work, including the capacity of staff to address the enduring challenges and predictable errors inherent in this work. Community Services reviews have found examples of excellent supervision, but also examples where supervision had not equipped staff to deliver best practice.

A key challenge for managers in this area has been developing the skills to deliver reflective supervision and prioritising it in a crisis-driven environment. The importance of prioritising professional supervision is illustrated in the following example of a child who died in 2009. The review found that:

> *...it is a strength that caseworkers reported positive experiences of supervision and felt supported by their manager. However, there may have been an imbalance between the amount of formal supervision provided and informal case discussion, which predominated. While professional supervision and informal case discussion are both important aspects of enabling caseworkers to undertake the very difficult and important work of child protection practice, frequent unplanned conversations about a case are usually limited to whatever is most salient about the case at a particular time without looking at the case holistically. It seems that had formal supervision been prioritised, it is more likely that a case plan would have been developed that ensured that casework was planned, purposeful and focused on increasing safety for the children in this family. As a result, casework lacked a focus on the children's experiences.*

61 Section 13 of the *Children and Young Persons (Care and Protection) Act 1998* stipulates the hierarchy of placement considerations that must be followed for the placement of Aboriginal and Torres Strait Islander children and young people.

3.2 Working with competing priorities

Background

As noted in Chapter 1, the reduction in reports to Community Services since the introduction of the *risk of significant harm* (ROSH) threshold in January 2010[62] has not increased casework capacity to undertake child protection work[63]. A significant number of cases are closed due to 'competing priorities'.

This does not mean the child is not at risk of significant harm. Rather, it means there are other cases where the reported risks are considered to be more serious. Once those cases are allocated to a caseworker for a risk assessment, all the caseworker hours available in that Community Services Centre in that week may have been exhausted.

Practice and systemic issues

Community Services' review work over the past five years has identified two major challenges that managers experience when prioritising work:

- Managers Client Services[64] make weekly decisions about which new cases can be allocated for a risk assessment and which must be closed because of competing priorities.
- Managers Casework[65] make daily decisions about the work that can be done on all allocated cases.

Prioritising cases for allocation or closure

It is important to acknowledge that for the majority of cases that have been reviewed, the risks reported to Community Services before the child's death were not linked to the issues that caused the child's death.

Community Services Centres operate in a high workload environment. This is confirmed by child death review work over the last five years, which has consistently identified issues with competing priorities. In 64 of the 139 cases reviewed by Community Services in 2010, the majority of reports received for the child and/or their sibling/s had been closed without an assessment due to prioritisation of other cases where risk was more immediate.

In some cases, allocation and closure decisions must be made using very limited information. In other cases, careful analysis of volumes of files is needed to decide which cases to allocate. In addition, it is often not possible, on the basis of the available information, to identify those children who may be at risk of serious or even fatal outcomes amongst the hundreds of cases that Community Services deals with every day. This means that when casework staff are interviewed for child death reviews, they often quite reasonably state that the reports received for the child prior to the death did not stand out over and above many other high risk cases. This is consistent with international research:

> *Most commentators conclude that it is not possible to predict accurately which parent will kill their child*[66].

An example of this issue is highlighted in a case reviewed where a child died of suspicious injuries while in the care of a non-family member. Shortly before the child's death, Community Services received a report concerning the child due to the mother's deteriorating mental health and increased drug use, and the father's criminal history.

62 There was a 33% reduction in reports to the Child Protection Helpline and a 53% reduction in reports transferred from the Child Protection Helpline to Community Services Centres.

63 NSW Ombudsman (2011). *Keep Them Safe?* A special report to Parliament under section 31 of the *Ombudsman Act 1974*. NSW Ombudsman Sydney.

64 The Manager Client Services is the senior Community Services officer in the Community Services Centre and is responsible for the management of all aspects of Community Services' work in the local area serviced by the Community Services Centre.

65 Managers Casework provide direct supervision and support to a team of Community Services' caseworkers. They promote the development of casework practices that are aligned to Community Services policies and guidelines to ensure best outcomes for children, young people and families. They work collaboratively with other agencies to achieve high quality service delivery for children, young people and their families.

66 Reder, P. & Duncan, S. (1999). *Lost innocents: a follow-up study of fatal child abuse*. Routledge: London, P135.

In the process of reviewing this report along with 75 other reports received that week:

> *A Manager Casework took that report along with nine others out of the 75 reports considered to be high risk to a weekly allocation meeting*[67]*. All the Managers Casework at the meeting were in agreement that four cases could be allocated and the other six would be closed. The report about the child referred to above was not one of the four reports to be allocated. It was closed due to competing priorities with the other five reports.*
>
> *Of the four reports that had been allocated:*
>
> - *two involved babies experiencing medical complications following their premature births. Both mothers had extensive substance misuse histories;*
> - *one was about a teenager who had significant behavioural and psychiatric diagnoses. The mother was requesting urgent assistance as she was not coping with her child's difficult behaviours. There were concerns that the child was at risk of serious physical abuse from her mother*
> - *the final report was about an infant who had been abandoned by the mother and left in the care of other family members.*

The review found that after reviewing the records for the four cases that were allocated:

> *...the report for the child who later died was acknowledged to be serious, evidenced by this report being prioritised over 65 other reports received that week. However, when considering the information available to the Managers Casework at the time allocation decisions were being made, it was appropriate that the risks identified in this report did not receive priority over the four cases that were allocated.*

It is often not possible to identify those children who may be at risk of serious or even fatal outcomes

67 Weekly allocation meetings (WAMs) are a statewide procedure. Managers in all Community Services Centres meet weekly to review new reports that cannot be allocated due to insufficient resources. During the meeting decisions are made based on resources and capacity in the Community Services Centre: to allocate for case management; to close; to hold an interagency case discussion prior to closure; to gather further information prior to closure; to transfer to another Community Services Centre or team, e.g. early intervention; or to hold over for review at the following week's meeting.

Allocating tasks on a day-to-day basis

Child death reviews commonly reveal issues about the difficulties in prioritising day-to-day tasks within the context of a constantly shifting work environment. The dynamic nature of child protection work means that in addition to new, more urgent reports being received on a daily basis, crises in allocated cases continue to occur. An immediate response is required for these cases, which often diverts caseworkers' attention away from the completion of planned tasks.

In 2010, seven reviews noted that effective, child focused case plans were established for a family after a risk assessment, but that tasks were not followed up as planned. In one case reviewed in 2010, a child died of suspicious injuries. The review of this case noted:

> *In response to reports received just prior to the child's death alleging that the child had been physically harmed, caseworkers interviewed the child's parents. They provided inconsistent explanations for the injuries. Caseworkers arranged for the child to undergo a medical examination*[68]*. Medical opinion was that the injuries were not due to abuse and that plausible explanations could be provided.*
>
> *Caseworkers remained ambivalent about the findings of the medical examination. Out of their continued concern for the child's safety, the caseworkers, in consultation with their manager, were tasked with arranging for the child to undergo a second medical examination. However, this did not occur before the child died.*

The review found that:

> *...Community Services appropriately arranged a medical examination for the child. Despite the best intentions of the caseworkers, the case plan could not be followed up. The following day, these caseworkers were tasked with responding to a case where the risks were assessed to be more urgent – an infant had been seriously harmed and there were concerns about the safety of the infant's siblings in the home which required immediate assessment.*

The caseworkers worked in a very small Community Services Centre with significant staff shortages. As the child (who later died) had received a medical assessment that did not raise concerns of abuse, the follow-up of this case to obtain a second medical opinion was reasonably considered to be a lower priority to the other and more urgent matter.

Current reforms to improve services

As noted in Chapter 1, Community Services is implementing a number of ongoing initiatives designed to improve productivity These include Structured Decision-Making (SDM) tools and streamlined Triage and Assessment at Community Services Centres.

68 Section 173, *Children and Young Persons (Care and Protection) Act 1998.*

3.3 Assessing cumulative and changing risk

Background

Improving the quality of risk assessment is one of the enduring challenges of child protection work. It is a practice issue that has been extensively discussed in child death reviews over the past five years. Undertaking risk assessments is an integral part of Community Services' core work, as risk assessment informs decision-making about a child's safety and their need for care and protection.

In 2010, 24 reviews examined the quality of risk assessment for the family of a child who subsequently died. In 10 of these, strengths were identified in the quality of the assessment. These assessments appropriately considered Community Services' historical involvement with the family, the assessed issues were thoroughly documented, and the assessment was completed in a timely manner.

In 14 reviews, issues of concern were identified with the risk assessment process. These assessments had focused solely on the reported information, or lacked integration with and analysis of the family's history and/or current experiences, and the children were not sighted or spoken to during the assessment period.

Practice and systemic issues

Three issues have emerged from Community Services' review of cases where the quality of the risk assessment is an identified issue. These are:

- the importance of assessing cumulative harm
- the need to revise judgements and decisions in light of new information
- the need to sight children.

The importance of assessing cumulative harm

Child death reviews conducted over the past five years have found that while most deaths are not the result of intentional harm on the part of the parents/carers, some deaths are linked to the parents'/carers' inability to provide the child with an appropriate level of care.

In a child death review conducted in 2009, it was apparent that medical neglect was a contributing factor to the death of an infant. The infant had experienced recurrent illness since birth that did not appear to be life threatening, however, the parents had not sought medical treatment.

The review noted:

> *Over an eight-year period, the infant and siblings were reported to Community Services with multiple risk factors, in particular concerns about parental drug and alcohol abuse, domestic violence and serious and chronic neglect. The family's living conditions were in a constant state of disarray, infested with cockroaches, cigarette butts and beer bottle tops were strewn across the floor, parts of the carpet had stains, rubbish and dog faeces. The children had recurrent bouts of head lice and nappy rash that were untreated and the older children were presenting to school with soiled and torn clothing. The younger children were not up-to-date with their immunisations and were delayed in their speech.*

Most deaths are not the result of intentional harm on the part of parents or carers

The review found that:

> *...Community Services' involvement with the family resulted in temporary and minor improvements to their circumstances followed by a decline in the living conditions and in the children's physical wellbeing. A holistic and child focused risk assessment was needed that integrated and analysed the historical and current child protection issues, in particular, the continuation of poor parenting practices and the impact on the children's overall development living with serious and chronic neglect.*

Revising judgements and decisions in light of new information

Revising judgements and decisions when new information is received is a practice issue that has been extensively discussed in Community Services' review work over the past five years. The reluctance to revise judgements and decisions in light of new information is one of the predictable errors of child protection reasoning[69].

The critical importance of revising judgements and decisions when new information is received is illustrated in a review:

> *Shortly after the infant's birth, Police attended the family's home because of a verbal dispute between the mother and her boyfriend. Police were concerned about the children's safety because of the poor state of the living conditions. The infant required immediate medical attention for an infection. The mother had also not sought treatment for the infant's severe nappy rash. The infant was described as looking 'very sick'. Despite the parents' stated intentions, the infant had not been presented for a medical examination, and although the mother was referred to a family support service, she refused their assistance except for food vouchers. Caseworkers attempted to visit the family, but learned that they had relocated.*

The review found that:

> *...the decision to close the case did not demonstrate an acceptable level of understanding of the impact of cumulative harm and changing risk for the children. Despite evidence of persistent neglect, and new information about the infant's development and the apparent deterioration in the infant's physical health, no assessment of this information occurred.*

The reluctance to revise judgements and decisions in light of new information is one of the predictable errors of child protection reasoning

Sighting children

The one unwavering truth about child protection is that children and young people need to be seen by caseworkers, and seen often. Community Services' policy and procedure on conducting risk assessments indicates that during the assessment process, children and young people must be observed and, wherever appropriate, spoken with, taking into account their age and developmental level. However, the NSW Ombudsman has reported that child protection workers see fewer children despite the changed reporting thresholds for children at risk[70].

The value in sighting children can not be overstated. It improves caseworkers' engagement with children and young people. It enables caseworkers to build a more accurate picture of the child's day-to-day experiences and to develop a better understanding of what life is like for the child in their family and community. Where caseworkers are unable to adequately interact or speak with a child, it is equally important to make observations of the child, such as the child's interactions with parents and siblings, and whether the child is meeting their developmental milestones. Seeing children also supports more accurate risk assessments and decisions about the level of safety and protection for the child. The importance of seeing children is demonstrated in the review of an infant who died in 2008. The review found that:

> *...over an eight-year period, the family was reported to Community Services on 20 occasions. When the reported information was considered holistically, a strong picture of neglect emerged. It was obvious that the parents were not coping with the care of their young children and it is concerning that, despite serious risk, the majority of the reports were closed without assessment. During the eight-year period, the children were sighted on five occasions. Prior to the infant's death, concerns had been*

69 Munro, E. (2005). A Systems Approach to Investigating Child Abuse Deaths. *British Journal of Social Work*, 35, 351-546.
70 NSW Ombudsman (2011). *Keep Them Safe?* A special report to Parliament under s31 of the *Ombudsman Act 1974*. (www.ombo.nsw.gov.au).

reported about developmental delay and the possibility of failure-to-thrive. The infant who died was not sighted by caseworkers prior to the death. Community Services learned after the infant's death that the infant suffered significant health issues and that the parents did not seek medical treatment after the initial diagnosis was made. It is possible that had the infant been sighted, concerns for the infant's overall development may have been identified.

Current reforms to improve services

Structured Decision-Making

Community Services has recently implemented a new Structured Decision-Making (SDM®) system for assessing risk – Safety and Risk Assessment (SARA). The new approach is research and evidence-based and has been customised specifically for NSW. The goals of the system are to determine risk to children and young people through a structured process of information gathering and analysis. This is intended to produce more methodical and thorough assessments.

SARA includes three distinct tools:

- Safety Assessment: concentrates on identifying factors that represent imminent danger to the child or young person.
- Risk Assessment: provides an estimate of the probability that a child will be abused or neglected in the future.
- Risk Reassessment: considers progress and estimates the probability that a child will be abused or neglected if the case is closed.

The tools will enable caseworkers and managers to identify critical decision points, to increase the reliability and validity of decision-making, and to focus the information gathering and assessment process. After a trial period, these tools were rolled out statewide, and are now being used by all Community Services Centres for most risk assessments. In future years, Community Services will continue to gather data and report about their use and development.

The tools ensure that any previous reported concerns for the child, their relative priority, and the potential for cumulative harm, are considered when deciding whether the case can be closed or if it should proceed to further assessment. Where there have been multiple previous reports, the potential for cumulative harm impacts for the child must be taken into account when making this decision.

As these tools were not used in the majority of Community Services Centres in 2010, findings about risk assessment in this Child Deaths Annual Report mainly relate to the framework previously used for risk assessment within Community Services.

The one unwavering truth about child protection is that children and young people need to be seen by caseworkers, and seen often

3.4 Assessing risk from new partners or adult household members

Background

While research presents no unequivocal indicators to predict with certainty which children will die from fatal assault, step-parents, overwhelmingly step-fathers, are twice as likely to kill a child than the birth parent[71]. The research also reveals that children who were fatally assaulted experienced at least one previous violent episode prior to their deaths[72]. The predictive value of this indicator is of course limited given that the vast majority of step-parents do not kill their children.

It is critical that risk assessment considers the history of the new partner or household member to identify any patterns of violence or other factors that may pose a risk to children

As noted in Chapter 2, of the 690 children who died between 2006 and 2010, 31 children whose families were known to Community Services, died from suspicious or inflicted injuries. Although the majority of these children sustained non-accidental injuries, allegedly caused by their biological parents, research highlights the particular risk posed by non-biological parents, particularly the male partner of a child's mother.

Of these 31 children, in four cases the mother's partner was charged with the child's murder. In another case, both the mother and her partner were charged with the child's murder. All the partners were male and had been in a relationship with the mother for less than two years.

Practice and systemic issues

Three key issues emerged from Community Services' review of child death cases where partners were suspected of causing the child's injuries:

- the importance of broadening assessment to include new partners or adult household members when this information is available to Community Services
- the challenges in assessing risk when families conceal a new partner or household member
- the importance of intervention including a strong focus on children and considering what they can tell us about their experiences.

Including information about new adult household members in risk assessment

A number of recent child death reviews have highlighted the risks that can emerge when new partners join a household. Of particular concern are cases where the new partner has a history of perpetrating serious domestic violence or a record of other violent and anti-social behaviours.

Community Services may not always receive information about new partners or household members. However, when it does, it is critical that risk assessment considers the history of the new partner or household member to identify any patterns of violence or other factors that may pose a risk to children.

Risks can emerge when new partners join a household

Many of the reviews highlight the need for thorough assessment of new partners. In one case reviewed in 2009, an infant died from injuries allegedly inflicted by the mother's partner. The review noted:

> *Two months before the infant's death, information was received that the mother had commenced a relationship with a new partner and that she and the infant were residing with him. Her residence was a considerable distance from supports. The name and details of the new partner were provided to Community Services; however, further inquiries were not made about him.*

The review found that:

> *...assessment of the change in the family's circumstances was particularly important in this case, as the mother and infant were residing with a person about whom the Community Services Centre had information. There was no assessment of the new partner or the risk that he posed to the mother and her infant. An immediate assessment was warranted to consider risk and plan for safety for the mother and infant; however, this did not occur prior to the child's death.*

71 Cavanagh, K., Dobash, R. E. & Dobash, R. P. (2007). The murder of children by fathers in the context of child abuse. *Child Abuse and Neglect,* 31, 731-746.
72 Lawrence, R. (2004). Understanding fatal assault of children: a typology and explanatory theory. *Children and Youth Services Review*, 26, 837-852.

Assessing risk when information is withheld about new adult household members

Reviews also found that despite efforts by Community Services staff to gather information about the structure of households in which children were living, information was not always accurate or forthcoming. These cases, such as the one described below, highlight the significance of information obtained about a history of aggressive and violent behaviour by a household member, usually the partner of a birth parent.

In a 2010 review, this was not identified as a potential risk for the child and considered as part of ongoing risk assessment:

> *A young child was living in a household where the new partner of the child's carer had a history of extremely violent behaviour toward a previous partner. This behaviour and the perpetrator's history of other anti-social behaviour posed a significant risk to children in the past and to this child.*
>
> *Caseworkers repeatedly acted on information that the perpetrator was living in the household, but were met with outright denial and hostility by the carer. This was coupled with active attempts by the carer to conceal the involvement of the perpetrator in the household.*

The review found that:

> *....a more objective and thorough assessment would have resulted in consideration of the source of the evidence and review of Community Services and Police records. This would have provided an opportunity to challenge the carer with evidence about the involvement of the perpetrator in the household and to deliver the 'bottom line' that it was unacceptable for the child to continue living in the same household as the perpetrator.*

Current reforms to improve services

Assessing and managing risks to children posed by adults in carer households

A child is cared for in a household, not only by a single carer.

That is why Community Services is working with other stakeholders, including the Ombudsman and Children's Guardian, to establish a whole-of-sector position on assessing and managing the risks posed to children by partners of authorised carers. This work considers all adults who play a significant role in the household.

There is strong support for an improved and consistent cross-sector approach to assessment and probity checking.

Community Services will review and make any necessary changes to its policy and procedures in this area, in collaboration with its key partners.

Assessing and managing risks to children posed by persons on the NSW Child Protection Register

The Child Protection Register (CPR)[73] enables Police to manage and monitor the conduct of persons who have been convicted of child sex offences, to reduce the risk of re-offending.

A CPR working group has been established with Community Services, NSW Police and Corrective Services to develop a better understanding of each agency's respective roles, responsibilities, powers and limitations in matters involving persons listed on the CPR. In addition to this, work is currently underway in partnership with Community Services and Police to improve systems regarding the exchange of information and assessment in matters involving persons on the CPR.

73 In accordance with the *NSW Child Protection (Offenders Registration) Act 2000*, other registrable offences include the murder of a child, kidnapping of a child, child prostitution and offences relating to child pornography.

3.5 Working with intergenerational risk factors

Background

Undertaking comprehensive assessments of families who have been known to the child protection system for several generations presents significant challenges in child protection casework. Child death reviews have found that such families often present with complex dynamics and a consistent range of risk factors across successive generations. Community Services' reviews have found that children in these family environments often experience instability in their living and care arrangements.

Of the 139 children who died in 2010, generational patterns of risk featured in 56 of the children's family histories. For example, in many of these cases, records note that parents who were alleged perpetrators or victims of domestic violence had also been exposed to domestic violence as children. Further, 44 of the children had one or both parents (61 parents in total) who were known to Community Services as children.

As noted in Chapter 1, families in which parents present with multiple risk factors often experience wider societal disadvantage including housing instability, financial difficulties, low educational attainment and social marginalisation[74]. Such families are often high-need, are frequently reported to Community Services, and are often known to multiple agencies including Housing NSW, now within the Department of Family and Community Services, Corrective Services, Health, Police, Centrelink and non-government services.

Family homelessness and poverty[75] featured in 29 of the 139 families reviewed with intergenerational family histories. Reviews also found that as a result of homelessness and transience, these families become known to several Community Services Centres, further complicating the assessment and intervention process.

> The allocation of cases involving families with complex and lengthy histories comes at the cost of not allocating other urgent cases

Practice and systemic issues

Two key themes emerged from Community Services' review of child death cases where intergenerational abuse was a feature:

- the challenges for casework intervention with families with complex histories
- the importance of conducting a clear analysis of the underlying issues.

Challenges for casework intervention with families with complex histories

In the context of staffing and workload pressures within Community Services Centres, Managers Casework know that allocation of cases involving families with complex histories can be resource intensive and lengthy purely in terms of the sheer volume of history, which often runs into hundreds of pages and takes significant time to read. This comes at the cost of not allocating other multiple, less complex but nevertheless urgent cases. In addition, when a chronic pattern of multiple risk factors is apparent across generations, practitioners may form the view that these families have a certain level of dysfunction that may not be possible to change despite intensive casework.

74 Bromfield, L., Lamont, A., Parker, R. & Horsfall, B. (2010). *Issues for the safety and wellbeing of children in families with multiple and complex problems – the co-occurrence of domestic violence, parental substance misuse, and mental health problems*, National Child Protection Clearinghouse, Australian Institute of Family Studies.

75 For the purposes of this report, family homelessness refers to the family having no accommodation or living in short-term temporary accommodation; family poverty refers to children in the family being significantly disadvantaged by the family's financial circumstances.

The complex nature of these families was demonstrated in a 2010 review of a child who died. Several generations of the family were known to Community Services. The review noted:

> *The child who died, the siblings and the parents have been known to Community Services for nearly 10 years. Reported concerns during this time included parent/child attachment issues, maternal involvement with violent partners, parental drug and alcohol abuse, mental health issues, involvement in criminal activity, allegations of child sexual abuse, and physical abuse and neglect of the children.*
>
> *The family's history features two generations of children being removed from their parents' care and repeated teenage pregnancies, concerns about parenting and protective capacities and the range of risk factors described above. When the child started to live with a family member, an assessment of the child's safety did not occur.*

The review found that:

> *…undertaking a comprehensive assessment would have been lengthy and challenging. The challenges of comprehensive risk assessment in child protection work are amplified in situations where the context of assessment includes abuse and neglect across generations and in complex extended families. However, it could have identified concerns for the child's safety.*

Conducting a clear analysis of the underlying issues

Brandon et al.[76] describe the concept of the 'start again syndrome' as a common feature of practice with families with complex intergenerational abuse and neglect. They suggest that casework intervention tends to be focused on the 'here and now', and any historical intervention that may have occurred with the family is ignored. Evidence of the 'start again syndrome' in casework includes responding in an overly optimistic way to a new pregnancy, a new baby or a new report. Starting again can include referrals to support services or parenting skill development when evidence in the family's history indicates that the parents failed to attend such services when previously referred. Reviewing casework files for these families is a significant task. However, without a comprehensive file review, it is difficult to identify what intervention occurred with the family historically and how they responded to this intervention. This contributes to an understanding of the real level of risk facing the child.

Community Services' reviews of families with complex histories find that it is not uncommon for the cases to be allocated only for short periods of intervention. Again, this is common across jurisdictions, with Brandon et al. referring to this approach as 'displacement practice'[77]. Family 'symptoms' are treated rather than conducting a clear analysis of the underlying problems, and cases can be closed despite evidence of increasing risk.

In a case reviewed in 2010:

> *A child was the subject of multiple reports to Community Services. The child was born prematurely and with multiple and serious health issues. The reported risk factors for this child related to chronic family transience, inadequate accommodation, and the parents' failure to present the*

76 Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D. & Dodsworth, J. (2008). The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect. *Child Abuse Review*, 17, 313-330.

77 Ibid.

child for follow-up medical appointments. These concerns were raised within the context of other contributing risk factors, namely generations of child protection history for a number of family members. Numerous attempts were made to provide practical support to the family prior to the child's death through the provision of household goods and in obtaining appropriate accommodation.

The review found that:

...concerns about the child's significant and ongoing medical needs were overlooked. Given the generational history and multiplicity of chronic issues in the extended family, a rigorous assessment of the impact of the family's history and current circumstances was needed to identify the cumulative risks to the child.

When working with families with complex intergenerational abuse and neglect, a good investment of casework time is examining the history to understand the complex dynamics in these families. The value in doing this work is that caseworkers will be better able to identify the whole experience of the child, the issues impacting on parenting and how these may place children at risk, and possibly to identify family strengths that could be built on or decide whether removal is the only alternative. It is important to understand what intervention has already occurred. This work will support staff to develop effective case plans that are purposeful and unique to the needs of individual families.

A good investment of casework time is examining the history to understand the complex dynamics in these families

Current reforms to improve services

Adolescents with Complex Needs Panel

The Department of Family and Community Services' (FACS') *Integrated Service Delivery for Clients with Complex Needs Program* focuses on children of all ages who have complex needs, present an extreme risk to themselves and others and whose needs cannot be met by existing mainstream services.

This work has resulted in the establishment of the Adolescents with Complex Needs Panel where senior representatives from FACS, Health and Education bring together a holistic and therapeutic service response specifically targeted to the needs of children and young people.

Family Case Management

Family Case Management (FCM) is an integrated case management response to families who frequently come into contact with multiple government agencies and non-government organisations and show little improvement in their situations. Family Case Management currently focuses on those families with a child or young person at risk of harm, rather than risk of significant harm. The aims of FCM are to strengthen overall family functioning and reduce the risk of harm to children and young people. There is also a focus on improving agency collaboration so that procedural, policy, and system barriers do not prevent frontline staff from effectively helping families. FCM is running in eight sites in three regions: South West Sydney, South East NSW and Western NSW.

The Child Assessment Tool

The Child Assessment Tool will more effectively assess the needs of children and young people to determine the level of care and type of placement required, from general foster care to intensive residential care. Its application has the benefit of ensuring that children and young people are better placed, where their needs are most likely to be met.

A shared approach to child wellbeing

The cases described in this section are two of many reviewed by Community Services where re-reported families with complex and extensive histories, despite presenting with a multiplicity of chronic issues never reach the threshold for sustained intervention. A coordinated and continuously focused approach from Community Services and government departments is needed to overcome intergenerational cycles of abuse and neglect.

Addressing intergenerational disadvantage requires a whole-of-government approach

Many of the problems faced by these families relate to their social and/or economic disadvantage, and addressing them is beyond the capabilities of any one department.

Addressing intergenerational disadvantage requires a whole-of-government approach involving stamina and persistent casework, and robust interagency relationships that provide a sustained multi-agency case managed response.

3.6 Engaging parents, caregivers and children

Background

Community Services' review work has highlighted that the involvement of statutory child protection can cause parents and other family members to respond in a variety of ways. Many parents and caregivers engage well with caseworkers, but some respond with fear, hostility, aggression or reluctance. In the face of Community Services' involvement, family members may unintentionally or deliberately withhold critical information about risks to children.

Individual child death reviews have identified that in an attempt to engage one or both parents, or with the wider family, caseworkers can sometimes lose focus on the experience of the child. Community Services' reviews have also identified a tendency for caseworkers to focus their assessment and intervention on the mother, unintentionally missing the key role of the father. This is particularly problematic in cases where risk factors are largely related to the father's behaviour, for example his violence or substance misuse.

Practice and systemic issues

Three key issues related to engagement have been identified in Community Services' review work, each of which impacts on the enduring practice challenge of keeping a clear focus on the child's experience. These issues are:

- engaging fathers in casework
- working with reluctant families
- working with extended family members.

Engaging fathers in casework

Overlooking the father or partner in the risk assessment process or case planning has been identified as an ongoing issue in child protection work. Community Services' reviews have found that this is of particular concern where there is domestic violence in which the father or male partner was the alleged perpetrator. Internal reviews have also identified good practice. For example, in a review conducted in 2010, the father was appropriately engaged in assessment work. The review noted that the baby who died in undetermined circumstances:

> *The child had been reported prenatally, and the siblings had been reported on multiple occasions with concerns about parental mental health issues, substance misuse, domestic violence perpetrated by the children's father on their mother, the unhygienic state of the house and concerns the children were not adequately fed.*

The review found that:

> *...the risk assessment clearly benefited from the involvement of the father in the process. He himself commented to caseworkers several times that 'I can't believe you got me in here, no one has ever asked me about what I think'. The review found that the caseworker confidently and appropriately challenged the father to take responsibility for his behaviours and to understand the impact of his violent behaviour on the children.*

However, in three of the 2010 reviews, it was noted that there were a number of missed opportunities to invite men to be accountable for their violence and to consider the impact of their actions on the mother and her children. In each case, the father was not spoken to during assessment. The intervention focused on mothers and asked them to protect the children, failing to acknowledge and address either the power imbalance in the relationships or the fathers' equal responsibility to parent their child.

This is an issue commonly encountered in child protection work referred to as the 'Invisible Man Syndrome' where *'we see the impact of his actions but we never see him'*[78]. Burke wrote about the tendency for statutory interventions to be gender biased, focusing on the mother as the primary carer and person responsible for providing protection to the children[79].

"I can't believe you got me in here, no one has ever asked what I think."

It is important to acknowledge that a perpetrator's violent or intimidating behaviour can result in caseworkers feeling reluctant to engage or challenge men in these situations. However, effective engagement with perpetrators of violence provides valuable opportunities for casework staff to gather critical information about the family and invite the father to take responsibility for his violent behaviour and its impact on his child. It also enables the caseworker to advise the father of the potential consequences for the family, including the removal of the child.

Engaging reluctant families

Obtaining a clear picture of what life is like for a child can be a significant challenge in child protection work when there are difficulties engaging with a family. Understanding the reasons why parents or other family members may be reluctant to engage with caseworkers is a key first step to addressing this. A child death review undertaken in 2010 noted:

> *Two young children were reported to Community Services on a number of occasions because of the mother's alcohol abuse and concerns that she may have been physically harming the children. During one home visit, the mother became verbally aggressive towards caseworkers when they raised the allegations with her. After several unsuccessful attempts to investigate the reported concerns, caseworkers made contact with the mother when a report was received about her deteriorating mental health. She agreed to remain in contact with the Community Services Centre and for the children to be involved with support services. Despite her stated intentions, the mother did not comply with any aspects of the agreed case plan. The parents were separated because of a history of domestic violence.*

The review found that:

> *...the mother's continued avoidance of Community Services' attempts to monitor her parenting and her inconsistent use of support services should have amplified rather than allayed concerns about the children. The mother seemed to be quite adept at keeping services at a distance through a range of strategies. A sustained and assertive intervention designed around ensuring the children's immediate safety, rather than around what the parent was prepared to tolerate, was needed.*

A key feature observed in this and other reviews was poor understanding of the concept of *'disguised compliance'*[80]. The authority of the caseworker is *'neutralised'* by apparent cooperation from the family, and apparent cooperation and engagement can reduce or end Community Services involvement. Reder et al. argue that the primary cause of this behaviour is about control – *'it would seem that the parents' tenuous sense of control over their lives was threatened... (and)... they responded by distancing themselves and withdrawing'*[81].

Supervision is essential in order to keep perspective and to reflect on how the parents' behaviour can affect the way that a caseworker works with the family

78 Burke, C. (1994). Redressing the balance: child protection intervention in the context of domestic violence. In Breckenridge, J. & Laing, L. (1999). *Challenging Silences and Innovative Response to Sexual Assault and Domestic Violence*. Allen & Unwin: Sydney.

79 Ibid.

80 Reder, P., Duncan, S. & Gray, M. (1993). *Beyond blame: Child abuse tragedies revisited*. Routledge: London, p106.

81 Ibid, p99.

Community Services has found in previous reviews that the challenge of trying to engage a reluctant parent or carer can lead to caseworkers losing sight of the child. In the face of competing demands, the parents' superficial engagement with a case plan may be missed.

Caseworkers need to challenge pre-existing ideas of the cause of parents' or other family members' reluctance to engage. Supervision is essential in order to keep perspective and to reflect on how the parents' or carers' behaviour can affect the way that a caseworker works with the family and whether risk is reducing to the child.

Disguised compliance is where the authority of the caseworker is *neutralised* by apparent cooperation from the family

Working with extended family members

In order to support children to remain with their family where possible, Community Services is required to work closely and collaboratively with extended family members to develop and implement safety plans for children. However this is often difficult when these family members are also reluctant or unwilling to engage with caseworkers. This is particularly significant when there are chronic child protection issues that span several generations, which can lead to negative perceptions of the agency.

A 2010 child death review noted that:

> *...the children had been removed from their parents' care as a result of chronic and serious parental substance misuse. The children were placed with family members, who had agreed to supervise any contact between the child and the parents. However, the parents did have unsupervised contact with the child without the department's knowledge.*

The review found that:

> *...in this case an appropriate balance between engagement, participation and child safety was not achieved. The decision to place the children with family members was flawed, given that they were not in agreement with Community Services' assessment of the potential risks posed by the parents, despite evidence to the contrary. The family members were not in a position to provide adequate supervision.*

When engaging with extended family members, particularly when they are being assessed as potential carers for children, Community Services' reviews have found that it is essential to have direct or 'bottom line' conversations with them to clearly communicate the risks to the child, as well as what is and what is not negotiable in relation to the care of a child. If extended family members do not agree with Community Services' assessment, then Community Services must decide if it can ensure the children's safety when in their care.

Current reforms to improve services

Learning resources

Community Services has made changes to learning resources and tools to assist caseworkers to promote better engagement with families. Casework practice topics, research papers and training modules for caseworkers and managers are some of the strategies that have been developed to support caseworkers. Caseworkers can access comprehensive information on domestic violence on Community Services' intranet. The Domestic Violence site provides information and practice tips on working with families affected by violence.

Community Services has recently published an information resource about domestic violence for caseworkers. This resource includes separate topics about working with both victims and perpetrators of violence. These topics contain advice about engaging with families in these situations in addition to a resource tool for assessing a perpetrator's capacity to change.

The Clinical Issues Unit

Community Services' Clinical Issues Unit (CIU) provides clinical advice on domestic violence, drugs and alcohol and mental health concerns to frontline staff working with complex, high risk families. A consultation can help to unpack the complexities of a case where there are multiple problems and provide advice about how to engage with families and the best sequence of interventions.

Training to work better with aggressive and violent men

In October 2011, training commenced for caseworkers on 'Working with men who use violence in the home'. The training aims to assist caseworkers to develop new strategies for establishing and maintaining effective conversations and respectful relationships with men who use violence in the home, while holding them accountable for their actions to ensure the safety of children, young people and women.

A shared approach to child wellbeing

A key principle of NSW child protection legislation[82] is that when taking action to protect a child, the 'course of action must be the least intrusive intervention' which is consistent with the safety of a child. This requires Community Services to consider all avenues before casework decisions are made to use statutory child protection interventions such as removing a child from their family. It is known that children in the out-of-home care system are among the most vulnerable and disadvantaged groups in society. Research[83] shows that this group of children is likely to experience poorer outcomes including health, social and educational deficits and involvement in criminal activity. Balancing the impact of placing children in out-of-home care with the risk of supporting children to remain with their parents, without compromising children's safety, is a key issue for Community Services.

Balancing the impact of placing children in out-of-home care with the risk of supporting children to remain with their parents, without compromising children's safety, is a key issue for Community Services

82 Pursuant to section 9, *Children and Young Persons (Care and Protection) Act 1998.*

83 Mendes, P. (2009). Improving outcomes for teenage pregnancy and early parenthood for young people in out-of-home care, *Youth Studies Australia*, 28(4).

3.7 Working with risk in early intervention

Background

The Brighter Futures program provides voluntary targeted support tailored to meet the needs of vulnerable families. This program provides families with services and resources to prevent an escalation of emerging child protection issues. The program is delivered by both Community Services and non-government agencies. Community Services' early intervention teams are located in all Community Services Centres across NSW and work alongside child protection teams.

As discussed in Chapter 2, in 35 of the 139 cases, the family was assessed as eligible for Brighter Futures services. Overall, 22 families received a service from either a Community Services early intervention team or from a Brighter Futures non-government organisation. The remaining families who were determined to be eligible either declined the service, or there was no capacity to allocate the cases.

Practice and systemic issues

Three key issues emerged from Community Services' review of child death cases where Brighter Futures was involved:

- there are significant advantages in delivering Brighter Futures services to families across the spectrum of risk
- there are difficulties in managing cases within the Brighter Futures program where risks are escalating for the children
- there is a challenge in preventing cases from falling into a 'service gap', where risks are too high for the Brighter Futures program, but current capacity in child protection teams does not allow the cases to be allocated.

The advantages of delivering Brighter Futures services

An evaluation of the early intervention program undertaken in 2010 by the Social Policy Research Centre (SPRC) found that this service appeared to be improving outcomes for the majority of involved families. The overall finding was that family functioning was improved, parents were feeling better about themselves and were better connected to supports and services, there was more positive parenting and children's behavioural outcomes had improved. The evaluation also identified a significant reduction in reports made for families involved with the program, and children of these families were less likely to go into out-of-home care than those families who had declined services from the program[84].

Many reviews have supported these findings, with several positive practice examples of Brighter Futures service involvement noted. In one case reviewed in 2010, a child died as a result of a terminal illness. The review noted:

> *Prior to the child's death, the family was referred to the Brighter Futures program. The referral occurred after reports were received about stressors for the family relating to the child's medical needs, the parents' history of drug abuse and mental health issues. After a detailed assessment, early intervention caseworkers developed a support plan with the family. This involved regular visits to the family, arranging child care and respite services, and collaborating with health services to ensure that the child's medical needs were being met. When the child died, the caseworkers supported the family by providing emotional and practical support.*

The review found:

> *...the family valued the involvement of the Brighter Futures program. The practical and emotional support provided by early intervention caseworkers was appropriate during a very difficult time in this family's life and following the child's death.*

84 Social Policy Research Centre (2010). The Evaluation of Brighter Futures, NSW Community Services' Early Intervention Program, report for Community Services, University of NSW (www.community.nsw.gov.au).

Community Services' reviews have also found a range of advantages in early intervention teams working with families where there are risk issues. This is particularly the case for parents who may be suspicious or avoidant of child protection intervention due to having a history of involvement with statutory child protection services either as an adult or as a child. The capacity for early intervention teams to offer families a range of intensive supports through child care, home visiting or parenting programs is a significant benefit of the program in that these supports can both prevent and mitigate risks.

There are a range of advantages in early intervention teams working with families where there are risk issues

Managing significant risk in Brighter Futures

As noted above, changes to the Brighter Futures program mean that managing significant risk of harm in the Brighter Futures program will become more common within Community Services. To do this effectively, reflective discussions, ongoing planning and review are essential. A key observation of Community Services' reviews has been that as participation in Brighter Futures program is voluntary, early intervention teams can feel that they need to be cautious in challenging parental behaviour due to fear of parental withdrawal from the program.

A case review clearly illustrates this issue:

> *Both young parents, with their own child protection histories, agreed to the involvement of Brighter Futures. The parents were enthusiastic about learning positive parenting strategies. However, reports continued to be received about the child due to concerns about the mother's escalating mental health issues and new information about the father's criminal history. The case could not be allocated for a child protection response.*
>
> *A case plan was developed in consultation with the early intervention team and casework specialist with the objective of addressing the risk issues while maintaining the case within the Brighter Futures program. However, by this point, the family had begun to withdraw from the program. They did not return the early intervention caseworker's phone calls and cancelled planned home visits. The case plan could not be implemented and the case was closed after the family told the caseworker that they no longer wished to participate in the Brighter Futures program.*

The review found that:

> *...although this family was on the higher end of the risk spectrum for Brighter Futures services, it was appropriate for early intervention caseworkers to work with this family. However, when significant child protection issues began to emerge, the early intervention team became preoccupied with the limitations of their program area. This meant that opportunities to implement an innovative case plan to address risks were lost. Although the early intervention team did not cause the withdrawal of the parents from the Brighter Futures program, the team did not actively try to prevent it.*

Despite its limitations, the Brighter Futures program does allow caseworkers to address escalating risk. Good collaboration and partnership with child protection teams is one way of working with children at risk. Additionally, although having a direct, honest or 'bottom line' conversation with a parent about child protection concerns is more common within child protection, these discussions can also occur effectively within the Brighter Futures program.

Bottom line conversations with a parent can occur effectively in early intervention

The service gap between Brighter Futures and child protection

As discussed earlier, in 14 cases where children died in 2010, the case was streamed to the Brighter Futures program, but was determined to be ineligible and referred back to child protection teams. In nine of these cases, the family did not receive a service from child protection, as other cases had a higher priority.

This 'service gap' is a common problem. Current capacity issues in child protection mean that cases where there are more immediate risk issues must be prioritised, and as a consequence some cases with less immediate risk are closed without receiving a service.

A review conducted in 2010 illustrates this issue.

The review noted that the child:

> *...was part of a family who had been reported to Community Services on 15 occasions over a period of five years. The reports were about domestic violence, mental health and neglect. While each individual report fluctuated between a medium and a high level of risk, the issues in the family were long term and chronic, and never presented as urgent enough for allocation in child protection. But when considered holistically, the combined reports provided a very concerning picture of risk for the children in this family.*

The review found that:

> *...the family would have benefited from multi-agency support services to achieve a reduction in identified risks to the children. However, the risks in the case were too high for Brighter Futures services, while never being quite high or urgent enough for allocation in child protection.*

The Social Policy Research Centre's 2010 evaluation examined this service gap in detail[85]. A key aim of the Government's changes to Brighter Futures is to reduce the current service gap between Brighter Futures services and child protection, and to better support families with more complex issues.

Current reforms to improve services

Strengthening Families

From January 2012, Community Services' early intervention teams, renamed as 'Strengthening Families' will work with families with needs complex enough to put them above the ROSH threshold. As a statutory child protection response, Strengthening Families will not be a voluntary program. Where families seek to withdraw from the program, caseworkers will conduct an assessment to determine the appropriate follow-up action required, up to and including the removal of a child.

Non-government agencies will have a greater share of funding to work with families eligible for Brighter Futures services, including families who may not yet have come into contact with statutory child protection services.

Strengthening Families caseworkers will use the SARA tools to assess safety and risk in families. To better support families with more complex issues, the core program model is being strengthened to include a casework and case management focus on the parent vulnerabilities of domestic violence, mental health issues and drug and alcohol misuse and will more accurately reflect the needs of families participating in the program. This enhanced program response will apply both to the Brighter Futures program and the Strengthening Families program.

Casework will focus on the impact of these vulnerabilities on children and on parenting capacity. This will involve overt discussion with parents about existing risks to children and the need for change. Parents will be actively engaged around the development and implementation of strategies to address the identified risk issues. They will be supported to develop the necessary skills and resources to increase the safety of their children at home.

85 Social Policy Research Centre (2010). The Evaluation of Brighter Futures, NSW Community Services' Early Intervention Program, report for Community Services, University of NSW (www.community.nsw.gov.au).

In addition, case management will focus on facilitating access to specialist services, service coordination and, where appropriate, joint interagency case planning. Service managers will be required to promote the enhanced program model through appropriate guidance and support to caseworkers.

Strengthening Families will work with families above the ROSH threshold

Intensive Family Preservation

The Intensive Family Preservation (IFP) service is Community Services' highest-intensity early intervention program. It is designed to work with children or young people and their families to reduce the risk of children and young people being removed from their families and placed in out-of-home care. The IFP service uses a holistic approach to addressing families' needs. It offers an intensive level of casework and a broad spectrum of support services to families in crisis, over a 12-month period. The service is targeted at children and young people who are at imminent risk of removal from their families, but where an assessment is made that there is a reasonable prospect of improvement within the family with the right kind of targeted support.

A shared approach to child wellbeing

Government agencies, including Community Services, make a key contribution to effective early intervention. Community Services in particular is accountable for the delivery of early intervention to families at the higher risk end of the spectrum through Strengthening Families. This new program has two key aims:

- to ensure that Strengthening Families contributes to closing the gap between early intervention and child protection
- to ensure that caseworkers are well equipped to work confidently and assertively with the risk issues faced by families in the program.

Reducing the number of children at risk of significant harm who require a statutory response from Community Services cannot be achieved by Community Services alone. Early intervention is a key contributor, as are Child Wellbeing Units and Family Referral Services. Providing early intervention to families through both government and non-government agencies is a key contribution towards achieving this goal.

Children in NSW will be safer due to greater flexibility within the program, as well as better harnessing of the capacity of non-government agencies to provide services to children at the lower spectrum of risk.

Reducing the number of children at risk of significant harm who require a statutory response from Community Services cannot be achieved by the Government alone

Chapter 4: Improving Services Through Reform

Chapter overview

This chapter outlines the NSW Government's reform agenda for Community Services and outlines priorities and initiatives underway to improve services, to set the scene for the year ahead.

The NSW Government is committed to improving services, boosting accountability and transparency and empowering local communities. This first Child Deaths Annual Report delivers increased accountability for and transparency about the deaths of children and young people in NSW. For the first time, it shares with the public Community Services' reviews of its involvement with the families of children who died and how the agency aims to improve casework practice by learning from these tragedies.

If NSW is to overcome disadvantage rather than simply manage it, government (including Community Services, Health, Police, Education, Premier and Cabinet and others) and non-government organisations, their staff, supervisors and managers need to work in better ways and with fresh vigour. The NSW Government is determined to improve the protection of vulnerable children and young people.

This report refers to a number of initiatives and improvements underway at the change of Government in March 2011, as well as early fresh approaches over the first months of the new Government.

4.1 Leadership and goals

The Department of Family and Community Services brings together Community Services, Housing NSW and the Aboriginal Housing Office and Ageing, Disability and Home Care. The NSW Government is committed to full integration of the department to ensure that it effectively supports the most vulnerable in our community. Fundamental to an integrated department is leadership.

The NSW Government is confirming the leadership of the division of Community Services and the Department of Family and Community Services, following the departure of valued and long-standing leaders. The Chief Executive of Community Services, with the Director General of Family and Community Services, will lead corporate planning to deliver the Government's goals and reform agenda.

The *NSW 2021* State Plan goals for children are explicit. This in itself heightens accountability. The Government aims are:

- an increased proportion of NSW children who are developmentally on track in Australian Early Development Index domains
- a reduced rate of children and young people reported at risk of significant harm, by 1.5% per year
- a reduced rate of children and young people in statutory out-of-home-care, by 1.5% per year.

The Government will report on its performance in relation to these goals in the Family and Community Services Annual Report each year.

4.2 Reform in Community Services

In the short time since the March election this year, the NSW Government has started the process of reform to improve services.

At the heart of the reform agenda is a commitment to much needed organisational reform in Community Services and throughout the wider Department of Family and Community Services. A reformed Community Services will ensure that a person or organisation with the right experience and skills provides improved services and is accountable for those services. The reformed division will also ensure that performance over time will be visible to individuals, agencies, the Government and the public, including through Child Deaths Annual Reports.

Reforms to improve services will mean that:

- every child or young person who needs a service receives a service which is aligned to their needs, to help them stay safe at home wherever this is possible
- out-of-home care is a response of last resort; children are kept safe within their families or with kin or are adopted or provided with a permanent guardian
- where a child cannot remain in or return to the family home, there is timely decision-making about a permanent placement for the child
- services are provided as close to the child or young person as possible, harnessing the services of the whole of the child protection and child wellbeing sector including non-government organisations and are delivered in a timely and coordinated manner
- the statutory child protection agency focuses on children and young people at risk of significant harm
- a highly competent, as distinct from highly qualified, workforce uses evidence-informed interventions to sustain children and young people with their families and in out-of-home care.

A reformed Community Services will ensure that a person or organisation with the right experience and skills provides improved services and is accountable for those services

Boosting accountability and transparency

The NSW Government is delivering heightened accountability and transparency in Community Services for two reasons. The people of NSW need their government to face independent scrutiny and be transparent about what they have achieved, and what remains to be done. Secondly, transparency and accountability are key drivers of reform.

This *Child Deaths 2010 Annual Report* is an unprecedented publication of critical thinking and findings never previously shared with the public, with other government agencies or non-government organisations. Each year, the Government's publication of child death data and detailed updates about how it is working to improve the child protection system will both educate the public about the challenges of child protection and simultaneously empower the people of NSW to ensure that this and future state governments pursue real, challenging reform to improve services.

In November 2011, the NSW Government fulfilled an election commitment to increase the independence and authority of the Child Death Review Team by passing legislation to release the Ombudsman, as convenor of the Team, from a number of requirements which restricted the independence of his and the Team's oversight of government. As a result, external scrutiny of and accountability on government about child deaths and Community Services' involvement with these has been heightened.

These two measures – Child Death Annual Reports and increased independence for the Child Death Review Team – will underpin significant and enduring accountability for, and transparency about, child protection services.

Working better and smarter

Already in the early months of the Government, efforts are underway to improve services and the capacity of the child protection system.

Work to transfer out-of-home care to the non-government sector is well underway and the Government is forming a real partnership with the non-government sector. The transition will be long and careful. Securing real and enduring improvements in child protection requires nothing less.

Contracting, monitoring and other systems within Community Services and non-government organisations will need to be improved. Reforms will be challenging. Only real reform can increase the total capacity of the child protection system by harnessing the great talents and potential of everyone in the community, in government and non-government agencies alike.

Similarly, the Government has already transferred more early intervention work to the non-government sector to increase the system's capacity. Increased funding will be tied to innovative projects for adolescents, a group for whom we need to do so much better. This reform will encourage Community Services' early intervention caseworkers to focus on families at risk of significant harm. This reform will result in more caseworkers seeing more families.

A minimum monthly visit trial is underway at the time of publication. This important work will provide more ideas about how more caseworkers can see more children more often. As discussed earlier, the trial of the Child Assessment Tool, which commenced in 2010, aims to better match the needs of the child and their out-of-home care placement.

Working better and smarter also means reducing the need to remove children and young people. When a child needs to be removed, he or she will be. Nevertheless, the entire sector accepts that out-of-home care too often is not in the best interests of children and young people.

Reducing the proportion of children and young people in out-of-home care in NSW will also require real reform and changing the way we help families. That is why the NSW Government is encouraging innovative early intervention approaches through the development of a Social Benefit Bond, where investors are encouraged to buy bonds in a welfare venture aimed at doing good. Investors will be repaid their money with interest, if the trial venture demonstrates it has prevented entry into out-of-home care.

This is a new and very innovative public policy approach, so a great deal of work is being done to scope a bond and the benefits of preventing a child entering out-of-home care. Social Benefit Bonds, properly nurtured, can play an important part in broadening community involvement and increasing the resources applied to supporting all children and families to live safe, healthy and productive lives. Successful new programs should spread to other government activities.

The Government will continue to work with caseworkers and other child protection workers throughout the sector, as well as other stakeholders, to seek ways to improve existing systems and processes so we can work better and smarter to strengthen the child protection system.

Improving services: the challenge

The Ombudsman in his *Keep Them Safe?* and *Addressing Aboriginal Disadvantage* reports has clearly and strikingly outlined the challenge of improving services in child protection overall, and for Aboriginal people. Nothing less than a determined improvement in the way the Government designs and delivers programs and the way we all work each day can offer improvement in services and outcomes for vulnerable children, young people and families.

> Innovative approaches, working with and learning from our partner agencies, are critical

Improvements in how we work with Aboriginal children and young people at risk and with our most complex clients will be key indicators of service improvement overall. Innovative approaches, working with and learning from our partner agencies, are equally critical.

Aboriginal children and young people

The ongoing and significant over-representation of Aboriginal children and young people in child deaths reflects the continuing disadvantage faced by Aboriginal people. Aboriginal children are also highly over-represented in out-of-home care, representing 34% of children in out-of-home care in NSW in 2011[86]. Aboriginal families too frequently live in circumstances of severe poverty, homelessness, domestic violence, intergenerational neglect and abuse, parental substance abuse and mental illness.

Effective programs must address the structural disadvantage which underlies the social problems which contribute to child abuse and neglect within Aboriginal families. *Addressing Aboriginal Disadvantage*[87] reinforces the importance of closing the gap between Aboriginal and non-Aboriginal communities in NSW.

The commitment and efforts of the whole system are needed to work with and build the capacity of both the system overall and of Aboriginal organisations and communities. The Ministerial Taskforce for Aboriginal Affairs is leading this effort.

Complex clients

Complex clients are families, children and young people who experience multiple risks and are clients of multiple government and non-government agencies.

The NSW Government is committed to integrating services to overcome disadvantage, including for our most complex clients.

We are working to understand who and where our complex clients are, what is needed to free disadvantaged people and the gap between what is needed and current services provided by agencies across the child protection system.

The Department of Family and Community Services brings important services under one roof to encourage coordination and integration of improved services. Housing, for example, is a central player in the intergenerational cycle of disadvantage and poverty. Safe and affordable homes are central to safe and secure families and children. Support for children with disabilities is important to encourage their care away from home and adoption.

86 *Department of Family and Community Services Annual Report 2010/11*, p99.

87 NSW Ombudsman (2011). *Addressing Aboriginal Disadvantage: the need to do things differently*. A Special Report to Parliament under s31 of the *Ombudsman Act 1974*. NSW Ombudsman: Sydney.

Intelligence-driven child protection

The Government is also considering how intelligence-driven child protection can be used to understand and better provide for our complex clients. Intelligence-driven child protection is an approach which brings together information held across the child protection system to identify children at most risk and build interventions based on a complete picture of their needs and circumstances.

An early priority will be to consider how agencies' existing intelligence about children and families can help to build a rich and complete understanding of children at the most significant risk.

Income management

The Commonwealth Government is tying income management to improved social outcomes across Australia, including trials in NSW.

The NSW Government has already engaged with the Commonwealth to discuss integrating this tool with NSW services to help vulnerable families.

Learning from other jurisdictions

Community Services is currently reviewing the international literature on child death review and comparing the NSW approach to data collection, reporting and review with that adopted in other Australian jurisdictions.

Practices and experiences from other jurisdictions can help to inform our reform agenda.

4.3 Conclusion

We all need to believe in change and seek to build a culture that thrives on the challenge of continuous change for the better.

This report and Annual Child Death Reports in future years are an important contribution to this new approach. They deliver on the Government's commitment to transparency about the deaths of children reported to Community Services.

This report shares with the public and our partners in the non-government sector the complexity of the circumstances which lead to the death of children. It sets out the scale of the challenge for the whole of society, as well as government, if we are to reduce the number of those deaths which are preventable. Critically, it also shares for the first time the extent of Community Services' involvement in the lives of those children, what was done well, what needed to be done better and what can be done to reform and improve services.

Families, like all of us, are responsible for their choices. Where the state takes over families' primary responsibilities for their children, continuous reform will deliver improved services.

We all need to believe in change and seek to build a culture that thrives on the challenge of continuous change for the better

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Glossary

Aboriginal and Torres Strait Islander

Community Services recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. Community Services also acknowledges that Torres Strait Islander people are among the First Nations of Australia. This report acknowledges that it is possible that some families identified as Aboriginal could in fact be Torres Strait Islanders. However, as none of the 139 families were identified on Community Services' electronic database as Torres Strait Islander, this report uses the term Aboriginal.

Abuse

The abuse of a child or young person can refer to different types of maltreatment. It includes assault (including sexual assault), ill treatment, neglect and exposing the child or young person to behaviour that might cause psychological harm, whether or not, in any case, with the consent of the child.

Allocated case

A case that has been allocated to a caseworker for case management.

Analysis

In the context of risk assessment, analysis is the organisation of and/or the examination of information to identify risk factors and strengths that lead to decisions and judgements about a child or young person's need for care and protection.

Authorised carer

A person who is authorised as a carer including kinship or relative carer by a designated agency.

Brighter Futures

Community Services' Brighter Futures early intervention program provides families with the necessary services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing.

Case closure

Case closure is a considered casework decision that signals the end of Community Services' involvement with a matter.

Case meeting

Meetings held to facilitate information sharing, case planning, case review, decision-making and interagency coordination. The specific purpose of a meeting will depend on the particular type of plan or action required.

Case plan

A case plan is a document that sets out what action will be taken to enhance the child or young person's safety, welfare and wellbeing.

Casework

Casework is the implementation of the case plan and associated tasks.

Caseworker

A Community Services officer responsible for working with children, young people and their families, and other agencies in child protection, out-of-home care and early intervention. Caseworkers have day-to-day case coordination responsibilities. Caseworkers report to the Manager Casework.

Casework Specialist (CWS)

The Casework Specialist is a member of a regional team that fosters the implementation of quality casework practice that is consistent with the centrally developed Community Services professional development program. Casework Specialists are based in Community Services Centres. They maintain a strong operational focus in assisting caseworkers and Managers Casework to meet corporate operational standards around casework practice and quality improvement.

Child

The Children and Young Persons (Care and Protection) Act 1998 defines a child as a person under the age of 16 years.

Child Assessment Tool (CAT)

The CAT is designed to determine the placement type most appropriate for a specific child or young person. The tool captures information about behaviours, health and developmental issues to determine level of care.

Child Protection Helpline

The Child Protection Helpline (132 111) provides a centralised system for receiving reports about unborn children, children and young people who may be at risk of significant physical, sexual or psychological abuse or neglect, or families who are in need of assistance. It operates 24 hours a day, 7 days a week.

Child Wellbeing Unit (CWU)
CWUs were established in NSW Health, NSW Police Force, Department of Education and Communities and Department of Family and Community Services. CWUs assist mandatory reporters in government agencies to ensure that all concerns that reach the threshold of risk of significant harm are reported to the Child Protection Helpline. Concerns that do not meet the new threshold are referred to alternative services within that agency, or in other organisations, which could support the family.

Children's court
The court designated to hear care applications and criminal proceedings concerning children and young people.

Community Services Centre (CSC)
The locally based Community Services offices. There are 81 Community Services Centres across NSW.

Cumulative harm
Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.

Domestic violence
This is violence between two people who are, or have been in the past, in a domestic relationship. The perpetrator of this violence can cause fear, physical and psychological harm. Domestic violence is usually committed by men against women within heterosexual relationships, but can also be committed by women against men, and can occur within same sex relationships. Domestic violence can have a profound negative effect on children and young people.

Drug and/or alcohol abuse
A significant substance abuse problem that interferes with a parent's daily functioning, where the substance abuse problem negatively impacts on his/her care and supervision of the child or young person to the extent that there is risk of significant abuse.

Engagement
An ongoing and dynamic process of attracting and holding the interest of a person in order to build an effective and collaborative relationship.

Family Case Management (FCM)
Family Case Management (FCM) is an integrated case management response to families who frequently come into contact with multiple government agencies and NGOs and show little improvement in their situations.

Key Information and Directory System (KiDS)
Community Services' electronic system for keeping records and plans about children, young people and their families.

Manager Casework
Managers Casework provide direct supervision and support to a team of Community Services caseworkers.

Manager Client Services
The Manager Client Services is the senior Community Services officer in the Community Services Centre and is responsible for the management of all aspects of Community Services work in the local area served by the Community Services Centre.

Mandatory reporter
A person who as part of their professional or other paid work or as the supervisor/ manager of a person who as part of their professional or paid work, delivers health care, welfare, education, children's services, residential services or law enforcement to children. Mandatory reporters are required under Chapter 3, Part 2, section 27 of the *Children and Young Persons (Care and Protection) Act 1998* to make a report to Community Services if they suspect that a child is at risk of significant harm as detailed in Chapter 3, Part 2, section 23 of the Act.

Medical examination
Pursuant with section 173 of the *Children and Young Persons (Care and Protection) Act 1998* if the Director General or a police office believes on reasonable grounds that a child is in need of care and protection, the Director General or the police officer may serve a notice requiring the child to be presented to a medical practitioner specified or described in the notice at a hospital or some other place so specified for the purpose of the child being medically examined.

Mental health concerns
A mental health problem or diagnosed mental illness that interferes with a parent's daily functioning, where the mental health issue or diagnosed mental illness negatively impacts his/her care and supervision of the child or young person to the extent that there is significant risk of serious abuse or neglect.

Neglect (educational)
The child or young person is of compulsory school age (six to 17 years) and is not enrolled; or is habitually absent (a minimum of 30 days absence within the past 100 school days) from school (or employment/training).

Neglect (general)
The child or young person's basic needs (e.g. supervision, medical care, nutrition, shelter) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions.

Neglect (medical)
The child has an acute and/or chronic medical or mental health condition that requires immediate or ongoing treatment by a medical or mental health professional, but the parent/carer is not obtaining or maintaining essential services for the child or young person or is not following a prescribed plan of treatment for the child/young person (includes over-medicating).

Neglect (supervisory)
The child or young person's need for supervision is unmet as a result of being left unattended (parent/carer is absent, or is present but not attending to the child or young person) in circumstances that represent a significant risk to his/her safety; or the parent/carer has failed to protect the child from other people who have abused or neglected the child.

Non-organic failure to thrive
Non-organic failure to thrive is a term used to describe when a baby is not receiving enough nutrients due to non-medically related factors including parental neglect.

Order
Includes an order of a court or an administrative order.

Out-of-home care
Residential care and control of a child or young person that is provided by a person other than a parent of a child or young person and at a place other than the usual home of the child or young person. It includes the care of a child or young person who lives with an authorised carer and is in the Parental Responsibility of the Minister.

Parental responsibility
All of the duties, powers, responsibilities and authorities which parents generally have in relation to their children.

Parental Responsibility of the Minister
An order of the Children's Court placing the child or young person in the Parental Responsibility of the Minister under Chapter 5, Part 2, section 79(1)(b) of the Act.

Physical abuse or ill-treatment
Physical abuse or ill-treatment is harm to a child or young person that is caused by the non-accidental actions of a parent, caregiver or other person responsible for the child or young person.

Prenatal report
The Children and Young Persons (Care and Protection) Act 1998 allows for prenatal reports to be made to Community Services under section 25 where a person has reasonable grounds to suspect that an unborn child may be at risk of significant harm after birth.

Removal
The action by an authorised Community Services officer or NSW Police Officer to take a child or young person from a situation of immediate risk of serious harm and to place the child or young person in the care and responsibility of the Director General.

Report
A report made to Community Services, usually via the Helpline, to convey a concern about a child or young person who may be at risk of significant harm.

Reporter
Any person who conveys information to Community Services concerning their reasonable grounds to suspect that a child, young person or unborn child (once born) is at risk of significant harm.

Restoration
When a child returns to live in the care of a parent or parents for the long term.

Risk of harm assessment
A process that requires the gathering and analysis of information to make decisions about the immediate safety and current and future risk of harm to the child or young person.

Risk of significant harm (ROSH)

Risk of significant harm is present if there are current concerns that a child or young person may suffer physical, sexual, psychological and/or emotional harm as a result of what is being done or not done by another person, often an adult responsible for their care. Risk of significant harm is defined in Chapter 3, Part 2, section 23 of the Act.

Risk-taking behaviour

Includes but is not limited to:

- suicide attempts or ideation
- self-harm
- engaging in criminal activities
- gang association and/or membership
- drug dealing
- drug, alcohol and/or solvent use
- engaging in unsafe sex
- prostitution.

Safety and risk assessment (SARA)

SARA is a Structured Decision-Making system for assessing risk. The goals of the system are to determine the risk to children and young people through a structured process of information gathering and analysis. This is intended to produce more methodical and thorough assessments. SARA includes three distinct tools: Safety Assessment, Risk Assessment and Risk Reassessment.

Sexual abuse or ill-treatment

This is any sexual act or threat to a child or young person which causes that child or young person harm, or to be frightened or fearful. Adults or young persons who perpetrate child sexual abuse exploit the dependency and immaturity of children. Coercion, which may be physical or psychological, is intrinsic to child sexual assault and differentiates such assault from consensual peer sexual activity.

Structured Decision-Making (SDM)

Structured Decision-Making aims to achieve greater consistency in assessments and support professional judgement in decision-making. The SDM process structures decisions at several key points in case processing through use of assessment tools and decision guidelines.

Supervision (formal)

Professional supervision is a process by which the supervisor is given responsibility by the organisation to work with the supervisee in order to meet certain organisational, professional and personal objectives which together promote the best outcomes for children, young people and their families.

Supervision (informal)

Informal supervision is the daily support and advice given by a supervisor to a supervisee including instructions, tasks and informal conversations.

Suspected suicide

The term 'suicide' is used to refer to any self-inflicted injury resulting in death where it is established by a Coronial inquiry that the death resulted from a deliberate act by the deceased person with the intention of taking his/her own life. Until such a death has been established by a Coroner it is referred as a 'suspected suicide'.

Suspicious or inflicted injuries

Includes children and young people who died from alleged assault, abuse, or other types of injuries that were investigated by Police to be inflicted by another person or highly suspicious to be non-accidental.

Tasks

Individual actions required to achieve objectives in a plan. Tasks document the actual activities undertaken by persons identified in the plan to achieve the current objective.

Triage and assessment practice guidelines

The practice guidelines describe the process of triaging ROSH events and non-ROSH information at Community Services Centres and outline the minimum practice required by Community Services Centres when a ROSH event and non-ROSH information is received.

Weekly allocation meeting (WAM)

Weekly allocation meetings (WAM) are a statewide procedure. Managers in all Community Services Centres meet weekly to review new reports that cannot be allocated due to insufficient resources.

Young person

Chapter 1, section 3 of the *Children and Young Persons (Care and Protection) Act 1998* defines a young person for the purposes of risk of harm as a person aged 16 years or above but under the age of 18 years. However, under the *Crimes Act 1900* or the *Commission for Children and Young People Act 1998*, any person under the age of 18 years is defined as a child.

Published by

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If you think a child or young person is at risk of significant harm, contact the Child Protection Helpline on 132 111

ISSN 1839-8375

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