



Family &  
Community  
Services

# Child Deaths 2014 Annual Report

Learning to improve services





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## Minister's foreword

Each year Family and Community Services (FACS) reviews the deaths of children and young people who were known to the NSW child protection system.

This is incredibly important work. Examining the deaths of these young people who were known to our state's child protection system enables us to learn from these tragedies.

This is the first I have launched as Minister for Family and Community Services. It reviews the practice and decisions made in respect of 79 children and young people known to FACS who died in 2014. This year's report also contains a chapter specifically focusing on vulnerable teenagers who died between 2009 and 2014.

The report highlights the very real disadvantage faced by many families who come into contact with the child protection system. Most importantly, it identifies opportunities for us to improve our systems and practice.

While it is an incredibly sad and difficult read, it is essential to help us to reflect on our work with families and consider the ways we can do things better.

I want to personally thank each and every practitioner as you rise to this crucial task. Child protection is both challenging and demanding work and good practice too often goes unacknowledged. Together, we will continue to do our best to provide a safe and secure future for our community's children.



**Brad Hazzard**  
Minister for Family and Community Services

## Secretary's foreword

Everyone feels deep sadness when a child dies. But we need to be more than sad. Grief must embolden us to be brutally honest about our practice and ask ourselves the hardest of questions in this line of work – was it good enough?

FACS reviews our work for all cases where children who died were known to our system. We owe it to all the children and their families to be meticulous and brave in the examination of our work.

The child death reviews I have read as Secretary over the last few years remain with me and strengthen my commitment to improving child protection practice and the systems that support our work.

The *Child Deaths 2014 Annual Report* explains what is known about the deaths of 79 children and young people who died in 2014 and were known to FACS. It also sheds light on the practice complexities and challenges and the opportunities to improve.

Each year, this report draws our attention to something new and sharpens our focus on doing things better. This means continually developing our skills in working with children and families, and equally, our structures, functions and systems, to create meaningful change.

This year, the focus on adolescents (Chapter Three) will hopefully spark new conversations in FACS offices around the state – and not just on the frontline – and remind us that all the bravado in the world, should never blind us to the vulnerability of teenagers who have experienced abuse and neglect.

The way in which a child protection system responds to the death of a child has a strong influence on subsequent practice. For every practitioner who has been a part of a child death review process, I thank you for your courage in openly discussing your practice. Continuous learning is critical in supporting practitioners about the best way to make a difference for high risk families.



**Michael Coutts-Trotter**  
Secretary

# Executive Summary

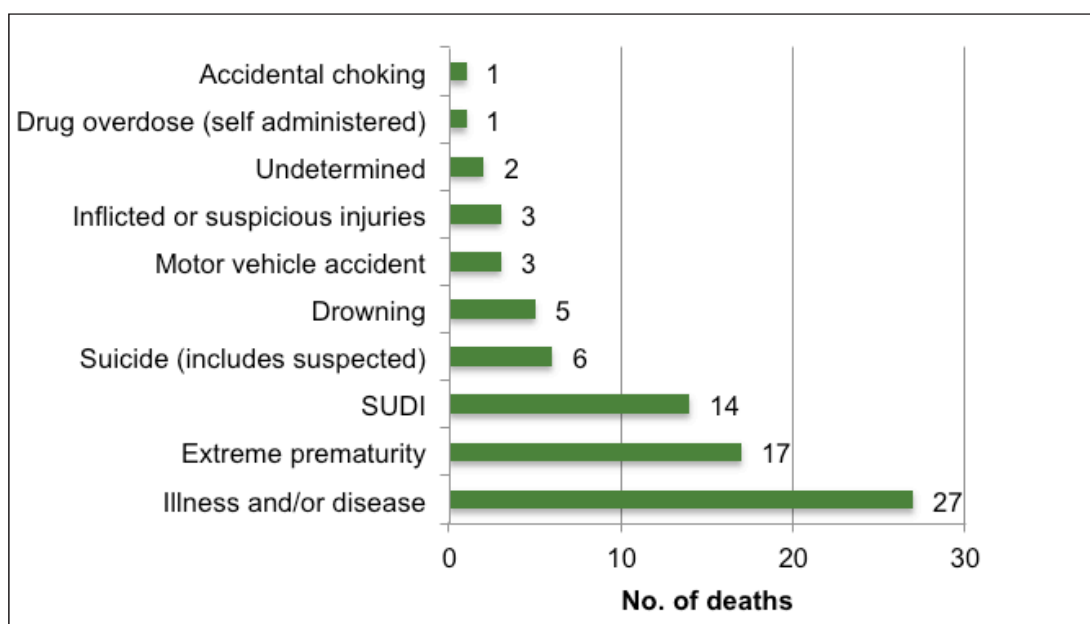
The *Child Deaths 2014 Annual Report* is Family and Community Services (FACS) fifth public report examining our involvement with the families of children and young people<sup>1</sup> who died and were known to FACS.

This report aims to provide context about the deaths of children who were known to FACS with the intention to improve child protection practice, and strengthen the NSW child protection system, as well as support other services working with vulnerable children and families. As this report is available to the public, it also hopes to enhance community understanding of the complexities of the work, and the reality of disadvantage many of the families who come into contact with a child protection system face every day.

## Child deaths in 2014

Chapter 2 of this report summarises information about the 79 children and young people who died in 2014 who were known to FACS<sup>2</sup>. As outlined in Figure 1, most of these children died in circumstances related to illness, disease or extreme prematurity.

**Figure 1: Children who died in 2014 and were known to Family and Community Services by circumstances of death**



Almost a third (32 per cent) of the 79 children who died in 2014 and were known to FACS were Aboriginal and/or Torres Strait Islander. This is a decrease from 2013, when Aboriginal and/or Torres Strait Islander children comprised almost half (47 per cent) of all deaths for the year. Despite this decrease since 2013, the over-representation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures has persisted over the years – 30 per cent of children in 2011 and 32 per cent of children in 2012 who died and were known to FACS were Aboriginal and/or Torres Strait Islander.

<sup>1</sup> The *Children and Young Persons (Care and Protection) Act 1998* defines a child as aged under 16, and a young person as aged over 16 years and under the age of 18 years. For the purposes of this report, the terms 'child' and 'children' are used to refer to both children and young people.

<sup>2</sup> Known to FACS' includes children and young people (or their sibling/s) who were the subject of a Risk of Significant Harm (ROSH) report within three years of the death.

Ten children were not living with their immediate families at the time of their death. Nine of these children were under the parental responsibility of the Minister and one was under the parental responsibility of a relative.

Most of the children (60 children or 75 per cent) who died in 2014 were the subject of a risk of significant harm (ROSH) report within three years of their death. The remaining children were not reported but their siblings were the subject of a report within three years of the child's death.

For 52 (72 per cent) of the children, FACS completed an assessment prior to the child's death. For 43 of the 57 children (75 per cent), the assessment occurred within the three years prior to the child's death. Twenty-two families (28 per cent) did not receive a completed assessment due to higher priorities of other matters (18 children), the child being allocated for a response at the time of the child's death (two children), or an assessment not being required (two children)<sup>3</sup>.

## Vulnerable teens

The need to better understand and support vulnerable teenagers known to the child protection system has been highlighted consistently through our review work. To this end, FACS undertook a cohort review of 111 teenagers aged between 13 and 17 years who were known to FACS and died between 2009 and 2014. Chapter 3 of this report provides a summary of the major findings of the review, with a particular focus on practice themes, and consideration as to how these findings can inform our current practice.

Chapter 3 shows the very real vulnerability of the teenagers with whom FACS practitioners work. All 111 teenagers known to FACS between 2009 and 2014 were considered to be vulnerable, with their deaths occurring in the context of suicide, alcohol and/or drug misuse, risk taking behaviour or other vulnerabilities including medical neglect. Many of the deaths of the 111 teenagers included in this cohort review resulted from risk taking behaviour or occurred in preventable circumstances.

A number of de-identified case studies have been used in the chapter to highlight circumstances of death and themes. There are three themes identified: understanding the warning signs, systemic barriers and personal barriers. The themes acknowledge the challenges faced when working with teenagers, as well as the importance of practitioners being curious and understanding the underlying reasons for a teenager's behaviour. The importance of strong and effective working relationships cannot be understated and was a dominant theme across many of the reviews for teenagers in this cohort.

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<sup>3</sup> FACS determined that an assessment was not required after further intake work at the CSC.



## Improving the way we work with children and families

Work to reform and improve the child protection system has progressed significantly since last year's *Child Deaths 2013 Annual Report*. Some of the main achievements for 2014–15 are detailed in chapter four, and there is a focus on current work and future initiatives that seek to strengthen the child protection system.

Significant funding for FACS was included in the 2015–16 NSW Budget, including a 7 per cent increase in funding from last year. This investment will continue to support our goal of providing vulnerable children and young people with long-term, stable environments, to help keep them safe, whether this is at home with their families, in an out-of-home care placement or with an adoptive family. Major projects include:

- Safe Home for Life – More support is being invested in caseworker support workers to enable caseworkers to spend more time working with families. Family Group Conferencing is being implemented to support work with families in a way that demonstrates partnerships and encourages greater parental decision making and responsibility
- The development of a Quality Assurance Framework to enhance the outcomes for children and young people in out-of-home care placed with NGOs or FACS
- Technology and innovative IT solutions are continuing to design and replace frontline technology systems for child protection workers. This will improve the productivity of caseworkers by freeing them up to spend more time with vulnerable families.

# Chapter 1: Child deaths in context

This chapter sets out the objectives of the report and outlines the context of the child protection system and systems for child death review and oversight in NSW. This context is outlined to understand factors that underpin child abuse and child deaths. This assists the public and other agencies to appreciate the issues underlying child abuse at a societal level. It demonstrates that, in addition to quality tertiary child protection services, agencies and the community need to work together to reduce risk and enhance child wellbeing.

## 1.1 Child protection in NSW

Family and Community Services (FACS) is the statutory child protection agency in NSW. It works closely with other government departments and non-government organisations (NGOs) to support families to keep children and young people safe from abuse and neglect.

FACS caseworkers work with some of the most vulnerable children and families in the community. Many of these families live with extreme disadvantage because of poverty, lack of access to services, parental unemployment, homelessness, social isolation and reduced access to education. Often families are living with the effects of parental substance misuse, unaddressed mental health concerns and violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect<sup>4</sup> and lead to many of the risk of significant harm (ROSH) reports made about children in NSW.

An intergenerational cycle of disadvantage commonly underpins the abuse and neglect of children, particularly for vulnerable groups such as young parents and Aboriginal and/or Torres Strait Islander families. For Aboriginal and/or Torres Strait Islander people, a history of trauma and dispossession has exacerbated these inequities, resulting in higher rates of disadvantage.<sup>5</sup>

## 1.2 Examining child deaths

### 1.2.1 FACS child death reviews

Children in NSW with a child protection history have a higher mortality rate than those not known to statutory child protection authorities.<sup>6</sup> Other jurisdictions across Australia have similar findings.<sup>7</sup>

While most children die from causes or in circumstances not related to the reasons for their child protection reports, the fact remains that children known to FACS are at greater risk.

4 NSW Family and Community Services (2014b) *Annual Statistical Report*, [http://www.community.nsw.gov.au/docswr/assets/main/documents/docs\\_data/annual\\_statistical\\_report\\_2012-13.pdf](http://www.community.nsw.gov.au/docswr/assets/main/documents/docs_data/annual_statistical_report_2012-13.pdf)

5 Australian Institute of Health and Welfare (AIHW) (2015) *Child Protection Australia 2013-14*, <https://aifs.gov.au/cfca/2015/05/11/report-child-protection-australia-2013-14-aihw-report>

6 The NSW CDRT found that children with a child protection history had 1.4 times the mortality rate than children without a history, see NSW Child Death Review Team (2014b), *Causes of Death of Children with a Child Protection History 2002-2011: A Special Report to Parliament under S.34h of the Community Services (Complaints, Reviews and Monitoring) Act 1993*, NSW Ombudsman: Sydney.

7 Previous contact with child protection services is often noted as a common factor in child death reviews. Australian Institute of Family Studies (2014) *Child deaths from abuse and neglect*, Child Family Community Australia (CFCA) Resource Sheet – August 2014.

The *Child Deaths 2014 Annual Report* is FACS fifth publically available report examining the deaths of children known to FACS. To formalise the government's commitment to transparency and accountability about child deaths, the *Children and Young Persons (Care and Protection) Act 1998*, requires the Minister for Family and Community Services to present this report to Parliament annually<sup>8</sup>.

Each year the Child Deaths Annual Report has four objectives:

1. To boost transparency and accountability about child deaths by publicly reporting on FACS involvement with the families of children who have died
2. To increase public trust and confidence in FACS by reporting on lessons learnt from child death reviews, the improvements to practice and systems made as a result of this learning
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage impacting on outcomes for families
4. To share learning from child death reviews with practitioners and our interagency partners in other government and non-government departments.

FACS undertakes its own rigorous internal child death reviews for all children who were known to the Agency before they died. By reviewing the deaths of children, FACS not only demonstrates accountability; it also critically reflects on its work and learns from the experiences of children in order to change systems and practice for the better.

### **Serious Case Review unit (SCR)**

The Serious Case Review unit (SCR)<sup>9</sup>, which sits within the Office of the Senior Practitioner (OSP), reviews FACS involvement with the families of children who have died and were reported (or their sibling was reported) to be at risk of significant harm in the three years prior to their death. The unit also reviews cases where a child was in care at the time of their death.

The recent change in name for the unit (formerly 'Child Deaths and Critical Reports unit') better captures the review work undertaken. While the death of a child prompts a review, the focus of the review is not the child death, but rather FACS involvement with the child and their family and the broader practice and system issues arising in the case. The change in name also reduces barriers to learning – the words 'child deaths' often illicit distress and emotive responses that can lead to anxiety and defensiveness among practitioners when they come into contact with the unit. This can impact negatively on learning opportunities, as will be discussed later in this chapter. And lastly, the more generic name, Serious Case Review, broadens the scope of the review work.

SCR has adopted a systems approach to child death reviews<sup>10</sup> which emphasises the need to understand not just what happened in a case but, where possible, why it happened. These reviews consider how FACS systems at a local and organisational level impacted on practice with the families of children who died. The review process seeks to examine learning opportunities for practitioners who work with families by not only identifying practice issues but also promoting good practice.<sup>11</sup> This in turn can lead to systems improvements to promote best practice.

<sup>8</sup> The relevant amendment was passed into law on 1 April 2014.

<sup>9</sup> Formerly known as the Child Deaths and Critical Reports unit.

<sup>10</sup> This has been adapted from a case review model in England sourced from Fish, Munro & Birstow (2008).

<sup>11</sup> What practice means, in this context, is the way the agency, via casework staff, responds to reports about the safety of children.

Many child death reviews make recommendations aimed at improving identified systemic issues or direct casework with the family. For example, a number of recommendations from the reviews of children in care has led to better screening processes for carers, including improved probity checking and better assessments of the physical safety of the home environment (such as backyard swimming pools). Reviews also recognise good practice and acknowledge practitioners appropriately.

### **Practitioner support and consultation**

When a child dies, SCR provides practical support to practitioners straightaway so they can get on with the important job of supporting families and assessing the safety of surviving siblings. In many cases SCR works together with casework staff to understand vital contextual information, and to reflect critically on practice. Despite this being an understandably difficult process for staff, SCR has been impressed by practitioners' courage and determination to learn from the tragedy of a child's death.

Practitioners are often given an opportunity to talk about their thoughts about the management of the case and they are consulted about recommendations aimed at practice and system improvements. SCR provides practitioners with the opportunity to read the review and any critique of their practice.

The staff consultation process is critical because, done well, it reduces the risk of a practitioner's experience of child death impacting negatively on their future practice with other vulnerable children. It can also reduce staff defensiveness and ensures the most accurate information and robust analysis. If review processes are to lead to genuine learning and practice/system improvement, and if they are to support staff to work differently with future children, then a process that allows them the opportunity to understand what has been said about their work is crucial. If staff feel they have been consulted, they are more than likely to accept the review findings, even those that are critical of practice. SCR's experience is that consultation can also impact positively on the openness of other staff engaging with the review process in future cases.

### **Turning child death reviews into learning**

There is considerable learning from many child death reviews, and the OSP looks for opportunities to share the learning proactively with practitioners in order to improve practice. Some examples of the ways FACS learn from child death reviews are highlighted below.

**Child Deaths Annual Reports** – This report is published at the end of each calendar year, providing information about the children who died, including their characteristics, the circumstances of their deaths, and how FACS responded to the families before and after their death. The reports aim to engage practitioners and the community in the stories of the children who have died, as well as highlighting the complexities of child protection work in NSW.

**Cohort reviews** – Each year SCR undertakes a cohort review, which looks at a group of children who died and were known to FACS, who share common statistical characteristics. Previous reviews include an analysis of the death of children who were reported to be at risk of significant harm (ROSH) because of domestic violence (2013) and those who had young parents (2012). In 2014, SCR published the *Safe Sleeping* report, which examined the cases of 108 babies who died suddenly and unexpectedly. This review focused on how practitioners, both within and outside of FACS, can support parents to make safer choices when placing their babies to sleep in order to prevent these tragic deaths.

This year SCR completed a cohort review of 111 vulnerable teenagers who died between 2009 and 2014. This review examined deaths that were attributed to circumstances of suicide, alcohol and/or drug misuse, or occurred in the context of risk taking behaviour. Chapter 3 of this report presents the data, trends and findings from this cohort review. Themes that stand out are discussed in order to inform future practice with adolescents.

**Practice review sessions and other forums** – The OSP regularly conducts ‘practice review’ sessions with CSC staff following a child death review. These sessions support practitioners to reflect on the dynamics within a child’s family and identify learning from the case, including what could have been done differently and how learning could be applied to work with other families. The sessions also give staff an opportunity to share their expertise and learning about a family or about the broader issues raised in the review.

The stories of children who have died are at the heart of many broader OSP learning forums. For example, a child death case study was used during a Research to Practice Seminar – ‘Home Truths: Rethinking Our Response to Family Violence’ (April 2015). The OSP’s quarterly report shares news about learning from child death reviews or cohorts, such as the Safe Sleeping report.

### 1.2.2 Public and interagency understanding of child deaths

In providing public information about the circumstances surrounding individual child deaths, FACS is committed to protecting the privacy of vulnerable families who are impacted by the death of a child.<sup>12</sup> Parliament has also responded by protecting privacy and confidentiality in a range of legislation that governs the disclosure of information on individual child deaths.<sup>13</sup>

While FACS cannot report on individual cases, there is a strong commitment to greater transparency and accountability about child deaths. The annual publication of this report reflects this commitment. Annual reports provide an opportunity to further examine the complexities of child protection work and allow for the identification of crucial learning from these cases, especially for practitioners. The process of collecting data for the report gives insight as to possible trends, and these may lead to cohort reviews or recommendations.

#### Child deaths and the impact of media

Every child death is a tragedy and should be the subject of scrutiny and review. Drawing attention to the stories of vulnerable children and families helps the community to understand the nature of child protection work and some of the complexities involved in working with vulnerable families. If people have a better understanding of what life could be like for a child at risk, there is a greater chance they will be able to work together to protect those children.

Every year a small number of child deaths are the subject of considerable media attention and scrutiny. These deaths often involve children who have died as a result of abuse by a parent or carer. Understandably, these stories spark strong reactions from the community. The challenge is to not let these cases in and of themselves dictate service reform.

The media plays an important role in supporting the community to gain a better understanding of child deaths, however there remains an ever present risk if coverage is not balanced. As Professor Eileen Munro<sup>14</sup> argues, if sensitive and balanced media coverage of child deaths is not achieved, it can have a considerable impact on vulnerable children:

**A one dimensional view can impact on the child protection system in a way that makes it less safe for children. A lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among child protection workers can also be damaged, leading to more workers leaving the profession and making it more difficult for the profession to attract candidates and attract staff.<sup>15</sup>**

<sup>12</sup> Although information of children and young people who died is given in this report, the identifying details of the families and cases have been removed to protect their privacy.

<sup>13</sup> *Children and Young Persons (Care and Protection) Act 1998; Children (Criminal Proceedings) Act 1987; Privacy and Personal Information Protection Act 1998; Health Records and Information Privacy Act 2002 and (Cwlth) Privacy Act 1988.*

<sup>14</sup> Professor Eileen Munro is a Professor of Social Policy at the London School of Economics specialising in child protection research.

<sup>15</sup> Munro, E. (2011) *How Organisations Can Learn to Reduce Risk to Children*, Community Services: Sydney, [http://www.facs.nsw.gov.au/\\_data/assets/pdf\\_file/0018/251415/how\\_reduce\\_risk.pdf](http://www.facs.nsw.gov.au/_data/assets/pdf_file/0018/251415/how_reduce_risk.pdf)

Recent research has indicated that high profile child deaths can weaken the identity of a child protection service and emotionally affect field practitioners, causing feelings of distress, poor communication with management, lowered confidence and lowered morale among the workforce.<sup>16 17</sup> This can impact directly on children and families as well. For example, in England, the death of 'Baby P'<sup>18</sup> received extensive and highly critical media coverage. Following his death (between the 2008–09 and 2012–13 periods), the child protection service where Baby P died increased the number of care and supervision court order applications by more than 50 per cent.<sup>19</sup> There was also an increase in the number of child protection reports, as well as increased fragmentation and competition between partner agencies rather than collaboration and cooperation. There was also a significant impact on staff morale and increased stress, causing problems with staff retention, long-term staff absence and problems attracting new workers to child protection work.<sup>20</sup>

Review work undertaken by SCR has also highlighted the impact on staff involved with child death cases that receive extensive and critical coverage in the media. A defensive response is potentially dangerous for children because of the risk that casework staff may be overly cautious, leading to an overly intrusive approach with families and not recognising opportunities to build safety for a child within their family. Defensive practice can also paralyse the judgement of a practitioner and reduce their belief that families can achieve positive change.<sup>21</sup>

At an organisational level, it helps when leaders acknowledge the uncertainty of the work and share the anxiety between workers and management. The FACS Care and Protection Practice Framework and Practice Standards provide a foundation to support work with families and address core areas of practice, including relationship-based practice, critical reflection, developing expertise and sharing risk. Within these frameworks, FACS child death review work acknowledges that reviews are one of many ways we can create a culture of continual learning, which can encourage caseworkers to reflect critically on how their own practice and the broader system impacts on the lives of children and families.

FACS review work also acknowledges two other important points: that the deaths of children are rarely predictable, and that decisions about children are made within the context of resources, demand and culture.

### 1.2.3 Child death oversight in NSW

FACS works closely with a number of agencies in NSW to support a strong system of oversight, review and investigation of child deaths. The NSW Ombudsman, the NSW Police Force, the NSW State Coroner and the Office of the Children's Guardian all have responsibility for child death oversight, investigation and review.

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16 Cleborun-Jacobs, T.V. (2013) 'How does a high profile child death impact child protective service workers?', Doctorate in Social Work (DSW) Dissertations School of Social Policy and Practice, University of Pennsylvania.

17 Taylor, J. (2008) 'Lifting social work morale after public criticism', Community Care: UK, <http://www.communitycare.co.uk/2008/06/19/lifting-social-work-morale-after-public-criticism/>

18 Baby P is a 17 month old boy who died in London after suffering more than fifty injuries over an eight month period. He was repeatedly seen by Children's Services and National Health Service Professionals during this period.

19 Cappleman, L.T. & Green, R. (2013) *The Work of the Children's Guardians in Care Cases*, Cafcass Children and Family Court Advisory and Support Service (UK).

20 Macleod, S., Hart, R., Jeffes, J. & Wilkin, A. (2010) *The Impact of the Baby Peter Case on Applications for Care Orders*, LGA Research Report, NFER: Slough, UK.

21 Turnell, A. & Edwards, S. (1999) *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection*, W.W. Norton & Company, Inc: New York.

## 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 neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which have occurred in a care setting. The aim of this function is to review the causes and patterns of those deaths and identify ways they can be prevented or reduced. The Ombudsman is required to report to Parliament every two years. The last report of Reviewable Child Deaths was tabled in June 2015 and the next report will be tabled in 2017.

## NSW Child Death Review Team

The Child Death Review Team (CDRT) reviews the deaths of all children in NSW with the objective of preventing and reducing child deaths. The Ombudsman is the convenor of the CDRT. The team includes the Advocate for Children and Young People, the Community and Disability Services Commissioner, representatives from other government departments (including FACS), and individuals with expertise in relevant fields, including health care, child development, child protection and research methodology. The CDRT reports annually to the NSW Parliament about its work, including research projects.

The CDRT reported that the deaths of 485 children and young people were registered in NSW during 2014.<sup>22</sup> These figures differ from FACS data, highlighting important differences between the two categories:

- CDRT reports on the deaths of children and young people that were *registered* in a calendar year with the NSW Registry of Births, Deaths and Marriages, while FACS reports on deaths that actually *occurred* in a calendar year.<sup>23</sup>
- FACS may include cases where NSW children died in another state in its annual total of child deaths, while CDRT reports on those cases separately and does not include them in the annual total.
- CDRT does not include cases where children died in care in the ‘child protection history’ category.<sup>24</sup>
- CDRT reports on the deaths of children and young people who were reported to FACS but whose reports did not reach the statutory threshold of risk of significant harm (ROSH).
- In addition to reporting on the deaths of children who were known to FACS, CDRT also includes children who were known to Child Wellbeing Units.<sup>25</sup>

<sup>22</sup> Information received from NSW CDRT, 2015.

<sup>23</sup> For example, a child who died in December 2014, but whose death was registered in January 2015, would be included in Family and Community Services 2014 figures and CDRT’s 2015 figures.

<sup>24</sup> Some children in care may have been reported to Family and Community Services in the three years prior to their death, so these cases would be included in the ‘child protection history’ category. The CDRT report does note the number of children who were in care as a separate category.

<sup>25</sup> The Child Wellbeing Units (CWUs) established in NSW Health, NSW Police Force, Department of Education and Communities assist mandatory reporters in government agencies to ensure that all concerns that reach the threshold of risk of significant harm (ROSH) are reported to the Child Protection Helpline. In other cases, they identify potential responses by agency or other services to assist the child or family.

## NSW Police Force and NSW Coroner

The NSW Police Force investigates child deaths where the circumstances of the death are suspicious or undetermined.

A senior coroner has the power to hold an inquest into a child's death where it appears to the coroner that there is 'reasonable cause to suspect' that the child:

- was in care
- was reported to FACS within a period of three years immediately preceding their death, or a child who is the sibling of a child reported to FACS within three years preceding their death
- died in suspicious circumstances, or circumstances that may have been due to abuse or neglect.

FACS is responsible for reporting to the State Coroner the deaths of children known to the Agency. FACS and the State Coroner's office also regularly share information about child deaths.

## Domestic Violence Death Review Team

The Domestic Violence Death Review Team is convened by the NSW State Coroner. The team includes representatives from 11 key agencies, including police, justice, health and social services, and representatives from the non-government and academic sectors.

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths<sup>26</sup>
- 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.

The death of a child in the context of domestic violence is subject to review by the team. The team's third annual report (2012–13) was released in March 2015.

## Children's Guardian

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

- promote the best interests of all children and young people in out-of-home care (OOHC)
- ensure the rights of all children and young people in OOHC are safeguarded and promoted
- exercise functions relating to persons engaged in child-related work, including the working with children check clearance under the *Child Protection (Working with Children) Act 2012*
- accredit designated agencies and monitor their responsibilities under the *Children and Young Persons (Care and Protection) Act 1998* and the *Children and Young Persons (Care and Protection) Regulation 2012*
- administer the Child Sex Offender Counsellor Accreditation Scheme (CSOCAS), a voluntary accreditation scheme for persons working with those who have committed sexual offences against children
- encourage organisations to develop their capacity to be safe for children, as referred to in Section 38 of the *Child Protection (Working with Children) Act 2012*.

FACS is required to notify the Children's Guardian about the deaths of all children in statutory or supported OOHC.

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<sup>26</sup> Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as the death that is caused directly or indirectly by a person who was in a domestic violence relationship with the deceased person. The *Coroners Act 2009* (NSW) also provides that a domestic violence death is '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.



### 1.2.5 Reviewing the deaths of children in out-of-home care (OOHC)

NSW has a particularly strong system of oversight into the deaths of children in out-of-home care (OOHC). Where a child dies in OOHC, their case may be examined by the CDRT, reported to the Coroner and the Children's Guardian, investigated by police and the Coroner, and reviewed by both FACS and the NSW Ombudsman.

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. This includes children placed with FACS or NGO carers and children who died in a facility funded, operated or licensed by the Ageing, Disability and Home Care section of FACS. These reviews consider the adequacy of the involvement of all agencies with the child and family up to the child's death, including when children have been placed with NGO authorised carers.

In response to the significant progress that has been achieved in transitioning the provision of statutory OOHC services from government to the non-government sector, SCR are working with our non-government partners more often as part of the review process. The deaths of children in NGO OOHC have led to a broadening of review mechanisms, with some reviews being undertaken jointly and others separately. This flexible and collaborative model of review provides the opportunity for all services to reflect upon their involvement with children and young people and to share reflections and learning in order to improve service provision to benefit all children in care.

## Chapter 2: Child deaths in 2014

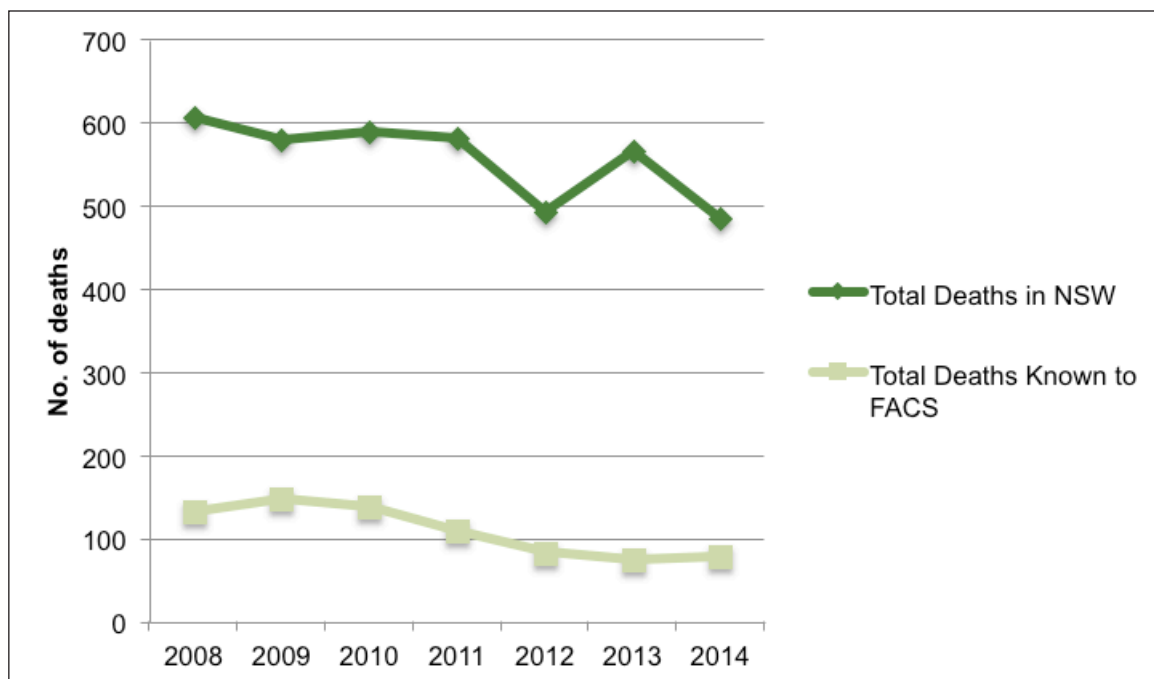
This chapter provides a summary of information about the children and young people who died in 2014 and were known to FACS prior to their death. It includes the characteristics of children; their age, gender and Aboriginal and/or Torres Strait Islander status. Analysis considers the child protection history, FACS response prior to and following the child's death, as well as the circumstances in which the child died.

The chapter provides context to the deaths of the 79 children who died in 2014 and were known to FACS. While this report cannot tell each of the 79 children's individual stories, this information provides a picture of the circumstances in which these children died, and some of the lived experiences they had.

### 2.1 Child deaths in NSW in 2014

Between 1 January 2014 and 31 December 2014, the deaths of 485 children were registered in NSW.<sup>27</sup> In the same period, 79 children died who were known to FACS.<sup>28</sup>

**Figure 2: Children who died in NSW, by number of total deaths and whether they were known to FACS, 2008–2014**



Source: Family and Community Services and NSW CDRT, 2015.

<sup>27</sup> Information provided to FACS from the NSW CDRT, 2015.

<sup>28</sup> 'Known to FACS' includes children and young people (or their siblings) who were the subject of a risk of significant harm report within three years of the death.

Although there has been an overall decline since 2009 in the number of deaths of children who were known to FACS, the number of deaths increased in 2014 (from 75 to 79). The overall decline in numbers coincides with the introduction of the risk of significant harm (ROSH) threshold, which was proclaimed on 24 January 2010.<sup>29</sup> This legislative change resulted in lower numbers of reports meeting the threshold for reporting to FACS, and therefore a lower rate of deaths of children who were known to FACS.

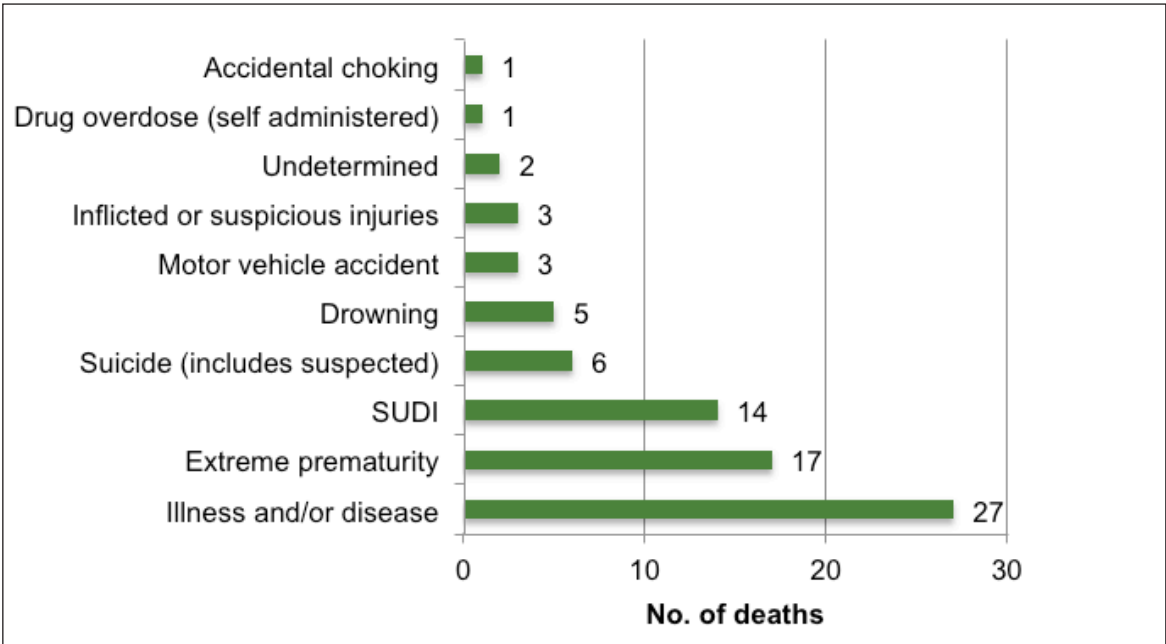
The slight increase in child deaths observed for 2014 likely reflects the increase in ROSH reports received in 2014<sup>30</sup>. Between 1 January and 31 December 2014, FACS received 127,188 ROSH reports, involving 74,026 children<sup>31</sup>. During this period, 79 children who were known to FACS died, representing 0.1 per cent of the total number of children reported to FACS in 2014. This small proportion is consistent with previous year’s findings.

### 2.2 Circumstances of child deaths

SCR receives information about the medical cause and circumstances of a child’s death from the State Coroner and the NSW Registry of Births, Deaths and Marriages (via the NSW Ombudsman). Based on this information, we report on the circumstances of the child’s death. Considering the child protection history of a child’s family, along with understanding the circumstances in which a child died, provides a solid context to explore FACS response prior to and following the child’s death.

Figure 3 describes the circumstances of death and shows that, as in previous years, most of the deaths in 2014 were associated with illness and/or disease, followed by death as a result of extreme prematurity or Sudden and Unexpected Death in Infancy (SUDI).

**Figure 3: Children who died in 2014 and were known to FACS, by circumstances of death<sup>32</sup>**



29 On 24 January 2010, the threshold for reporting to FACS changed from ‘risk of harm’ (ROH) to ‘risk of significant harm’ (ROSH).

30 In 2013, FACS received 116,370 ROSH reports involving 69,167 children. In 2014, there was an increase of 10,818 more reports and 4,859 more children reported to FACS.

31 Information provided by Family and Community Services Business Reporting Unit.

32 The ‘undetermined’ category includes cases where post-mortem information has not yet been received and where the coroner has been unable to determine a cause of death.

The categories used to describe the circumstances of death may be different from those for cause of death. For example, the cause of death could be multiple injuries but the circumstances of death could be suicide, motor vehicle accident or an inflicted or suspicious injury.

**In 2014, over half of the children known to FACS died from illness, disease or extreme prematurity.**

**Table 1: Circumstances of death for children who died between 2011 and 2014 and were known to FACS<sup>33</sup>**

Circumstance of death	2011		2012		2013		2014	
	no.	%	no.	%	no.	%	no.	%
Accidental asphyxia	0	0%	0	0%	1	1%	0	0%
Accidental choking	1	1%	0	0%	0	0%	1	1%
Drowning	7	6%	5	6%	3	4%	5	6%
Drug overdose (self administered)	3	3%	2	2%	0	0%	1	1%
Extreme prematurity	14	13%	13	15%	15	20%	17	21%
Fire	0	0%	0	0%	2	3%	0	0%
Illness and/or disease	38	35%	25	30%	22	29%	27	34%
Inflicted or suspicious injuries	7	6%	2	2%	2	3%	3	4%
Motor vehicle accident	8	7%	7	8%	6	8%	3	4%
Other accidental injury	4	4%	1	1%	1	1%	0	0%
SUDI	21	19%	16	19%	16	21%	14	18%
Suicide (includes suspected)	4	4%	12	14%	5	7%	6	8%
Undetermined	3	3%	1	1%	2	3%	2	3%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>	<b>84</b>	<b>100%</b>	<b>75</b>	<b>100%</b>	<b>79</b>	<b>100%</b>

Table 1 compares the circumstances of death for children who died between 2011 and 2014 and were known to FACS. Despite the overall decrease in the number of total deaths, the percentage of children who died in each category remains largely consistent.

<sup>33</sup> Note that this data may have changed from previous years' reports due to new information and changes in reporting methods.

## 2.2.1 Deaths from illness and/or disease

In 2014, 27 children who died from an illness and/or disease were known to FACS, and the number of deaths due to illness and/or disease has decreased since 2011, as shown in Table 2. However, the percentage of deaths due to illness and/or disease has remained consistent.

**Table 2: Children who died from an illness and/or disease between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	38	25	22	27
% of deaths	35%	30%	29%	34%
Age range	0–17 yrs	0–16 yrs	0–17 yrs	0–17 yrs
Aboriginal and/or Torres Strait Islander	7	5	8	6

For the children who died in 2014 due to illness and/or disease, 18 of the 27 children had been diagnosed with a medical condition before their death.<sup>34</sup> 14 of the 27 children had a diagnosed disability before their death. For 13 of the 27 children, the child had both a medical condition and a diagnosed disability before their death.

**Although fewer children died from illness and disease since 2011, it still remains the most common circumstance of death for children known to FACS.**

These deaths account for the greatest proportion of child deaths in 2014 and the data SCR has collected as part of the review process provides further information about the circumstances and experiences for these children.

For 21 of the 27 children, reports about neglect were received about the family prior to the child's death, with seven involving medical neglect. Of the 21 children, other issues – including parental mental health (four, 19 per cent), parental alcohol and/or drug misuse (nine, 43 per cent) and domestic and family violence (eight, 38 per cent) – were also reported to FACS for these families. The percentage of reports involving other factors where neglect had also been reported was lower in 2014 than in previous years.<sup>35</sup>

Recognising the challenges faced by parents helps practitioners understand and better support families to keep their children safe. For five of the 27 children, transience, homelessness and poverty were stressors which likely influenced how a family may have responded to and cared for a sick child.

<sup>34</sup> This figure is based on information known to Family and Community Services. It is possible that more children had an existing medical condition prior to their death that was not reported to the Agency.

<sup>35</sup> Reports about parental mental health in 2013, 2012 and 2011 were 42%, 31% and 27% respectively. Reports about parental misuse of alcohol and/or drugs in 2013, 2012 and 2011 were 58%, 46% and 47% respectively. Reports about domestic and family violence in 2013, 2012 and 2011 were 58%, 46% and 67% respectively.

There are many reasons why children do not always receive the medical care they need, including:

- financial hardship and/or the inability of a caregiver to take time off work to care for a sick child
- family chaos that makes it difficult for a caregiver to respond to a child's needs in an effective manner
- a caregiver possibly not being aware of the signs or symptoms in their children that could indicate serious illness
- a caregiver's lack of trust in health care professionals
- a developmental delay or mental illness makes it difficult for a caregiver to respond to a child's health needs.

These are just some of the factors that should be considered by practitioners when working with families where medical neglect is considered a risk factor.

### 2.2.2 Deaths related to premature births

In 2014, 17 babies died from conditions related to their premature birth, as shown in Table 3.<sup>36</sup> Twelve babies died at birth or within the first 24 hours after birth, four died within the first month, and one died within the first three months. Table 3 highlights a slight increase in the proportion of deaths related to premature births since 2011.

**Table 3: Babies who died from conditions related to their premature birth between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	14	13	15	17
% of deaths	13%	15%	20%	21%
Age range	0–3 wks	0–1 mth	0–2 mths	0–3 mths
Aboriginal and/or Torres Strait Islander	4	8	10	12

It is important to understand the broader social factors that may have contributed to the premature deaths of these 17 babies in 2014. Perinatal mortality often reflects the health status and health care of the general population, their access to and quality of preconception, reproductive, antenatal and obstetric services for women, and health care in the neonatal period.<sup>37</sup> Maternal education, nutrition, smoking, alcohol misuse in pregnancy, and poverty are all significant social factors that may have contributed to these premature deaths.

Eight of the 17 babies who died in 2014 were reported to FACS during their mother's pregnancy with concerns about:<sup>38</sup>

- the mother's drug and/or alcohol misuse during pregnancy (five babies)
- the mother being the victim of violence during pregnancy (five babies).

Four babies experienced multiple and co-existing concerns, including:

- the mother's drug or alcohol misuse during pregnancy and the mother being the victim of violence during pregnancy
- the mother having an intellectual disability which impacted their parenting
- poor antenatal care.

<sup>36</sup> Children were included in this group when prematurity was recorded as either an underlying, associated or contributing factor in the death.

<sup>37</sup> Department of Prime Minister and Cabinet (2014) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, <https://www.dpmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-1-health-status-and-outcomes/121-perinatal-mortality.html>

<sup>38</sup> Numbers do not add to a total of eight because two babies were reported to FACS during their mother's pregnancy with concerns about drug and/or alcohol misuse and their mother being the victim of violence during pregnancy.

**There is not only an over-representation of Aboriginal babies dying because of their premature birth, there has also been a steady increase since 2011. Recent research confirms this continuing trend with Aboriginal families experiencing markedly worse maternal and child health outcomes than non-Aboriginal families.**

Twelve of the 17 babies were Aboriginal and/or Torres Strait Islander. Table 3 reflects the steady increase in the number of deaths of Aboriginal and/or Torres Strait Islander babies related to premature births since 2011. Aboriginal and/or Torres Strait Islander women continue to be two to three times more likely to have a stillbirth or neonatal death, preterm birth and/or low birth weight infant.<sup>39</sup>

### 2.2.3 Sudden and Unexpected Death in Infancy

Sudden and Unexpected Death in Infancy (SUDI) is not considered a cause of death. It is a classification applied to seemingly healthy babies aged less than 12 months old who die suddenly, without warning, and in circumstances that include:

- unexpected or unexplained at autopsy (meeting the criteria for Sudden Infant Death Syndrome)
- an acute illness that was not recognisable by carers and/or health professionals as potentially life threatening
- an existing health condition that was not previously recognised by health professionals and
- deaths resulting from accident, trauma or poisoning where the cause was not known at the time of the death.<sup>40</sup>

In most circumstances, these babies died after they had been placed to sleep.

**Table 4: Babies who died suddenly and unexpectedly between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	21	16	16	14
% deaths	19%	19%	21%	18%
Age range	0–8 mths	0–5 mths	0–10 mths	0–6 mths
Aboriginal and/or Torres Strait Islander	8	4	9	3

As shown in Table 4, in 2014 the deaths of 14 babies were classified as SUDI,<sup>41</sup> comprising 18 per cent of deaths of all children known to FACS for the year. Post mortem reports were available for 11 of the 14 babies. The reports provide the following cause of death information:

- undetermined (four babies)
- SIDS or SUDI (five babies)
- positional asphyxia<sup>42</sup> (one baby)
- hypoxic ischaemic encephalopathy<sup>43</sup> (one baby).

39 Brown, S.J., Weetra, D., Glover, K., Buckskin, M., Ah Kit, J., Leane, C., Mitchell, A., Stuart-Butler, D., Turner, M., Gartland, D. & Yelland, J. (2015) 'Improving Aboriginal women's experiences of antenatal care: Findings from the Aboriginal Families Study in South Australia', *Birth*, 42(1), pp. 27–37.

40 NSW Child Death Review Team (2012) *Annual Report 2011*, NSW Ombudsman: Sydney.

41 These data are based on information provided to FACS by the NSW CDRT.

42 Positional asphyxia is a form of asphyxia which occurs when someone's position prevents the person from breathing adequately.

43 Hypoxic ischaemic encephalopathy (HIE) is a condition that occurs when the entire brain is deprived of an adequate oxygen supply. It is a sign of asphyxia at birth leading to brain damage which may or may not lead to a diagnosis of cerebral palsy, learning difficulties or developmental delay. See Jowitt, M. (2010) 'Hypoxic ischaemic encephalopathy', *AIMS Journal*, Vol. 22, No. 30, p. 13, [http://firstfamily.org.uk/wp-content/uploads/2011/03/AIMS223-Alb3-07.12.10\\_AIMS.pdf](http://firstfamily.org.uk/wp-content/uploads/2011/03/AIMS223-Alb3-07.12.10_AIMS.pdf)

Of the 14 babies who died suddenly and unexpectedly in 2014, one or more modifiable risk factors were found in 11 cases. A modifiable risk factor increases the risk of SUDI, and includes:

- the baby sleeping with their parent at the time of death
- the position the baby was placed to sleep
- the baby sleeping with loose bedding
- exposure to cigarette smoking
- the baby being prop-fed with a bottle.<sup>44</sup>

One of the ongoing challenges for practitioners when working with vulnerable families with a range of safety concerns and support needs is that messages communicated to parents about safe sleeping and other risk factors are not always put into practice. This may be because parents are reluctant to change their habits, particularly if their child has become used to sleeping with them or if they have older children with whom they co-slept. Where there are various risk factors, parents need to be supported to make changes and their capacity to maintain practices that promote safety for their baby needs to be assessed.

### 2.2.4 Suicide

In 2014, six children died by suspected suicide, as shown in Table 5. Five of these deaths were as a result of hanging, and one child died as a result of being hit by a train. Four of the children were girls, two were boys. Before their deaths, all six children had been reported with concerns about risk taking behaviour, such as unprotected sex, alcohol and/or drug misuse, and self-harming behaviours.

**Table 5: Children who died by suspected suicide between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	4	12	5	6
% deaths	4%	14%	7%	8%
Age range	14–17 yrs	13–17 yrs	13–16 yrs	Under 13–17 yrs
Aboriginal and/or Torres Strait Islander	1	4	0	0

A review of cases where children died by suicide highlighted consistently that these children faced multiple risk factors that heightened their vulnerability and compromised their safety. Providing effective intervention for these children is a priority for FACS and is an area of child protection practice that requires intensive and sensitive casework.

**While the number (and per cent) of children dying as a result of suicide has remained relatively stable since 2013, the range of ages of the children who died as a result of suicide has increased in 2014. The suicide of children is considered in chapter 3 of this report.**

<sup>44</sup> NSW Family and Community Services (2014a) *Safe Sleeping: Supporting Parents to Make Safer Choices When Placing Their Baby to Sleep*, [www.facs.nsw.gov.au](http://www.facs.nsw.gov.au)



## 2.2.5 Drowning related deaths

In 2014, five children died after drowning, as shown in Table 6. Two children drowned in a swimming pool, one child drowned in a bathtub, one child drowned at the beach, and one drowned in a dam. The number of children who have died from drowning and the percentage of these children who were known to FACS have remained stable since 2011.

**Table 6: Children who died after drowning between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	7	5	3	5
% deaths	6%	6%	4%	6%
Age range	1–14 yrs	1–13 yrs	0–1 yr	0–12 yrs
Aboriginal and/or Torres Strait Islander	6	1	2	1

Supervision, safe pool fencing and teaching swimming skills continue to be promoted as effective preventative measures against drowning.<sup>45</sup> Lack of adequate supervision is a significant problem associated with drowning of children in Australia and was a contributing factor in all five deaths in 2014. Practitioners need to be aware of the risks of drowning, particularly where young children are living in homes with swimming pools or in close proximity to other bodies of water and have conversations with parents and carers about the need for close, ongoing and attentive supervision. An assessment of a child's safety needs to consider problems such as alcohol and drugs, mental health and domestic violence which may be so consuming they often compound a parent's ability to provide appropriate supervision. For example, for three children, reports were received by FACS regarding supervisory neglect. Other reports were also received regarding parental alcohol and drug misuse, mental health and family violence.

**A substantial number of deaths each year result from people accidentally falling or wandering into water. More deaths in swimming pools and in lakes, dams or lagoons, are attributed to people accidentally entering the water than to swimming, paddling or wading. Young children aged 1– 4 years have the highest drowning rate of any age group. These findings are consistent with 2014 child death review data where three children drowned in a swimming pool or dam after falling in while unsupervised. (Australian Bureau of Statistics, 2000).**

<sup>45</sup> World Health Organization (2014) *Global Report on Drowning: Preventing a Leading Killer*, [http://apps.who.int/iris/bitstream/10665/143893/1/9789241564786\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/143893/1/9789241564786_eng.pdf?ua=1)

## 2.2.6 Motor vehicle accidents

In 2014, three children died in motor vehicle accidents, as shown in Table 7. Although small numbers, there has been a steady decrease and the numbers have more than halved since 2011.

**Table 7: Children who died in a motor vehicle accident between 2011 and 2014 and were known to FACS**

	2011	2012	2013	2014
No. of deaths	8	7	6	3
% deaths	7%	8%	8%	4%
Age range	9–17 yrs	9–17 yrs	5–15 yrs	13–17 yrs
Aboriginal and/or Torres Strait Islander	3	1	4	1

## 2.2.7 Other circumstances of death

### Inflicted or suspicious injuries

In 2014, three children died of suspicious injuries. For two of the children, the mother's partner was charged with murder and sexual assault. For the third child, FACS received a report about physical abuse the day before the child's death, following the child being taken to hospital with multiple injuries.

Such deaths often attract considerable media attention and demand explanations. With a focus on families where a child has died from inflicted or suspicious injuries, assumptions are often made that all children who die and who are known to FACS died as a result of abuse and neglect. However, what is often missing in the media coverage is an understanding of the complex nature of child protection work with some of the most disadvantaged families in NSW.

All three were girls. Two were less than 12 months old and the third was two years old. Two had been reported at ROSH for parental alcohol and/or drug misuse, domestic violence, and emotional abuse and neglect, among other risk issues. ROSH reports were received about family violence and physical abuse for the third child.

**Media reporting of child deaths frequently focuses on the most sensational cases where children are severely abused and neglected or where there was a high level of risk either known at the time or with the benefit of hindsight. This has contributed to the thinking that all child deaths are high risk and stand out from other families FACS works with. In reality, it is not always the children considered to be at the highest risk who will be the ones to die. There is always learning from child death reviews, about the importance of every report and every opportunity to intervene, however the small number of such tragic deaths reflects the quality of the work practitioners have done in other high risk families.**

FACS was working with one of the families prior to the child's death. FACS did not have contact with another family before the injuries that led to the child's death, although the matter was allocated for a response. For the third family, the last contact FACS had prior to the child's death was with the older siblings in 2008.

## 2.3 Characteristics of the children

### 2.3.1 Age and gender

**Most children known to FACS who die are less than 12 months old, reflecting the physical vulnerability of babies. Like previous years, boys continue to die in higher numbers than girls. Research has shown that baby boys are more likely to be seriously or fatally assaulted than baby girls. There is not an agreed understanding about these gender differences (Dale, Green, & Fellows, 2005).**

In 2014, 53 (67 per cent) of the children who died were male and 26 (33 per cent) were female. Males died in higher numbers in all circumstances of death except suicide, where four females died compared to two males.<sup>46</sup>

Statistics about gender in the child protection literature are interesting. Although boys are less likely to be sexually abused than girls, they have a greater risk of serious injury, as well as emotional and physical neglect.<sup>47</sup>

The majority of children (43, or 53 per cent) who died in 2014 were younger than 12 months. Of the 43 babies, 32 died within their first three months. The circumstances of these 32 deaths included:

- prematurity (17 babies)
- SUDI (eight babies)
- an illness or disease (four babies)
- undetermined (two babies)
- inflicted or suspicious injuries (one baby).

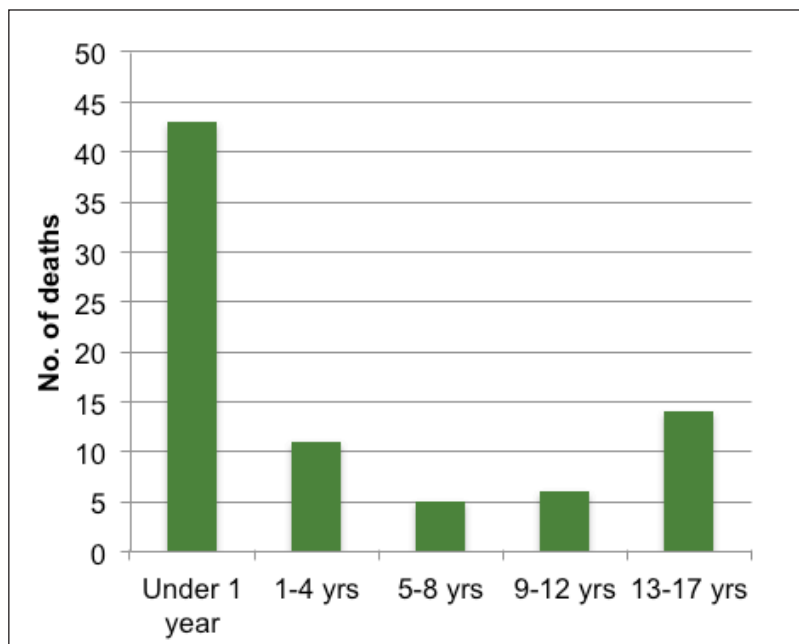
Of the 79 children who died and were known to FACS, 14 (18 per cent) were adolescents aged 13 to 17 years. This is relatively consistent with the number (12) and proportion (16 per cent) in 2013. The circumstances of these 14 deaths comprised:

- an illness or disease (five children)
- suicide (five children)
- motor vehicle accidents (three children)
- drug overdose (one child).

<sup>46</sup> Suicide deaths by gender in previous years are: 2013 – three females and two males; 2012 – four females and eight males; 2011 – two females and two males.

<sup>47</sup> Sedlack & Broadhurst (1996); Wolfner & Gelles (1993) as cited in Righthand, S., Kerr, B. & Drach, K. (2003) *Child Maltreatment Risk Assessments: An Evaluation Guide*, The Hamworth Maltreatment Press: Binghamton, NY.

Figure 4: Children who died in 2014 and were known to FACS, by age



### 2.3.2 Aboriginal and/or Torres Strait Islander children

Note: the statistics in this section may cause distress for Aboriginal people. A list of contacts for support is provided in Appendix 1 of this report.

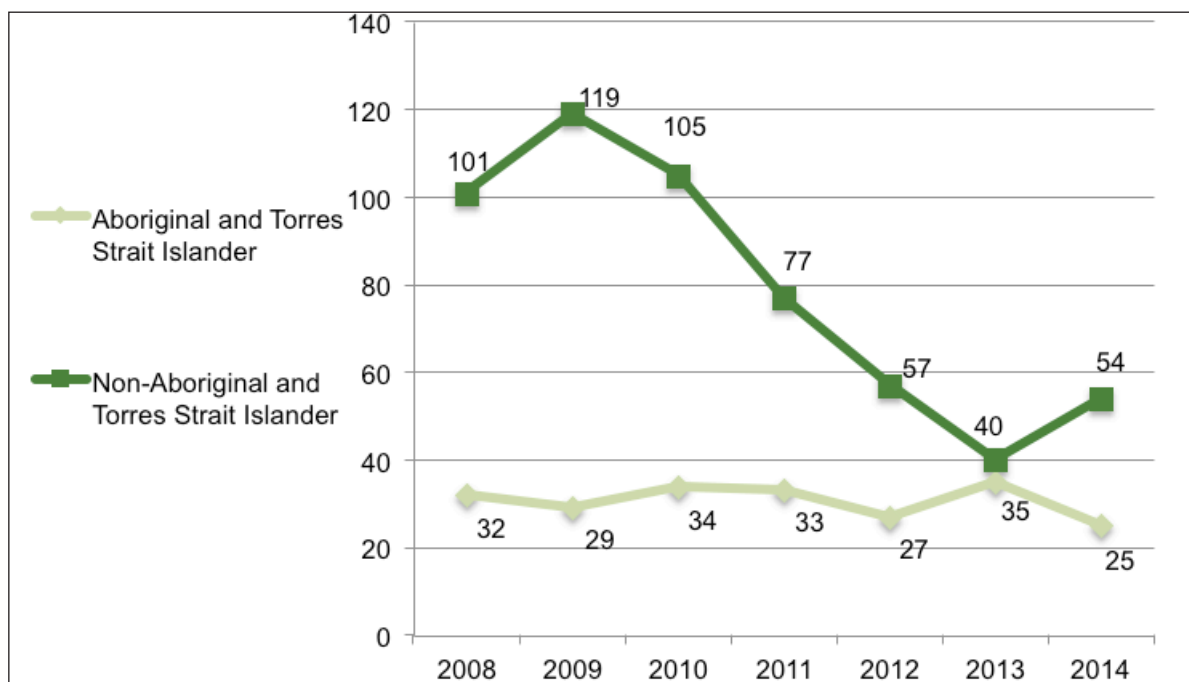
The number of Aboriginal and/or Torres Strait Islander children known to FACS who died is down from one half of all children in 2013 to one quarter in 2014. This is still an over-representation of Aboriginal and/or Torres Strait Islander children in the data and the reasons for this are immensely complex and experienced differently for each family. The skill of empathy is crucial in building a trusting relationship that seeks to understand an Aboriginal and/or Torres Strait Islander child, and their family’s unique story and experiences.

Almost a third (32 per cent) of the 79 children who died in 2014 and were known to FACS were Aboriginal and/or Torres Strait Islander. This is a decrease from 2013, when Aboriginal and/or Torres Strait Islander children comprised almost half (47 per cent) of all deaths for that year.

Since the introduction of the ROSH threshold in 2010, there has been a reduction in the numbers of non-Aboriginal children who died and were known to FACS. However, there was a slight rise in 2014.

The numbers of Aboriginal and/or Torres Strait Islander children who died and were known to FACS have remained relatively stable. Figure 5 reflects the ongoing vulnerability of Aboriginal and/or Torres Strait Islander children.

**Figure 5: Children who died between 2008 and 2014 and were known to FACS, by Aboriginality**



**Table 8: Over-representation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures**

	%
Aboriginal and/or Torres Strait Islander children as a percentage of children in NSW <sup>48</sup>	5
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2014 <sup>49</sup>	13
Aboriginal and/or Torres Strait Islander children as a percentage of children who were the subject of a ROSH report in 2014 <sup>50</sup>	22
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2014 who were known to FACS	32

The over-representation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures is consistent with national research. The Australian Institute of Health and Welfare (AIHW) report *Child Protection Australia 2013–14* provides information on the characteristics of Australian children within the child protection system.

48 At June 2014, there were 91, 472 (5.5 per cent) Aboriginal and/or Torres Strait Islander children and young people and 1, 591, 212 (94. 5 per cent) non-Aboriginal and/or Torres Strait Islander children and young people. The total population of children and young people in NSW at June 2014 was 1, 682, 684; see Australian Institute of Health and Welfare (AIHW) (2015).

49 Information provided to FACS from the NSW CDRT, 2015.

50 Between 1 January and 31 December 2014, 74, 026 children were the subject of a ROSH report. Of these children, 15, 956 (21.5 per cent) were identified as Aboriginal and/or Torres Strait Islander.

The report reflects that across all Australian jurisdictions:

- in the 2013–14 financial year, Aboriginal and/or Torres Strait Islander children were seven times as likely as non-Aboriginal and/or Torres Strait Islander children to be receiving child protection services
- in the 2013–14 financial year, the rate of Aboriginal and/or Torres Strait Islander children in out-of-home care was nine times the rate for non-Aboriginal and/or Torres Strait Islander children
- for the four year period 30 June 2010 to 30 June 2014, the rate of Aboriginal and/or Torres Strait Islander children subject to care orders has risen steadily, while the rate of non-Aboriginal and/or Torres Strait Islander children has remained relatively stable, and the rate of Aboriginal and/or Torres Strait Islander children subject to a care order was higher (almost nine times) than the rate for non-Aboriginal and/or Torres Strait Islander children.<sup>51</sup>

Underlying factors which are likely to contribute to the ongoing over-representation of Aboriginal and/or Torres Strait Islander children in the child protection system include the legacy of past policies of forced removal; the impact of intergenerational factors, including the effects of previous separations from family and culture; poverty; and perceptions arising from cultural differences in child-rearing practices.<sup>52</sup>

Aboriginal and/or Torres Strait Islander children had higher rates of death due to circumstances such as extreme prematurity,<sup>53</sup> unsafe sleeping environments (in the SUDI category), accidents and drowning. Some contributing factors for higher rates of preventable deaths among Aboriginal and/or Torres Strait Islander children are intergenerational cycles of poverty, domestic and family violence, alcohol and/or drug misuse, and inadequate housing.<sup>54</sup> Applying the knowledge that many of these deaths are preventable, along with understanding some of the contributing factors, can assist practitioners to target their work with families and make changes that will enhance safety and reduce these avoidable deaths.

Of the 25 Aboriginal and/or Torres Strait Islander children who died in 2014, intergenerational risk factors were identified in 13 cases. These factors included the parents of the 13 children experiencing trauma in their own childhood, including alcohol and/or drug misuse, domestic violence, chronic neglect and/or serious physical abuse. The mothers of 19 of the 25 children had their own child protection history, as did six of the children's fathers.

Socio-economic factors were evident among 11 of the 25 Aboriginal and/or Torres Strait Islander children who died in 2014, including:<sup>55</sup>

- family transience (eight children)
- homelessness (six children)
- poverty (four children)
- geographical isolation (one child).

51 Australian Institute of Health and Welfare (AIHW) (2015).

52 Human Rights and Equal Opportunity Commission (1997), cited in Australian Institute of Health and Welfare (AIHW) (2015).

53 See section 2.2.2 for more information on prematurity related deaths for Aboriginal and/or Torres Strait Islander children.

54 Scott, D. & Nair, L. (2013) *Child Protection Statistics for Aboriginal and Torres Strait Islander Children*, Australian Institute of Family Studies (AIFS): Melbourne, <http://www.aifs.gov.au/nch/pubs/sheets/rs10/rs10.html>

55 Some children experienced more than one socio-economic factor, some none.

## 2.4 FACS response to the children who died

This section outlines FACS involvement with the families of the 79 children who died in 2014. Information is provided about the number of reports received, what the reports were about, the decisions made in response to the reports and whether the child was living with their family at the time of their death. This section also considers how FACS responded to families after their child's death.

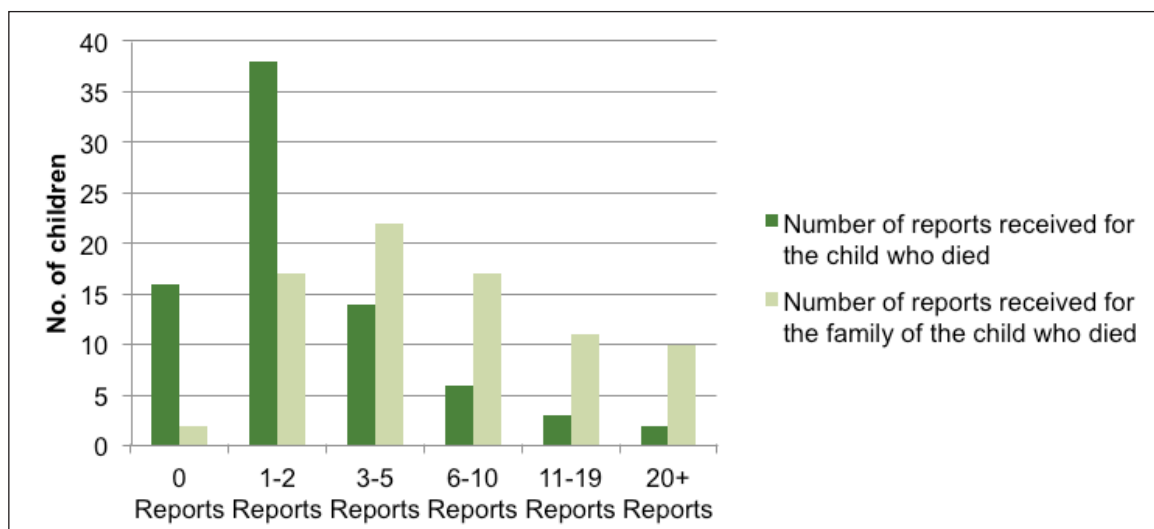
### 2.4.1 Reports

Of the 79 children who died in 2014, 62 (78 per cent) were the subject of a report to FACS prior to their death.<sup>56</sup> Of these, 60 were the subject of a ROSH report (made between 24 January 2010 and when they died). The remaining 17 children were not the subject of a report, their sibling/s were.

Most of the children who died (54, or 68 per cent) did not have lengthy child protection histories.<sup>57</sup> Eleven (14 per cent) were reported to FACS on more than five occasions and two were reported 20 and 48 times respectively. Fourteen children (18 per cent) were reported between three and five times.

Not surprisingly, there was a higher rate of reports received for families where both the child who died and their sibling/s were reported compared to families where reports were received for the child who died only. This is consistent with findings from previous years.

**Figure 6: Number of reports received for children who died and their families<sup>58</sup>**



The number of reports shown in Figure 6 does not directly correlate with the level of risk for a child. Factors such as a child's visibility in the community means they may be the subject of more frequent reporting, including from mandatory reporters. Younger children who are less visible in the community, or children who live in rural or remote locations, may be the subject of fewer reports, though the nature of the reports received indicate a high level of risk.

<sup>56</sup> A report includes either a 'risk of harm' report received prior to 24 January 2010, or a 'risk of significant harm (ROSH)' received on and after 24 January 2010. Reports that were determined to be non-ROSH are not included in this count.

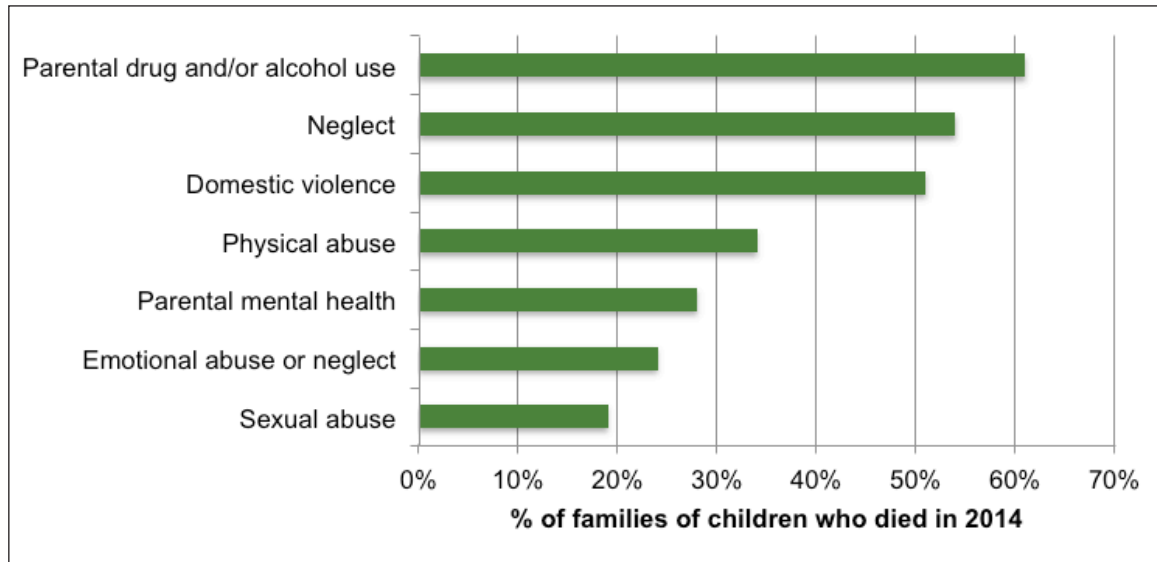
<sup>57</sup> This figure includes children who were not reported to FACS, or those who received one or two reports.

<sup>58</sup> The 10 families who were reported over 20 times include three families who were the subject of over 46 reports.

## 2.4.2 Reported risk concerns

Consistent with the findings across previous years, parental alcohol and/or drug misuse, neglect and domestic violence were the primary reported issues identified from the ROSH reports received for the families of children who died in 2014.

**Figure 7: Children who died in 2014 by selected primary reported issues in ROSH reports received about them and their families<sup>59</sup>**



A total of 43 families were reported to FACS due to ROSH concerns about neglect. These families were reported for either one or more types of neglect, including:<sup>60</sup>

- physical neglect (22 families)
- supervisory neglect (22 families)
- medical neglect (21 families)
- emotional abuse/neglect (20 families)
- educational neglect (nine families).

**While alcohol and/or drug misuse, neglect and domestic violence were the main problems reported for children who died in 2014, these rarely occurred in isolation to one another. In 2014, 30 per cent of the children who died had a history of concerns about all three problems.**

The problems facing families are diverse and experienced differently for each family. Demonstrating genuineness and sensitivity to an individual's context and needs is vital. Twenty four of the 79 families had co-existing risk factors, including alcohol and/or drug misuse, neglect and domestic violence present, exacerbating the existing vulnerability of children known to FACS.<sup>61</sup>

<sup>59</sup> Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.

<sup>60</sup> Numbers do not add to 43 as multiple neglect issues can be present in one family.

<sup>61</sup> This included any reports or information received about the family to indicate that these issues were present.



Research confirms that the importance of a relationship between a family and their caseworker has consequences for a family's ability to make changes in their lives.<sup>62</sup> Development and maintenance of effective relationships is difficult work, particularly in statutory child protection. It requires great skill and self-awareness to support change in the context of crisis and frequently involuntary service provision. In recent years, FACS has worked hard to promote relationship-based practice. FACS Care and Protection Practice Framework<sup>63</sup> positions relationships as critical to the casework role, and provides a mandate for our workforce to value and create meaningful relationships. iPractice (an interactive practice resource) provides meaningful information and support to practitioners in their daily work.

### 2.4.3 FACS response prior to the child's death

Almost three-quarters (72 per cent) of the 79 children who died in 2014 received a completed assessment from FACS prior to their death,<sup>64</sup> while 22 (28 per cent) did not. Of the 57 children who received an assessment, 43 received an assessment within three years of their death (i.e. between 2011 and 2014).

For the 22 children who were known to FACS and did not receive an assessment:

- 18 children were not allocated to a caseworker due to the higher priorities of other children at risk
- two children were allocated for a response at the time of the child's death<sup>65</sup>
- two children had their cases closed after further intake work determined that an assessment was not required.

### 2.4.4 Children in out-of-home care (OOHC)

In 2014, there was an increase in the number and percentage of children who were not living with their immediate family members, but were in out-of-home care at the time of their death, as shown in Table 9.

**Table 9: Children who were living in out-of-home care when they died between 2011 and 2014**

	2011	2012	2013	2014
No. of deaths	11	7	6	10
% of deaths	10%	8%	8%	12%
Age range	0–16 yrs	0–17 yrs	0–15 yrs	0–15 yrs
Aboriginal and/or Torres Strait Islander	7	2	1	1
Parental responsibility of Minister (any aspect)	9	4	4	9
Placed with a relative	4	5	3	2
Placed with authorised carers	5	1	3	7
Other (e.g. placed in residential care, hospital)	2	1	0	1

Ten children were not living with their immediate families at the time of their death. Nine of these were under the parental responsibility of the Minister and one was under the parental responsibility of a relative.

62 Ashley & Nixon (2007). Family Group Conferences - where next? Policies and practices for the future. Family Rights Group, the Print House, London

63 FACS Care and Protection Practice Framework mandate: is to understand each child's experience, build relationships with parents, families and communities and use collective wisdom, skills and courage to achieve change.

64 This includes an assessment by the FACS early intervention program.

65 In these cases, reports were received by FACS just prior to the child's death. A decision was not made about what action was required.

Of the 10 children, two were placed with relatives and seven with authorised carers who were not related (one child with a FACS carer and six with NGO carers). One child resided in a disability hospital at the time of their death. The circumstances of death for these 10 children included illness and/or disease, accidental choking, drug overdose, drowning, suicide and SUDI.

Authorised carers open their homes to children who have experienced significant trauma and abuse. Carers need to be equipped with the knowledge, skills and support to respond effectively and empathically to children. It is crucial that carers are able to provide children with safe and nurturing environments and healthy attachments. Equally important is the need for authorised carers to be able to access appropriate support networks, including caseworkers, to work in partnership so that children in OOHC have every opportunity to reach their potential.

Recent Australian research confirms that the rate of children entering OOHC continues to rise.<sup>66</sup> From March 2012 to 30 April 2015, 5,675 children in OOHC have been transitioned to non-government agencies.<sup>67</sup>

In 2014, of the 79 children who died and were known to FACS, six were placed with NGO carers at the time of their deaths. As more children in OOHC are being supported by NGOs, strong interagency collaboration between FACS and NGOs is instrumental in children receiving quality, safe and supported OOHC.

#### 2.4.5 FACS response after the child death

When a child dies, FACS has the responsibility to assess the safety of any other children residing in the same household, including unborn children of any known pregnancies. This is especially important when the death may be due to abuse, neglect or suspicious circumstances.

Of the 79 families of children who died in 2014 and were known to FACS, 31 (39 per cent) received an assessment by FACS following the child's death which involved:

- FACS providing ongoing case management to the family (20 children)
- the families being referred to other services and the case being closed (seven children)
- the siblings being removed from the family home and assumed into care (four children).

The remaining 48 families (61 per cent) did not receive an assessment by FACS following the child's death. For 45 of these families, a decision was made that no response was required<sup>68</sup> due to:

- no siblings living in the same household who were under the age of 18 (22 children)<sup>69</sup>
- no risk issues identified for the surviving siblings (21 children).<sup>70</sup>

The remaining three of the 48 families could not be allocated due to the priority of other matters.<sup>71</sup>

66 Australian Institute of Health and Welfare (AIHW) (2015).

67 NSW Family and Community Services (2015) 'Empowering people to live fulfilling lives and achieve their potential: FACS stakeholder 2015–16 budget briefing', [http://www.facs.nsw.gov.au/\\_data/assets/pdf\\_file/0020/318305/FACS\\_budget-summary\\_2015-16.pdf](http://www.facs.nsw.gov.au/_data/assets/pdf_file/0020/318305/FACS_budget-summary_2015-16.pdf)

68 Two children were identified as non-applicable, without explanation as to why.

69 This includes where the child who died did not have any siblings or the child had siblings who were in out-of-home care at the time of the child's death.

70 This includes children where no ROSH concerns were identified by the Helpline or after further follow-up by the CSC.

71 These three children died as a result of extreme prematurity. Two of these children were twins.

## Chapter 3: Vulnerable Teenagers Cohort Review

*In this chapter, the term 'teenager' is used rather than 'young people' because it better captures a broad age group (13 to 17 years). The term 'young people' is limited in its definition to children aged 16 and 17 years only.<sup>72</sup>*

The transition from childhood to adolescence can be 'rocky', and the challenges faced can be particularly tough for teenagers who experience abuse and neglect. The need to better understand and support vulnerable teenagers known to the child protection system has been highlighted consistently in the review work of the Serious Case Review (SCR) unit.

SCR reviewed the cases of 140 teenagers known to FACS who died between 2009 and 2014. Of these teenagers, 111 were considered to be vulnerable, with their deaths occurring in the context of suicide, alcohol/drug misuse, risk taking behaviour or other vulnerabilities such as medical neglect. The other 29 deaths occurred in circumstances of an accident unrelated to the teenagers' child protection history or from a life-threatening condition or illness, often diagnosed from birth or during their early childhood; these 29 deaths are not considered in the cohort review.

This chapter presents the cohort review in three sections. Section 3.1 describes the circumstances of death and characteristics of the teenagers who died. Section 3.2 discusses practice themes and considers how findings from the review can inform current practice. The themes identified are: understanding the warning signs, systemic barriers and personal barriers. Section 3.3 highlights the power of relationships between practitioners and the teenagers they work with and their potential for positive outcomes.

A number of de-identified case studies have been used in the chapter to highlight circumstances of death and themes. Some of these case studies are based on child death reviews, and others are examples of recent casework with teenagers collated by the OSP. Some of the case studies are very sad and make for a challenging read.

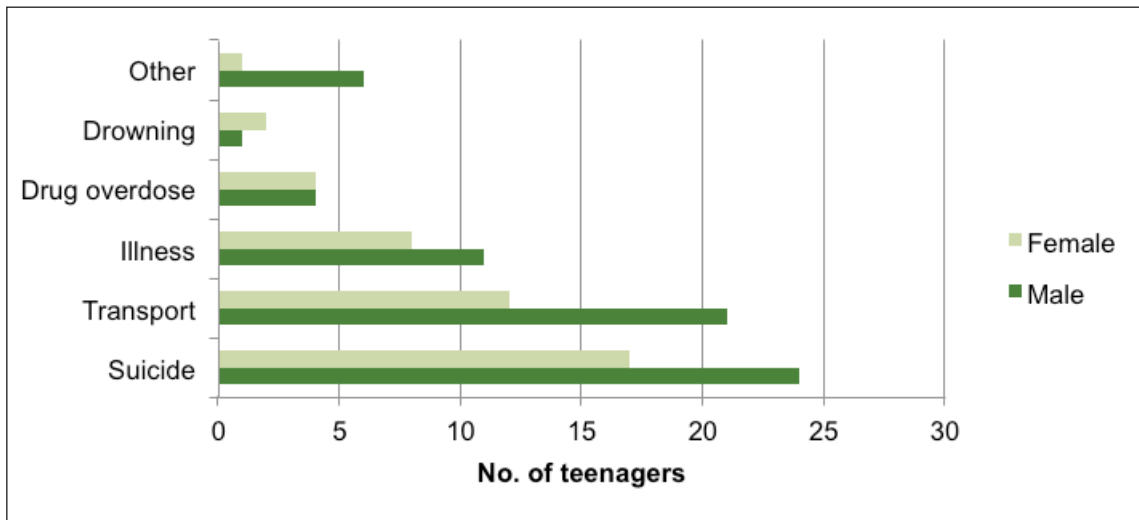
### 3.1 Deaths of vulnerable teenagers 2009–2014

#### 3.1.1 Circumstance of death

The primary circumstance of death for the 111 vulnerable teenagers was suicide (41), followed by motor vehicle accidents (33), illness or disease (19), drug overdose (8) and drowning (3). The remaining seven deaths resulted from injury or occurred in suspicious circumstances.

<sup>72</sup> In the *Children and Young Persons (Care and Protection) Act 1998*, a child is defined as aged under 16 and a young person as aged over 16 years and under the age of 18 years.

**Figure 8: Vulnerable teenagers who died between 2009 and 2014 and were known to FACS by circumstances of death**

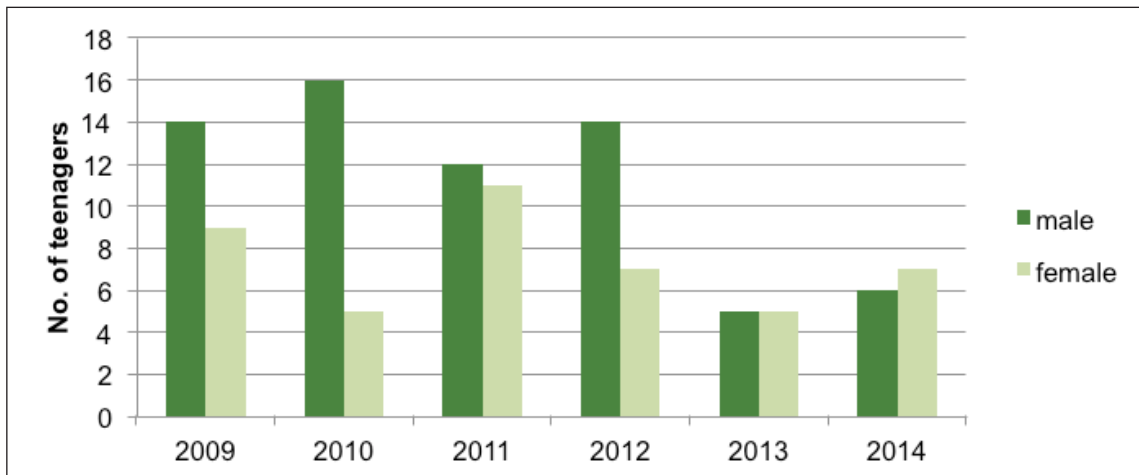


### 3.1.2 Characteristics of vulnerable teenagers

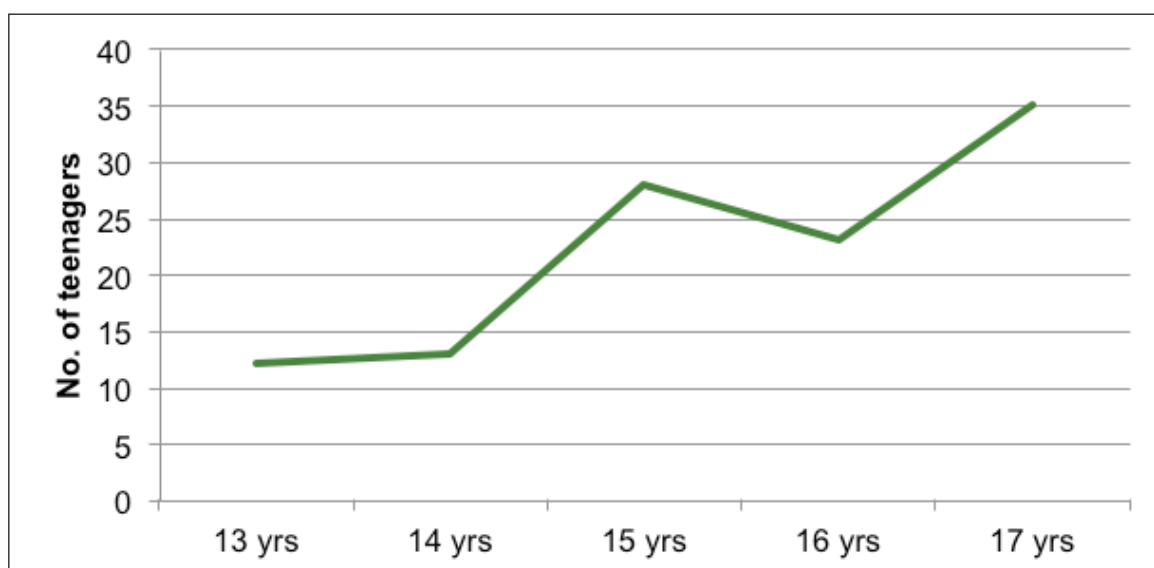
#### Age and gender

Of the 111 vulnerable teenagers, 67 were male and 44 female. The statistics show an increased number of deaths among older teenagers (aged 15–17), and, consistent with the general gender pattern, more boys than girls in this older group.

**Figure 9: Vulnerable teenagers who died between 2009 and 2014, by gender**



**Figure 10: Number of teenagers who died and were known to FACS over a six year period, by age.**



### **Aboriginal and/or Torres Strait Islander background**

Only 4.9 per cent of the child population in Australia identifies as Aboriginal and/or Torres Strait Islander, yet 25 of the 111 teenagers in the cohort identified as Aboriginal and/or Torres Strait Islander. The deaths of these 25 teenagers featured across all circumstances of death but predominantly in the categories of suicide (9) and transport accidents (8).

### **Mental health**

In 2007, the AIHW estimated that 9 per cent of young Australians aged 16–24 had high or very high levels of psychological distress and that one in four experienced a mental disorder.<sup>73</sup>

Thirty-four of the 111 teenagers in the cohort were found to have a diagnosed mental health illness.<sup>74</sup> The prevalence of mental health is much higher among children and young persons known to FACS than in the general teenage population in Australia.

### **Living circumstances**

Twenty eight of the teenagers in the cohort were not living with their families at the time they died, and sixteen were under the parental responsibility of the Minister or a relative. Of these 16, seven were living in a residential care placement or semi-independent living, seven were being cared for by a member of their extended family, and two were placed with a foster carer.

Twelve of the teenagers were homeless when they died and 20 had experienced periods of homelessness or housing instability that contributed to their vulnerability. Once homeless, teenagers are often exposed to situations and risks that heighten their vulnerability. They are more likely to become disengaged from education or employment and are at increased risk of developing substance misuse or dependence or experiencing mental health problems.<sup>75</sup>

<sup>73</sup> Australian Institute of Health and Welfare (2011) *Young Australians: Their Health and Wellbeing*, Cat. No. PHE 140. Canberra: AIHW.

<sup>74</sup> Mental health illness was included when a formal diagnosis had been made. This mainly included diagnosis of depression or anxiety. Other diagnosed conditions included attention deficit and conduct disorders.

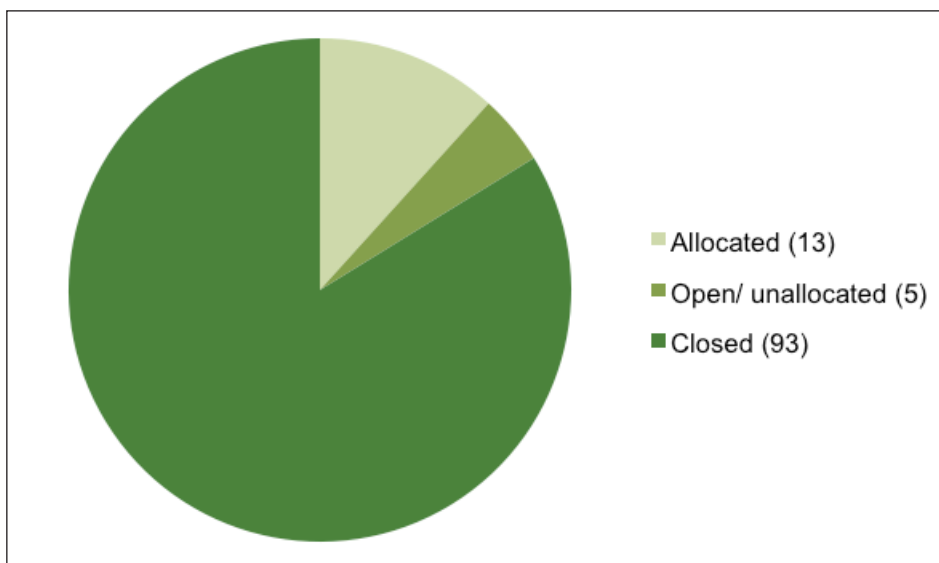
<sup>75</sup> Department of Families, Housing, Community Services and Indigenous Affairs (2008) *Literature Review: Effective Interventions for Working with Young People Who are Homeless or at Risk of Homelessness*, Institute of Child Protection Studies and Australian Catholic University, [www.dss.gov.au/sites/default/files/documents/06\\_2012/literature\\_review.pdf](http://www.dss.gov.au/sites/default/files/documents/06_2012/literature_review.pdf).

## Allocation of cases

FACS was not working with the majority of the teenagers (93 of the 111) in the time leading up to their deaths. Thirteen teenagers had an allocated caseworker at the time of their death<sup>76</sup> and five were not receiving active casework intervention (that is, FACS had not made recent contact). The five teenagers who were not allocated to a caseworker included:

- two teenagers whose parental responsibility was allocated to a relative and who were being paid a supported care allowance
- two teenagers who were in out-of-home care and whose cases were open but unallocated at a Community Services Centre (CSC), and;
- one teenager who had not yet been allocated to a caseworker or responded to before their death.

**Figure 11: Proportion of 111 teenagers that were allocated to a caseworker, unallocated or closed**



### 3.1.3 Suicide

Suicide was the leading circumstance of death in the cohort (41 out of 111). In its 2013 Annual Report, the NSW Child Death Review Team noted that young people known to FACS were four times more likely to die from suicide than those not known to FACS.<sup>77</sup> The vulnerability of this age group is not a unique problem for NSW.

Analysis of the information known for the 41 teenagers who died from suicide found the following:

- Twenty-four were male and 17 female.
- Almost all (36) died by hanging.<sup>78</sup>
- Nine identified as Aboriginal and/or Torres Strait Islander. This over-representation is consistent with national data showing that deaths due to suicide for Indigenous children aged 0–17 between 2007 and 2011 were at nearly seven times the rate for non-Indigenous children.<sup>79</sup>
- There were slightly more from areas classified as rural (23) than from capital cities and metropolitan areas (18).

<sup>76</sup> Two of these cases were teenagers in OOHC and had had their case management transferred to an NGO.

<sup>77</sup> NSW Child Death Review Team (2014a) Annual Report 2013, NSW Ombudsman: Sydney.

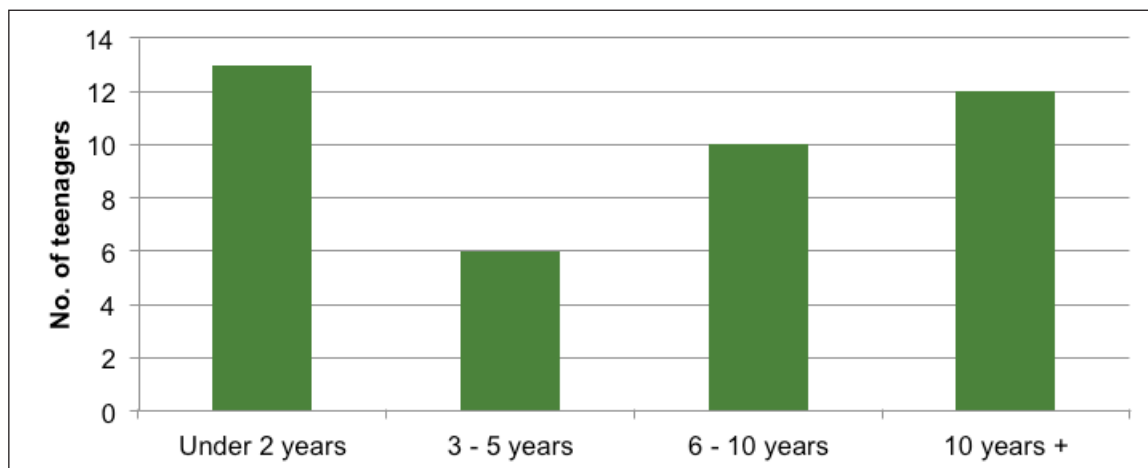
<sup>78</sup> The other five deaths included, but were not limited to, deaths from carbon monoxide poisoning and other intentional injury.

<sup>79</sup> Australian Institute of Health and Welfare (AIHW) (2014).

- Thirty-five demonstrated clear risk taking behaviours before their death, including the problematic use of alcohol or drugs, self-harming behaviours and engagement in high-risk sexual behaviour.
- Seventeen had been diagnosed with a mental illness before they died.
- Ten had made a previous suicide attempt and 11 had indicated their intent to commit suicide or had expressed suicidal thoughts before their death.
- At least eight had experienced the suicide of a family member or friend prior to their own death, indicating that 'suicide contagion' was a risk factor. This is the process whereby the likelihood of suicide is increased by direct or indirect exposure to the suicidal behaviour of others who are known to the person contemplating suicide.<sup>80</sup>

For the 41 teenagers who died from suicide, the time between FACS first receiving a report and the teenager dying varied. Thirteen had been reported to FACS for the first time within two years of their death, and 12 had been known to FACS for over 10 years. The remaining 16 had child protection histories between three and ten years. The high number of teenagers who died from suicide with a relatively short child protection history suggests that a lengthy child protection history should not be the only factor used to determine risk.

**Figure 12: Teenagers who died as a result of suspected suicide by the number of years since they were first reported to FACS at ROSH**



There are difficulties in reporting accurately about the deaths of children in circumstances of suicide or intentional self-harm. There is much debate about the age when children begin to understand concepts of death and suicide.<sup>81</sup> Recent research highlights that most children have an understanding of death and the concept of suicide by the age of eight. It has become more accepted that intent to cause self-harm or death is most important when assessing risk of suicide, regardless of the child's cognitive understanding of the lethality, finality, or outcomes of their actions.<sup>82</sup>

For the teenagers considered for the cohort review, warning signs (self-harm behaviour and suicide attempts) had been noted at various ages. While the review considered the deaths of teenagers only, the SCR has also reviewed the death of a child under the age of 13 who died in circumstances of suicide. Collectively, the reviews of both young children and teenagers highlight the need to consider suicide as a possible risk for a child of any age.

<sup>80</sup> Davidson, L. & Linnoila, M. (2012) *Risk factors for Youth Suicide*, Routledge: New York.

<sup>81</sup> Kolves, K (2010).

<sup>82</sup> Soole, R., Kolves, K. & De Leo, D. (2014) 'Factors related to childhood suicides: Analysis of the Queensland Child Death Register', *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 35(5), pp. 292-300.

**Practice tips for working with children and teenagers who are self harming or have thought about suicide:**

- Remember children and teenagers who are afraid may appear reluctant to engage
- Use what you have noticed to ask questions and be curious *'you look distracted and unwell – I feel worried about you – can you tell me what's been going on?'*
- Show the child or teenager you care about them
- Be encouraging, consistent and reliable
- Normalise feelings of hopelessness or despair to reduce stigma and shame
- Separate out self harming behaviour. Self harming behaviour can be different to suicide and can sometimes be a strategy teenagers use to help cope with unmanageable feelings. Talk to them about this and what other ideas the teenager has to help manage strong feelings or thoughts.
- Ask very clear questions about intent and plans and self harming behaviour. For example, *'when other young people have been going through tough times or feel this way, they have told me it gets too much and they have thought about hurting themselves. Have you ever felt like this?'*
- Language is important – use words that accurately and sensitively describe suicide and self harm
- Consider warning signs (threats of suicide, expressing hopelessness, withdrawal, dramatic change in personality, lack of interest in future, mental illness, family history of suicide, experiences of abuse and neglect, relationship break-up)
- Acknowledge the factors that influence a teenager's mental health and normalise those feelings *'It is no wonder you feel pretty low sometimes – you have had a huge amount to deal with'*
- Role model and reinforce nurturing behaviours and relationships
- Know your local adolescent and mental health services
- Refer to Psychological Services resources *'Suicide and Self Harm: Risk Management for FACS staff'* and *'Risk Management Guidelines for Preventing Suicide and Self Harm'*
- Offer creative alternatives to help a teenager access resources they find useful – apps and internet resources.



### 3.1.4 Transport accidents

Thirty-three of the 111 teenagers died in an accident involving a form of transport (motor vehicle, motorbike or trail bike). Of these, 21 were male and 12 were female, and eight identified as Aboriginal and/or Torres Strait Islander. Over the past six years, a decreasing number of transport related teenage deaths has been noted, with deaths falling from 12 in 2009 to three in both 2013 and 2014.

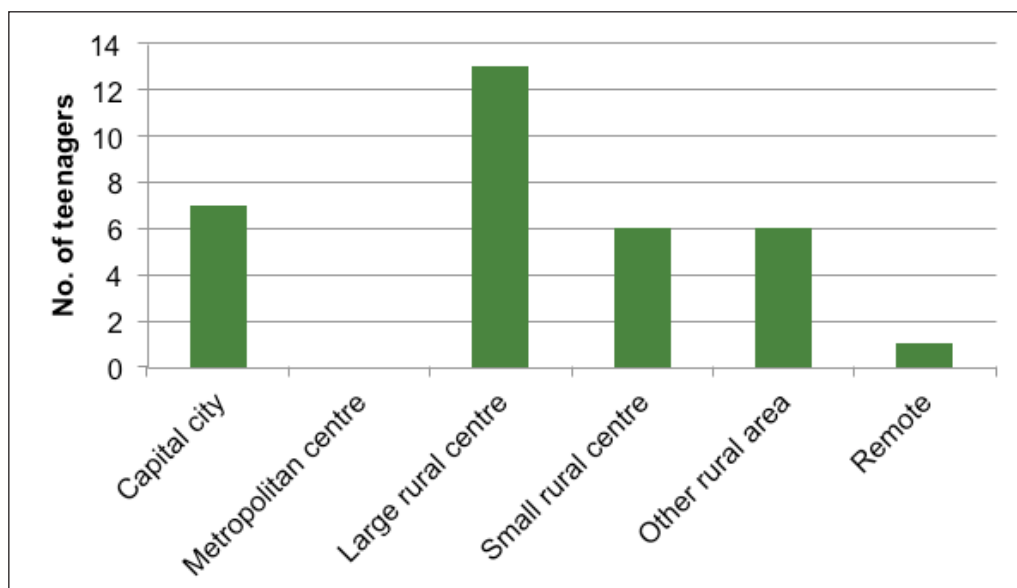
The cohort numbers are consistent with the NSW Child Deaths Review Team (CDRT) report on deaths of children in transport accidents over 15 years.<sup>83</sup> This report highlighted a declining number of transport related deaths, a higher number of boys than girls, and that one quarter were Aboriginal and/or Torres Strait Islander children. In fact, it found that the mortality rate of Aboriginal and/or Torres Strait Islander children from transport accidents was more than five times that of non-Aboriginal and/or Torres Strait Islander children.

Twenty six of the teenagers displayed clear risk taking behaviours before they died. Fourteen were known to be using alcohol or drugs prior to their death and five had a diagnosed mental health condition.

Sixteen were driving the vehicle when the accident took place and 10 were in a car driven by another child. Not having a licence, speeding and having too many passengers in the vehicle were factors present in many of these teenagers' deaths. Three were hit by a car because they were on the road, while the remaining four were in a car with a licensed adult when the accident occurred. Risk factors such as speeding or alcohol and/or drug misuse by the driver were evident.

Analysing where teenagers were living when they died shows a clear increase in the number of transport-related accidents for teenagers living in rural areas. This could be linked to factors usually identified as causing higher numbers of vehicle accidents in rural areas – road conditions, alcohol misuse, speeding drivers, greater distances travelled and lack of safety restraints.<sup>84</sup> This could also be related to reasons more specific to teenagers, such as boredom, substance use and driving unlicensed.

**Figure 13: Number of teenagers who died in transport accidents by rural or regional area**



<sup>83</sup> NSW Child Death Review Team (2014a).

<sup>84</sup> Chen, H.Y., Ivers, R.Q., Martiniuk, A.L.C., Boufous, S., Senserrick, T., Woodward, M., Stevenson, M., Williamson, A. & Norton, R. (2009) 'Risk and type of crash among young drivers by rurality of residence: Findings from the DRIVE study', *Accident Analysis and Prevention*, Vol. 41, pp. 676–82.

### 3.1.5 Illness/disease

Nineteen of the teenagers in the cohort died from illness or disease, highlighting the impacts of medical neglect and cumulative harm over time. The review found that the parents or carers were often unable to provide for the teenagers' medical needs. For many, there was evidence that intervention may have improved the teenagers' experiences of the disease or illness.

Social and economic factors also contribute to the neglect of teenagers. The review identified that poverty (4), transience (2) and homelessness (5) were present in the lives of several teenagers. Nine of the teenagers had a parent with an alcohol or drug problem, and six had a parent diagnosed with a mental health condition.

It is concerning that three of the teenagers in the cohort died from asthma. Asthma is a common long-term condition that affects young Australians, but deaths from asthma are uncommon. The review found evidence of neglect, parental conflict, suicidal thoughts, mental health diagnosis and drug misuse for the three teenagers who died from asthma. Two teenagers experienced transience, moving regularly between different addresses and caregivers.

In 2013 the NSW CDRT conducted a 10-year review of deaths of children due to asthma, including 20 children aged between four and 14. Psychosocial issues, such as family breakdown, substance abuse, domestic violence and neglect, were present in more than half of the families. Eight of the 20 children were known to FACS and had a child protection history.<sup>85</sup>

### 3.1.6 Substance use

The cohort review identified illicit alcohol and drugs as a risk factor for many of the 111 teenagers, with 57 known to be using alcohol and/or drugs before they died. Eight died from a drug overdose, and all of these teenagers displayed risk taking behaviour and were misusing substances before they died.

Teenagers with a child protection history who have experienced time in out-of-home care or had a parent who misuses alcohol and/or drugs are at greater risk of substance use themselves.<sup>86</sup> Sixty-seven of the 111 teenagers had a parent who was known to have misused alcohol or drugs, and 40 of these were known to have alcohol or drug problems prior to their death.

Alcohol is the most commonly used drug among young Australians and is a particularly significant risk factor for transport related accidents and suicides.<sup>87</sup> Using alcohol can lead to risk taking activities, ease social inhibitions and encourage acceptance by peers.<sup>88</sup> Using drugs and alcohol can provide teenagers with a way of coping with their environment. Drugs and alcohol can be used as self-medication, a method to avoid loneliness or a way to be accepted by a social group.

<sup>85</sup> NSW Child Death Review Team (2014a).

<sup>86</sup> Cheng, T.C. & Lo, C.C. (2010) 'Drug use among maltreated adolescents receiving child welfare services', *Children and Youth Services Review*, Vol. 32, pp. 1735–39.

<sup>87</sup> Centre for Accident Research & Road Safety (CARRS) (2010) 'Adolescent risk taking: State of the road', factsheet, [www.carrsq.qut.edu.au/publications/corporate/adolescent\\_risktaking\\_fs.pdf](http://www.carrsq.qut.edu.au/publications/corporate/adolescent_risktaking_fs.pdf)

<sup>88</sup> Willoughby, T., Good, M., Adachi, P.J.C., Hamza, C. & Tavernier, R. (2014) 'Examining the link between adolescent brain development and risk taking from a social-developmental perspective', *Brain and Cognition*, Vol. 89, pp. 70–78.

### Practice tips when working with teenagers use alcohol and drugs:

- Use empathy and be genuine
- Understand resistance to wanting help or changing, and be persistent
- Talk to the teenager about the pros and cons of their drug/alcohol use
- Explore ways to educate teenagers about the effects of their alcohol/drug use
- Talk to the teenager about reducing the harm of problematic drug and/or alcohol use
- Acknowledge effort to change regardless of success
- Be responsive to new circumstances
- Build partnerships with family, professionals and people important to the teenager
- Use local resources or internet resources to support the young person's attempts to change their behaviour, for example, Somazone.

## 3.2 Implications for practice

### 3.2.1 Understanding the warning signs

Of the 111 teenagers considered for the cohort review, 85 were involved in risk taking behaviours before their death. These behaviours included alcohol and/or drug misuse, transport related risk taking, absconding from home or placements, criminal behaviours, high risk sexual behaviour, suicidal ideation, self-harming and problematic relationships with adults.

Practitioners should carefully consider the underlying reasons why teenagers engage in risk taking behaviour if they hope to make a change through intervention. Though risk taking is commonly understood as a rite of passage, practitioners need to be curious about what is behind the behaviours and not minimise or underestimate them as merely attention seeking or 'ordinary' teenage behaviours. Engaging in conversations early on with colleagues, including FACS Psychologists or Clinical Consultants, can help practitioners contextualise a teenager's behavior and consider the ways they may engage and support them in their casework role.

Teenagers often participate in risk taking to gain social acceptance or reward.<sup>89</sup> Research has shown that risk taking can provide them with a way to learn more about themselves and their environment. A moderate amount of risk taking helps develop social competence and adult behaviours.<sup>90</sup> However, analysis of the deaths of young people in Australia indicates that many of these happen in the context of risk taking behaviour and that many of these deaths are considered preventable.<sup>91</sup>

There were worrying signs for most of the teenagers in the cohort – they were putting themselves in danger increasingly. Noticing an escalation or noting a pattern in absconding behaviour, alcohol/drug misuse and/or involvement in criminal activity is an essential part of good practice when working with vulnerable teenagers. For example, many teenagers may be reported to FACS for behaviours that do not meet ROSH, however these reports often contain information that should form part of a comprehensive risk assessment.

89 Sheehan, M., Siskind, V. & Schonfeld, C. (2004) 'A longitudinal study of adolescent drink driving and other risk taking behaviours: Challenges for the change process', 17th International Conference on Alcohol, Drugs and Traffic Safety: Glasgow; Willoughby et al (2014).

90 Johnson, S.B., Sudhinaraset, M. & Blum, R. (2010) 'Neuromaturation and adolescent risk taking: Why development is not determinism', *Journal of Adolescent Research*, Vol. 2, pp. 4–23. Kolves, K. (2010) 'Child suicide, family environment, and economic crisis', *Crisis*, Vol. 31(3), pp. 115–17.

91 Sheehan et al (2004).

Several of the SCR reviews for teenagers in the cohort noted the importance of conducting a holistic assessment of parents, caregivers and siblings in the home in order to gain an understanding of a teenager's experience in the family. As discussed earlier, eight of the 41 teenagers who died from suicide had been exposed to the suicide of a family member or close friend prior to their own.

The following case study below illustrates how behaviours can escalate and shows the importance of observing and assessing this escalation when working with a teenager.

case study	<p>Clare had been in out-of-home care since she was three. She had experienced several placements, including an unsuccessful restoration to her father. She was sexually abused by an older foster child in one of her placements, and at age 12 she moved to a residential care placement.</p> <p>In this placement Clare began to meet other children who had experienced trauma, abuse and neglect and was exposed to their risk taking behaviours. She began running away with other children from the placement and experimenting with alcohol and marijuana.</p> <p>Clare had developed a positive relationship with her caseworker, and this was used to create a safety plan and discuss the risks associated with her behaviour. Although she still ran away occasionally, she was home in her placement more and her drug and alcohol misuse lessened.</p> <p>When she was 14, Clare was sexually abused again, this time by an older male. Shortly after, her behaviour changed – she disengaged from her caseworker and refused to discuss her experiences. FACS started to receive frequent reports about Clare running away from her placement, using alcohol and drugs, and being involved in criminal activity. She would often go missing for weeks at a time, and her drug misuse escalated. She was now injecting 'ice' and had been arrested for possessing a large quantity of marijuana. She was increasingly away from her placement and was associating with older people who were known to police. Clare died from suspected suicide when she was 15.</p>
what can practitioners do?	<ul style="list-style-type: none"><li>• Be upfront about risk taking behaviour</li><li>• Recognise that alcohol and drug use can increase a teenager's risk of suicide</li><li>• Talk with a teenager about how they can stay safe when using drugs and alcohol</li><li>• Be persistent in trying to build a relationship, visit, text and call if a teenager does not respond</li><li>• Understand that the people a teenager become involved with may be providing security and belonging. Consider other ways to create safe relationships.</li></ul>

### 3.2.2 Systemic barriers to working with teenagers

#### Allocation of cases

Responding to and prioritising teenagers is an ongoing challenge for FACS. In the cohort of 111 teenagers, only 13 were allocated to a caseworker when the teenager died. Since 2009, teenagers have consistently been the second highest group of children (behind babies aged less than one year) who were known to FACS before their death and whose deaths are reviewed by SCR.

The risks and vulnerabilities for very young children are well understood. However, the cohort review highlights that signs of escalating risk and vulnerability for teenagers may not be as well understood. There were several cases examined within this review where allocation may have assisted both FACS and other services to gain a better understanding of the experiences the child was facing.

### **Incident based response**

Many of the teenagers included in the cohort review only received a casework response when an incident or crisis occurred. Without sustained contact, practitioners were not able to engage with them in any meaningful way. In one teenager's death review, this resulted in *'each report being treated individually rather than as evidence of an historic and escalating pattern of risk'*. To work effectively with teenagers, the challenge is to respond simultaneously to both the crises brought on by high-risk behaviour and to address their underlying needs.

Practitioners can often struggle to work with teenagers when time and resources are limited, and as a result focus only on immediate or presenting problems.<sup>92</sup> This was evident in several of the death reviews for teenagers included in the cohort review. In one review practitioners *'seemed focused on homelessness rather than significant issues associated with the child's drug misuse, limited supports, poor family relationships and mental health'*. Ensuring that a teenager has a bed for the night can be all-consuming and time-intensive, leaving little room for practitioners to begin addressing the underlying issues.

The cohort review found examples of strong practice<sup>93</sup> where practitioners used any opportunities to build a relationship with a teenager. When this occurred, casework was more consistent, engaging, and effective, rather than reactive to crises only.

### **Working with other services**

Working with other services can be challenging. Many of the cases considered in this review highlighted frustrations practitioners face when trying to support a teenager when using other services. These included strict referral criteria, a lack of appropriate services, the need for a stable address, or long referral waiting lists. There were times when the behaviour of a teenager prevented them from being accepted by a service or when they were seen to be too high risk. This was problematic for practitioners when trying to collaborate with other services in order to protect a teenager.

#### **Practice tips for good interagency work:**

- Keeping cases open for a longer time after a referral is made to allow a relationship to be built and for the service to appropriately address risk
- Holding regular interagency meetings to develop coordinated case plans
- Extending invitations for case conferences to the teenager, their family and all relevant agencies
- Confirming other services' capacity before assuming they can address concerns
- Discussing risks early with other services so that a collaborative response can be planned.

At least 40 of the 111 teenagers in the cohort review were involved with services other than FACS. Many of the reviews completed by the SCR for teenagers in the cohort noted opportunities for improved interagency work. The following case study is an example of how lack of interagency collaboration can hinder understanding what is happening for a teenager.

<sup>92</sup> Schmied, V. & Walsh, P. (2010) 'Effective casework practice with adolescents: Perspectives of statutory child protection practitioners', *Child and Family Social Work*, Vol. 15, pp. 165–75.

<sup>93</sup> Refer to section 3.3, How relationships can influence positive outcomes.

Jenny was a young Aboriginal girl that FACS caseworkers first met when she was 12. Reports were received about Jenny self-harming, having suicidal thoughts and drinking alcohol in public. She told a caseworker that her mother was not home much, and that she was often left to care for her younger siblings. When Jenny's mother met with FACS caseworkers, she was assessed as caring and cooperative. She hoped Jenny would 'grow out of her dangerous behaviours'. Jenny would move frequently between her mother's and father's homes.

When Jenny was 14, more reports were received that she was using alcohol, was not attending school and had become sexually involved with an older man. At 15 Jenny self-harmed at school and was taken for a mental health assessment. She told the health worker that she had been sexually assaulted, and she was then referred to a psychologist.

In the 12 months before Jenny died, her risk taking behaviour escalated. She was admitted to hospital with a head injury after a fight, was often seen intoxicated, was using marijuana regularly and had begun using 'ice'. She had become involved with police and was being supervised by Juvenile Justice.

FACS involvement with Jenny was episodic. When she was 12 she had been allocated a caseworker and had built a positive relationship with FACS. When she moved to her father's place she had been doing well, so her case was closed. Later reports were either closed or sometimes assessed, but Jenny was difficult to engage so often her case was closed.

The cohort review identified critical information held by other agencies (such as Jenny's school, Juvenile Justice, Police and Health) that FACS did not know. A coordinated interagency approach may have helped FACS to identify a suitable person to engage Jenny.

- Gather information from a teenager and all services involved (Health, Juvenile Justice, Police). A case conference will make sure that all services hear and know the same information
- A teenager's perspective is really important. Practitioners need to ask questions about their experiences. For example, *'I'm really interested to know why do you use marijuana and alcohol? Are you trying to block things out? What are you trying to block out?'*
- Consult with an Aboriginal practitioner and work in a way that respects the teenager's family and kinship structures – make sure the right people are involved in decision making
- Determine responsibilities. Who is the primary point of contact for the teenager? What role is each service taking? How will the services communicate in between formal meetings?

### 3.2.3 Personal barriers

#### Recognising the vulnerability of teenagers

Child protection practice is strengthened when a teenagers' behavior is recognised as an indicator of their vulnerability. Many of the teenagers in the cohort review had early experiences of abuse and neglect which had heightened their vulnerability.

In many of the reviews for teenagers included in this cohort, SCR noted that they had been described as having '*difficult behaviour*', being '*hard to reach*' or '*going through an oppositional or difficult phase*'. While it can seem intuitive to assign responsibility for a young child's difficult behaviours to a parent or caregiver, the teenagers themselves are often blamed for their challenging behaviours. SCR also noted that in some reviews behaviours had been minimised as 'typically teenage'. In one case, '*behaviours were misunderstood and minimised, resulting in an underestimation of risk*'.

Practitioners quite rightly associate age to vulnerability. However, this does run the risk of practitioners believing that the older the child, the less vulnerable and more resilient they are.<sup>94</sup> Yet, compared to younger children, teenagers are more mobile, come into contact with wider social networks, face more social and environmental risks and are more likely to become involved in risk taking behaviours that make them vulnerable.<sup>95</sup> Practitioners can often over-emphasise the resilience and capacity of teenagers to manage, take care of themselves and manage difficult situations. In fact, the mobility of teenagers and their ability to 'vote with their feet' should be seen as potentially increasing their vulnerability.

#### Understanding the impact of trauma on brain development

Research has shown that normal brain development is impacted by experiences of trauma, abuse or neglect. Most brain development happens in the first three years of life, and complex functioning of the brain relies on the proper organisation and development of the brain in these early years.<sup>96</sup> A child's early experience of family, social and environmental factors will have a critical role to play in shaping the architecture and functioning of their brain.<sup>97</sup>

Many of the teenagers that FACS practitioners work with may have been exposed to experiences that negatively impact on brain development, or they may have missed out on experiences required for normal brain development. Having a general understanding of brain development and the developmental process can help us to respond to a teenager's risk taking behaviour. Teenagers may not be at the developmental stage that is assumed for their age and so they may require additional support to face the usual challenges of adolescence.

94 Gorin, S. & Jobe, A. (2013) 'Young people who have been maltreated: Different needs – different responses', *British Journal of Social Work*, Vol. 43, pp. 1330–46.

95 Gorin & Jobe (2013).

96 Perry, B. & Szalavitz, M. (2008) *The Boy Who Was Raised as a Dog and Other Stories from a Child Psychiatrist's Notebook*, Basic Books: New York.

97 Johnson et al (2010).

The following case study highlights the importance of considering a teenager's experiences of trauma and abuse in childhood, both for case planning and when referring to other services.

case study

Travis was aged one when FACS received the first report about him. There were concerns about his mother's mental health, domestic violence in the home and psychological harm to Travis. More reports were received when Travis was aged three and four. His mother had entered a new relationship and there were concerns about her partner's violence. She was verbally abusive towards Travis and was heard referring to him as 'her punishment'.

When Travis started primary school, he was bullied and regularly got into fights with other students. His mother told FACS that his behaviours were very challenging. She was reported as threatening Travis with knives to keep him in his room and manage his behaviour. FACS referred his mother to parenting programs.

When Travis was nine, his mother told FACS that he had been diagnosed with attention deficit disorder (ADHD) and oppositional defiance disorder (ODD). This was never confirmed in formal records.

When Travis turned 13, his mother was unable to cope with his behaviour and started to lock him out of the house. He went to stay with his father, but after a few months this relationship deteriorated. His father said Travis could not follow house rules and was not attending school, so he was asked to leave. He was referred to two emergency accommodation facilities but was unable to stay at either of them long term due to his violent outbursts.

Travis then returned to his mother's home. FACS received more reports about him being homeless and his suicidal ideation. FACS responded to these reports and worked with Travis mother. She signed a temporary care agreement and accepted referrals to services, but never engaged with them.

In the year before Travis died, FACS continued to receive reports about his homelessness, threats of suicide and alcohol misuse. Though he had been known to FACS from the age of one, he did not receive an ongoing casework response until he was 13. Travis died in a motor vehicle accident – he was driving the car, was alone and did not have a licence.

what can practitioners do?

- Seek to understand the trauma a teenager has experienced that may have impacted on their self control and ability to think about consequences
- Talk to a teenager about their emotions and anger. Help them to understand the link between their feelings and their behaviour. Validate a teenager's feelings but set limits with them about their behaviour. For example, *'I know you get really angry at your Mum but it's not ok to hit her'*
- Help a teenager develop new skills and ways to manage their emotions that does not put them or others at risk
- Avoid using labels when talking about a teenager. Help other people involved with a teenager to understand the reasons for their behaviour
- Involve a teenager more in case planning. Ask a teenager what they want and make sure that their needs are prioritised.



## Personal anxiety about teenagers

It is a normal response for practitioners to feel anxious about working with teenagers. Teenagers have often developed their own personality, have their own ideas and are able to act on these a lot easier than younger children. Developing a relationship with them can be challenging and requires practitioners to draw on their interpersonal skills to tap into a teenager's world to understand what is important to them and what kind of support they think may be useful.

It is challenging to work with teenagers whose lives are characterised by risk taking or who have complex needs due to their level of distress or experienced trauma.<sup>98</sup> One study found that some practitioners felt intimidated by adolescents and would use strategies such as not returning their calls to avoid them.<sup>99</sup> While not an uncommon reaction, avoiding the intensive work associated with teenagers and not facing the confronting reality of the teenager's experiences can be detrimental to practice.

Discussing mental health issues, particularly related to suicide or self-harm, can be particularly confronting for many practitioners. Avoiding such discussions was noted in some of the reviews for teenagers in the cohort; this may be due to a lack of experience or to an assumption that mental health issues require specific expertise and are not the responsibility of child protection. While referring a teenager to an appropriate mental health service is important, this should not be the end of the practitioner's responsibility for their mental health. Conversations with teenagers about these issues are challenging but important when assessing risk. Openly discussing mental health issues, particularly concerns about why a child is self-harming or whether they have had suicidal thoughts, can result in a child feeling supported and cared for.<sup>100</sup>

### Practice tips for working with teenagers who have mental health problems:

- Be honest, authentic and consistent
- Let them know you care
- Be patient
- Talk about emotions and acknowledge feelings
- Normalise the experience of mental health problems
- Reflect what you hear and what you see
- Focus on strengths as well as problems
- Form goals collaboratively
- Know your local adolescent and mental health services.

98 Schmied & Walsh (2010).

99 Schmied & Walsh (2010).

100 FACS caseworkers can access resources specific to suicide, self harm and child protection on the FACS intranet. These are located in 'Research to Practice' and were updated in December 2014. FACS Psychological Services also released guidelines in Feb 2015 on *Suicide and Self Harm: Risk Management for FACS staff*.

### 3.3 How relationships can influence positive outcomes

Relationships are central to working with vulnerable teenagers. This was a major theme across the reviews of teenagers in this cohort. Research has demonstrated that forming healthy relationships and increasing the quality and number of these in a young person's life is the most effective treatment for those who have experienced trauma.<sup>101</sup> Evidence of this was seen to make a difference and in one teenager's review it was commented that *'persistence in relationship building was a critical step in supporting the young person to address his trauma'*.

Reviews completed by SCR noted a lack of stable and secure relationships for many of the teenagers in the cohort. Many had not received reliable and trusting care in their childhood, had moved between different caregivers and had displayed behaviours as a teenager that prevented them from forming relationships.

The desire of the teenagers in the review to form connections and build relationships was clear. Sadly there were many examples of teenagers who had not experienced stable, healthy relationships in their family and had formed negative relationships with peers or older adults. Some of the negative relationships seen in the review included those in which teenagers were introduced to drugs, alcohol misuse, sexual activity, criminal activities, drug dealing or sexual exploitation. These relationships are incredibly dangerous for teenagers and only heighten their vulnerability and risk.

A study in NSW (2010) emphasised commitment, connection and continuity as necessary components to a relationship when working with a teenager.<sup>102</sup> Many of the reviews for teenagers in this cohort found that frequent changes of worker, the geographical movement of teenagers and an inability to keep cases open for long periods of time all impacted on practitioners' ability to include these components in their relationships with teenagers.

The administrative burdens of casework were evident across many of the teenager's reviews, often taking away from time that we could spend building relationships. The review included a powerful reflection from a worker who had been unable to meet with a teenager until one week after her disclosure of sexual abuse: *'I remember her first words to me, "Where have you been?" I had been stuck in the office taking care of all the calls and other administrative work. I needed to be there. She needed me there and I should have been there, just to be with her.'*

Establishing meaningful relationships for a teenager is a key way to influence change in their lives. The case studies below are examples of how practitioners have successfully built relationships with vulnerable teenagers.

#### Increasing resilience and hope

When working with teenagers, practitioners may be faced with complexity and chaos but should not let this affect their ability to engage and protect the teenager.<sup>103</sup>

Contemporary thinking in the areas of child development and resilience theory suggest that practitioners need to maintain hope and that positive change can occur late in childhood or in adolescence for children who are high risk.<sup>104</sup> Practitioners should maintain hope as they approach case planning, make referrals and advocate for teenagers to receive appropriate services. Any loss of hope might be sensed by the young person and may affect their beliefs about their potential for change.

<sup>101</sup> Perry & Szalavitz (2008).

<sup>102</sup> Schmied & Walsh (2010).

<sup>103</sup> Queensland Government Department of Child Safety (2008) Practice Paper, *A Framework for Practice with 'High Risk' Young People* (12–17 years), [www.communities.qld.gov.au/resources/childsafety/practice-manual/prac-paper-framework-high-risk-young-people.pdf](http://www.communities.qld.gov.au/resources/childsafety/practice-manual/prac-paper-framework-high-risk-young-people.pdf)

<sup>104</sup> Queensland Government Department of Child Safety (2008).

The following case study illustrates the positive changes that are possible for a teenager when their caseworker maintains hope.

case study

Anna was reported to FACS during her childhood but these reports had been closed. Her father was violent towards her mother and left the home when Anna was two. She began seeing a psychiatrist when she was six and was diagnosed with childhood anorexia. She was bullied at primary school, and at age 12 she was diagnosed with depression, self-harming (cutting) and an eating disorder. Later, she disclosed sexual abuse by her stepfather that had been happening since she was 10.

Anna's caseworker met her when she was 14 years old. She was in a refuge at the time, following discharge from a mental health facility where she had been an inpatient for two months. She could not return home as her mother had ongoing mental health concerns and could no longer manage Anna's behaviour. She had stopped going to school and had told her caseworker she felt rejected.

Anna experienced several more rejections. Her father had a new family and decided he did not want to be involved in her life, and then she was asked to leave the refuge because of her self-harming behaviour.

Anna's caseworker maintained hope for her throughout these rejections, hope that things could be different and would get better. The caseworker met with her regularly and found ways to increase her resilience and strength. Anna had an amazing voice, and the caseworker encouraged her to start singing with a local group. She also introduced Anna to kickboxing. By building a relationship with Anna, the caseworker took time to understand her interests and supported her to engage in activities that provided positive experiences. These activities helped Anna to develop relationships that were mutually rewarding in a safe social setting. The strength of their relationship became evident as Anna started to call and text the caseworker more regularly, sometimes when she was sad and sometimes just to stay in touch.

Anna came into care when she was 15 years old and was placed in a high-needs residential care home. She likes her placement and feels it is home. Her self-harm has stabilised and she continues to see her psychologist. The caseworker has supported Anna to re-establish a connection with her mother and other relatives. This has helped Anna to feel connected to her family. She has enrolled in a new school and is attending regularly, and she has begun to establish some new friendships.

## Building a team

Ryan's story reflects strong casework focused on building a support network. When practitioners do not have time to build relationships with teenagers, or their involvement will not be long term, it is vital we help build a team of people who can provide ongoing support.

### case study

FACS had been working with Ryan since he was three. He had been in multiple placements and had changed caseworkers several times. By the age of 14 he was living in a youth refuge, had become disengaged from the education system and was well known to Police and Juvenile Justice. When he was 15, he was arrested for aggravated assault.

Around this time his case was allocated to a new worker who had not met Ryan before. His worker recognised the difficult task he had ahead and knew that he would be yet another FACS worker to Ryan. He learned that Ryan had built a good relationship with his worker from Juvenile Justice over several years so arranged to attend one of their regular meetings and meet Ryan.

The FACS worker listened to Ryan and heard the sadness in his voice when he spoke about family members that he no longer had contact with. He learned that Ryan loved Brazilian jiu jitsu and that he wanted to be able to get a job one day. The FACS worker referred Ryan to a local NGO service that could provide intensive support and meet with Ryan weekly. He also contacted family members and began to explore connections for Ryan that had not been pursued when he was first removed at age three. This helped Ryan see that the caseworker understood how important family was to him.

Ryan is now living with a relative (who was assessed and authorised as a carer) and has not been in trouble with the police for over a year. He still meets with the NGO worker and is attending TAFE. The NGO worker linked him with a local jiu jitsu club and. Ryan attends the club weekly and has formed strong relationships with some of the young men he has met there.

## Engaging both the teenager and their family

When working with teenagers, practitioners face the challenge of engaging both the young person and their family in the child protection process. Case planning for a teenager should always include the teenager, their family and significant others.

Several reviews noted that increased effort to engage the child could have benefited casework interventions. The increasing level of independence that a child gains with age is challenging for casework. Compared to a younger child, a teenager will have their own voice and opinions which need to be heard. Teenagers will want to participate in decision making surrounding their case. Practitioners should facilitate and encourage this as there will be a dependence on the teenager to accept and participate in services and interventions.<sup>105</sup>

While remaining focused on the teenager, practitioners also face the challenge of increasing parental capacity to manage their child's behaviour. A parent's willingness to engage in this process will often be influenced by their previous experiences with FACS.

<sup>105</sup> Schmied & Walsh (2010).

The following case study illustrates the importance of casework remaining focused on the teenager while also listening to and building the capacity of their carers.

case study

John was known to FACS when he was young, due to his parents' violence, drug misuse and reported neglect. His grandparents started looking after him when he was six.

When John was 13, FACS started to receive reports about John not going to school and his difficult behaviour. He was often involved in fights, was aggressive towards teachers and was drinking alcohol and attending school intoxicated. His grandparents were still caring for him but were struggling to manage his behaviours.

When the FACS caseworker began meeting with John at his grandparents' home, John would often yell at the caseworker and then leave. The caseworker decided to try a new approach. He began collecting John from school every Wednesday, taking him to play video games and spending time together before dropping him home. Over several months, John's verbal aggression and outbursts towards the caseworker reduced. The creativity of this casework tapped into John's interests and sent a strong message to John that his caseworker genuinely cared about him, wanted to spend time with him and was there to help.

The caseworker continued to meet with John's grandparents while John was at school and supported them by providing referrals to parenting support and suggesting practical ways to manage John's behaviour.

Over time, John began to trust the caseworker and would participate in case planning. The caseworker took on a strong coordination role between John's school, the grandparents and services involved. The caseworker maintains regular communication with all of them and ensures that consistent behaviour management strategies are in place for John at home and school. Slowly the triggers for John's behaviour are being understood and effective strategies are being put in place. The caseworker no longer picks up John every week but still sees him regularly. John gets to choose what they do together and the caseworker uses this as an opportunity to talk to John and listen to what he needs.

### Facilitating reconnection to family

Facilitating reconnection to family can be important for increasing stability and structure in a young person's life, while also providing emotional and social support. Research suggests that positive contact with family members and a competent formal support service can help facilitate pathways out of homelessness.<sup>106</sup> Many of the teenagers in the cohort review were transient – moving between family members' homes, staying in refuges or experiencing periods of homelessness.

The lack of stable and secure relationships observed in the reviews suggests that a lot of teenagers likely experienced loneliness. Recent research has identified loneliness as a public health issue and showed that social isolation, emotional isolation and lack of social connections can increase risk of death.<sup>107</sup> Working to increase the number of relationships a young person has can improve their health and reduce the chance of them becoming socially isolated.

<sup>106</sup> Lindsey, E.W., Kurtz, P.D., Jarvis, S., Williams, N.R. & Nackerud, L. (2000) 'How runaway and homeless youth navigate troubled waters: Personal strengths and resources', *Child and Adolescent Social Work Journal*, 17(2), pp. 115–41.

<sup>107</sup> Worland, J. (2015) 'Why loneliness may be the next big public health issue', *Mental Health Psychology*, <http://time.com/3747784/loneliness-mortality/>; Shulevitz, J. (2013) 'The lethality of loneliness: We now know how it can ravage our body and brain', *New Republic*, 13 May, [www.newrepublic.com/article/113176/science-loneliness-how-isolation-can-kill-you](http://www.newrepublic.com/article/113176/science-loneliness-how-isolation-can-kill-you)

Reconnection with family members, whether immediate or extended, can be one way of increasing social connections and reducing loneliness. Relationships with family can also provide long-term connections for a teenager. The following case study illustrates how casework focused on listening and responding to a teenager's needs can help reconnect them to family.

case study

Brittany had been removed from her mother when she was four years old following concerns about her mother's drug misuse and relationships with men who were violent towards Brittany and herself.

Over the next 10 years, Brittany moved through a series of placements that included kinship, foster care and residential homes. Her early life experiences and constant changes of placement resulted in her not having any stable attachments to a care giver, and she began running away from her placements when she was 12.

FACS was beginning to receive reports about Brittany's involvement with police and her alcohol misuse. Many of the reports also included information about her choosing to stay with her mother. Initially Brittany's caseworker did not support this placement, due to the history of being removed from her, and tried to maintain her placement at the residential house. However, the caseworker met with Brittany to understand why she continued to leave her placement to stay with her mother. Despite having doubts the caseworker was respectful and curious in her approach. When Brittany indicated she wanted to go home and be a family with her mother, the caseworker understood Brittany's need to feel a sense of connection and belonging that she was not experiencing in her placement.

There was recognition by everyone that Brittany returning to live with her mother permanently would involve a lot of work and support to keep her safe. This work meant Brittany's mother needed to make changes, and so did Brittany.

Eighteen months of intensive support followed during which FACS coordinated supports for both Brittany and her mother that would help the placement to work. When Brittany was 14, FACS applied to change Brittany's order, and the Children's Court approved her returning to her mother's care.

Brittany is now 16 and still lives with her mother. Her attendance at school has improved and she has a part-time job that she enjoys. Brittany's mother is doing well and is working with FACS towards also restoring Brittany's younger brother to her care.

### 3.4 Conclusion

This chapter has highlighted the clear vulnerability of teenagers known to FACS. Many of the deaths of the 111 teenagers included in this cohort review resulted from risk taking behaviour or occurred in preventable circumstances. The stories of teenagers used in this chapter are powerful because they provide further insights to behaviours that are considered typical of teenagers. This is important because behaviours considered typical of a teenager may actually be indicative of something more concerning that requires professionals to follow up. These teenagers' stories have been shared so that we can learn from their deaths and improve practice.

The practice themes discussed have acknowledged the challenges that are faced when working with teenagers as well as the importance of practitioners being curious and understanding the underlying reasons for a teenager's behaviour. The importance of relationships can not be understated and was a strong theme across many of the reviews for teenagers in this cohort.

The teenagers included in this cohort review represent only a very small proportion of the teenagers with whom FACS is involved. The final three case studies highlight just a snapshot of the creativity and compassion that practitioners use when working with teenagers. It is hoped that the findings from this cohort review can be used to inform understanding about working with teenagers and encourage practitioners to persevere in achieving positive outcomes for teenagers.

# Chapter 4: Progress in child protection reform

This last chapter focuses on the progress of reform initiatives referenced in the *Child Deaths 2013 Annual Report*. It highlights the continuum of child protection services from prevention and early intervention through to permanency planning, placing an emphasis on practice principles and standards. This chapter also outlines the current and future initiatives that seek to strengthen the child protection system.

## 4.1 The FACS Strategic Statement

FACS works with the most disadvantaged and vulnerable people in NSW to improve their futures through access to housing, safety from violence and abuse, increased social connectedness, meaningful participation in the community, and protection of children and young people from abuse and neglect.

FACS works with the community on behalf of the community and, as such, needs to be transparent and accountable about where we put our efforts, how we work and what we achieve.

The environments in which we work are highly challenging, often with a myriad of entrenched issues requiring expert input from a range of disciplines. The issues FACS encounters are often systemic and extend well beyond the individuals and families with whom the Agency comes into contact with.

Making a difference in this context is not possible without a shared understanding of the issues, how to address them and what success will look like. To this end, the Strategic Statement for FACS sets out the vision, values and objectives that will guide and unite our efforts over the next few years. The key objectives are that:

- children and young people are protected from abuse and neglect
- social housing assistance is used to break disadvantage
- people are assisted to participate in social and economic life
- people at risk of, and experiencing, domestic and family violence are safer
- Aboriginal people, families and communities have better outcomes.

### 4.1.1 Improving the NSW child protection system

As part of this broader commitment and vision, FACS continues its work in reforming the child protection system in NSW to deliver more contemporary, responsive, child-focused services that are locally driven and based on strong collaborative relationships with our community partners so that:

- fewer children and young people are vulnerable to abuse and neglect
- children and young people at risk of significant harm are safer
- children and young people in out-of-home care (OOHC) have a better future
- a capable organisation and service system is in place.

The planned changes will improve services across the continuum of child protection, from early intervention and prevention through to better permanency planning for children and young people in OOHC.



During 2014–15, staff at all levels of the Agency have continued to progress this challenging and complex agenda. The learning from child death reviews and critical reports has played a significant role in shaping improvements to our practice and the child protection system and will continue to inform the implementation of these changes during the next 12 months and beyond.

Some of the achievements during 2014–15 are highlighted below.

## 4.2 Fewer children and young people are vulnerable to abuse and neglect

FACS recognises the importance of intervening early in the life of a child and much effort continues to be concentrated here. In the 2015-16 Budget FACS has invested more than \$337 million to early intervention, prevention and community support activities.

During the review period, the **Child, Youth and Family Support Program** has continued to deliver intensive early intervention services to meet the needs of vulnerable children, young people and families who fall below the threshold for statutory child protection intervention. The service model involves two streams of service delivery: the Child and Family Support (CFS) stream, which targets families with children aged 0 to 12 years; and the Youth and Family Support (YFS) stream, which targets young people aged 12 to 18 years.

Through the **Families NSW Program**, FACS has worked with other government and non-government agencies to assist vulnerable families who are expecting a child or have children up to eight years old. This work includes providing supported playgroups, family worker services and parenting programs. FACS has continued to prioritise community capacity-building and networking initiatives which strengthen early intervention services in local communities.

The **Aboriginal Child, Youth and Family Strategy** has delivered a prevention and early assistance program through services for Aboriginal families across NSW who are expecting a child or have children up to five years old. Families have accessed supported playgroups, family worker services, parenting programs, school transition programs and community outreach events that promote local parenting services.

The NSW Government's OHCRE<sup>108</sup> **Plan for Aboriginal Affairs: Education, Employment and Accountability** builds the capacity of NGOs, including those delivering OOHC, child protection and family support services. FACS is leading this initiative to support Aboriginal NGOs to provide better services for families and communities involved in kinship care and in helping to provide support to Aboriginal parents and children.

## 4.3 Children and young people at risk of significant harm are safer

### 4.3.1 Safe Home For Life – child protection legislative reforms

FACS has continued to implement legislative reforms designed to reduce the number of children and young people at risk of significant harm (ROSH), improve the NSW child protection system and provide permanency for those children who cannot live at home safely.

Specific initiatives implemented during 2014–15 included revising the Parent Responsibility Contracts and introducing Parent Capacity Orders and Family Group Conferencing. FACS Safe Home for Life program is strengthening the child protection system with \$60.4 million funding this year.

<sup>108</sup> OHCRE (Opportunity, Healing, Choice, Responsibility, Empowerment) is culturally significant for Aboriginal communities in NSW and is used in ceremonies to bind people to each other and their Country, see [http://www.aboriginalaffairs.nsw.gov.au/wp-content/uploads/2013/04/AA\\_OCHRE\\_final.pdf](http://www.aboriginalaffairs.nsw.gov.au/wp-content/uploads/2013/04/AA_OCHRE_final.pdf)

### 4.3.2 Promoting good parenting to keep families together

FACS has continued to invest in programs and services that build parenting capacity and resilience and reduce risks to children and young people so that they are safe to stay at home and do not enter the statutory OOH system.

The **Brighter Futures Program** can support 3,152 vulnerable families with complex needs at any one time. This service is delivered by 16 community organisations that are building the resilience of families and children considered at high risk of entering or escalating within the statutory child protection system, so that children can live safely at home. There are three Aboriginal Brighter Futures program offered through Tharawal, Kari and Wandiyali. There is also a service for culturally and linguistically diverse families managed by Metro Assist Incorporated.

In 2013–14, Brighter Futures Lead Agencies provided services to 3,262 families and 7,510 children. In July 2014, Brighter Futures Lead Agencies commenced working with children and families where there has been a report of ROSH, and by June 2016 the program will work mainly with these families.

The **Intensive Family Support and Intensive Family Preservation Programs** have continued to target families in crisis whose children and young people (aged 0 to 15 years) are at risk/imminent risk of removal and placement in OOH. Following referral from FACS, NGOs provided case management and service delivery. Families receive 12 weeks of intensive support (including 24-hour on-call assistance) followed by up to 40 weeks of continuous and individually tailored casework. In 2014–15 non-government services were contracted to provide 268 places for families who met the program criteria.

**Intensive Family Based Services (IFBS)** for Aboriginal families in crisis continued during 2014–15. The program was delivered by a combination of FACS caseworkers and Aboriginal NGOs. Each family received 12 to 16 weeks of intensive case management, with caseworkers working with no more than two to three families at any time in order to provide intensive casework services to each family.

The IFBS pilot, in four Aboriginal NGOs located in Wagga Wagga, Clarence Valley, Kempsey and Wyong/Lakes, is continuing and has been extended until June 2016.

### 4.3.3 Better responses to young people at risk of significant harm (ROSH)

Providing effective services and supports to adolescents continues to be challenging within our existing service system.

The FACS-funded **Youth Hope** program commenced as a trial in five districts in April 2014 and is providing valuable insights into effective service models for adolescents. Five different, innovative and intensive services led by NGOs have been working with families of children and young people aged 9–15 years who are deemed to be at ROSH or likely to be so in the future.

## 4.4 Improving the future for children and young people in out-of-home care (OOHC)

Children and young people who are unable to live safely with their families need safe and stable homes. Our partnership with the non-government sector to provide children in out-of-home care (OOHC) with quality care that meets their individual needs and optimises their social, emotional, health and educational outcomes has been a key feature of our work over the last 12 months.

### 4.4.1 Continued transition of OOHC to the non-government sector

The transition of statutory OOHC services from FACS to the non-government sector has been an important initiative for strengthening and expanding the capacity of the system. Significant progress has been made in this area, with 57 per cent (7, 447 of the 13, 076)<sup>109</sup> children and young people in statutory OOHC now being case-managed by non-government service providers. And in the 2015–16 FACS Budget, \$50 million will continue to support the transition of OOHC services to the non-government sector.

A key driver of successful transition continues to be local implementation through dedicated Regional Implementation Groups (RIGs),<sup>110</sup> consisting of government and non-government partners. Regional Implementation Plans guide local implementation, ensuring the best interests of children and young people are central to the process.

The process continues to be supported by the Child Assessment Tool, for placement-matching, and the online Referral Management System. As a result of capacity-building work with Aboriginal non-government service providers, there are now 11 accredited OOHC Aboriginal non-government service providers and eight partnerships between Aboriginal non-government services and non-Aboriginal services.

**Raising Them Strong** continues to be a resource to support Aboriginal kinship and foster carers. This resource was developed with Aboriginal kinship and foster carers, carer support workers, caseworkers and the Aboriginal Child, Family and Community Care State Secretariat (AbSec). It includes a DVD and topic cards.

The transition continues its work to build service system capacity and establish and improve systems and processes around governance, collaboration and carer support.

### 4.4.2 Accreditation of OOHC services

Meeting the NSW Standards for Statutory Out of Home Care ('the Standards') and becoming an accredited designated agency is an important process to improve the safety and quality of care provided to children and young people who cannot live at home safely. It ensures that FACS is held to the same high standards as non-government organisations. Six Intensive Support Services and Sherwood House, have received OOHC accreditation from the Children's Guardian.

The OOHC Accreditation Service Delivery Plan 2015–2016 details the processes, practices and procedures the remaining FACS units are required to complete to meet the Standards by 31 July 2016. All FACS Districts continue to implement and monitor local plans to demonstrate progress towards meeting and sustaining practice that meets the Standards.

Fifty two funded non-government agencies are accredited by the Office of the Children's Guardian. Currently 19 agencies are provisionally accredited on the basis of policies and procedures alone. These agencies have not made any arrangements for providing OOHC services during the 12 months prior to applying for accreditation.

<sup>109</sup> OOHC Transition Dashboard 2013/2014.

<sup>110</sup> While FACS has been localised into 15 districts, OOHC transition continues to be managed according to former Community Services regions and led by hosting Districts.

## 4.5 A capable organisation and service system

To ensure that FACS is well placed to deliver the planned reforms and improve outcomes for its clients, significant work continues to realign and streamline the organisational structure.

FACS continues its commitment to shifting the focus of service delivery from programs to a person-centred approach and to creating a service delivery approach which provides services targeting various stages of a person's life.

Accordingly, FACS has been concentrating resources at the local level and working with service and community partners to deliver innovative and flexible services. NSW is now divided into 15 Districts, and work is being undertaken to reconfigure and structure our central functions and culture to better support Districts.

## 4.6 Improving the way we work with children, young people and families

### 4.6.1 Office of the Senior Practitioner

The Office of the Senior Practitioner (OSP) continues to provide practice improvement leadership and support to caseworkers and managers to achieve the best outcomes for children and young people.

The combined efforts of the units<sup>111</sup> that make up the OSP have provided the opportunity to promote best practice, undertake independent reviews of our practice and provide evidence-based advice and guidance to field staff during the year.

#### Practice First

To provide greater support to caseworkers and build their capability to work effectively with children and families, the NSW Government has provided an additional \$1.2 million per annum for two years (2014–15 and 2015–16), as part of the Safe Home for Life funding, to increase the number of Practice First sites.

As a result of this funding, 13 additional Community Service Centres (CSCs) commenced as Practice First CSCs in October 2014. The implementation of Practice First has now expanded to 39 sites around NSW, representing 44 per cent of CSCs across the state.

An external evaluation of Practice First is being undertaken and is due for release in late 2015. Early findings from this evaluation suggest that Practice First is achieving the desired culture change and is a model worth investing in.

#### Good Practice Report

*Shining a light on good practice in NSW* ('the Good Practice Report') was first published in December 2013. The report features inspiring stories from child protection and OOHC which highlight innovative and quality practice among FACS and NGOs working with children, young people and families.

The language used in the report is carefully chosen to remain true to practitioners' voices, but also with an understanding that the way an organisation talks about its work influences how it works. By focusing on the small details – a child's dream of having a dog, a caseworker folding a mother's washing when her children enter care – the stories highlight important practice themes and ultimately influence how practitioners work with families.

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<sup>111</sup> The OSP is made up of the Practice Quality and Clinical Support Unit, Serious Case Review Unit, Reportable Conduct Unit, and Practice Support (Southern, Northern, Western Clusters).

The aims of the report are to:

- celebrate the success and commitment of practitioners in NSW to achieve positive outcomes for children, young people and families
- demonstrate innovative methods used by the child protection sector to achieve positive outcomes for children, young people and their families
- encourage practitioners to use skilled, creative and principles-based approaches to achieve positive outcomes for children, young people and their families
- broaden best child protection practices across NSW
- help strengthen interagency partnerships.

The second report was published in September 2014, with 1,200 being distributed to staff, NGOs and academics. The online version has been viewed more than 2,000 times by 1,500 individuals and shared close to 100 times on Facebook.

The 2015 report will be published later this year. Work is underway, and close to 100 submissions from FACS and NGO staff have been received from around the state.

### **Care and Protection Practice Framework, iPractice and the Practice Standards**

The Care and Protection Practice Framework ('the Practice Framework') provides a common frame of reference for caseworkers in NSW. It outlines the values and principles that underpin effective work with children and families, and it describes the specific skills and knowledge fundamental to respectful practice. The Practice Framework provides the broad structure and context within which practitioners operate each day.

iPractice was launched in September 2014 as an interactive practice resource based on the Care and Protection Practice Framework. It explores the key aspects of good child protection practice and provides a range of practice tools, videos and learning modules to support casework staff with their daily work. Work is underway to make iPractice available to the broader child protection sector as a tool for sharing resources and learning.

The revised 2014 Practice Standards were launched with a kit of resources that managers can use to inspire and develop practice. A number of CSCs have held specific practice development days to ensure that the Standards are understood by staff and incorporated into everyday practice. An information brochure was also developed for families working with FACS, outlining each of the Standards and explaining what families can expect from their caseworker.

### **Practice Conferences and Research to Practice**

The 2015 Practice Conference was the third conference led by the Office of the Senior Practitioner. This year's theme, 'Creativity and Courage', attracted prominent keynote speakers such as Sue Lorhbach<sup>112</sup> and Paul Nixon<sup>113</sup>. The conference was attended by more than 540 people and there were 650 single connections via live streaming.

In 2015 two Research to Practice seminars have been held. In April, Home Truths: Rethinking Our Approach to Family Violence, was attended by more than 200 FACS and NGO participants. The second Research to Practice seminar, Smoke and Mirrors, was held in August; it was attended by approximately 300 FACS and NGO participants. It explored practice where alcohol and other drugs is a presenting concern, with national and international experts providing keynote addresses about best practice approaches and information on new and emerging drugs such as 'ice'.

<sup>112</sup> Executive Director, KVC Institute for Health Systems Innovation (US). Sue consults and presents nationally and internationally on differential response systems in child welfare, intervention in high risk child protective service delivery, domestic violence, family involvement, youth development, research-to-practice initiatives, and group supervision in child welfare systems.

<sup>113</sup> Chief Social Worker, Child, Youth and Family, Ministry of Social Development in New Zealand. Paul has provided consultancy, research and evaluation and training on work with children and families around the world.

In October 2015, a Research to Practice seminar featured internationally renowned child psychiatrist Bruce Perry. This seminar explored the area of early neglect and its impact on brain development, with a focus on reparative strategies to improve outcomes for children.

To promote access of all staff to the knowledge exchanged via the Research to Practice seminars, as well as the Practice Conferences, FACS initiated live streaming of keynote presentations. During the seminar held in April, 230 people logged into the FACS network to access this unique learning opportunity. For the August seminar, the number of people logging on to view the seminar had more than doubled to over 500.

During the year the Research team within the OSP continued to promote and support evidence-informed child protection practice. Their work has included developing two literature reviews, one on the disclosure of child sexual abuse (published in late 2014) and another on identifying and responding to child sexual abuse in order to inform the development of a child sexual assault resource kit for all staff. Research work also continued on adoptions in OOHC, with the aim of ensuring that our open adoption reforms are evidence based and effectively implemented.

### **Practice Advisory Group and Research team**

The Practice Advisory Group continues to meet quarterly to raise emerging practice concerns and champion best practice. Sub-committees of the Practice Advisory Group provide more detailed practice input on key initiatives, including revising the neglect policy and practice guidelines.

#### **4.6.3 Supporting practitioners in the field**

The OSP's Practice Support team includes Casework Specialists, Practice Managers and Directors Practice Support working throughout all Districts in NSW and reporting centrally to the OSP. The team was established to provide on-the-ground, frontline support to child protection caseworkers and managers so their practice is enhanced and meets the Care and Protection Practice Framework and Practice Standards.

The types of support services provided include consultation, practice review, practice coaching, implementation of Practice First, and staff learning and development. Through these services, Practice Support teams reflect, facilitate and model the principles which underpin the Practice Framework – keeping children and young people at the centre of our practice, using contemporary knowledge and skills, building relationships to create change, and respecting culture and context.

### **Clinical Issues team**

The Clinical Issues team provides expertise and support to frontline staff about drug and alcohol misuse, domestic violence and mental health issues.

The team's clinical consultants directly support practice by providing case-specific information and advice to caseworkers on safety and risk assessment and case planning. The team has also started to provide guidance to caseworkers about child sexual assault, in recognition of the co-occurrence of child sexual assault and existing clinical issues. Over 3,000 consultations were conducted in 2014–15.

The project workers who support the work of the team have been developing resources to assist casework practice. One resource aims to strengthen practitioner capacity to respond to child sexual assault matters and another resource is being developed to support skills in case planning, particularly in matters where there are alcohol and/or drug, mental health and/or domestic violence concerns. Both of these resources are in the final stages of development and are due to be distributed in 2015–16.

#### 4.6.4 Improving our response to domestic and family violence

The **Domestic and Family Violence Framework for Reform – It Stops Here: Standing together to end domestic and family violence in NSW** – was launched in early 2014. The framework will deliver a more integrated and coordinated statewide system to ensure the safety of victims and their children.

Legislative change in mid-2013 improved information-sharing between agencies in order to better support people who are the victim of domestic and family violence. **Safer Pathway** and the accompanying **Information Sharing Protocol** have been developed to ensure that victims of domestic and family violence have access to support services and are safe.

Key priorities for implementation include:

- a common risk identification tool
- a central referral mechanism
- a network of local coordination points
- Safety Action Meetings to coordinate activities that will support victims' safety.

Safer Pathway is now being used in six locations across NSW and will be rolled out to further sites over the next three years.

These reforms will improve integration between domestic and family violence referral pathways and those in the child protection system. They will also support our work with service delivery partners and specialist domestic violence services, to develop appropriate actions plans with families.

FACS also continued to deliver a range of programs to support people who are the victim of domestic and family violence. FACS is leading work on improving collaborations between agencies that provide child protection responses and those providing domestic violence responses. This is in recognition of the reality that the children's safety is interwoven with the safety of their parents.

**The Staying Home Leaving Violence (SHLV) program** worked with women and children escaping domestic violence, supporting them to remain safely in their homes. There are 23 SHLV services across NSW, and in 2015–16 four new services will be established.

In 2012, this program trialed an innovative SOS duress response system that quickly connects victims with police when needed. As of January 2014, the SOS response system was expanded and is now offered across all SHLV locations.

FACS also committed \$31.2 million to the **Start Safely program** over three years to assist 3,900 households who are escaping domestic violence and are homeless or at risk of homelessness to access safe, secure housing. As part of the program, households received referrals to a range of support services (including domestic violence services) so they could receive the help they needed. An evaluation of Start Safely by the Social Policy Research Centre in 2014 found that the program had become a valued option for providing assistance to those escaping domestic violence.

**The Integrated Domestic and Family Violence Services Program (IDFVSP)** continued its multi-agency, coordinated response to improving the safety of women, children and young people, with the aim of lowering community tolerance to domestic and family violence.

#### 4.6.5 Improving our response to SUDI

The *Child Deaths 2013 Annual Report* provided a summary of the findings of a FACS cohort review of the deaths of 108 babies who died suddenly and unexpectedly, meeting the criteria for Sudden and Unexpected Death in Infancy (SUDI). A key finding was that, while babies in all families can die unexpectedly and suddenly, families known to child protection services are more vulnerable. Of the total number of SUDI deaths in NSW between 2008 and 2012, almost half of the infants were known to FACS over the same five-year period.<sup>114</sup>

As well as child protection concerns, families may have complex needs and issues – such as those arising from domestic violence, parental mental health problems, substance misuse, homelessness and transience – which impact on parents' access to resources and ability to make safer choices for their babies. The review's findings supported the need for practitioners to continue to learn about safe sleeping, to be able to recognise risks in a baby's sleeping environment or sleeping arrangement, and to be able to provide an effective response when they observe unsafe practices.

To increase knowledge and improve practice in relation to SUDI, the findings of the *Child Deaths 2013 Annual Report's* SUDI cohort review were expanded upon and published in the OSP report *Safe Sleeping: Supporting parents to make safer choices when placing their baby to sleep*. This report was distributed to NGOs and FACS frontline staff and management in 2014–15.

A briefing package about safe sleeping and child deaths was developed by the OSP Serious Case Review team and distributed to CSCs and the Helpline with the *Safe Sleeping* report and *2013 Annual Report*. The team presented on this at a Practice Conference and briefings were delivered in CSCs and at the Helpline by managers and casework specialists.

A one-day training package for caseworkers on the risks of SUDI is being developed by the OSP Clinical Issues team. This package integrates the Serious Case Review briefing so that consistent messages about safe sleeping and modifiable risk factors are delivered to families.

FACS is also developing an interagency online learning package, in collaboration with other government agencies and NGOs, which includes content on safe sleeping.

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<sup>114</sup> Data provided to FACS by the NSW CDRT.



## 4.7 Conclusion

Much was achieved during 2014–15 to improve the delivery of services to children and families. Significant funding for FACS (including a seven per cent increase) was included in the 2015–16 NSW Budget. This budget investment will continue to support FACS goal of providing vulnerable children and young people long-term, stable environments, to help keep them safe, whether this is at home with their families, in a placement or in OOHC or with an adoptive family. Major projects include:

- Safe Home for Life - More support is being invested in caseworker support workers to enable caseworkers to spend more time working with families. Family Group Conferencing is being implemented to support work with families in a way that demonstrates partnerships and encourages greater parental decision making and responsibility
- The development of a Quality Assurance Framework to enhance the outcomes for children and young people in OOHC placed with NGOs or FACS
- Technology and innovative IT solutions are continuing to design and replace frontline technology systems for child protection workers. This will improve the productivity of caseworkers by freeing them up to spend more time with vulnerable families.

Continued support and increased funding reflects a commitment across the Agency to enhance the work to improve the lives for the children, young people and families we work with.

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## Appendix 1 Counselling and support services

Name	Description	Contact
<b>Child Protection Helpline</b>	Report suspected child abuse or neglect to FACS	<b>132 111</b>
<b>Aboriginal Counselling Services (ACS)</b>	Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	<b>0410 539 905</b>
<b>Aboriginal Medical Service</b>	Provides comprehensive health care to the Aboriginal community	<b>Local contacts can be found at: <a href="http://www.ahmrc.org.au">www.ahmrc.org.au</a></b>
<b>SIDS and Kids NSW and Victoria</b>	Provides 24/7 bereavement support to families who have suffered the loss of a baby	<b>1300 308 307</b>
<b>NALAG Centre for Grief and Loss</b>	Provides free face-to-face and telephone loss and grief support	<b>02 6882 9222</b>
<b>Lifeline</b>	Provides 24/7 telephone crisis support and suicide prevention services.	<b>13 11 14</b>

# Glossary

## **Aboriginal and/or Torres Strait Islander**

FACS recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. FACS also acknowledges that Torres Strait Islander people are among the First Nations of Australia.

## **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.

## **Alcohol and/or drug misuse**

A significant substance abuse problem that interferes with a parent's daily functioning, and 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.

## **Authorised carer**

A person who is authorised as a carer by a designated agency.

## **Case closure**

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

## **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 FACS officer responsible for working with children, young people and their families, and other agencies in child protection, OOHC and early intervention. Caseworkers have day-to-day case coordination responsibilities. Caseworkers report to the Manager Casework.

## **Casework specialist (CWS)**

The CWS is a member of a regional team that fosters the implementation of quality casework practice that is consistent with the centrally developed FACS professional development program. CWS are based in FACS Community Service Centres (CSCs). They maintain a strong operational focus in assisting Caseworkers and Managers Casework to meet corporate operational standards around casework practice and quality improvement.

## **Child**

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* defines a child as a person under the age of 16 years.

## **Child Protection Helpline**

The Child Protection Helpline provides a centralised system for receiving reports about unborn children, children and young people who may be at risk of significant harm. 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 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 in NSW.

### **FACS Community Services Centre (CSC)**

The locally based Community Services offices. There are 82 CSCs across NSW.

### **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.

### **Engagement**

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

### **Key Information and Directory System (KIDS)**

The FACS electronic system for keeping records and plans about children, young people and their families.

### **Manager Casework**

Managers Casework provides direct supervision and support to a team of FACS caseworkers.

### **Mandatory reporter**

A person who, in the course of their professional or other paid employment, delivers health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children, or a person who holds a management position in an organisation, the duties of which include direct responsibility for or direct supervision of the provision of health care, welfare, education, children's services, residential services, or law enforcement wholly or partly to children. If a mandatory reporter has reasonable grounds to suspect that a child is at risk of significant harm and those grounds arise during the course of or from the person's work, it is the duty of the person to report to FACS as soon as practicable, the name or a description of the child and the grounds for suspecting that the child is at risk of significant harm. This is outlined in section 27 of the *Children and Young Persons (Care and Protection) Act 1998*.

### **Medical examination**

Pursuant with Section 173 of the *Children and Young Persons (Care and Protection) Act 1998*, if the Secretary of FACS or a police officer believes on reasonable grounds that a child is in need of care and protection, the Secretary or the police officer may serve a notice naming or describing the child requiring the child to be forthwith 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. The notice is to be served on the person (whether or not a parent of the child) who appears to the Secretary or the police officer to have the care of the child for the time being.

## **Mental health concerns**

A mental health problem or diagnosed mental illness that interferes with a parent's daily functioning, and 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 significant harm.

## **Neglect**

Neglect means that the child or young person's basic needs (for example, 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.

Supervisory neglect means that 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.

Medical neglect means 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 medical services for the child or young person or is not following a prescribed plan of treatment for the child/young person (includes over-medicating).

Educational neglect can occur when a parent or other carer is unable or unwilling to arrange for a child or young person to receive an education. Refer to the *Children and Young Persons (Care and Protection) Act 1998, Section 23 (1) (b1)*.

## **Order**

An order of a court or an administrative order.

## **Out-of-home care (OOHC)**

For the purposes of the *Children and Young Persons (Care and Protection) Act 1998* OOHC means residential care and control of a child or young person that is provided by a person other than a parent of the child or young person, and at a place other than the usual home of the child or young person. There are three types of OOHC provided for in the *Children and Young Persons (Care and Protection) Act 1998*; statutory OOHC (Section 135A), supported OOHC (Section 135B) and voluntary OOHC (Section 135C).

## **Parental responsibility**

In relation to a child or young person, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children.

## **Parental responsibility to the Minister**

An order of the Children's Court placing the child or young person in the parental responsibility of the Minister under Section 79(1)(b) of the *Children and Young Persons (Care and Protection) Act 1998*.

## **Physical abuse or ill-treatment**

Physical abuse or ill-treatment is physical 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 FACS under Section 25 where a person has reasonable grounds to suspect an unborn child may be at risk of significant harm after birth.

## **Removal**

The action by an authorised FACS officer or NSW Police Force 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 responsibility of the Secretary.

## **Report**

A report made to FACS, usually via the Child Protection 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 FACS 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)**

For the purposes of Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* a child or young person is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances:

- (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met
- (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
- (b1) in the case of a child or young person who is required to attend school in accordance with the Education Act 1990 – the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act
- (c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated
- (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm
- (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm
- (f) the child was the subject of a prenatal report under Section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.



### **Risk taking behaviours**

Includes but is not limited to:

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

### **Safety and risk assessment (SARA)**

SARA is a SDM® system for assessing risk. 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, 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. 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®)**

SDM® 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**

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.

### **Supported care allowance**

Financial support provided by FACS to relative/kin carers where there is no legal order. To be eligible for Supported Care Allowance, FACS must form an opinion that the child or young person is in need of care and protection. An annual review must occur to determine whether restoration is possible and, if not, how the parenting needs of the child are to be met; and whether a care application should be made to reallocate parental responsibility.

## **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 CSCs and outline the minimum practice required by CSCs when a ROSH event and non-ROSH information is received.

## **Weekly allocation meeting (WAM)**

Weekly allocation meetings (WAM) are a state-wide procedure. Managers in all CSCs meet weekly to review new reports that cannot be allocated due to insufficient resources.

## **Young person**

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* defines a young person as a person who is aged 16 years or above but who is under the age of 18 years.



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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.**

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