Report of Reviewable Deaths in 2008 & 2009

Volume 1: Child Deaths

August 2011

NSW Ombudsman

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Ombudsman's Foreword

This is the sixth report I have tabled about reviewable deaths since 2004, and the first since legislative amendments significantly changed my responsibilities for reviewing the deaths of children.

This volume relates to the deaths of 77 children and young people that occurred in the two-year period from January 2008 to December 2009.

I am tabling this report to Parliament later than has been my practice. This is due to the changes in my jurisdiction for reviewable child deaths, as I will describe here, and moreover, the uncertainty that accompanied these changes.

In April 2009, and following on from Justice Wood's Special Commission of Inquiry into Child Protection Services in NSW, the NSW Parliament assented to three significant changes to my work in child deaths:

- First, reviewable deaths would no longer include the deaths of children (or siblings of children) who had previously been the subject of a report of risk of harm to Community Services.
- Second, my report would be tabled biennially, rather than annually and on a financial, rather than calendar year basis.
- Finally, I was to become Convenor of the NSW Child Death Review Team (CDRT), and my office would provide support and assistance to the Team in its work reviewing the deaths of all children in NSW. Justice Wood's vision in making this significant change was to ensure that scrutiny and reporting of reviewable child deaths would be *'enhanced through an integrated function that examines all child deaths in NSW to enable the making of more systemic recommendations to prevent child deaths.*'

I welcomed these changes. However, the amendment Act created some anomalies. The Act shifted the reviewable deaths reporting timeframe from calendar to financial year, which was at odds with the CDRT's work, and left a gap of six months from our previous reporting period. The removal of provisions allowing for information exchange between the Team and my office created an uncertainty about the legality of sharing information between the two functions. In addition, the transfer of the CDRT did not take place at the same time as other provisions.

These issues were not resolved quickly. In late 2010, the reporting period for reviewable deaths was adjusted to calendar year, and a clear provision was included in the Act to make certain the legality of an integrated approach to using information about child deaths across the CDRT and reviewable death functions. It was not until February this year that the CDRT transferred to my office.

This report lays the groundwork for my office's future work in reviewing the deaths of very vulnerable children: those who died in circumstances of abuse and neglect, and those who died while living in care.

It is sobering to note that most of the children who died in circumstances of abuse died within the family, as a result of the actions of a parent, carer or relative. The largest single grouping of the children whose deaths were related to neglect were very young children – aged two years or less – who drowned in backyard swimming pools, mostly because they were not adequately supervised and had access to the pool. We also reviewed a significant number of neglect-related deaths that were Sudden and Unexpected Deaths in Infants. These children were all three months of age or younger.

Our work is about prevention: about identifying how children die and in what circumstances, in order that we can advise government and other agencies about risks to children and possible strategies to address them.

While I no longer review the deaths of children by virtue of the fact that they had a child protection history, over half of the families of children in this report had been involved with Community Services. Our reviews of children who died in 2008 and 2009 took place in a period of significant scrutiny and change for the NSW Child Protection System. The Special Inquiry into Child Protection Services commenced in 2008, and handed down its final report in late 2009.

The child protection system has changed substantially since that time, and since the period of time covered by this report. For that reason, our analysis of child protection issues does not make commentary on the contemporary system in NSW. My office is, however, conducting a separate inquiry into issues relating to the implementation of *Keep Them Safe*, and the capacity of the new system to respond appropriately to children at risk of significant harm.

Importantly, many of the children we reviewed lived in families where no child protection concerns had been raised or previously identified. Developing a strong understanding of risk and from this, feasible prevention strategies in these circumstances is a very complex challenge. My office will work closely with the Child Death Review Team and expert advisers to build on

work already done to better understand risk in this context, and how as a community, we can best work to reduce these risks.

Finally, I would like to take this opportunity to thank the members of the former Reviewable Child Deaths Advisory Committee for their invaluable advice and assistance in my work, including for the time covered by this report. In early 2010, we took the decision to disband the committee, given our changed jurisdiction and the pending transfer of the Child Death Review Team. I have greatly appreciated the Committee's commitment and expertise.

Bruce Barbour
Ombudsman

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Executive summary

This report is the first biennial report of reviewable child deaths, and covers the period 1 January 2008 to 31 December 2009. In this period, 1181 children died in NSW, and 77 (6.5%) of these deaths were reviewable:

- 20 children died as a result of abuse
- 23 children died as a result of neglect
- 14 children died in circumstances suspicious of abuse (6) or neglect (8)
- 20 children died while in care.

Changes to reviews of child deaths in NSW

In July 2009, and following the recommendations of the Special Commission of Inquiry into Child Protection Services in NSW, the scope and reporting of reviewable child deaths changed.

A child's death is now reviewable by the Ombudsman if the child died as a result of abuse or neglect, or their death occurred in suspicious circumstances; or at the time of their death, the child was in care or in detention.

Changes also mean that the Ombudsman now reports about reviewable deaths to the NSW Parliament on a biennial, rather than annual, basis.

In addition, and subsequent to a recommendation of the Inquiry, the operations of the NSW Child Death Review Team (CDRT) were transferred from the Commission for Children and Young People to the Office of the NSW Ombudsman in February 2011. The Ombudsman is now Convenor of the Team, and Ombudsman staff provide support and assistance to the Team in its work.

Changes to the child protection system in NSW

Keep Them Safe: A shared approach to child wellbeing commenced in 2010 as the NSW Government's response to the Special Commission of Inquiry.

Keep Them Safe aims to make child protection a shared responsibility across government agencies and between government and non-government agencies. *Keep Them Safe* came into effect in January 2010 and represents significant and far-reaching change in the delivery of child protection services. Among other strategies, the statutory reporting threshold has been raised to 'risk of significant harm'; and new intake and referral pathways have been or are being implemented, including Child Wellbeing Units and Family Referral Services. Longer term goals of *Keep Them Safe* include expanding the role of non-government agencies in child protection, enhancing provision of early intervention and community based services; and improving services for Aboriginal children.

The reviews we report here, and any contact between child protection services and the children who died and their families pre-date the *Keep Them Safe* changes.

The children who died

The deaths of 48 boys and 29 girls were reviewable.

Almost one quarter (20) of the 77 children were Aboriginal. Eleven children were from culturally or linguistically diverse backgrounds.

The majority of children were under five years of age (46 of 77).

Child deaths as a result of abuse and neglect were most prevalent in the one to nine year age range (34 children). All 14 children who died in suspicious circumstances were less than ten years of age.

Thirty of the 57 children whose deaths occurred as a result of abuse or neglect, or in suspicious circumstances, had been the subject of a report to Community Services that they were at risk of harm within the three years prior to their death.

Deaths resulting from abuse or suspicious of abuse

The deaths of 26 children in 21 separate incidents were a result of abuse or were suspicious of abuse. Nine children died in four incidents where their sibling(s) also died. Four children died in two incidents where the offender committed suicide, and three in two incidents where the offender attempted suicide.

There were 20 identified offenders or alleged offenders. Most were male (16 male, four female), and most (15) were in a familial relationship with the child. Eight were biological parents of the child.

Of the 15 offenders or alleged offenders who were family members, or living as part of the family, we found some evidence of factors that are associated with child abuse and neglect: domestic violence (seven cases) and substance abuse (six cases). We also found evidence of parental mental health problems in six families, and current relationship problems between parents in four of the families. Seven of the 15 offenders or alleged offenders presented a combination of these risk factors.

In contrast however, there was little indication in the known history of three offenders or alleged offenders that they could pose a risk to children.

Agency contact and child protection history

Eleven of the 20 families of children who died as a result of abuse had had recent contact with government agencies that indicated the children were, or may have been at some risk, or that the family was in vulnerable circumstances. In nine of the 11 cases, the main contact was with Community Services following reports about risk of harm to the child being made to the agency.

Prevention strategies

Developing strategies to prevent the fatal abuse of children is complex. It is difficult to point to any particular family type or circumstance or combination of factors where risk is likely to escalate to fatal abuse.

In this context, efforts to prevent child deaths generally focus on improving and expanding universal services, or in a more targeted area, child protection services. Changes through *Keep Them Safe* are targeted to improving the capacity and responsiveness of child protection services. Our reports of child death reviews have consistently identified lack of capacity within the child protection system to provide a comprehensive response to children at risk as a predominant and ongoing concern.

Deaths resulting from neglect or suspicious of neglect

We identified the deaths of 31 children in 2008 – 2009 as resulting from neglect (23) or suspicious of neglect (eight). The children died in 29 separate incidents.

Most of these deaths resulted from drowning, or were Sudden and Unexpected Deaths of Infants (SUDI). Other neglect-related deaths were due to trauma from a motor vehicle crash and injuries sustained in house fires.

Most of the children who died in circumstances of neglect or suspicious of neglect were very young. Of the 31 children, 26 were five years of age or younger; 21 were aged two or under, and 10 were infants less than a year old.

Ten of the children who died in neglect-related circumstances were Aboriginal, and four were from cultural and linguistically diverse backgrounds.

In almost all cases, family members were responsible for the care and supervision of the child at the time they died. Twenty-four of the 31 children were in the direct care of their parent(s).

Agency contact and child protection history

Eighteen of the 31 children who died in neglect-related circumstances had been the subject of at least one report of risk of harm to Community Services in the three years before their death. For most of the families, current or previous contact with Community Services indicated a history of neglect or issues related to inadequate supervision of children, including inadequate accommodation, parental substance abuse, carer emotional or psychological state, and failure to access medical care.

Drowning deaths

Fourteen children drowned in neglect-related circumstances. Most of the children (12) drowned in a private swimming pool.

The most significant contributing factors in relation to children who drowned were inadequate supervision in or around water, and lack of, or faulty, child resistant safety barriers.

It is widely acknowledged that the main strategies necessary to prevent the drowning deaths of children are adequate and active supervision; the maintenance of effective pool barriers or safe play areas where water hazards are unfenced; water familiarisation for children; and parent/carer knowledge of resuscitation techniques.

Sudden and Unexpected Deaths of Infants

Ten infants died suddenly and unexpectedly in circumstances of neglect (three), or suspicious of neglect (seven). All of the infants were aged three months or less. Eight of the 10 infants died in sleep incidents.

Our reviews identified a number of risk factors associated with SUDI in eight of the ten families, including inappropriate bedding, and bed sharing with drug or alcohol affected parents.

We noted particular circumstances for some parents, including the young age of some of the mothers; parents' own child protection histories; and in four families, homelessness or insecure housing. Eight of the 10 families who had experienced SUDI had a child protection history, which in most cases was extensive.

Modifiable risk factors associated with infant sleep have been the subject of major campaigns over the last decade, and NSW – along with other states and internationally – has seen a decrease in SIDS deaths. In a child protection context, *Keep Them Safe* initiatives of particular relevance include the expansion of health home visiting services to work intensively with vulnerable families in pregnancy and in the first two years of the child's life.

Transport fatalities

Five children died in transport fatalities in circumstances that were neglect-related. Two children were under three years of age and three were aged between 13 and 15 years.

- Four children who died in three incidents were passengers. The three drivers were the child's parent, a close relative, and an unrelated and informal carer. One child who died in a pedestrian incident was related to the driver of the car.
- Our reviews identified that speed was a factor, or possible factor in relation to three incidents. In all three crashes this was combined with other dangerous behaviour, including the child being unrestrained, and a driver's a blood alcohol level being over the legal limit. In the fourth incident, the driver of the vehicle was drug affected.

House fires

Fatal house fires do not happen frequently, but they occur regularly.

Two children died in neglect-related circumstances in two separate house fires. The two children were both aged less than five years and were in the care of their parents when the fire occurred. Both children had child protection histories.

In both cases, the child had access to lighters and had some history of interest in fire, or attempts to light fires.

Adequate supervision, safe storage of matches and lighters, modelling of safe fire behaviour and explaining the risks associated with fire, are identified as important strategies in minimising fire fascination in children. In a child protection context, *Keep Them Safe* has a stated focus on intervening early with vulnerable families, and strengthening early intervention and community based services to do so.

Deaths of children in care

Twenty children who died were in care. Ten of the children in care were subject to final orders of the Children's Court, and three were subject interim orders. Seven children were in voluntary care.

Most of the children in care died either when they were very young or during adolescence; nine children were five years or younger, three were aged between 10 and 14 years, and eight were aged between 15 and 17 years.

Seventeen of the children were male. Eight were Aboriginal.

The majority of the 20 children (17) died as a result of natural causes. Most (15) of these children had high or complex needs relating to disabilities and/or chronic health issues. Our reviews found that these children had, in the main, received adequate care and support from service providers, including disability service providers and health services.

Three of the 20 children died from external causes. One child died in a motor vehicle crash, and two teenagers committed suicide. Both young people had high needs. Our reviews identified the importance of appropriate training and supervision for carers of young people with high needs; timely responses to these young people, and strong collaboration and cooperation between relevant agencies.

Preventative measures

Community Services and Ageing, Disability and Home Care have implemented joint training of managers and staff of both agencies on the Community Services and Ageing, Disability and Home Care *Memorandum of understanding on children and young people with a disability*, and developed a model for joint recruitment and training of foster carers.

Keep Them Safe also undertakes to develop additional models of out-of-home care for children and young people with disabilities. In regard to high needs adolescents, *Keep Them Safe* has acknowledged shortcomings in existing models of care for these young people, and commits to the development of new models of care for them.

1 Introduction

This report is the first biennial report of reviewable child deaths, and covers the period 1 January 2008 to 31 December 2009.

In this period, the deaths of 77 children were reviewable:

- 20 children died as a result of abuse
- 23 children died as a result of neglect
- 14 children died in circumstances suspicious of abuse (6) or neglect (8)
- 20 children died while in care.

1.1 Changes to the review of child deaths in NSW: responsibilities of the NSW Ombudsman

Reviewable child deaths

Since December 2002, the NSW Ombudsman has been responsible for reviewing the deaths of certain children, and people with disabilities living in care. The details of this responsibility are set out in the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS-CRAMA).*

Since our last report of reviewable deaths[1], there have been important changes to this work.

Until 30 June 2009, the death of a child was reviewable if the child, or their sibling, had been the subject of a report of risk of harm to Community Services within the three years prior to the child's death; if a child's death was the result of abuse or neglect, or occurred in suspicious circumstances; or if a child died while in care or in detention.

In July 2009, and following the recommendations of the Special Commission of Inquiry into Child Protection in NSW, the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* changed the scope and reporting of reviewable child deaths.

The Ombudsman no longer has responsibility for reviewing the deaths of children on the basis of previous reports to Community Services. Children or siblings of children who have been the subject of such reports within the three years prior to their death will only be reviewed by this office if they also meet the revised criteria for a reviewable death.

A child's death is now reviewable by the Ombudsman if:

- the child died as a result of abuse or neglect, or their death occurred in suspicious circumstances;
- at the time of their death, the child was in care;[2]
- at the time of their death, the child was in detention.

In addition to these changes, the Ombudsman is now required to present a report about reviewable deaths to the NSW Parliament on a biennial, rather than annual, basis.

The NSW Child Death Review Team

In February 2011, the operations of the NSW Child Death Review Team (CDRT) were transferred from the Commission for Children and Young People to the Office of the NSW Ombudsman. The Ombudsman is now Convenor of the Team, and Ombudsman staff provide support and assistance to the Team in its work.

The CDRT reviews the deaths of all children in NSW. The purpose of this work is to prevent and reduce the deaths of children. The Team comprises representatives from key government agencies including Community Services, NSW Health and the NSW Police Force; and independent members, including Aboriginal representatives, medical practitioners, and academics.

This change resulted from a recommendation of the Special Commission of Inquiry into Child Protection in NSW. In proposing the transfer of the Team, the Special Commission noted:

> *It is evident to the Inquiry that in considering reviewable child deaths it is critical to examine and compare the contexts in which the deaths occur. This can be enhanced through an integrated function that examines all child deaths in NSW to enable the making of more systemic recommendations to prevent child deaths.*[3]

1 *NSW Ombudsman (2009) Report of reviewable deaths in 2007*. Sydney: NSW Ombudsman

2 'In care' in this context refers to a child under the age of 18 years who is in care as defined in section 4 (1) of the Community Services (Complaints, Reviews and Monitoring) Act 1993.

3 Hon James Wood AO QC (2008) *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, p 921.

1.2 Community Services child death reviews

In removing responsibility from the Ombudsman for reviewing the deaths of children on the sole basis that they had been the subject of a report of risk of harm to Community Services, the Special Commission of Inquiry into Child Protection in NSW recommended that:

> *DoCS [Department of Community Services] should review the death of any child or young person about whom a report was made within three years of the death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.*[4]

This recommendation was endorsed by the NSW Government.

The Child Deaths and Critical Reports Unit within Community Services reviews both serious cases and the deaths of children as outlined above. The unit was established in 2004.

A significant number of cases that are reviewed by Community Services are also reviewable deaths. This was acknowledged by the Special Commission of Inquiry, which noted:

> *The Inquiry is satisfied that neither the Ombudsman nor DoCS should cease reviewing and preparing reports into child deaths. In the interests of transparency and public accountability it is important to preserve the oversight role of the Ombudsman. It is equally important that DoCS should retain a responsibility for ensuring that its casework is effective and that it accepts responsibility for systemic failure.*

This office provides information to Community Services about child deaths that meet its review criteria. Community Services also provides this office with a copy of its completed child death reviews.

1.3 Changes to the child protection system

Many of the children whose deaths are reviewable – under both previous and current definitions – have had contact with the child protection system.

As noted above, the period covered by this report coincided with the conduct of the Special Commission of Inquiry into Child Protection in NSW (November 2007 – November 2008), and the release and commencement of the NSW Government's subsequent plan to reform child protection in NSW: *Keep Them Safe: A shared approach to child wellbeing* in 2009.[5]

The goal of *Keep Them Safe* is to make child protection a shared responsibility across government agencies and between government and non-government agencies, and to limit the statutory role of Community Services to children at risk of *significant* harm. Reports that do not meet the threshold for Community Services' statutory involvement are now handled by the reporter either through referral, or through the resources of the reporting agency.

The main changes arising from *Keep Them Safe* came into effect in January 2010. They include:

- Raising the statutory reporting threshold to 'risk of significant harm'.
- Introduction of new intake and referral pathways, including:
  - Child Wellbeing Units in key public sector agencies (NSW Police Force, Department of Human Services, Department of Education and NSW Health). The Units assist their agencies to identify child protection concerns that constitute risk of significant harm, and to respond to children and families where risk is below that threshold.
  - Family Referral Services, to facilitate referrals to appropriate support services. Three family referral services were piloted throughout 2010 in Dubbo, Newcastle and Mt Druitt. Additional services will be rolled out across the state in 2011.
- Legislative amendment to permit the exchange of information relating to the safety, welfare and wellbeing of children between certain human service and justice agencies.

Longer term goals are to:

- Build capacity within, and expand the role of, non-government agencies.
- Enhance the provision of early intervention and community based services.
- Improve services to Aboriginal children and young people and reduce the number of Aboriginal children coming into contact with the child protection system.

It is important to note that reports of risk of harm made about the children who died in 2008 and 2009, and the agency responses to these reports, pre-date the *Keep Them Safe* changes. For this reason, our report does not include commentary on the contemporary child protection system.

This office is however, separately reviewing the capacity of the new child protection system to respond appropriately to children assessed as being at risk of significant harm.

4 ibid. p 953

5 NSW government, 2009, *Keep Them Safe*: *A shared approach to child wellbeing 2009 - 2014*, March 2009

Our reports of child death reviews since 2004 have consistently raised concerns about lack of capacity within the child protection system to provide a comprehensive response to children reported to be at risk of harm. One of the predominant and ongoing issues – and reflected again in this report – has been the extent to which child protection cases have been closed due to competing priorities, and before risk to a child has been properly assessed.

2 Recommendations

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* provides for the Ombudsman to formulate recommendations that can be implemented by government and service providers to prevent or reduce reviewable deaths.

The Act also requires the Ombudsman to include in the biennial report information about the implementation (or otherwise) of previous recommendations.

As the report outlines below, the period covered by this report pre-dates *Keep Them Safe*, which sets an agenda for far-reaching reforms to the child protection system in NSW.

Many of the recommendations we made in previous reports informed the Special Inquiry into Child Protection Services in NSW, and have been subsumed by these changes. *Keep Them Safe* commenced in 2010, and our next biennial report – for 2010–2011 – will be the first period in which our reviews will have direct reference to the contemporary system.

In this context, and given the change to our own jurisdiction, we make no recommendations in this report. Rather, we will provide our report to all agencies that play a role, both directly and indirectly, in protecting children from harm, and seek their comment on key issues raised in this report, including:

- Capacity and service improvement through *Keep Them Safe*, in particular:
  - Capacity to undertake comprehensive assessment of risk to children, either through Community Services or agencies with child protection responsibilities.
  - Enhancement of the role of early intervention services and community support services for vulnerable families, particularly in relation to neglect.
  - Support for young mothers, particularly those who are homeless or in marginal housing.
  - Support for high needs adolescents living in care, particularly in relation to mental health concerns.
- Developments in swimming pool safety measures, particularly consideration of Coronial and Child Death Review Team recommendations.

Through our review and broader monitoring work, we will also consider ongoing developments under *Keep Them Safe* and in other key areas we have identified.

3 Reviewable child deaths

3.1 Identifying reviewable child deaths

We use the following definitions to determine whether a child's death is reviewable:

Abuse

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

Neglect

Conduct by a parent or carer that results in the death of a child or young person, and that involves:

- Failure to provide for basic needs such as food, liquid, clothing or shelter;
- refusal or delay in providing medical care;
- intentional or significantly careless failure to adequately supervise; or
- a significantly careless act.

Suspicious circumstances

Deaths are considered suspicious if:

- There is some evidence or information that indicates the death may have been the result of abuse or neglect.
- Police identify the death as suspicious at the time of the death or any time subsequent to the death and there is some evidence that indicates the death may have occurred in circumstances of abuse or neglect as defined above.[6]
- The autopsy cause of death is undetermined and there is an indication of abuse or neglect.
- The autopsy cause of death is a treatable illness and there is an indication that unjustified delay in seeking treatment may have contributed to the death.

In care

A child under the age of 18 years who is in care as defined in section 4 (1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This definition includes children in voluntary out-of-home care and disability accommodation services.

3.2 The purpose of reviews

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the functions of the Ombudsman are to monitor and review reviewable deaths, maintain a register of these deaths, and:

> *To formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths of children in care, children at risk of death due to abuse or neglect, children in detention centres, correctional centres or lock-ups or persons in residential care (s.36 (1) (b)); and*
>
> *To undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable (s.36 (1) (d)).*

We maintain a register of reviewable deaths that holds information about causes of death and the characteristics and circumstances of children who died. It provides the basis for our reporting, and allows us to monitor trends and issues over time.

The focus of reviews is systemic. That is, we look for any issues or trends that may inform preventative strategies to reduce risk to children.

From time to time we identify concerns about individual cases. When this happens, we can provide information to agencies or service providers, make inquiries or where relevant, conduct an investigation.

3.3 Sources of information for reviews

In the course of reviewing child deaths, information is gathered from many sources. We receive initial information about a child's death from the Registry of Births, Deaths and Marriages. We have direct access to Community Services' database, the Key Information Directory System (KIDS) and to the NSW Police Force's database, the Computer Operated Policing System (COPS). In addition, relevant government and non-government agencies and service providers are required to provide this office with 'full and unrestricted' access to records that we reasonably require to conduct our reviews.

6 If subsequent police investigations result in the death no longer being treated as suspicious, we also reassess inclusion of these deaths as reviewable.

In order to ensure that our work is informed by specialised areas of knowledge, including medical or forensic science, the Ombudsman appointed an advisory committee of experts in several relevant fields to provide advice on individual cases and systemic issues.

In the context of changes to the Ombudsman's responsibilities in reviewing child deaths, including the pending transfer of the NSW Child Death Review Team, the Child Deaths Advisory Committee was disbanded in February 2010. Details of the Committee membership are at *Appendix 1.*

3.4 About this report

As noted, this report is the first biennial report of reviewable child deaths, and covers the period 1 January 2008 to 31 December 2009.

In order to enable comparisons with previous data, we have separated and reported against cases from 2004 – 2007 that met the present criteria for reviewable deaths.

Throughout this report and where possible, we have also separately analysed information about children who died while in care, given the very different circumstances generally pertaining to the deaths of this group of children.

3.5 Future directions for biennial reports of reviewable child deaths in NSW

This report lays the groundwork for our future work in reviewable child deaths, in accordance with our revised jurisdiction.

The integration of our work with the work of the NSW Child Death Review Team provides us with great opportunity to consider reviewable deaths in a broader context of all child deaths.

Our reviews – and the work of the CDRT – aim to identify factors that may have contributed to child deaths, and from that, propose strategies that could act to reduce those same risks for other children. While our jurisdiction has changed, this remains our core purpose.

The deaths we now have responsibility to review, particularly those resulting from abuse or neglect, are deaths that from any perspective should not have happened. That being said, we also know from our work over the past eight years that identifying risk factors for the child and the characteristics of perpetrators or carers, does not in itself present simple answers to what could have been done to predict and prevent a death.

In this context, we believe it is important not only to monitor and report on all reviewable child deaths, but also to give specific focus to themes that are constant in our work. These include, for example:

- The number of abuse and neglect-related deaths where the child's family has a child protection history.
- The high number of infants represented in reviewable deaths.
- The high number of Aboriginal children represented in reviewable deaths.
- The prevalence of mental illness amongst offenders, particularly in female offenders.
- The prevalence of murder-suicide and murder-attempted suicide.

Our future reports will include specific focus on these issues.

4 Overview of reviewable child deaths 1 January 2008 – 31 December 2009

4.1 Children who died in 2008 - 2009

This report covers the two year period from 1 January 2008 to 31 December 2009, and relates to children who died as a result of abuse or neglect, or in suspicious circumstances, and children who died who were in care.

According to information provided to us by the Registry of Births, Deaths and Marriages, 1181 children died in NSW between 1 January 2008 and 31 December 2009. We identified 77 (6.5%) of these deaths as reviewable.[7]

Table 1 details the number and proportion of child deaths that were reviewable in 2008 and 2009, and Table 2 provides details of reviewable child deaths from 2003, adjusted to reflect the revised 2009 criteria for reviewable deaths.

Table 1: Children whose deaths were reviewable 2008 and 2009, number (per cent)

Status	Number (per cent)
Child deaths in NSW	1181
Reviewable child deaths in NSW (2009 criteria)	77 (6.5%)
Abuse	20 (2%)
Neglect	23 (2%)
Suspicious circumstances	14 (1%)
In care	20 (2%)

Table 2 shows the number of reviewable deaths has fluctuated over the years and across categories. The notable rise in the number of deaths of children in care in 2009 should be seen in this context, and in relation to the increased number of children in care. As at 30 June 2009, there were 16 524 children in out of home care, an increase of 30 per cent from the 12 712 children in care at 30 June 2007.[8]

It should be noted that with small numbers, changes will result in significant shifts in percentages.

Table 2: Children whose deaths were reviewable, 2003-09 (January –December)[9] Number and per cent

	2003	2004	2005	2006	2007	2008	2009
Child deaths in NSW	561	544	605	622	603	603	578
Reviewable child deaths in NSW (criteria 2003 – 09)	124	106	120	126	162	-	-
Reviewable child deaths in NSW (revised criteria 2009)	54(10%)	32(6%)	38(6%)	39(6%)	48(8%)	32(5%)	45(8%)
Abuse	18(3%)	8(1%)	14(2%)	11(2%)	8(1%)	13(2%)	7(1%)
Neglect	14(2%)	7(1%)	12(2%)	12(2%)	11(2%)	10(2%)	13(2%)
Suspicious circumstances	12(2%)	9(2%)	8(1%)	12(2%)	24(4%)	5(1%)	9(1%)
In care	10(2%)	8(1%)	4(1%)	4(1%)	7(1%)	4(1%)	16(3%)

7 This figure may differ from the number of child deaths reported by the NSW Child Death Review Team. The difference relates to legislative requirements: while the CDRT is required to review deaths registered in NSW, the Ombudsman reviews deaths that occurred in the state in any given year.

8 Community Services (2011) *Annual Statistical Report 2009/10*, NSW Government- Department of Human Services, accessed via http://www.community.nsw.gov.au/docswr/_assets/main/documents/docs_data/annual_statistics_report09-10.pdf, p 57

9 Numbers for 2003 cover the 13 month period from December 2002, when our jurisdiction for reviewable child deaths commenced.

4.2 Demographic factors

Age

Table 3 shows the numbers and percentages of children who died in NSW by age and reviewable status. While the greatest number of children who died were under one year of age, the highest percentage of children whose deaths were reviewable were between one and four years of age. Most accidental deaths that are considered to have resulted from neglect occur in this age range, as well as a large proportion of deaths due to abuse, or suspicious of abuse.

Table 3: Children whose deaths were reviewable (2008 and 2009) by age, number and per cent

	<1 year	1-4	5-9	10-14	15-17	Total
Reviewable	18	28	11	9	11	**77**
Not reviewable	734	108	76	70	117	**1104**
Percent reviewable	2.4%	21%	13%	11%	8.6%	**6.5%**

Figure 1 shows the age categories of children who died in NSW for reviewable and non-reviewable child deaths in NSW as a percentage.

As in previous years, the majority of children whose deaths were reviewable were under five years of age. This is consistent with all child deaths. Most children who died in care, however, were over 10 years of age, with a majority aged 15-17.

Child deaths as a result of abuse and neglect were most prevalent in the one to nine year age range. A notable feature of Figure 2 is that all children who died in suspicious circumstances were less than ten years of age.

Figure 1. Children whose deaths were reviewable (2008 and 2009) by age

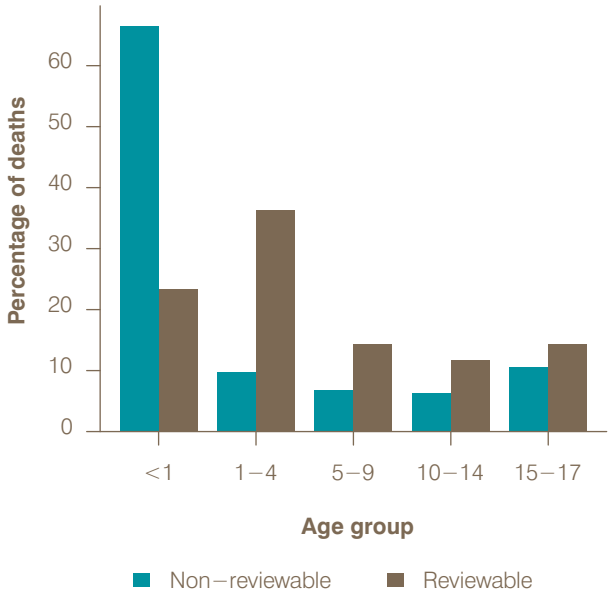


Figure 2. Children whose deaths were reviewable (2008 and 2009) by age and reviewable status

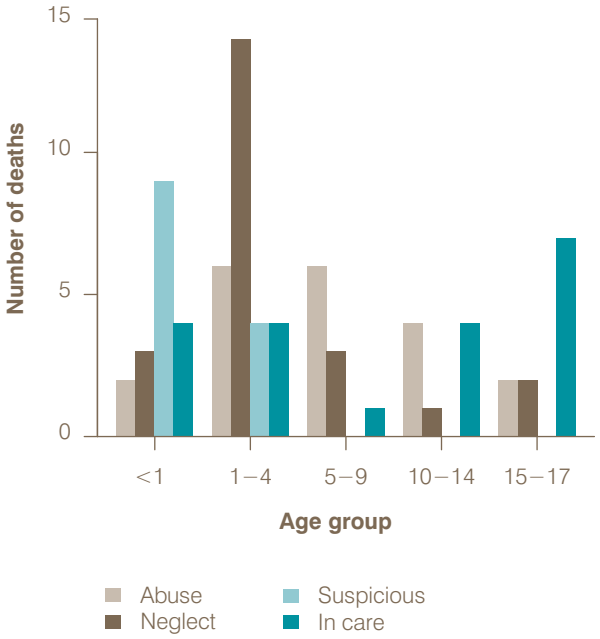


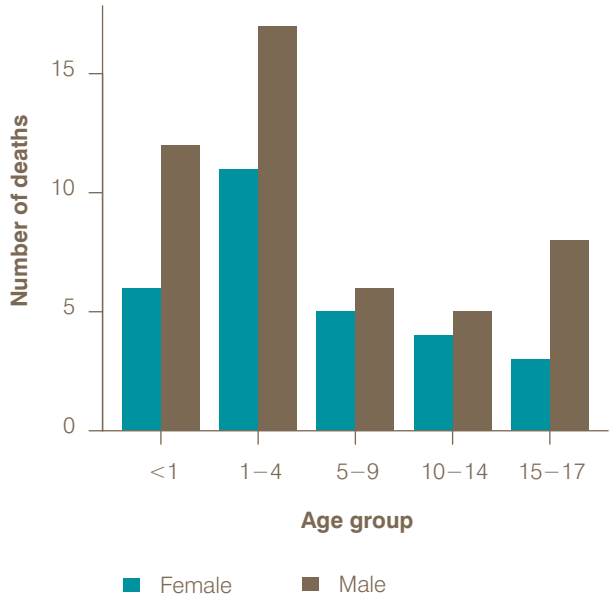
Table 4: Children whose deaths were reviewable (2008 and 2009) by age and reviewable status

	<1 year	1-4	5-9	10-14	15-17	All ages
Abuse	2	6	6	4	2	**20**
Suspicious of abuse	2	3	1	0	0	**6**
Neglect	3	14	3	1	2	**23**
Suspicious of neglect	7	1	0	0	0	**8**
In care	4	4	1	3	8	**20**

Gender

The deaths of 48 boys and 29 girls were reviewable.

Figure 3. Children whose deaths were reviewable (2008 and 2009) by gender and by age



The deaths of more boys than girls were reviewable in all age groups, with the most noticeable difference in the 15-17 year age group. This is consistent with other studies of child deaths.[10]

Aboriginality

In 2009, over seven per cent of the children who died in NSW were Aboriginal and Torres Strait Islander.[11] This is higher than would be expected from the estimated four percent of the NSW population under 18 who identify as Aboriginal or Torres Strait Islander.[12] However, and indicating a much higher over-representation, almost a quarter (20) of all children who died whose deaths were reviewable were Aboriginal.

As can be seen in Figure 4, the percentage of Aboriginal children who died in each age group was higher than the estimated percentage of indigenous people in these age groups in the general population (represented by the broken horizontal lines).[13] This difference was greatest in the under one year age group and tended to decrease with age, except for the noticeable rise in the 10-14 year age group.

Figure 4. Children whose deaths were reviewable (2008 and 2009) by Aboriginal status and age

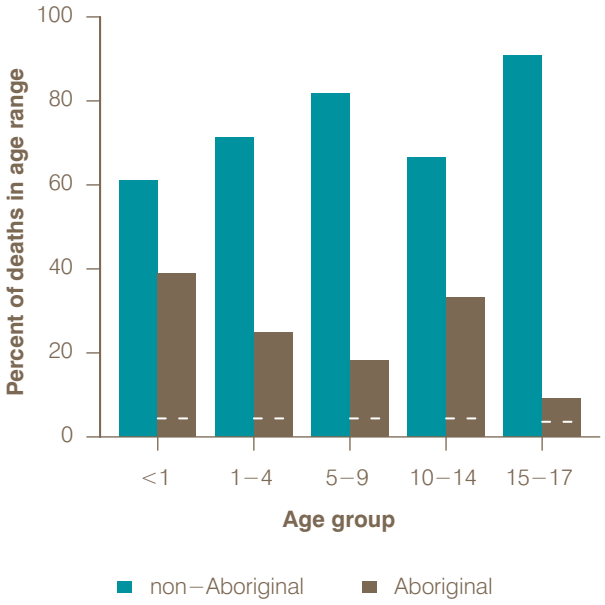


Table 5 shows that the over-representation has been consistent since 2003. The percentage of deaths of Aboriginal and Torres Strait Islander children that were reviewable has ranged from 17 – 29 per cent, with the average being 22 per cent.

Table 5: Aboriginal status of children who died in NSW 2003-09

	2003	2004	2005	2006	2007	2008-2009
Number of deaths	36	25	20	21	30	20
% of reviewable deaths	29%	24%	17%	17%	19%	26%

10 NSW Child Death Review Team 2009, Annual Report 2008. Sydney: Commission for Children and Young People.

11 NSW Child Death Review Team 2010, Annual report 2009, Volume 1: External Causes of Death, NSW Commission for Children and Young People, p 10

12 Australian Bureau of Statistics 2006), *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, Jun 2006 (cat. no. 3238.0.55.001). Canberra: Australian Bureau of Statistics.

13 Australian Bureau of Statistics (2009) 3238055001DO006_200606 *Experimental Estimates of Aboriginal and Torres Strait Islander Australians,* June 2006. Canberra: Australian Bureau of Statistics

Cultural and linguistic diversity

In NSW, approximately 27 per cent of people have either one or both parents born overseas.[14] Culturally and linguistically diverse is a broad term which can have different applications in different settings.[15] Where we find evidence in our reviews that either the child or a parent was born in a non-English speaking country, or belong to a cultural minority group, we record the child's background.

In 2008 and 2009 we identified 11 children whose deaths were reviewable and who were from culturally or linguistically diverse backgrounds. The children's backgrounds included Maori, Tongan, Samoan, East Timorese, Vietnamese, Chinese, Indian and Iranian. Two of these children also had an Aboriginal parent. The lower than average number of CALD children may reflect in part lack of capture of this information in records reviewed.

4.3 Child and family circumstances

Where the children lived

Most children whose deaths were reviewable resided more than half of the time with at least one biological parent. Nine of the 20 children in care also lived with family or kin; five of these children lived with biological parents, including children were who were in disability respite care or who were being restored. Another four children of these children lived with extended family or kin.

Table 6: Usual place of residence

Usual place of residence	Number
Biological parent(s)	59
Other family member(s)	4
Unrelated person(s)/in statutory or disability care	11
Child never discharged from hospital	2
Uncertain	1
Total	**77**

Place of death

Table 7 refers to the location of the incident related to the child's death, rather than the location where the child was declared deceased. In a number of cases, children were recorded as dying at the hospital although they had shown no signs of life when discovered or when paramedic assistance arrived. Of the nine children who are included in Table 7 as having died in hospital, all were in care and died as a result of natural causes.

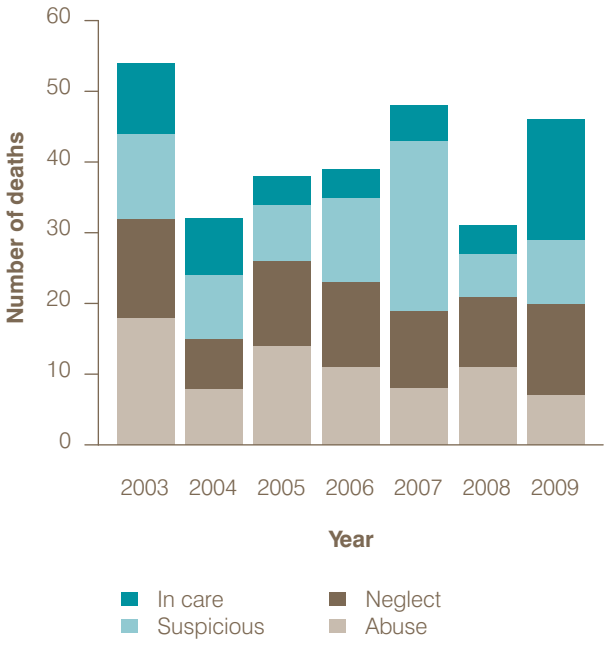
Table 7: Place of child's death

Place	Number
Family home	38
Other home	14
Residential service	6
Public place	9
Hospital	9
Unknown	1
Total	**77**

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

Figure 5 relates to the current criteria for reviewable deaths and shows the reason for the reviewable status of children between 2003 and 2009.

Figure 5. Children whose deaths were reviewable under the 2009 criteria and reason for reviewable status (2003-09)



14 Department of Immigration and Citizenship (2008) *The People of New South Wales: Statistics from the 2006 Census,* Commonwealth Government, accessed via http://www.crc.nsw.gov.au/__data/assets/pdf_file/0008/9692/NSW_PONSW_Vol_1.pdf, p 2

15 Pooja Sawrikar and Ilan Katz, Social Policy Research Centre, University of New South Wales, (2009) 'How useful is the term 'Culturally and Linguistically Diverse' (CALD) in Australian research, practice, and policy discourse?', *Australian Social Policy Conference* 8-10 July 2009, accessed via **http://www.sprc.unsw.edu.au/media/File/Paper276.pdf**

Deaths resulting from, or suspicious of, abuse

For 20 of the 26 children who died as a result of abuse, or in circumstances suspicious of abuse, the perpetrator, or alleged perpetrator, was a family member.[16]

In six cases where the child died as a result of abuse more than one person died in the same incident, including murder-suicide and multiple homicides.

Six children died in circumstances suspicious of abuse. Five of these children were under three years of age.

Table 8: Children whose deaths were the result of, or suspicious of, family or other homicide by age category

	<1	1-4	5-9	10-14	15-17	All
Family homicide – Abuse	2	6	6	2	0	**16**
Suspicious	2	2	1	0	0	**5**
Other homicide – Abuse	0	0	0	1	3	**4**
Suspicious	0	1	0	0	0	**1**
All homicides	4	9	7	3	3	**26**

Deaths resulting from, or suspicious of, neglect

Twenty-three children died as a result of neglect and eight in circumstances suspicious of neglect. Most of the children died as a result of drowning (14). Circumstances also included transport incidents (five), Sudden and Unexpected Death of an Infant (10) and house fires (two).

Table 9: Deaths related to neglect

	Drowning	Transport	House fire	SUDI	All
Neglect	14	5	1	3	**23**
Suspicious of neglect	0	0	1	7	**8**
All neglect	14	5	2	10	**31**

Child protection history

While the existence of a child protection report within the past three years is no longer a criterion for inclusion as a reviewable death, the families of over half of the children who died as a result of abuse or neglect or in suspicious circumstances had a recent child protection history.

In 2008 and 2009, 30 of the 57 children whose deaths occurred as a result of abuse or neglect or in suspicious circumstances had been the subject of a report to Community Services that they were at risk of harm at some point in the three years prior to their death. Almost all of these children (27 of 30) had been the subject of such a report within the twelve months before they died, and nine were reported in the month prior to their death.

Of the 30 children:

- 12 died in circumstances of neglect
- Six died in circumstances suspicious of neglect
- Eight died in circumstances of abuse, and
- Four died in circumstances suspicious of abuse.

In an additional case, the child who died was not the subject of a risk of harm report concerning issues within the family, but the child's sibling was.

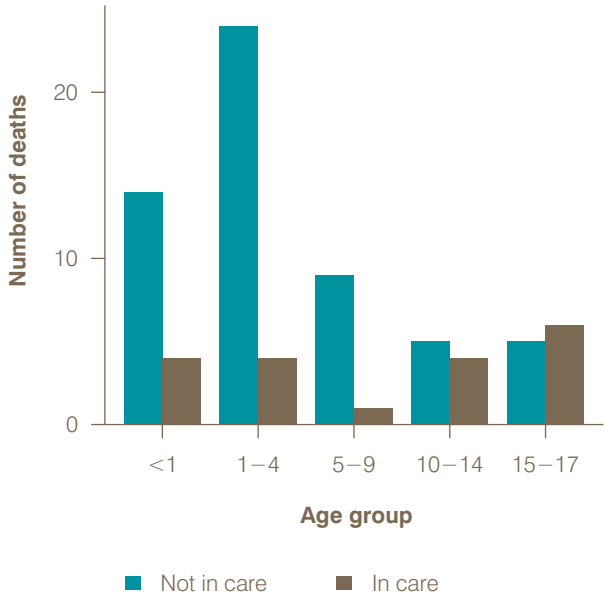
16 Either immediate or extended family, and we have included partners of parents living full or part-time in the household.

4.5 Children in-care

Twenty children who died were in care.

Figure 6 illustrates the age distributions of children who were in care at the time of their death and those children who were not in care. The majority of the 20 children in care died as a result of natural causes, often related to disability and complex health needs.

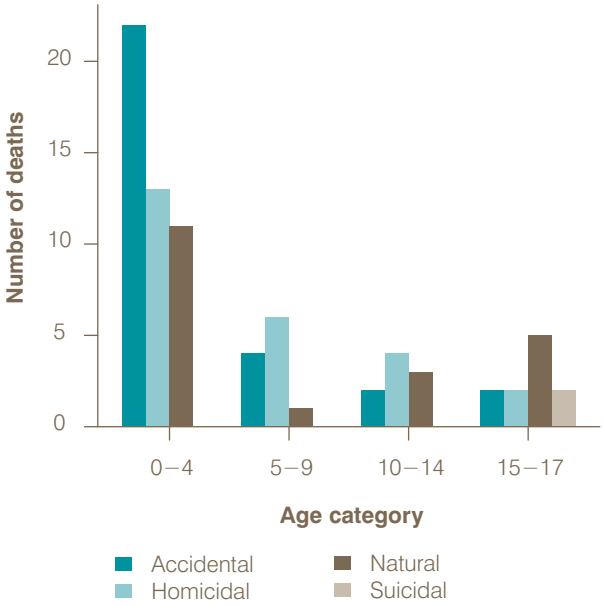
Figure 6. Children whose deaths were reviewable by age and in care status



4.6 Coronial and criminal status

As Figure 7 shows, homicides are most frequent in the youngest age groups and decline with age, while accidental deaths are concentrated in the one to four year old age range. Accidental deaths continue to occur at a reduced rate through the older age ranges.

Figure 7. Manner of death by age category



Reviewable deaths from natural causes are almost always of children in care who have had significant and complex health needs. Suicide deaths were only recorded in the oldest age group.

Table 10: Coronial status by manner of death

	Accidental	Homicidal	Natural	Suicidal	Total
Held	7	4	0	0	**11**
Dispensed	13	1	14	0	**28**
Pending	6	7	5	2	**20**
Suspended	4	13	1	0	**18**

Under s 24 of the *Coroners Act 2009 (NSW)* the Coroner has specific jurisdiction to conduct an inquiry concerning the death of a child that is reviewable. The Coroner may determine whether or not a full inquest is required.[17] At the time of writing the coronial process had been finalised, dispensed or suspended for about three quarters (57) of the children. Inquests are generally suspended when charges are laid.

17 s 25 Coroners Act 2009 (NSW). This section also extends to children, or the siblings of children, who had been the subject of a risk of harm report within three years prior to their death.

Table 11: Coronial status

Coronial status	Abuse/neglect	In care	All deaths
Held	11	0	11
Dispensed	15	13	28
Pending	14	6	20
Suspended	17	1	18
Total	**57**	**20**	**77**

In relation to the 20 children who died as a result of abuse:

- Four children died in two murder-suicide incidents. Both murder-suicides were subject to a Coronial inquest.
- Eight convictions have been recorded for the deaths of nine children. Four perpetrators were convicted of murder and four of manslaughter.[18]
- A further five persons have been charged with murder (four) or manslaughter (one).

Of the 23 deaths that were a result of neglect there have been three convictions: two of manslaughter in relation to the one incident and one of dangerous driving occasioning death.

18 As at May 2011

5 Children who died in circumstances of abuse or suspicious of abuse

Twenty six children died in circumstances of abuse (20) or suspicious of abuse (6) between 1 January 2008 and 31 December 2009. The children died in 21 separate incidents. In all but one of these incidents, offenders or alleged offenders have been identified.

Nine children died in four incidents where their sibling(s) also died.

Four children died in two incidents where the offender committed suicide, and three in two incidents where the offender attempted suicide.

The 26 children died as a result of physical injury, carbon monoxide poisoning or drowning.

5.1 Age and gender and cultural background: children and families

Research indicates that child homicides decrease in frequency with age until the teenage years.[19] Half of the children (13) who died in NSW as a result of abuse or in circumstances suspicious of abuse in 2008 – 2009 were under five years. Four of these children were under one year of age.

Two of the children who died as a result of abuse or in circumstances suspicious of abuse were identified as Aboriginal. Another six children (in five families) were from culturally and linguistically diverse backgrounds.

5.2 Offender relationship to the child

Of the 20 identified offenders or alleged offenders, most were male (16 male, four female).

Homicide research indicates that most child homicides in Australia are committed by family members, usually a parent or stepparent.[20] Our work has reflected this: over three-quarters of children who died as a result of abuse and whose deaths were reviewable between 2003 and 2007 died in family homicides.[21]

This was also the case in 2008 – 2009. Twenty of the 26 deaths of children that resulted from abuse, or were suspicious of abuse, occurred within the family.

There were 20 identified offenders or alleged offenders:

- a biological parent (eight, four fathers and four mothers)
- step parent (two, both male)
- partner of a biological parent living in the household, on either a full-time or part-time basis (three, all male)
- partner of a biological parent not living in the household (one, male)
- close relative (two, male)
- peer (three, all male)
- other unrelated person (one, male)

In a further case, there is no identified offender.

The four incidents in which offenders either killed themselves or attempted to do so were biological parents (two male and two female).

The ages of offenders and alleged offenders – excluding peers who were all teenagers - ranged from 19 to 69. Male partners of biological parents tended to be younger, with an average age of 23 years, compared to natural fathers, with an average age of 39 years.

The four mothers were aged in their late twenties or early thirties.

Teenagers are more likely to be killed by peers or unrelated adults, and their deaths are more similar to those of adults than those of younger children.[22] Of the 11 teenage homicides we reviewed between 2003 and 2007, the offender was a peer in over half (6) of the cases. In 2008 and 2009, three of the four teenage deaths resulting from abuse involved peers as offenders.

19 Strang H. (1996) Children as victims of homicide. *Trends and issues in crime and criminal justice, 53*, Canberra: Australian Institute of Criminology.

20 Strang 1996, op. cit.

21 We define family homicide to include filicide, siblicide and killings by other family members, as well as biological, step or defacto parents. See Mouzas J and Rushforth C (2003) Family homicide in Australia, *Trends and Issues paper 255*, p 2 Australian Institute of Criminology.

22 Strang, 1996, op. cit.

5.3 Offender and family characteristics

As part of our reviews, we sought to identify any particular characteristics that may have contributed to the circumstances leading to the child's death, or indicated some risk to the child. We did this through examination of records, including government and non-government agency client files, briefs of evidence, coronial documents, and court transcripts.

Non-familial homicides

Five of the 20 offenders or alleged offenders were not in a familial relationship with the child. Three were peers of the young person who died.[23] One was the partner of the child's mother, but resided elsewhere, and the fifth was otherwise known to the family.

Of the three young people who died in incidents involving peers, two of the deaths appear to have been accidental. Both young persons responsible for the deaths were convicted of manslaughter. In addition, in both cases, the offenders' parents were charged with firearms offences in relation to unregistered weapons and failure to secure weapons that were used in the incidents. The third young person died in the context of an affray. The offender was convicted of murder.

Family homicides

It is well recognised that factors such as parental mental health problems, substance abuse and domestic violence can place children at risk of significant harm. However, these factors, either as single issues or in combination, are not clear predictors of fatal maltreatment.[24]

It is notably difficult to identify underlying motives for child homicide within the family. One analysis in Australia found the underlying motive for child homicide within the family was undetermined in 61 per cent of cases, while the most prevalent identified motives were domestic altercations (21%) and *'jealousy/termination of the relationship – where the child is killed by one parent as the consequence of the actual or pending separation from the other parent'* (9%).[25] Overwhelmingly, the offenders in these circumstances are male. Mental illness has been identified as a significant factor on the part of mothers who kill their children.[26]

Previous indicators of risk

Of the 15 offenders or alleged offenders who were family members, or living as part of the family, we found some evidence in the documents we reviewed of factors that are commonly associated with child abuse and neglect: domestic violence, substance abuse and parental mental health problems.[27] We also found evidence that relationship problems between parents was a current issue for a number of the families.

Alcohol and other drugs

In the records we reviewed, particularly health, police and child protection, we identified that alcohol and / or other drugs were an ongoing problem in six of the 15 families. Two offenders or alleged offenders had a history of chronic drug and / or alcohol abuse, and for four others, there was evidence of regular excessive alcohol consumption or alcohol and other drug consumption.

In the context of the incident that resulted in the child's death, police and court records indicate that three of the offenders or alleged offenders may have been substance affected at the time: one offender had a blood alcohol level of 1.01 after the incident, and another – who had been assessed following his incarceration as having a 'binge drinking profile' – was reported to have been drinking excessively in the hours prior to the incident. Another tested positive for low levels of cannabis, although pathology indicated that the level of drug present would not have been enough to significantly alter the offender's thought process.

Domestic or other violence

Seven of the 15 offenders or alleged offenders (six male and one female) had some history of violence against others. Police, child protection and other agency records indicated that five of these seven offenders or alleged offenders had been violent within their family prior to the child's death.

The other two had a history of other violent assault or anger management issues. In police interviews following the death of the child, family members of both reported to police that the men displayed angry, over-protective and/or controlling natures.

In three families, records indicated that domestic violence in the family was known to agencies. In one

23 One offender was related to the child, but the incident occurred in the context of their peer relationship

24 Brandon M et al, 2009, *Understanding serious case reviews and their impact, A biennial analysis of serious case reviews 2005-07*, Department for Children, Schools and Families, University of East Anglia, p 118).

25 Mouzos, J and Rushforth, C (2003) *Family Homicide in Australia: Trends & issues in crime and criminal justice*, Australian Institute of Criminology, pages 3 – 4.

26 Ibid, page 4.

27 Bromfield, L et al, 2010, Issues for the safety and wellbeing of children in families with multiple and complex problems. National Child Protection Clearinghouse *NPC Issues no 33*. Australian Institute of Family Studies 2010

case, the offender had been previously charged with assault causing grievous bodily harm against the mother, and in another, domestic violence had been notified to police and was the basis of risk of harm reports made about the child to Community Services. In the third family, the mother and child had sought refuge in a domestic violence service.

In two of the five families where there was evidence of domestic violence, no reports had been made to police, with the violence being reported by family members after the child's death.

Mental illness or mental health problems

While research indicates that mental illness is associated with increased risk of child abuse and neglect, we note that parental mental illness alone need not indicate significant risk to a child. Agency and court records provided evidence that six of the 15 offenders or alleged offenders had some level of mental health problem prior to the death of the child:[28]

- Two had diagnosed psychotic illness, and psychosis was noted to be evident at the time of the incident in which the children died.
- Depression and anxiety were identified for one offender in psychiatric assessments following the death of the child. The assessment indicated these conditions had been present for some time.
- Two offenders had previously diagnosed depression, in both cases present with other disorders, including obsessive compulsive disorder and anxiety and post traumatic stress disorder.
- One alleged offender had a history of depression, and concerns had been raised to Community Services about risk to the child arising from their emotional state.

Family breakdown

Current relationship problems between adult partners were evident in four of the 15 families. In all four cases, coronial inquests or finalised court proceedings identified the prospects of a relationship breakdown or its consequences as possible motives.

Multiple risk factors

Records provided evidence that seven of the 15 offenders or alleged offenders presented a combination of factors known to present risks to children.

One offender had a known history of excessive alcohol and/or drug use, was violent, and was involved in a relationship that had broken down. The offender committed suicide after killing the child.

Of four offenders who experienced some level of mental health problem, two were also experiencing family breakdown, and another two evidenced domestic violence and anger management issues.

Two offenders had substance abuse problems with a history of domestic or other violence and anger management issues.

No prior recorded history

There was little indication in the known history of three offenders or alleged offenders that they could pose a risk to children.

Court records noted an absence of any explanation or motive for the offence for one offender, a family member, who was convicted of murder.

The sentencing Judges in two separate homicide cases noted a lack of any prior relevant record and identified a sudden anger and loss of control by the offender at the time of the incident in one case, and an isolated act or aberration inconsistent with the offender's character in the other. Notably in both of these cases, the child who died was under two years of age and the offender was a teenager who had been in a short-tem relationship with the child's mother. Both children had a child protection history, but not in relation to the offender. Both children died as a result of blunt force head injury.

5.4 Agency issues

Our reviews looked at whether the children who died as a result of abuse, or their families, had had contact with government agencies prior to the death of the child.

Of the 20 families where children died as a result of abuse, 11 had had recent contact with government agencies that indicated the children were, or may have been at some risk, or that the family was in vulnerable circumstances. In most cases, the main contact was with Community Services following reports about risk of harm to the child being made to the agency.

Child protection history

Nine of the 20 families had been the subject of one or more reports of risk of harm to Community Services in the year before they died, and/or were involved with Community Services. In seven of these families, the offender or alleged offender was related or living as part of the family, or was the partner of a parent. In the other two cases, the young person died in an incident where a peer was the perpetrator, and reports did not relate to the perpetrator.[29]

28 This excludes cases where situational depression or anxiety was diagnosed after, and considered to be primarily in relation to, the child's death.

29 In the other two cases, the young person died in a peer related incident and reports did not relate to the perpetrator.

The children who died in a family context where there were child protection concerns were mainly very young; five were aged three years or less. In another family, more than one child died, including a child under two.

Exposure to domestic violence and risk of physical abuse were common reported issues. Other reported concerns were neglect, psychological harm, emotional state of the carer and parental substance abuse.

Two children had open and allocated cases with Community Services. In one of these cases, the child's mother was under 18 years of age and was in the care of Community Services. Both children who died were very young: one was an infant, and the other under two years of age. In another case, a family had been reported to Community Services in the days prior to the incident in which children died. The report was made by police, following a domestic violence incident in relation to which police had issued an Apprehended Violence Order against the offender. Community Services accepted the report and attempted to phone the family, but no contact was made.

Involvement with Community Services was recent but not current for four families. One child had been the subject of a secondary assessment by the agency six months prior to his death, but had been found not to be in need of care and protection. One child was reported as being at risk of harm due to, among other concerns, parental alcohol and drug use. The case was unallocated and closed six weeks prior to the child's death.

Our reviews identified a number of practice and systems issues, similar to those we have identified in previous years. These issues included:

- Risk assessment being neither timely nor comprehensive, with a number of reports about serious risk not receiving adequate assessment, particularly in the context of changing circumstances.
- Inadequate history searches, and/or consideration of a family's child protection history in assessments of risk of harm.
- The difficulty in obtaining relevant information from reporters about the impact of domestic violence on children, and the adequacy of prioritisation of domestic violence in assessments of risk of harm.
- In the context of limited resources, the inability to allocate reports relating to low level violence, mental health issues and drug and alcohol use, resulting in a lack of response to chronic neglect.

In six cases where the offender or alleged offender was a family member or living with the family, Community Services' Child Deaths and Critical Reports unit undertook an internal review of its work with these families. In the main, the issues identified by Community Services concurred with our review findings. Community Services also noted in most instances that these issues were present in environments that included very high workloads, caseworker vacancies, and significant numbers of reports requiring priority responses.

Community Services' actions arising from the reviews included practice reviews for staff; directing the findings of reviews to improve staff training, supervision and feedback; and new procedures and strategies to improve interagency work.

The intention of *Keep Them Safe* is to address key concerns about capacity, scope and responsiveness within the child protection system. *Keep Them Safe* is based on delivering child protection services as a shared responsibility across government agencies, and between government and non-government agencies.

As noted previously, contact between the families of children who died in circumstances of abuse in 2008 and 2009 pre-date the *Keep Them Safe* changes.

Other agency contact: families with no child protection history

Two families that had no previous child protection history had recent contact with other agencies prior to the child's death that indicated some concerns for the child.

One parent with mental health issues had contact with a number of health services – including different general practitioners – during which the parent raised concerns about their coping ability, social isolation and the impact of their mental health problems on the child. The parent provided assurance that they had no thoughts of harming themselves or the child. Records indicate that in all contacts, the parent presented as stable and was offered referral to mental health specialists, which they declined. There were no apparent grounds to warrant a risk of harm report being made.

Another family had contact with a non-government support service, where the mother of the child indicated to the service that her partner had threatened to harm her. The service did not make a risk of harm report in relation to the child, although a report may have been warranted. We sought information about this from the service, and in response to our inquiries, the service told us that the nature of threats in relation to the child were unclear. The service also advised that it had subsequently resolved to report any child who was living with or returning to an abusive situation.

5.5 Our previous work – child deaths as a result of abuse

Since 2003, we have reviewed 80 child homicides.

In many respects, our reviews in 2008 and 2009 identified similar themes to our previous work. Most children who died were killed in family homicides (58, 73%), including a number of incidents in which the parent committed suicide or attempted to commit suicide. Most of the offenders were biological parents. Most of the children who died were very young, with the majority aged less than five years.

However there were some differences.

Compared to previous years, the families within which a child homicide occurred were less likely to have a child protection history. Previous involvement with Community Services has ranged from less than a third of families in 2004 to three-quarters of families in 2006 and 2007. In 2008, just over half of the families had been the subject of a previous risk of harm report(s) and in 2009, a third of the families had. We also saw less contact between the families and agencies that related to, or raised concerns about, the child, their family or the offender.

Between 2003 and 2007, almost half of all offenders were female with the majority being the child's birth mother. These mothers most often had a mental illness, and the homicide generally occurred in the context of a psychotic episode. In 2008 and 2009, a larger proportion of the offenders were male. While offenders displayed at least some characteristics considered to pose a risk to children, including drug and alcohol misuse, a history of violence or mental illness, and current relationship stressors, these were not evident to the degree we identified in previous years.

5.6 Preventative strategies

In previous reports, we made a range of recommendations resulting from our reviews of abuse-related deaths. The majority were targeted to government agencies in the context of their child protection responsibilities.

Developing strategies to prevent the fatal abuse of children is clearly complex. As we have previously noted, it is difficult to point to any particular family type or circumstance or combination of factors where risk is likely to escalate to fatal abuse.[30] Further, where there is a known history of risk to children within the family, it is generally acknowledged that those same risk factors are present in thousands of child protection cases which do not have a fatal outcome.[31]

In this context, efforts to prevent child deaths generally focus on improving and expanding universal services, or in a more targeted area, child protection services.

In regard to our work, it is our intention to give some specific focus to factors we commonly see in reviewing the deaths of children in circumstances of abuse, in an effort to more clearly identify where preventative strategies may be best targeted.

30 NSW Ombudsman 2009, *Report of reviewable deaths in 2007, volume 2: Child deaths*. NSW Ombudsman, Sydney, p. 47

31 Wood, Hon James, AO QC, 2008 *Report of the Special Commission of Inquiry into Child Protection Services in NSW.*, NSW Government.

6 Child deaths resulting from neglect, or suspicious of neglect

There is no nationally or internationally recognised definition of neglect.[32] It is generally agreed that failure to provide adequate nutrition, shelter, emotional support and medical care to a child constitutes neglect. Neglect is, however, often more broadly defined, with more inclusive definitions to some degree incorporating parental or carer responsibility to anticipate harm. For example:

> *Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.*[33]

In regard to a failure to prevent, or attempt to prevent, clearly dangerous activities such anticipation is reasonable. As the probability of harm decreases, it is less clear that anticipation of harm is possible, and cases in which a strict definition of neglect is applied may impose an unreasonable burden of prediction upon the carer.

The definition of neglect used by this office attempts to restrict cases of neglect to those in which the behaviour of those caring for the child indicated an obvious lack of supervision in relation to the developmental capacity of the child, or ignorance or disregard of the dangers attending some activities beyond that expected of a responsible carer. In addition to failure to provide for basic needs, we consider that a death resulting from an intentional or significant failure to adequately supervise a child, or from a significantly careless act on the part of a carer, constitutes fatal neglect.

Our reviews consider a range of factors, including evidence of the carer's own behaviour; influences that may have reduced the carer's vigilance or capacity to care for the child, such as drug or alcohol use; and other expert opinions, including those of the Coroner and medical professionals. The interaction between the carer's knowledge and motivation, and the child's developmental stage and willingness to follow the carer's instructions are also factors in determining neglect.[34]

6.1 Neglect related deaths 2008 – 2009

We identified the deaths of 31 children in 2008 – 2009 as resulting from neglect (23) or suspicious of neglect (eight). The children died in 29 separate incidents.

Most of these deaths resulted from drowning, or were Sudden and Unexpected Deaths of Infants (SUDI), particularly in the context of sleep or apparent failure to provide for basic needs of a child. Other neglect-related deaths were due to trauma from a motor vehicle crash and injuries sustained in house fires.

In the majority of cases, the incidents that resulted in the child's death had elements that constituted significant carelessness on the part of the carer, either through an action they took or through failure to supervise in clearly dangerous circumstances for the child. This might mean, for example, parental knowledge of, and failure to rectify, faulty pool fencing in addition to lack of adult supervision of children in the vicinity of the pool. It would include undue reliance on flotation devices for children unable to swim, or driving a car under the influence of alcohol or drugs, or while a child is unrestrained.

6.2 Child and family characteristics

Age, gender and cultural background

The large majority of children who died in circumstances of neglect or suspicious of neglect were very young. Of the 31 children, 26 were five years of age or younger; 21 were aged two or under, and 10 were infants less than a year old.

Age was a key factor in the circumstances of a child's death. All seven children who died in bed sharing or sleep incidents were under one, and most (13 of 14) children who drowned were three years of age or less.

32 Alexander R (ed) *Child fatality review: An interdisciplinary guide and photographic reference*. GW Medical Publishing inc, St Louis. Page 181.

33 Child Welfare Information Gateway (2009) *Definitions of Child Abuse and Neglect: Summary of State Laws*. http://www.childwelfare.gov/systemwide/laws_policies/statutes/define.cfm, accessed 16/7/2010

34 Liller, K.D. (2001) The Importance of Integrating Approaches in Child Abuse/Neglect and Unintentional Injury Prevention Efforts: Implications for Health Educators. *International Electronic Journal of Health Education*, 4: 283-289.

Nearly one third (10) of the children who died as a result of neglect or in circumstances suspicious of neglect were identified as indigenous, and four were from cultural and linguistically diverse backgrounds.

Responsibility for care and supervision

In almost all cases, family members were responsible for the care and supervision of the child at the time they died. Twenty-four of the 31 children were in the direct care of their parent(s), including a child who had been left at home unattended; and six were being cared for by extended family, including grandparents, aunts and uncles and cousins. In only two cases was the responsible carer an unrelated adult, such as a family friend (see table 12).

Table 12: Persons responsible for the care and supervision of the child

Person(s) supervising	Number of children
Mother and father	5
Mother only	12
Father only	2
Parent(s) with other persons (including siblings)	5
Other relatives	5
Unrelated carers	2
Total	**31**

Previous indicators of risk

In some of the families, we identified a number of characteristics or behaviours on the part of parents or carers that are generally considered to pose risks to children. In six of the 24 families where parents were supervising the child at the time, we identified parental mental health issues. In a quarter of the families (eight), records indicated a history of domestic violence within the family, or violence on the part of a parent of carer, and parental substance abuse was an identified issue for eight families.

While present, these issues were not necessarily relevant to the circumstances of the child's death. However in some cases, parents or carers presented with multiple risk factors that together, indicated ongoing concerns for the welfare and wellbeing of the child. This was particularly the case in relation to children who died in sleep incidents, where substance abuse, mental health issues and a history of domestic violence were all present in a number of families.

Child protection history

Eighteen of the 31 children who died in circumstances of neglect or suspicious of neglect had been the subject of at least one report of risk of harm to Community Services. In a further case, the child who died was not the subject of a risk of harm report concerning issues within the family, but the child's sibling was.

For 16 of the 18 children, risk of harm concerns had been reported within the 12 months prior to the child's death. For six families, risk was identified as being current and the case was open and allocated. In most of these families, the child who died was an infant.

For most of the families, current or previous contact with Community Services indicated a history of neglect or issues related to inadequate supervision of children, including inadequate accommodation, parental substance abuse, carer emotional or psychological state, and failure to access medical care. Domestic violence was also a commonly reported concern. These issues are discussed below, in the context of the circumstances in which children died.

6.3 Circumstances of neglect-related deaths

Of the 31 children who died as a result of neglect or in circumstances suspicious of neglect, 14 died in drowning incidents, five in transport fatalities and two in house fires. In 10 cases the deaths of children were Sudden and Unexpected Death of an Infant (SUDI), including in sleep incidents (seven) and apparent failure to provide for basic needs (three).

6.3.1 Drowning

Drowning is a common cause of death among children, particularly where natural or artificial bodies of water are close to the dwelling.[35] International research has led to estimates of between ten and twenty non-fatal drowning incidents requiring medical attention for every death.[36]

During the reporting period, 28 children died from drowning in NSW.[37] Half (14) of these deaths are included here as neglect-related.

Our reviews examined factors including the level and type of supervision at the time of the incident, the developmental stage of the child, and child-related safety arrangements. Where information was available, we also considered whether there was prior parental awareness of safety issues and hazards for children.

35 WHO (undated) *Facts about injuries: drowning*. Geneva: World Health Organization.

36 Shepherd, S.M. & Shoff, W.H. (2009) Drowning. URL: http://emedicine.medscape.com/article/772753-overview, accessed 9/6/2010.

37 The figure relates to drowning deaths that occurred in NSW in 2008 / 2009. Note the NSW Child Death Review Team provides information on deaths registered in any given year.

Four families of the child who drowned had been the subject of a previous report to Community Services and in three of these families, neglect was a concern: In two, the issue(s) reported related at least in part to inadequate supervision or neglect. In another family, concerns about neglect of siblings were reported following the incident in which a child drowned.

Reviewable drowning deaths 2008-2009

As in previous reports, and reflecting the most common circumstance in which children drown in Australia, the majority of reviewable drowning deaths (12 of the 14) in 2008 – 2009 occurred in private swimming pools.

The oldest of the children who drowned had disabilities, and the child required full adult assistance in a swimming pool. Of the other children, the average age was less than two years, with boys having an average age about a year younger than girls.

Two children, both under three years of age, fell into a body of water while unattended. In one case, the carers were apparently unaware the child was in the vicinity of water, and in another, the child fell off a boat and was not wearing a personal flotation device.

Factors identified in our reviews

In our reviews for 2008 -2009, the issues we identified mirror those in our previous report.[38] Most significantly, these are inadequate supervision and child resistant safety barriers:

Adult supervision

Inadequate supervision was a primary contributing factor in all drowning deaths. The age of the majority of the children was such that 'active supervision' would be required in or around water – that is, the adult being within arms reach of, and interacting with, the child.[39] All of the children who drowned had been left without active adult supervision. In most cases, this was in the context of the carer assuming the child was safe indoors, or with others. In two cases, some alcohol had been consumed by the primary carer, but attending police did not consider the adult to be affected by alcohol.

Seven children were not directly supervised in or around water for reportedly less than ten minutes while carers attended to other children, went to the toilet, were on the phone or computer or distracted in conversation. Three children had been left unsupervised for 20 minutes or more, and the length of time the remaining four children were unsupervised was unclear. In the 12 cases in which children drowned in backyard pools, 10 children had accessed the pool without their carer's knowledge.

Pool security: child resistant safety barriers

Records we reviewed indicated that in addition to poor supervision, most of the children who drowned in pools had easy access to the pool. The combination of poor supervision and access posed a significant and reasonably forseeable level of risk to the child:

- In six drowning incidents, the pool fence or gate was not compliant with current standards. This ranged from faulty locking mechanisms to incomplete fencing.
- Two children drowned in pools that had an automatic exemption from fencing requirements. For one pool, the exemption related to construction prior to 1990, and for the other, the size of the property.
- Two children drowned in pools after they were able to access them because an otherwise compliant gate had been propped open.

Our previous work – child drowning deaths

Between 2003 and 2007, 89 children and young people drowned in NSW.[40] Of these deaths, we reviewed 42 as occurring in neglect-related circumstances.

Our work has consistently identified the critical importance of adequate adult supervision for infants and young children around water.

As we note above, private swimming pools have been the most common site of drowning for children whose deaths we have reviewed (25 of 42 deaths). Overwhelmingly, our work has identified that inadequate supervision combined with faulty or compromised pool safety barriers – such as pool gates being propped open – resulted in the children's deaths. This was reflected in our reviews for 2008 and 2009.

The second most common site of drowning for children whose deaths were reviewable was bathtubs. In 2008 – 09 there were no child deaths attributed to bathtub drowning.

We did not identify this year, as we had previously, the influence of crowds of people – for instance at parties – on the effective supervision of children around pools. Nor did we identify children being left in the supervision of other young children, which was the case in previous years.

On average since 2003, just over half of the neglect-related drowning deaths occurred in families where there was a previous child protection history. In 2008 and 2009, one third of families had this background.

38 NSW Ombudsman 2009, *Report of reviewable deaths 2007: Volume 2: Child deaths*, NSW Ombudsman, Sydney

39 Royal Lifesaving Australia *Fact Sheet number 1 – supervise.* http://www.royallifesaving.com.au//resources/documents/Fact_Sheet_No._1_Supervise.pdf

40 NSW Child Death Review Team, 2010, *Annual Report 2009*, p 53.

Preventive measures: drowning

It is widely acknowledged that there are a number of strategies necessary to prevent the drowning deaths of children: adequate and active supervision; the maintenance of effective pool barriers or safe play areas in situations where water hazards are unfenced; water familiarisation for children; and parental / carer knowledge of resuscitation techniques.[41]

2009 Review and amendment of the Swimming Pool Act

In 2009 the Department of Local Government undertook a review of the *Swimming Pool Act 1992 (NSW)* to identify appropriate amendments to enhance the safety of children under the age of five around backyard swimming pools.[42] Subsequent amendments to the Act include:

- The removal of automatic exemptions from the requirement for child-resistant safety barriers for very small, large and waterfront properties. All new swimming pools must now have such barriers.
- A requirement that Councils investigate complaints about non-compliance with the Act.
- The provision of additional powers for Councils enabling them to undertake remedial work in situations where non-compliance with pool barrier fencing poses a significant risk to public safety.

Joint inquest into infant swimming pool drownings

In April 2010 the State Coroner's Court conducted an inquest into the deaths of eight children aged four years or less who drowned in backyard pools between June 2006 and January 2009.

The Inquest identified a number of common factors in the deaths of the eight children, including supervision of children near swimming pools and maintenance of barrier fences and gates.[43] The Coroner made a number of recommendations, including:

- Media campaigns about the need for constant supervision of children in the vicinity of pools, the need for approvals for construction or installation of pools, and the need for regular maintenance of barriers and gates and ensuring gates are never propped open.
- Development of a centralised register of private swimming pools, and a systematic plan for the regular review of all private swimming pools in NSW.
- Consideration of all exemptions from the Swimming Pools Act.
- Legislative changes in relation to obligations on owners of rental properties to ensure swimming pool and barriers are compliant.
- Implementation of systems to ensure purchasers are made aware of their obligations on purchase of an aboveground swimming pool, and sellers advise the relevant local authority of the sale of such a pool.
- Consideration of enactment of a criminal offence in circumstances where a person dies as a result of the negligence of a third party with respect to the use or maintenance of a private swimming pool.

The NSW Child Death Review Team has also recommended that local authorities be required to inspect all swimming pools notified within their area, monitor compliance with the Swimming Pools legislation, and develop and report periodically against local council plans for inspections.

We note that the Department of Local Government (now the Division of Local Government within the Department of Premier and Cabinet), in response to the Child Death Review Team's recommendation, indicated that the Minister for Local Government was considering the findings and recommendations of the Coronial Inquest discussed above, including the need for further amendments to the *Swimming Pools Act*.[44]

We will review advice regarding the Minister's consideration once it has been provided to the Team.

41 Royal Lifesaving Society 'Home Pool Safety in a Box' see *NSW Drowning Report 2010*, www.royalnsw.com.au; Queensland Commission for Children and Young People and Child Guardian 2010 *Annual Report: Deaths of Children and Young People*, Commission for Children and Young People, Brisbane, p 73.

42 Department of Local Government *Review of Swimming Pool Act,* p 2, August 2008. Accessed 21/1/11, via http://www.dlg.nsw.gov.au/dlg/dlghome/documents/Information/Swimming%20Pools%20Act%201992%20Review%20-%20Report.pdf

43 Joint Inquest Infant Swimming Pool Drownings, Magistrate P. A MacMahon, NSW Coroners Court, Glebe, 30 April 2010.

44 NSW Child Death Review Team 2010, *Annual Report 2009 Volume 2: Diseases and morbid conditions*, page 362, NSW Commission for Children and Young People 2010.

6.3.2 Sudden and Unexpected Deaths of Infants

The term Sudden and Unexpected Death of an Infant (SUDI) relates to deaths of otherwise healthy and normal infants aged less than 12 months. This includes Sudden Infant Death Syndrome (SIDS), undetermined causes of death, deaths arising from accidents or trauma where the cause of death was not known at the time, and deaths occurring in the context of an unrecognised pre-existing condition or illness.[45]

The NSW Child Death Review Team *Annual Report 2009* records 90 SUDI deaths in NSW in 2008 and 2009.[46] The majority of these were children who had been placed for sleep.

In the same period, we identified 10 SUDI deaths as neglect (three), or suspicious of neglect (seven).[47] Four of the 10 families were Aboriginal.

Eight of the infants died in sleep incidents. Three babies, including one baby who was bed sharing, died in the context of a parent's apparent failure to provide for their child's basic needs, including medical care.[48]

Reviewable SUDI deaths 2008 – 09

All of the neglect-related SUDI deaths were infants aged three months or less. Four of the children were neonates, aged from less than 24 hours to 27 days.

Seven of the infants died while co-sleeping:

- Three infants were sharing a bed with parent(s) who were drug and/or alcohol affected.
    - Two of the infants were less than a month old. One had shown signs of Neonatal Abstinence Syndrome following birth, and the other had additional risk factors, including prematurity, low birth weight and exposure to tobacco smoke. The Coroner determined the cause of death for both children as Category II Sudden Infant Death Syndrome (SIDS II).[49] Appendix 2 provides definitions for SIDS and SIDS II.
    - One infant was placed in the parent's bed for feeding, and both parents fell asleep. The cause of death for the child is undetermined.
- One infant died after being placed in the parent's bed and 'prop fed' with a bottle. The parent fell asleep. The cause of death for the child is undetermined.
- One child died as a result of bronchopneumonia, in the context of co-sleeping. Our review of the case by a medical expert indicated that the child would have been noticeably unwell prior to death, and carers would reasonably have been expected to present the child for medical attention.
- One infant was placed for sleep by the parents in inappropriate adult bedding with a number of others. The Coroner determined the cause of death to be accidental asphyxiation.
- The circumstances of another infant's death are unclear, however the child was in the parental bed when discovered deceased. The cause of death for the infant is undetermined.

One baby was sleeping in a pram filled with excessive and inappropriate bedding. The Coroner determined the child's cause of death as SIDS II.

Two infants were born following either concealed pregnancy or unrecognised pregnancy and unassisted birth, and did not appear to have been provided with the care and attention necessary to sustain life. Both babies died less than a day after birth. The cause of death for the two infants is undetermined.

45 See for example, NSW Child Death Review Team (2010), *A Preliminary Investigation in Neonatal SUDI in NSW 1996-2008: Opportunities for Prevention* NSW Commission for Children and Young People. Heather E. Jeffery, Lucia Wang & Angela Carberry, p 19

46 NSW Child Death Review Team 2010, *Annual Report 2009, Volume 1: External causes of death.* P165. This figure includes neonates (infants less than 28 days), which are not always included in definitions of SUDI. For a discussion of SUDI age ranges, see NSW Child Death Review Team, 2010, *A preliminary investigation of neonatal SUDI in NSW 1996-2008: opportunities for prevention*. NSW Commission for Children and Young People.

47 In the context of our reviewable death function, we have not included in this section the deaths of infants that are a result of, or suspicious of abuse. Two infant deaths where the cause of death at the time was undetermined have been reported as deaths suspicious of abuse. These deaths have been assessed as abuse or suspicious of abuse, and are included in section 4.

48 In reporting SUDI in this section, we have excluded three deaths of infants that were related to trauma where the cause of death was not known at the time.

49 Sudden Infant Death Syndrome (SIDS). SIDS is defined as the sudden unexpected death of a child aged under one year, with onset of a fatal episode apparently occurring during sleep, that remains unexplained after thorough investigation, including autopsy. Category II SIDS is distinguished by additional criteria, including an age below 21 days and more than nine months; similar deaths among siblings, close relatives or other infants in the custody of the same caregiver; and where mechanical asphyxia or suffocation caused by overlaying is not determined with certainty. See Perinatal Society of Australia and New Zealand 2009, *Clinical practice guideline for perinatal mortality Chapter 7: Perinatal Mortality Classifications* http://www.psanz.com.au/files/Section_7_Version_2.2_April_2009.pdf

Factors identified in our reviews

SIDS risks

Our reviews identified a number of risk factors associated with SIDS in eight of the ten families where the infant death was SUDI. There are a number of identified risks associated with infant sleeping, including:

- The position a baby is laid for sleep, with higher risks presented by placing a baby to sleep prone or on their side.
- Co-sleeping or bed sharing, particularly in the context of parental drug or alcohol use.
- Inappropriate bedding, such as sofas or inflatable beds; or too much bedding, which poses a suffocation risk for a baby.
- Exposure to tobacco smoke.[50]

A number of these elements were present in the SUDI deaths during sleep that occurred in a context of neglect.

In five of the seven co-sleeping incidents, parents were drug or alcohol affected. In three of the five families, the records we reviewed provided evidence that parent(s) had chronic drug and/or alcohol issues, including maternal substance use in pregnancy.

In four families, smoking in the household was identified as an issue in police reports of the death, with records citing poor ventilation and noticeable effects of cigarette smoke. In three of the four, police also reported the premises to be in generally filthy and neglected state. In two of these families, parents had been previously provided with advice and direction from caseworkers or nursing staff about the risks of co-sleeping (in the context of the mother's drug use), and inappropriate bedding. The children subsequently died in these circumstances.

Circumstances for parents

While the actions or inactions of parents contributed to the deaths of the children, we also identified significant social and environmental challenges being faced by the families.

Over half of the parents were very young. Six of the mothers were 22 years or younger, with four being teenagers. Three of the six mothers had had their first child at the age of 15 years. In a number of cases, the parents, particularly mothers, had a child protection history themselves. One mother was in care at the time of the baby's birth and death.

Importantly in the context of agency assessments about how parents provided for their child, four of the families were reported to be homeless or in very marginal housing circumstances at the time the infant died. One family of five, including the baby, were living in a caravan. The family had a history of transience and homelessness. Three families were living temporarily with relatives or friends, in lounge rooms, or in crowded circumstances where the family had access to only single beds or inflatable mattresses. All of the four families had been the subject of one or more risk of harm reports to Community Services. In two cases, concerns about the living conditions for two families were recorded by caseworkers, noting crowding as an issue and for one, expressing concern that 'the arrangements were *'just acceptable as a very short term alternative'*. At least two of the families were on the waiting list for public housing.

It is evident that homelessness and itinerancy would create a very difficult environment within which to ensure a newborn baby's needs were adequately met.

Notably, of the six families that had stable accommodation, three were living in public housing. For an additional family, the very young mother had a history of homelessness and transient living. At the time of the baby's death, the family were living with the father's parents in an apparent long term arrangement.

Child protection history

Eight of the 10 families who had experienced SUDI had a child protection history, which in most cases was extensive. A child protection case was open for five of the eight families, with four having an allocated caseworker.

Four of the 10 children who died had been the subject of a pre-natal report to Community Services, relating to issues including homelessness, drug use in pregnancy, lack of ante-natal care and domestic violence.

For five children, our reviews identified some concerns about Community Services' response to child protection issues in the families, the main of which were:

- Premature case closure, where risks in the family remained apparent.
- A lack of assessment where reported risks indicated further consideration of the circumstances of the child and their family was warranted.
- Lack of comprehensive risk assessment, inadequate history checks or consideration of cumulative risk.

50 see http://www.sidsandkids.org/wp-content/uploads/SidsSafeSleeping14ppa1.pdf also NSW Child Death Review Team (2010), A Preliminary Investigation in Neonatal SUDI in NSW 1996-2008: Opportunities for Prevention NSW Commission for Children and Young People. Heather E. Jeffery, Lucia Wang & Angela Carberry, p 19

Pre-natal reports

Pre-natal reporting provides an opportunity for early support and assistance to pregnant women. These reports allow services to engage early with the mother to identify problems, arrange support, and where necessary, make prompt decisions to ensure the safety and protection of the newborn baby.

In 2004, pre-natal reports were not mandatory. For cases we reviewed, we identified pre-natal reports were not leading to effective early intervention. We found such reports were often given a low response priority, and were not being consistently followed-up once the baby was born.[51]

In 2006, legislative amendment to the *Children and Young Persons (Care and Protection) Act 1998* responded to these concerns by including children subject to a pre-natal report as a mandatory risk of harm report if the birth mother of the child did not engage successfully with support services to eliminate, or minimise, the risk factors that gave rise to the pre-natal report. Community Services also developed and trialled a policy in 2008 to give effect to the legislation, *Responding to Prenatal Reports*.

As noted, in 2008 and 2009, four families were subject to pre-natal reports for the child that died. One of the four children was the subject of six pre-natal reports, and another five. In both cases, consideration was given to referring the family to an early intervention service, but the risks presented by the family's history were deemed too high. One of the families was subsequently referred to a family support service, and was linked to a substance use in pregnancy service through NSW Health. For the other families, there was little active intervention prior to the child's birth in response to pre-natal reports.

Under the *Keep Them Safe* changes, unborn children are to be reported as at risk of significant harm if these grounds exist to a 'significant extent'. *Keep Them Safe* commits to closely monitoring the statutory and policy changes which have been made in relation to pre-natal reporting, and to ensure they are fully evaluated.[52]

- Lack of response to prenatal reports, representing missed opportunities to engage families with support services or early intervention.
- Inadequate support to young parents, themselves under the parental responsibility of the Minister.

The agency's Child Death and Critical Reports Unit also reviewed these deaths and identified similar concerns. The reviews recommended strategies to address these concerns, including practice and case reviews to incorporate lessons from the cases into current policy and practice.

Our previous work – deaths of infants in co-sleeping incidents

Between 2003 and 2007, we reviewed the deaths of 27 infants in co-sleeping incidents.

Similarly to our findings for 2008 and 2009 SUDI, the majority of these babies were aged less than three months and a significant number (10 of 27) were Aboriginal. We also identified that many of the infants had been exposed to risk factors associated with SUDI, including co-sleeping with substance-affected adults, being placed in inappropriate bedding, exposure to tobacco smoke, and maternal substance use in pregnancy.

Again, reflecting our reviews in 2008 and 2009, three-quarters of the families (21) had a previous child protection history, with many of the families reported for concerns about parental substance abuse, domestic violence and neglect. Just under half of these families had been the subject of a pre-natal report of harm to Community Services, concerning the baby who died.

Preventative measures: SUDI and SIDS

Modifiable risk factors associated with infant sleep have been the subject of major campaigns over the last decade, and NSW – along with other states and internationally – has seen a decrease in SIDS deaths. Nationally, the SIDS and Kids Safe Sleeping campaign is an evidence-based health promotion campaign which aims to reduce the rates of SIDS and fatal sleeping accidents. The campaign promotes key messages to promote:

- Sleep baby on the back from birth;
- Sleep baby with face uncovered;
- Avoid exposure to tobacco smoke before and after birth;
- Provide a safe sleeping environment; and
- Sleep baby on its own in a safe sleeping environment next to the parent's bed for the first 6 – 12 months.

Since its inception in the early 1990's, the campaign has reduced the incidence of SIDS by 85% saving over an estimated 6000 babies' lives.[53]

51 NSW Ombudsman (2007) *Report of reviewable deaths in 2006: Volume 2: Child deaths*, p9.
52 NSW Government 2009, *Keep Them Safe: A shared approach to child wellbeing*, p.11
53 SIDS and Kids *Safe Sleeping,* accessed via http://www.sidsandkids.org/safe-sleeping/

Child protection measures

In a child protection context, and following an internal review of co-sleeping deaths of children reported to the agency, Community Services developed a *'Safer Sleep'* resource pack to assist caseworkers to highlight the risks of co-sleeping with parents and carers, and to promote safe sleeping options.[54] The agency has also developed similar resources targeted specifically to Aboriginal families.

Keep Them Safe initiatives of particular relevance include the expansion of health home visiting services to work intensively with vulnerable families in pregnancy and in the first two years of the child's life.

In addition, NSW Health provides services for pregnant women with substance abuse problems. Following a recommendation arising from our reviewable deaths work, the Department undertook a comprehensive review of substance use in pregnancy services in 2009, and a substance use in pregnancy advisory committee was established in 2010 to, among other things, oversee the development and implementation of a NSW standard of care for these services (see 7.2.2 below for more details).

6.3.3 Transport fatalities

Transport related deaths are the most common external cause of death for children and young people in New South Wales.[55]

In 2008 and 2009 we identified five transport deaths as neglect-related. Four children or young people were passengers when the vehicle they were in crashed, and one child was a pedestrian. The deaths occurred in four separate incidents.

Relevant factors in our consideration of whether a transport-related death constitutes neglect on the part of a carer include evidence that the parents or carers were driving while substance affected, driving dangerously, and whether and how children were restrained in the vehicle.

As our definition of neglect focuses on the actions of parents and carers we do not include the deaths of teenagers where they or a peer are driving, or of older children as pedestrians where it is appropriate for the child not to be supervised by an adult.

Reviewable transport deaths 2008 and 2009

Of the five children who died in transport incidents, two were under three years of age and three were aged between 13 and 15 years.

Four children who died in three incidents were passengers. The three drivers were the child's parent, a close relative, and an unrelated and informal carer.

One child who died in a pedestrian incident was related to the driver of the car.

Of the four incidents, three occurred during in daylight hours. However, in one of these cases, the crash occurred in torrential rain. The fourth incident occurred in the morning before dawn.

Factors identified in our reviews

Speeding is the most common factor contributing to vehicle crashes. A blood alcohol level over the legal limit, or driving while fatigued are also significant contributors.[56] Other relevant factors include poor road conditions and substandard vehicle safety. Proper use of restraints is widely acknowledged as the primary protection measure in case of a vehicle crash.[57]

Our reviews identified that speed was a factor, or possible factor in relation to three incidents. In all three crashes this was combined with other dangerous behaviour:

- One child died in a crash that occurred at high speed while the driver was attempting to overtake another car in very poor weather conditions. The child was unrestrained, and sharing the front seat of the car with another person.
- Two children died in the same incident when the driver lost control of an unregistered vehicle in which there were more passengers than seatbelts; both children were wearing seatbelts.
- One child, a passenger on a motorbike, died when the driver failed to negotiate a sweeping bend in the road. The driver had a blood alcohol level well over the legal limit.

In the fourth incident where the child was a pedestrian, the driver of the vehicle tested positive for cannabis and alcohol, with expert evidence noting the levels found would have been sufficient to impair the driver's ability to drive. The driver had a history of substance abuse.

54 Community Services 2008 *Inside Out* September / October 2008 http://www.community.nsw.gov.au/about_us/news_and_publications/community_services_news/archives/child_protection_week_2008.html

55 NSW Child Death Review Team (2010) *Annual Report 2009*, NSW Commission for Children and Young People, p 22

56 Roads and Traffic Authority (2010) *Annual Report 2010*, Department of Transport, NSW Government, p 50

57 Roads and Traffic Authority (2011) *Seatbelts*, accessed http://www.rta.nsw.gov.au/roadsafety/seatbelts/index.html

Child protection history

Three of the five children who died in transport incidents had a child protection history. While the reported issues were not directly relevant to the circumstances of the children's deaths, the family histories did indicate a care environment characterised by carer drug and alcohol use, inadequate supervision or risk taking. For example, in relation to the incident in which a pedestrian died, the vehicle was also transporting children who were unrestrained. One of the children killed in a pre-dawn crash was 13 years of age, had been at a party and was in a vehicle in which other children were unrestrained.

Our previous work – transport fatalities

Between 2003 and 2007, 256 children and young people died in transport fatalities in NSW: 130 as passengers in vehicles, and 52 as pedestrians.[58] We reviewed 11 of these deaths as neglect-related. Most of the children (nine) died as passengers in vehicles that were being driven by their parents or carers.

Overall, our reviews noted an association between adverse environmental conditions, including wet roads, poor visibility and unexpected hazards, and impaired driving skills as a result of substance use or fatigue. Lack of, or inadequate, restraint of children in the vehicle was also a factor in four of the crashes, as was excessive speed. These factors were also evident in 2008 and 2009.

As in 2008 – 09, a number of families (four of the 11) had a previous child protection history.

Preventative measures

Speed and alcohol are well recognised causes of transport fatalities.

The NSW Centre for Road Safety, established in 2008 and part of the NSW Roads and Traffic Authority, has a mandate to *'change cultural values on road safety in NSW'*, targeting strategies to 'safer roads, safer people, safer vehicles'. The Centre has undertaken a number of campaigns to address speeding, drink driving and other driving risks.[59]

The need for adequate restraints for children travelling in vehicles has also been the subject of recent legislative change. New requirements for child restraints came into force through an amendment to the *Road Rules 2008 (NSW)*.[60] The new Rules introduce an age-graduated system which requires

- Children younger than six months to be secured in rearward facing restraints;
- Children between six months and four years to be secured in either a rear or forward facing restraint; and
- Children between four and seven years to be secured in forward facing child restraint or booster seat.

6.3.4 House fires

Fatal house fires do not happen frequently, but they occur regularly. In NSW 17 people died in building fires in 2006-07.[61]

In 2008 and 2009 we identified the deaths of two children in two separate house fires as neglect.

Our reviews took into account the level and type of supervision at the time of the incident, the capacity and developmental stage of the child, and measures to restrict children's access to hazards. Where information was available, we also considered whether there was prior parental awareness of safety issues and hazards for children.

Reviewable deaths – house fires 2008 and 2009

The two children who died were both less than five years of age. Both children were in the care of either one or both of their parents when the incident occurred. In one case, the child was awake while the parents were sleeping and in the other, it is unclear whether the child was being actively supervised. In one case the child lit the fire themselves and in the other it appears that a sibling started the fire.

In both cases, the child had access to lighters and had some history of interest in fire, or attempts to light fires.

Factors identified in our reviews

Children will often find fire fascinating, and the NSW Fire Brigade has estimated that 10 per cent of fires in the state are started by children.[62]

In both cases, parents and other adults smoked in the house and lighters and matches were kept

58 NSW Child Death Review Team 2010, *Annual Report 2009*, NSW Commission for Children and Young People, p 71. Other transport fatalities included driver crashes and pedal cycles.

59 See http://www.rta.nsw.gov.au/roadsafety/index.html

60 *Road Amendment (Isabelle Broadhead Child Restraint Measures) Rules 2010*

61 NSW Fire Brigade (2007) *Annual Statisitcal Report 2006-07*, accessed http://www.nswfb.nsw.gov.au/page.php?id=171, Table 31 http://www.nswfb.nsw.gov.au/page.php?id=597

62 NSW Fire Brigade (2007) *Children and Fire Fascination*, accessed http://www.nswfb.nsw.gov.au/page.php?id=307

within accessible reach of the children. Both families were reportedly aware of their child's interest in fire. One family advised police that they had previously attempted to explain the danger of fire to the child.

Both homes were described as filthy by various agencies. One house was reported as having toys, clothes and rubbish on the floors and household items piled half way up the wall of one room. Squalor can increase the risk and severity of fire as it provides more fuel to burn.[63]

Both houses had smoke alarms installed; one sounded when the fire occurred, for the other it is not clear if it sounded or was in working order.

Child protection history

Both children had child protection histories and both had been the subject of recent risk of harm reports to Community Services.

The risk of harm reports, when taken together, reveal a persistent theme of neglect. Reported concerns included parenting capacity, inadequate supervision, clothing and shelter, filthy home environment, failure to provide medical treatment, domestic violence, and parental substance abuse.

Our reviews identified concerns about the adequacy of Community Services' response to issues of neglect, especially in recognising cumulative risk and remaining child-focused in the context of chaotic family circumstances.

One family was referred to Brighter Futures, but was assessed as being too high risk for the program. The family was referred to a family support service with whom they were engaged at the time of the child's death. Community Services had commenced a secondary assessment that was not complete at the time of the child's death.

The family of the second child had been the subject of 15 risk of harm reports over two and a half years. None of the reports received comprehensive assessment and 12 of the reports were closed due to competing priorities. Community Services' Child Death and Critical Report Unit also reviewed this death and found that the agency had not engaged with the central question of whether the care provided was adequate for the children's needs, particularly in the context of chronic neglect.

Our previous work – house fire fatalities

Twenty five children died in house fires in NSW between 2003 and 2007.[64] We reviewed five of these deaths as occurring in circumstances of neglect. The five children died in two separate fires.

Common with 2008 and 2009 deaths, the key factor we identified in our reviews was inadequate supervision of children and in one review, inadequate supervision coupled with access by children to lighters and matches.

Both families had a child protection history, which included concerns about inadequate supervision.

Preventative measures

Adequate supervision, safe storage of matches and lighters, modelling of safe fire behaviour and explaining the risks associated with fire are identified as important strategies in minimising fire fascination in children.[65]

Since 2006 legislation has required all residential dwellings to have smoke alarms. To ensure they are maintained properly the NSW Fire Brigade run the *'change your clocks, change your smoke alarm batteries'* campaign to encourage people to change their batteries at the end of Daylight Saving each year.

In a child protection context, *Keep Them Safe* has a focus on intervening early with vulnerable families, and strengthening early intervention and community based services to do so.

63 Ibid
64 Information drawn from the child death register maintained by the NSW Child Death Review Team.
65 Ibid

7 Deaths of children in care

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the definition of 'child in care' is broad. In addition to children who are the subject of a statutory care order, the definition includes children who are in supported relative or kinship care, and children in voluntary out-of-home care and disability accommodation services.

We review the deaths of children in care with a view to identifying systemic issues and trends, with a focus on how such deaths may be prevented or reduced. In reviewing the death of a child in care, we consider any information that may be relevant to the circumstances of the child's death. Depending on the child's situation, we may consider their care arrangements and support needs, case management and service provision. We also consider any reviews undertaken following the child's death by agencies that were involved with the child.

7.1 Changes to the provision of out-of-home care

As noted, the period of time covered by this report coincides with the Special Commission of Inquiry into Child Protection Services in NSW and the release and implementation of *Keep Them Safe*. In addition to child protection strategies, certain initiatives within *Keep Them Safe* are focused on improving the system of out-of-home care.

Currently, out-of-home care is mainly provided or arranged by Community Services. A key recommendation of the Special Commission of Inquiry was that most out-of-home care services be transferred to the non-government sector, over the three to five years. *Keep Them Safe* supported this recommendation in principle, and the (then) government undertook to develop a plan to gradually increase non-government provided out-of-home-care.

In 2009, Community Services, NSW Treasury and the Department of Premier and Cabinet commissioned the Boston Consulting Group to examine the cost drivers in out-of-home-care and identify measures to address expenditure increases. In response to the review, Community Services developed the Major Change Program, a comprehensive plan intended to build on the *Keep Them Safe* reforms, stabilise the increasing numbers of children entering care, and promote quality out-of-home care.

The *Keep Them Safe* plan included improved safeguards for children in voluntary out-of-home care, many of whom have disabilities. Legislation introduced in January 2010 is intended to improve the consistency and quality of intake, assessment, case planning and interagency coordination for children in voluntary out-of-home care and their families. The legislation gives the Children's Guardian a role in developing certain procedures for voluntary out-of-home-care providers and enables the Guardian to monitor their service provision.

Also as a result of the Special Commission of Inquiry and *Keep Them Safe*, initiatives intended to improve the health outcomes for children in out-of-home care are underway. NSW Health and Community Services have developed a Health Screening and Assessment Pathway model that provides access to health screening, assessment, intervention and review and the development of health management plans, to ensure that children entering out-of-home care receive necessary health screening, assessments and care.

7.2 Children in care who died during 2008 and 2009

Twenty children who died during this reporting period were in care.[66]

The majority of the 20 children (17) died as a result of natural causes. Most (15) of these children had high or complex needs relating to disabilities and/or chronic health issues. Overall, we found that the children who died of natural causes had received adequate care and support.

Three of the 20 children died from external causes, including suicide (two), and a motor vehicle crash.

The majority of the 20 children (16) had a child protection history, including a number of the children with disabilities who were in voluntary care. Four children in voluntary disability accommodation had no child protection history.

Age, gender and cultural background

Most of the 20 children in care died either when they were very young or during adolescence:

- Four children were more than 28 days old and under one year old
- Four children were aged 1-4 years

66 We have not included one child as a death 'in care' who died as a result of suspected non-accidental injury. This child's care was assumed by Community Services as a result of the incident which ultimately led to his death in hospital. The child was never placed with carers. This child's case is included in our report of deaths resulting from abuse or suspected abuse in section 4.

- One child was 5 years old
- Three children were aged 10-14 years
- Eight children were aged 15-17 years.

Almost three-quarters (17) of the children were male. Over a third (eight) of the children were Aboriginal which is largely consistent with the proportion of Aboriginal and Torres Strait Islander children in the care population (33%).[67]

One child was from a culturally and linguistically diverse background.

Parental responsibility and care status

Ten of the children in care were subject to final orders of the Children's Court:

- Parental responsibility for seven children was allocated to the Minister for Community Services until 18 years of age.
- Two children were subject to short term (two year) care orders allocating parental responsibility to the Minister, with a view to restoration. Both of these children had been restored prior to their death and while the care order was still current.
- Parental responsibility for one child was allocated to a relative with whom the child lived.

Three children were subject to interim Children's Court care orders, with court proceedings underway when the child died. This includes three infants who were born prematurely and with significant health problems. In each case, Community Services assumed the child's care due to child protection concerns following their birth and while the child was still in hospital.

Seven children were in voluntary care. Six of these children had significant disabilities. Three had a child protection history.

Placement at time of death

Children placed in a disability accommodation service

Seven of the 20 children were living in, or temporarily absent from, a disability accommodation service provided or funded by Ageing, Disability and Home Care:[68]

- Three children died in respite care. In all three cases, the child lived primarily with their family and the placement was voluntary.
- Two children usually lived in a disability accommodation service and died in hospital.
- One child died in a palliative care unit operated by the disability accommodation service where the child had lived for some years prior.
- One child died while placed with a host family.

The children placed in disability accommodation services ranged in age from one to 17 years; the majority (five) were adolescents aged 13 to 17 years. Two of the seven children were in statutory care; five children were in voluntary care.

Children in out-of-home care placements provided or funded by Community Services

Nine of the 20 children in care were residing in placements provided or funded by Community Services:

- Four children were living in relative/kinship care supported by Community Services, including three children who were placed with their grandmothers.
- Four children were living in foster care provided by non-government agencies.
- One child was placed in a 'high needs' placement with 24 hour one-to-one supervision provided by a non-government agency.

The majority (seven) of the nine children were in statutory care; two children were in voluntary care living with grandparents and supported by Community Services. Six of the nine children had significant disability and/or chronic health issues.

The age of the children in placements provided or funded by Community Services ranged from 20 days to 17 years; just over half of the children (five) were aged 15-17 years.

Other placement arrangements

As previously stated, two unrelated children were restored to their parents but were still subject to a statutory care order at the time they died. These two children had case plans supporting restoration and were supervised by Community Services. Both children died in hospital.

Two infants who died in hospital had never been discharged from hospital after their birth.

67 NSW Department of Human Services, Community Services (January 2011) *Annual Statistical Report 2009/10*, p 59
68 The deaths of these children will also be included in the report of reviewable disability deaths.

7.3 Deaths of children in care due to diseases and morbid conditions

The majority of the 20 children (14) died as a result of complications of multiple disabilities and related health issues (10), or congenital or degenerative disorders (four). The children had disabilities including Rhetts syndrome, Duchenne muscular dystrophy, cerebral palsy, mitochondrial disorder, and spastic quadriplegia. Associated health conditions included epilepsy, diabetes and chronic lung disease. Eight of the children were fed through percutaneous endoscopic gastrostomy (PEG) tube.

Two children, who were previously healthy, died unexpectedly from natural causes: one died of encephalitis, possibly secondary to chicken pox; the other of a cardiac arrest of unknown cause.

One child died as a result of complications arising from extreme prematurity.

At the time of writing, the coronial process had been finalised for ten of the 17 children in care who died from natural causes. The Coroner dispensed with an inquest in each of these ten cases.

Factors identified in our reviews

As stated, we found that the children who died of natural causes had, in the main, received adequate care and support from service providers, including disability service providers and health services. In two cases, we made reports to agencies to bring their attention to issues which were unrelated to the child's death.

Our review of the death of a child in disability respite care found that there was a lack of documentation and planning to manage identified risks associated with the child's disability and complex health needs, and a lack of communication between support agencies. We found there had been some intervention by Ageing, Disability and Home Care practitioners; however there were no documented risk management plans, assessments or a health care plan for the child. We wrote to the respite service and Ageing, Disability and Home Care about our review findings. The respite service advised us that since the child's death, a number of positive changes had been put in place, including improved communication with Ageing, Disability and Home Care.

Our review of the death of a child in disability respite care identified concerns regarding Community Services' response to child protection reports for the child and the child's siblings. In the six months prior to child's death, 11 reports of risk of harm for the child and the child's siblings had been made to Community Services. The case was subsequently allocated for assessment by the agency, however, little assessment or casework had occurred and no case plan was in place when the child died. We wrote to Community Services and, independently, Community Services completed an internal review. As a result of the circumstances surrounding the child's case, Ageing, Disability and Home Care and Community Services developed a joint local protocol to manage shared cases. The protocol involved Ageing, Disability and Home Care working as secondary caseworker and being involved in all aspects of casework. Community Services undertook to assess the child's siblings and develop a case plan for them.

7.4 Deaths due to external causes

Three children in care died as a result of external causes. At the time of writing, the coronial process was underway in each case.

One child died as a result of injuries sustained as a passenger in a motor vehicle crash. The driver of the vehicle, an unrelated young person, was convicted of offences related to dangerous driving causing death, driving a vehicle without consent and being an unaccompanied learner driver.

Two teenagers committed suicide. Both children were under the parental responsibility of the Minister until the age of 18, as a result of ongoing care and protection concerns. Both children were case managed by Community Services and placed with non-government out-of-home care service providers.

Factors identified in our reviews: suicide

The two teenagers whose deaths were suicide had a history of self-harm and suicidal behaviour and identified high needs in relation to their behaviour and mental health. The two teenagers had received support from mental health services and had also demonstrated a degree of non-compliance with mental health recommendations, including compliance with prescribed medication.

The circumstances of these two teenagers highlight the challenges and difficulties faced by agencies working with children and young people who have intensive support needs, challenging behaviours and complex mental health issues. In both cases, our review identified a need for improvement in certain areas, including:

- Suitably qualified staff, with ongoing and appropriate training and supervision, to work with children in care with high/intensive needs;
- Assessment, identification and timely responses to the needs of children in care; and

- Collaboration, communication and information sharing between key agencies involved with children in care, including Community Services, non-government out-of-home care service providers, schools and health services (particularly mental health services).

For each of the two teenagers, we found that internal reviews conducted by agencies after the teenager's death were comprehensive and identified relevant issues and opportunities for improvement in service provision.

In one case, Community Services' recommended the supervising Community Services Centre convene a meeting with health services to examine the management of the case and to develop a plan to improve service delivery to children in statutory care. The out-of-home care agency made a number of recommendations aimed at improving its practice, policy and procedures relevant to issues the review identified. These issues included carer assessment, authorisation and review; staff supervision and support; and assessment of, and attention to, the child's needs.

In the second case, Community Services recommended that the region facilitate a case practice discussion between relevant managers and caseworkers to consider identified practice and systemic issues and ways to incorporate learning from the discussion into casework practice.

Our previous work: suicide of young people in care

Between 2003 and 2007, 73 young people in NSW committed suicide.[69] We identified that three of these young people were in statutory care at the time of their death.

Similar to the young people in care who committed suicide in 2008 and 2009, two of the young people had been identified as at risk of suicide prior to their deaths, and all three had high needs in relation to challenging behaviour and mental health problems.

The issues we identified in 2008 and 2009 were also reflected in these earlier reviews, particularly the need for appropriately trained and qualified staff to work with young people in care who have high needs; the critical importance of timely assessment and effective response to identified needs for intervention; and the need for effective collaboration between relevant agencies, particularly in relation to mental health and suicide risk.

7.5 Preventative measures

In relation to children with disabilities, the Special Commission of Inquiry into Child Protection Services in NSW acknowledged that *'…the intersection between children and young persons with a disability and their families, and child protection issues can be a fraught and troubled area.'*[70] A number of recommendations arising from the Inquiry were directed at developing shared responsibility between Community Services and Ageing, Disability and Home Care.

Keep Them Safe notes that there are complex issues associated with disability support in the context of child protection, and acknowledges the need for greater collaboration between Community Services and Ageing, Disability and Home Care. To this end, the agencies have implemented joint training of managers and staff of both agencies on the Community Services and Ageing, Disability and Home Care Memorandum of Understanding on Children and Young People with a Disability, and developed a model for joint recruitment and training of foster carers.

Keep Them Safe also undertakes to develop additional models of out-of-home care for children and young people with disabilities. Community Services and Ageing, Disability and Home Care have commenced a project in this regard and established a reference group to support the project.

In regard to high needs adolescents, the Special Commission of Inquiry into Child Protection recommended that there should be sufficient numbers of care options for children and young persons with challenging behaviours that include specialised models of therapeutic care.[71] *Keep Them Safe* has supported this recommendation in principle, acknowledging existing models of care were insufficient for a small number of children in out-of-home care. *Keep Them Safe* commits to the development of new models of care for these children.[72]

69 NSW Child Death Review Team 2010, *Annual Report 2009*, NSW Commission for Children and Young People, p 145
70 Hon James Wood AO QC (2008) *Special Commission of Inquiry into Child Protection Services in NSW*, p874
71 Hon James Wood AO QC (2008) *Special Commission of Inquiry into Child Protection Services in NSW*, p 690
72 NSW Government 2009, *Keep Them Safe - a shared approach to child wellbeing 2009 - 2014*, p 81

8 Monitoring recommendations

Since our last report, we have monitored the implementation of outstanding or ongoing recommendations made in previous reports, one of which was directed to the NSW Police Force and others to NSW Health.

8.1 NSW Police Force: Child Protection Code of Practice

In our 2009 report, and in relation to our recommendations, we noted the advice of the NSW Police Force (NSWPF) that a number of the agency's strategies for improving child protection responses had been put on hold, pending the outcome of the Special Commission of Inquiry into Child Protection Services. One of these was the development and implementation of the police *Child Protection Standard Operating Procedures*.

The NSWPF originally advised us of their intention to review the procedures in 2006. In our view, the Standard Operating Procedures were important for providing frontline police with appropriate and consistent guidance when dealing with children at risk. Our reviews had identified issues relating to compliance with requirements to report risk of harm, and the type of information being provided by police to Community Services.[73]

Throughout 2010, this office was involved in discussions with, and provided comment to, NSWPF regarding the revision of the operating procedures, which are now referred to as the *Child Protection Code of Practice-the Investigation of Child Abuse and Neglect*.

In December 2010, NSWPF advised us that the *Code of Practice* had been subject to a substantial review and was awaiting endorsement. NSWPF anticipated that this process would be finalised by July 2011.

We welcome the advice that the Code of Practice is expected to be endorsed soon. Since our initial recommendation in 2006, the roll out of *Keep Them Safe* has given rise to significant new responsibilities and obligations for all agencies, including NSWPF. In this context, clear operating guidelines for frontline police dealing with children at risk of harm are essential.

We will await the endorsed Code of Practice.

8.2 NSW Health: Parental substance abuse

In our *Report of Reviewable Deaths in 2007* we detailed NSW Health's progress in implementing strategies the Department had put in place to address previous recommendations, particularly in relation to parental substance abuse.

In 2010, we sought advice from the Department in relation to two specific strategies that we considered remained highly relevant in the post-*Keep Them Safe* environment: the Department's Review of Substance use in Pregnancy Services, and its audit of methadone take-away doses in 2008.

Substance use in pregnancy services

In our *Report of Reviewable Deaths in 2005*, we identified that there appeared to be no central coordination, monitoring or review of the various drugs in pregnancy services across NSW, and there were no common standards or benchmarks for service delivery.

In response to our recommendations, NSW Health conducted an independent review of these services in 2009. The review proposed a number of strategies to develop a more consistent approach to supporting women in pregnancy where substance abuse is an issue, and for ensuring a consistent standard of care.

In 2010, NSW Health provided further advice on these strategies. Of note:

- In February 2010, an advisory committee was convened with the key objective of overseeing the development and implementation of the recommendations of the Review. The committee meets quarterly.
- Funding has been provided to a consortium of clinicians to develop a state wide consensus dataset for Substance Use in Pregnancy Services and to establish a single state wide on-line database. NSW Health advised that this should be completed in July 2011 and that it will form the basis for the establishment of a standard of care for substance use in pregnancy services.
- In October 2010 a survey of substance use in pregnancy services was undertaken to ascertain service capacity, current demand and workforce development requirements. The department advised that the results from this survey will be used to direct resources to areas of greatest need.

73 NSW Ombudsman 2006 *Report of reviewable deaths in 2005, Volume 2: Child deaths*, p 58.

The Review also indicated that further work was required regarding the level of awareness, knowledge and compliance with the *Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn*; and that the Guidelines needed updating to reflect changes to the National Health and Medical Research Council Guidelines regarding alcohol use in pregnancy; recent findings with respect to the safety of buprenorphine use in pregnancy; changes to the child protection system in NSW; and to ensure that the Guidelines were applicable for use in rural and remote parts of NSW. It was also noted that the Guidelines had not been broadly disseminated.

NSW Health advised that the Mental Health Drug and Alcohol Office has commissioned the National Drug and Alcohol Research Centre to undertake a NSW revision of the National Guidelines and to develop a dissemination and implementation strategy. The project is expected to be complete in July 2011.

We note the positive work undertaken by the Department in implementing the recommendations arising from the Review.

Census of methadone take-away doses in 2008

In 2006, the Department released new guidelines: *NSW Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*. These guidelines strengthened focus on the management of clients with dependent children. We asked NSW Health to advise us how it would monitor compliance with the new guidelines, particularly in relation to contra-indications for take-away doses for clients with children in their care.

Among other strategies, NSW Health advised that it would conduct a one-week census in 2007 of prescribed methadone take-away doses and observed doses across NSW, with the objectives of measuring the adherence of prescribers to the Guidelines, and informing policy development around methadone take-away dosing.

In 2008, the Department conducted another census and provided us with its report in 2010.

In response to our request for information about any policy changes or clinical investigations arising from the audit, NSW Health advised:

- The majority of prescribers are prescribing within the guidelines and do not require follow-up.
- Prescribers who demonstrated a 'moderate' rate of prescribing outside of the Guidelines and those who were found to be prescribing outside of the Guidelines for a significant number of their patients were contacted about their results, and were re-audited in October 2010. Providers who were found to be prescribing outside of the Guidelines for a significant number of their patients were also involved in a clinical visit by the Mental Health Drug and Alcohol Office Drug and Alcohol Clinical Advisor.
- NSW Health indicated that the results of the follow-up audit are being analysed to determine the level of compliance with the Guidelines, and to outline key recommendations.

We note the positive work undertaken by the Department in implementing the audit and responding to its findings.

Appendix 1

Reviewable Child Deaths Advisory Committee: membership to February 2010

Until being disbanded in February 2010, the Advisory Committee members were:

Mr Bruce Barbour: Ombudsman (chair)

Mr Steve Kinmond: Deputy Ombudsman, Community and Disability Services Commissioner, Community Services Division

Dr Judy Cashmore: Associate Professor, Faculty of Law, University of Sydney; Honorary Research Associate, Social Policy Research Centre, University of New South Wales; Adjunct Professor, Arts, Southern Cross University.

Dr Ian Cameron: CEO, NSW Rural Doctors Network

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

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

Dr Bronwyn Gould: Child protection consultant and medical practitioner

Ms Pam Greer: Community Worker, trainer and consultant

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

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

Ms Toni Single: Clinical Psychologist, former Senior Clinical Psychologist, Child Protection Team, John Hunter Hospital, Newcastle

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

Appendix 2

Definitional approach to Sudden Infant Death

General Definition of SIDS

SIDS is defined as the sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

Category IA SIDS: Classic Features of SIDS Present and Completely Documented

Category IA includes infant deaths that meet the requirements of the general definition and also all of the following requirements.

Clinical

- More than 21 days and <9 months of age.
- Normal clinical history, including term pregnancy (gestational age of ≥ 37 weeks).
- Normal growth and development.
- No similar deaths among siblings, close genetic relatives (uncles, aunts or first-degree cousins), or other infants in the custody of the same caregiver.

Circumstances of Death

Investigation of the various scenes where incidents leading to death might have occurred and determination that they do not provide an explanation for the death. Found in a safe sleeping environment, with no evidence of accidental death.

Autopsy

Absence of potentially fatal pathologic findings. Minor respiratory system inflammatory infiltrates are acceptable; intrathoracic petechial haemorrhage is a supportive but not obligatory or diagnostic finding.

No evidence of unexplained trauma, abuse, neglect, or unintentional injury.

No evidence of substantial thymic stress effect (thymic weight of <15g and/or moderate/severe cortical lymphocyte depletion). Occasional "starry sky" macrophages or minor cortical depletion is acceptable.

Negative results of toxicologic, microbiologic, radiologic, vitreous chemistry, and metabolic screening studies.

Category IB SIDS: Classic Features of SIDS Present but Incompletely Documented

Category IB includes infant deaths that meet the requirements of the general definition and also meet all of the criteria for category IA except that investigation of the various scenes where incidents leading to death might have occurred was not performed and or ≥ 1 of the following analyses was not performed: toxicologic, microbiologic, radiologic, vitreous chemistry, or metabolic screening studies.

Category II SIDS

Category II includes infant deaths that meet category I criteria except for ≥ 1 of the following.

Clinical

Age range outside that of category 1A or 1B (i.e., 0-21 days or 270 days [9 months] through first birthday).

Similar deaths among siblings, close relatives, or other infants in the custody of the same caregiver that are not considered suspect for infanticide or recognised genetic disorders.

Neonatal or perinatal conditions (for example, those resulting from preterm birth) that have resolved by the time of death.

Circumstances of Death

Mechanical asphyxia or suffocation caused by overlaying not determined with certainty.

Autopsy

Abnormal growth and development not thought to have contributed to death.

Marked inflammatory changes or abnormalities not sufficient to be unequivocal causes of death.

Unclassified Sudden Infant Death

The unclassified category includes deaths that do not meet the criteria for category I or II SIDS but for which alternative diagnoses of natural or unnatural conditions are equivocal, including cases for which autopsies were not performed.

Post-resuscitation cases

Infants found in extremis who are resuscitated and later die ("temporarily interrupted SIDS") may be included in the aforementioned categories, depending on the fulfilment of relevant criteria.

Source:

Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality; Second Edition, Version 2.2, April 2009. Section 7: Perinatal Mortality Classifications; Appendix 1:

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