NSW Ombudsman

Report of Reviewable Deaths in 2007

Volume 2: Child Deaths

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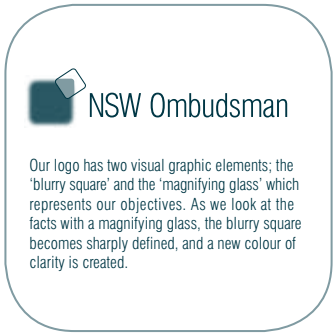

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ISBN 978-1-921132-36-0 ISSN 1832 1674

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April 2009

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

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

Dear Mr President and Mr Speaker

I am pleased to present the NSW Parliament with volume two of our fifth report on reviewable deaths. This volume concerns the deaths of certain children.

The report contains an account of our work and activities and is made pursuant to s.43 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. The report includes data collected, and information relating to, reviewable deaths that occurred in the period ending December 2007; our recommendations; and information with respect to the implementation or otherwise of previous recommendations. The report includes material on developments and issues current at the time of writing.

I recommend that this report be made public forthwith.

Yours faithfully

Bruce Barbour
Ombudsman

Ombudsman's message

This is the fifth report since my office assumed responsibility for reviewing the deaths of certain children at the end of 2002.

In part, this report concerns the reviewable deaths in 2007 of 162 children. In addition, we have included the findings of a special review of almost 50 children who had no child protection history and who died during the five years from 2003 to 2007. These children died of abuse or neglect, or in suspicious circumstances.

We prepared the report during the course of the Special Commission of Inquiry into the child protection system in NSW. The Commission reported its findings in late 2008 and the NSW Government released its action plan in response to the recommendations in March 2009.

In April, the Children Legislation Amendment (Wood Inquiry Recommendations) Bill 2009 was passed by the NSW Parliament.

The passage of the legislation paves the way for the child protection system to undergo major change. Among other changes, the reporting threshold for statutory child protection intervention will be limited to reports that a child is at 'risk of significant harm'. To assist children and families below this threshold, there will be a realignment of roles and responsibilities among government agencies, and a bigger role in child protection for non-government organisations. The changes are significant and represent a fundamental shift in the way we collectively respond to vulnerable children and families.

The work of this office will also be affected by the recommendations of the Inquiry, and it is these changes that I will reflect upon here.

The Special Commission of Inquiry made three related recommendations in regard to child death reviews.

First, it recommended that DoCS should review the deaths of children, or siblings of children, reported to the department within three years of their death.

Second, that the Ombudsman's power to review these deaths should be repealed. The Inquiry recommended that instead, my review function should be limited to the deaths of children who died as a result of abuse, neglect or in suspicious circumstances.

Thirdly, the Inquiry recommended that the Child Death Review Team (CDRT) should transfer from the NSW Commission for Children and Young People to my office.

In the context of the proposed transfer, the Commission of Inquiry noted that scrutiny of reviewable child deaths could 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'. In addition, the Commission indicated that those deaths to be removed from my jurisdiction would still be the subject of scrutiny by the transferred CDRT and that information from these deaths could inform child protection work.

I am pleased that all three recommendations have been endorsed by the NSW Parliament.

I should also note that the Bill passed through Parliament as this report was going to print. As a result, some of the report content does not reflect the final legislation in relation to child death reviews.

In responding to the recommendations of the Special Commission of Inquiry, the NSW Government supported only two of the three above recommendations. The Government supported DoCS reviewing deaths of children reported to that agency and my office no longer reviewing those cases, unless they resulted from abuse or neglect, or occurred in suspicious circumstances. The Government did not support the relocation of the CDRT.

Accordingly, some parts of the report reflect the Government's position prior to the passage of the Bill.

However, following completion of our report, there was considerable debate in Parliament about how to best structure a system to review, and learn from, the deaths of children. I believe the system that has been adopted by Parliament, which is consistent with the recommendations of the Special Commission, will bring about a cohesive approach to the review of child deaths in this state, and with this, an enhanced opportunity to identify strategies to prevent these deaths.

Bruce Barbour
Ombudsman

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Reviewing child deaths

The Ombudsman reviews the deaths of:

- a child, or the sibling of a child, who had been the subject of a risk of harm report to the Department of Community Services (DoCS) at some point in the three years prior to their death
- a child whose death is, or may be, due to abuse or neglect or that occurs in suspicious circumstances
- a child in care
- a child who was an inmate of a children's detention centre, a correctional centre or a lock-up
- a person (whether or not a child) who was living in a disability accommodation service or a licensed boarding house.

In 2007, 603 children and young people died in NSW. Of these deaths, 162 (27%) were reviewable child deaths.

By virtue of definition, the majority of reviewable child deaths will be children, or the siblings of children, who had been the subject of risk of harm reports to DoCS. In 2007, this group of children represented 93 per cent of all reviewable child deaths, which was consistent with previous years. In this context, it is important to note that the number of children who are reported to DoCS each year has increased steadily over the past five years. Between 2002/03 and 2006/07, DoCS reported a 27 per cent increase in the number of reports received by the department.

Many of the children whose deaths we review were also known to or involved with other agencies, including the NSW Police Force (NSWPF) and NSW Health services. In this context, our work is focused on how agencies and service providers have acted, and can act, to ensure the safety of children. Our reviews look at agency systems or practice, and can identify shortcomings in these that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future.

Special Commission of Inquiry into child protection services in NSW

The Special Commission of Inquiry into Child Protection Services in NSW was conducted during 2008. The Inquiry's final report was made public on 24 November 2008. The report contained 111 recommendations. Among these the Inquiry:

- Proposed legislative amendments, including the requirement that only children at risk of significant harm should be reported to DoCS.
- Presented a blueprint for structural changes to the delivery of child protection services that would see:
  - units established in key agencies to manage risk of harm reports, and
  - new regional intake and referral services to be located in non-government organisations. These services would respond to children where risk did not meet the new threshold for reporting to DoCS.

In March 2009, the NSW Government released an action plan *Keep them safe: A shared approach to child wellbeing* in response to the Inquiry report and recommendations. The Government supported in full 89 of the Inquiry's 111 recommendations.

Our work arising from child deaths in 2007

Of the 162 child deaths we reviewed, we took further action including direct investigations and reports to agencies about issues identified in relation to 38 (23%). This action included 16 investigations into eight deaths, and 33 reports to agencies relating to the deaths of 27 children. In some cases, action related to more than one agency. Most of our work focused on DoCS, with a number of cases also involving Area Health Services and the NSWPF, other government agencies and non-government organisations.

Issues identified through our work: Child deaths in 2007

It is six years since we started reviewing child deaths. Over this time, the child protection system has been subject to a five year reform program. The reforms — including increased numbers of caseworkers and the implementation of the Brighter Futures early intervention program — have now been largely rolled out or are well in train.

In many cases, our reviews identified effective responses by DoCS and other agencies to children at risk and their families. Our work also identified policy and practice issues, most of which were consistent with those we have previously identified. In the main, they relate to:

- the adequacy of agency identification and reporting of risk of harm to children
- the capacity of DoCS to assess risk of harm reports to the level required
- the quality of response from DoCS and other support agencies when children are determined to be at risk of harm and in need of care and protection, and
- interagency coordination and cooperation in responding to children at risk of harm or in need of care and protection.

Many of the issues we have identified have been central in the considerations of the Special Commission of Inquiry, and are the subject of Inquiry recommendations that have subsequently been supported by the NSW Government.

Recommendations

In the context of the scope of recommendations arising from the Special Inquiry, and the government's action plan, we have chosen not to make new recommendations arising from our work in 2007. However, we will be seeking advice later in 2009 from agencies about specific strategies they intend to implement to further the intent of our previous recommendations, in the context of the action plan.

Part 2: Reviewable deaths of children with no child protection history

Background to the group review

Each year, approximately eight per cent of the families of children whose deaths are reviewable have no, or no recent, child protection history. The deaths of these children are reviewable because they were due to abuse or neglect, or occurred in circumstances suspicious of abuse or neglect.

In 2008, we conducted a group review of 47 children who died between 2003 and 2008 [Corrigendum: reference to 2008 should read 2007] who had not been the subject of a risk of harm report to DoCS prior to their death.

In regard to abuse, our review focused on children who died in family homicides, as these incidents accounted for the majority of abuse-related deaths (18 of 21 deaths). In regard to neglect, our review focused on the most common circumstances of death for children with no child protection history: drowning, transport and co-sleeping incidents, which together accounted for 29 of 34 deaths. The group review also included a comparative analysis of 76 children who died in similar circumstances, whose families had a child protection history.

The purpose of the review was to:

- identify any patterns in the profiles of the families with no child protection history
- ascertain whether there were any discernible differences or similarities between this group and the group of children who had previously been the subject of reports to DoCS, and
- determine whether risk was apparent in the backgrounds of the children who had not been identified as at risk, and whether their circumstances would have warranted them being brought to the attention of DoCS.

Family homicide

Of the 18 children who had no child protection history and who died in incidents of familial homicide:

- 10 were male and eight were female
- the majority of the children were aged five years and younger.

The majority of perpetrators were the natural parents of the children. Of the 14 identified perpetrators, nine were male and five were female. Half of the children died in incidents where the perpetrator also killed themselves, or attempted to.

Profiles of the families

The profiles of children, perpetrators and families identified through our review reflect key findings of previous work on child homicide in NSW and Australia. In particular, researchers have noted links between child homicide and parental mental health and family breakdown.

In relation to families with no child protection history, in most cases, mental illness was identified as a significant contributing factor in the actions of women (mainly natural mothers) who killed. A number of the women had experienced family breakdown within the 12 months prior to the incidents. Most of the male perpetrators also had some history of mental health issues, primarily depression. In some cases, diagnosis only occurred after the children's deaths. A minority of the men also had histories of substance abuse.

In most of the cases where families had no child protection history, and while noting the possible limitations to the information available, our reviews found no evidence that professionals held a reasonable suspicion that a child was at risk of harm, or failed to make a mandatory report to DoCS on that basis.

In cases where families had been reported to DoCS, the perpetrator or alleged perpetrator was likely to have a history of substance abuse, and particularly for females, a history of mental health issues. Mothers who killed their children in these families were most likely to have a mental illness, often accompanied by substance abuse issues. They were also likely to have been the victim, and in some cases the perpetrator, of domestic violence and previous physical abuse of their children.

In regard to males, including fathers, step-fathers and defacto partners, those from families with a child protection history were most likely to have a previous history of perpetrating violence, and of substance abuse. Some of the men had records indicating mental health issues, but this was not as predominant as it was with the women.

Neglect-related deaths

We define fatal neglect as 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. Deaths are considered suspicious of neglect where there is evidence that indicates the death may have occurred in these circumstances.

Between 2003 and 2007, 29 children with no child protection history died in these circumstances. Our review also considered 47 children who died in similar circumstances and whose families had a child protection history.

Drowning

Between 2003 and 2007, 38 drowning deaths occurred in neglect-related circumstances. In 16 cases, the children had no child protection history and in 22, the families of the children had been the subject of previous reports to DoCS.

Of the 16 children who drowned and who had no child protection history:

- 10 were male and six were female.
- The ages of the children ranged from seven months to eight years. All but one child were three years of age or less.

Ten of the children drowned in swimming pools. In all except one case, the pools were in private premises. Three children drowned in open bodies of water, such as dams or rivers. Three babies, all aged less than a year old, drowned in bathtubs.

Circumstances of death and family profiles

The drowning deaths of all 16 children were predominantly associated with inadequate supervision and inadequate safety measures to limit access by children to swimming pools and other bodies of water.

We found no notable differences in the circumstances of the deaths of children from families with, and without, child protection histories in this regard. Inadequate supervision was the common factor in the deaths of all 38 children. In pool drowning, the risks associated with inadequate supervision were amplified by the failure of child resistant

safety barriers. An additional factor we identified was the occurrence of drowning where there were large groups of people, indicating a possible lack of clarity around supervisory responsibility.

The principle difference between the families related to previous, and relevant, identified risk for those children who had been reported to DoCS. In these families, there was often a prior pattern of inadequate supervision in the life of the child. In some cases, we found additional risks associated with impaired parenting capacity, particularly related to substance abuse.

Our review reinforces the critical importance of adequate supervision of children near water, and installation and maintenance of effective child resistant safety barriers.

Transport fatalities

Between 2003 and 2007, seven children who had no child protection history died in transport fatalities that were neglect-related. Our review also considered four children who died in similar circumstances and whose families had been the subject of previous reports to DoCS.

Of the seven children:

- Four were female and three were male
- Their ages were three, five, eight, nine, 12 and 15 years.

Six of the children who died were passengers in cars driven by a parent. Five of these were single vehicle crashes. One child was riding a motor bike.

Circumstances of death and family profiles

In all seven cases, we identified a significant level of carelessness on the part of the driver, mostly in relation to excessive speed and/or drug or alcohol consumption. Police laid charges against the six surviving drivers. Prosecution resulted in convictions in all six cases.

We found some indication of previous related risks related to driving behaviour. Of the three cases in which we identified driver drugs or alcohol use as a factor in the incident, we found evidence that two drivers had a previous history of substance use. Three drivers who had been exceeding the speed limit at the time of the incident had received a previous police warning for using excessive speed.

For both the children with and without a child protection history, we noted combinations of factors that could be considered as contributing to the children's deaths. In relation to the drivers, these factors included:

- consumption of alcohol or prescription or illegal drugs that impaired driving ability
- excessive speed and/or negligent driving
- failure to provide for the developmental needs of children, including lack of appropriate safety restraints, inadequate supervision in pedestrian incidents, and allowing children control of a vehicle.

We also noted an association between adverse environmental factors, including wet roads, poor visibility and unexpected hazards, and impaired driving skills as a result of substance use or fatigue.

In regard to previous risk, we found that in both groups, there were cases where the driver's previous history was relevant to the circumstances at the time of the incident in which a child died.

Co-sleeping

Between 2003 and 2007, six children whose families had no child protection history died while co-sleeping with their parents in circumstances that we considered constituted neglect or were suspicious of neglect. Our review also considered 21 children who died in similar circumstances and whose families had a child protection history.

All of the six children with no child protection history who died while co-sleeping were infants:

- Five of the infants were aged three months or less, with the youngest being five weeks old. One infant was aged eight months. Two of the babies were born prematurely.
- Three children were male and three were female. Two of the children were indigenous.

Circumstances of death and family profiles

Three of the six babies died as a result of suffocation or asphyxia due to overlaying. Two deaths were classified as SIDS Category II, indicating the possibility of mechanical asphyxia.

In all of the six families, we found evidence of a history of illegal drug use, and/or drug or alcohol use in the hours prior to the incident. Four of the six mothers smoked cigarettes during pregnancy and four used illicit drugs while pregnant.

Records indicated that four of the six families had a police history relating to possession of illegal drugs (two families) and drink driving offences (two families).

A number of families for whom drug use was an issue were in contact with health services during or after the birth of the child. In two cases, records indicate that health services were aware of illicit drug use and were either working with the parent or had made attempts to assist in this regard. We located no reports of risk of harm, or prenatal reports, that were made by services.

Overall, we noted similarities in the profiles of the families with and without a child protection history. Both groups evidence a high proportion of Aboriginal children dying in co-sleeping incidents.

In particular, there were indications that parents' use of drugs and/or alcohol was a significant risk factor. The parents of 15 of the 21 children who had been the subject of reports to DoCS had a history of drug use or drug or alcohol abuse. This was also the case for all six families who did not have a child protection history.

Available records confirmed that drug and/or alcohol use in the hours prior to the co-sleeping incident occurred in more than a third (10) of the families with and without a child protection history.

Our previous work has clearly identified the need for support and follow up where women have substance abuse issues during pregnancy.

The prevalence of parental substance abuse in relation to the children who died in co-sleeping incidents, underscores the importance of comprehensive assessment when substance using women present to prenatal and maternity services. Prenatal reporting can serve both as an early warning to the child protection system about possible risks to a child after birth, and trigger provision of support to birth mothers, including by referral to Drugs in Pregnancy services or DoCS' early intervention services.

Part 1: Reviewable child deaths in 2007

1. Introduction

1.1 Reviewable deaths

Since December 2002, the Ombudsman has had responsibility for reviewing the deaths of people with disabilities in care, and of certain children and young people.[1] Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA), the Ombudsman reviews the deaths of:

- a child in care[2]
- a child in respect of whom a risk of harm report was made to the Department of Community Services (DoCS) within the three years prior to the child's death[3]
- a child who is a sibling of a child in respect of whom a risk of harm report was made to DoCS within the three years prior to the child's death
- a child whose death is, or may be, due to abuse or neglect or that occurs in suspicious circumstances
- a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place)
- a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider authorised or funded under the *Disability Services Act 1993* or a licensed boarding house.

The Act requires the Ombudsman to report to NSW Parliament each year about reviewable deaths. The report must include data about deaths that occurred during the previous calendar year, recommendations that have arisen from the reviews, and information about the implementation of previous recommendations.

This report is the fifth annual report we have prepared. The report is released in two volumes: the first is about disability deaths and this second report is about child deaths.

In NSW in 2007, the deaths of 260 individuals were reviewable deaths. Of these, 162 were reviewable child deaths. One child who died had a disability and lived in a disability accommodation service. The review of this child's death is therefore included in both volumes of this report.

1.2 The scope of our work

Under CS-CRAMA the functions of the Ombudsman are to monitor and review reviewable deaths, maintain a register of these deaths, and:

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

1 In this report, reference to a 'child' or 'children' includes young people unless otherwise stated.
2 A child is defined as a person under 18 years of age.
3 A report must be made under part 2 of chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998*.

In the broadest sense, our work is focused on how agencies and service providers have acted, and can act, to ensure the safety of children. Our reviews look at agency systems or practice, and can identify shortcomings in these that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future.

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

1.3 Reviewing deaths

To assist in the identification of deaths that are reviewable, section 37 of CS-CRAMA requires the State Coroner, the Registrar of Births, Deaths and Marriages and the Director-General of the Department of Ageing, Disability and Home Care to provide information to us about individuals who have died. In regard to identifying children whose deaths are reviewable, we also have access to the client database of DoCS.

CS-CRAMA also requires relevant government agencies and service providers to give us full and unrestricted access to records that are reasonably required to exercise our reviewable death functions. This means that we are able to draw on relevant documented information about the characteristics and circumstances of the person or child who died.

We have established two advisory committees to assist in our work in reviewing deaths. The committees provide us with valuable advice on child or disability death matters, and on policy and practice issues.

Membership of the child death advisory committee is detailed in Appendix 2. The committee provided advice in the preparation of this report.

1.3.1 Other agencies' role in review and examination of child deaths

A number of other agencies have a role in examining child deaths in NSW:

- Reviewable deaths are also coronial deaths under section 13AB of the *Coroner's Act 1980*. The Coroner examines these deaths and may hold an inquest.
- DoCS conducts internal reviews of children, or siblings of children, who die and who have been involved with the department. The purpose of DoCS' internal reviews is to 'examine the case history and action taken prior to the child's death, and identify ways in which existing policies, procedure and practice might be improved.'
- The role of the NSW Child Death Review Team (CDRT) is to prevent or reduce the number of child deaths in NSW. The team maintains a child death register, classifies deaths according to cause, demographic and other factors, identifies patterns and trends, undertakes research and makes recommendations for the prevention of child deaths. The CDRT does not review the deaths of children that fall within the Ombudsman's jurisdiction, but may include reviewable deaths in research.

1.4 Reviewable child deaths that occurred in 2007

In 2007, 603 children and young people died in NSW.[4] Of these deaths, 162 (27%) were reviewable child deaths. The definition of a reviewable death means that the majority will be children, or the siblings of children, who were the subject of a risk of harm report to DoCS at some time in the three years prior to their death.

The following outlines why these deaths were reviewable. As a death may be reviewable for more than one reason, the categories are not exclusive:

- 152 (94%) child deaths were reviewable because the child, or a sibling of the child, had been the subject of a risk of harm report to DoCS in the three years prior to their death:
  - in 102 (63%) cases, the child had been the subject of a risk of harm report,
  - in 50 (31%) cases the child themselves had not been the subject of a risk of harm report, but their sibling(s) had.

  109 of these 152 children had been the subject of a report within 12 months of their death.
- 43 (27%) child deaths were reviewable because the child died in circumstances of abuse, neglect or in suspicious circumstances:
  - in 33 of these cases the child or their sibling had been reported to DoCS,
  - in 10 of these cases neither the child, nor their sibling had been reported to DoCS.

It is important to acknowledge that where children had been reported to DoCS, in the majority of cases, the child's death had no connection to reported child protection concerns. In some cases, DoCS may have appropriately had little or no recent contact with the children in the period prior to their deaths.

DoCS has reported that among children reported to be at risk of harm, the occurrence of multiple reports per child has increased over time. In 2006, the average number of reports per child was 2.3.[5]

For the 102 children who died in 2007, and had been the subject of a report(s) to DoCS within three years of their death, the average number of reports in the 12 months prior to their death was 2.7.

For the 50 children whose deaths were reviewable because their sibling had been the subject of a report(s) to DoCS in the three years before the child died, the average number of reports for the siblings in the 12 months prior to the child's death was 3.1.

1.5 Special Commission of Inquiry into Child Protection Services in NSW

In December 2007, the NSW Government appointed the Honourable James Wood AO, QC, to head a Special Commission of Inquiry into Child Protection Services in NSW.

1.5.1 Inquiry terms of reference

The Inquiry terms incorporated a range of issues that this office has identified through reviews of child deaths over the past six years. The terms also included consideration of oversight agencies in child protection, including this office. In full, the Special Commission of Inquiry was tasked to:

4 While this report refers to 603 child deaths, this may differ from the figure reported by the NSW Child Death Review Team (CDRT). The difference is related to legislative requirements. The CDRT considers deaths that were registered in NSW in the given year. The Ombudsman reviews deaths that occurred in NSW in the given year. Deaths may not be registered in the year they occur.

5 Department of Community Services (2008) Annual statistical report2006/07, page 21.

… conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

i. *The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters.*
ii. *Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making.*
iii. *Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families.*
iv. *Recording of essential information and capability to collate and utilise data about the child protection system to target resources efficiently.*
v. *Professional capacity and professional supervision of the casework and allied staff.*
vi. *The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies.*
vii. *The adequacy of arrangements for inter-agency cooperation in child protection cases.*
viii. *The adequacy of arrangements for children in out of home care.*
ix. *The adequacy of resources in the child protection system.*

1.5.2 The Inquiry report

The Inquiry's final report was made public on 24 November 2008. The report contained 111 recommendations.

Among these, the Inquiry proposed legislative amendments, structural changes to the delivery of child protection services, and new child protection reporting arrangements.

The Inquiry recommended that the *Children and Young Persons (Care and Protection) Act 1998* be amended to require that only children and young people who are suspected, on reasonable grounds, to be at risk of significant harm should be reported to DoCS. Currently, the threshold laid out in section 23 of the Act applies where children are suspected of being 'at risk of harm'.

In association with this proposal, the Inquiry proposed the establishment of units in state agencies to advise staff on whether a report should be made to DoCS. The Inquiry identified the relevant agencies as Area Health Services, the Children's Hospital at Westmead, NSW Police Force, and the Departments of Juvenile Justice, Ageing, Disability and Home Care, and Education and Training.

Under the proposal, where reports did not meet the new threshold for reporting to DoCS, the agency units would direct them to recommended new regional intake and referral services to be located in non-government organisations, or to the Brighter Futures early intervention program, which would also be located (over time) within the non-government sector.

In addition, the Inquiry recommended that the agencies use a common assessment framework to identify and respond to the needs of children and families.

Under the proposed new arrangements, DoCS would be required to investigate reports it received where the matter was urgent, the risk was high or the child was young. The department would refer other reports it received to the regional referral and early intervention services noted above.

Among other significant recommendations, the Inquiry proposed legislative change to remove restrictions on the exchange of information for child protection purposes between agencies, including those in the non-government sector. Also recommended was a strengthening of government agencies' statutory obligations to work together in child protection, and greater non-government sector involvement as an interagency partner.

In relation to oversight arrangements, the Inquiry recommended a package of changes to the system of child death reviews. The three key proposals were that:

- DoCS would review the deaths of children who were reported to the department within three years of their death, or who had a sibling who was reported in that period
- the Ombudsman's role in reviewing deaths would be limited to deaths that resulted from abuse or neglect, or that occurred in suspicious circumstances. The Government would repeal those parts of the legislation that provided for the Ombudsman to review the deaths of children, or siblings of children who had been reported to DoCS, and
- the Ombudsman would become convenor of the Child Death Review Team (CDRT), and the secretariat for the CDRT would be transferred from the office of the Commissioner for Children and Young People to the Ombudsman's office. The rationale for the transfer was the Inquiry's view that in considering reviewable child deaths, it was critical to examine and compare the contexts within which the deaths occur. The Inquiry noted this 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'.[6]

1.5.3 The NSW Government response to the Inquiry report

In March 2009, the NSW Government released an action plan *Keep them safe: A shared approach to child wellbeing* in response to the Inquiry report and recommendations.[7]

Some of the main reforms supported by the Government include:

- Raising the threshold for reporting children at risk of harm to 'risk of significant harm' commencing in January 2010.
- Establishment of specialist child wellbeing units within Area Health Services, NSW Police, Department of Education and Training, Department of Ageing, Disability and Home Care, Housing NSW, Juvenile Justice and Children's Hospital Westmead. The units will:
  - advise, support and educate mandatory reporters as to whether there is a risk of significant harm, and report matters to the Helpline
  - in other cases, identify potential responses by the agency or other services to assist the child or family, and
  - (over time) deliver better alignment and coordination of agency service systems.
- Establishment of regional intake and referral services (RIRS) which will work with the new child wellbeing units. The services will aim to 'improve access to services

6 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page 921.
7 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing.

for children and families who cannot be assisted directly by a government agency, by putting families in touch with services in the local area.' The action plan proposes a trial of the RIRS in three areas, one metropolitan and two regional.

- Extending the Brighter Futures program to provide support to an additional 200 families, with future enhancements to be based on the outcomes of a program evaluation. The Government will not, however, transfer all of Brighter Futures to the non-government sector, as recommended by the Inquiry. DoCS will retain its existing involvement in the program 'at least until' completion of the program evaluation in 2010. Growth funding for Brighter Futures will be directed to the non-government sector.
- Building capacity in the non-government sector. The action plan proposes a five year plan that will support the development of capacity within non-government organisations to deliver more family and community services.

Overall, the Government supported in full 89 of the 111 recommendations made in the Inquiry report. A further 10 recommendations were supported in principle and seven others were supported in part. The Government did not support five recommendations.

Oversight of child protection

In relation to the role performed by this office in reviewing child deaths, the Government supported the second and third elements of the Inquiry's proposed change to the process of review of child deaths in NSW.

Government will repeal section 35(1)(b) and (c) of CS-CRAMA. This revokes the Ombudsman's capacity to review the deaths of children, or the siblings of children, who had been the subject of a report to DoCS in the three years prior to their death. This role will now be undertaken directly by DoCS.

The Government did not support the Inquiry's recommendation that the NSW Ombudsman become convenor of the CDRT, and the secretariat and research functions associated with the Team be transferred to the Ombudsman's office. The Government stated its view that the CDRT's broad research role is better suited to the Children's Commission, with the Ombudsman focusing on reviewable deaths.

There is no proposed change to the operation of the CDRT. In effect however, the scope of the CDRT's work is dependent on the scope of reviewable deaths. Section 45N(2) of the *Commission for Children and Young People Act 1998* prescribes that while the CDRT may include a reviewable death in research, the CDRT may not review a reviewable death. Removing the deaths of children, or siblings of children, who were the subject of risk of harm reports from the Ombudsman's jurisdiction therefore creates the potential for the CDRT to review these deaths.

Given the Ombudsman's continuing role in reviewable deaths and broader role in monitoring the delivery of community services, greater overlap and duplication between the work of the CDRT and the Ombudsman is likely and needs to be addressed.

1.6 About this report

This report consists of two parts:

- Part 1 considers the 162 children who died in 2007 and whose deaths were reviewable, and issues we identified through our reviews.
- Part 2 reports on the findings of a review we conducted which focused on children who died in the five years from 2003 to 2007, whose families had no, or no recent, child protection history.

1.6.1 Review of children with no child protection history (2003–2007)

Each year, approximately eight per cent of the families of children whose deaths are reviewable had not been the subject of a report to DoCS in the three years prior to the child's death. The deaths of these children are reviewable because they were due to abuse or neglect, or occurred in circumstances suspicious of abuse or neglect.

In 2008, we conducted a group review of these children. In regard to abuse, our review focused on children who died in family homicides, as these incidents accounted for the majority of abuse-related deaths (18 of 20 deaths). In regard to neglect, our review focused on the most common circumstances of death for children with no child protection history: drowning, transport and co-sleeping incidents (29 of 34 deaths). The group review also included a comparative analysis of 76 children who died in the same circumstances whose families had a child protection history.

The purpose of the review was to identify any patterns in the profiles of the families with no child protection history, or in the circumstances leading to the deaths of the children. We sought to ascertain whether there were any discernible differences or similarities between this group and the group of children who had previously been the subject of reports to DoCS. The review also aimed to determine whether risk was apparent in the backgrounds of the children who had not been identified as at risk, and whether their circumstances would have warranted them being brought to the attention of DoCS.

1.6.2 Agency feedback

All the agencies whose work is referred to in this report were given an opportunity to comment on relevant sections prior to publication. All comments were considered and incorporated as appropriate in the final report.

1.6.3 Case studies

Throughout the report we refer to cases we have reviewed. In relation to children who died in 2007, we have drawn primarily on matters we have made inquiries about or investigated. The cases relate to children who died and/or their surviving siblings. In reporting these cases, we have aimed to protect identities and to reflect the range of issues identified through our work.

1.6.4 Data

Particularly in relation to data for our group review in part 2, reporting of numbers of reviewable deaths and/or the reason they are reviewable may not be consistent with data reported in our previous annual reports. This is because each year there are a number of deaths that cannot be determined to be reviewable or otherwise until further information, predominantly coronial, is received and considered. In addition, some deaths classified as 'suspicious' may be confirmed as neglect or abuse, or new information may result in a death no longer being considered reviewable.

This report presents information for reviewable deaths that have been revised on this basis and which was current as at November 2008.

2. Overview of reviewable child deaths that occurred in 2007

This section provides an overview of the background, family characteristics and circumstances of death for the children who died in 2007, including notable differences in comparison with previous years (2003–2006).

2.1 Why the deaths were reviewable

The Registry of Births, Deaths and Marriages (BDM) notified us of the deaths of 603 children and young people in NSW in 2007. This represents a decrease of approximately three per cent on the number of deaths registered in 2006.

The deaths of 162 (27%) of these children were reviewable in accordance with section 35(1) of the CS-CRAMA.

Between 2004 and 2006, while the number of child deaths that were reviewable increased each year, the proportion of child deaths that were reviewable in any one year remained stable at around 20 per cent. In 2007, however, both the number and proportion of reviewable child deaths increased.

Table 1: Number and proportion of child deaths that were reviewable

	2003	2004	2005	2006	2007
All child deaths in NSW	561	544	605	622	603
Reviewable child deaths in NSW	124 (22%)	106 (20%)	120 (20%)	126 (20%)	162 (27%)

As determined by our legislation, most of the deaths were reviewable because the children, or their sibling, had been the subject of a risk of harm report to DoCS in the three years prior to the child's death (94%). This is largely consistent with previous years. Regarding the increase in reviewable deaths, it is important to note that the number of children in NSW who are reported to DoCS each year has also increased steadily (90,558 in 2002/03 to 123,690 in 2006/07).[8]

Six per cent of deaths we reviewed were children who had not been reported to the department, but who died as a result of abuse or neglect, or in suspicious circumstances.

Due to the nature of the legislation, a child's death may be reviewable for more than one reason. The following table outlines the basis for the reviewable status of the deaths of children over the five years to 2007.

8 NSW Department of Community Services (2008), Annual Statistical Report 2006/07, page 6.

Table 2: Reviewable status

Reason for reviewable status	Number of children, % and additional information				
	2003 reviewable deaths (124 children)[9]	2004 reviewable deaths (106 children)	2005 reviewable deaths (120 children)	2006 reviewable deaths (126 children)	2007 reviewable deaths (162 children)
Death occurred due to:	44 (36%) of all reviewable deaths	24 (23%) of all reviewable deaths	34 (28%) of all reviewable deaths	35 (28%) of all reviewable deaths	43 (27%) of all reviewable deaths
• Abuse	18 (14%)	8 (8%)	14 (12%)	11 (9%)	8 (5%)
• Neglect	14 (11%)	7 (7%)	12 (10%)	12 (10%)	11 (7%)
• Suspicious circumstances	12 (10%)	9 (9%)	8 (8%)	12 (10%)	24 (15%)
Reported to DoCS in the three years prior to the child's death:	114 (91%) of all reviewable deaths	99 (93%) of all reviewable deaths	111 (93%) of all reviewable deaths	113 (90%) of all reviewable deaths	152 (94%) of all reviewable deaths
• Child reported to DoCS	95	75	71	80	102
• Sibling reported to DoCS	19	24	40	33	50
The child died while in care	10 (8%)	8 (8%)	4 (3%)	4 (3%)	5 (3%)
The child died in a detention or correction facility	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

9 In 2005 we modified our definitions of abuse, neglect and suspicious deaths. To provide a comparative base we re-assessed the deaths that occurred during the 2003 reporting period according to our new definitions. In our 2005 Report of Reviewable Deaths in 2004, we reported on the changes that would result had we applied the new definitions. The figures in table 1 are based on an application of the definitions adopted in our 2005 report.

2.2 Demographic details

2.2.1 Age

Table 3 shows the ages of children who died in 2007.

Table 3: Age category of children who died in NSW in 2007

	Non-reviewable deaths	% of all non-reviewable deaths	Reviewable deaths	% of all reviewable deaths
< 12 months	293	66%	83	51%
1-4 years	48	11%	24	15%
5-9 years	29	7%	9	6%
10-12 years	19	4%	12	7%
13-17 years	52	12%	34	21%
Total	**441**	**100%**	**162**	**100%**

Consistent with previous years, most of the 162 children who died and whose deaths were reviewable in 2007 were very young. The large majority of children (66%) were aged four years or younger.

Just over half (83, 51%) of the children whose deaths were reviewable were infants aged less than 12 months. A quarter of these infants (40, 25%) were aged less than four weeks at the time they died. The majority of these children (30, 75%) were never discharged from the hospital in which they were born. We found some evidence of maternal substance abuse during pregnancy for seven of the 30 mothers. In a further six cases, while we found no recorded evidence of concerns about substance abuse during the pregnancy, the mothers had some previous history of substance abuse.

Table 4 illustrates an increase in the number of reviewable infant deaths each year since 2004. As noted, the number of all reviewable child deaths has also increased in the same period.

The relatively high proportion of infants in the reviewable deaths population reflects the general population of child deaths. In 2007, 62 per cent of all children who died in NSW were infants.[10]

10 According to data provided to this office by the NSW Registry of Births, Deaths and Marriages for child deaths in 2007.

Table 4: Reviewable child deaths: infants aged less than 12 months

	2003 (124 deaths)	2004 (106 deaths)	2005 (120 deaths)	2006 (126 deaths)	2007 (162 deaths)
Number	54	57	63	73	83
% of all reviewable deaths	44%	54%	53%	58%	51%

Thirty-four (21%) reviewable deaths in 2007 were of young people aged 13 to 17, which is higher than that reported in the previous two years. The number of adolescent deaths has fluctuated over the past five years as shown in table 5.

Table 5: Reviewable child deaths: young people aged 13–17 years

	2003 (124 deaths)	2004 (106 deaths)	2005 (120 deaths)	2006 (126 deaths)	2007 (162 deaths)
Number	37	22	12	17	34
% of all reviewable deaths	30%	21%	10%	14%	21%

2.2.2 Gender

Over the last five years there has been very little variation between the proportion of male and female reviewable deaths. In 2007, there were more male (56%) than female deaths and this is consistent with data from previous years and with child deaths in general.[11] This pattern was reflected across all age categories except adolescents, where more females than males died.

Table 6: Gender of children who died in NSW in 2007

	Non-reviewable deaths	% of non-reviewable deaths	Reviewable deaths	% of reviewable deaths
Male	252	57%	91	56%
Female	189	43%	71	44%
Total	**441**	**100%**	**162**	**100%**

The age and gender distribution of the children is presented in figure 1.

11 Australian Bureau of Statistics (1998) Causes of infant and child deaths – Australia ABS, Canberra, Cat No. 4398.0. Page 4.

2.2.3 Aboriginality

Aboriginal children are over-represented in all child deaths in NSW,[12] and also in relation to reviewable deaths. Each year the deaths of Aboriginal children represent approximately 20 per cent of all reviewable deaths. In 2007, this was 22 per cent.

As noted above, just over one-quarter (27%) of all child deaths in NSW were reviewable in 2007. In contrast, almost two-thirds of the deaths of Aboriginal children were reviewable (36 of 58 deaths, or 62%). This represents an increase, in both number and proportion, from 2006. However, table 7 illustrates there has not been a consistent increase in number and proportion of Aboriginal children whose deaths were reviewable across all years. In 2006, the same number of Aboriginal children died as in 2007 (58), but fewer of the deaths were reviewable (25, or 43%). Table 7 shows the Indigenous status of children whose deaths were reviewable between 2003 and 2007.

Figure 1: Reviewable deaths: age and gender

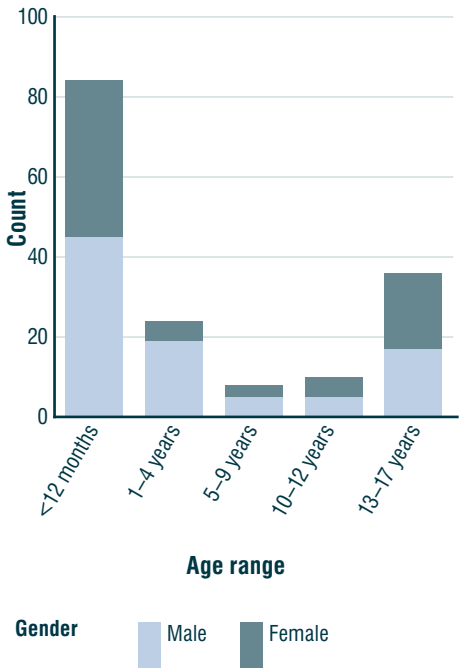

Table 7: Indigenous status of children who died in NSW 2003–2007

Year	Aboriginal child deaths (NSW)	Reviewable Aboriginal deaths	Non-Aboriginal deaths (NSW)	Reviewable non-Aboriginal deaths
2007	58	36 (62% of all Aboriginal deaths)	545	126 (23% of all non-Aboriginal deaths)
2006	58	25 (43%)	564	101 (18%)
2005	44	20 (46%)	561	100 (18%)
2004	32	21 (66%)	512	85 (17%)
2003	48	30 (63%)	513	94 (18%)

DoCS' data also demonstrates that Aboriginal children are overrepresented in the child protection system and, on average, DoCS receives more risk of harm reports per year for Aboriginal children than non-Aboriginal children. Drawing from DoCS' published quarterly data, approximately 17 per cent of all risk of harm reports concern Aboriginal children and young people.[13]

12 NSW Child Death Review Team (2007), Annual Report 2006, page 23, NSW Commission for Children and Young People.
13 Department of Community Services (2007), Child protection quarterly data July 2006 to December 2007, page 7.

We have previously reported that the deaths of infants make up the majority of reviewable Aboriginal deaths (18, 72% in 2006). This was the case again in 2007 with 25 (69%) deaths of Aboriginal children aged less than 12 months being reviewable.

The families of all Aboriginal children we reviewed had been the subject of a report to DoCS through a report in the previous three years in relation to the child themselves (24) or through a report about the child's sibling (12). Thirty-one families had been the subject of a report within 12 months of the child's death.

Two Aboriginal children died in circumstances of abuse and two as a result of neglect. In a further five cases the deaths occurred in suspicious circumstances.

2.2.4 Child and Family Circumstances

Where the children lived

Close to three-quarters of the children (119, 74%) usually resided with at least one biological parent. Five children lived with members of their extended family, and two young people were living independently. One child with severe intellectual and physical disabilities was living in a residential supported accommodation service.

Table 8: Usual place of residence

	All reviewable deaths	% reviewable deaths
Biological parent(s)	119	74%
Other family member(s)	5	3%
Non-related person(s)/in statutory or disability care	6	4%
Young person living independently	2	1%
Child never discharged from hospital	30	18%
Total	**162**	**100%**

Family size

Of the 162 children whose deaths we reviewed, 134 children had siblings:[14]

- 36 children had one sibling
- 41 children had two siblings
- 28 children had three siblings
- 13 children had four siblings, and
- 16 children had five or more siblings.

Care status

Four children lived in statutory care. These children were the subject of long term care orders that allocated parental responsibility to the Minister for Community Services, and were placed with extended family or foster carers.

14 28 children had no siblings, and in three cases this information was not available.

Place of death

Almost half of the children (72, 44%) died in the family home.

Just over a third of the children (57, 35%) died in a hospital or health facility. As noted, 30 of these children died in hospital following their birth, having never left hospital. The deaths of this group of children were largely attributed to complications associated with extreme prematurity and/or conditions arising during pregnancy.

Table 9: Place of the child's death

	All reviewable deaths	% reviewable deaths
Child's family home	72	44%
Other private home	11	7%
Residential service	2	1%
Hospital or health facility	57	35%
Public place[15]	14	9%
Other location	6	4%
Total	**162**	**100%**

Disability

Twenty-nine children were identified as having had either an intellectual and/or physical disability, five had a severe or profound level of intellectual impairment.[16] One child, who had a profound intellectual disability and complex medical needs, was receiving ongoing support services on a respite basis and was residing away from the family home at the time he died.

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

The definitions used by this office to determine deaths resulting form abuse or neglect, or those that occur in suspicious circumstances, are:

2.3.1 Deaths due to abuse

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

2.3.2 Deaths due to 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
- a significantly careless act.[17]

15 Public places include natural bodies of water, parks, recreational facilities, bushland, railways and roadways.

16 This is a conservative figure and is likely to understate the number of children who had disabilities because the types of records we review would not necessarily contain this information.

17 Our definition has previously used the term 'reckless'. We have amended this to 'significantly careless'. There are legal interpretations of the term 'reckless' that do not accurately reflect the cases that we consider constitute neglect. 'Significantly careless' is a more accurate descriptor for cases we have classified as neglect.

2.3.3 Suspicious deaths

Deaths where there is some evidence or information that indicates the death may have been a result of abuse or neglect. Deaths would be considered suspicious if:

- 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)
- 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.

We note that this definition of suspicious is broader than that used by the NSW Coroner's Office. In the Coronial context, suspicious is generally attributed to a death that is a possible homicide. However, we use outcomes of Coronial and Court proceedings to make a final determination about whether a death should be considered abuse or neglect.

Our categorisation of deaths resulting from abuse or neglect is more conclusive after coronial and criminal processes have been finalised. Coronial outcomes are pending for a number of 2007 deaths. For this reason, figures may change for any one year in subsequent annual reports. In particular, the category of 'suspicious' is likely to change over time as coronial and criminal processes are concluded.

Table 10: Abuse, neglect or suspicious circumstance deaths: reports to DoCS

	All children (162)	Children reported to DoCS within three years prior (102)	Siblings of children reported to DoCS within three years prior (50)	Children not reported to DoCS within three years prior (10)
Abuse	8	6	0	2
Neglect	11	5	1	5
Suspicious	24	17	4	3
Total	**43**	**28**	**5**	**10**

Of the group of 43 children who died as a result of abuse or neglect, or whose deaths occurred in suspicious circumstances:

- over half were male (25, 58%)
- children less than 12 months of age were most likely to die in suspicious circumstances (see figure 2)
- current literature indicates that deaths as a result of abuse occur most among children in the one to four year age group and young people aged 13 to 17.[18] This was reflected in the deaths that we reviewed this year (see figure 2)

18 NSW Child Death Review Team (2008), Trends in Child Deaths in NSW 1996- 2005, page 227, NSW Commission for Children and Young People.

- nine children (21%) were identified as Aboriginal children
- criminal charges have been laid in relation to nine of the deaths.[19] Police inquiries are continuing into a number of deaths.

2.4 Children reported at risk of harm

In relation to 152 of the 162 deaths we reviewed (94%), either the child who died or their sibling had been the subject of a risk of harm report(s) to DoCS in the three years prior to the child's death. Table 11 presents this information for the period 2003 to 2007.

Figure 2: Age of children where deaths resulted from abuse or neglect or in suspicious circumstances

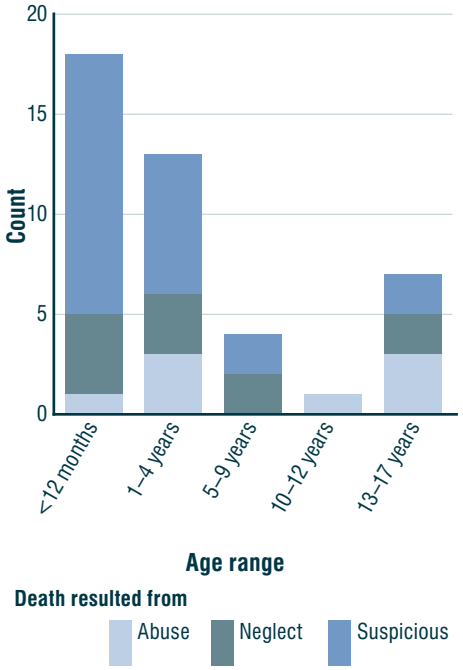

Table 11: Children reported to DoCS

Year	Total child deaths in NSW	Either child or sibling reported to DoCS in three years prior	Neither children nor siblings reported to DoCS in three years prior	Number of reviewable deaths/% of all child deaths in NSW
2007	603	152	10	162 (27%)
2006	622	113	13	126 (20%)
2005	605	111	9	120 (20%)
2004	544	98	8	106 (20%)
2003	561	103	21	124 (22%)

As we have noted earlier, the number of children in NSW who are reported to DoCS each year has also increased steadily.

19 Information provided by the NSW Police Force 12 September 2008, in response to a request by this office for information in relation to the status of various reviewable death matters. Of the nine cases, eight children died as a result of abuse and one child died in circumstances of neglect.

For the 102 children who were themselves the subject of a report to DoCS, the status of their involvement with the department at the time of their death was as follows:

- Open and allocated to a departmental caseworker (31 children). Nine of these children died as a result of abuse or neglect, or in suspicious circumstances.
- Open and unallocated (5 children). This means that a report or case plan may be open, but is not allocated to a caseworker for active casework. None of these children died as a result of abuse or neglect, or in suspicious circumstances.
- Open but unable to ascertain allocation status from available records (one child). This child died as a result of abuse or neglect, or in suspicious circumstances.
- Closed (65 children). Eighteen of these children died as a result of abuse or neglect or in suspicious circumstances.

In relation to the 50 children whose deaths were reviewable because they had a sibling who was reported to DoCS, the status of the siblings' involvement with the department at the time of the child's death was:

- Open and allocated to a departmental caseworker (27 children).
- Open and unallocated (8 children).
- Closed (15 children).

Five children whose deaths were reviewable because a sibling had been the subject of a risk of harm report died as a result of abuse or neglect, or in suspicious circumstances.

2.5 Coronial and criminal status

All reviewable deaths are examinable by the NSW Coroner, pursuant to section 13AB of the *Coroners Act 1980*. The Coroner determines which deaths are subject to a full inquest.

At the time of writing, the coronial process had not been finalised for 29 (18%) reviewable deaths that occurred in 2007.

Table 12: Status of the coronial process

	All reviewable deaths	% reviewable deaths
Inquest held	3	2%
Inquest dispensed	118	73%
Inquest terminated	12	7%
Inquest decision pending	29	18%
Total	**162**	**100%**

For the 133 children where the coronial process has been finalised, the manner of death determined by the Coroner is as follows.

Table 13: Manner of death (finalised cases)

	All reviewable deaths	% reviewable deaths
Natural manner	82	61%
Accidental manner	18	13%
Suicidal manner	8	6%
Homicidal manner	6	5%
Undetermined/unascertained	10	8%
Coroner dispensed with an inquest but did not record the manner of death on the death notice	9	7%
Total	**133**	**100%**

In relation to the eight deaths that we have classified as resulting from abuse, murder charges have been laid in five cases, and a charge of manslaughter has been laid in one case.[20] An inquest decision is pending in relation to the other two deaths which occurred in an apparent murder-suicide context.

Of the 11 deaths we have determined as being due to neglect, charges have been laid in relation to two. The charges relate to negligent driving and murder respectively. The Coroner has determined that the manner of death was accidental in five of these cases, and in a natural manner in one case. In a further two cases, the manner of the child's death was found by the Coroner to be undetermined. We are awaiting a Coronial determination in relation to the remaining three deaths.

The fact that the Coroner determines an accidental or natural manner of death does not exclude this office from identifying the death as a result of neglect or suspicious of neglect. For example, drownings that are not homicidal or suspicious of a criminal offence may be deemed by the Coroner to be accidental.

20 Ibid.

3. Our work – reviews of child deaths in 2007

3.1 The nature of our work

Reviews of child deaths incorporate assessment of relevant information about the child and their family, and their contact with various government and non-government agencies. At a minimum, this information includes:

- DoCS' Key Information Directory System (KIDS) records. These records contain information provided to DoCS about a child and/or their family, and details about the nature of DoCS' subsequent response and any contact with families or other parties, including case plans and secondary assessment records.
- NSW Police Force Computer Operated Policing System (COPS) records. These records provide details of police events, including information relating to children identified as being at risk of harm.
- Death registration information provided by the Registry of Births, Deaths and Marriages.
- Coronial information, including the police report of the death to the Coroner.

Following an initial review, we may also seek and examine other agency records including DoCS' files for the child and siblings, records held by NSW Health and private medical practitioners, school records and records of non-government agencies involved with the child and/or the child's family.

In most cases, our reviews do not identify concerns about how agencies interacted with or responded to the child and their family. In some cases, however, we identify practice, procedural or policy issues that warrant further action by this office. The type of action we take may relate to the child who died, or their surviving siblings, or both, and includes:

- Providing reports to agencies, service providers or other appropriate persons about issues relating to a reviewable death, or arising from our work (s.43(3), CS-CRAMA). The nature of these reports can range from providing information to assist the work of an agency, to raising concerns about how an agency managed a case or incident. We can also require agencies to provide information about the issues we raise in a report (s.18, Ombudsman Act).
- Making preliminary inquiries of agencies, for the purpose of deciding whether the conduct of an agency should be the subject of investigation (s.13AA, Ombudsman Act).
- Conducting investigations into the conduct of an agency in relation to a child and/or their family (s.16, Ombudsman Act).

Decisions to report issues to an agency that we identified through an individual review, or to take further action under the Ombudsman Act, are based on a number of factors. Generally, we take these steps where we identify concerns about practice, policy or procedure that we believe have currency and warrant further consideration and/or action by the agencies concerned. Particularly in relation to investigations, we take into account the seriousness of the concerns raised and whether they are of a systemic nature. We also take account of any current action that an agency may be taking that would address the issues of concern. We may defer action where the matter is subject to inquest by the NSW Coroner, or subject to internal review by the relevant agency.

3.2 Our work arising from child deaths in 2007

Of the 162 child deaths we reviewed, we took further action in relation to 38 (23%). In some cases, action related to more than one agency. Most of our work focused on DoCS, with a number of cases also involving Area Health Services and the NSWPF, other government agencies and non-government organisations.

3.2.1 Investigations

In relation to eight deaths, we commenced 16 investigations under section 16 of the Ombudsman Act. The investigations concerned the conduct of agencies dealing with the child who died (in four cases), the child and their siblings (in two cases); and in two cases, a sibling only. The issues we considered generally related to the adequacy of agencies' response to risk of harm to a child or children.

The 16 investigations considered the conduct of:

- DoCS (six investigations) including two relating to DoCS' role in a Joint Investigation Response Team (JIRT).[21] We discontinued two of these investigations.[22]
- The NSWPF (four investigations), including two relating to the role of the NSWPF in a JIRT. We discontinued one of these investigations.
- Six agencies were each the subject of one investigation: Sydney South West Area Health Service; an individual hospital; Department of Education and Training; Department of Housing; Department of Ageing, Disability and Home Care (DADHC); and a non-government family support service.

3.2.2 Preliminary inquiries

In relation to three deaths, we undertook five preliminary inquiries. Our inquiries concerned how agencies responded to risk to the child and their siblings (in two cases); and the child's sibling only (in one case).

Our inquiries were directed to DoCS in all three cases, one of which related to DoCS' role as a JIRT partner. In one case, we also made inquiries of DADHC, and the NSWPF, the latter in relation to their role as a JIRT partner.

While none of these matters proceeded to investigation, we continued to hold some concerns about agencies' handling of cases in three of the five inquiries, and detailed our concerns to the relevant agencies. In response to the other two inquiries, agencies adequately addressed the issues we had raised.

3.2.3 Reports to agencies

We made 33 reports to agencies under section 43(3) of CS-CRAMA arising from our reviews of the deaths of 27 children.

In the main, we used these reports to provide agencies with information to assist their work, or to draw attention to issues we identified that we believed the agency needed to consider and, where appropriate, respond to.

In five cases, our reports were about the child only. Our reports concerned both the child who died and their sibling(s) in 15 cases, and the child's siblings only in seven cases.

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21 A JIRT is a team of DoCS and police officers formed to conduct joint investigations of serious cases of child abuse. NSW Health provides support to such investigations. JIRT deals with reports that may be subject to criminal charges.

22 We generally discontinue an investigation if information indicates that the issues of concern have been resolved and there is no likelihood of them recurring, or we consider it unlikely that unreasonable or other conduct under section 26 of the Ombudsman Act will be identified, and there is no public interest in continuing the investigation.

Reports were directed to the following agencies:

- DoCS (25 reports)
- The NSWPF (three reports)
- NSW Health Services (five reports, to Hunter New England Area Health Service; Greater Western Area Health Service; Sydney West Area Health Service and an individual hospital).

3.3 Issues identified through our work: Child deaths in 2007

It is six years since we started reviewing child deaths. When we assumed responsibility for this work in late 2002, the child protection system was entering a period of significant change, based on a five-year reform program. The reforms — including increased numbers of caseworkers and enhancements to Community Service Centres (CSCs) across NSW, and the implementation of the Brighter Futures early intervention program — have now been largely rolled out or are well in train.

The profile of the families of children who died largely mirrors the profile of many families involved with DoCS. In a significant number of cases, families of the children who died had a child protection history related to parental substance abuse, domestic violence or parental mental health issues. In many families, these factors co-existed, presenting significant risks to children and challenges to agencies attempting to respond to risk and provide support to the family.

In many cases, our reviews identified effective responses by DoCS and other agencies to children at risk and their families. Our work also identified policy and practice issues, most of which were consistent with those we have previously identified. In the main, they relate to:

- the adequacy of agency identification and reporting of risk of harm to children
- the capacity of DoCS to assess risk of harm reports to the level required
- the quality of response from DoCS and other support agencies when children are determined to be at risk of harm and in need of care and protection, and
- interagency coordination and cooperation in responding to children at risk of harm or in need of care and protection.

Many of the issues we have identified have been central in the considerations of the Special Commission of inquiry into Child Protection Services in NSW.

The Inquiry's recommendations are consistent with concerns we have identified in our previous reports of reviewable child deaths and in other work over the past six years. In the main, the Inquiry supported and verified our views regarding key challenges for the child protection system, and critical areas for improvement. Many of the Inquiry's recommendations go directly to the issues raised above, and overall they are focused on re-directing the child protection system to respond more effectively to children at risk of harm and families in need of support.

The Inquiry recommendations foreshadow a system based on a range of pathways to ensure children receive a response commensurate with the level of risk or need they face; greater involvement of all agencies, including non-government agencies, in providing protective services to children; and improved structures for supervision and professional development for DoCS' caseworkers.

The NSW government's response to these recommendations will determine the way forward for child protection services in NSW. In the following section, we refer to specific recommendations relevant to the issues we have raised above.

3.3.1 Identifying and reporting risk of harm

Anyone who has reasonable grounds to suspect that a child or young person may be at risk of harm can make a report to DoCS. Staff employed in health, welfare, education, children's or residential services and in law enforcement that provide services to children, are mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998*.

Mandatory reporters must notify the DoCS Helpline, a centralised intake point, if they have reasonable grounds to suspect that a child is at risk of harm. Reports can also be made about an unborn child where a person believes the child will be at risk after birth. These pre-natal reports are not mandatory.

In most cases we reviewed, agencies effectively identified children at risk and made reports to DoCS, in line with their responsibilities as mandatory reporters. However, at times, we found that risk was either not identified by agencies, or was identified but not reported.

NSW Police Force

The NSWPF is the agency that makes the most risk of harm reports to DoCS. DoCS data indicates that police make, on average, almost 25,000 risk of harm reports to DoCS each quarter.[23] These reports relate mainly to incidents of domestic violence. The NSWPF operating procedures require police to report a child to DoCS if they have been present at a domestic violence incident. This is an additional requirement to mandatory reporting. In the main, our reviews showed that police reported risk in line with their own policy. In a small number of cases, however, we found that incidents attended by police may have warranted a report to DoCS, but we found no evidence that a report was made.

In response to similar issues we raised with police in 2007, the NSWPF has established a working party to improve police reporting of, and response to, children at risk of harm. The NSWPF has advised us that the work of this group is progressing and will ultimately lead to improved systems that will be incorporated into the *Child Protection Standard Operating Procedures* (SOPS). The NSWPF told us that the Special Commission of Inquiry had affected the original timeframe for the completion and implementation of the SOPS, as a number of critical issues being considered would likely affect the procedures.[24]

The Special Commission of Inquiry made a number of recommendations targeted to police reporting of risk of harm. The Inquiry recommended that the NSWPF amend its policies regarding reporting of domestic violence incidents to align with the requirements of the *Children and Young Persons (Care and Protection) Act 1998*.[25] This would mean that only those children considered to be at risk of serious physical or psychological harm as a result of domestic violence would be reported to DoCS. The NSW Government has supported this recommendation.[26]

In addition, the Inquiry recommended, and the NSW Government has also supported, that DoCS and the NSWPF:

> *agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made.*[27]

23 Department of Community Services (2008) Child Protection Quarterly Data July 2006 – December 2007, page 8.
24 NSW Police Force correspondence dated 21 August 2008.
25 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page 734.
26 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 85.
27 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page 734; NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 85.

NSW Health

Along with the NSWPF and Department of Education and Training, NSW Health is one of the three largest reporting groups to DoCS. DoCS data indicates that in 2007, NSW Health made between 11,000 and 12,000 child protection reports each quarter.[28] The main issues reported by health professionals involve parental mental health issues, domestic violence, physical abuse, parental drug or alcohol use and neglect.[29]

In the majority of our reviews, we found that NSW Health provided appropriate responses where child protection concerns were identified, including direct provision of support and assistance to mothers of newborn babies.

In four cases, we alerted health services to our concerns that health workers had not made risk of harm reports where they may have been warranted. In two of these cases, the child was a newborn baby and the mother had a known history of substance abuse.

Last year, we noted that a number of reviews had raised questions about the degree to which possible risk had been fully considered by health professionals, particularly in the context of physical injury. In one case in 2007, we questioned whether a hospital made reasonable inquiries to ascertain the level of possible risks to a child who presented with a physical injury, and whether appropriate efforts were made to effectively coordinate responses with DoCS.

In response to our inquiries, individual health services reviewed the issues we raised, and took steps to ensure improved staff awareness of child protection and reporting requirements.

Also of note, in 2008 DoCS and NSW Health commenced a joint trial of a new prenatal reports policy, which is intended to maximise preventative and early intervention strategies to reduce risk of harm to newborn babies.

The Special Commission of Inquiry made a number of recommendations relating to mandatory reporting of risk of harm to DoCS. As we outlined in section one, the NSW Government has supported the Inquiry's proposal that the Act be amended to require mandatory reporting of children at risk of 'significant' harm, rather than the current 'risk of harm'.[30] The Inquiry also proposed a range of pathways for channelling responses to children at risk, which would see agencies such as NSW Health and NSWPF move to centralised reporting systems. This proposal has also been endorsed by the government.[31]

3.3.2 Responding to reports of risk of harm

Risk of harm reports are made to the DoCS' Helpline. When reports are made, the Helpline determines whether they require further assessment and how urgently this should be done. The Helpline refers reports that require further assessment to local DoCS' CSCs or JIRTs.[32]

At a CSC, secondary assessment is undertaken in two stages. Stage 1 (SAS 1) provides for limited information gathering and analysis to determine whether stage 2 (SAS 2), or more comprehensive, assessment should be undertaken. JIRT has particular eligibility criteria, and can accept or reject a referral.

28 Department of Community Services (2008) Child Protection Quarterly Data July 2006 – December 2007, page 8.

29 Department of Community Services (2006) Annual statistical report 2004/05, page 17.

30 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW See recommendation 6.2.

31 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, see chapter 10, 'Directions for the way forward', page 379.

32 Where urgent responses are required outside standard hours, Helpline staff conduct assessments.

As noted above, the families of 152 children who died in 2007 had been reported to DoCS at some time in the three years prior to their death. In total, the children who died and/or their siblings were the subject of 725 risk of harm reports over the three years prior to their deaths, 401 of which occurred in the 12 months prior.

In the majority of cases, our reviews found that DoCS' response to reports of risk of harm was appropriate. In 28 cases (18 per cent of the children or siblings of children who had been reported to DoCS), we raised some concerns with DoCS about the department's response. These related to the child who died or their siblings, or both, and were mainly about the extent and/or quality of secondary assessment undertaken, and the adequacy of protective intervention. The following provides an overview of the issues we identified in these cases.

In considering DoCS' capacity to respond fully to risk of harm reports, we note the context of limited resources and increasing demand. In 2007–08, DoCS received 303,121 reports of risk of harm.[33] This represents a six per cent increase on the 286,033 reports received in 2006–07, and continues the upward trend in demand experienced by the department over a number of years. DoCS has also noted that between 2001/02 and 2006/07, the number of individual children and young people reported increased by 46 per cent and the reporting rate per 1,000 children and young people in NSW increased from 53 to 78.[34]

Closure of cases due to competing priorities

In many of the cases we raised with DoCS, one of our main concerns was the closure of reports without further assessment. In almost all cases, the reason DoCS closed a case early was competing priorities – that is, a lack of capacity in a CSC to fully assess reported risk to children due to a combination of lack of resources and the relative urgency of other cases at hand.

We have previously noted the closure of cases due to resource constraints and competing priorities being one of the greatest challenges in achieving a strong child protection system.[35] We have also highlighted the need for accurate data about the number of child protection reports in which assessments and inquiries are not able to be commenced or completed due to resource constraints.[36]

Since our last report, DoCS has finalised and rolled out the *Intake Assessment Guidelines*, which are designed to provide clear guidance on case closure and bring greater consistency to decisions to allocate reports for Stage 1 Secondary Assessment.

The Special Commission of Inquiry noted that child protection work will always involve prioritising resources, and that this will affect the allocation of resources. In this context, the Inquiry proposals have sought to:

> *ensure that more families receive assistance, not just from DoCS, and that caseworkers become more skilled and have access to the necessary expertise to address reports and families.*[37]

33 Department of Community Services Annual Report 2007/08, page 43.

34 Department of Community Services (2008) Submission to Special Commission of Inquiry: Child protection assessment models and process, page 8.

35 NSW Ombudsman (2008) Submission to the Special Commission of Inquiry into Child Protection Services in NSW, part 6: Assessment and early intervention and prevention, page 8.

36 NSW Ombudsman Report of reviewable deaths in 2006, page 51.

37 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page 279.

In regard to data, the Inquiry also recommended enactment of section 28 of the Children and Young Persons (Care and Protection) Act. The section requires the DoCS Director-General to keep a record of all reports made to or by the Director-General, any action taken as a consequence of a report, and any 'subsequent disposition of and dealings with' the reported children or young people.38 The Government has supported this recommendation and will introduce legislation to implement the change.39

Assessment of risk

In previous years, we have reported our findings that initial and secondary assessment is most effective where it is comprehensive in scope and gives sufficient consideration to the range of factors in the child's life that resulted in harm or risk of harm.[40]

While we saw examples of comprehensive and timely assessment, our reviews of some child deaths in 2007 raised questions about how decisions were being made by DoCS about the level of risk to children:

- In some cases, we found history checks were inadequate. These checks identify a family's previous child protection background in order to inform an initial assessment of risk to a child. We found that in some cases, checks were insufficient or inaccurate, and did not provide a sound basis for determining whether intervention by DoCS was warranted. For example, we reviewed cases where a carer's history of causing harm to a child was not identified in the process of formulating a family history, and where previous and relevant child protection issues relating to siblings were not identified. In our last report, we noted that errors in history checks can be carried over if a child is re-reported, so that subsequent assessments replicated an inaccurate child protection history.[41] DoCS has advised us that a root cause analysis conducted by the Helpline in late 2007 identified a number of system complexities in the use of KiDS database, and found that the current structure of KiDS 'did not make it easy for Helpline caseworkers when conducting history checks'.[42] DoCS indicated the analysis would inform projects that will result in the enhancement of KiDS.
- In some cases, our reviews highlighted a limited response to multiple reports for a child and/or siblings. At times, our reviews indicated multiple reports were considered on an incident-by-incident basis and were not subject to holistic assessment, although our review of records indicated escalating risk.
- In some cases, our reviews found that assessments gave inadequate consideration to factors beyond the immediate concerns facing the child and their family, or did not address all substantive risk issues. In one case, for example, a secondary assessment did not substantiate risk of harm in relation to a number of children, and concluded the risk level to the children was low. However, our review identified that the secondary assessment did not appear to have addressed a number of significant reported issues, including the mother's history of chronic alcoholism, prior incidents of violence against the children, and allegations of risk of sexual harm in relation to one of the children. In another case, a secondary assessment concluded that a two year old child was safe and that DoCS' protective action could be ceased. Our review identified that the assessment did not take into account available contemporary information that the family was homeless and the mother had been sighted drug affected and dealing drugs.

38 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, see recommendation 11.1.
39 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing page 72.
40 NSW Ombudsman (2006) Report of reviewable deaths in 2005, page 26; and (2005) Report of reviewable deaths in 2004, page 75.
41 NSW Ombudsman (2007) Report of reviewable deaths in 2006, volume 2: Child deaths, page 46.
42 Department of Community Services response to requirement for a statement of information, dated 20 February 2008.

DoCS has generally provided a comprehensive response to the issues we have raised about the quality of assessment in relation to individual cases. This has included conducting full risk assessments and case reviews, with subsequent intervention where appropriate.

More broadly, over the course of the department's reform process, DoCS has implemented a number of initiatives to address issues about the quality of risk assessment. These have included revision of the department's secondary assessment procedures and development of a neglect policy, and staff training programs to support the roll-out of these.

A key initiative to ensure quality in the delivery of DoCS' services is its plan to implement 'quality reviews' of all CSCs over four years, initially planned from November 2007.[43] In August 2008, however, DoCS advised us that the pilot quality reviews were on hold, pending discussions with the Public Service Association.

The Special Commission of Inquiry focused a number of recommendations on assessment processes and quality assurance. In addition to the range of structural changes outlined in the previous section, the Inquiry proposed that:

- The trial of the quality review tools proceed immediately, with approved tools being applied and audits of all CSCs undertaken, commencing in the 2008/09 financial year.
- DoCS test the use of actuarial model of risk assessment, *Structured decision making*, at the Helpline and CSCs. The model provides tools to guide assessment and decision-making.
- A common assessment framework for assessing risk be developed for use by DoCS and other agencies.[44]

The NSW Government has supported these recommendations, and has indicated they will be substantially commenced by August 2009.[45]

3.3.4 Responding to children in need of care and protection

Our annual reports have consistently identified the importance of good liaison and information exchange between agencies providing services to children and their families, and effective coordination and monitoring by DoCS of the outcome of intervention strategies.

In our reviews of deaths in 2007, we identified some cases where strategies to protect children at risk were affected by inadequate information exchange and coordination:

- In two cases, we raised concerns to DoCS about children who were in out of home care. In the first, we raised concerns with DoCS about an apparent failure of the department to undertake a formal carer assessment for a child placed in voluntary care. Our concerns were in the context of our review identifying that the carers had previously had a child removed from their care, and that one had been the subject of serious criminal allegations. In another case, we identified inadequate consideration by DoCS of the support and material needs for a child placed with a relative carer, where our review indicated a carer assessment had identified the need for significant material and in-home support prior to children being placed there.[46]

43 Department of Community Services, correspondence dated 27 February 2008.

44 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW. See recommendations 2.3, 9.1 and 9.2.

45 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 53.

46 At the time of writing, we were awaiting DoCS' response to both these matters.

- In relation to adolescents with mental health issues, we raised concerns with an Area Health Service about the discharge of a young person from a mental health facility without adequate support. The young person committed suicide following discharge from the service. The young person had a history of mental illness and had previously attempted suicide. Although the young person was assessed as being stable, discharge took place without adequate arrangements in place to ensure continuity of care and support. In response to this case, the Area Health Service advised us that it had revised its discharge policy for children and adolescents. Included in the revised policy is the requirement for a comprehensive crisis and risk management plan to be developed for each patient, in collaboration with the patient and family.[47]
- One case we reviewed raised questions about the management of methadone patients who have children in their care. DoCS was involved with the family through a supervision order of the Children's Court and had requested the mother undergo regular urinalysis. We found that while the mother refused 13 requests to provide urine, she continued to receive take-away methadone from her prescriber without the level of review required by health policy.[48] The concerns we raised to the Area Health Service focused on the apparent lack of monitoring of compliance by methadone prescribers with the department's clinical guidelines for opioid treatment, and failure to review the circumstances of the patient in the context of known DoCS involvement and refusal to participate in urinalysis. We also raised questions with DoCS about the adequacy of the department's role in monitoring the mother's compliance with court sanctioned undertakings that she abstain from drug use.

In this case, the Area Health Service advised us of a number of initiatives to address the issues, including:

- Development of protocols relating to provision of take-away methadone, and for structured programs of care in provision of opioid treatment.
- Expansion of capacity for delivery of early childhood services and management of child protection issues within opioid treatment services.

The Area Health Service advised us in February 2009 that these initiatives were in train.

More broadly, NSW Health has continued implementation of our earlier recommendations relating to parental substance abuse. This includes finalisation of a review of Drug Use in Pregnancy Services, and planning for a one-week census of take-away methadone doses.

DoCS has also trialled a drug testing policy, linked to the introduction of Parent Responsibility Contracts. The policy provides for the use of formal undertakings by parents about refraining from drug use and undergoing a testing regime. At the time of writing, DoCS was awaiting a report from an independent evaluation of the trial.[49] DoCS has also clarified the department's policies as they relate to undertakings, including the requirement to monitor and review case plans.

As indicated above, a number of Inquiry recommendations focused on ensuring a range of pathways for provision of support to vulnerable children and families. The NSW Government has supported the establishment of child wellbeing units within agencies to refer reports meeting the threshold of 'risk of significant harm' to DoCS, supported by regional intake and referral units to assist families who do not meet the threshold to access appropriate support services.

47 Area Health Service response to Ombudsman request for statement of information.
48 NSW Health (2006) NSW Health Clinical guidelines for Methadone and Buprenorphine Treatment of Opioid Dependence.
49 Department of Community Services, correspondence dated 8 August 2008.

To implement broader structural changes, the Inquiry proposed a period of capacity building in non-government agencies, and recommended changes in information technology and workforce capacity within DoCS. The Inquiry also put forward that non-government and state agencies should be funded to deliver universal, secondary and tertiary services to support the pathways model.

Capacity building in NGOs, Aboriginal and non-Aboriginal, has been supported by the Government as a strategy over a five year period. Similarly, the Government has stated support for 'the availability of services across the service continuum' as a long-term strategy, to be substantially commenced within two to three years, through a lead agency partnership of DoCS, NSW Health, Department of Aboriginal Affairs and the Attorney General's Department.[50]

3.3.5 Interagency cooperation

We have consistently identified the importance of effective interagency coordination and the need for agencies to work well together to provide a sustained response to children at risk and their families.

In our reviews of deaths in 2007, we found agencies often worked well together to promote an appropriate protective response to children at risk of harm, or in need of protection. However we also identified and raised with agencies a number of cases where there was poor information exchange between agencies, and inadequate coordination of responses to risk of harm.

Of particular note, four cases we considered closely in 2007 focused on JIRT.

Our reviews of cases that were referred to JIRT, or were the subject of JIRT investigation, identified some concerns that we raised with JIRT partner agencies, including:

- Inconsistencies in how JIRT eligibility criteria were interpreted, with some reports being rejected for JIRT investigation that appeared to meet the criteria.
- Poorly coordinated responses to reported risk of harm in cases where reports were referred to JIRT but were not accepted under JIRT criteria.
- Poorly coordinated joint case allocation across the NSWPF and DoCS, where reports were accepted for JIRT investigation. In one case, we raised concerns that poor coordination and delays in providing information impeded a timely and effective response to risk of harm concerns.

A review of JIRT was completed in late 2006. In response to the review recommendations, DoCS, the NSWPF and NSW Health are in the process of implementing structural and procedural changes to the operation of JIRT. Among a range of changes, the agencies are trialling a central 'joint decision making unit'. It is intended the JIRT Referral Unit will provide improved consistency and transparency in decision making, and free up local resources.[51] Physical abuse criteria have also been revised, and sexual abuse criteria are under review.

In June 2008, DoCS published revised procedures for handling matters rejected by JIRT. The procedures require the receiving CSC to 'undertake a timely response that reflects the level of risk and safety issues identified in the reports.'

In relation to interagency practice more broadly, the Interagency Guidelines on Child Protection Intervention, released in 2006, are currently subject to evaluation.

50 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 65.
51 Department of Community Services, response to final report of an Ombudsman investigation, dated 4 July 2008.

Interagency cooperation was a significant focus of the Special Commission of Inquiry. The Commission emphasises that 'the child protection system in New South Wales consists of much more than the Department of Community Services.'[52] It considers, as a key principle, that child protection is the collective responsibility of the whole of government and of the community.[53]

Many of the Inquiry's proposals promoted this view and are consistent with observations and recommendations made by this office. Among other strategies, notably, the multi-pathways nature of the proposed structure for delivering child protection services, the Inquiry recommended:

- Use of a common assessment framework to identify and respond to the needs of children and families, and integrated case management for families who are 'high end users' and identified by DoCS as frequently reported families. Government has supported this recommendation for immediate implementation (substantially commenced within six months). The Government's response notes that DoCS has commenced development of a 'threshold tool' for use by mandated reporters. Further, the Government will commence a 'frequently encountered families' case coordination project in selected locations. The focus of the project will be on families that are already 'high end users' of government services, or known to multiple agencies.[54]
- Amendment of legislation governing each human service and justice agency to insert a provision that obliges the agency to 'take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children' to ensure the care and protection needs of children are met. The Government has supported this recommendation 'with some variation' for immediate implementation.[55]
- Inclusion of provisions in the performance agreements of CEOs that they perform in ensuring interagency collaboration in child protection matters. The Government has supported this recommendation for immediate implementation.[56]
- Cross-agency training on interagency collaboration and coordination. The Government has supported this recommendation for short-term implementation (substantially commenced within 12 to 18 months).[57]
- Amendment to the Children and Young Persons (Care and Protection) Act to assist more effective exchange of information relating to child protection work between government agencies, and between them and the non-government sector. The Government has supported this recommendation for immediate implementation.[58]

In relation to JIRT, the Commission has proposed completion of the JIRT reform program, and regular auditing of JIRT.[59] The Government has supported these recommendations for implementation in the short term. The Government proposes an audit of JIRT every three years, commencing in 2010.[60]

52 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page i.
53 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page v.
54 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 58 and 68.
55 Ibid, page 65.
56 Ibid.
57 Ibid, page 93.
58 Ibid, page 94.
59 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW. See recommendations 10.7, 24.1, 24.2, 24.3, 24.4, 24.6, 8.1, 8.2.
60 NSW government (March 2009) Keep them safe: A shared approach to child wellbeing, page 57.

4. Recommendations

As we have noted above, the concerns we identified about the child protection system in 2007 were, for the most part, not new. Broadly, those concerns related to the adequacy and quality of agency actions to identify, report and respond to children at risk of harm or in need of care and protection.

As detailed in Appendix 3, agencies have in the main made commitments to take, or have taken, positive steps to address these recurrent concerns.

These issues were also among those scrutinised by the Special Commission of Inquiry into Child Protection Services. The NSW Government's support for the large majority of the Inquiry's recommendations heralds a significant shift in the State's approach to the provision of child protection services.

In this context, we have chosen not to make new recommendations arising from our work in 2007. However, and as indicated in Appendix 3, we will be seeking advice later in 2009 from agencies about specific strategies they intend to implement to further the intent of our previous recommendations, in the context of the NSW Government's plans arising from the Inquiry.

Part 2: Reviewable deaths of children with no child protection history

1. Introduction

1.1 Background to the group review

Each year, approximately eight per cent of the families of children whose deaths are reviewable had not been the subject of a report to DoCS in the three years prior to the child's death. The deaths of these children are reviewable because they died as a result of abuse or neglect, or in circumstances suspicious of abuse or neglect.

Over the five years from 2003 to 2007, 180 children died in NSW as a result of abuse or neglect, or in suspicious circumstances. Of these children, 55 (30 per cent) had no child protection history.[61]

Having reviewed each of these deaths individually, we decided to conduct a review of these 55 deaths as a group.

The purpose of our review was to examine the profiles of these children and their families, and the circumstances leading to the deaths of the children, in order to identify any specific trends or patterns. Identifying trends is an essential step in developing effective prevention strategies. We also wanted to know whether there were notable differences in the demographic profile and circumstances of death for children with a child protection history, and those without. To address this question, the group review also included some comparative analysis of children who had a child protection history and who died in the same circumstances. The review further aimed to determine whether risk was apparent in the backgrounds of the children who had not been reported to DoCS, and whether their circumstances prior to their deaths would have warranted them being brought to the attention of the department.

Of the 55 children who had not been reported to DoCS, 20 died as a result of abuse and 34 in circumstances of neglect.

In relation to deaths resulting from abuse, most of these children (18) died as a result of abuse perpetrated by a family member.[62] Our review focused on these cases. We also compared the family characteristics and circumstances of death of these children with 29 children who died in family homicides and had a child protection history.

In regard to deaths resulting from, or suspicious of, neglect, the majority (29) of the 34 children died in a limited range of circumstances. These were drowning (16), in transport fatalities (7), and while co-sleeping with parents (6). We focused our attention on these cases.[63] We compared these cases to 47 children from families with a child protection history who died in like circumstances of drowning (22), in transport fatalities (4) and in co-sleeping incidents (21).

Overall, our group review considered 47 deaths of children with no child protection history, with some comparative examination of 76 deaths of children from families that had been the subject of a report to DoCS.

Approximately three-quarters of the 47 children with no child protection history were younger than five when they died:

61 This includes five children who had been the subject of a report to DoCS, but that report related to the incident which subsequently resulted in their death.

62 Two young people died in incidents unrelated to family, including peer-related violence. These deaths have not been included in the review.

63 The deaths of five children with no child protection history who died in circumstances of, or suspicious of, neglect are not included in this group review. The circumstances in which these children died were failure to seek timely medical treatment, strangulation resulting from a faulty cot, poisoning from over-the-counter medication and electrocution.

- 14 were aged less than 12 months
- 22 were aged between one and five years
- four children were aged between six and 10 years, and
- seven were aged between 10 and 15 years.

Twenty-eight of the children were male and 19 were female. Five children were indigenous.

1.2 Children with a child protection history

In order to examine whether there were different profiles in families with and without a child protection history, we also considered 76 children whose families had previously been the subject of a report to DoCS.

The 76 children also died as a result of abuse, or in circumstances of neglect related to drowning, transport fatalities and in co-sleeping incidents.

1.3 Information sources and limitations

For each case, we reviewed all known available records for the child who died and, where relevant, their family. Generally, our reviews included examination of some or all of the following:

- Death registration data from the NSW Registry of Births, Deaths and Marriages
- NSW Police record of death report (P79A report)
- NSW Police Force databases
- NSW Health records
- Interim and final autopsy reports prepared for the Coroner
- Coronial report (s.16A notice)
- Inquest transcripts, where available
- Briefs of evidence prepared for the Coroner
- NSW court records
- Department of Education and Training records
- Non-government organisation records
- Other agency records.

Where relevant, we also scrutinised records of private practitioners involved with the child or their family. These included general practitioners and psychiatrists.

1.3.1 Limitations

The information provided about the children and their families through records was, in many cases, substantial. In some cases, however, information about the circumstances and background of the child and family was more limited and did not provide all the information we sought.

In addition, the number of cases we have considered is relatively small, particularly when we have broken down the information to look at smaller sub-groups of children and families. Categories where there are small numbers of cases need to be interpreted with caution, as very minor fluctuations over time can have a significant impact on findings or results.

For these reasons, we have exercised caution in drawing conclusions from our analysis, and in the main, we have provided observations only.

Our observations will provide direction for our future work in reviewing child deaths.

2. Homicide and murder-suicide

2.1 Family homicide: data and research

Most child homicides occur within families. In an analysis of child deaths between 1996 and 2005, the NSW CDRT reported that almost 96% of child homicides were perpetrated by 'parents, spouses or domestic partners or other family members'.[64] 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.[65]

A study of homicide in Australia over the ten years to 1999 identified that biological parents were responsible for a greater proportion of deaths of children (64%) than de facto parents, and the likelihood of homicide was more or less the same for girls and boys.[66]

The homicide rate for children decreases in relation to increasing age, with infants under one year of age most at risk, followed by those aged between one and five years. The greater robustness of older children is one factor that helps to explain this pattern. Also relevant may be the regular involvement of older children in activities outside the family home, given that children are most likely to be killed at home and by a family member.[67]

There is no universally accepted classification of the circumstances of child homicides. Strang has noted a number of distinguishable 'major scenarios', including children who died as a consequence of a family dispute, were victims of fatal abuse or the psychiatric illness of the offender, or were the subject of a fatal sexual assault. Most common are family disputes and fatal abuse.[68] The NSW CDRT has considered fatal assault deaths in clusters related to precipitating incidents; non-accidental injury, parents affected by mental illness, family breakdowns and killings of teenagers.[69]

Underlying motives for parental killing of children are difficult to explain. One analysis of such homicides in Australia found the motive 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%).[70] Overwhelmingly, these perpetrators are male. Mental illness has also been identified as a significant factor on the part of mothers who kill their children.[71]

Given the difficulties of attributing motive in child homicides, it is notable that those motives that have been identified, including adult relationship conflict and mental illness, are also prevalent throughout the community, while the deaths of children in familial homicide are relatively rare. For example, national data has indicated that almost one in

64 NSW Child Death Review Team (2006) Trends in the fatal assault of children in NSW: 1996 – 2005, page 3, NSW Commission for Children and Young People.

65 For the purposes of this paper, we have used 'family homicide' to include filicide, siblicide and killings by other family members. It does not include parricide (children killing their parents) or intimate partner killings. See Mouzas J and Rushforth C (2003) Family homicide in Australia. Australian Institute of Criminology, trends and issues paper 255. Page 2. Reviewable deaths that were not family homicides occurred primarily in the context of peer-related violence or involved unknown or unrelated perpetrators.

66 Mouzos, J (2000) Homicidal Encounters A Study of Homicide in Australia 1989 – 1999, Australian Institute of Criminology Research & Public Policy Series No 28, page 140.

67 Strang, Heather (1996) Children as Victims of Homicide in Trends and Issues in Crime and Criminal Justice, No. 53, March 1996, Australian Institute of Criminology, page 2.

68 Ibid, page 3.

69 NSW Child Death Review Team (2003) Fatal Assault and Neglect of Children and Young People, page 4, NSW Commission for Children and Young People.

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

71 Ibid, page 4.

five Australians has reported experiencing a mental disorder. The same survey reported that about six per cent of the population of people aged 18 and above had experienced depression in the previous 12 months. Rates of depression were higher for females than males.[72] In 2006 divorces occurred at a rate of 2.6 per 1000 population.[73] In the same year, about 15 per cent of all couple families were living in a de facto relationship.[74]

2.1.1 Murder-suicide

A notable characteristic of child homicides is the prevalence of subsequent suicide by perpetrators. Between July 1989 and December 2002, 25 per cent of parents who killed their children committed suicide, compared with six per cent of perpetrators of homicide generally.[75] Additionally, murder-suicides tend to have more victims than other types of homicide.[76] These incidents are also more likely than other homicides to involve firearms. Firearms were used in 60 per cent of all murder-suicides in Australia from 1989 to 1996, compared with 19 per cent of other homicides in the same period.[77]

Researchers have expressed caution about classifying murder-suicides according to the context of the incident and reasons for it because of a lack of sufficiently detailed information about perpetrators' motives. On an indicative basis, however, nearly 70 per cent of all murder-suicides in a seven-year period occurred in the context of 'disputes relating to termination of a relationship, jealousy or other domestic matters.'[78]

2.2 Deaths included in our review

All child deaths that are, or may be, due to abuse are reviewable.

In the context of fatality, we define abuse as an act of violence by any person directly against a child or young person that causes injury or harm leading to death.

We focused our review on children who had no child protection history and who died in family homicides. Between 2003 and 2007, 18 children with no child protection history died in these circumstances. Our review also considered 29 children who died in family homicides and whose families had a child protection history.

2.3 Fatal abuse: the children with no child protection history

Of the 18 children who had no child protection history and who died in incidents of familial homicide, 10 were male and eight were female. The majority of the children (13) were aged five years and younger, with five of these children being infants under 12 months of age.

Half of the children (nine) died in incidents where the perpetrator also killed themselves, or attempted to. Six children died in four murder-suicides, and three children died in three murder-attempted suicides, where the perpetrator attempted suicide after killing the child.

Two of these children were of indigenous background. The perpetrators were also indigenous. Three children lived in families that were culturally and linguistically diverse.

The children died as a result of physical assault with no weapon (six), stabbing (three), shooting (three), suffocation (three), drowning (three), and poisoning (one).

72 Australian Bureau of Statistics (1997) National Survey of Mental Health and Wellbeing of Adults.
73 Australian Bureau of Statistics (2006) Divorces Australia catalogue no. 3307.0.55.001.
74 Australian Bureau of Statistics (2008) Australian Social Trends Data Cube table 1 catalogue no. 4102.0.
75 Mouzos J.(2002), Homicide in Australia: 2000 – 2001 National homicide monitoring program annual report, Research & Public Policy Series, no 40, Australian Institute of Criminology.
76 Carach, C and Grabosky, P N (1998) Murder-suicide in Australia: Trends and issues in crime and criminal justice no 82, Australian Institute of Criminology.
77 Ibid, page 3.
78 Ibid.

2.3.1 Charges and convictions

In relation to the 16 incidents, 14 perpetrators have been identified through either finalised Court proceedings or Coronial inquests. In relation to the two incidents where no perpetrator has been identified, in one a person was charged but found not guilty, and in the other, a person has been charged and court proceedings are pending.[79]

Of the 14 perpetrators:

- The Coroner held an inquest for each of the four incidents of murder-suicide, involving the deaths of six children.
- In all 12 homicides or murder-attempted suicides, a person was charged and in 11 cases, court proceedings have been finalised:
  - five perpetrators were found guilty of murder
  - two perpetrators were found guilty of manslaughter, and
  - three perpetrators were found not guilty of murder by reason of mental illness.

2.3.2 Relationship of the perpetrator to the victim

Of the 14 perpetrators, nine were male and five were female.

The majority of perpetrators (nine) were natural parents of the children: five were natural fathers and four were natural mothers. All perpetrators of murder-suicides and murder-attempted suicides were natural parents (three fathers and three mothers). Other perpetrators were a step-father, defacto partner of the child's mother, a sibling, an uncle and a cousin.

In all but two of the families, the perpetrator and child or children who died lived in the same household. In one further case, the perpetrator had moved out of the family home in the weeks before the incident, and in another, the perpetrator's spouse and children were temporarily staying elsewhere.

2.3.3 Perpetrator characteristics

We identified key characteristics that related to the perpetrators and incidents, which in the main accord with previous research into family homicide: the presence of mental illness or mental health problems in relation to the perpetrator, evidence of family breakdown, and the use of firearms in murder-suicides. We also considered common risk factors to children. This included whether there was any prior history of violence, or any evidence of substance abuse on the part of perpetrators. We also looked at available evidence of financial stressors on the family.

Mental health

For 10 of the 14 perpetrators, we found some evidence that the perpetrator had a mental illness or mental health problem. This ranged from depression diagnosed by a general-practitioner to florid mental illness.

The distinction between mental health problems and diagnosable mental illness or mental disorder is difficult to define.[80] In some matters we reviewed, mental illness was a documented characteristic of the perpetrator. In other cases, mental health problems such as recent depression were evident in a perpetrator's history. Some perpetrators were taking anti-depressant medications in the period before the homicide.

79 www.lawlink.nsw.gov.au/scjudgements In this case the Judge noted 'I am satisfied beyond reasonable doubt that they [the injuries] were inflicted when the deceased was either shaken and/or struck by or against some firm object such as a wall.'

80 Commonwealth Department of Health and Aged Care National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-promote.

In three cases, all female perpetrators, the homicide occurred in the context of the perpetrator's mental illness:

- A mother killed her child at home during a psychotic episode. She was subsequently diagnosed as having 'major depression with psychotic delusional beliefs'.[81] The woman was charged with murder and found not guilty on grounds of mental illness. Records indicate that the woman had a number of prior episodes of depression.
- A woman killed a relative during a psychotic episode. She had previously been diagnosed with schizophrenia, and was found not guilty of murder because of mental illness.
- A woman who killed her child had a history that included recurring depression, anxiety and panic attacks. Police and coronial records indicated that the woman had formed an intention to kill herself after her child's death but was stopped from doing so. The woman was found not guilty of murder because of mental illness.

In a further two cases, including one murder-attempted suicide, mental disorder on the part of the perpetrator was identified as a contributing factor to their actions:

- A woman was taken to hospital as an involuntary mental patient after being found with her dead child. A psychiatrist assessed the woman as suffering psychosis and she was administered anti-psychotic drugs. She was subsequently found not to be suffering any mental illness, although it was noted that there was some possibility of recurrent episodes of psychosis. At trial, she pleaded guilty to the manslaughter of her child. The judge noted that, on the balance of probabilities, she was 'suffering an acute disturbance of her mental state, possibly of a psychotic type, at the time her child died', and that the defence of mental illness was 'clearly open to her on the expert evidence'.[82]
- A man killed a child relative and attempted to kill himself. Passers-by found the man semi-conscious and alerted police. While in custody the man was diagnosed as having an obsessive-compulsive disorder, which had contributed to his actions. He pleaded guilty to murder and was jailed for life.

A total of six perpetrators were identified as having current or previous depressive conditions. In four of the six cases, depressive disorders were present along with other mental health problems.

In the two cases where depression was the sole identified mental health problem, the perpetrators were being treated with medication for the condition. Both perpetrators were male, and committed two of the four murder-suicides:

- A man had previously been hospitalised after an attempted suicide and had been taking anti-depressant medication prescribed by a GP in the months leading up to a murder-suicide incident. Some questions were raised by the Coroner about the level of medication in the man's body, a 'high but not fatal' level, and the possibility of this contributing to the man's actions.[83]
- A man had been experiencing episodic depression in the 20 months prior to the incident. He was prescribed treatment, and had seen a psychologist.

In relation to the other two murder-suicides, we located no records that indicated the perpetrator had any identified mental health problem.

81 Justice Health records.
82 http//www.lawlink.nsw.gov.au/scjudgements Regina v RG [2006].
83 NSW Coronial records.

Family breakdown

Records indicated that in three of the four murder-suicides, the parents were experiencing relationship difficulties:

- In one case, the documented family history included mutual domestic violence, relationship difficulties and a period of separation before the incident. The couple was attending relationship counselling in the period prior to the deaths.
- A family was reportedly experiencing marital conflict that led to family breakdown. The husband moved out of the household several weeks before the incident, in which he killed his wife and children before committing suicide. The couple was attending relationship counselling in the period prior to the deaths.
- A couple were reportedly experiencing difficulties in their relationship, and an appointment for relationship counselling had been arranged. The man's wife and children were staying temporarily away from home. The man killed one of the children who was staying with him, and then himself.

In the fourth murder-suicide, the male perpetrator was a single parent. Neither he nor the child had contact with the child's mother.

In two of the three murder-attempted suicides, the parents had separated. In one, the child's parents separated in the months before the child's death and in the other, the parents of one child had been separated for the 12 months prior to the incident.

Where the perpetrator did not suicide or attempt to, we found no documented evidence of family separation at the time of the deaths. In regard to relationship difficulties, in one case, a woman had reportedly informed her partner (the perpetrator) that she wished to end their intimate relationship.

History of violence

From the records we reviewed, we identified a recent history of domestic violence in two families involved in separate murder-suicides.

In one of the families, domestic violence on the part of the father was noted to have escalated prior to the murder-suicide. However, there was no police involvement with this family in relation to domestic violence. In the other family, both parents were reported to be violent towards each other. In the latter case, police attended domestic violence incidents on two occasions prior to the deaths. In the other two murder-suicides, there was no recorded history of violence on the part of the perpetrator.

Among the remaining 10 cases:

- For one family, we located one notification to police about a domestic violence incident. While police attended, they recorded this as a verbal domestic argument, and no children were present. In this case however, a post mortem examination found evidence of previous injury to the child that was consistent with child abuse. The perpetrator told police that he had abused the child in the week prior to the killing.
- In two further cases, there was evidence of previous abuse of a child. In one case, the perpetrator was charged and convicted of manslaughter in relation to the death of a two year old child that occurred 11 years previously.[84] In another, a post mortem examination found evidence of previous injury to the child that was consistent with child abuse.

84 http//www.lawlink.nsw.gov.au/scjudgements Regina v RHB [2007]. Charges relating to the earlier death were pursued following the death of the second child.

Drug and alcohol use

We identified a recent history of drug and/or alcohol abuse for three of the 14 perpetrators.

The three, all male, were users of heroin and cannabis; amphetamines, cannabis and alcohol; and alcohol and cannabis. All three were convicted of murder:

- In one case, the perpetrator denied using any substances on the day of the killing.
- In the second case, the trial judge noted a forensic psychiatrist's assessment that the attack was 'due to [factors including] a combination of the effects of [the man's] personality traits, chronic depression … chronic cannabis use and cannabis use withdrawal … rapid consumption of alcohol'.[85]
- In the third case, the perpetrator was reportedly experiencing withdrawal symptoms from methadone.

In the remaining 11 cases, we found no record of any significant drug or alcohol histories. Two perpetrators consumed large amounts of drugs and/or alcohol just prior to the incident, but had no known history of substance abuse. Another who had been smoking cannabis had some record of previous ongoing use of the drug.

Financial circumstances

Six perpetrators were in receipt of benefits, including the supporting parents benefit and disability pension.

In one case, records indicated financial pressure may have been a contributing factor in the actions of the perpetrator. In this family, the perpetrator was unemployed, living in public housing, had a history of gambling and had current debts.[86]

2.3.4 Use of firearms

Firearms were used in three incidents, all of which were murder-suicide. In two cases, a perpetrator used a licensed firearm to kill the victims and then to take his or her own life. In the third case, the perpetrator used other methods to kill the victims and then shot himself with a licensed firearm.

In two of the three cases, firearms had previously been removed by police, and the owners' licences suspended:

- Police had temporarily removed firearms from the family home and suspended the owner's gun licence after learning of his suicide attempt. This man successfully applied for the return of the weapons and licence. The application was supported by references, including a letter from the man's GP that he was fit to hold a licence. In the inquest into this matter, the Coroner noted that there is no requirement for a firearms licence to be suspended following a suicide attempt or in response to a mental health issue. The Coroner subsequently recommended to the NSWPF that people with a history of attempted self harm be required to provide a psychiatrist's assessment in support of an application for a firearms licence.
- In the second family, police seized and then returned firearms on two occasions after incidents of domestic violence. No charges were laid or apprehended violence orders taken out in relation to either incident, and as a result, on both occasions the suspension was lifted and the firearms restored. In this case, the partner of the licence holder was the perpetrator.

85 http//www.lawlink.nsw.gov.au/scjudgements Regina v DN [2007].
86 NSW Coronial records.

In the third incident of murder-suicide, a spouse had removed guns from the family home shortly before the incident because of what records indicate was her concern about the mental state of her partner. However, the man had access to a weapon that was not removed.

2.3.5 Previous indicators of risk

We considered the question of whether there was any evidence of risk to the children prior to the incident that resulted in their death.

Above, we noted a range of factors in the lives of the children that are recognised child protection risk factors. In a number of the families, more than one of these factors existed in combination. For example, in three of the four incidents where the children died in murder-suicides, mental health problems and family breakdown were evident in the families leading up to the incident. In one of these families, domestic violence was also a recorded issue.

Contact with agencies

Some of the families had contact with health service providers, counsellors and police in the weeks or months prior to the deaths of the children. Our reviews identified two cases where some risk to children may have been indicated:

- A husband and wife had a series of contacts, together and separately, with a counsellor from a family support service. Records indicated that the counsellor held concerns about escalating domestic violence and the husband's threatening behaviour, and urged the man's wife to contact police and take out an AVO. There had been no reports of domestic violence to police. At inquest the Coroner noted the confidential and supportive nature of counselling and the subsequent difficulty faced by counsellors in directly engaging other agencies in relation to identified risks. The Coroner recommended that counsellors and other health professionals be required to notify police if they believe or suspect that a person is at risk of self harm or harming others by having access to firearms.
- In the eight months prior to a murder-suicide, police attended the family home in response to a complaint of domestic violence by the husband on one occasion, and by the wife on another. Each spouse sought an Apprehended Violence Order (AVO) against the other but subsequently withdrew the application. In one incident, children were recorded as being 'at risk' by police, as is required by standard operating procedures if children are present at a domestic violence incident. However, we found no record on the DoCS system of a corresponding risk of harm report being made to DoCS.

In addition to the two cases above, we identified that a further six perpetrators had contact with health professionals or police in the period leading up to the homicides.

- One woman was under the care of a psychiatrist. She had ceased medication for her condition but there was an indication that her mental illness was becoming florid in the period prior to the incident in which a family member died.
- One woman was receiving assistance from a community health service for an issue unrelated to mental health. The woman had a documented history of significant mental health problems, but this was not known to the service. The woman had recently moved to the area, and the service identified the woman had few social supports. The records indicated, however, that she was receiving assistance from the child's father and had enquired about joining parent and play groups. Client files relayed no concerns about risk to the child.

- A mother was attended by ambulance officers in relation to what records described as a 'panic attack' five days before the child's death. The following day she saw a GP who prescribed anti-depressant medication.
- A mother had an extensive history of involvement with health services in relation to recurrent depression and other mental health issues. In the weeks before the incident the woman was assessed by a GP and recommenced anti-depressant medication.
- A man who had previously received drug treatment and counselling for depression visited his doctor and was again prescribed anti-depressant medication a week prior to the incident in which he killed himself and his child.
- Police responded to a domestic violence incident two weeks prior to the homicide. The incident was a verbal argument, and the mother advised police she did not fear the father and did not wish to pursue an AVO. No children were present at the time, so police had no cause to make a risk of harm report.

In these cases, there was no indication in agency records that they held any concerns that the perpetrator was a direct threat to their child or children, or that the children were at serious risk of harm.

We found no record that the remaining seven perpetrators had any contact with government agencies or health professionals in the period leading up to the homicides. This included three cases where the perpetrator's mental health problem or illness was not diagnosed until after they were in custody and facing court in relation to the incident. The diagnosed illnesses were major depressive disorder, anxiety and depressive conditions, and obsessive compulsive disorder.

While the records we reviewed did not indicate that agencies or professionals held concerns about immediate or serious risk to children, inquests or police investigations in some cases noted that family or friends had held some concerns about the wellbeing of the family, and/or the mental health of the perpetrator. However, these concerns were not referred to agencies with a role in child protection.

2.4 Children with a child protection history who died between 2003 and 2007

In the five years from 2003 to 2007, 44 children whose deaths were the result of abuse had been the subject of a report to DoCS in the three years prior to their death, or had a sibling who was reported.[87] Almost two-thirds of these children (29) died in incidents involving family or household members.

Of the 29 children, seven died in four murder-suicides or apparent murder-suicides,[88] and two in murder-attempted suicides.

The children died as a result of physical assault without a weapon (12), poisoning (five, including three deaths as a result of methadone ingestion), suffocation or strangulation (two), stabbing (three), drowning (two), multiple injuries (one), burns (one), and smoke inhalation (one). The cause of death for two children has not been confirmed.

Of the 29 deaths, 13 were the subject of a formal Ombudsman investigation.

87 As noted above, this figure does not include five children who were the subject of one report to DoCS, where that report was made after, and about, the incident that ultimately resulted in their death.

88 One incident in which two children died is pending an inquest.

2.4.1 Charges and convictions

In relation to the deaths of the 29 children with a child protection history:

- Criminal proceedings have been finalised in relation to 10 deaths. Of the 10 defendants:
  - seven were convicted of manslaughter, one on the grounds of diminished responsibility
  - two were found not guilty by reason of mental illness, and
  - one perpetrator was convicted of murder.
- Inquests were also held into the deaths of seven children. Six of the children died in murder-suicides and one child in a homicide where the perpetrator died accidentally in the same incident.
- Charges have been laid in relation to 10 deaths. Of the pending charges, nine are for murder and one for manslaughter.
- No charges have been laid in relation to the deaths of two children. Coronial information has confirmed that the deaths of these children were a result of abuse.

2.4.2 The children with a child protection history

Approximately two-thirds of the children with a child protection history who died as a result of abuse were male (18), and 11 were female. Proportionately, this is similar to the gender difference for children with no child protection history. The age ranges of the children were also similar, with four-fifths of the children from families who had been the subject of reports to DoCS (23) being five years of age or less. Three children were aged between six and 10 years, and three were older than 11, with the oldest being 14 years of age.

Six of the 29 children were indigenous, which is a higher proportion than identified in the group of children who had not been the subject of a risk of harm report to DoCS. Four children were from a culturally and linguistically diverse background.

2.4.3 Previous indicators of risk

Clearly, the main difference between children who died and who had a prior child protection history, and those that did not, was that risk to them had been previously identified by relevant agencies.

Some of the families had a lengthy child protection history, with reports spanning 12 months to a number of years. A number of these families had also been involved with police and health services, and were the subject of reports because of risk posed by parental mental health issues, and/or substance abuse. Reports often raised concerns about child neglect and parental incapacity to adequately care for children. For families with significant child protection histories, physical abuse of children was also a commonly reported concern.

In four cases, the child, or other siblings, had been previously assessed by DoCS as being in need of care and protection, and had been removed from the family's care.[89]

In about a third of the cases (11), however, the child protection history of families was either relatively short (less than 12 months) or consisted of a small number of reports. For a number of the children, reported concerns were raised in the days or months prior to the

89 In a response to a draft copy of this report (February 2009), DoCS noted that 'comments about children having been in departmental care and then returned to a family member's care prior to the child's death are made in isolation, without context, and do not reflect the complexities of decision-making resulting in children exiting care.' We acknowledge that decisions to return, or otherwise, children to a family are complex and involve a range of parties, including the courts. In the context of this report, previous removal of children indicates only that the families had a significant child protection history.

incident, and related directly to the circumstances in which the child died. In three cases, reports related to the perpetrator's threats to kill the child. In one case, reports were made by hospitals after the child was presented with physical injuries, following an incident that occurred in the months prior to the incident in which they died.

In some cases, investigation by this office indicated that reports of risk were not effectively responded to, or information known by different agencies was not exchanged or coordinated. Particularly relevant issues we identified in this work included the capacity of agencies to effectively recognise and respond to parental mental health and substance abuse issues. In addition, our work has consistently identified poor information exchange between agencies, and inadequate coordination of agency responses to respond to identified risk of harm.

In response to a draft copy of this report, DoCS noted that the review included cases from 2003, and 'although the report is reflecting on a cohort review of cases which includes deaths from 2003, many changes have occurred which have addressed those issues.' We acknowledge, and detail in Appendix 3, that DoCS and other agencies have implemented some significant and positive changes to policy and practice over the past number of years. However, limited capacity and effective interagency work have been consistent issues identified in our reviews over the past five years. These issues were also a focus of the Special Commission of Inquiry, and are the subject of a number of key recommendations.

2.4.4 Perpetrators

Of the 14 identified perpetrators, more than half (eight) were women:

- Half (seven) were the child's natural mother
- three were the child's natural father
- three were the defacto of the child's natural parent, one female and two male. All of these relationships had been of relatively short duration, between seven and eight months, and
- one was the child's step-father.

Over half of all perpetrators (eight), including all seven mothers, had a history of mental illness or mental health problems. This ranged from GP-diagnosed depression to paranoid schizophrenia and drug-induced psychosis.

Natural mothers

All of the perpetrators who were the natural mothers of the children they killed had recorded mental problems or illnesses. In all seven cases, the mother's mental health and its effect on the child was one of the issues raised in risk of harm reports to DoCS, along with issues of neglect and inability to cope.

There was evidence in two cases of previous violence toward a child on the part of a mother. Three of the mothers were victims of domestic violence, and three had identified substance abuse problems.

In addition, natural mothers comprised the largest single group of alleged perpetrators, with four mothers facing charges in relation to the death of their child. Our review indicated that natural mothers in this group were also likely to have a history of substance abuse in addition to mental illness. Most had been a victim of domestic violence, and in a small number of cases, were a perpetrator of domestic violence. In most cases, the mother's mental illness and other risk factors had been the basis of reports to DoCS.

Male perpetrators

Males were the perpetrators in three of the four murder-suicides and three homicides.

Mental illness or mental health problems were less apparent in the backgrounds of the six male perpetrators than for the perpetrators with no child protection history, with the records of only two men indicating prior concerns. In one case, the perpetrator had been prescribed anti-depressants. In another, we located no history of mental health issues, but the perpetrator had reportedly become increasingly 'unstable' in the period before the incident.

In four of the cases, we identified some history of violence on the part of the perpetrator, primarily domestic violence:

- In one case, there was a significant history of violence. Physical injury to the child who died was the subject of a report to DoCS in the month prior to the child's death.
- In two cases, domestic violence appears to have escalated in the period prior to the incidents.
- In one case, there was one report made to police about a domestic violence incident.

A history of drug and/or alcohol abuse was an identified issue for six perpetrators. Our review indicated that in at least four of these cases, substance abuse was an issue at the time the child died.

Five of the six perpetrators, including two who committed murder-suicide, were reportedly experiencing family breakdown or relationship difficulties.

A further five males were facing charges in relation to the death of a child. Two were natural fathers, one a step-father, one a defacto partner and one a household member. Similar to the group of convicted perpetrators, the men were likely to have a history of substance abuse and a previous record of violent behaviour. Mental health issues were clearly evident in one case, and there was some evidence of concerns about mental health in two.

2.5 Review observations

Taken together, we considered the deaths of 47 children, 29 with a child protection history and 18 without. In relation to these deaths, there were 39 identified perpetrators or alleged perpetrators: 20 were male and 19 female.

In regard to the perpetrator's relationship with the child, the largest grouping was natural mothers. Seventeen perpetrators or alleged perpetrators, including 14 who have been convicted or found not guilty because of mental illness, were the children's mothers.

A further 10 perpetrators were natural fathers, five were defacto partners (four male and one female), three were step fathers, and four were other relatives or household members.

2.5.1 Characteristics of perpetrators and alleged perpetrators

In relation to families with no child protection history, in most cases, mental illness was identified as a significant contributing factor in the actions of women (mainly natural mothers) who killed. The records we reviewed showed no patterns of substance abuse or previous violence on the part of these women. A number of the women had experienced family breakdown within the 12 months prior to the incidents.

In cases where families had been reported to DoCS, the perpetrator or alleged perpetrator was likely to have a history of substance abuse, and particularly for females, a history of mental health issues. Mothers who killed their children in these families were most likely to have a mental illness, often accompanied by substance abuse issues. They were also likely to have been the victim, and in some cases the perpetrator, of domestic violence and previous physical abuse of their children. Such profiles are common to many families who have contact with the child protection system.

In regard to males, including fathers, step-fathers and defacto partners, those from families with a child protection history were most likely to have a previous history of perpetrating violence, and of substance abuse. Some of the men had records indicating mental health issues, but this was not as predominant as it was with the women. Most of the male perpetrators who had not previously been linked to child protection concerns also had some history of mental health issues, primarily depression. In some cases, diagnosis only occurred after the children's deaths. A minority of the men also had histories of substance abuse.

We also noted, particularly where families had no child protection history, that some families had sought support for family conflict and/or mental health issues. Where support was provided, this was either through counselling and/or medication.

2.5.2 Identifying risk

Overall, 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.

Children with no child protection history

In most of the cases where families had no child protection history, and while noting the possible limitations to the information available, our reviews found no evidence that professionals held a reasonable suspicion that a child was at risk of harm, or failed to make a mandatory report to DoCS on that basis.

Further, in those instances where a mandatory reporter could have considered making a risk of harm report, the level and type of risk reported may not have been sufficient to warrant a child protection response.

However, we did note that Coronial and police investigations in a number of cases noted concerns held by families and friends about the perpetrator's behaviour. These concerns were not relayed to authorities until after the child's death.

Children with a child protection history

In relation to families who had a child protection history, the majority had been the subject of reports over the period of a year or more. In some of these cases, DoCS was, or had been, working with the family. In these families, there were a range of reported issues, often including neglect, inadequate supervision and the effects on children of parental substance abuse and mental health problems. Of particular significance, in four cases children had been previously removed from families by DoCS due to abuse or neglect.

Not all families who had been the subject of a report to DoCS had chronic child protection histories. Some were the subject of only recent reports of risk of harm to DoCS. In a number of these cases, however, the reports were about serious concerns and were relevant to the circumstances of the deaths of the children. This was particularly so where the concerns reported included threats to kill made by the perpetrator, and where children had been presented to medical services with physical injury.

2.5.3 Murder-suicide and murder-attempted suicide

Profiles of families where children were killed in murder-suicide and murder-attempted suicides were largely similar for families with and without child protection histories.

Where there was a child protection history in families involved in murder-suicide, it was mostly recent, with the most serious reports occurring shortly before the incident in which the children died.

We identified relationship conflict and family breakdown as distinguishing features in nine of the 12 cases where perpetrators or alleged perpetrators committed suicide or attempted it after the children died. Mental health problems featured strongly in the four cases of murder-attempted suicide and all four perpetrators were mothers.

2.6 Policy and practice implications

The profiles of children, perpetrators and families identified through our review reflect key findings of previous work on child homicide in NSW and Australia. In particular, researchers have noted links between child homicide and parental mental health and family breakdown.[90]

A range of responses have also been proposed in the literature. For example, suggested strategies include the improvement of counselling and support services for separating parents, parenting programs, and the use of home visitation programs for the families of children deemed to be 'at risk' of abuse.[91]

Many of these proposed initiatives would undoubtedly assist families where children may be at risk of abuse or neglect. Researchers have noted that given the difficulty of predicting families where fatal abuse may occur, intervention strategies should be directed at the wider at-risk population.[92]

As indicated in our observations above, the factors that may be implicated in child homicide are complex. Family types and circumstances are not homogenous. Indicators of a child being at risk may or may not be apparent to agencies, or may be identified by family and friends but not referred to any authority.

In this context, it is illustrative that characteristics of familial child homicides are also evident in a range of other domestic or familial homicides. Data for 2005–2006 shows that more than half (58%) of all female homicide victims were killed as a result of a domestic altercation and 13 per cent of all homicides involved a victim or perpetrator with a previous history of domestic violence.[93] In 2004–2005 over half of the 66 intimate partner homicides that occurred had a recorded history of domestic violence.[94] Other research indicates that mentally disordered perpetrators are most likely to kill a family member.[95]

In 2006 this office expressed support for the establishment of a domestic homicide review process.[96] We have since reiterated our support on a number of occasions.

90 Lawrence R (2004) 'Understanding fatal assault of children: a typology and explanatory theory', Children and Youth Services Review 26, pages 837 – 852.

91 Mouzos M and Rushforth C (2003) Family homicide in Australia. Trends and issues in crime and criminal justice no. 255.

92 Strang, H (1996) Children as victims of homicide, Trends and issues in crime and criminal justice, no. 53, Australian Institute of Criminology, Canberra.

93 Davies, M and Mouzos, J (2007) Homicide in Australia: 2005-06 National homicide monitoring program annual report Australian Institue of Criminology, Canberra, pages 17 – 23.

94 Mouzos, J and Houliaras, T, Homicide in Australia: 2004-05 National homicide monitoring program annual report, Research and Public Policy Series, no.72, Australian Institute of Criminology, 2006.

95 Mouzos, J Mental Disorder & Homicide in Australia: Issues in crime and criminal justice, no. 133, Australian Institute of Criminology, Canberra.

96 NSW Ombudsman (2006) Domestic Violence: improving police practice, page 81.

Domestic violence death review teams have been operating since the early 1990s across the United States, Canada and the United Kingdom. We believe such a process has the potential to improve the collective understanding and knowledge of agencies and services about how domestic homicides come to occur and what strategies and practices may reduce the risk of their occurrence.

In December 2008, the NSW Government announced plans to review all domestic violence-related homicides in the State over the past five years. We understand that the review will be conducted by an advisory group that will report to the Minister for Women.

That review also has potential to contribute to the ongoing work of identifying strategies that could contribute to the prevention of familial child homicides.

3. Neglect-related deaths

3.1 What is neglect, or suspicious of neglect?

There is ongoing debate about what constitutes fatal neglect.[97] We define it as 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. Deaths are considered suspicious of neglect where there is evidence that indicates the death may have occurred in these circumstances.

In most of the cases we consider in this section, the conduct that led to us determining the death as reviewable involved significant carelessness on the part of a parent or carer. In line with our definition of neglect, we aimed to focus on cases where the conduct of a parent or carer went beyond a momentary lapse in supervision, or error of judgement. In this regard, we took into account whether there were any indications that parents or carers were aware of the risks that were present in the circumstances of a child's death. We considered the presence of well known risks to children, such as high and recent levels of drug or alcohol consumption while caring for children. We took into account the developmental needs of children, and whether the actions of parents or carers accorded with these needs. The Coroner's determination of cause of death was also a key consideration.

3.1.1 Deaths resulting from, or suspicious of, neglect included in our review

As noted, we focused our review on children who had no child protection history and who died in neglect-related circumstances as a result of drowning, transport fatalities and co-sleeping incidents.

Between 2003 and 2007, 29 children with no child protection history died in these circumstances. Our review also considered 47 children who died in transport fatalities and whose families had a child protection history.

All of the deaths we included had elements of significant carelessness on the part of a parent or carer. This might mean, for example, parental knowledge of problems with pool security in addition to failure to adequately supervise a child in the vicinity of the pool. It included a parent or carer driving a car while under the influence of drugs and/or alcohol, or parents co-sleeping with their baby while affected by substances that have a sedative effect.

Because we focused in the group review on the three main circumstances of death for children whose deaths were neglect-related, we did not include in this analysis a small number of reviewable deaths that occurred in other circumstances. These children died in circumstances where they were inadequately supervised in a hazardous area, placed in unsafe bedding, or not provided with timely medical attention.

97 See, for example, NSW Child Death Review Team (2003), Fatal assault and neglect of children and young people, Commission for Children and Young People.

3.2 Drowning

Between 2003 and 2007, a total of 90 children drowned in NSW.[98] Almost half of these deaths (42) were reviewable.

Of the 42 deaths, 38 occurred in neglect-related circumstances. In 16 cases, the children had no child protection history and in 22, the families of the children had been the subject of previous reports to DoCS.

3.2.1 Determining neglect in relation to drowning

There are various views about the extent to which incidents of childhood drowning should be defined as neglect. For example, one view suggests that any drowning of a child can be equated with neglect if the parent was not directly supervising the child at the time.[99] Such a definition would result in the large majority of the drowning deaths of children being considered neglect. A contrary view argues that such a broad approach 'implies that no reasonable parent should ever leave a preschool child unobserved, a position incompatible with normal childhood development.'[100]

In determining whether drowning deaths were due to neglect, or were suspicious of neglect, we used the same definitions that we use for reviewable child deaths generally. For deaths due to drowning, the most relevant elements of the definition relate to conduct by a parent or carer that involves an intentional or significantly careless failure to adequately supervise.

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

As noted above, we did not consider over half of drowning deaths to be related to neglect or suspicious of neglect. Some examples of these cases include incidents where lack of adult supervision would not be unreasonable, for instance, adolescent beach drownings; or incidents in which adult carers could not reasonably have foreseen hazards or risks.

3.2.2 Previous research: child drowning

Research indicates that children younger than five are more likely to die as a result of drowning than any other age group. Drowning is the most common cause of injury-related death for the under-fives. The Australian Water Safety Council has, however, reported a reduction in the number of drowning fatalities in the last decade, with a significant decline in drowning deaths in the nought to five year age group.[101]

Toddlers have been identified as being at particular risk of drowning. The reason young children are at greater risk of drowning is due to a combination of children's low risk awareness, undeveloped gross motor skills, mobility and natural curiosity.[102] Toddlers are also physically vulnerable to drowning as they are top heavy and more prone to toppling forward.[103]

98 Child Death Review Team (2008) Annual Report 2007, NSW Commission for Children and Young People.

99 Feldman KW, Monastersky C, Feldman G.K (1993). 'When Is Childhood Drowning Neglect?' Child Abuse and Neglect 17(3). Pages 329-36.

100 Ibid.

101 Ibid.

102 Department of Local Government (2006). Review of the *Swimming Pools Act 1992*: Discussion Paper, page 5.

103 Australian Bureau of Statistics (2000). Mortality and morbidity: Accidental drowning. 4101.0 Australian Social Trends. Page 5.

Children who survive a near-drowning incident often experience serious long term health problems. It is estimated that for every drowning death of a child under five years of age, there are between four and 10 hospital admissions for near drowning.[104] Researchers estimate that around five to 10 percent of children admitted to hospital following near-drowning will experience some neurological damage.[105]

Inadequate supervision is consistently highlighted as a contributing factor in nearly all of the research examining child drowning fatalities. In addition, the research indicates that most drowning deaths of children occur when a number of contributing factors are present at the same time.[106]

Backyard Swimming Pools

Almost half of the drowning deaths of Australian children under five years of age occur in backyard pools, with researchers reporting inadequate supervision and inadequate pool security as significant contributing factors.[107] Research has shown that pool owners' compliance with pool security requirements improves significantly with the implementation of inspection programs, and that without such programs in place, compliance levels are typically low.[108]

In NSW, the *Swimming Pools Act 1992* regulates the installation and maintenance of private swimming pools. The Department of Local Government (DLG) considers that the aim of the legislation:

> *…is to impose requirements in regard to swimming pool barriers to mitigate the effects of lapses in adult supervision. The legislation relates both to the physical features of the barrier restricting access and to behavioural matters on the part of persons who use the pool.*[109]

Under the Act, the basic requirement for owners of swimming pools on residential properties constructed after 1990 is that a functional child resistant barrier (which complies with Australian standards) separates the pool from the house and adjoining land at all times. Pools constructed prior to 1990 need only be surrounded by a child-resistant barrier that separates the pool from any neighbouring property, but not necessarily from the pool owner's house. The Act also provides that the barrier must be maintained in a good state of repair and that gates or doors be kept securely closed when not in use.

The NSW Water Safety Taskforce (now the NSW Water Safety Advisory Council) has noted that even if safety barriers are properly maintained, in around 40 per cent of cases involving children younger than six years, the child who drowned reached the pool by breaching the barrier. The most common scenarios include the gate being propped open, or a ladder or chair being located close to the pool fence.

Councils have certain powers and responsibilities under the Swimming Pools Act. Section 5 of the Act sets out the general duties of Councils concerning swimming pools and states that 'each local authority is required:

104 NSW Injury Risk Management Research Centre, University of NSW (2000), Analysis of Drowning in Australia and Pilot Analysis of Near-Drowning in New South Wales, report prepared for the Australian Water Safety Council.

105 Australian Institute of Health and Welfare: Kreisfeld R & Henley G (2008) 'Deaths and hospitalisations due to drowning, Australia 1999-00 to 2003-04'. Injury Research and Statistics Series Number 39 (Cat. no. INJCAT 109) Adelaide: AIHW.

106 Williamson A, Irvine P and Sadurai S (2002), Analysis of drownings involving children aged five years and under in NSW, report prepared for NSW Water Safety Taskforce, October 2002.

107 NSW Water Safety Taskforce, (2002), Analysis of drownings involving children aged five years and under in NSW, page 11, www.safewaters.nsw.gov.au.

108 Mitchell R & Haddrill K, (2004) 'Swimming pool fencing in New South Wales: who is checking compliance?' Health Promotion Journal of Australia, 15(1), pages 68 – 72. Van Weerdenburg K, 2005, Management of Domestic Swimming Pools and Compliance Levels. A comparison of approaches in three local government areas in NSW, report prepared for the NSW Water Safety Task Force, 2005.

109 Department of Local Government, 2006, Review of the *Swimming Pools Act 1992* Discussion Paper, page 11.

a) to take such steps as are appropriate to ensure that it is notified of the existence of all swimming pools to which this Act applies that are within its area, and

b) to promote awareness within its area of the requirements of this Act in relation to swimming pools.' [110]

Councils also have a range of powers in relation to enforcing pool owners' compliance with the Act. For example, councils can appoint inspectors with certain powers of entry and the ability to issue compliance directions, and in some cases, penalty notices in relation to certain prescribed offences set out in the Act.

However, there is no clear requirement in the Act for councils to inspect swimming pools on a regular basis. In practice, it is up to each local authority to decide whether routine inspection programs are necessary to promote pool owners' awareness of the legislation in line with their general duties under the Act.

In February 2009, the DLG advised us that a review of the Swimming Pools Act had been completed. The review identified a range of issues that require further consideration and consultation, including existing exemptions for pool barriers, compliance certification, penalties for non-compliance, pool barrier inspections and pool registers.

Bathtubs

Children who drown in bathtubs are usually infants.[111] In an analysis of children aged less than five years who drowned between 1995 and 2001, with one exception, all infants aged less than 12 months drowned in the bath.[112]

Dams and natural bodies of water

A Victorian study examined the drowning deaths of children in dams over a 13 year period. The study identified that, in addition to lapses in supervision combined with the absence of an effective barrier to keep children away from the dam, one of the main contributing factors was the placement of a dam within 300 metres of children's usual outdoor playing area.[113]

Researchers estimate that approximately 80 per cent of rural properties in NSW have at least one dam. They also report that it is common for dams to be within 50 metres of the residence.[114]

3.2.3 Reviewable drowning deaths: children with no child protection history

Of the 16 children who drowned and who had no child protection history, 10 were male and six were female. Their ages ranged from seven months to eight years. All but one of the children were three years of age or less:

- three children were under 12 months of age
- 10 children were between one and two years of age
- two children were three years of age
- one child was eight years old.

Because of their age and developmental stage, most of the children would have required constant supervision in or near water. None of the children who drowned were identified in records as being able to swim.

110 Section 5, *Swimming Pool Act 1992*.

111 Grossman D (2000) 'The history of injury control and the epidemiology of child and adolescent injuries,' The Future of Children, `10 (1), pages 23 – 52.

112 NSW Water Safety Taskforce, (2002), Analysis of drownings involving children aged five years and under in NSW, page 11, www.safewaters.nsw.gov.au.

113 Bugeja L & Franlin R (2005), 'Drowning deaths of zero-five year old children in Victorian dams, 1989 – 2001', Australian Journal of Rural Health, 132. Pages 300-8.

114 Mitchell R & Haddrill K, (2004), 'From the bush to the beach: water safety in rural and remote NSW,' Australian Journal of Rural Health, 12. Pages 246 – 250.

3.2.4 Circumstances of death for children with no child protection history

Swimming pools

About two-thirds of the children (10) drowned in swimming pools. In all except one case, the pools were in private premises. Nine of the children who died were aged under three years, one child was eight.

In relation to seven of the 10 deaths, we found there was a combination of inadequate supervision on the part of parents or carers, and faulty pool enclosures.

The records we examined in our review, including police records of interview, indicated the parents in all of these cases had some prior awareness of the safety hazards posed by inadequate barriers to the pool. In some, repairs to faulty gates had been attempted but had not been sufficient. In one case, for example, a two year old child who drowned in the family's pool had reportedly attempted to access the pool through a non-compliant gap in the fence on a number of occasions. While he had been given warnings by his family of the dangers of this, the gap had not been remedied. The child was unsupervised at the time he managed to gain access through the gap.

In two cases, we identified inadequate supervision on the part of parents or carers, in addition to pool enclosures being propped open to allow others to have easy access to the pool. For example, a pool gate was propped open to allow a two year old child to move freely between the pool and house. Although adults were in both areas, at some stage the child was not directly supervised and entered the pool without the knowledge of an adult.

In three cases, the hazard posed by faulty or propped pool gates was exacerbated by the presence of large numbers of people at social gatherings. In these cases, it appears that there was some lack of clarity about adult supervision of children accessing the pool area.

Of the nine incidents in private pools, seven were at the child's own residence and the child's immediate family were the owners or occupiers of the premises. In two cases the children were visitors to the premises containing the pool and the owner/occupiers were not related to the children who drowned.

Five of the private pool drownings occurred in a metropolitan area and four were in regional areas.

In one case, the child was being supervised at a school outing to a public swimming pool. The death of this child was subject to Coronial inquest, with the Coroner finding that the death of the child was avoidable.

Open bodies of water

Three children drowned in open bodies of water. In all three cases, the child was living, or staying, within walking distance of a river, dam or creek and was not adequately supervised at the time of the incident. In one case for example, a child under two years old wandered away from the unfenced house and accessed the water. The child was not in sight of the carer for some time. The carer told police they believed that the child was playing elsewhere near the house.

Bathtubs

Three babies, all aged less than a year old, drowned in bathtubs. In two cases, the parent or carer responsible for supervising the babies was impaired, either by fatigue or intoxication. In one case, for example, the child was left in the care of a man who consumed a significant amount of alcohol prior to bathing the child. The man fell asleep and the baby drowned. Police noted the man was heavily intoxicated when they attended the scene.

In a third case, the baby was left in the bath under the supervision of a toddler.

3.2.5 Factors identified in the review

Adult supervision

As noted above, previous research has indicated that child deaths as a result of drowning are often characterised by a lack of direct adult supervision combined with inadequacies in child-resistant safety barriers.[115] This was confirmed by our review.

In most cases, the carers were absent and unable to see the child. In some cases, the length of time parents or carers reported they were not with the child was relatively short. However, researchers and water safety advocates frequently emphasise that children generally drown quickly and silently.[116] In a number of cases, adults were present or in the vicinity, but were not providing direct supervision. This included two cases where carers had fallen asleep. In 10 cases, children gained access to pools without the knowledge of adults. In two cases, children aged 18 months old walked unobserved from their homes to a nearby unfenced pond or creek. One family was residing within 15 metres of an unfenced river where the child drowned, the other was within 100 metres.

Responsibility for supervision

In four incidents, absence of supervision appeared to have been based on delegation of responsibility for supervision of a very young child to siblings, or reliance on the presence of a sibling as a protective measure.

In these four incidents, the children who were left alone with the child were aged 10 years or younger, with the youngest aged two years. In each of these incidents the older child lacked the capacity to provide adequate supervision or protection. In one case a baby who drowned in the bath was left in the supervision of a toddler, and in another, an older child was given responsibility for supervising a very young child but at some stage left the child to play with other children. In one instance, police noted a parent's view that a toddler may have been able to leave the family house to get to a dam because an older sibling, a five year old) opened an external door. Several parents who were involved in activities in or around their homes believed that their children were playing inside or nearby. In these cases, the parents were unaware that the children had gone to bodies of water that were unfenced and close to the dwelling.

Large groups

The presence of numerous children and adults was notable in four of the pool drownings.

Police documented the presence of at least 10 children and five adults at one social event and over 20 people, including an unknown number of children, at another party. A third social event was a regular gathering of several families; there were around 20 children and an unspecified number of adults.

Records indicate that at two of these events, numbers of children were repeatedly entering and leaving via the pool gate. Available information does not indicate whether this occurred in the other case. Common to all of these cases was a failure on the part of the parents to take steps to ensure their child was being adequately supervised.

In the fourth case, the child drowned in a public pool during a school excursion attended by a large number of children.[117] Pool lifeguards and a number of teachers were responsible for supervision. In a subsequent inquest, the Coroner found that inadequate supervision and non-compliance with school risk assessment guidelines contributed to the death, as did

115 Child Death Review Team (2004) Annual Report 2003, NSW Commission for Children and Young People. Page 47.

116 For example, The Royal Life Saving Society Australia: 35 toddlers drowned in 2006-07 financial year. Royal Life Saving reminds parents to Keep Watch and prevent their child from drowning. Media release 13 November 2007.

117 This death is reviewable because the school was responsible for, and thus a carer of, the child.

non-compliance with pool guidelines on supervision by lifeguards, and the school's failure to identify the child as a non-swimmer.

The coroner recommended that all NSW primary school students should be assessed as swimmers or non-swimmers, and identified as such by wearing coloured wrist bands during unstructured school swimming activities. Further, the Coroner recommended that consideration be given to the adoption by all council and private pool operators of a ratio of one lifeguard to 50 students (rather than the current ratio of one lifeguard to 100 students) during unstructured primary school swimming events.

In separate advice to us, the DLG advised that the NSW Water Safety Advisory Council, of which the department is a member, has proposed a review of the DLG practice note on water safety. The practice note provides guidance to councils in relation to swimming pools and waterways. The proposal includes that the review of the practice note consider recommendations of Coronial inquiries into drowning deaths in public swimming pools, including the specific recommendations in the case above.[118]

Flotation devices

One bathtub drowning involved a parent who fell asleep while sitting next to the bath where a baby was playing while wearing what police records described as a floating baby seat/ring. Records indicate the parent had been drinking alcohol earlier in the afternoon.

We note that South Australia authorities recommended national consideration of the ongoing sale of baby bath seats after finding in 2002 that a baby in that state drowned while in such a seat. The Coroner in that state also recommended a strong public awareness campaign about the necessity of direct supervision of infants in bathtubs.[119]

Pool security

In eight of the 10 cases in which children drowned in pools, the pools were not completely enclosed by a child-resistant safety barrier that complied with legislation, or barriers were propped open. Two pools had gates that were not self-closing and in three cases, latches or safety locks were broken or defective. Another pool was not completely surrounded by a safety barrier, one was newly installed with only partially completed fencing and one had a gap sufficient for the child to breach.

3.2.6 Previous indicators of risk

In the majority of cases, the records we reviewed did not indicate prior risk to the children who drowned that might have been identified and followed up by agencies with child protection responsibilities. As we have noted however, hazards in relation to child-safe barriers to swimming pools had been identified, but not addressed, by parents or carers.

In one case, we identified a history that was relevant to the circumstances of the child's death. This child was in the temporary care of an unrelated adult who got into a bath with the baby and fell asleep while intoxicated. The adult's history included extensive alcohol abuse. This case was the only one to result in a criminal prosecution. The carer was charged and subsequently acquitted of the child's manslaughter.

Overall, our review found the key issue in drowning deaths was inadequate supervision. This was through parental or carer absence or inattentiveness, or inappropriate delegation of supervision. In pool drownings, inadequate supervision was a key factor, mainly in combination with poor fencing or other ineffective child-resistant safety measures.

118 Department of Local Government response to a draft copy of this report, correspondence dated 24 February 2009.

119 Australian Institute of Health and Welfare: Kreisfeld R & Henley G (2008). 'Deaths and hospitalisations due to drowning, Australia 1999-00 to 2003-04', Injury Research and Statistics Series Number 39, (Cat. No. INJCAT 109) Adelaide: AIHW, page 61.

3.2.7 Drowning deaths: children with a child protection history

Between 2003 and 2007, 26 children who had been the subject of reports to DoCS, or whose siblings had been reported, died as a result of drowning. Of these, we determined that 22 deaths occurred in circumstances of neglect, or were suspicious of neglect. We have reviewed these matters in comparison with the drowning deaths of children who had no child protection history.

In relation to bathtub drownings, some researchers have identified a strong association with previous histories of child abuse or neglect. A review of near drownings over a ten-year period found that in 25 per cent of cases, a previous child abuse report had been filed and for 38 per cent of victims, there were other physical findings indicative of abuse.[120]

Demographic profiles and circumstances

The demographic profiles and circumstances of death of the 22 children with a child protection history were largely similar to those children described previously who drowned and had no such history:

- A higher proportion of the children were male (15) than female (7). Their ages ranged from five weeks to seven years:
  - three infants were less than 12 months
  - seven toddlers were between 12 – 22 months
  - five toddlers were between two and three years
  - three preschoolers were aged three to four years
  - four children were five to seven years.
- Swimming pools and household baths were the most common location for drowning, accounting for 20 of the 22 deaths:
  - 12 children drowned in swimming pools
  - eight children drowned in baths
  - two children drowned in open bodies of water.
- A parent was responsible for supervising the child in most cases (15 of the 22 matters). Older siblings and other adults, such as friends, extended family members, or, in one case, professional carers, were supervising the seven remaining children who died.

As was the case for children who had no child protection history, we identified inadequate supervision as the primary issue for children who had been reported to be at risk of harm. Inadequate pool security was also a common factor and featured along with inadequate supervision in eight of the 12 incidents of pool drowning.

In 10 cases the incident occurred in a pool at the child's own place of residence. One child drowned on premises owned or occupied by relatives and one child drowned on premises owned or occupied by a person unrelated to the child.

Of the 12 incidents in private pools, 10 were located in a metropolitan area and two were in a regional area.

Previous indicators of risk

Among children with a child protection history, we found six cases where previously reported risk factors were directly relevant to the circumstances of death, including inadequate supervision and parental substance abuse. In some cases, risks featured in the family history but were not relevant to the incident, including reports of domestic violence.

120 Lavelle J et al (1995). Ten-Year Review of paediatric bathtub near-drownings: Evaluation for child abuse and neglect, Annals of Emergency Medicine, 25(3), pages 344-8.

Among the 22 families, identified risks included:

- Parental substance abuse. In eight cases, prior concerns had been raised to DoCS about parental substance abuse, including two where records indicated a parent may have been substance affected when the child died.
- Parental mental health. Four cases featured a history of reports or risk related to parental mental health problems.
- Inadequate supervision. Four cases involved documented concerns about poor supervision of the child or children in the family.

In 14 of the 22 cases, we identified various combinations of these risk factors in the family history.

3.2.8 Review observations

Our analysis of reviewable child deaths involving drownings of children who had no child protection history, and those that had been the subject of a report to DoCS, serves to reinforce the findings of previous research on the drowning deaths of children. That is, drowning deaths were most associated with inadequate supervision and inadequate safety measures to limit access by children to swimming pools and other bodies of water.

We found no notable differences in the circumstances of the deaths of children from families with, and without, child protection histories in this regard. Inadequate supervision was the common factor in the deaths of all 38 children. In 20 of the 22 pool drownings, the risks associated with inadequate supervision were amplified by the failure of child resistant safety barriers. An additional factor we identified was the occurrence of drownings where there were large groups of people, indicating a possible lack of clarity around supervisory responsibility.

In relation to private pools, most of the children were in metropolitan areas (15 of 21) and the majority drowned in the family's own pool (17 of 21).

The principle difference between the families related to previous, and relevant, identified risk for those children who had been reported to DoCS. Child protection histories often indicated a prior pattern of inadequate supervision in the life of the child. In some cases, we found additional risks associated with impaired parenting capacity, particularly related to substance abuse.

3.2.9 Policy and practice implications

Our review reinforces the critical importance of adequate supervision of children near water, and installation and maintenance of effective child resistant safety barriers.

There have been some initiatives in this regard, for example:

- Farmsafe Australia has developed a child safety checklist that addresses safety issues for children living in farming communities. The checklist includes strategies aimed at reducing drowning of children on farms. The key message promoted by Farmsafe is that although it is not a legislative requirement to separate a house from dams or other bodies of water on the property, it is important to provide a safe, fenced-off outdoor play area for young children that is located in a position where children can be easily observed at all times.[121]

121 Fact sheet and child safety checklist accessed from www.farmsafe.org.au.

- Coinciding with the start of summer each year, another initiative that promotes key water safety messages is the National Water Safety Week. This is an annual campaign in which organisations across Australia (in NSW, the Water Safety Advisory Council) conduct water safety events and activities aimed at increasing community awareness about the importance of water safety.[122]

Australian and overseas studies consistently emphasise that the most effective way to prevent drowning deaths of children under five years of age in backyard swimming pools is to legislatively mandate isolation fencing that separates the pool/spa from the residence.[123] In NSW, the CDRT has noted 'an ongoing problem of private pool owners not complying with the *NSW Swimming Pools Act 1992* and the inadequate monitoring and enforcement of the legislation by local councils.'[124] The CDRT has recommended:

> *That the NSW Swimming Pools Regulation 2008 require local authorities to inspect all swimming pools notified within their area and monitor compliance with the legislation. This could occur through councils developing a plan for inspection and monitoring over a period of years, and reporting periodically against the plan.*[125]

We note that new regulations governing swimming pools have been introduced to NSW, effective from 1 September 2008.[126]

The main change in the regulation is that it provides for a new Australian standard for pool barriers. The standard applies to new pools only and includes new requirements in relation to: non-climbable zones, adjusted mesh sizes for fences, retaining walls that form part of a barrier, and balconies that project into the pool area.

The new regulation does not introduce any changes or impose additional requirements upon councils in relation to pool inspection activities carried out in accordance with the Swimming Pools Act. In practice, it is up to councils to decide whether regular inspections of swimming pools are necessary to promote pool owners' awareness of the legislation. Activities carried out by councils to discharge their responsibilities under the Act vary widely and can range from routine inspection programs to the mailing out of information to pool owners.

The DLG has advised us that following on from the review of the Swimming Pools Act, the department is preparing a Swimming Pools Act options paper as a basis for consultation. The paper will consider ways in which an inspection program for swimming pool barriers could be implemented. The paper will seek feedback from local councils, key stakeholders and the community.[127]

In this regard, however, the DLG told us:

> *It is important to note that, should a mandatory pool barrier inspection program be introduced for backyard swimming pools, inspections can only be conducted at certain points of time. While the barrier may be compliant at the date of inspection, it doesn't guarantee compliance all the time. The research confirms that appropriate supervision of young children is still the key factor in ensuring their safety.*[128]

122 NSW Water Safety Taskforce, http://www.safewaters.nsw.gov.au.

123 Thompson DC, Rivara FP (1998), Pool fencing for preventing drowning in children, Cochrane database of systematic reviews. Issue 1. article no: CD001047.

124 NSW Child Death Review Team (2007) Annual Report 2006, NSW Commission for Children and Young People, page 48.

125 NSW Child Death Review Team (2008), Trends in Child Deaths in New South Wales 1996 – 2005, NSW Commission for Children and Young People, page xxxii.

126 Swimming Pools Regulation 2008.

127 Department of Local Government response to a draft copy of this report, dated 24 February 2009.

128 Ibid.

3.3 Transport fatalities

Transport fatalities are the most common external cause of death for children and young people aged between nought and 17 years in NSW.[129] In a 10 year study of child deaths in NSW, the CDRT reported that nine per cent of the deaths of children and young people resulted from transport-related fatalities.[130]

Transport fatalities are also the most common specific underlying cause of death for children whose deaths are reviewable.[131]

Between 2003 and 2007, seven children who had no child protection history died in transport fatalities that we considered constituted neglect. Our review also considered four children who died in similar circumstances and whose families had been the subject of previous reports to DoCS.

3.3.1 Determining neglect in relation to transport fatalities

In determining whether a transport-related death constituted neglect, or was suspicious of neglect, we took into account whether the actions of parents or carers could be considered 'significantly careless', in line with our definition.

Some of the particular factors we considered included whether there was evidence that parents or carers were driving in a dangerous or negligent manner at the time of the incident, or were affected by alcohol or other substances. We also took account of whether, and how, children were restrained in the vehicle.

Our definition of neglect focuses on the actions of parents or carers, and therefore does not include teenage driving deaths, including deaths resulting from risk-taking behaviour by adolescents, which accounted for almost 30 per cent of transport related reviewable child deaths. The deaths of these young people were reviewable because they, or a sibling, had previously been reported to DoCS. Other circumstances where transport fatalities would not be considered neglect include where a crash was caused by the actions of another vehicle and the child was correctly restrained, or pedestrian accidents where it was not unreasonable for older children to be walking without parental supervision.

3.3.2 Previous research: transport fatalities

In a 10-year study of the causes of child deaths in NSW, the CDRT reported that of all the transport-related fatalities occurring in the study period, children and young people were most likely to die as passengers in a car crash.[132]

Excessive speed and driving while affected by alcohol have consistently been identified in research as the most common contributing factors to vehicle crashes. Other common risk factors include fatigue, poor road conditions, compromised vehicle safety and inappropriate use of restraints.

In terms of restraint use, research shows that a large majority of Australian children use a car restraint or seatbelt, the rate of use is more than 92 %. Research also demonstrates that while any form of restraint is better than none in preventing risk of injury, children receive the best protection from dedicated child restraints.

129 NSW Child Death Review Team (2007) Annual Report 2006 NSW Commission for Children and Young People, page 43.

130 NSW Child Death Review Team (2008). Trends in Child Deaths in New South Wales 1996 – 2005. NSW Commission for Children and Young People, page 63.

131 National Centre for Classification in Health (2007) Causes of death of reviewable children in NSW from 2003 – 2006: A report for the NSW Ombudsman, unpublished. A summary of the paper is reported in NSW Ombudsman (2007) Report of reviewable deaths in 2006: Volume 2: Child deaths. Between 2003 and 2007, 56 children whose deaths were reviewable died in transport-related incidents, including vehicle and bicycle crashes and pedestrian fatalities.

132 NSW Child Death Review Team (2008), Trends in Child Deaths in New South Wales 1996 – 2005, NSW Commission for Children and Young People.

Indeed, certain patterns of serious injury are associated with what researchers have identified as premature graduation of young children to adult seatbelts, misuse of seatbelts, or use of lap-only belts.[133] Studies in NSW, South Australia and elsewhere indicate that many children move too early to an adult seat belt. Road safety experts in Australia recommend that children remain in appropriate child restraints until they weigh 26 kilos, or about seven years old.[134] Additionally, while the rear seat has been shown to be the safest position for children, 'at least a quarter of Australian parents feel it is safe for a child aged seven years to travel in the front seat.'[135]

The authors of a literature review published in 2007 conclude that the high level of restraint use in Australia indicates that parents are motivated to protect their children. However, inadequate parental knowledge of optimal restraint use places children at unnecessary risk.[136]

3.3.3 Reviewable transport fatalities: children with no child protection history

The deaths of the seven children that occurred in circumstances of neglect who had no child protection history, or none that was recent, occurred in seven separate transport incidents. Of the children:

- Four were female and three were male; their ages were three, five, eight, nine, 12 and 15 years.
- Two children were from culturally or linguistically diverse backgrounds and one young person was indigenous.

3.3.4 Circumstances of death for children with no child protection history

Six of the children who died were passengers in cars driven by a parent. One child was riding a motor bike. In one incident, the driver of the vehicle in which the child was a passenger also died. In all other six cases, police laid charges against the driver.

Single vehicle incidents

Five deaths occurred in single vehicle crashes. In three incidents, the child who died was in a car that ran off a rural road at night and in one further case, a car ran off a rural highway during daylight hours. Two incidents happened on metropolitan roads.

- One child aged three was travelling in the front seat when the family vehicle ran off the road and rolled. The child was thrown from the car. Police determined that the child was not wearing a restraint or seatbelt at the time of the crash. The driver had a blood alcohol reading over the legal limit.
- A child died in an accident where the driver swerved to avoid an obstacle on a rural road. It was raining and the road surface was wet. The driver was under the influence of sedatives at the time of the incident. Police records indicate the young person was wearing a seatbelt.
- In one case, the family car ran off a rural road in the rain and into a body of water and a child died. Police identified excessive speed, and the driver told police that the vehicle had previously performed poorly in wet conditions.

133 Reeve, Katie N et al (2007) 'Seatbelts and the law: how well do we protect Australian children?' Medical Journal of Australia 186 (12), pages 635-638.

134 NSW Roads and Traffic Authority Safer Child Restraints, http//www.rta.nsw.gov.au

135 Reeve, Katie N et al (2007) Seatbelts and the law: how well do we protect Australian children? Medical Journal of Australia 186 (12), pages 635-638.

136 Ibid.

- A parent and a child aged five years were in a car that ran off a rural highway. The car was reportedly speeding. The vehicle rolled and the child was thrown out. Police inquiries found that the child was sitting unrestrained in a booster seat in the rear of the vehicle.
- One incident occurred when the car a 12 year old was travelling in collided with safety barriers on a metropolitan road at night. The driver was driving at excessive speed at the time.

Multiple vehicle incidents

- Two of the seven incidents involved the child's vehicle and a second vehicle.
- One child died after the family car ran over a median strip onto the wrong side of a metropolitan road at night and collided with an oncoming vehicle.
- One collision involved a nine year old child riding a trail bike on a public unsealed and single-lane road in a regional area.

3.3.5 Factors identified in the review

All of the cases involved a significant level of carelessness on the part of the driver, mostly in relation to excessive speed and/or drug or alcohol consumption.

Charges and convictions

Police laid charges against all surviving drivers. Four faced charges of dangerous driving occasioning death and two were charged with negligent driving occasioning death. Prosecution resulted in convictions in all six cases.

Speed

Investigating police identified excessive speed as a factor in four of the seven incidents.

Drug and alcohol use

Records indicate that three drivers were above the legal limit for alcohol and/or tested positive for drugs. In one case the driver tested positive for cannabis, and in another, the parent was driving at the time of the incident under the combined influence of prescribed methadone and a prescription sedative. In a further case the driver was found to be over the legal limit for alcohol.

Forensic analysts expressed a view that in one case, the adult's driving ability would have been significantly impaired by drug consumption. In another case, a police analyst reported only that the driver would have been 'affected' by drug use. For a driver who died, no conclusion was reached but police noted that alcohol was a possible contributory factor.

3.3.6 Previous indicators of risk

We found some indication of previous related risks related to driving behaviour.

Of the three cases in which we identified driver drugs or alcohol use as a factor in the incident, we found evidence that two drivers had a previous history of substance use.

A parent who was charged with driving under the influence of cannabis during the fatal incident had a previous conviction for driving under the influence of alcohol and other convictions relating to the cultivation and possession of a prohibited drug. A parent who was charged with driving under the influence of prescribed drugs following the fatal incident had a history of intravenous drug use and a previous drink driving conviction.

Three drivers who had been exceeding the speed limit at the time of the incident had received a previous police warning for using excessive speed. Another driver had no prior record of infringements, but a speeding infringement was issued following another incident after the death of the child.

3.3.7 Reviewable transport fatalities: children with a child protection history

During the years 2003–2007, four children who had a child protection history in NSW or interstate died in transport incidents that we identified as occurring in circumstances of neglect, or that were suspicious of neglect.[137]

Of the four children with a documented child protection history:

- the children were, on average, younger than the group of children with no child protection history. All were younger than five, including two babies
- three children were passengers in vehicles and one was a pedestrian
- three of the drivers were parents. In the fourth case, a parent was responsible for supervising the child at the time of the pedestrian incident in which the child died.

Two of the three crashes were single vehicle incidents. In one case, the family vehicle was in a collision with another vehicle. One child was run over in a car park.

Seatbelts and restraints

Two of the four children were not appropriately restrained in the vehicle. One toddler was not wearing any form of restraint or seatbelt, and a four-year old was wearing an adult seat belt in the front seat of a vehicle.

Drug and alcohol use

In three of the four incidents, records indicated that the parent's capacity was impaired by alcohol and/or substance use. In two cases, parents were driving and in one, the child was a pedestrian being supervised by a parent.

Previous indicators of risk

For two of the four children, reported child protection concerns or other history appear relevant to the circumstances of the child's death. Concerns regarding inadequate supervision, neglect and carer drug and alcohol use were relevant in two cases.

3.3.8 Review observations

For the 10 vehicle collisions, single vehicle incidents predominated. Seven of the 10 incidents involved only the family vehicle.

For both the children with and without a child protection history, we noted combinations of factors that could be considered as contributing to the children's deaths. In relation to the drivers, these factors included:

- consumption of alcohol or prescription or illegal drugs that impaired driving ability
- excessive speed and/or negligent driving, and
- failure to provide for the developmental needs of children, including lack of appropriate safety restraints, inadequate supervision in pedestrian incidents, and allowing children control of a vehicle.

We also noted an association between adverse environmental factors, including wet roads, poor visibility and unexpected hazards, and impaired driving skills as a result of substance use or fatigue.

137 We have included here the death of one child who died in NSW, but had not been reported to DoCS. The child previously resided in another state, and had been involved with that State's child protection authority.

In regard to previous risk, we found that in both groups, there were cases where the driver's previous history was relevant to the circumstances at the time of the incident in which a child died.

In four cases, one where the family had been the subject of an earlier risk of harm report and three where they had not, the parent was impaired by drugs or alcohol at the time of the incident and had a previous history of substance use or abuse. Speed was an identified factor in five cases, and in at least three cases, the drivers had previous traffic infringement notices for speeding.

In one case, we identified the primary factor in a child's death to be inadequate supervision. In this case, previous reports to DoCS had raised concerns about inadequate supervision of the child.

3.3.9 Policy and practice implications

The key factors we identified have also been the subject of ongoing research in NSW.

Notably, recent work by the CDRT has identified a decline in the likelihood of passenger deaths of children between the first and second halves of the 10 year period from 1996.[138]

The NSW Government and state authorities have implemented or foreshadowed initiatives in relation to the key factors of speed, drug and alcohol use by drivers, and inappropriate or inadequate child restraints.

A priority of the Government's State Plan is safer roads.[139] The related target is a reduction in the rate of road fatalities. Recent initiatives include expansion of roadside drug driving testing and additional funding of police random breath testing operations.

Linked to the State Plan priority, in 2007 the NSW Government established the Centre for Road Safety within the Roads and Traffic Authority (RTA). This organisation aims to 'change cultural values on road safety'.[140] An initial goal in 2008 has been to reduce the incidence of speeding through community education campaigns that have addressed specific areas of concern, including speeding on country roads.

The RTA advised us of a range of initiatives that the Authority and its partners are implementing to address the causes of crashes outlined in this report.[141] In addition to deterrence and Police enforcement initiatives, random breath testing and drug testing and preventative programs such as the 'Sober Driver' program, the RTA noted specific child safety initiatives:

- roll out of flashing lights and speed cameras in school zones
- road safety education in NSW schools, and
- staged implementation of new child restraint legislation that will require all children under seven years of age to be fitted in appropriate restraints within vehicles. Stage one will focus on children under four years and stage two on children under seven. The RTA advised that implementation will be accompanied by 'a very extensive communications campaign'.

Kidsafe NSW, funded by the Motor Accidents Authority, is also leading a child passenger safety project. The goal of this project is to 'increase the incidence of children travelling in the most protective restraint for their size through increased awareness and improved behaviour of parents and caregivers regarding child passenger safety.'[142]

138 Child Death Review Team (2008) Trends In Child Deaths In New South Wales 1996 – 2005, NSW Commission for Children and Young People, page 98.

139 www.nsw.gov.au/stateplan.

140 http://www.rta.nsw.gov.au/roadsafety/aboutthecentre.html.

141 RTA response to a draft copy of this report, dated 15 February 2009.

142 http://www.kidsafensw.org/roadsafety/overview_childpassenger.htm.

Taken together, these initiatives have potential to reduce key risks to children in transport incidents.

3.4 Co-sleeping

Between 2003 and 2007, six children whose families had no child protection history died while co-sleeping with their parents in circumstances that we considered constituted neglect or were suspicious of neglect. Our review also considered 21 children who died in similar circumstances and whose families had a child protection history.

3.4.1 Determining neglect in relation to co-sleeping

There is no universally accepted definition of co-sleeping.[143] For the purpose of this review, co-sleeping means an infant sharing a bed or other sleep surface with one or more adults.

In determining whether a co-sleeping death constituted neglect, or was suspicious of neglect, we took into account whether the actions of parents or carers could be considered 'significantly careless', in line with our definition.

Generally, we considered the deaths to be related to neglect if parents were affected by alcohol or drugs that have sedative effects or induce heavier sleep, or if the child was placed in inappropriate bedding, such as on sofas, in overcrowded beds or under heavy doonas or blankets. Mostly, the cases we included combined a number of these factors. Our definition of suspicious of neglect includes cases where the autopsy cause of death is undetermined and there is an indication of abuse of neglect.[144]

The Coroner's determination of cause of death was important in this regard. In the main, if the Coroner ruled out suffocation or overlay and determined SIDS (category 1) to be the cause of death, we did not include the child's death as neglect-related, unless additional records provided information indicating otherwise.[145]

3.4.2 Previous research: co-sleeping deaths

In a 10-year study of child deaths in NSW, the CDRT reported that 10 per cent of child deaths were infants who died suddenly and unexpectedly.[146] They note that for most of these deaths, at least one known risk factor, including co-sleeping, was evident.

There has been a gradual decline in SIDS deaths since 1986.[147] The reduction in deaths has been largely attributed to an increased awareness of safe sleeping practices and associated changes in parental behaviour involving sleeping position and tobacco smoking.[148]

143 Various terms are identified in literature, including co-sleeping, bed sharing and sleep sharing. The Child Death Review Unit in the Office of the Chief Coroner, British Columbia, defines bed sharing as sleeping with a baby on the same sleep surface and co-sleeping as sharing a room, but not a sleep surface [and] baby's sleep surface is proximate to the parents. The CDRT has defined co-sleeping as sleeping together with an infant, as distinct from bed-sharing, where a carer and infant share a bed for the purpose of feeding and settling. Queensland's Commission for Children and Young People and Child Guardian has noted that it has used the terms co-sleeping and bed sharing interchangeably.

144 It is important to note that attributing a cause of death to SIDS is a classification of exclusion. This means that when no conclusive cause of death is found, a SIDS diagnosis may be used. Information from the National Coroners Information System suggests that more recently, and often in association with environmental factors such as co-sleeping, the terms 'unascertained' or 'undetermined' have been used.

145 In 2004, a national definition of SIDS was adopted: 'the sudden unexpected death of an infant under one year of age, with onset of the lethal 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.' National SIDS Council of Australia (SIDS and Kids) www.sidsandkids.org/about_us.html.

146 NSW Child Death Review Team (2008), Trends in Child Deaths in New South Wales 1996 – 2005, NSW Commission for Children and Young People, page 63.

147 Australian Bureau of Statistics (2003), SIDS in Australia 1981 – 2000: A statistical overview, Australian Bureau of Statistics: Canberra.

148 NSW Child Death Review Team (2008), Trends in Child Deaths in New South Wales 1996 – 2005, NSW Commission for Children and Young People.

There is no consensus on the risks and benefits of co-sleeping. Some researchers have suggested that co-sleeping with infants may actually reduce the risk of sudden infant death syndrome (SIDS); whereas in other studies, co-sleeping has been identified as a significant risk factor for SIDS.[149]

Notwithstanding the debate, the balance of opinion in the literature favours avoidance of co-sleeping. Some authorities recommend that infants do not sleep in a bed with a parent or other persons.[150] NSW Health guidelines state that co-sleeping with a baby may increase the risk of SIDS and fatal sleep accidents in some circumstances. These include when the infant is younger than four months and the mother or father is a smoker, and when a co-sleeping adult has consumed alcohol or drugs that induce heavier sleep.[151]

Researchers have noted that babies aged less than four months are most at risk of SIDS or sleeping accidents.[152] In some studies, the risk associated with co-sleeping was significantly raised when either the mother or both parents smoked cigarettes.[153]

Other risk factors include the use of loose, soft bedding such as doonas or quilts that may completely cover a baby during sleep and the use of a lounge or sofa as a sleep surface where a baby may become wedged or trapped and unable to breathe.[154]

3.4.3 Co-sleeping deaths: children with no child protection history

All of the six children with no child protection history who died while co-sleeping were infants:

- Five of the infants were aged three months or less, with the youngest being five weeks old. One infant was aged eight months.
- Three children were male and three were female. Two of the children were indigenous.

An inquest was held for two of the six deaths. In one case the Coroner could not state the cause of death and so returned an open finding. An inquest for the other case was pending at the time of writing. The Coroner dispensed with an inquest in relation to four of the deaths.

Cause of death

Three of the six babies died as a result of suffocation or asphyxia due to overlaying. Two deaths were classified as SIDS Category II. This category is defined as:

> *the sudden and unexplained death of an infant under one year of age, and apparently occurring during sleep, and which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history, but where age range outside [SIDS] IA/IB (i.e. outside of >21 days but <9 months), where there is a history of deaths in siblings or other infants under the same caregiver, where mechanical asphyxia is considered but not determined with certainty and/or where abnormal growth, or more marked pathological abnormalities are identified at autopsy.*[155]

149 Sullivan F.M & Barlow S.M (2001) 'Review of risk factors for Sudden Infant Death Syndrome', Paediatric and Perinatal Epidemiology, 15, pages 144 – 200.

150 Ostfeld et al, (2006) 'Sleep Environment, Positional, Lifestyle, and Demographic Characteristics Associated With Bed Sharing in Sudden Infant Death Syndrome Cases: A Population-Based Study'. Paediatrics, 118.

151 NSW Health (2005) Sudden Infant Death Syndrome (SIDS) and safe sleeping for infants http://www.health.nsw.gov.au/policies/gl/2005/GL2005_063.html.

152 Blair P.S, et al.(1999) 'Babies sleeping with parents: case control study of factors influencing the risk of the sudden infant death syndrome'. British Medical Journal 319 (7223), pages 1457- 1462.

153 Sullivan F.M and Barlow S.M (2001) Review of risk factors for Sudden Infant Death Syndrome, Paediatric and Perinatal Epidemiology, 15, pages 144 – 200.

154 Byard et al (2001) 'Specific dangers associated with infant sleeping on sofas', Journal of Paediatric Child Health, 37, pages 476-478.

155 Perinatal Society of Australia and New Zealand: Perinatal Mortality Audit guidelines, page 130. http//www.psanzpnmsig.org/classification.html

In one of the two cases classified as SIDS Category II, a pathologist reported that the possibility of mechanical asphyxia due to overlaying had to be considered. In the other case, the pathologist could not determine the cause of death.[156]

In one case, the cause of death is pending. This death is suspicious of neglect.

3.4.4 Circumstances of death for children with no child protection history

Four of the six children died in the family home. Two babies died when their families were staying away from home. In the six cases:

- A baby was found under a blanket next to the sleeping mother. The mother had a long history of substance abuse, and indicated she had used heroin the afternoon prior to the baby's death. She also admitted infrequent heroin use during the pregnancy. Records indicate a number of attempts by health professionals to engage the mother with relevant support services in previous contacts. At the time of writing, the cause of the baby's death had not been determined. The family had an early child protection history, with a report being made about alcohol abuse some years prior.
- In a case where the baby was in bed with both parents, police were unable to locate a cot anywhere in the family home, and found a recently used bong and cannabis at the home. Police records indicated that the baby was found deceased lying between the parents, with the cause of death undetermined.
- Police documented information that a baby sometimes slept in a cot and sometimes with the mother in a single bed in the same room. On the morning the baby died, the bedding consisted of a doona and what police described as 'numerous' pillows. They also observed an ashtray, cigarettes and a quantity of marijuana but reported that they could not determine if the drug had been 'recently' consumed in the bedroom. The cause of death was determined to be SIDS Category II.
- A mother woke and found the baby deceased beside her. The cause of death was identified as suffocation. Police established that the mother used heroin and cannabis during the day and two types of benzodiazepines in the evening before going to sleep. Both parents had histories of drug abuse dating from their early teens. Health records indicate that the mother referred herself to a drug and alcohol service a week before the baby died. Over the course of the week, the service prescribed medication to assist detoxification, including benzodiazepines. Records indicate that the service advised the woman to avoid using benzodiazepines because she was breastfeeding and that combining them with heroin would result in a sedative effect.
- A baby died while co-sleeping with both parents. The family were staying away from their home at the time. The mother reportedly drank a number of glasses of wine and the father had up to 12 cans of beer, and both had consumed cannabis. Health records indicate that the father had previously been referred to a drug and alcohol service. Police noted that both parents and the baby slept together under a double cotton doona; the bedroom where the baby died had a double glass window and no air conditioning vents or fans. The cause of death was determined as SIDS Category II.
- One family had been away from home for some time. On one evening, the baby was placed on a lounge next to a parent and was found suffocated under the sleeping parent in the morning. Police reported that the parent was affected by drugs and alcohol at the time, and ascertained that they had consumed wine in the afternoon and evening. They also ascertained a history of cannabis consumption in the weeks prior to the baby's birth and a previous conviction for a drink driving offence.

156 NSW Coronial records.

Prenatal care

All six mothers received varying degrees of prenatal care and all six babies were born in hospital.

Four of the six mothers smoked cigarettes during pregnancy and four used illicit drugs while pregnant. In one case, health records indicated that a woman was referred prenatally to a drug and alcohol service. Other than a tick-box entry on an assessment form, the records contained no documentation relating to this referral or its outcome.

Health and coronial records indicated that information about SIDS and safe sleeping practices was given to three of the six women. We were unable to determine whether the other three women were also recipients of information about SIDS. However, NSW Health policy requires staff in maternity units to provide information about SIDS and safe sleeping, and to strongly encourage parents to maintain safe sleeping practices at home, including by keeping babies smoke-free before and after birth.

Postnatal care

Two of the six births were premature; one child was born at 32 weeks and one at 36 weeks gestation. Researchers have identified premature babies and those who are small for their gestational age as among those most at risk of SIDS or sleep accidents.[157]

The child who was born at 32 weeks was discharged from a special care nursery four weeks after the birth. Nursing staff gave the mother a referral to a doctor and documented plans to refer the family to community health and family support services. The baby died three days after discharge and the cause of death was determined to be suffocation. The baby born at 36 weeks also died, aged five weeks, as a result of suffocation while sharing a bed with a parent in the family home.

Health records indicate that three of the women received postnatal care that included home visits by an early childhood nurse or midwife. One of these women was also referred to a young parents support team, but declined the referral.

In one case, available health records did not indicate the nature or extent of postnatal care for the mother or child.

3.4.5 Previous indicators of risk

In all of the six families, we found evidence of a history of illegal drug use, and/or drug or alcohol use in the hours prior to the incident. Records indicated that four of the six families had a police history relating to possession of illegal drugs (two families) and drink driving offences (two families).

A number of families for whom drug use was an issue were in contact with health services during or after the birth of the child. In two cases, records indicate that health services were aware of illicit drug use and were either working with the parent or had made attempts to assist in this regard. We located no reports of risk of harm, or prenatal reports, that were made by services. In one case, where a woman was using opiates during pregnancy, consideration of a prenatal risk of harm report may have been warranted. Prenatal reports are not mandatory but are intended to allow assistance and support to an expectant mother to address risk factors. In the records that were available to us, we did not identify documentation relating to consideration of prenatal reporting.

157 Blair P.S et al (1999) 'Babies sleeping with parents: case control study of factors influencing the risk of the sudden infant death syndrome', British Medical Journal 319 (7223), pages 1457 – 1462.

In four cases, mandatory reporters notified DoCS following the deaths in relation to concerns about the welfare of siblings of the child who died. DoCS records indicate that in one case, the Helpline assessed risk of harm to two siblings as high, due to the mother's chronic drug use. The department subsequently placed the children in the care of relatives on a long term basis.

3.4.6 Children with a child protection history

From 2003 to 2007, 21 children with child protection histories died in circumstances of co-sleeping that we identified as neglect or as suspicious of neglect.

Of these 21 children:

- eleven were female and 10 were male, and more than one third (eight) of the children were Aboriginal
- the youngest was aged 19 days and the oldest was 12 months
- seven children slept with both parents, six with the mother only, three with mother and siblings, four with the father only and one with infant siblings only, and
- twelve of the children were co-sleeping in a bed, seven were co-sleeping on a lounge and two children were co-sleeping on a mattress.

Coronial cause of death has been determined in 20 of the 21 cases:

- The deaths of seven children were classified as SIDS, five of which were SIDS Category II
- three deaths resulted from suffocation or asphyxia/overlying
- one death was caused by an apnoeic episode and potential hypoxia in a co-sleeping situation,[158] and
- in nine cases, the Coroner found cause of death to be undetermined or unascertained.

Previous indicators of risk

Nine of the children who died were the subject of prenatal reports to DoCS.

Reports relating to the families of the 21 children included concerns about:

- parental substance abuse, alcohol abuse or drug use (15 cases)
- domestic violence (15 cases)
- neglect (12 cases)
- parental mental health problems (six cases).

Four of the children who died had a sibling or siblings previously placed in long term care by the NSW Children's Court.

3.4.7 Review observations

Taken together, the majority of the children who died in co-sleeping incidents were aged three months or younger. Overall, we noted similarities in the profiles of all of the families. For example, the proportion of indigenous children among those with a child protection history (eight of 21) was similar to that among the children with no such history (two of six). Both groups evidence a very high proportion of Aboriginal children dying in co-sleeping incidents.

158 Hypoxia is defined as a deficiency of oxygen.

In particular, there were indications that parents' use of drugs and/or alcohol was a significant risk factor. The parents of 15 of the 21 children who had been the subject of reports to DoCS had a history of drug use or drug or alcohol abuse. This was also the case for all six families who did not have a child protection history.

Available records confirmed that drug and/or alcohol use in the hours prior to the co-sleeping incident occurred in more than a third (10) of the families with and without a child protection history.

In the cases where families were not known to DoCS, we found that NSW Health services were aware of maternal drug use, particularly during pregnancy, in two of the six cases. Assistance provided include referrals to appropriate services both prior to and following the child's birth. However, our review indicated that these referrals were not consistently taken up, or followed up by the service.

Our previous work has clearly identified the need for support and follow up where women have substance abuse issues during pregnancy.

3.4.8 Policy and practice implications

In relation to the seven children who had no child protection history, we identified co-existing risk factors similar to those among children with these histories.

We have noted previously that parental substance use or abuse was prevalent in many of the cases we reviewed, and that it was often present with other risk factors. Parental behaviour associated with substance abuse can make assessment of child protection issues a complex task.[159]

The prevalence of parental substance abuse in relation to the children who died in co-sleeping incidents underscores the importance of comprehensive assessment when substance using women present to prenatal and maternity services. Prenatal reporting can serve both as an early warning to the child protection system about possible risks to a child after birth, and trigger provision of support to birth mothers, including by referral to Drug Use in Pregnancy services or DoCS' early intervention services.

In response to recommendations we made in 2006, NSW Health is presently undertaking a review of Drug Use in Pregnancy Services, with a view to developing minimum standards for drugs in pregnancy service provision.[160] DoCS has also been trialling a prenatal reports policy that was developed in conjunction with NSW Health and endorsed in March 2008.

Both DoCS and NSW Health have undertaken important initiatives to promote safe sleep practices.

DoCS has finalised an issues paper on co-sleeping, and has developed *Safer Sleeping* resources. These include wallet sized information cards, fridge magnets and posters. Separate and targeted resources have been developed for Aboriginal families. In addition, DoCS has advised that information learnt through its co-sleeping project is being provided to all community service centres.

DoCS resources can be viewed on the department's website www.community.nsw.gov.au in the section for parenting resources.

NSW Health and DoCS recently re-ran a child safety campaign prompted by a joint review of child deaths. The campaign was designed to provide advice to parents on opioid treatment regarding safe storage of methadone, the dangers of sleeping with babies whilst under the influence of methadone, and safe sleeping and settling practices for babies.

159 NSW Ombudsman (2006) Report of Reviewable Deaths in 2005 Volume 2: Child Deaths, page i.
160 Ibid. Page vi.

A 'Your child's safety' poster and a 'Kids and drugs don't mix' brochure have also been developed and distributed.

NSW Health also advised us that the department is now developing a generic campaign for parents in the general community to inform on the dangers of drugs and co-sleeping with children.

The provision of post birth services to women, particularly home visiting services, is also an important part of promoting safe sleeping messages. At present, all new mothers are offered a home visit from a child and family nurse within 14 days of the baby's birth. Families NSW also provides support in-home to new mothers who are considered vulnerable.

We will continue to monitor responses to parental substance abuse and pre and post natal support services as an important part of our work in reviewing child deaths.

Appendices

Appendix 1

Definitions

Definitions we have adopted to determine whether deaths are due to abuse or neglect or occurred in suspicious circumstances are:

Deaths due to abuse

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

Deaths due to 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
- a significantly careless act.

Suspicious deaths

Deaths where there is some evidence or information that indicates the death may have been a result of abuse or neglect. Deaths would be considered suspicious if:

- 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)
- 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.

We note that this definition of suspicious is broader than that used by the NSW Coroner's Office. In the Coronial context, suspicious is generally attributed to a death that is a possible homicide.

Appendix 2

Reviewable Child Deaths Advisory Committee: Members

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 3

Agency responses to recommendations

Making recommendations

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* requires us to:

- Formulate recommendations that can be implemented by government and service providers to prevent or reduce reviewable deaths or the deaths of children at risk.
- Provide information in our reviewable deaths annual report about the implementation or otherwise of previous recommendations.

In each annual report, we have made recommendations to a number of agencies, mainly DoCS, the NSWPF and NSW Health.

In our work, we have acknowledged that it may take time for agencies to fully address recommendations, and that priorities within an area subject to recommendation can change. In this context, we review our recommendations each year, and where they have not been fully implemented, we update them to take into account progress to date and where appropriate, to reflect other relevant changes. Where commitments are made by agencies, we seek progress reports in order to monitor and report accurately on how agencies are working to address the issues identified through our work.

Monitoring recommendations

In our *Report of reviewable deaths in 2006*, we made eight recommendations in relation to child deaths:

- Three recommendations were directed to DoCS. One of these sought progress on previous commitments made or advice provided by the department about how it would address our recommendations.
- One recommendation was directed to NSW Health, which focused on seeking progress on previous commitments made or advice provided by the department about how it would address our recommendations.
- One recommendation was directed to the NSWPF. This sought progress on previous commitments made or advice provided by the Force about how it would address our recommendations.
- Two recommendations were directed jointly to DoCS and NSW Health.
- One recommendation was directed to the Department of Education.

All agencies provided an initial response to the recommendations early in 2008, and a further update in July/August 2008.

The following provides an overview of what agencies told us they were doing to implement our recommendations, and our assessment of progress in this regard. Our assessment is based on the advice provided by agencies and, where appropriate, additional information from our work.

In some cases, agencies advised us that some work relating to implementation of our recommendations had been put on hold, pending the findings and recommendations of the Special Commission of Inquiry into Child Protection Services.

Since we received agency progress reports, the Commission has finalised its work and the NSW Government has responded to the Inquiry recommendations, and has indicated full, partial or in principle acceptance of 106 of the 111 proposals. As described in section 1 of this report, major recommendations are focused on structural change to the delivery of child protection services. Implementation of these recommendations will have significant impact on agencies' future approach to meeting their child protection obligations.

NSW Police Force

Recommendation 1: Progress on previous recommendations

In our *Report of reviewable deaths in 2006: Volume 2: Child deaths,* we asked NSWPF to provide us with progress reports on a range of strategies that police had advised us would meet the intent of our previous recommendations. These recommendations related to aspects of the child protection and domestic violence standard operating procedures, particularly in relation to reporting risk of harm to DoCS. We also made recommendations about particular JIRT procedures.

NSWPF provided this office with progress reports in February 2008 and July 2008.

For recommendation 1(a) and 1(c), we have also included DoCS response to the same recommendations, which both relate to joint agency initiatives.

Recommendation 1(a) (and 2(b), to DoCS)

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

Police response

The NSWPF advised us that work with DoCS in this area is on-going. The NSWPF completed an analysis of child at risk incidents on its Computer Operated Policing System, and it was anticipated that a final proposal for a specific tool to enhance the quality of information communicated by police would be provided to the DoCS Child Protection Major Project Board.

In addition, DoCS provided advice to the NSWPF in relation to the revised Domestic Violence Standard Operating Procedures and will also be consulted once the new Child Protection Standard Operating Procedures have been developed.

In August 2008, the NSWPF advised that the Force and DoCS had agreed to await the recommendations of the Special Commission of Inquiry into Child Protection Services before undertaking further project work.

DoCS response

DoCS advised that:

- In late 2007, the Director-General of DoCS endorsed a draft Memorandum of Understanding (MoU) between DoCS and NSW Police. DoCS advised that the NSWPF were seeking further advice prior to endorsement of the MOU.
- DoCS has established a working group to progress an 'implementation strategy' in relation to a draft tool to assist police to provide better information about domestic violence incidents to DoCS.
- DoCS has produced an information paper *'Mandatory Reporting FAQ'*, and the NSWPF is currently using the standard fax form for all mandatory reporters.
- The DoCS' Helpline has started planning for implementation of a proposed data collection tool which the NSWPF has been asked to complete when reporting children at risk, in addition to the standard fax form and the COPS event narrative which police provide now. The tool will collect additional details about incidents involving children and young people.

Our comments

This recommendation arose from our work over a number of years that identified the need for police reports to provide comprehensive information from which DoCS could accurately assess the level of risk to a child. While project work was deferred, there has been progress with this recommendation.

Moreover, the Special Commission of Inquiry has recommended, and the NSW Government has in the main supported:

- A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors. (9.2)
- DoCS and NSW Police should agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made. (17.2)

The Inquiry also proposed that the NSWPF amend reporting policies to align with the requirements of s.23(d) of the *Children and Young Persons (Care and Protection) Act 1998* (recommendation 17.1). s.23(d) identifies a child at risk of harm if they live in a household where there have been incidents of domestic violence and as a consequence, the child or young person is 'at risk of serious physical or psychological harm.' In addition and more broadly, the Commission has proposed that reports should be made where a child is reasonably considered to be at risk of 'significant' harm, rather than the current 'risk of harm'. (recommendation 6.2)

In order to report further progress, we will seek further information on NSWPF strategies to improve reporting of risk of harm, revision of the child protection SOPS and the status of the police/DoCS MOU, following the NSWPF consideration of the findings and recommendations of the Special Commission and the NSW government's response.

Recommendation 1(b)

Outcomes of the NSWPF working party to address reporting issues, in particular, strategies to:

- improve compliance with risk of harm reporting requirements
- improve the quality of the police response to children at risk of harm
- provide police with better information and support in relation to managing children and young people at risk of harm and working with other agencies
- implement a more systematic, focused approach in Local Area Commands relating to children at risk of harm.

Police response

The NSWPF linked the focus of the working party to the development of revised Child Protection SOPs.

Police told us that the revised procedures would 'incorporate a much more systemic approach to child protection across NSWPF by having clearer instructions on reporting and support for police in monitoring child protection'.

The NSWPF advised their response to the revised Child Protection SOPs was complete, but that implementation had been put on hold pending the findings and recommendations of the Special Commission of Inquiry into Child Protection.

Our comments

In 2007, we conducted a targeted review of police and DoCS records for a sample of children who died in 2006. The review found that police reporting of risk of harm did not consistently meet reporting requirements. In response, the NSWPF advised us that they had established a working party to consider and respond to the issues we raised.

We note the NSWPF decision to defer implementation of the SOPS pending the findings and recommendations of the Special Commission of Inquiry.

Recommendation 1(c) (and 2(c), to DoCS)

Implementation of the JIRT review recommendations.

Police response

The NSWF advised that implementation of the recommendations of the JIRT review is being managed under five projects:

- JIRT response
- Aboriginal community and culture
- JIRT criteria
- JIRT governance
- Forensic medical.

Police told us that DoCS has assumed responsibility for project management of the first four projects, with NSW Health having sole responsibility for the fifth.

DoCS response

DoCS provided some detail of the scope of progress with the JIRT review recommendations. Of particular note:

- JIRT will trial a central joint decision making unit, the JIRT Referral Unit, which commenced in September 2008.
- Additional physical abuse criteria will be implemented, and draft sexual abuse criteria will be tested.
- Changes will be made to JIRT local management groups and the JIRT structure within DoCS is being centralised.
- A review of JIRT agencies' professional development and staff support strategies has been completed and the NSWPF is leading the review of JIRT training.
- In February 2008, DoCS advised that a trial of draft guidelines for engagement with Aboriginal communities was expected to commence in March at Wollongong JIRT. 'The guidelines will be progressively rolled out after that'. In further correspondence in August 2008 DoCS advised that 'a culturally appropriate model for JIRT in working with Aboriginal families (recommendation 18) includes components of other recommendations. Wollongong JIRT is working to address these recommendations with the Nowra community.'

Our comments

We have made a number of recommendations about the operation of JIRT, particularly in relation to appropriateness of referrals to JIRT and the relationship between JIRT, police and DoCS. DoCS and the NSWPF have previously advised that the JIRT review recommendations would address our recommendations.

We note there has been progress in implementing key recommendations from the review.

Moreover, the Special Commission of Inquiry recommended, and the NSW Government has supported:

- The JIRT Reform Program, as set out in the Implementation Plan, should be completed. (8.1)
- JIRT should be regularly audited. (8.2)

We will monitor JIRT developments through our reviews and broader work.

Department of Community Services

Recommendation 2: Progress on previous recommendations

In our *Report of reviewable deaths in 2006: Volume 2: Child deaths,* we asked DoCS to provide us with progress reports on a range of strategies that the department had advised us would meet the intent of our previous recommendations. Since our first report in 2004, we have made a range of recommendations to DoCS relating to child protection policy and practice, and quality assurance processes. The department has responded to the recommendations in the context of the ongoing DoCS reform process.

DoCS provided this office with progress reports in February 2008 and July 2008.

For recommendation 2(f) we have also included NSW Health response to the same recommendation, which relates to a joint agency initiative.

Recommendation 2(a)

The roll out of quality reviews of CSCs in NSW.

DoCS response

In February 2008, DoCS advised that a full pilot of the quality reviews was approved in November 2007. However, the pilot was suspended following Public Service Association (PSA) concerns about the impact of participation on staff. In August 2008, DoCS further advised that the reviews remained on hold, with discussions between DoCS and the PSA aimed at 'addressing the PSA's concerns and retaining the integrity of the review process'.

Our comments

Over the years, we have made a number of recommendations relating to the quality of DoCS' assessment processes and the need for systematic performance audits of each CSC in NSW. In 2006, DoCS advised us that the department was planning a quality review program that would address the concerns we had raised and provide a basis for ongoing performance improvement across the state.

At that time we acknowledged that DoCS had taken on a significant commitment in undertaking the quality review and that the reviews would provide an opportunity to address the frontline response to children at risk of harm.

DoCS has indicated that significant work has been undertaken in regard to the department's preparation for roll out of the program, pending outcomes of negotiations with the PSA.

Our comments cont'd

The Special Commission of Inquiry noted the issues relating to the PSA, and DoCS' 'concessions' that have seen agreement to replace the audits with case practice reviews. The Inquiry recommended, and the Government has supported:

- The trial of the quality review tools should proceed immediately and the approved tools should then be applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.

We will monitor developments through our reviews and broader work.

Recommendation 2(b)

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

See 1(a) above.

Recommendation 2(c)

Implementation of the JIRT review recommendations.

See 1(c) above.

Recommendation 2(d)

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

DoCS response

DoCS advised that revised procedures for handling matters rejected by JIRT were published in June 2008 and provided a copy of these.

Our comments

This recommendation arose from our concerns that reports rejected by JIRT did not receive a consistent casework response when referred back to CSCs for risk assessment.

The new policy requires that a search is undertaken twice a day for matters received at a CSC following rejection from JIRT and that these matters be allocated according to risk, urgency and vulnerability. The policy requires that Manger Case Work and Manager Client Services review the JIRT Rejection Database once a week and the Regional Director Child and Family reviews the database and a sample of plans monthly.

These practices substantively meet the intent of this recommendation.

Recommendation 2(e)

Outcomes of the pilot of the drug testing policy and Parent Responsibility Contracts, and finalisation of the case planning and care plan policies.

DoCS response

In August 2008, DoCS advised that the drug testing policy trial in four CSCs had concluded, and an evaluation report was pending. DoCS told us that 'The evaluation will inform consideration of the policy and operational impacts which will influence planning for state wide implementation.'

Parent Responsibility Contracts were trialled in eight CSCs, and subsequently rolled out across the state.

Our comments

This recommendation arose from our concerns about the use of informal 'undertakings' with parents as a protective measure. In particular, we had concerns about poor monitoring by DoCS of compliance with undertakings, and lack of clarity about how caseworkers should respond to breaches. We particularly highlighted concerns about the use of undertakings in cases where parental substance abuse was an issue.

DoCS agreed that policies were not clear and undertook to review the relevant Casework Practice topics. DoCS further advised us that new legislation allowing for parent responsibility contracts would address many of the concerns raised in our reports.

We note in addition to drug testing and Parent Responsibility Contracts that case planning and care plan policies have been finalised. The policies now clarify that undertakings should only be used where there is a care order accepting undertakings and not in relation to Parent Responsibility Contracts, case plans or registered care plans.

These measures meet the intent of this recommendation. We will monitor the ongoing implementation of these strategies through our reviews.

Recommendation 2(f) (and 5(f), to NSW Health)

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

DoCS response

DoCS advised that the *Methadone Related Child Deaths* report had been endorsed by the Directors-General of DoCS and NSW Health. The paper makes 19 recommendations, six of which are directed specifically to DoCS and five to DoCS and NSW Health jointly. DoCS advised that the Joint Child Death Review Group is meeting quarterly to progress the recommendations.

DoCS provided specific advice on the implementation of the following joint and DoCS' specific recommendations. In summary, the actions arising from these recommendations include:

- In December 2007 DoCS established the Drug and Alcohol Expertise Unit. 'The unit is currently assisting caseworkers to understand and negotiate the drug and alcohol system; and in the longer term will establish strategies and systems for enhancing interagency relationships both in the field and at head office levels'.
- The development of information resources advising of the dangers of methadone for children (*'Your Child's Safety'*).
- Plans to include methadone related child deaths in the 2009 DoCS' Research to Practice Forum program.
- The development of an interim procedure for the use of hair shaft testing, particularly where there is reasonable suspicion of a child's exposure to drugs and alcohol, or for parents, who have undertaken to be abstinent.
- As part of a recommendation that DoCS and NSW Health work together to negotiate, document and implement a process of joint case planning identifying each agency's responsibility and role in supporting mothers and babies born with Neonatal Abstinence Syndrome. NSW Health is consulting internally about discharge options and follow up services for mothers whose babies develop Neonatal Abstinence Syndrome.

Recommendation 2(f) (and 5(f), to NSW Health) cont'd

NSW Health response

NSW Health noted that 'DoCS and Health have been working closely together since September 2005 to reduce methadone child deaths.' In addition to the strategies identified by DoCS above, advice from NSW Health included the following strategies:

- The development of an information sharing protocol between DoCS and NSW Health to facilitate the sharing of information in relation to patients undergoing opioid treatment who have children under the age of 16 in their care.
- NSW Health development and distribution of the policy directive *'Prenatal Reports – NSW Department of Health'*. A trial of the system will run to the end of 2008 in three DoCS CSCs and selected NSW Health services in South Eastern Sydney Illawarra and North Coast Area Health Services.
- The revision of NSW Health's Opioid Treatment Guidelines, which have an increased focus on child protection.
- NSW Health plans to undertake an audit of the 16,000 patients on the opioid treatment program to determine how many have children under the age of 16 in their care, with results anticipated in late 2008.
- Training is planned for opioid treatment prescribers in stability and the appropriate prescribing of buprenorphine/naloxene.
- Child protection training is planned for drug and alcohol related staff in Area Health Services and non-government organisations. Focus of the training will include the legislative and policy context of child abuse and neglect; prenatal reports, parental responsibility contracts and drug testing; engagement strategies for workers where there are child protection concerns; and the development of effective intra and interagency networks. The training will occur over two years to 2010, and it is anticipated that delivery will be to 1,500 Health and NGO workers.

Our comments

Our 2006 *Report of reviewable deaths in 2005* focused on parental substance abuse. DoCS advised this office that it was undertaking a joint review, with NSW Health, of methadone related child deaths. DoCS advised that 'the intention is to examine systemic issues regarding child deaths from methadone poisoning and develop a pilot interagency training program on the issues arising.' Through our recommendations we have been monitoring the progress of the review and its outcomes.

Both DoCS and NSW Health have implemented, or have plans to implement, a range of strategies that have significant potential to improve agency responses to children at risk due to parental substance abuse.

We will monitor these strategies through our reviews.

Recommendation 2(g)

Completion and implementation of the Intake Assessment Guidelines.

DoCS response

As at late July 2008, the Intake Assessment Guidelines were implemented in all except two CSCs in NSW, with plans to implement in these CSCs by August 2008.

Our comments

In previous reports, we have consistently raised concerns through our reports about high risk cases being closed without being allocated for assessment.

DoCS did not support our original recommendations that there should be a threshold for risk above which cases cannot be closed without assessment, on the grounds that this would result in a number of cases remaining open without allocation.

DoCS indicated that the Intake Assessment Guidelines would enable consistency in prioritisation of cases for secondary assessment.

We note the completion of the guidelines and the importance of consistency in decision making about which cases should proceed to further assessment.

We will monitor use of the guidelines through our reviews and broader work.

Recommendation 2(h)

Completion and implementation of the prenatal policy.

DoCS response

In July 2008 DoCS advised that a trial of the *Responding to Prenatal Reports* policy began in June 2008 and would continue for six months across three CSCs and the Helpline.

DoCS previously advised that it is intended that the policy will complement both Brighter Futures and the Aboriginal Maternal Infant Health Strategy.

Our comments

This recommendation arose out of our observations that prenatal reports were not assigned a high risk or urgency level and were often not allocated for further assessment. We were concerned that this resulted in lost opportunities to provide support and assistance to pregnant woman.

In late 2006, the State Government amended child protection legislation to include, among other things, a child being specifically identified as being at risk of harm if they were the subject of a prenatal report and the birth mother of the child did not engage with support services to eliminate or minimise risk factors that gave rise to the report.

Finalisation of the *Responding to Prenatal Reports* policy and commencement of a trial of the policy provide support to the legislative change and indicate significant progress in improving capacity to respond to prenatal reports.

We will monitor responses to prenatal reports through our reviews.

Recommendation 2(i)

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

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

DoCS response

Development of a consultation model for use by CSC staff

In February 2008, DoCS advised that a consultation model that will be uniform across regions is being developed and that 'a draft concept paper outlining key principles of the new consultation framework should be finalised in March/April 2008'. In August 2008 DoCS advised that the draft concept paper was due for completion.

Establishment of a regional Aboriginal advisory group

DoCS told us that Regional Commitment of Service Aboriginal Advisory Groups have been established in each DoCS region. These advisory groups 'provide a mechanism for the identification of key issues and priorities for Aboriginal families and communities'.

Strengthening the capacity of mainstream early intervention services to better meet the needs of Aboriginal children, families and communities

DoCS advised that a range of resources have been developed for DoCS caseworkers and lead agency caseworkers to 'provide support and assistance to workers providing services to Aboriginal children, families and communities'.

- 'The DoCS Early Intervention Major Project Plan has been updated with potential strategies and initiatives to ensure active engagement of Aboriginal people with the program.'
- DoCS has funded a three year research project conducted by researchers from Macquarie and Charles Sturt Universities to examine early childhood education within Indigenous communities (Child Care Choices of Indigenous Families). This project is due for completion in early 2009.
- A literature review on early intervention strategies for Indigenous children is underway.
- Workshops were held at the Aboriginal Staff Conference in November 2007.

DoCS response cont'd

Increased resources to better support Aboriginal foster carer recruitment

In February 2008 DoCS told us of several strategies underway to better support Aboriginal foster care recruitment, including:

- The development of foster carer training packages specifically for Aboriginal foster carers (Our Carers for Our Kids).
- ACWA was funded to modify the general foster carer assessment tool, Step by Step, for use with Aboriginal foster care applicants.
- Carer support teams, which commenced in May 2006, have identified Aboriginal caseworkers 'to provide additional support to Aboriginal carers' in the majority of teams.

In August 2008 DoCS also provided advice on the following strategies:

- DoCS is developing an Aboriginal carer recruitment strategy in consultation with the Aboriginal Child, Family and Community Care Secretariat.
- The Aboriginal Out of Home Care Service Capacity Building initiative will increase the resources available to support Aboriginal carers. The aim of the initiative is to 'explore opportunities for Aboriginal OOHC service providers to build upon programs to become strong and sustainable providers of OOHC for Aboriginal children … The initiative plans to enhance funding by around $10m to Aboriginal OOHC service providers in the third year of the project.'
- DoCS has responded to gaps in the out of home care system for Aboriginal children 'via the recent OOHC EOI (Expression of Interest) and through direct negotiations with Aboriginal services engaged in direct negotiations with Aboriginal services interested in becoming OOHC providers.'

Development of guiding principles and protocols to inform engagement with isolated communities

DoCS advised that local communication and consultation guidelines and standards have been developed through the Aboriginal Advisory Groups for working with Aboriginal families, children and young people. The guidelines contain 'cultural information relevant to each region as well as on specific issues and key practices that need to be used when engaging with local Aboriginal communities'.

In addition, DoCS has published on the intranet a guide to the use of appropriate language with Aboriginal communities.

DoCS also noted the longitudinal study of children and young people in out of home care in NSW will include a sub-study of Indigenous children and young people.

Recommendation 2(i) cont'd

Our comments

In our Report of Reviewable Deaths in 2005, we asked DoCS to consider strategies to enhance the department's capacity to respond effectively to Aboriginal children at risk of harm, and improve interagency coordination and collaboration in the care and protection of Aboriginal children.

In response, DoCS advised us that the Aboriginal Strategic Commitment would outline how DoCS would work to provide better services for Aboriginal people. We note the strategies in train.

The Special Commission of Inquiry considered the over-representation of Aboriginal children in child protection and agency responses to Aboriginal children and families at risk. The Inquiry made a number of recommendations aimed at building capacity in Aboriginal organisations, which the Government has supported in part.

The Inquiry also urged the NSW Government to implement the recommendations of the Aboriginal Child Sexual Assault Task Force report, and proposed that the Ombudsman be given the authority to audit this implementation. The Government has supported this recommendation in part, by proposing to give the Ombudsman authority to audit the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006 – 2011*. The Government does not propose that the Ombudsman audit the Taskforce report separately.

Recommendation 3: Competing priorities

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

DoCS response

DoCS advised that recruitment of caseworkers had impacted positively on DoCS' capacity to respond to an increasing proportion of reports. However, as the number of reports has also risen 'resource constraints continue to be an issue'.

DoCS noted that while there is capacity on the KiDS database to record whether a case has been closed due to current competing priorities, this data has not been remediated.

DoCS noted that 'the quality, meaningfulness and usability of such information will be addressed and shaped by the Child Protection Major Project and the findings from the Special Commission of Inquiry into Child Protection Services in NSW'.

DoCS further advised that the department would wait for the Commission's report 'before considering action on this Recommendation.'

Our comments

This recommendation relates to our previous recommendations about the need for data to enable accurate monitoring of system capacity, including data that identifies the number and proportions of reports that cannot be actioned due to lack of resources.

In 2006 DoCS provided advice that its capacity to report and analyse data through KiDS would be addressed as part of the Child Protection Major Project and that the department was working with NSW Treasury on a final set of key performance indicators for the child protection system, including an indicator to measure allocation capacity.

In relation to DoCS' performance measures, the Special Commission of Inquiry stated that 'generally, DoCS measures process or outputs rather than outcomes for children.'[161] The Inquiry has suggested a range of indicators that are outcome-focused, and notes the importance of performance measurement in identifying the most effective allocation of resources and areas of service that 'on the one hand, require modification or remediation, and, that on the other hand, provide good outcomes.'[162]

The Inquiry also recommended enactment of section 28 of the Children and Young Persons (Care and Protection) Act. The section requires the DoCS Director-General to keep a record of all reports made to or by the Director-General, any action taken as a consequence of a report, and any 'subsequent disposition of and dealings with' the reported children or young people.[163] This recommendation has been supported by the NSW government.

161 Hon James Wood AO QC (2008) Report of the Special Commission of Inquiry into Child Protection Services in NSW, page 1027.
162 Ibid, page 1029.
163 Ibid. See recommendation 11.1.

Recommendation 4: Early intervention

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

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

DoCS response

DoCS advised that better identification of 'high risk children and families' is part of the Child Protection Major Project and it is anticipated that the outcome of the Special Commission of Inquiry into Child Protection Services would further contribute to work in this area.

DoCS specifically advised that 'when DoCS develops an evaluation framework for the child protection program, the response to children and families who are not accepted into Brighter Futures may be considered, if appropriate'.

Our comments

This recommendation arose from some cases we reviewed where reports referred to Brighter Futures were subsequently rejected because the reports indicated too high a risk for early intervention. In the cases of concern, reports were re-referred to CSCs and subsequently closed without further assessment.

We considered evaluation of this issue would identify options for improved pathways for reports that do not meet early intervention criteria and are clearly child protection matters.

The Special Commission noted that the Inquiry 'shares the concerns of the NSW Ombudsman that while there are procedures in DoCS to refer cases back to the child protection team, there is no requirement for these cases to be allocated for further secondary assessment by that team.'[164] Further, the Inquiry made the observation that DoCS' policies were not clear as to what child protection histories disentitle a family from the Brighter Futures program. The Inquiry recommended that DoCS revise its Brighter Futures guidelines to clarify the account to be taken of child protection history in determining eligibility. (7.1) The NSW Government has supported this recommendation, with implementation over the short-term (12-18 months).

The Special Commission's proposed 'pathways' model for directing child protection reports is of significant relevance to early intervention in this context. It also envisaged that in the future, early intervention services should be carried out primarily by the non-government sector. In response, the NSW Government has proposed that DoCS will maintain its role in the program until at least the completion of the evaluation of Brighter Futures in 2010. Growth funding for the program will, however, be directed to non-government organisations.

164 Ibid, page 246

NSW Health

Recommendation 5: Progress on previous recommendations

In our *Report of reviewable deaths in 2006: Volume 2: Child deaths,* we asked NSW Health to provide us with progress reports on a range of strategies that the department had advised us would meet the intent of our previous recommendations. Following our earlier work on parental substance abuse, we made a number of recommendations to NSW Health that focused on improving responses to mothers using drugs during pregnancy, and to children born into families with substance abuse issues. We also made recommendations about responding to children presenting at hospital as a result of methadone poisoning. NSW Health proposed a range of initiatives to address the recommendations.

NSW Health provided this office with progress reports in February 2008 and July 2008.

Recommendation 5(a)

Terms of reference and timeframes of, and methodology for, the audit of Drug Use in Pregnancy services in NSW. On completion, please provide a copy of the audit report.

NSW Health response

NSW Health provided us with terms of reference for the Drug Use in Pregnancy Services and Linkages Review. The findings of the review will 'be the basis for the development of minimum standards for drugs in pregnancy service provision across NSW.'

The review methodology described in the terms includes visits to each Area Health Service in NSW, specifically to drug and alcohol and maternity services; review of relevant documentation provided by Area Health Services; and seeking submissions from key NGOs.

The final report is expected in May 2009.

Our comments

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

We note the progress of the review and the intention to develop minimum standards in the context of the review findings.

We will report on the outcomes of the review in our next annual report, and will continue to monitor the provision of services to pregnant women with drug and alcohol issues through our reviews.

Recommendation 5(b)

Outcomes of NSW Health's approach to the Intergovernmental Committee on Drugs regarding the issue of ensuring compliance with the *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn*.

NSW Health response

NSW Health advised that the report of the Drug Use in Pregnancy Services and Linkages Review will include a chapter on feedback relating to the dissemination, uptake and applicability of the *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn*.

Further, the department told us that the Mental Health and Drug and Alcohol Office will use that information, and the recommendations of the review, to formulate a strategy to ensure ongoing compliance with the guidelines.

Our comments

In our *Report of reviewable deaths in 2005*, we asked NSW Health to advise us of strategies to ensure compliance with relevant procedures relating to maternal substance abuse.

In 2006, the department subsequently advised us that it intended to raise the issue of compliance with the national guidelines with the Intergovernmental Committee on Drugs. The department has not provided further information about this proposed action, however we note the relevance of plans for development of a compliance strategy.

Recommendation 5(c)

Development of a state-wide system for the reporting of fatal and non-fatal methadone poisoning of children.

NSW Health response

NSW Health advised that limitations in information systems in emergency departments have affected the ability to institute reliable timely statewide reporting of incidents of child methadone poisoning.

Notably, there are a number of data systems operating in NSW.

However, the department has developed a number of pathways for reporting:

- In relation to one of the systems, used in 42 emergency departments (Public Health Real Time Emergency Department Surveillance System), the department has access to regular reports. The last report provided for the period January to June 2008 indicated no incident pertaining to methadone poisoning in children.
- The emergency department data collection also records children's admissions with methadone poisoning, but this is not in 'real time', nor does the data cover all emergency departments. NSW Health indicated this system may be used for auditing purposes.

NSW Health response cont'd

- As we have previously reported, it is now mandatory that incidents involving methadone or buprenorphine poisoning in children are 'reportable incidents' within NSW Health. There are a range of procedures which follow a reportable incident, including provision of prompt advice to a drug treatment prescriber where a patient's child has been diagnosed with methadone/buprenorphine poisoning. An investigation team has also been established to review prescribing practices in these cases.

(**See also response to recommendation 6 below**)

Our comments

The intention of this recommendation was to develop a state wide system for reporting of fatal and non-fatal methadone poisoning of children.

While the systems identified by Health above are not a consistent statewide collection, the steps put in place to ensure reporting of, and promote a response to, incidents of child methadone/buprenorphine poisoning largely meet the intent of this recommendation.

Recommendation 5(d)

Establishment of the proposed Compliance and Quality Control Program for the NSW Opioid Treatment Program.

NSW Health response

The department advised that there is a compliance framework comprised of:

- An investigation team, focusing on investigating critical incidents/child methadone poisonings.
- The Compliance and Quality Control Program (CQCP), being established at Sydney South West Area Health Service. The CQCP will advise practitioners when they are due for re-accreditation, and monitor compliance with the accreditation requirements. The CQCP will also work closely with the Pharmacotherapy Credentialing Subcommittee 'to advise the Director-general on matters relating to the prescribing of drugs of addiction in NSW.
- Accreditation and re-accreditation for prescribers. NSW Health advised us that the department is currently reviewing the requirements for re-accreditation in relation to patient numbers.

NSW Health also advised that the Mental Health and Drug and Alcohol Office is developing governance principles to guide the interface between the Compliance Team, the Investigation team and the Pharmacotherapy Credentialing Subcommittee.

Recommendation 5(d) cont'd

Our comments

In 2006, NSW Health released revised guidelines for the opioid treatment program with a strengthened focus on child protection concerns.

NSW Health has outlined a number of initiatives to ensure compliance with the new guidelines and have also strengthened their complaint and investigation functions with respect to prescribers.

The intent of this recommendation has been substantively met.

Recommendation 5(e)

Outcome of the proposed one-week census of take-away methadone doses.

NSW Health response

In 2007, NSW Health advised us that the department intended to conduct a one-week census of prescribed methadone takeaway doses and observed doses across NSW. NSW Health provided advice that an audit is in planning.

The department noted that there are approximately 740 dosing points accessed by 17,200 patients across NSW.

Our comments

This recommendation also goes to monitoring compliance with the Opioid Treatment Guidelines. It is clear from Health's response that work on the audit is progressing.

Recommendation 5(f)

Implementation of the recommendations of the joint review of methadone-related child deaths with DoCS.

See 2(f) above.

NSW Health and Department of Community Services

Recommendation 6: Advising prescribers of child methadone poisoning

NSW Health and DoCS should prioritise the development of a clear process for providing prompt advice to a methadone prescriber when their patient's child is admitted to an emergency department as a result of ingestion of methadone.

NSW Health response

NSW Health advised that its *Incident Management* Policy has been amended to make it mandatory to report all children who present to hospital with poisoning associated or potentially associated with methadone and/or buprenorphine. Medical staff in all emergency departments must notify the Mental Health and Drug and Alcohol Office (MHDAO) of any such admission or presentation.

MHDAO has responsibility for identifying and informing the relevant prescriber (where the parent is registered on the Pharmaceutical Drugs of Addiction System database). The MHDAO will also check that a report has been made to DoCS.

In addition, the Opioid Investigation Team will review prescribing practices where the child of a parent or guardian on the Opioid Treatment Program is found to have methadone/buprenorphine poisoning.

NSW Health also advised it had drafted procedures, and would be meeting with DoCS in regard to whether the procedures appropriately address issues pertaining to the prompt notification of prescribers in the event of a child's presentation to an emergency department as a result of ingestion of methadone or buprenorphine.

DoCS response

DoCS confirmed its understanding that NSW Health is responsible for advising (methadone and buprenorphine) prescribers when a child is presented to a hospital after ingesting methadone.

Our comments

In our *Report of reviewable deaths in 2005*, we recommended that NSW Health identify and inform the relevant methadone prescriber when the child of a patient is admitted to an emergency department as a result of ingestion of methadone. NSW Health accepted this recommendation, but advised us that the department would negotiate specific roles and responsibilities with DoCS, including who would contact prescribers in these cases.

DoCS and NSW Health have identified their respective roles and responsibilities in this regard and have met the intent of our recommendation.

Recommendation 7: Responding to adolescents

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

NSW Health response

NSW Health advised that the Child Protection Senior Officers Group (CPSOG) is undertaking an audit of the various tools used by agencies to assess young people who are at risk.

The CPSOG established a working group in April 2008, comprised of representatives of NSW Health and the Departments of Community Services, Ageing Disability and Home Care, Housing, Corrective Services and Juvenile Justice. The working group will 'consider and report on future directions and the development of a work plan, its key objective being to improve outcomes for vulnerable young people.'

NSW Health indicated that DoCS and the working group have:

- Completed an audit of assessment tools used by CPSOG agencies.
- Conducted a literature review of evidence based assessment tools to assist in the identification of suicide risk in young people.
- Developed objectives for a 2008/09 work plan, including developing a cross agency agreement on strategies to identify young people at risk who come into contact with CPSOG agencies with a role in service delivery.

However, in February 2009, in response to a draft copy of this report, NSW Health advised that the implementation of the work plan is now on hold, pending the NSW Government response to the Special Commission of Inquiry into Child Protection Services.

Other strategies noted by NSW Health were identified as:

- Joint work between DoCS and Health to develop comprehensive health care service pathways (including mental health care) for children and young people in out of home care. NSW Health advised us that the DoCS Health Memorandum of Understanding is being revised to take into account the new roles and responsibilities of non government organisations, and to align with the NSW Government response to the Special Commission of Inquiry.
- A joint initiative between Redbank House (Sydney West Area Health Service), DoCS Metro West and DoCS Intensive Support Services to provide better access and treatment for children and adolescents with significant mental health problems including risk of suicide.

DoCS response

DoCS also informed us of the formation of the CPSOG activities and the formation of the Working Group. DoCS advised that 'the objective of the project is to improve agency awareness and interagency communication about vulnerable adolescents in order to promote more effective and efficient provision of services'.

In addition, DoCS advised that agencies are currently engaged in examining their intake procedures and policies to determine whether these identify clients shared by two or more agencies and what is done with that information.

Our comments

Over a number of years, we have raised concerns about interagency responses to young people at risk of harm, particularly where child protection concerns are coupled with mental health issues and/or risk-taking behaviour.

Of specific relevance to responding to this group of young people, the Special Commission of Inquiry proposed that the work of the DoCS' Drug and Alcohol Expertise unit be expanded to include mental health and domestic violence (9.8). The NSW Government has supported this recommendation in principle, noting it will be considered in the context of a longer term review of the future of the unit after 2009/10.

In addition, the Inquiry recommended that DoCS should train and appoint to each DoCS region, specialist caseworkers to assist in the case management of young people. (20.1) The NSW Government has stated support for this recommendation, with substantial commencement within the next 12-18 months.

We will continue to monitor the provision of services to adolescents at risk through our reviews.

Department of Education and Training

Recommendation 8: Mandatory reporting obligations

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

DET response

DET advised us that the department had considered the issues raised by our case study, and had immediately implemented a number of responses to the recommendation. A 'child protection annual update training package' which reinforced the mandatory reporting obligations of staff was made available from December 2007, and all workplace managers were reminded that all staff must participate in annual child protection update training. DET also planned to revise the department's policies and procedures relating to mandatory reporting.

In May 2008, DET told us that the policies and procedures had been redrafted, but the department would await any relevant recommendations from the Special Commission of Inquiry in order that any further revisions could be made prior to distribution.

As previously described in this report, the Inquiry made substantive recommendations relating to the process for mandatory reporting which have been supported by the NSW government. Proposals relating to the establishment of centralised units for reporting, and amended thresholds, will have significant implications for agency procedures and guidance in this area.

The Inquiry also recommended targeted training strategies for key mandatory reporters, including DET, in relation to the circumstances in which reports need to be made and the information required from reporters (6.5). This has been supported by the NSW government, with implementation envisaged in the short term.

Our comments

DET has considered, and responded to, the issues raised in our report.

NSW Ombudsman

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