



Family &  
Community Services  
Community Services

# Child Deaths 2011 Annual Report

Learning to improve services



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**Published by**

Department of Family and Community Services  
Community Services

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[www.community.nsw.gov.au](http://www.community.nsw.gov.au)

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

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

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

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# Minister's foreword



The *Child Deaths 2011 Annual Report* is the second annual report about the deaths of children and young people who were known to Community Services, a division of Family and Community Services. The report examines Community Services' involvement with the families of 110 children and young people who died in 2011, the response received from Community Services, lessons learned from reviewing these cases and initiatives that are currently being implemented to improve the delivery of services in NSW.

The death of any child is a tragedy, and I extend my sympathy to the families and communities of the children discussed in this report. Child death is an emotive issue, one that often raises reasonable questions from the public about whether these deaths could have been prevented. The public's attention will often be directed towards the role of Community Services, the agency responsible for protecting children who are at risk of significant harm in NSW. Government can choose how to respond to this scrutiny – reactively or thoughtfully, transparently or defensively. This

government chooses to respond thoughtfully and transparently. This annual report is part of my commitment to being more open and accountable to the people of NSW. This report is transparent about the system's strengths and weaknesses and reiterates a public commitment to continuous improvement.

This report also provides us with an opportunity to share the learning from Community Services' involvement with the families of the children who died, so that the whole system can work better and smarter with families to improve services and improve children's lives. Child death reviews help us to focus our attention on what can be done to improve practice for all children, young people and their families. They help us to understand the complexities and challenges of child protection work. This focus, and this understanding, make a key contribution to our considered and coherent program of reform in NSW.

This government is committed to meeting the goals of the NSW State Plan, *NSW 2021*. One of those goals is to reposition the child protection system so that it puts families at the centre of attention. This is the best possible means to reduce unmet demand, as well as the numbers of children and young people in out-of-home care.

To meet this challenge, the *Community Services Plan 2012–2014* has been developed. The Plan is a two-year program that aims to get more value from our investment in prevention and early intervention programs, improve our casework with families, help parents to take responsibility to reduce risks to children, give children in care a better life, and develop a seamless system that works for families.

Importantly, the *Community Services Plan 2012–2014* commits Community Services to partnering and building on the strengths of the non-government sector to develop a progressive child protection system that is better able to respond to the contemporary challenges facing vulnerable families today – intergenerational abuse, drug and alcohol addiction, mental health issues, chronic violence, unemployment and social disadvantage.

I am continually inspired by the professionalism, dedication, resourcefulness and empathy of those who work in the challenging area of child protection. The government is committed to building on the strengths of our staff, and particularly our caseworkers, and providing a work environment that enables, rather than restricts them. This report is one of many initiatives focused on finding smarter and more effective ways of delivering child protection services into the future to improve the lives of children.

A handwritten signature in black ink, appearing to read 'Pru Goward'. The signature is fluid and cursive.

**Pru Goward**

Minister for Family  
and Community Services  
Minister for Women

# Executive summary

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## The *Child Deaths 2011 Annual Report* is Family and Community Services' second public report examining our involvement with the families of children and young people who died and who were known to Community Services.

Children and young people known to Community Services are defined as those where a report was received about the child or young person, or their siblings, in the three years prior to the death. This definition also includes children and young people who were in statutory care at the time of their death. There were 110 children and young people known to Community Services who died between 1 January and 31 December 2011.

This report is informed by Community Services' internal child death reviews. It also analyses available information about the children and their families to identify relevant trends. This year's report includes a review of lessons learned from a review of Community Services' involvement with young parent families between 2006 and 2011. We report on the progress with reforms highlighted in the *Child Deaths 2010 Annual Report* and discuss further reforms which target the areas for improvement identified in child death reviews.

## Objectives of this report

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The *Child Deaths 2011 Annual Report* has four key objectives:

1. To boost transparency and accountability about child deaths by publicly reporting on Community Services' involvement with the families of the children who have died.
2. To increase public trust and confidence in Family and Community Services by reporting on lessons learned from child deaths reviews, the improvements to practice and systems made as a result of this learning, and how these are integrated into the government's reform agenda.
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage impacting on outcomes for families.
4. To share learning from child death reviews with Family and Community Services staff and with our interagency partners in other government departments and non-government organisations (NGOs).

## Chapter 1: Child deaths in context

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The NSW Government supports a strong system of oversight of child deaths in NSW. A range of agencies are responsible for oversight, including the NSW Ombudsman, the Child Death Review Team, the State Coroner, the NSW Police Force and the Office of the Children's Guardian. The role of each of these agencies is detailed in Chapter 1.

The government is committed to boosting accountability, transparency and understanding about Community Services' involvement with children who have died. This report ensures that the public is better informed about Community Services' response to the families of children who have died, and sets that response in context. Child protection work is complex and challenging, and there are strong links between socioeconomic disadvantage and risks to children.

There are also significant opportunities for practitioners who work with children and families to learn from child death reviews. Given that the government is working towards a shared approach to child welfare and wellbeing, it is a priority that Community Services shares learning from child death reviews with interagency partners.

## Chapter 2: Child deaths in 2011

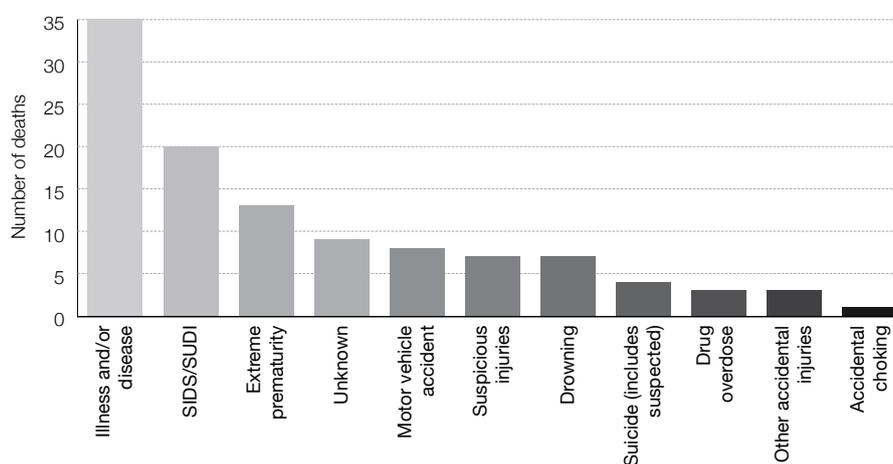
The Child Death Review Team (CDRT), convened by the NSW Ombudsman, reported in October 2012 that 581 deaths of children and young people were registered in NSW between 1 January and 31 December 2011. Of these, 110 were known to Community Services. 61,641 children and young people were reported to Community Services in 2011<sup>1</sup>.

Most of the 110 children known to Community Services died from an illness or disease, prematurity, or in sudden or unexpected circumstances<sup>2</sup>. The cause of a child's death was usually not linked to the risk issues that were reported to Community Services. However, some of these deaths may have been linked to a combination of physical illness or vulnerability in the child and poor parenting capacity in the carers.

Most of the 110 children known to Community Services died from an illness or disease, prematurity, or in sudden or unexpected circumstances.

The data are discussed in detail in Chapter 2.

**Figure 1: Circumstances of death of children and young people who died in 2011 and were known to Community Services.**



Source: Community Services, 2012.

<sup>1</sup> Source: Corporate Information Warehouse dynamic production environment (Community Services' data).

<sup>2</sup> The Sudden and Unexplained Deaths in Infancy (SUDI) category includes the deaths of infants who died from Sudden Infant Death Syndrome (SIDS). See Chapter 2 for more information.

### Characteristics of the children and young people

Infants (under one year of age) continue to represent the most vulnerable age group. In 2011, there were 49 infants known to Community Services who died, accounting for 45% of all deaths.

Consistent with previous years, male children were more vulnerable than females. In 2011, 61 males (55%) and 49 females (45%) who were known to Community Services died.

Aboriginal and/or Torres Strait Islander children continue to be over-represented in Community Services' child death data. Thirty-three Aboriginal and/or Torres Strait Islander children and young people known to Community Services died in 2011, accounting for 30% of all deaths of children known to Community Services for that year.

Ninety-nine (90%) of the children were living with their immediate families at the time of death. Eleven of the children and young people who died in 2011 (10%) were not living with their immediate families at the time of their death, including eight children (7%) who were under the parental responsibility of the Minister.

### Community Services' involvement with the children and families

Eighty (73%) children who were known to Community Services had been the subject of at least one report to Community Services within three years of their death. The remaining 30 (27%) children were not themselves the subject of a report to Community Services, but their sibling/s had been reported in the three-year period before their death.

Parental substance abuse was the primary risk of significant harm (ROSH)<sup>3</sup> reported issue, reported in 27% of cases. This reflects recent changes in the threshold for reporting to the Child Protection Helpline.

Intergenerational risk factors featured strongly in the family histories of the children who died. Intergenerational risk factors were identified in 31 (28%) of the 110 child death reviews. The most common intergenerational risk factors were domestic violence, parental drug and alcohol use, and neglect issues.

In 40 (36%) cases, the child who died had at least one parent who had their own child protection history, and/or was under the parental responsibility of the Minister as a child.

## Chapter 3: Lessons for improvement – working with young parents

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In 2011, Community Services conducted a cohort review of 105 children known to Community Services who died between 2006 and 2011 and had at least one young parent<sup>4</sup>. These cases were compared with 285 cases of children of older parents who died within the same period and with a separate group of children of young parents who did not die, and where positive outcomes were noted.

Our review of the data found that there were higher rates of death for the children of young parents in the extreme prematurity, SUDI/SIDS, suspicious injury, and accidental smothering (including co-sleeping) categories, and lower rates of deaths due to illness or disease. Aboriginal and/or Torres Strait Islander children and infants under one were over-represented in the young parents group. There were also significant intergenerational risk factors for the children of young parents. The majority (86%) of the 105 cases had one or both parents who were known to Community Services as children, including one-quarter of cases (25%) where one or both parents were leaving, or had left care at the time of the child's death.

<sup>3</sup> The threshold for reporting to Community Services was raised from 'risk of harm' to 'risk of significant harm' in January 2010.

<sup>4</sup> For the purposes of the review, a young parent is defined as a person less than 22 years old.

Our review of practice confirmed that children living in young parent families are a particularly vulnerable group in our community, especially when the family is living with disadvantage; the young parents experienced abuse, neglect and/or have left care; or there are poor family and professional support networks available.

However, our review also found a window of opportunity to intervene with young parents from disadvantaged backgrounds, who may view parenthood as an opportunity to make positive changes and provide their children with a better upbringing than they themselves had.

Finally, we identified three key success factors for effective practice with young parents: risk assessment, which takes account of the developmental stage of the young parents and the impact of their own child protection histories; engagement, which builds parenting capacity; and working effectively with dual clients – the young parent and the child.

## Chapter 4: Progress in child protection reform

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The NSW Government, through the NSW State Plan *NSW 2021*, is committed to improving the protection of vulnerable children and young people, delivered through much needed organisational reform in Community Services. Chapter 4 also outlines the NSW Government's reform agenda for Community Services.

Chapter 4 also provides an update on the initiatives and reforms listed in the *Child Deaths 2010 Annual Report*, particularly on the reforms that target the themes identified from Community Services' child death reviews in 2010: capacity to respond, assessing cumulative and changing risk, engaging with families, working with intergenerational risk, working with risk in early intervention, and assessing risk from new partners or adult household members.

The chapter also reports on a number of new, important initiatives that will support young parents. Directly relevant to the practice themes discussed in Chapter 3, these initiatives demonstrate the strong commitment from the government to help young parents and their children realise their full potential.

# Chapter 1: Child deaths in context

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## Chapter overview

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This chapter outlines the objectives of the *Child Deaths 2011 Annual Report* and discusses child deaths in the context of child protection work in NSW. Specifically, this chapter outlines how the government's commitment to accountability and transparency on child death reporting aligns with the Wood Special Commission of Inquiry into Child Protection Services in NSW's vision of a shared approach to child wellbeing, where child protection is understood as the collective responsibility of the whole-of-government and the community.

This chapter provides an overview of the rigorous system of child death review and oversight in NSW. It explains how Community Services' review functions align with the roles of other agencies such as the NSW Ombudsman, the NSW State Coroner, the NSW Police Force and the NSW Children's Guardian.

The *Child Deaths 2011 Annual Report* aims to add a deeper appreciation of practice and systemic issues to the intensive focus on individual child deaths. It sets child deaths in context for the public and for our interagency partners. This is particularly important in the context of the transition of out-of-home care to the NGO sector, which has seen a number of new partners in NSW.

## 1.1 *Child Deaths 2011 Annual Report*: objectives

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The *Child Deaths 2011 Annual Report* is Family and Community Services' second publicly available report, examining the deaths of children who were known to Community Services. This report is a key element of the government's reform agenda. Its purpose is to:

- boost transparency and accountability about child deaths by publicly reporting on Community Services' involvement with the families of the children who have died
- increase public trust and confidence in Family and Community Services by reporting on lessons learned from child deaths reviews, the improvements to practice and systems made as a result of this learning, and how these are integrated into the government's reform agenda

- inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage impacting on outcomes for families
- share learning from child death reviews with Family and Community Services staff and with our interagency partners in other government departments and non-government organisations (NGOs).

The NSW Government is currently proposing amendments to the *Children and Young Persons (Care and Protection) Act 1998* to require the Director General of the Department of Family and Community Services to present this report to Parliament annually. If this amendment is made, it will formalise the government's commitment to transparency and accountability about child deaths.

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...there are blockages in the system created by unnecessary procedures that stop caseworkers from spending time with families in need.

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## 1.2 Child protection in NSW

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### Community Services

Community Services is the statutory child protection agency in NSW. Community Services works closely with other government departments, NGOs and the community to support vulnerable families to keep children and young people safe from abuse and neglect.

### Child protection reform in NSW

There are significant challenges in delivering services across the NSW child protection system. While the number of reports Community Services receives is declining following the increase of the statutory threshold to 'risk of significant harm', this has not resulted in an increase in the number of children who are seen by caseworkers.

The *Child Deaths 2010 Annual Report* highlighted the difficulties that Community Services' managers face on a daily basis in deciding which cases can be allocated and which need to be closed because there is limited capacity to respond. There has been a strong focus on addressing this challenge, with independent reviews demonstrating that there are blockages in the system created by unnecessary procedures that stop caseworkers from spending time with families in need. Documentation, non-case related administration, court work and training have each had an impact on the productivity of caseworkers.

The *Community Services Plan 2012–2014* outlines the significant policy, practice and legislative reforms to achieve four overarching goals:

1. Ensure that fewer children and young people are vulnerable to abuse and neglect.
2. Protect children and young people at risk of significant harm.
3. Provide a better future for children and young people in care.
4. Deliver a capable organisation and service system.

This plan aims to build on the strengths of the NSW system, including a committed Community Services workforce, good collaboration between government agencies and a strong NGO sector. Planned reform work includes:

- continuing the out-of-home care transition to NGO providers
- ongoing implementation of the Structured Decision Making (SDM<sup>®</sup>) tools to guide decision making in the child protection and out-of-home care systems, and to achieve greater consistency in outcomes across all assessments, including the consistent identification of those children most in need of further assessment and
- continued investment in prevention and early intervention services.

Community Services will also continue to review and expand current pilots and trials where evidence shows they are making a difference.

The government's current reform work also builds on changes following the Wood Special Commission of Inquiry into Child Protection Services in NSW. Commissioner Wood's vision for NSW was a shared approach to child wellbeing so that Community Services can focus on children at the greatest risk; those children who may require statutory intervention. This then enables partner agencies and NGOs to provide early intervention and support to children for whom statutory intervention is not required. Key changes have included:

- raising the threshold for reporting to Community Services from 'risk of harm' to 'risk of significant harm'
- the establishment of Child Wellbeing Units (CWUs) in the NSW Ministry of Health, the Department of Education and Communities, the NSW Police Force and Family and Community Services
- a focus on early intervention services to support families to receive services earlier, with a particular focus on sharing these services more broadly with human services and justice agencies through the *Brighter Futures* program
- ongoing work to transition out-of-home care placements to non-government providers.

### The social context of child protection and child deaths

The *Child Deaths 2010 Annual Report* highlighted a number of social and environmental factors that have been linked to an increased risk of child abuse and neglect. These include low socioeconomic status, lack of access to services, parental unemployment, homelessness, social isolation and reduced access to education<sup>5</sup>. All of these factors can contribute to, and be exacerbated by, domestic violence, parental mental health concerns, and parental drug and alcohol use.

An increase in birth rates for families facing socioeconomic disadvantage<sup>6</sup> continues to place pressure on health and welfare resources, particularly in the child protection context. Children at risk are commonly exposed to parental drug and alcohol use, parental mental health issues and domestic violence. These issues are often the product of an intergenerational cycle of disadvantage and commonly underpin the abuse and neglect of children, especially in young parent families (as discussed further in Chapter 3). This challenge is not unique to NSW.

There are also links between child deaths and disadvantage. Homelessness, poverty and intergenerational involvement with statutory services are common findings in Community Services' child death reviews<sup>7</sup>. The NSW Child Death Review Team (CDRT) has noted growing inequities in health outcomes for children who are Aboriginal, geographically isolated or living with socioeconomic disadvantage<sup>8</sup>.

### Public and interagency understanding of child deaths

One element of the NSW Government's child protection reform agenda is to deliver on Commissioner James Wood's vision of a shared approach to child wellbeing, where child protection is understood as the collective responsibility of the whole-of-government and the community.

The Child Deaths Annual Reports not only increases awareness about Community Services' work with the children who died, but also illustrates the challenges and complexities of this work.

The reality of child protection is that families who are involved with statutory services will often face multiple, interacting and complex issues. Increased transparency and public awareness of these issues may contribute to the community viewing child protection as a collective responsibility and having a greater understanding of the role they can play in protecting children and young people. For example, increased public awareness of the context of child protection may encourage more active support from extended family, neighbours and communities, and more targeted and informed reports from concerned members of the public. It may also encourage other government agencies such as the NSW Ministry of Health, the NSW Police Force, and the Department of Education and Communities to appreciate the increased risks for children in these families.

The public receives the majority of its information about child protection work via the media. Coverage tends to focus on individual child deaths, particularly those where police are involved or where agency or system failure is suspected. This can contribute to a distorted perception that all children who died and were known to Community Services died as a result of abuse or neglect<sup>9</sup>.

It is important to recognise the crucial role that the media plays in holding services to account and better informing the public about child protection work, especially when reporting about child deaths. It is important that the public understands that parental capacity can contribute to a wide range of circumstances that may result in a child's death.

5 Nivison-Smith, I. & Chilvers, M. (2007). *Child Protection Reports in Context, Statistical Report*. NSW Department of Community Services: Sydney. Available [www.community.nsw.gov.au](http://www.community.nsw.gov.au)

6 Australian Bureau of Statistics (2010). *One for the country: recent trends in fertility, Australian social trends*. Australian Bureau of Statistics: Canberra. Available [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication14.12.02/\\$File/41020\\_Fertility2010.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication14.12.02/$File/41020_Fertility2010.pdf)

7 See Chapter 2 for further information.

8 NSW Child Death Review Team (2008). *Trends in Child Deaths in New South Wales 1996 – 2005*. NSW Commission for Children and Young People: Sydney. Available [www.kids.nsw.gov.au](http://www.kids.nsw.gov.au)

9 As outlined in Chapter 2, suspicious injuries were identified in the cases of seven of the 110 children and young people who died in 2011. These numbers may change due to the ongoing work of police, the Coroner and the Ombudsman to determine or characterise children who died from abuse, neglect or in suspicious circumstances. It is further acknowledged that some of the other deaths may have involved a combination of physical illness, other vulnerabilities in the child, and poor parenting capacity in the carers.

Last year, Professor of Social Policy at the London School of Economics, Eileen Munro, wrote a paper<sup>10</sup> to accompany the *Child Deaths 2010 Annual Report* where she argued that enhanced and sensitive media coverage of the issue will inform the debate about child protection:

*Presenting the full picture in relation to the complexities of child protection can help society to understand more about what child protection work entails. A one-dimensional view, however, can impact on the child protection system in a way that makes it less safe for children. A lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among child protection workers can also be damaged, leading to more workers leaving the profession and making it more difficult for the profession to attract candidates and attract staff<sup>11</sup>.*

There are equal benefits in raising interagency awareness of child protection in the context of child deaths. Community Services works with a wide range of government and non-government agencies to deliver effective child protection services to families in NSW. Given that these agencies now have a greater share of responsibility for child protection, it is a key priority of Community Services to share learning from child deaths with our community partners and, in turn, to learn from their experience and expertise.

As part of this commitment, the Minister for Family and Community Services launched the inaugural *Child Deaths 2010 Annual Report* at a Partner Seminar in Parliament House on 14 December 2011. The seminar was attended by academics and child protection experts from government and non-government agencies. Feedback from attendees about both the seminar and the report was positive. Most participants felt that the report and the seminar were relevant to their work, that the report was a useful addition to the suite of existing public child death reports in NSW, and that the report and the seminar underlined the need to make significant reforms to the child protection system in NSW.

## 1.3 Child death review in NSW

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

### **The NSW Ombudsman**

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children which may be due to abuse or neglect or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which have occurred in a care setting.

The Ombudsman is required to report to Parliament on a biennial basis. His first report for 2008 and 2009 was tabled under these arrangements in August 2011<sup>12</sup>. His next report will be tabled in the first quarter of 2013.

10 Munro, E. (2011). *How organisations can learn to reduce risk to children*. Community Services: Sydney. Available [http://www.facs.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0018/251415/how\\_reduce\\_risk.pdf](http://www.facs.nsw.gov.au/__data/assets/pdf_file/0018/251415/how_reduce_risk.pdf)

11 Ibid, 2011, p.11.

12 NSW Ombudsman (2011). *Report of Reviewable Deaths in 2008 and 2009*. NSW Ombudsman: Sydney. Available [www.ombo.nsw.gov.au](http://www.ombo.nsw.gov.au)

### The NSW Child Death Review Team

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

In 2011, the CDRT reported that the deaths of 581 children and young people were registered in NSW. Of these cases, the team identified the deaths of 119 children who had a child protection history<sup>13</sup>. These figures differ slightly from Community Services' data, which highlights important differences between the CDRT and Community Services' categories:

- CDRT reports on the deaths of children and young people that were registered in a calendar year with the NSW Registry of Births, Deaths and Marriages while Community Services reports on deaths that occurred in a calendar year<sup>14</sup>
- Community Services may include cases where NSW children died in another state in its annual total of child deaths, while CDRT reports on these cases separately, but does not include these cases in their annual total
- CDRT does not include cases where children died in care in the 'child protection history' category<sup>15</sup>
- in addition to reporting on the deaths of children who were known to Community Services, CDRT also includes children who were known to CWUs.

### The NSW Coroner and the NSW Police Force

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

Under Section 24 of the *Coroners Act 2009*, a senior coroner has the power to hold an inquest into a child's death where it appears to the coroner that there is 'reasonable cause to suspect' that the child:

- was in care
- was reported to Community Services within a period of three years immediately preceding the child's death, or was a sibling of a child who was reported to Community Services within three years preceding the child's death
- died in suspicious circumstances, or circumstances that may have been due to abuse or neglect
- died while living in, or temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for people with disabilities
- was a person who is in a target group within the meaning of the *Disability Services Act 1993* who received from a service provider assistance to enable the person to live independently in the community.

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

13 NSW Child Death Review Team (2012). *Annual Report 2011*. NSW Ombudsman: Sydney. Available [www.ombo.nsw.gov.au](http://www.ombo.nsw.gov.au)

14 For example, a child who died in December 2011, but whose death was registered in January 2012, would be included in Community Services' 2011 figures and CDRT's 2012 figures.

15 Some children in care may have been reported to Community Services in the three years prior to their death, so these cases would be included in the 'child protection history' category. The CDRT report does note the number of children who were in care as a separate category.

### **The Domestic Violence Death Review Team**

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

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths<sup>16</sup>
- establish and maintain a database to identify patterns and trends relating to such deaths
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

The death of a child in the context of domestic violence is subject to review by the team. The team's first report was released in October 2011<sup>17</sup>.

### **The Children's Guardian**

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

- promote the best interests of all children and young people in out-of-home care
- ensure that the rights of all children and young people in out-of-home care are safeguarded and promoted
- accredit designated agencies and monitor their responsibilities under the *Children and Young Persons (Care and Protection) Act 1998* and the Children and Young Persons (Care and Protection) Regulation 2012.

Community Services is required to notify the Children's Guardian about the deaths of all children in statutory or supported out-of-home care.

### **Community Services**

Community Services reviews the deaths of all children who were 'known to Community Services' prior to death. Known to Community Services means children who were reported to Community Services in the three years prior to their deaths, or whose siblings were reported in that same period. It also includes children who were in statutory care at the time of their death. These reviews focus on the involvement of Community Services with the child and the family, including how staff worked with partner agencies to promote a child's safety and wellbeing. Reviews make recommendations to improve practice and the systems supporting practice.

Community Services has adopted a systems approach to child death reviews<sup>18</sup>, which emphasises the need to understand not just what happened, but why it happened. Reviews consider how Community Services' systems at a local and organisational level impacted on practice with the families of children who died, identifying both good and problematic practice.

16 Domestic violence deaths are defined in the *Coroners Act 2009* as the death of a person that is caused directly or indirectly by a person who was in a domestic violence relationship with the deceased person. The *Coroners Act 2009* also provides that a domestic violence death is 'closed' if the Coroner has dispensed with or completed an inquest concerning the death, and any criminal proceedings (including appeals) concerning the death have been finally determined.

17 Available [http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/\\_assets/coroners/m40160115/dvdr Annual\\_report\\_oct2011x.pdf](http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m40160115/dvdr Annual_report_oct2011x.pdf)

18 This has been adapted from a case review model in England sourced from: Fish, S., Munro, E. & Bairstow, E. (2008). *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*. Children and Families Services Report 19. Social Care Institute for Excellence: London.

In addition to contributing to the NSW Government's commitment to increased accountability and transparency, the findings from Community Services' child death reviews also provide rich learning opportunities for practitioners, both within the organisation and externally. For example, the findings from the *Child Deaths 2010 Annual Report* have been shared with Community Services' frontline managers via a state-wide program of learning sessions. The program has been strongly welcomed by managers, with one Director summing up her learning as follows:

*What I took out of this report is that we need to develop a culture where we all have a 'critical friend' who can help critique our work and make sure we've covered off the basic casework. It's important for someone to say things like, 'In your notes, I see you didn't talk to the man in the house' or 'Did you actually see the children?' This won't be easy, but we need to do it to create a culture that's honest, safe and comfortable with constructive criticism. We all hate to be criticised – me included – but it's a necessity to do our jobs better.*

Managers were also provided with a presentation so they could deliver this material to their own casework teams.

### **Reviewing the deaths of children in out-of-home care**

NSW has a particularly strong system of oversight into the deaths of children in out-of-home care.

Where a child dies in out-of-home care, their case may be examined by the CDRT, reported to the Coroner and the Children's Guardian, investigated by police and the Coroner and reviewed by Community Services and the Ombudsman.

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

We have begun discussions with our partners to ensure that the NSW Government's leading-edge approach to child death review keeps pace with key changes in child protection and out-of-home care, particularly with the transition of out-of-home care to the NGO sector. Over the coming months, Community Services will participate in discussions with the Ombudsman and out-of-home care transition partner agencies to ensure that we continue to learn from each and every child death.

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NSW has a particularly strong system of oversight into the deaths of children in out-of-home care.

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# Chapter 2: Child deaths in 2011

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## Chapter overview

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Community Services reviews its involvement with the families of all children and young people who die, where a report was received about the child and/or their sibling/s within three years of the death. Community Services also reviews cases where the child or young person who died was in statutory care at the time of death. These cases are included in the 'known to Community Services' category.

This chapter reports on the 110 children and young people who died in 2011 who were known to Community Services. The circumstances of these children's deaths are examined, as well as the child's characteristics, including age, gender and Aboriginal and/or Torres Strait Islander status. This chapter also outlines the extent of Community Services' involvement with the families of the children who died, including reported risk factors, whether reports met the 'risk of significant harm' (ROSH) threshold introduced in January 2010, and how Community Services responded to information about these risk issues.

Overall, 80 (73%) children and young people who died were the subject of at least one report to Community Services before their death. For the remaining 30 (27%) cases, the child or young person had not been reported to Community Services; however, one of their siblings had been reported in the three-year period before the death. The most common reported issue for ROSH reports was parental drug and/or alcohol use.

Eleven (10%) children and young people who died in 2011 were not living with their immediate families at the time of their death, including eight (7%) children who were under the parental responsibility of the Minister for Family and Community Services. The remaining three children were either placed with an extended family member under a Federal Court order or in a disability setting arranged through Ageing, Disability and Home Care (ADHC).

The primary circumstance of death was illness or disease. For many of the infants (under one year), the cause of death has not been determined, or has been determined as Sudden Infant Death Syndrome (SIDS), placing these cases in the Sudden and Unexpected Deaths in Infancy (SUDI) category.

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

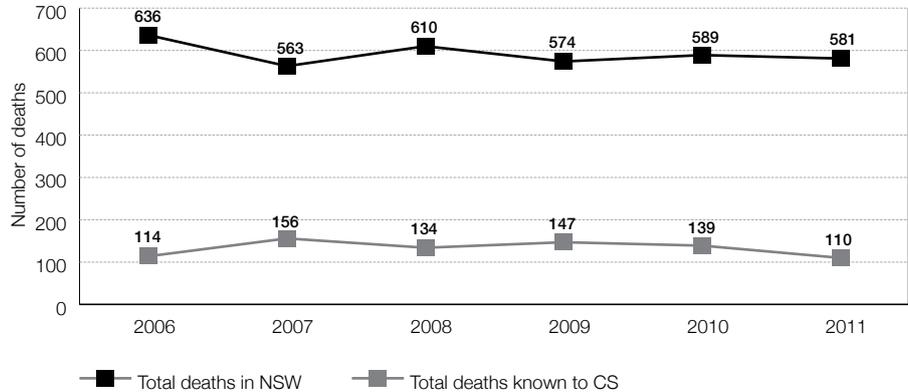
## 2.1 Child deaths in NSW in 2011

The NSW Child Death Review Team (CDRT) reported that the deaths of 581 children and young people were registered in NSW between 1 January 2011 and 31 December 2011<sup>19</sup>.

A total of 110 children and young people who were known to Community Services died in 2011. This figure is a decrease from 2010 when 139 children and young people in this category died.

This decrease is likely to be due to changes to the threshold for reporting to Community Services. In January 2010, the reporting threshold was changed from 'risk of harm' to 'risk of significant harm'. These changes have resulted in a lower rate of reporting to Community Services<sup>20</sup>. As Community Services' criteria for child death review include reports made within three years of the death, it is possible that child deaths in the 'known to Community Services' category will continue to decrease until 2013.

**Figure 2: Children and young people who died in NSW, compared to children who died and were known to Community Services, 2006 to 2011.**



Source: Community Services and CDRT, 2012.

<sup>19</sup> NSW CDRT, 2012.

<sup>20</sup> Between 2008–09 and 2010–11, there was a 56.4% decline in the number of reports (*Community Services' Annual Statistical Report 2010–11*. Available [www.community.nsw.gov.au](http://www.community.nsw.gov.au))

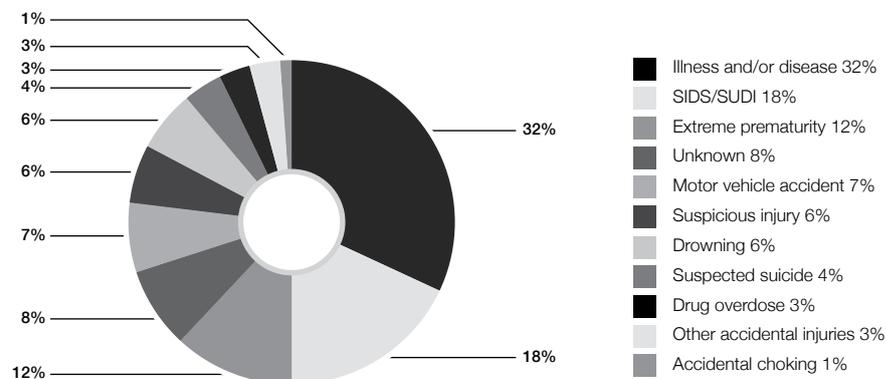
## 2.2 Circumstances of child deaths

The medical causes of child deaths in NSW are determined by a medical practitioner or the State Coroner. The cause of death is recorded by the NSW Registry of Births, Deaths and Marriages. The Registry of Births, Deaths and Marriages provides the NSW Ombudsman with a list of all child deaths in NSW, including causes of death, if this information is known. Community Services uses these data as well as information obtained from the State Coroner to identify the circumstances of death for the children known to Community Services.

The categories used by Community Services to describe a child's circumstances of death are outlined in Figure 3. These categories may be different to the medical cause of death that is listed on the child's death certificate or post-mortem examination report. For example, the cause of death for a child could be carbon monoxide poisoning, but the *circumstances* of the death could be a suicide, a suspicious injury, or another type of accidental injury.

Community Services focuses on a child's circumstances of death, rather than the medical cause, as the circumstances are more relevant to an evaluation of the child protection history and opportunities that Community Services may have had to intervene with a family prior to the death.

**Figure 3: Circumstances of death of children and young people in 2011 who were known to Community Services<sup>21 22</sup>.**



Source: Community Services, 2012.

<sup>21</sup> Thirteen categories are used in Figure 4, compared to 11 categories in Figure 3. This is because, in 2011, there were no deaths due to accidental smothering or house fires.

<sup>22</sup> These data are likely to change in future years as new information is received by Community Services.

Only a very small number of child deaths each year are considered suspicious by police, including deaths where investigations have determined that the injuries were inflicted by another person. While most of the deaths in 2011 were associated with illness, disease, extreme prematurity, or were unexplained<sup>23</sup>, child health issues may be exacerbated by socioeconomic disadvantage or child protection concerns, such as neglect or the capacity of parents to nurture and care for the child. Parental capacity may also impact on deaths in a number of categories where modifiable risk factors are sometimes evident.

The circumstances of death are not always known, or not available to

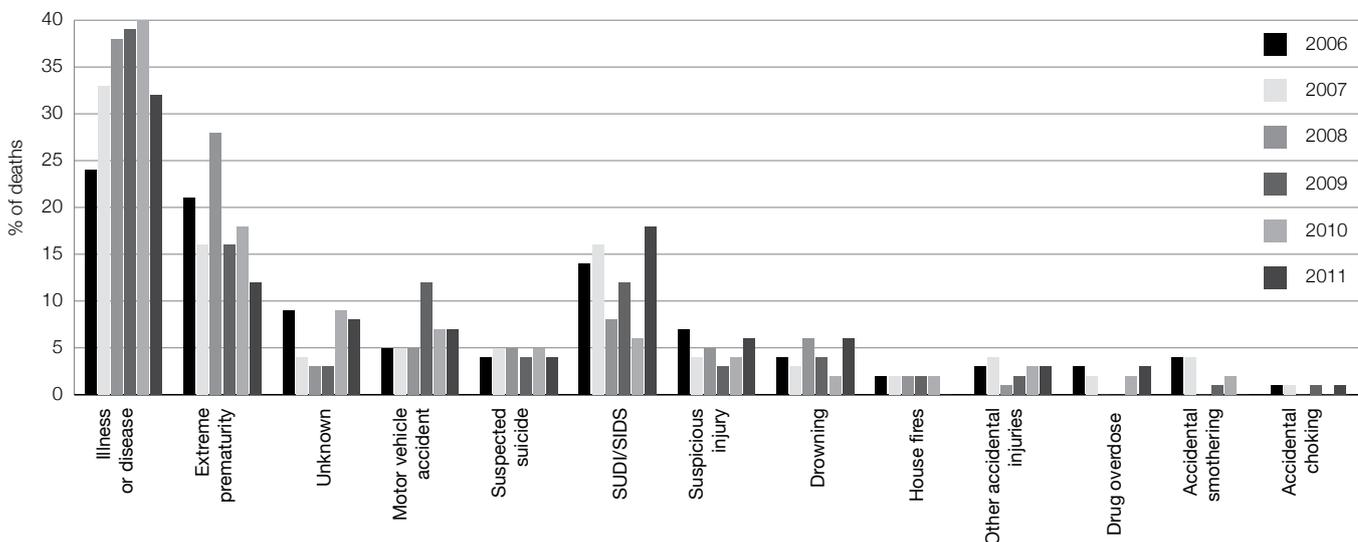
Community Services when reviews are being completed. At the time of this report, the circumstances of nine deaths in 2011 were unknown, or were unable to be determined<sup>24</sup>.

Figure 4 compares the circumstances of death for children who were known to Community Services and died between 2006 and 2011. As this figure shows, illness or disease has been the primary circumstance of death since 2006. The extreme prematurity and SUDI/SIDS categories have also been common circumstances of death.

The actual numbers of deaths are relatively small in many of the categories presented in Figure 4. This should be taken into account when analysing and drawing conclusions about changes from year to year.

The rise of child deaths in the SUDI category in 2011 is likely to be due to different information available for this year. Community Services previously relied on information provided by the State Coroner. The NSW CDRT now also provides relevant information.

**Figure 4: Circumstances of death of children and young people from 2006 to 2011 who were known to Community Services** <sup>25 26 27</sup>.



Source: Community Services, 2012.

23 Many of the unexplained deaths of infants under one were included in the SUDI category. This information was sourced from both the State Coroner and NSW CDRT.

24 The exact circumstances of death have not been determined for this group of children and young people. This could be because a cause of death could not be determined at autopsy or because the post-mortem examination report is not yet available to Community Services. This category is separate to the SUDI category, which includes the unexplained or unexpected deaths of infants under one.

25 Other accidental injuries include accidental head injuries, dog attacks and fatal recreational associated injuries. The drug overdose category includes self-administered drug overdoses and cases where the drugs were reported to be administered by a parent/carer.

26 These data are likely to change in future years as new information is received by Community Services.

27 Section 2.2.2 provides further explanation about SUDI deaths.

### 2.2.1 Death from illness and/or disease

<b>35</b> Deaths	<b>32%</b> Of all deaths
<b>16</b> Males	<b>19</b> Females
<b>0 – 17 years</b> Age range	<b>7</b> Aboriginal and/ or Torres Strait Islander children

The most common circumstance of death for children who died in 2011 was illness and/or disease. Figure 4 shows that, since 2006, this has consistently been the primary circumstance of death.

Thirty-five children and young people died from illness and/or disease in 2011, and this accounted for 32% of all deaths. Of these children and young people, 29 had been diagnosed with an illness, disease or disability before they died.

In 12 of the 35 cases, the family of the child who died had previously been reported for medical neglect. In five of the 12 cases, ROSH reports had been made about medical neglect following changes to the reporting threshold.

Community Services, the Department of Education and Communities and the NSW Ministry of Health are working together to identify strategies to strengthen cross-agency communication about high-risk cases where medical neglect has been identified. Further discussions between our agencies will examine key cases to identify potential systems improvements. This initiative is discussed further in Chapter 4.

### 2.2.2 Sudden and Unexpected Deaths in Infancy

<b>20</b> Deaths	<b>18%</b> Of all deaths
<b>13</b> Males	<b>7</b> Females
<b>0 – 7 mths</b> Age range	<b>7</b> Aboriginal and/ or Torres Strait Islander children

The category of Sudden and Unexpected Deaths in Infancy (SUDI) includes the deaths of infants under one who died:

- in circumstances that were unexpected, or unexplained at autopsy (meeting the category of SIDS)
- of an acute illness that was not recognised by carers and/or health professionals as potentially life threatening
- of an existing health condition that was not previously recognised by health professionals<sup>28</sup>.

Twenty infants who died in 2011 were in the SUDI category, based on information provided by the CDRT and/or the State Coroner. This accounts for 18% of all deaths. SUDI is a category used to describe a group of explained or unexplained infant deaths. The cases included in the Community Services' SUDI category are only those which are unexplained by autopsy, or where post mortem examination details are not yet available. The cases where the cause of death is 'explained' are directed to the appropriate category.

Research from the CDRT has shown that parental risk factors strongly linked to SUDI deaths include unsafe sleeping environments (including co-sleeping and inappropriate bedding), exposure to tobacco smoke, and infants being placed for sleep in a position other than on their back<sup>29</sup>.

In 18 of the 20 SUDI cases, Community Services' child death reviews identified modifiable risk factors<sup>30</sup>. In 11 cases, the infants were sharing a sleeping surface with an adult at the time of death. In a further seven cases, other modifiable risk factors were identified at the time of death, including inappropriate bedding, unsafe sleeping positions, exposure to cigarette smoke or the infant being prop fed with a bottle.

The CDRT also recently identified that children who had a child protection history were 2.6 times more likely to die suddenly and unexpectedly in infancy<sup>31</sup>. There are a range of complex issues facing families who are known to Community Services, which may increase the risk of infants in these families dying suddenly and unexpectedly. For example, Community Services' child death reviews have identified common themes in these cases, such as the family being transient, homeless or living in poverty. These factors can be linked to increased risk due to the impact on decisions about sleeping arrangements (i.e. the availability of cots or bedding) and the level of professional and family support and parenting advice provided to a family.

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

29 Ibid, 2010.

30 These decisions were based on information provided by the State Coroner, the NSW Police Force, the NSW Ombudsman or other mandatory reporters to the Child Protection Helpline.

31 NSW Child Death Review Team (2011). *Annual Report 2010*. NSW Ombudsman: Sydney. Available [www.ombo.nsw.gov.au](http://www.ombo.nsw.gov.au)

### Deaths associated with co-sleeping

In 2011, 13 infants known to Community Services died while sharing a sleeping surface, or co-sleeping with a parent and/or carer at the time of death. Five of these infants were identified as Aboriginal and/or Torres Strait Islander. Almost all of the infants who died while co-sleeping were in the SUDI category. One child died of an illness.

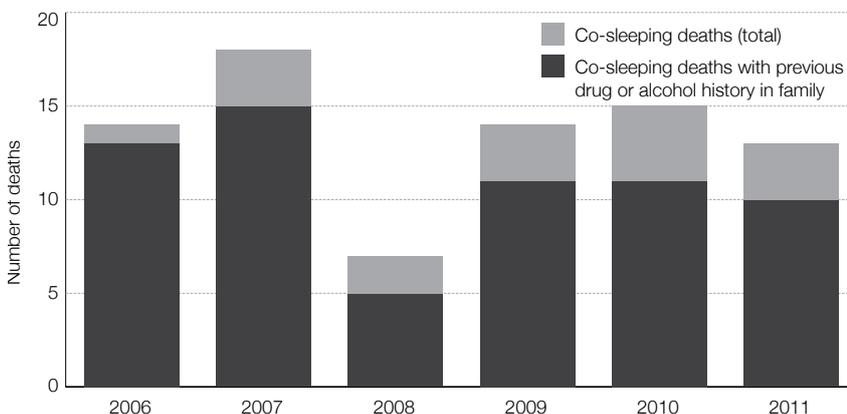
In 10 cases, the infant was sharing a bed or mattress with a carer, and in the other three cases, a lounge or sofa. In three cases, the mother fell asleep while breastfeeding prior to the infant's death.

Nine of the infants who died were aged less than three months. Three infants were aged between four and seven months, and one child was over the age of one year.

In 10 of these cases, the family of the child who died had been previously reported to Community Services due to parental drug and/or alcohol concerns. In six of the 10 cases, ROSH reports had been made involving these issues.

Co-sleeping has recently attracted public attention after the Victorian State Coroner handed down his findings in relation to an investigation into four infants who died in co-sleeping situations. The Coroner found that sharing a sleeping surface with an infant, particularly when the infant is under the age of six months, is 'inherently dangerous'<sup>32</sup>. SIDS and Kids' advice is not so unequivocal, but they do currently advise that the best place for a baby to sleep

**Figure 5: Co-sleeping related deaths for children from 2006 to 2011 who were known to Community Services, including cases with a previous drug or alcohol history in the family.**



Source: Community Services, 2012.

is in her or his own cot, next to their parents' or carers' bed<sup>33</sup>.

The clear message is that an adult who is affected by drugs or alcohol should not share a sleeping surface with a baby, as he or she is likely to be in a sedated state. This will affect their ability to respond to the baby and may present a risk of suffocation or smothering<sup>34 35</sup>.

The risks associated with co-sleeping while drug or alcohol affected are reflected in Community Services' data over the past six years. As Figure 5 shows, links between co-sleeping related deaths and parental/carer drug or alcohol histories have been a consistent finding.

Community Services has been working to develop the skills and confidence of caseworkers when talking with parents about the risks

of co-sleeping while drug or alcohol affected. A range of resources and tools have also been developed to help educate parents about these risks. Child death reviews have noted improvements in Community Services' practice in this area, and Community Services continues to work with other agencies, such as the NSW Ministry of Health, to promote consistent and clear messages to families about the risks associated with co-sleeping.

Community Services is also working towards ensuring that authorised carers are informed about the latest safe sleeping advice, with information being provided to carers through newsletter articles, SIDS and Kids pamphlets and amendments to training packages for new carers.

32 Victorian State Coroner 'Redacted Finding into Death with Inquest: Inquest into the death of Baby J', 6 July 2012. Available [http://www.coronerscourt.vic.gov.au/resources/86f5e612-9f25-40a6-9641-5b43b8d09a11/babyj\\_+258010+redacted.pdf](http://www.coronerscourt.vic.gov.au/resources/86f5e612-9f25-40a6-9641-5b43b8d09a11/babyj_+258010+redacted.pdf)

33 For further information about safe sleeping tips, visit <http://www.sidsandkids.org>

34 SIDS and Kids (2012). *Why are the SIDS and Kids 5 safe sleeping recommendations so important?* SIDS and Kids: Western Australia. Available [http://www.sidsandkids.org/assets/resources/hif19121\\_sids--kids\\_safe-sleeping-brochure\\_v7.pdf](http://www.sidsandkids.org/assets/resources/hif19121_sids--kids_safe-sleeping-brochure_v7.pdf)

35 Mesich, H. (2005). Mother-infant co-sleeping: Understanding the debate and maximising infant safety. *American Journal of Maternal Child Nursing*, 30(1): 30-37.

### 2.2.3 Prematurity related deaths

<b>13</b> Deaths	<b>12%</b> Of all deaths
<b>7</b> Males	<b>6</b> Females
<b>&lt; 1 month</b> Age range	

In 2011, 13 infants died from conditions related to their premature births<sup>36</sup>. Eleven of these infants died at birth and two infants lived for less than a month before their deaths.

In six of these deaths, Community Services received reports that the unborn child may have been exposed to drug use during pregnancy. In one of these six cases, it was reported that the mother had also been exposed to domestic violence, and in another two cases, it was reported that the mothers had sought insufficient prenatal care.

For the remaining seven cases, Community Services had received information about the deceased child's siblings. Six of these cases included reports involving:

- parental domestic violence in five cases
- parental substance abuse in three cases
- minimal or no prenatal care in two cases<sup>37</sup>.

Research supports the links between these risk factors and prematurity related deaths. Infants who are exposed to substance abuse<sup>38 39</sup>, domestic violence<sup>40</sup>, and/or poor prenatal care<sup>41</sup> during pregnancy are at increased risk of negative outcomes, including premature labour, low birth weight, foetal distress and death.

Domestic violence appears to be one of the most serious risk factors<sup>42</sup>, because of the physical risk to an unborn baby<sup>43</sup>, as well as the likelihood of multiple risk factors emerging for women who are victims of violence<sup>44</sup>. For example, a recent study found that women who were assaulted during pregnancy were four times more likely to use alcohol, and five times more likely to use illicit drugs during pregnancy than women who were not subject to domestic violence<sup>45</sup>.

36 Cases were included in this category when prematurity was recorded as either the underlying or an associated cause of death, or a contributing factor in the death.

37 Some cases were reported due to multiple risk factors.

38 Reference to the impact of drug and alcohol use retrieved from [http://www.marchofdimes.com/pregnancy/alcohol\\_illicitdrug.html](http://www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html)

39 Kothari, C., Wendt, A., Liggins, O., Overton, J. & Sweezy, L. (2010). Assessing maternal risk for fetal-infant mortality: a population-based study to prioritize risk reduction in a healthy start community. *Maternal Child Health*, 15: 68-76.

40 McMahon, S., Huang, C., Boxer, P. & Postmus, J.L. (2011). The impact of emotional and physical violence during pregnancy on maternal and child death at one year post-partum. *Child and Youth Services Review*, 33:2103-2111.

41 Kothari et al., 2010.

42 Humphreys, C., Houghton, C. and Ellis, J. (2008). *Literature Review: Better Outcomes For Children And Young People Experiencing Domestic Abuse – Directions For Good Practice*. The Scottish Government: United Kingdom.

43 Leone, J., Lane, S., Koumans, E., DeMott, K., Wojtowycz, M., Jensen, J. & Aubry, R. (2010). Effects of intimate partner violence on pregnancy trauma and placental abruption. *Journal of Women's Health*, 19(8): 1501-1509.

44 McMahon et al., 2011.

45 Leone et al., 2010.

### 2.2.4 Motor vehicle related deaths

<b>8</b> Deaths	<b>7%</b> Of all deaths
<b>2</b> Males	<b>6</b> Females

In 2011, eight children and young people died in motor vehicle accidents. One of these cases involved a child who was a pedestrian in an accident. In the other seven cases, the child or young person was a passenger.

Seven of the young people who died were aged over 14. In six of these cases, risk-taking behaviours were reported to be linked to the accident including:

- speeding by the driver
- substance use by the driver
- overcrowding in the car
- an unlicensed driver
- no seatbelt.

Five of these six children had previously been reported to Community Services due to their risk-taking behaviours including substance use, criminal behaviour, violence and school truancy.

#### Motor vehicle accidents since 2006

The relationship between motor vehicle accidents and a history of risk-taking behaviour has been noted in Community Services' reviews since 2006. Of the 56 children and young people who died in a motor vehicle accident between 2006 and 2011, half (28) were in accidents that were linked to risk-taking behaviour by the driver. Of these 28 children and young people, 20 were also the subject of previous reports to Community Services about their risk-taking behaviour.

### 2.2.5 Drowning related deaths

<b>7</b> Deaths	<b>6%</b> Of all deaths
<b>6</b> Males	<b>2</b> Females

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

Seven children died in 2011 after drowning in a swimming pool, bath or other body of water.

Six of the seven children were aged between one and four years. One child was an adolescent, and died in the context of risk-taking behaviour.

Of the seven drowning deaths:

- five cases involved an absence of parental supervision at the time of the incident and/or other safety issues, including no, or inadequate fencing, to prevent access to the pool or other bodies of water
- the families of six children who drowned had previously been reported to Community Services for issues related to supervisory neglect
- three of the children were under the parental responsibility of the Minister at the time of death.

In April 2012 the CDRT released findings from its study of drowning deaths of children in swimming pools<sup>46</sup>. The study showed that the two most critical factors for ensuring the safety of children are adult supervision and restricting access to pools. This is consistent with Community Services' child death review findings and is an issue that the agency is continuing to address. For example, in response to the drowning deaths of three children under the parental responsibility of the Minister in 2011, Community Services' staff and authorised carers have been provided with information and educational materials about swimming pool safety. The authorised carers' Code of Conduct also provides that any swimming pool at their home must be adequately fenced in accordance with the *Swimming Pools Act 1992*.

46 NSW Child Death Review Team (2012). *Child deaths: drowning deaths in private swimming pools in NSW*. NSW Ombudsman: Sydney. Available [www.ombo.nsw.gov.au](http://www.ombo.nsw.gov.au)

## 2.2.6 Suspicious or inflicted injuries

<b>7</b> Deaths	<b>6%</b> Of all deaths
<b>2</b> Males	<b>5</b> Females

Seven children died in circumstances involving suspicious injuries in 2011<sup>47</sup>. In six of the seven cases, the child was in the care of a parent and/or the partner of a parent at the time of death.

Females were over-represented in this category, when compared to previous years – five of the seven children who died in circumstances involving suspicious injuries in 2011 were female. In comparison, almost three-quarters of the children and young people who died between 2006 and 2010 in circumstances involving suspicious injuries were male<sup>48</sup>.

Of the seven children who died in circumstances involving suspicious injuries in 2011:

- one child was the subject of a ROH report, but had not been reported since the reporting threshold was changed to ROSH
- one child was not directly reported to Community Services, but was included in the 'known to Community Services' category due to sibling reports
- ROSH reports about abuse and/or neglect had been made about five of the children within 12 months of their death.

Community Services is currently exploring whether more targeted information can be routinely sought from partner agencies, particularly when reports are received about suspicious or inflicted injuries.

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

48 Department of Family and Community Services, Community Services, 2011.

### Suspicious or inflicted injury cases since 2006

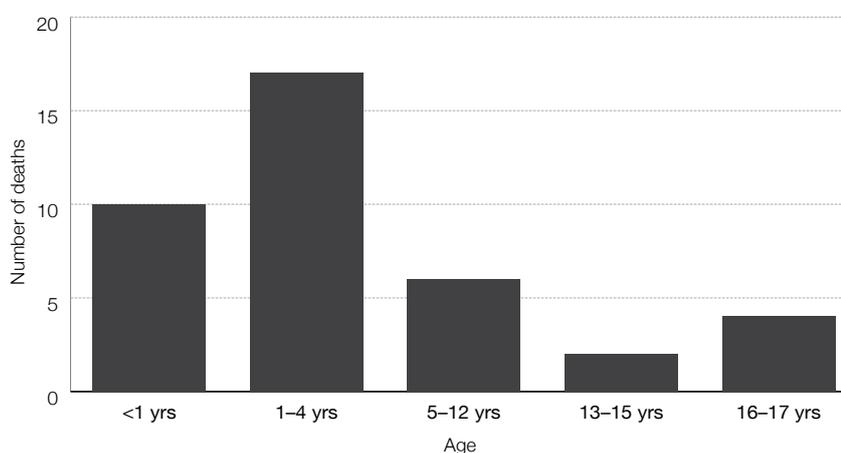
Of the 799 children known to Community Services who died between 2006 and 2011, 39 (5%) children and young people have died in circumstances involving suspicious or inflicted injuries.

The CDRT recently reported that children who had a child protection history were 2.1 times more likely to die as a result of fatal assault<sup>49</sup>. While the research presents no clear indicators about which children will die in these circumstances, the research identifies a number of risk factors, and these are supported by Community Services' data. For example, Aboriginal children are at a greater risk of death by assault than non-Aboriginal children<sup>50</sup>. Community Services' data also identified this over-representation, finding that almost one-third (12 cases) of the children and young people who died from suspicious injuries were Aboriginal and/or Torres Strait Islander<sup>51</sup>.

Twenty-five (64%) of the children who died from circumstances involving suspicious injuries were male, and 14 (36%) were females. International research has made similar findings that males are at greater risk of child death due to injury or homicide than females<sup>52</sup>.

Finally, as Figure 6 shows, young children under the age of four are most vulnerable, representing almost three quarters of deaths in this category. This is consistent

**Figure 6: Age of children and young people who died from suspicious or inflicted injuries from 2006 to 2011 and were known to Community Services.**



Source: Community Services, 2012.

with international research, particularly for infants under one year, who are, on average, eight times more likely to be victims of fatal assault than older children<sup>53</sup>.

The *Child Deaths 2010 Annual Report* considered cases where children had been allegedly fatally assaulted by a non-biological parent, particularly the mother's new partner. We discussed the challenges that workers can face in assessing risk from new partners or household members. Many of the child death reviews for these cases found that Community Services was either not aware of the presence of the new partner in the household, or did not seek information about this person that would have assisted risk assessment.

In response to these issues, the *New Partners and New Household Members* practice tool has been developed to support caseworkers to assess risk to children when a new adult enters a household. Further information about this tool is included in Chapter 4.

49 NSW CDRT, 2011.

50 NSW CDRT, 2008.

51 As outlined in Section 2.3.2, 25%, or one quarter of all children who died between 2006 and 2011 were Aboriginal and/or Torres Strait Islander.

52 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. & Black, J. (2009). *Understanding Serious Case Reviews And Their Impact: A Biennial Analysis Of Serious Case Reviews 2005 – 2007*. Department for Children, Schools and Families: London.

53 Retrieved from the National Society for the Prevention of Cruelty to Children (NSPCC) website. Available [http://www.nspcc.org.uk/Inform/resourcesforprofessionals/children\\_under\\_one\\_statistics\\_wda79305.html#Homicide\\_statistics](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/children_under_one_statistics_wda79305.html#Homicide_statistics)

## 2.2.7 Suspected suicide deaths

<b>4</b>	<b>4%</b>
Deaths	Of all deaths
<b>2</b>	<b>2</b>
Males	Females

Suicide<sup>54</sup> was the suspected circumstance of death for four children and young people in 2011, accounting for 4% of all deaths. In 2010, seven (5%) children and young people died in this category.

All of the children and young people who died of suspected suicide in 2011 were teenagers at the time of their death. Two were male and two were female.

In its annual report for 2010, the Child Death Review Team (CDRT) found that young people known to Community Services were over-represented in suicide figures in NSW, finding that these young people were 4.9 times more likely to commit suicide than young people not known to the agency<sup>55</sup>. This finding could be related to the fact that the histories of many of these young people included a number of factors that are linked to suicide risk.

The CDRT outlined risk factors which were linked to suicidal behaviour, including mental illness, previous suicidal behaviour, substance misuse, personal crises, family circumstances, a history of abuse or neglect and social exclusion or isolation<sup>56</sup>.

Many of these risk factors were noted in Community Services' reviews of the four suspected suicide deaths in 2011. For example, three of the children or young people

had previously been reported to Community Services for risk-taking behaviours, including self-harm and/or previous suicide attempts. All three of these children and young people had a history of involvement with

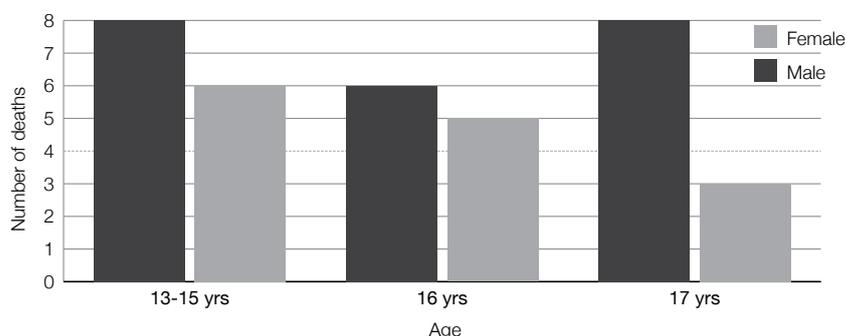
mental health services prior to their deaths. There was also a history of reports for these three children about alleged physical, sexual and/or emotional abuse prior to death.

### Suicide deaths since 2006

A total of 36 children and young people who were known to Community Services died from suspected suicide between 2006 and 2011. This represents 5% of the 799 child deaths during this period.

As Figure 7 shows, males are over-represented in suspected suicide deaths, particularly for young people aged 17 years. This is consistent with findings from the CDRT<sup>57</sup>. The over-representation of males in these suicide figures may be due to a greater likelihood of males having multiple risk factors such as mental illness and drug and alcohol use. Males are also more likely to have higher levels of aggression, and choose more lethal suicide methods, thus creating a higher chance of fatality than females<sup>58</sup>.

**Figure 7: Age and gender of children and young people who died from suspected suicide from 2006 to 2011 and were known to Community Services.**



Source: Community Services, 2012.

Community Services' reviews of children and young people who died in circumstances of suspected suicide or risk-taking behaviour found heightened vulnerability for many of these children and young people, including previous experiences of reported physical, emotional and sexual abuse; neglect; parental substance abuse; and domestic violence. We have used our reviews to increase staff knowledge and expertise about the risk factors and indicators of youth suicide, and we have made changes to introductory training to better cover best practice in working with children and young people at risk of suicide. Chapter 4 of this report outlines further measures that Community Services is taking to improve practice with vulnerable children and young people.

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

55 NSW CDRT, 2011.

56 Ibid, 2011.

57 The CDRT's historical analysis found that males were about twice as likely to commit suicide as females (NSW CDRT, 2011).

58 Bridge, J., Goldstein, T. & Brent, D. (2006). Adolescent suicide and suicidal behaviour. *Journal of Child Psychology and Psychiatry*, 47: 372-394.

## 2.3 Characteristics of the children and young people

This section outlines the characteristics of the children and young people known to Community Services who died in 2011 by age, gender, and Aboriginal and/or Torres Strait Islander status.

### 2.3.1 Age and gender

In 2011, 61 (55%) of the children who died were male, and 49 (45%) were female. This finding is consistent with the trends of previous years<sup>59</sup>.

Children aged under one are also over-represented, making up 45% (49) of the children who died. The majority of these infants (37) died in their first three months of life, and 25 infants died in the neonatal<sup>60</sup> period. The vulnerability of infants less than one, both from a physiological and from a child protection viewpoint, is reflected in Community Services' data from previous years, in the CDRT reports<sup>61</sup> and in international child death research<sup>62</sup>.

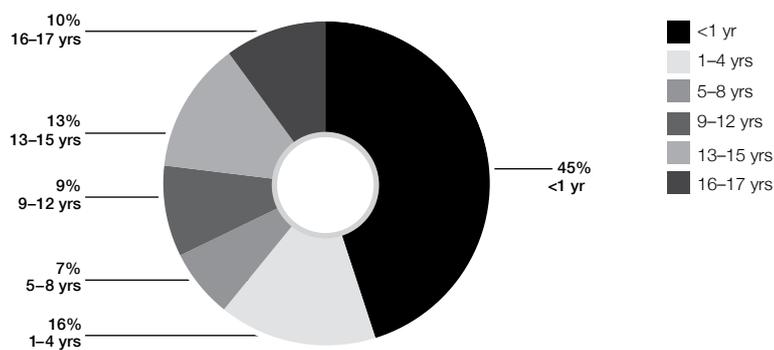
Of the 37 infants who died when they were less than three months old:

- thirteen died from extreme prematurity

- six died from an illness and/or disease
- thirteen were classified as SUDI/SIDS
- the circumstances of death for five children are not known.

Consistent with findings from 2010<sup>63</sup>, children and young people aged between 13 and 17 continued to represent a higher proportion of deaths that were linked to risk-taking behaviour, including accidents, suicide and drug overdose. International research has revealed similar findings, reflecting a particular vulnerability for adolescents due to the range of risk factors they may face, including family and societal alienation, the developmental pressures and challenges inherent in adolescence, accommodation and school problems, violence, drug and alcohol use, and mental health issues<sup>64</sup>.

**Figure 8: Age of the children and young people who died in 2011 and were known to Community Services.**



Source: Community Service, 2012.

59 Department of Family and Community Services, Community Services, 2011.

60 The neonatal period refers to the first 28 days after an infant's birth.

61 NSW CDRT, 2011.

62 Department for Education (2011). *Child Death Reviews: Year ending 31 March 2011*. Department for Education: London. Available <http://www.education.gov.uk/rsgateway/DB/STR/d001015/osr11-2011.pdf>

63 Department of Family and Community Services, Community Services, 2011.

64 Office for Standards in Education, Children's Services and Skills (Ofsted) (2011). *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*. Manchester: United Kingdom.

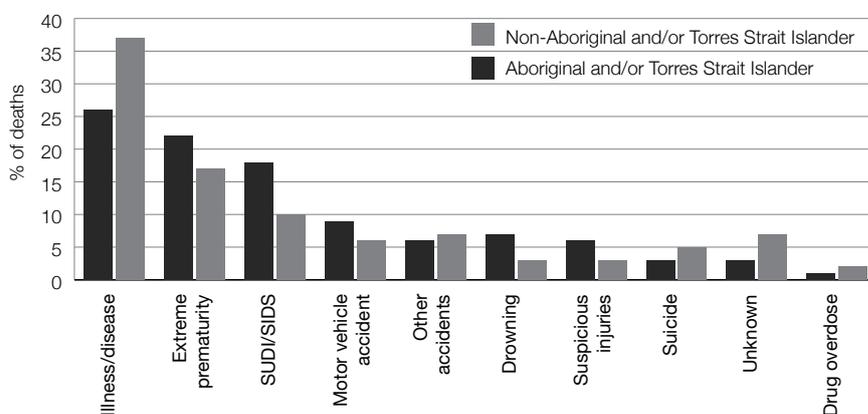
### 2.3.2 Aboriginal and/or Torres Strait Islander status

Aboriginal and/or Torres Strait Islander children continue to be disproportionately over-represented in child protection statistics. While Aboriginal children represent 4% of the population of children in NSW, 20% of the children involved in ROSH reports during 2011<sup>65</sup> were Aboriginal and/or Torres Strait Islander, which is a substantially higher rate of reports.

Aboriginal children are also over-represented in child death figures<sup>66</sup>. In 2011, 33 Aboriginal and/or Torres Strait Islander children who were known to Community Services died. This represents 30% of all child deaths for that year and this is an increase from 2010 (24%). Overall, of the 799 children and young people known to Community Services who died from 2006 to 2011, 197 (25%) were Aboriginal and/or Torres Strait Islander.

Aboriginal children are over-represented in child death figures due to the poorer health outcomes and increased vulnerability of children in this group<sup>67</sup>. This is also linked to the ongoing effects of social disadvantage, high rates of drug and alcohol use and violence, unsafe roads and poor access to health care in many Aboriginal communities<sup>68</sup>.

**Figure 9: Aboriginal and/or Torres Strait Islander status and circumstances of death for children and young people who died from 2006 to 2011 and were known to Community Services.**



Source: Community Services, 2012.

Figure 9 provides a comparison of the circumstances of death for Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or Torres Strait Islander children. A higher percentage of Aboriginal and/or Torres Strait Islander children died in circumstances involving extreme prematurity, motor vehicle accidents, drowning, suspicious injuries and in sudden or unexpected circumstances (SUDI). A lower percentage of Aboriginal and/or Torres Strait Islander children died from illness or disease, suicide, drug overdose, and in unknown circumstances. Of the 81 children who have died while co-sleeping since 2006, over one-third (31 children) were identified as Aboriginal and/or Torres Strait Islander.

The over-representation of Aboriginal children in particular circumstances of death is reflected in research

about the broader Aboriginal child population in NSW and Australia. Aboriginal children have higher rates of deaths in the SUDI/SIDS category and in the illness/disease category, due mainly to meningococcal disease and pneumonia, especially for infants<sup>69</sup>. There are also over-representations in other causes of death for Aboriginal children. The death rate due to external causes<sup>70</sup> for Aboriginal children is almost three times the rate for non-Aboriginal children<sup>71</sup>. Further, the risk of death by assault is 3.5 times greater for Aboriginal children when compared to non-Aboriginal children<sup>72</sup>.

One of Community Services' key priorities is to build a holistic system that supports Aboriginal and/or Torres Strait Islander families. To achieve this, a number of programs, strategies and trials are being implemented. Chapter 4 provides more information.

65 In 2010-11, 187.4 per 1,000 Aboriginal children were reported at ROSH, compared with 32.8 per 1,000 for non-Aboriginal children. Department of Family and Community Services, Community Services (2012).

66 While they are declining, the Aboriginal infant and child mortality rates are still approximately twice the rate than for non-Aboriginal children. Australian Bureau of Statistics (2010). *Mortality: Infant and Child Mortality – The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Australian Bureau of Statistics: Canberra. Available <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4704.0Chapter840Oct%202010>

67 NSW CDRT, 2008.

68 Australian Institute of Health and Welfare (AIHW) (2011). *Aboriginal and Torres Strait Islander child safety*. Australian Institute of Health and Welfare: Canberra.

69 NSW CDRT, 2008.

70 These causes include transport accidents, intentional self-harm and deaths due to fire.

71 AIHW, 2011.

72 NSW CDRT, 2008.

## 2.4 Community Services' involvement

### 2.4.1 Context

This section describes Community Services' response to reports received about the families of children who died in 2011. There are three key factors to consider in understanding Community Services' response to ROSH reports.

Firstly, reports to the Child Protection Helpline can be made if a person suspects that a child is at risk of significant harm. Not every child who is reported reaches the ROSH threshold. In some cases, Community Services, using Structured Decision Making tools and professional judgement, concludes that the reporter's concerns do not reflect risks which reach the ROSH threshold and therefore do not warrant Community Services' intervention. In other cases, while the reporter's concerns do reach the threshold, Community Services is already aware of the reported concerns and is working with the family to address risks. In some cases, Community Services may hold other information confirming that while the reporter's concerns reach the threshold, the child is not in fact at risk of significant harm. These cases can be closed without further assessment, referred for early intervention or referred to other agencies for ongoing support.

Secondly, child death reviews show that, in many cases, children die in circumstances unrelated to the parenting that they received. This means a child may die for reasons unrelated to the nature of the child protection report. Child protection intervention may have had no influencing impact on their deaths (e.g. in deaths due to illness or disease). Some children do die in circumstances related to parental actions or family risk factors and a small number of children die directly as a result of suspicious or inflicted injuries (6% of cases in 2011). International research confirms that it is simply not possible to predict which children will die based on the reports received about their families, meaning that child protection agencies cannot prioritise their responses on the basis that a reported child may die.

Community Services' child death reviews illuminate what the research refers to as "hindsight bias"<sup>73</sup>. When looking back at a case where there has been a tragic outcome, hindsight can lead us to identify actions and decisions which could have altered the outcome of the case using information which was not available at the time those actions were taken and those decisions were made. Child death review work needs to carefully distinguish which information would have been available at the time, and avoid making unrealistic comments about practice and raising unrealistic expectations about intervention.

Finally, the *Child Deaths 2010 Annual Report* highlighted the key theme of working with competing priorities. Community Services is working hard to remove the administrative layers that clog up the system and keep caseworkers at their desks and away from families. Streamlined processes, increased productivity and working more closely with community partners aims to increase the number of ROSH reports that receive a response. However, in the interim, managers continue to face the challenge on a daily basis of deciding which cases can be allocated and which need to be closed. The decision to close a case due to competing priorities is made carefully and in partnership by the management team in each Community Services Centre at a weekly allocation meeting. Managers across the state use triage and assessment tools to guide this decision making.

While it is crucial to understand this context, it is central to our review process that we identify where Community Services' intervention could have been better.

73 Munro, E. (2011). *The Munro review of child protection: Final report – a child-centred system*. Department for Education: The Stationery Office, p18. Available <https://www.education.gov.uk/publications/eOrderingDownload/Munro-Review.pdf>

## 2.4.2 Reports

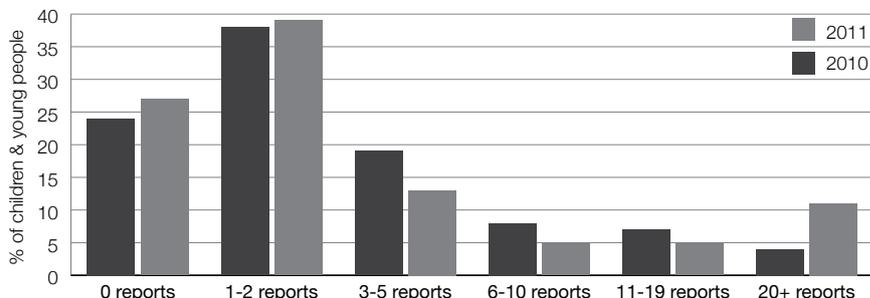
When reviewing child deaths, Community Services considers all reports received for a child during their lifetime that meet the statutory child protection threshold. This is because the history of reports about the child and their family is critical to gaining an in-depth understanding of the experience of the child.<sup>74</sup>

Eighty (73%) of the 110 children and young people who died in 2011 who were known to Community Services, were the subject of at least one report before their death<sup>75</sup>.

Thirty (27%) children and young people were not the subject of a report to Community Services, but their sibling/s were reported to Community Services.

As Figure 10 shows, 39% of the children and young people had received one or two reports. These findings are consistent with 2010 data. Twelve (11%) children were reported over 20 times<sup>76</sup>. This is an increase compared to the 2010 data. Caution should be used when interpreting these results due to the small numbers.

**Figure 10: Number of reports received for children and who died in 2010 and 2011 and were known to Community Services, by number of reports to the Child Protection Helpline.**



Source: Community Services, 2012.

74 This is different from other public reporting by Community Services which focuses on reports received within 12 months.

75 This includes 23 children who were the subject of a ROH report received prior to the introduction of the ROSH threshold on 24 January 2010. The remaining 57 children and young people were the subject of a ROSH report prior to their death.

76 This includes both ROSH and ROH reports.

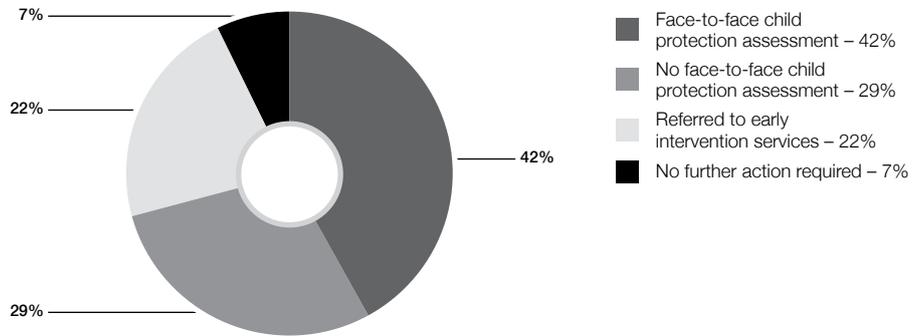
### 2.4.3 Community Services' response

As discussed earlier, many of the families of the 110 children and young people who died were reported to Community Services on a number of occasions, sometimes over an extended period. When reviewing child deaths, Community Services considers how the agency has responded to the child and their family, looking at all reports that meet the statutory child protection threshold.

These families received a variety of responses; for example, a family could have received both an early intervention service and a face-to-face child protection assessment. These families are classified by the highest level of response that they received. Of the 110 families where a child died:

- 8 (7%) cases did not require a response from Community Services as preliminary casework determined that statutory intervention was not required
- 24 (22%) were referred for an early intervention service; of these 12 (11%) received an early intervention service from either Community Services or a non-government lead agency; 12 (11%) did not receive a service<sup>77</sup>
- 78 (71%) were assessed as requiring a child protection response; of these 46 (42%) received a face-to-face child protection assessment from Community Services and 32 (29%) did not<sup>78</sup>.

Figure 11: Response to reports received about the families of children who died in 2011.



Source: Community Services, 2012.

It is concerning that 32 (29%) cases did not receive a face-to-face child protection assessment. Community Services is working on improving systems and practice with the aim of increasing the number of ROSH reports that receive a response, either from Community Services, or the broader service system.

For example, the *Practice First* initiative involves Community Services caseworkers working directly with families to reduce the risk to children. It is a model that covers the spectrum of child protection work (including early intervention and out-of-home care) and relies on principles of practice, streamlining of procedures and teamwork approaches to casework and decision making. *Practice First* also aims to achieve a shift in practice culture via shared risk and strengthened practice.

<sup>77</sup> Of the 12 who did not receive a service, six families chose not to engage with the service, five cases were closed due to competing priorities in the early intervention teams, and in one case, the child died before an assessment could be commenced.

<sup>78</sup> These families did not receive a face-to-face child protection assessment because other cases were assessed as having a higher priority.

Community Services is working with local partners to better connect and integrate local service systems, resulting in an improved responsiveness to the needs of vulnerable children, young people and families. For example, earlier, joint decision making by Community Services and non government services is resulting in children, young people and families getting a faster service from the most appropriate provider which might in some cases, be from a non government service. Community Services is also engaged with NSW Health and is referring families to Whole Family Teams where the carers have mental health and/or substance use problems and parenting difficulties. Whole Family Teams are increasing Community Services' capacity to respond to more families, particularly those where the risks to children are very high.

#### **2.4.4 Children in out-of-home care**

Eleven (10%) of the children and young people who died in 2011 were not living with their families at the time of their death. Eight of the 11 children were under the parental responsibility of the Minister. The remaining three children were either placed with an extended family member under a Federal Court order or in a disability setting arranged through Ageing, Disability and Home Care.

The circumstances of death for the eight children and young people who were under the parental responsibility of the Minister at the time of death included illness or disease, a motor vehicle accident, drowning, and SUDI/SIDS. Six of the eight children were Aboriginal and/or Torres Strait Islander. Of these eight children and young people, two were placed with Community Services authorised carers, two were with kinship carers authorised by Community Services, and four were placed with non-government authorised carers.

Caution should be used when interpreting these results due to the small numbers.

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Community Services is working with local partners to better connect and integrate local service systems, resulting in an improved responsiveness to the needs of vulnerable children, young people and families.

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## 2.5 Reported risk factors

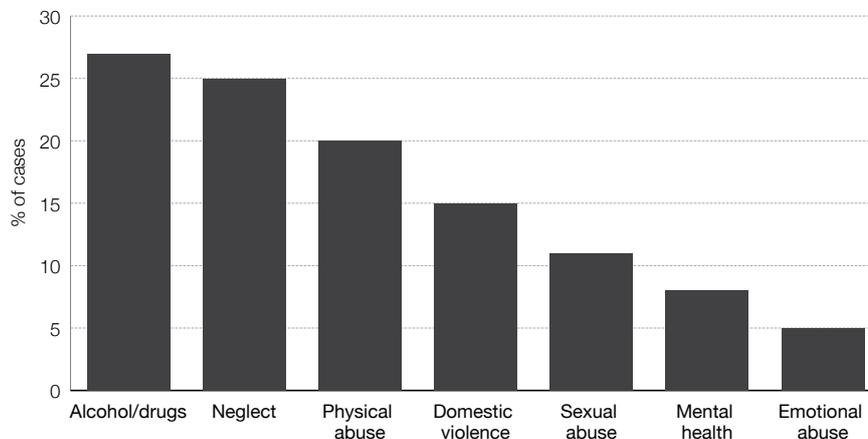
This section outlines the risk issues that were reported to Community Services about the families of the children who died in 2011. This information is collected from the child protection histories for the children who died and their sibling/s. This information can potentially span a period of many years.

### 2.5.1 Risk factors

Parental drug or alcohol use was the most common reported issue associated with ROSH reports for these families, followed by neglect, physical abuse and then domestic violence<sup>79</sup>.

Socioeconomic disadvantage was also a key theme in the reported issues for the families of children who died. Issues relating to transience, geographical isolation and/or poverty were reported in 40 (36%) cases<sup>80</sup>.

**Figure 12: Reported ROSH risk factors for the families of children and young people who died in 2011 and were known to Community Services<sup>81</sup>.**



Source: Community Services, 2012.

### *Intergenerational factors*

Of the 110 children and young people who died in 2011, reports of intergenerational risk factors were identified in 31 (28%) child death reviews. The most common reported risk factors identified across generations were domestic violence, neglect, and parental substance use.

Forty (36%) of the children who died in 2011 had at least one parent who was involved with child protection services when they themselves were children. This includes eight cases where the parent was under the parental responsibility of the Minister as a child.

Working with intergenerational risk is explored further in Chapter 3.

79 Note that multiple risk factors may have been reported in one case.

80 These data do not include reports received prior to the introduction of the ROSH threshold in January 2010.

81 For the purposes of this report, poverty refers to children in the family who are significantly disadvantaged by the family's financial circumstances. Transience is defined as families who move continuously and do not have a stable accommodation base. Geographical isolation refers to families who are living in a remote/isolated area, or families who are geographically isolated due to a lack of resources, such as a combination of poor transport, communication technology and poverty.

# Chapter 3: Lessons for improvement – working with young parents

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## Chapter overview

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Working with young parent families is an area of child protection practice which presents both challenges and opportunities. This is particularly so when the young parent has a child protection history, or where the young parent has been in out-of-home care. In these circumstances, the challenge for practice is to balance the support needs of these young parents, who are often children themselves, with the care and protection needs of their children. The key opportunity for practice is to build on the young parents' motivation to give their child a better start in life than they had themselves. Patterns of intergenerational risk are also common in the young parent families involved with statutory child protection. The key challenge for practice is to understand how approaches to parenting have been influenced by family culture and functioning. The key opportunity for practice is to support the young parents to break intergenerational cycles of abuse and neglect.

In 2011, Community Services examined practice with a cohort of children who died between 2006 and 2011 and had young parents. The purpose of this review was to identify the challenges for practice and strategies Community Services staff are using to deliver effective child protection services to this group. The review compared these cases to the children of older parents who died within the same period and to a group of children of young parents where positive outcomes were achieved. The review included quantitative and qualitative analysis of young parent cases where a child died, and qualitative analysis of young parent cases where casework

intervention resulted in positive outcomes for the child/ren<sup>82</sup>.

Section 3.1 considers 105 children who died between 2006 and 2011, and had one or both parents who were less than 22 years old. The data from this cohort are compared to 285 children who died within the same period, where both parents were aged 22 years or older at the time of death. Overall, this analysis identified higher rates of death for the children of young parents in the extreme prematurity, SUDI/SIDS, suspicious injury, and accidental smothering (including co-sleeping) categories, and lower rates of deaths due to illness or disease. Aboriginal and/or Torres Strait Islander children and infants under one were over-represented in the young parents group. There were also significant intergenerational risk factors for the children of young parents – the majority (86%) of the 105 cases had one or both parents who were known to Community Services as children, including one-quarter of cases (25%) where one or both parents were leaving, or had left care at the time of the child's death.

Section 3.2 reviews Community Services' work with young parent families through the lens of the enduring challenges and key themes identified in the *Child Deaths 2010 Annual Report*. It considers assessing risk in young parent families, engaging young parents to build their parenting capacity and maintaining a focus on the child in a young parent family. These themes are illustrated by de-identified case reviews as well as by current research.

Three key messages emerged from our review. Children who are

living in young parent families are a particularly vulnerable group in our community when the family is living with disadvantage, when there are intergenerational risks, when parents have a child protection history or where there are poor family and professional support networks. There is clear evidence that young parents from disadvantaged backgrounds can view parenthood as an opportunity to make positive changes and provide their children with a better upbringing than they themselves had. Where caseworkers are empowered to customise their assessment and intervention with young parent families to take account of both vulnerability and opportunity, positive outcomes for the next generation can be achieved.

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There is clear evidence that young parents from disadvantaged backgrounds can view parenthood as an opportunity to make positive changes and provide their children with a better upbringing than they themselves had.

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82 For this review, Community Services' Regions nominated cases where a positive outcome for the child was identified.

### 3.1 The deaths of children with young parents – 2006-11

Between 2006 and 2011, 799 children and young people died who were known to Community Services. This review considered 390 of these cases. The remaining 409 cases were excluded because either the age of one or both parents was not known to Community Services, or the child who died was aged seven years or over (the oldest child in the young parents group was six).

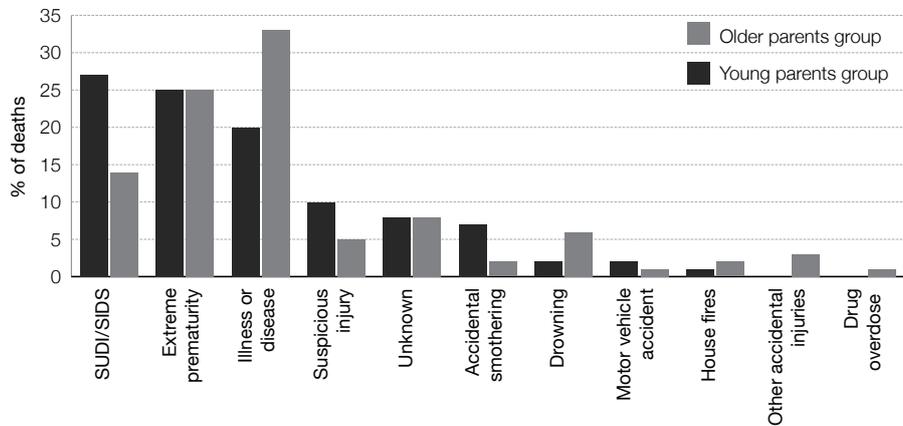
Of these 390 cases, 105 (27%) were included in the ‘young parents group’ because one or both parents were less than 22 years old. The remaining 285 (73%) were included in the ‘older parents group’ because both parents were aged 22 and over, and the child who died was aged six or under.

#### 3.1.1 Circumstances of death

The primary circumstance of death for children in the young parents group was the SUDI/SIDS category, followed by extreme prematurity, illness or disease, and suspicious injuries. For children in the older parents group, the primary circumstance of death was illness or disease, followed by extreme prematurity, SUDI/SIDS, and the unknown category.

A higher percentage of children in the young parents group were in the SUDI/SIDS, suspicious injury, and accidental smothering categories. A considerably lower percentage of children in the young parents group died in the illness or disease and drowning categories. In addition, a higher percentage of children in the young parents

Figure 13: Parent groups by circumstances of death, 2006 to 2011.



Source: Community Services, 2012.

group died while co-sleeping (21% or 22 cases), in comparison to the older parents group (14% or 39 cases). The majority of the co-sleeping deaths in the young parents group featured a history of reports about parental substance use (19 of the 22 cases). The findings about higher rates of SUDI/SIDS and/or co-sleeping related deaths in young parent families are also supported by research<sup>83 84</sup>.

Research has also found that young parents’ or caregivers’ inexperience can be a risk factor in child fatal assault<sup>85</sup>. Deaths due to circumstances involving suspicious injuries were particularly high in the young parents group — 10 (10%) children of young parents died in these circumstances, compared to 15 (5%) in the older parents group.

Of these 10 children of young parents, six were identified as Aboriginal and/or Torres Strait Islander. Nine of the 10 mothers and four of the 10 fathers of the children who died in circumstances involving suspicious injuries had a child protection history when they themselves were children. Three of the parents were in care or had left care.

Other common characteristics in the 10 young parent families included:

- nine cases involved a history of reports about parental domestic violence
- eight cases involved a history of reports about parental substance use
- five cases involved a history of reports about parental mental health issues
- five cases involved a history of reports about physical abuse for the child who died and/or sibling/s.

Most cases featured multiple risk issues.

83 Paterson, D. (2012). Sudden Infant Death Syndrome (SIDS). Boston Children’s Hospital: Boston. Available <http://www.childrenshospital.org/az/Site1654/mainpageS1654P0.html>

84 Fu, L., Colson, E., Corwin, M. & Moon, R. (2008). Infant sleep location: associated maternal and infant characteristics with sudden infant death syndrome prevention recommendations. *The Journal of Pediatrics*, 153(4): 503-508.

85 Brown, K. & Lynch, M. (1995). The nature and extent of child homicide and fatal abuse. *Child Abuse Review*, 4: 309-316.

### 3.1.2 Characteristics of the children who died in the young parents group

#### Age and gender

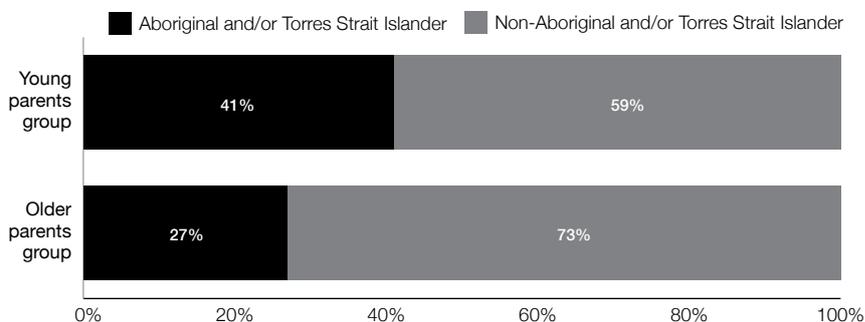
The vast majority (85%) of the children who died and had young parents were under the age of one at the time of their death. The average age of children in this group was approximately five months. In comparison, 70% of children who died in the older parents group were aged under one and the average age was 13 months. The difference in these two figures could be explained by the difference in the age groups of the parents — that is, older parents are more likely to have older children. However, in the absence of comparable data for children of young parents who have not died, this difference perhaps highlights the vulnerability of this young age group of children when combined with the vulnerability of this age group of parents.

The gender of the children who died in both the young and older parent group did not differ significantly. As with findings from other Community Services' child death reviews, males were over-represented in both the young and older parents groups, accounting for 57% and 61% of the children who died respectively.

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

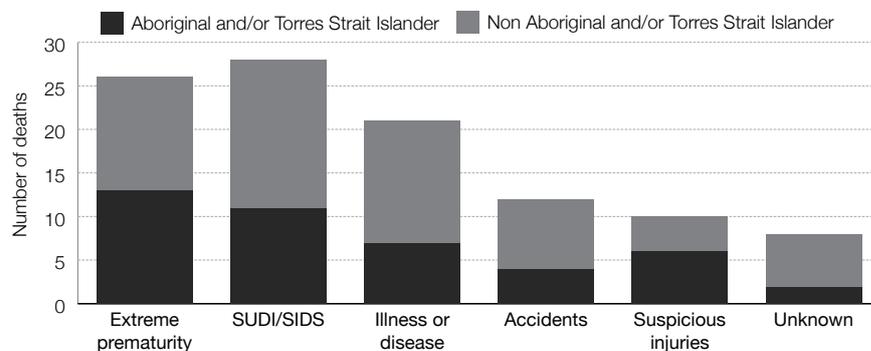
As discussed in Chapter 2, Aboriginal and/or Torres Strait Islander children are over-represented among those children who died between 2006 and 2011 and were known to Community Services, accounting for 25% of deaths. There is further over-representation among the young parent age group where 41% (43) of the children who died were recorded as being Aboriginal and/or Torres

Figure 14: Parent groups by Aboriginal and/or Torres Strait Islander status, 2006 to 2011.



Source: Community Services, 2012.

Figure 15: Young parent group by circumstances of death and Aboriginal and/or Torres Strait Islander status, 2006 to 2011.



Source: Community Services, 2012.

Strait Islander. In comparison, 27% (77) of children who died in the older parents group were recorded as being Aboriginal and/or Torres Strait Islander.

The over-representation of Aboriginal and/or Torres Strait Islander children in the young parents group may be partly explained by the fact that Aboriginal and/or Torres Strait Islander parents tend to be younger than non-Aboriginal/Torres Strait Islander parents and there are higher rates of births for Aboriginal and/or Torres Strait Islander teenage mothers<sup>86</sup>. While there are cultural reasons why Aboriginal and/or Torres Strait Islander women give birth at a younger age, there also appears to be socioeconomic

reasons, particularly in remote Aboriginal communities<sup>87</sup>. These issues were discussed in Chapter 2.

In the young parents group, Aboriginal and/or Torres Strait Islander children represented half of all cases in the extreme prematurity category, over half of all cases in the suspicious injuries category, and almost half of the cases in the SUDI/SIDS category.

86 In 2009, the Indigenous teenage birth rate was five times that for other Australian teenagers (Steering Committee for the Review of Government Service Provision (SCRGPS), 2011).

87 Lockyer, S. & Kite, E. (2007). Teenage pregnancies in East Pilbara Aboriginal communities. *Aboriginal and Islander Health Worker Journal*, 31(2): 26-29.

### 3.1.3 Characteristics of the young parents

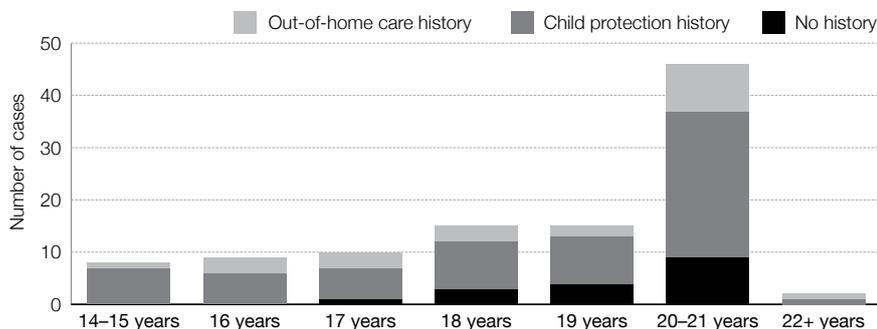
#### Mothers

Figure 16 shows that of the 105 families in the young parents group, 103 (98%) had a mother who was less than 22 years old. In the two cases where the mother was aged 22 years or older, the father was less than 22 years old at the time of the child's death. In the majority of cases in the young parents group (84%), the mother was known to Community Services as a child. This includes 21% of cases where the mother had recently left, or was still in care at the time of the child's death. In comparison, 34% of the mothers in the older parents group were known to Community Services, including 7% who were in care.

#### Fathers

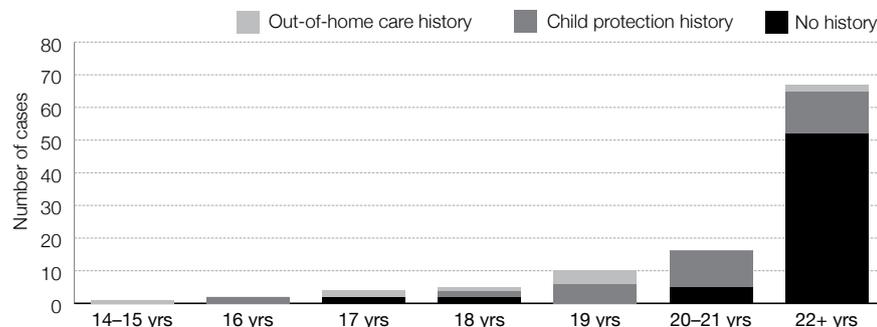
Figure 17 shows that of the 105 cases in the young parents group, 38 children (36%) had a father who was less than 22 years old at the time of the child's death. In 43 cases (41%), the fathers were known to Community Services as children, including 10 (9%) fathers who were in, or had left care. In comparison, 17% of the fathers in the older parents group were known to Community Services, including 5% who were in care.

**Figure 16: Age of mothers in the young parents group by child protection and care history.**



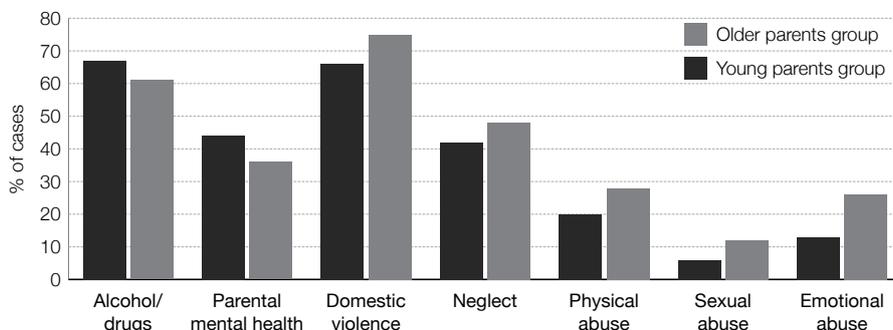
Source: Community Services, 2012.

**Figure 17: Age of fathers in the young parents group by child protection and care history.**



Source: Community Services, 2012.

**Figure 18: Parent groups by reported risk factors, 2006 to 2011.**



Source: Community Services, 2012.

### 3.1.4 Key risk factors for young parent families

The data for Figure 18 were collected from risk of harm reports made about the child and/or sibling/s prior to the child’s death. These data show that more children of young parents were reported for parental drug use and mental health and less children of young parents were reported for parental domestic violence, neglect, physical abuse, sexual abuse and emotional abuse.

When considering these findings, it is important to acknowledge that the children of young parents were predominantly young at the time of death whereas children in the older parents group were mainly over one year of age. The older ages of the children, combined with the higher likelihood that these children had older siblings, may explain in part why reports about abuse and neglect were more likely in the families in the older parents group.

The higher likelihood of reporting for substance use and mental health in young parent families may also be linked to the majority (86%) of these parents having a child protection history. Many of these young people were reported to be suffering from drug or alcohol problems (61 cases or 58%) and/or mental health problems (38 cases or 36%) during adolescence.

## 3.2 Practice themes – working with young parents

Three key themes and lessons for practice improvement emerged from Community Services’ review:

- assessing risk in young parent families
- engaging young parents to build parenting capacity
- keeping a focus on the child in a young parent family.

These themes are examined in two ways: through the lens of the enduring challenges of child protection work, identified in Community Services’ *Child Deaths 2010 Annual Report* and through research findings from both Australian and international studies. De-identified excerpts from reviews are provided in this section to illustrate the overwhelming evidence from the research that with appropriate supports, many young people can be successful parents. For those who cannot, many can successfully participate in the lives of their children.

For almost all of the cases considered in this chapter, the young parents are reported to have experienced a history of abuse and/or neglect throughout childhood. It appears that the capacity of a young person to overcome this disadvantage is dependent on a number of factors, primarily the provision of practical and emotional support from family and professional networks.

An understanding about what interventions assist young people to transition more successfully into parenthood extends beyond the involvement of Community Services. The extended family, the community and non-government agencies

play a key role in supporting young parent families. The provision of early intervention services, especially to young parents leaving the out-of-home care system, is particularly important. Regardless of the type of intervention, it is essential to ensure that the needs of the child are carefully balanced, in a child focused way, with the needs of the young parent.

### 3.2.1 The context of young parent families and child protection

#### *The links between disadvantage and early parenthood*

Research studies have consistently found a clear association between socioeconomic disadvantage and early parenthood<sup>88 89 90 91</sup>. For example, a Swedish study (2007) examining the prevalence of teenage parenthood among nearly 50,000 former child welfare clients found that young people who had been clients of a child welfare service were twice as likely to become teenage parents<sup>92</sup>.

This study also found that young people who had been reported to a child welfare service as adolescents were four to five times more likely to become teenage parents.

There also appears to be particularly significant links between early pregnancy and young people who are in or are leaving care. Research studies have estimated that between one-third and one-half of young people become parents shortly after leaving the care system<sup>93</sup>.

The links between disadvantage and early pregnancy are also reflected in Community Services' data, as outlined in Section 3.2. Of the 105 cases in the young parents group, 86% (90) of the cases featured a parent who had a history of reported abuse and neglect when they themselves were children, including 25% (26) of parent/s who were in, or who had recently left care. In comparison, 39% (110) of the parents in the older parents group had a child protection history, and 11% (31) had left care.

The research suggests that a range of factors explain the higher rates of pregnancy for disadvantaged young people:

- some young women view pregnancy as an opportunity to make positive changes in their lives, or to provide a different childhood experience than they themselves had as children<sup>94</sup>

- young parenthood may be a consequence, rather than a cause of social disadvantage, that is, that poorer outcomes for young parents may be a result of their backgrounds, rather than being young when their children are born<sup>95</sup>
- disadvantaged young women often have limited career or education options, so will be more likely to become a young mother to give them 'adult status' and identity<sup>96</sup>
- there are higher levels of idealisation about being a parent, particularly among young men<sup>97</sup>, care leavers<sup>98</sup> and Aboriginal young people, especially young Aboriginal men<sup>99</sup>
- there are possible links between having unprotected sex and overall risk-taking behaviours, which are more common in this group<sup>100</sup>
- there is a correlation between teenage pregnancy and dysfunctional family relationships — inadequate levels of parental monitoring and supervision may result in young people having more opportunities to engage in risk-taking behaviours, especially sexual risk-taking<sup>101</sup>

88 Chase, E., Maxwell, C., Knight, A., & Aggleton, P. (2006). Pregnancy and parenthood among young people in and leaving care: what are influencing factors, and what makes a difference in providing support? *Journal of Adolescence*, 29: 437-451.

89 Mendes, P. (2009). Improving outcomes for teenage pregnancy and early parenthood for young people in out-of-home care. *Youth Studies Australia*, 28(4):11-18.

90 Cashmore, J. & Paxman, M. (2007). *Longitudinal Study of Wards Leaving Care: Four to five years on*. Social Policy Research Centre: Sydney.

91 Woodward, L., Fergusson, D. & Horwood, L. (2001). Risk factors and life processes associated with teenage pregnancy: results of a prospective study from birth to 20 years. *Journal of Marriage and Family*, 63(4):1170-1184.

92 Vinnerljung, B., Franzen, E., & Danielsson, M. (2007). Teenage parenthood among child welfare clients: a Swedish national cohort study of prevalence and odds. *Journal of Adolescence*, 30: 97-116.

93 Mendes, 2009.

94 Quinlivan, J. (2004). Teenagers who plan parenthood. *Sexual Health*, 1: 201-208.

95 Evans, A. (2007). *Social disadvantage and teenage motherhood: A cohort perspective*. University of Melbourne: Victoria. Available <http://melbourneinstitute.com/hilda/conf/conf2007>

96 Bradbury, B. (2006). Disadvantage among Australian young mothers. *Australian Journal of Labour Economics*, 9(2):147-171 (page 148).

97 Quinlivan, J., & Condon, J. (2005). Anxiety and depression in fathers in teenage pregnancy. *Australian and New Zealand Journal of Psychiatry*, 39(10): 915-920.

98 Vinnerljung et al., 2007.

99 Larkins, S., Page, R., Panaretto, K., Mitchell, M., Alberts, V., McGinty, S. & Veitch, P. (2011). The transformative potential of young motherhood for disadvantaged Aboriginal and Torres Strait Islander women in Townsville Australia. *Journal of Australia*, 194(10): 551-555.

100 Morehead, A., & Soriano, G. (2005). Teenage mothers: constructing families. *Family Matters*, 72: 64-71.

101 Luster, T. & Small, S. (1994). Factors associated with sexual risk-taking behaviours among adolescents. *Journal of Marriage and the Family*, 56(3): 622-632.

- an absence of positive role models, peer norms or positive and communicative relationships with their parents may contribute to early parenthood<sup>102</sup>.

There are additional complicating factors contributing to early parenthood for care leavers linked to their experiences before, during and after care<sup>103</sup>. Prior to entering the care system, young people have usually experienced abuse, neglect and/or trauma. The experience of abuse and neglect may increase vulnerability to the development of attachment problems, poor peer relationships, drug and alcohol misuse, and teenage pregnancy<sup>104</sup>. While in care, many young people experience placement instability and variable levels of quality of care. This can result in inconsistent access to supports and services<sup>105</sup>, including education around sexual health and contraception<sup>106</sup>. For example, many young people in care can experience a disrupted school education due to frequent placement moves, truancy or exclusion and are more likely to miss out on school-based sex education programs<sup>107 108</sup>.

The link between disadvantage and a higher vulnerability to early pregnancy was demonstrated in our reviews:

*During childhood and adolescence, a young woman was the subject of a number of reports to Community Services. The reported risk factors for the young woman included allegations that she was the victim of sexual abuse, physical abuse*

*from her parents and bullying at school. She also suffered from depression, was expelled from school, and had a history of alcohol abuse. There were reports that the young woman had a pregnancy terminated after unprotected sex while highly intoxicated and was continuing to have unprotected sex with various young men.*

*Before she became pregnant with her first child, the young woman was interviewed by caseworkers. She told workers that she felt that she needed to 'fall pregnant to keep her boyfriend happy'. Information gathered during the period of assessment indicated that the young woman appeared 'vulnerable and may also want a child so that she can feel loved as she felt no-one loved her'.*

*By the time that this young woman was 18 years old, she had given birth to two children. She lived in a highly remote area with no access to a local family support service.*

The review found that:

*...the child protection history for the young person presented a picture of a vulnerable young woman who appeared to have been unable to pursue more positive outcomes for herself. Ideally, an assessment was needed prior to her pregnancy that explored the underlying causes of her high-risk behaviour.*

This review demonstrates a missed opportunity for Community Services and other agencies to target support to a young woman who was clearly vulnerable to early parenthood. The key message is that casework with at-risk young people, particularly those who have experienced abuse or neglect or who have been in care, should include sexual health support in the context of the young person's views and perceptions about parenthood. Relevant professional training provided to carers so that they can provide crucial information to young people will also be helpful<sup>109</sup>. Increasing a young person's realistic awareness of the responsibilities and impact of young parenthood is a strategy commonly referenced in the research<sup>110</sup>. However, as the above case study illustrates, supporting a vulnerable young person to address their history of trauma should be an equally important objective of this work. If sexual risk-taking behaviour is related to trauma, or if pregnancy is seen as the most viable route to self-esteem and loving relationships, sex education alone will not be effective.

Improving services and support for children and young people in care is one of the aims of the planned transition of out-of-home care services from the government to the non-government sector. Further information about the transition is outlined in Chapter 4 of this report.

102 Beers, L.A.S. & Hollo, R.E. (2009). Approaching the adolescent-headed family: a review of teen parenting. *Current Problem Pediatric Adolescent Health Care*, 39: 216-233.

103 Mendes, 2009.

104 Queensland Crime and Misconduct Commission (2007). Childhood physical abuse and adult offending: are they linked, and is there scope for early intervention. Crime and Misconduct Commission: Queensland.

105 Mendes, 2009.

106 Chase et al., 2006.

107 Ibid, 2006.

108 Mendes, 2009.

109 Ibid, 2009.

110 Condon, J., Donovan, J. & Corkindale, C. (2001). Australian adolescents' attitudes and beliefs concerning pregnancy, childbirth and parenthood: the development, psychometric testing and results of a new scale. *Journal of Adolescence*, 24(6): 729 – 742.

### 3.2.2 Assessing risk in young parent families

#### *The impact of early parenthood on young people and their children*

Community Services' child deaths data show that children born to young parents are at greater risk of negative outcomes. For example, the children of young parents had lower rates of deaths due to natural causes, and higher rates in circumstances involving SUDI/ SIDS and suspicious injuries.

While the research discusses positive changes that parenthood can bring to young people's lives<sup>111</sup>, there is also evidence that children born to young parents are at increased risk of a range of adverse outcomes. For example, infants born to young mothers are more likely to be premature and/or have low birth weight, and are at greater risk of dying in the perinatal period<sup>112</sup>. Studies have also found that children of young parents are more likely to have academic difficulties, school adjustment problems, and are at greater risk of developmental delay<sup>113</sup>. Children in young parent families have higher rates of maltreatment and injuries resulting from accidents<sup>114</sup>. Children of young parents are also at increased risk of substance abuse, of early sexual activity, of themselves becoming a young parent, and of ongoing cognitive and behavioural problems<sup>115 116</sup>.

There is also strong evidence that young parents, including care leavers, can experience negative outcomes, including the risk of enduring disadvantage and long-term social exclusion<sup>117</sup>. Young parents are more likely to have adverse pregnancy outcomes, poorer mental health, less education and employment opportunities, welfare dependency, and an unstable family situation<sup>118</sup>. Young mothers are more likely to experience violence<sup>119</sup>, (particularly during pregnancy<sup>120</sup>), live in unsafe or unhygienic environments<sup>121</sup>, and experience drug use<sup>122</sup>, all of which may have an impact on parenting capacity. As discussed earlier, young mothers are more likely to experience socioeconomic disadvantage which is likely to be linked to poorer outcomes for these young women.

The higher likelihood of poor outcomes for young parents and their children, especially where there is significant disadvantage, was demonstrated in Community Services' review of a child who died:

*Both young parents were from highly disadvantaged families and had histories of childhood abuse and neglect. The young mother's child protection history was particularly significant, characterised by sexual abuse, violence and exposure to her own parents' alcohol use and mental health issues. After the birth of their own children, reports were made about the*

*young family with concerns about serious levels of domestic violence, significant drug use and chronic homelessness. Both parents had a diagnosed mental illness and there was evidence that the mother was suffering from post natal depression. The family was geographically isolated and there were also very limited supports available from extended family. The baby was never sighted by any professional following discharge from hospital. Community Services learned of the baby's death in circumstances involving suspicious injuries.*

The review found that:

*Reports of neglect, domestic violence, drug use and parental mental health issues were associated with high risks to the baby. It is likely that the death of this child occurred within the context of chronic disadvantage for the parents, combined with the family's isolation, both in a geographical and emotional sense.*

However, our review also identified cases where young parents have overcome disadvantage, and have not only gone on to be successful parents, but have initiated positive changes in other aspects of their lives:

*A young Aboriginal woman entered statutory care at an early age after a significant child*

111 See Section 3.2.3 for further discussion of this research.

112 Beers & Hollo, 2009.

113 Ibid, 2009.

114 Vinnerjung et al., 2007.

115 Beers & Hollo, 2009.

116 Vinnerjung et al., 2007.

117 Chase et al., 2006.

118 Vinnerjung et al., 2007.

119 Woodward et al., 2001.

120 Covington, D.L., Justason, B.J. & Wright, L.N. (2001). Severity, manifestations, and consequences of violence among pregnant adolescents. *Journal of Adolescent Health*, 28:55-61.

121 Mendes, 2009.

122 Department of Family and Community Services, Community Services (2011). *Child protection and mothers in substance abuse treatment study: major findings*. Community Services: Sydney. Available [http://www.community.nsw.gov.au/docswr/\\_assets/main/documents/researchnote\\_mothers\\_substanceabuse.pdf](http://www.community.nsw.gov.au/docswr/_assets/main/documents/researchnote_mothers_substanceabuse.pdf)

protection history involving reports about serious levels of physical and verbal abuse and living with chronic neglect. While in care, the young woman experienced multiple placement breakdowns, exhibited challenging behaviours, and became pregnant at a young age. After a period of homelessness, she eventually moved in with her boyfriend who was reported to have perpetrated physical and verbal violence towards her. While she was pregnant, the young woman was the victim of a serious assault during pregnancy.

Following the assault, an allocated caseworker worked with the mother, and this work continued after the child's birth. The mother was supported by caseworkers to secure accommodation, to seek appropriate prenatal care, to obtain an Apprehended Violence Order against her boyfriend, and to reconnect with a supportive extended family member. Caseworkers also worked intensively with the mother to address her understanding of the impact of domestic violence on her and her baby. The young mother was able to end her relationship with the baby's father and successfully transitioned into independent living. She was supported to gain employment and re-enter the education system. No further concerns about her child have been identified since this intervention.

The review found that:

*The young mother's resilience, combined with intensive support from caseworkers and assistance from a supportive family member resulted in positive outcomes for both the child and the mother. The mother was able to overcome her difficult childhood and adolescence by completing her higher education, developing a strong support network and building her parenting capacity.*

These are two very different stories, and we cannot draw general conclusions from a simple comparison. However, the difference in support that these two families experienced leading up to and after the birth of their children is noteworthy. Although support was not the only cause of the poor/successful outcomes noted in these cases, our reviews found that it is a very significant contributing factor. Providing support to young parents can require a flexible approach, and this is discussed further in Section 3.2.3.

### ***The importance of including a young parent's history in risk assessment***

Comprehensive risk assessment in child protection is internationally recognised to be one of the enduring challenges of child protection work<sup>123</sup>. Assessing risk in young parent families has its own complexities, and will often require a unique approach, especially when intergenerational risk factors are present.

When conducting risk assessments for the children of young parents, it is important for child protection workers to consider the family's situation from two perspectives. Firstly, it is critical to recognise that young people may experience additional challenges in adjusting to the parenting role due to the likelihood that they are still developing physically, cognitively, and emotionally<sup>124</sup>. In addition to the typical challenges associated with progressing through adolescence, a young parent also needs to learn about the responsibilities and skills required to be a parent. It is critical that risk assessment recognises the concept of 'cognitive readiness' as it impacts on the young person's capacity to learn new skills during their particular developmental stage<sup>125</sup>. The combination of these two major milestones can impact on a young person's adjustment to the parenting role, especially when the young parent has had a poor experience of being parented, a conflicted relationship with his or her own parents or where there is an absence of other supports<sup>126</sup>. Risk-taking<sup>127</sup> is a natural part of a young person's development,

123 Department of Family and Community Services, Community Services, 2011.

124 Beers & Hollo, 2009.

125 Afifi, T. (2007). Child abuse and adolescent parenting: developing a theoretical model from an ecological perspective. *Journal of Aggression, Maltreatment and Trauma*, 14(3): 89-105.

126 Beers & Hollo, 2009.

127 Risk-taking can take the form of cigarette smoking, drug and alcohol use, violence behaviour, sexual intercourse and failure to take appropriate safety steps such as seatbelts in cars or wearing helmets.

and helps an adolescent to shape their identity and decision making skills<sup>128</sup>. This can be a particular challenge when the young parent must also focus on the safety and wellbeing needs of their child.

Secondly, the young parent's developmental stage also needs to be considered in light of their own history as a child and adolescent, particularly how both factors may impact on their parenting capacity and support needs. Research demonstrates that an early transition into parenthood may place further demands on the already limited resources of vulnerable young people<sup>129</sup>. This can not only have an impact on parenting capacity, but also on other life choices<sup>130</sup>.

Community Services' *Child Deaths 2010 Annual Report* highlighted the challenges in intervening when family histories feature generational patterns of risk and wider societal disadvantage. Child death reviews have frequently identified a common feature of practice, known in the research as the 'start again syndrome', where casework intervention is focused on the 'here and now', rather than on patterns of intergenerational abuse or neglect in the family<sup>131</sup>. As a result, caseworkers tend to respond in an overly optimistic way about a new pregnancy, new baby or new reports. There is also the tendency for casework to focus on treating the 'symptoms' in the family, rather than the underlying causes of these symptoms<sup>132</sup>. For example, casework may be targeted towards assisting a family with accommodation or buying groceries, without considering

how parental drug or alcohol issues may be impacting on life choices.

For young mothers and fathers with a child protection history, early parenthood can represent the continuation of an intergenerational pattern of early parenthood<sup>133</sup> disadvantage, abuse and neglect, and other associated factors<sup>134</sup>. A holistic approach to intergenerational risk issues is particularly important for young parent families. If young parents are to be supported in overcoming the cycle of intergenerational abuse and neglect, it is critical that assessments consider the impact of their history on their parenting capacity.

Community Services' reviews involving young parent families have frequently found that the assessment process is often limited to providing practical support for young parents, rather than considering the experiences of the parent and how this may link to their parenting capacity. An overly optimistic assessment of the young person's ability to effectively parent without the appropriate supports is a common feature in these reviews. This is demonstrated in the following review:

*A young Aboriginal woman was reported as a child to Community Services on multiple occasions with concerns about serious and chronic levels of neglect, exposure to domestic violence and parental drug use. As an adolescent, the woman spent periods of time in out-of-home care. During this period, Community Services received reports about her challenging and*

*risk-taking behaviours including excessive alcohol use and involvement in criminal activity. The baby's father was also known to Community Services as a child with reported concerns about parental drug abuse, neglect and risk of sexual harm. His adolescence was characterised by high-risk behaviours including criminal activity and drug use.*

*The baby of the young parents was reported to Community Services on several occasions. Reported concerns were about the parents' poor attendance at antenatal care and concerns about the baby being physically harmed because of physical violence in the household. Other reported concerns were about the young mother's mental health. The case was allocated for a risk assessment after concerns were reported about the baby looking lethargic and underweight. The assessment period involved interviews with the parents, observations of the parents with their baby, and engaging with interagency services.*

The review found a number of strengths in the casework with this family:

*...these included timely completion of a risk assessment and the skills demonstrated by the caseworkers that enabled them to raise challenging questions with the young parents about their behaviour, including their drug use, domestic violence, and the significant risks that these issues present to their child's safety.*

128 American Psychological Association. (2002). *Developing Adolescents: A resource for professionals*. Washington: United States. Available <http://www.apa.org/pi/families/resources/develop.pdf>

129 Woodward et al., 2001, p.1171.

130 Ibid, 2001, p.1171.

131 Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D. & Dodsworth, J. (2008). The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect. *Child Abuse Review*, 17, 313-330 (p.324).

132 Brandon et al., 2008.

133 Högnäs, R. & Carlson, M.J. (2012). "Like Parent Like Child?": The intergenerational transmission of nonmarital child bearing. *Social Sci. Res.* (article in press). Available <http://dx.doi.org/10.1016/j.ssresearch.2012.05.012>

134 Vinnerjung et al., 2007.

However, the review also found practice issues:

*...overly optimistic assessment of the young parents' capacity to keep the baby safe, and to sustain their ability to meet the baby's needs given their childhood history and young ages. The impact of the parents' own childhood histories, including reported exposure to chronic substance abuse, domestic violence, neglect, as well as the mother's frequent disruptions in her placements, were not recognised as important factors which might impact on their parenting and protective capacity.*

In this review, the young parents' extensive child protection history meant that there were significant gaps in positive parenting role models and family support. These gaps were particularly critical given their young age and inexperience. The lack of recognition of these factors in the child's risk assessment meant that the case plan did not address strategies to respond to gaps in supports and parenting skills in ways that may have improved the child's safety.

In comparison, the following review provides an example of how a holistic risk assessment allowed Community Services to develop a clear picture of risk for a child of a young parent:

*A young woman was the subject of multiple reports to Community Services that were increasing in frequency and severity. The reports reflect the woman's significant experiences of trauma, abuse and neglect throughout her childhood and as she transitioned into adolescence, a period which saw an increase in her risk-taking behaviour. She had an acrimonious relationship*

*with her mother who suffered from a mental illness. As a young teenager, the woman ran away from home and then became pregnant. She was placed in out-of-home care, where she experienced multiple placement breakdowns, and continued to form unsafe peer relationships.*

*An assessment of risk for the young mother and her child identified that '[the young woman's] significant experiences of trauma, abuse and neglect throughout her childhood into her adolescence increased her vulnerability to harm. This would undoubtedly have had a detrimental effect on her emotional development, notwithstanding the fact that she was a child in care with a history of placement instability and inconsistent parenting experiences. While [the young woman] is a mature and capable child, her problem solving and coping skills, and poor family supports may also increase her vulnerability and risk to her unborn child once born'.*

The review found that:

*...the risk assessment undertaken in this case was holistic and comprehensive. It appropriately considered and reflected the considerable impact of the young mother's history on her parenting capacity. While the assessment identified significant areas of concern about the mother's capacity to care for a dependent infant, it also considered how her emotional development, coping skills and absence of family supports would have had an overall impact on her capacity to take care of her child. The clearly articulated assessment allowed*

*for an effective and realistic case plan to be developed that focused on building the mother's parenting capacity, while keeping the child safe.*

These two reviews demonstrate one of the key success factors for effective practice with young parents: that risk assessment needs to take into account the developmental stage of the young parents and the impact of the parents' own child protection histories on their parenting histories. They also reflect the unique needs of adolescents as young parents and the need for highly skilled practitioners to deliver services to this group.

### **3.2.3 Engaging young parents to build support networks and parenting capacity**

#### *Early engagement and intervention with vulnerable young parents*

Consistent messages emerge from the research and international child death reviews<sup>135</sup> – the earlier the engagement with young parents, especially during pregnancy, the greater chance they have of making a successful transition to parenthood.

The critical importance of supporting vulnerable young women during this early period has also been demonstrated in Community Services' reviews. For example:

*A young woman in care experienced numerous placements and had very limited social and family supports. She had engaged in high-risk behaviour, used drugs and alcohol, and was a victim of violence. The young woman became pregnant at the age of 16. When Community Services learned about her pregnancy,*

casework was limited to a referral for accommodation which did not eventuate. Other casework to address parental drug use and domestic violence concerns could not be undertaken due to the competing priority of other matters.

The review found that:

*...the support provided to this young mother during pregnancy was inadequate, especially given that she was in care. Although resources at the Community Services Centre prevented this case from being allocated, a conversation could have occurred early with the mother to establish her views and expectations of the pregnancy, including supporting her to make informed choices about the pregnancy, and what assistance she needed to assist her transition into the parenting role smoothly.*

This is one of many child death reviews conducted by Community Services where the priority of other more urgent cases prevented the allocation of child protection reports about an unborn baby. As discussed in the *Child Deaths 2010 Annual Report*, Community Services' managers are faced with the daily challenge of deciding which cases to allocate for assessment, and which cases must be closed due to Community Services not having the capacity to respond. Because unborn babies are more likely to be seen as safe while in utero, these cases are sometimes given less priority than other cases where the risk to a child is more immediate.

While this thinking is understandable, it misses one of the key messages from reviews and research. For vulnerable young parents, early parenthood is often the continuation of an intergenerational pattern of young parenthood and disadvantage<sup>136 137</sup>.

There is a growing body of research suggesting that the period before and just after the birth of a baby can present valuable opportunities for services to engage with a young mother to address child protection concerns, which may assist in stopping the cycle of intergenerational abuse and neglect.

Research studies have found that some young parents, especially young mothers, view parenthood as a life-changing event that can enable them to move towards a more positive and settled lifestyle<sup>138 139 140</sup>. In a study undertaken by Chase et al. (2006) of 63 young people in England who had become parents or were pregnant since leaving care, the majority of these young mothers said that parenthood had 'turned their lives around'. Other studies present similar findings whereby vulnerable young mothers were motivated to leave behind high-risk behaviours such as substance misuse, unsafe sex practices and involvement in crime after falling pregnant or giving birth<sup>141 142</sup>.

Intervention with young pregnant women who are at risk of long-term involvement with child protection services can capitalise on this unique window of opportunity. Viewed from this perspective, early engagement with young parents

is a good investment of resources and can support good outcomes for children, including working towards ensuring that these families do not begin another cycle of long-term involvement with statutory services. The benefits of effectively engaging with a young mother early were demonstrated in the following review:

*A young woman was taken into care as a child, and became pregnant at the age of 15. The caseworker who had been allocated this case since the young person entered care continued to work with the mother during her pregnancy in order to plan and prepare for the birth of her child. The caseworker worked intensively to engage services flexible enough to adapt to the mother's learning and medical needs. Interagency service involvement focused on increasing the young woman's knowledge about child rearing, facilitating her attendance at a range of antenatal classes, and providing her with practical assistance and emotional support around the birth of the baby. The caseworker also worked with the young woman to transition her into independent living and increase her autonomy. These services remained involved with the young woman and her child well after the birth.*

136 Thompson, S.D. & Crase, S.J. (2004). Fathers of infants born to adolescent mothers: a comparison with non-parenting male peers and adolescent mothers. *Children and Youth Services Review*, 26:489-505.

137 Högnäs & Carlson, 2012.

138 Quinlivan, 2004.

139 Mendes, 2009.

140 Thompson & Crase, 2004.

141 Mendes, 2009.

142 Cashmore & Paxman, 2007.

The review found that:

*...the early engagement of the mother during pregnancy assisted her to prepare for and develop the necessary skills required to care for her child once born. This engagement supported the young woman to build her trust in these services and gave her the confidence to seek assistance when needed. In the absence of a family support network, a collaborative interagency approach meant that the young mother was able to develop a strong professional support network. The mother's child has never been the subject of a report to Community Services – demonstrating achievement of a motivating goal that the mother had expressed to her caseworker throughout the pregnancy.*

This review illustrates that the establishment of an effective, child-focused case plan during pregnancy, developed in conjunction with young parents, is one of the key success factors in working with young parent families. It not only assists in addressing risk issues early, but can also support a young person to overcome trust issues with professional services. The involvement of other adults, including family and professionals, is particularly important for young parents in assisting with their smooth transition into parenthood.

### **Effective engagement with young parents**

The differential child protection response provided by Community Services and early intervention services by non-government agencies<sup>143</sup> can be an excellent method of engaging young parents who are at risk of continuing the cycle of abuse and neglect. The early intervention program in NSW has been linked to a significant reduction in child protection reports about the children of families participating in the program<sup>144</sup>. Children from families who have successfully completed the program were also less likely to enter out-of-home care when compared with families who declined to participate in the program<sup>145</sup>.

Early intervention services can also be an alternative approach for young mothers and fathers who have had a long history of involvement with statutory services and may struggle to establish trust with child protection caseworkers. This is a common theme in the research, where young parents are more likely to view statutory services with mistrust or anxiety, which can impact on the likelihood that they will ask for help or assistance when necessary<sup>146 147</sup>. Care leavers can be particularly fearful of child protection intervention with their own children, experiencing anxiety about the prospect of their own children being taken into care<sup>148</sup>. This can be exacerbated when the parent has received little engagement, support or intervention prior to the baby's birth, but feels scrutinised and judged after the baby is born<sup>149</sup>.

A key step to building trust and effectively engaging with a young parent is having a clear understanding of normal adolescent development and behaviour. As adolescents develop their cognitive skills, some of their behaviours may appear confusing to adults who interact with them. For example, closed communication, 'arguing for the sake of arguing', presenting as 'me-centred' and being overly dramatic or exaggerating their opinions are all normal stages of adolescence<sup>150</sup>. However, for a professional who is trying to work with a young parent to address child protection concerns, there is a risk that this behaviour can be interpreted as the parent being resistant or hostile to support or intervention strategies. A professional who communicates flexibly with a young parent, in line with a clear understanding of adolescent behaviour, is more likely to successfully engage with the parent.

An example of successful engagement with a young parent is demonstrated in the following review:

*A young mother in care became pregnant at the age of 15. During her pregnancy, a number of risk of significant harm (ROSH) reports about her unborn child were received by Community Services. Due to the young woman's history of being in care, she was apprehensive about Community Services' involvement and told workers that she was not interested in involvement with the agency due to her fear that her child would be removed after birth. However,*

143 Community Services' differential child protection response, named *Strengthening Families*, works with families whose needs are complex enough to put them above the ROSH threshold. Non-government agencies now are entirely responsible to work with families eligible for *Brighter Futures* services.

144 Social Policy Research Centre (2010). *The Evaluation of Brighter Futures, NSW Community Services' Early Intervention Program, report for Community Services*. University of NSW: Sydney. Available [www.community.nsw.gov.au](http://www.community.nsw.gov.au)

145 Ibid, 2010.

146 Mendes, 2009.

147 Chase et al., 2006.

148 Cashmore & Paxman, 2007.

149 Chase et al., 2006.

150 American Psychological Association, 2002.

*the mother accepted a referral to Community Services' early intervention program. Over a two-year period, caseworkers worked closely with the mother to develop a plan to address risk and improve the circumstances of this young family. As this support continued, the mother started to seek additional advice and assistance, not only from Community Services, but also other agencies involved.*

The review found that:

*...the provision of support to the young mother through Community Services' early intervention program was a sensible decision, particularly due to the mother's reluctance to engage with caseworkers in light of her own child protection history and fears of having her own baby removed. Through persistence and collaboration, caseworkers were able to successfully engage the mother, resulting in an increased willingness for her to seek supports and assistance when needed.*

Community Services' policy on care leavers outlines that young women who are pregnant and leaving care should be given priority access to early intervention services. Young pregnant women have priority access to early intervention services provided by non-government organisations (NGOs), through the *Brighter Futures* program and to a differential child protection response provided by Community Services through the *Strengthening Families* program. Although the above review is an example of how Community Services' early intervention program engaged with a young family, there would be equal benefit in providing this service through *Brighter*

*Futures*, depending on the level of risk identified for the child.

The key characteristic of Community Services' successful work with this young family was based on consistent support over time. An absence of agency involvement with young parents, particularly care leavers, can often result in a significant support gap for the family as identified in this review:

*The mother entered care at a young age and experienced multiple placement changes during her time in care. Her case was unallocated at Community Services for the majority of her adolescence. In the two years leading up to her pregnancy, this young mother was reported to have engaged in high-risk behaviours including drug use and criminal behaviour. She was also reported to be highly transient and often homeless. A number of reports were made about risk factors for this young person, but Community Services was either unable to locate her, or allocate these reports due to competing priorities. When this young woman fell pregnant, Community Services was notified, but no contact was made with the mother prior to, or after the baby's birth.*

This review found:

*Due to frequent changes in placements and an absence of contact with her own parents, it was unlikely that this young woman would have formed a consistent attachment or connection to any primary carer during childhood or adolescence. The combination of multiple placement changes and a lack of contact from Community Services meant that this young mother was largely isolated and unprepared for the demands and pressures of parenthood. She would have benefited from practical and emotional support, which may have also decreased her expressed feelings of anxiety and mistrust towards Community Services.*

This case identifies the critical importance of filling the support gap that many disadvantaged young parents may face. Care leavers in particular will often lack family support, missing out on the emotional and practical support that extended family can provide for new parents<sup>151 152</sup>. This support is essential for young parents, who may need extra support to parent effectively. Community Services and our partner agencies have a role to play in filling these gaps, both through direct support from the allocated caseworker, but also by connecting the parent/s to other supports in the community.

151 Cashmore & Paxman, 2007.

152 Mendes, 2009.

### **Engaging young fathers**

The *Child Deaths 2010 Annual Report* highlighted a common finding of child death reviews — overlooking fathers in risk assessment, case planning and monitoring<sup>153</sup>. This issue is also highlighted in research about young fathers, who are often found to be ignored by services during casework<sup>154</sup>. The challenges of engaging young fathers were also identified in the young parents review, as illustrated by the following case:

*Both parents were 15 years old when they had their first child. This child was born with medical complications and required significant intervention. Both young parents had reportedly experienced abuse and neglect, inadequate supervision, risk-taking behaviours, and a lack of positive parenting and role modelling in the context of intergenerational patterns of risk. This included parental substance misuse, domestic violence, and parental mental health issues. The father was removed from his mother's care as an adolescent; however, after a period of living away from home, he had recently returned to live with his mother.*

*Community Services' intervention following the birth of the baby was primarily focused on ensuring that the mother had adequate support. However, the father was not included in the risk assessment, decision making about the infant's medical treatment or in the case plan to support the family.*

The review found:

*...Community Services was appropriately engaged with the young mother to ensure she was adequately supported prior to and following the child's death. However, it is apparent that the young father was not included in this process despite identifying himself as the child's father to workers, and expressing a wish to be involved. Considering that Community Services had knowledge of the young father's extensive child protection history, there was a missed and important opportunity to engage him, and to offer additional supports, particularly to address grief and loss issues following the death of his child.*

In contrast, positive engagement with a young father was noted in the following review:

*Two children were removed from the care of their young parents due to cumulating risk issues, especially the father's reported physical violence towards the mother. The young parents had also become increasingly resistant towards Community Services, to the extent that caseworkers were unable to contact them, and could not obtain entry into the home.*

*For nearly 12 months after the children were removed, a caseworker worked intensively with the mother, the father, and their children. Records note the positive changes made by the young parents, especially the father, to improve their circumstances. After the initial period following the children's removal, the parents, notably the father, appeared to be more cooperative with caseworkers. A case plan was developed with both parents to address a number of risk factors with many of these tasks focused on supporting the young father to make changes. Following the successful completion of this plan, the children were successfully restored to the care of their young parents.*

The review found that:

*...there were a number of strengths in casework undertaken with this family. During the initial assessment period, it was apparent that the young father was actively avoiding the caseworkers' attempts to contact him. However, the caseworker persisted in ensuring that the father was involved in the assessment process and was the focus of many aspects of the case plan. Many Community Services' reviews have found missed opportunities to invite men to take responsibility for their violence and the impact of their actions on the mother and children. The work undertaken by the caseworker with this young father appropriately identified the impact of his behaviour and engaged him with services to address his behaviour.*

153 Department of Family and Community Services, Community Services, 2011.

154 Thompson & Crase, 2004.

The importance of including fathers in casework is particularly important given findings that young fathers can experience greater difficulty coping with the transition to fatherhood, are more likely to become depressed compared to older fathers, and are more likely to be dissatisfied with life in general compared to young mothers<sup>155</sup>.

As with many young mothers, disengagement from their own families can mean that young fathers will struggle to learn how to become the parent that they wish to be<sup>156</sup>.

However, similar to the experiences of many young mothers, some young men perceive fatherhood as an opportunity to create new attachments and recreate elements of biological families (i.e. an ‘ambition to succeed where their parents failed’).

Engaging young fathers may also provide an alternative family placement if a child is unable to remain in the care of his or her young mother.

### 3.2.4 Maintaining the focus on a child in a young parent family

#### *The risk of over-identification in young parent families*

This chapter has documented the range of issues confronting disadvantaged young parents. During a time when these young people are developing into adults and addressing their own risk issues, they are also confronted with the responsibility for a vulnerable infant. The combination of these factors with the potential for feelings of mistrust or anxiety towards statutory services means that child protection work with young parent families can be resource intensive, complex and intellectually challenging.

There is also a significant emotional challenge that practitioners may experience when working with young parent families. Kari Killen (1996, p.792) discusses the difficulties that child protection workers face when trying to understand child abuse and neglect, particularly when facing these realities from the perspective of a parent’s disadvantage:

*It is...painful to understand and accept the parents’ losses and their grief for the life that never materialised, the help to grow up that they never had when they needed it – and the experience of inadequacy, pain and hopelessness they are left with<sup>157</sup>.*

Killen (1996, p.793) argues that over-identification is one of the most common mechanisms that workers use to protect themselves from this challenge. Workers can:

*...project onto the parents our own feelings and qualities or feelings and qualities we believe that we have towards children, instead of empathising with and facing the parents’ and children’s realities. We ignore or reduce the aspects of the parents’ personality and life that place great burdens on the child. We attribute to the parents more resources for further development than they have<sup>158</sup>.*

This is a particularly significant issue when considering the situation of a child in a young parent family. Young parents, who are often children themselves, may be part of a chronic cycle of intergenerational disadvantage. These young parents may have endured their own history of abuse and neglect and may not have received the support they needed in the years leading up to the birth of their own children.

155 Ibid, 2004.

156 Tyrer, P., Chase, E., Warwick, I., & Aggleton, P. (2005). ‘Dealing with it’: experiences of young fathers in and leaving care. *British Journal of Social Work*, 35: 1107-1121.

157 Killen, K. (1996). How far have we come in dealing with the emotional challenge of abuse and neglect? *Child Abuse and Neglect*, 20: 791-795.

158 Ibid, 1996.

While empathy and an understanding of this history is essential to effective casework, practitioners must be alert to the danger that this may obscure risks to the child, with efforts to create positive change in a family resulting in a focus on improvements that are not actually increasing safety<sup>159</sup>. This issue was identified in the following review:

*A young child living in a rural area was removed after reports about the young parents' significant mental health and drug issues. At the time of Community Services' intervention, the family were homeless and were living in a local park. The mother endured a significant and traumatic history of sexual abuse as a child, and was suffering from significant depression. At the time of this intervention, the caseworker had maintained a positive, collaborative relationship with the parents, but this was beginning to deteriorate as the parents began to direct a lot of anger towards the caseworker, and make complaints about this worker to Community Services.*

*The caseworker continued to work hard to engage the family and, as a result, relationships with the family improved again. A decision was made that the baby would be restored and that Community Services needed to take a less intrusive approach with the family. The reasons for this decision were mainly due to the increase in cooperation from the family. The review also identified significant resourcing issues at the Community Services Centre.*

The review found that:

*...there was no evidence that the risks that had led to the removal of the child had been resolved when this child was restored. It is important to consider the challenge that the caseworker would have faced in removing this child from the care of the young parents, particularly when considering the significant trauma that the young mother had already experienced in her short life. It is difficult for caseworkers to resist taking an optimistic view of a child's safety when cooperation from a family improves. However, this new sense of cooperation should not have been interpreted as increased protection of, or a decrease in risk to, the child. While the caseworker may have had a genuine belief that the parents would be able to provide a safe environment for the child, it is also possible that the decision to restore this child was influenced by the caseworker's over-identification with the parents, which may have obscured the worker's capacity to see significant risks for the child.*

Over-identification can result in case planning that is unrealistic, or places expectations and demands on young parents that are beyond their capacity to achieve, or beyond their capacity to achieve within the timeframes that a young child needs for stability and to form a secure attachment. While empathy is positive, over-identification is not. It can set the young parents up for disappointment and failure, leaving them with feelings of hopelessness and anxiety about their ability to change.

Alongside the challenges of emotionally navigating child protection work with young parents,

there are also intellectual challenges. Community Services' reviews of young parent families have commonly identified two predictable errors in child protection reasoning which can have significant bearing on the quality of risk assessments<sup>160</sup>. These are 'an uncritical attitude to new information' and 'a reluctance to review judgements in light of new information' (Munro, 1999, p. 748). Our reviews have highlighted the importance of reviewing assessments when new information is received which may affect risk; for example, a new partner.

Our reviews have consistently found that good-quality professional supervision plays a key role in navigating the intellectual and emotional challenges of child protection work for practitioners. This is equally true when working with disadvantaged young parents. Supervision can support caseworkers to reflect on how their personal feelings and beliefs about young parents may impact on their practice, and can assist caseworkers to step back and consider whether their practice is affected by predictable errors in reasoning or by over-identification with the parent. Delivered in this way, supervision can ensure that intervention is successful in achieving a balance between an empathic, supportive approach to a young parent, and a clear, objective picture of the experience of the child.

159 Cousins, C. (2005). "But the parent is trying...." The dilemmas workers face when children are at risk from parental substance use. *Child Abuse Prevention Newsletter*, 13(1):3-6.

160 Munro, E. (1999). Common errors in reasoning in child protection work. *Child Abuse and Neglect*, 23(8): 745-758.

A further challenge in avoiding over-identification with parents is how to manage dual clients within the same family – the child and the young parent. Both clients require very distinct supports and services, and their needs and wishes may not align. A caseworker may feel conflicted when the focus of the case needs to change from supporting a young person at risk, to the safety and wellbeing of that young person's new infant. Maintaining a balance between addressing the needs of the young parent and the needs of a child can be exceptionally challenging. It requires caseworkers to have the skills to form supportive relationships with potentially distrustful parents and to consider how casework may prevent the family from continuing down the spiral of further disadvantage and vulnerability, while at the same time ensuring that a child's environment remains safe.

Community Services' reviews have noted positive results when young parents have received separate casework support, support that is distinct from child protection intervention for the child. The following review demonstrates how the allocation of a caseworker for the young mother and a caseworker for the child was effective in addressing their individual needs in a balanced way:

*A young mother and her newborn were taken into care and placed with authorised carers. The mother had limited support from family. One caseworker was allocated to the baby and a second was allocated to the mother, as a young person in care. The two caseworkers worked with the mother to develop a case plan that allowed*

*her to receive support to develop her parenting capacity, as well as addressing other support needs in her life. Both caseworkers made consistent efforts to gain trust and build rapport with her and, as a result, were able to fill significant support gaps left by the absence of family support. For example, the caseworkers attended school events with the mother, took her to medical appointments and helped her when she moved house. The mother's caseworker used these 'incidental interactions' to build rapport and trust, such as discussions during long car trips about the mother's experiences as a child, and what this meant for her current parenting.*

The review found that:

*... while it was resource intensive, the decision to allocate two caseworkers to this case was appropriate and child focused. Both caseworkers worked hard to engage the mother, but any risk of over-identification was managed by the allocation of a second caseworker to focus on the safety and needs of the baby. The role of the mother's caseworker was a very effective aspect of this intervention as it provided support that the mother needed to develop her parenting skills. The mother was also able to develop a trusting relationship with the caseworker, which allowed her to be more open about any challenges she was experiencing as a new parent. As a result, Community Services was able to intervene early with potential child protection risks, rather than allowing the risks to escalate.*

The allocation of two workers to a family is an argument commonly made in the research<sup>161</sup>, and it was clearly effective in this case. However, the allocation of two caseworkers in one family carries risks as well as benefits, with the potential for splitting of the casework team an obvious risk. In addition, dual allocation may often not be feasible given resourcing issues. The key learning from this review is not that dual allocation is the only way forward, but that the provision of support to both the young parent and the child is needed. It is equally possible that one skilled worker could mobilise support for a young parent, while also keeping a child in focus. Successful outcomes have also been observed when young parents and their children have both been placed with an authorised carer. This can provide safety for the child while enabling the young parent to receive practical support and guidance. In some circumstances, the carer continues to provide support after the young family has left care.

The key message is that young parents who are assisted to increase their confidence and resources may increase their capacity to successfully transition into young parenthood. The transition of out-of-home care to the non-government sector may raise further opportunities for dual case management between sectors where the young parent is in out-of-home care or leaving care and there are child protection concerns for the child.

161 Mendes, 2009.

### **Supporting young parents to maintain links with a child who has been removed**

There are occasions when despite best efforts to keep children within their families, a young parent is not able to create a safe environment for their child. If this occurs, Community Services may remove a child from their family and bring the matter before the Children's Court. Some of the cases considered for this cohort review involved children who had been removed from their young parents, and placed in out-of-home care. Reviews of these cases have identified issues with how the young parent was supported to remain involved with the child after removal. For example:

*A child was placed in care after being removed from his young mother due to reported concerns about physical harm and poor parenting skills. The mother herself had an extensive child protection history, which included ongoing sexual abuse into her adolescence. After the removal of her child, the case was unallocated and Community Services eventually lost contact with the young mother. Consequently, the mother had no further contact with the child who had been removed.*

*Community Services later learned about the birth of the young mother's second child. This child was reported to Community Services with concerns about the mother's continued drug and alcohol use and domestic violence from her new partner. Community Services tried to engage the young mother and her partner; however, the parents were described as being very reluctant to engage with caseworkers. They did not attend scheduled*

*appointments and avoided caseworkers' attempts to contact them. The case was eventually closed due to the competing priority of other matters.*

The review found that:

*...the lack of contact and support that Community Services provided to the young mother after her child's removal had a significant impact on the continuation of a relationship between the child and mother. Poor engagement with the mother would have also impacted on any potential restoration of this child, should risk factors have improved. The review also found that the mother's relationship with Community Services as both a child and young mother, significantly affected her ability to seek support to care for her second child. It is likely that this contributed to her evasiveness when Community Services tried to engage with her after child protection reports were again received for the family.*

This cohort review has also identified cases where successful outcomes were noted for children who had been removed from their parents, but were able to maintain a positive relationship with their family.

*Community Services assumed care of the young parents' child at birth. The child was assessed as being at high risk of harm due to concerns about his parents' reported drug and alcohol use, domestic violence perpetrated by the young father, the unhygienic state of the home, and the intensive involvement of support services without any positive change demonstrated over a sustained period of time. Not long after the child was removed, the parents' relationship*

*ended. The young father's whereabouts became unknown.*

*The young mother's child protection history was characterised by allegations of sexual abuse, parental substance abuse and parental mental health problems. The mother came to the realisation that her childhood experiences were negatively impacting on her child, and wanted a better life for her child. She worked hard to have her child restored to her care. However, after a brief period of restoration, Community Services resumed care of the child after concerns about physical harm and poly drug use. The mother has maintained contact with her child with the support of caseworkers and the child's carers. The child has been observed to begin to recognise his mother as a significant person. In addition, the mother is working with Community Services to develop the child's cultural identity through contact.*

The review found that:

*...despite genuine attempts by Community Services and the family, the young woman was not able to demonstrate a capacity to sufficiently address the identified risk factors for herself and her child. It is positive that the mother was supported to maintain contact with her child. As long as this contact remains safe and child focused, it is likely to have a positive influence on shaping the child's identity, including cultural needs. If contact continues between the child and mother, it is also possible that this may increase the mother's confidence and capacity to parent in the future.*

Supporting a young parent to maintain a role in the life of a child who has been removed can be a difficult task to achieve. As discussed earlier, young parents may have feelings of mistrust towards Community Services, and this mistrust may continue if the parent's own child has been removed. However, as both of these reviews illustrate, the removal of a child does not need to signify the end of the relationship between the child and the parents. Child focused and safe contact between a child and his or her family has a range of advantages to the child. It can also lead to improved trust from the young parent towards Community Services, and increased capacity to parent successfully in the future.

### 3.3 Conclusion

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This chapter has examined the significant vulnerabilities that many young parents and their children face. It also reflects the unique opportunities that practitioners have to support a young parent family to overcome the intergenerational cycle of disadvantage.

The enduring challenges of child protection work – conducting holistic risk assessment, engaging families and maintaining a child focus – were evident in our review of young parent families. Our review also demonstrated that child protection work with young parent families requires a distinctive approach by practitioners.

We found three critical success factors for effective interventions with young parent families. Positive outcomes are more likely to be achieved when practitioners:

- recognise how a young parent's own childhood experiences, including a history of abuse and trauma, and their developmental stage, may impact on their parenting capacity
- understand a young person's motivations, goals and aspirations for their own children and target engagement strategies towards a shared aspiration that the child will have a better experience of childhood than the young parents had when they were children
- provide support to young parents to increase their parenting capacity coupled with a continued, persistent focus on the child.

Supporting young parents more effectively is an issue central to child protection reform. We hope that our staff, our partner agencies and the public will find the learning from our cohort review relevant and useful. Community Services is currently considering options for direct debate and dialogue on this important area of practice, in particular with our partner agencies in out-of-home care.

Chapter 4 summarises progress with reform initiatives highlighted in the *Child Deaths 2010 Annual Report*. The Chapter includes a particular focus on initiatives relating to young parents, particularly how the transfer of out-of-home care placements to non-government providers and an emphasis on leaving care plans may improve services to vulnerable young parent families.

# Chapter 4: Progress in child protection reform

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## Chapter overview

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The *Child Deaths 2010 Annual Report* explained the child protection system in NSW was part-way through a significant program of reform to capture the NSW Government's reform agenda and to continue to build on the work of Commissioner James Wood's 2008 Special Commission of Inquiry into Child Protection Services in NSW<sup>162</sup>.

There are a number of key themes to the work being undertaken. These include:

- helping parents to be responsible and reduce risks to their children
- reforming Community Services so it can focus on its core statutory child protection responsibilities
- using the expertise and capacity of government and non-government partners to give children and young people better and more stable lives in out-of-home care
- using and reforming programs with strong evidence bases, which helps to deliver better lives for vulnerable children and families.

This chapter considers progress in reform since 2010. In general terms, these reforms:

- address issues for vulnerable children and families including how caseworkers see the children and young people who need help
- consider how longer-term needs, rather than just immediate needs, receive attention
- focus on better engaging with parents, caregivers, children and young people
- improve how caseworkers address intergenerational risk factors, risk in early intervention, and assessing risk from new partners or adult household members.

Some of these topics have been discussed in Chapter 3. This chapter also outlines a number of specific initiatives that support young parents — a key vulnerable group identified in Chapter 3 of this report.

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<sup>162</sup> Wood, J. (2008). *Report of the Special Commission of Inquiry into Child Protection Services in NSW*. State of NSW. Available [www.dpc.nsw.gov.au](http://www.dpc.nsw.gov.au)

## 4.1 Current snapshot

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The NSW Government is committed to real reform of the NSW child protection system to make long-term improvements to services and lives.

Goal 13 of the State Plan, NSW 2021<sup>163</sup>, reflects the Government's commitment to "better protect the most vulnerable members of our community and break the cycle of disadvantage". These are bold targets the government is determined to meet.

Since the Coalition Government came to power in 2011, Community Services has begun reforming services to improve how the statutory child protection system can help vulnerable families. Through the *Community Services 2012-2014 Plan*, the government seeks to develop a culture of continuous learning and improvement in Community Services' practice and a commitment to evidence-based, sustainable solutions. The government has continued the investment in early intervention programs such as *Families NSW* and *Brighter Futures* (which is now wholly delivered by the non-government sector)<sup>164</sup> to engage families in services earlier and reduce risk.

The government has begun work to deliver a seamless service system that works for families. The transfer of out-of-home care to the non-government sector has begun<sup>165</sup> and Community Services now co-delivers with partner government agencies and NGOs integrated services across the child protection spectrum, from early intervention to leaving out-of-home care. The new *Strengthening Families* program is providing real help to families on the cusp of child protection intervention. Aboriginal Child and Family Centres, Family Referral Services and Child Wellbeing Units have been established and are linking vulnerable families to a range of support services in their local areas. The non-government sector's capacity to deliver services is growing exponentially, as is its expertise and ability.

The government is also implementing new collaborative systems and means to share information that has seen the delivery of more holistic and targeted services to support families. However, there is still more to do. Collaboration and data sharing between government and non-government agencies will keep a focus on outcomes and improving lives.

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The new *Strengthening Families* program is providing real help to families on the cusp of child protection intervention.

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<sup>163</sup> NSW 2021 can be accessed at <http://2021.nsw.gov.au/>. NSW 2021 commits to:

- reduce the rate of children and young people reported at risk of significant harm by 1.5% year
- reduce the rate of children and young people in statutory OOH by 1.5% year
- increase the proportion of NSW children who are developmentally on track in Australian Early Development Index domains.

<sup>164</sup> Early intervention and prevention services within *Brighter Futures* began to be entirely delivered across NSW by 16 non-government organisations (NGOs) from January 2012. *Brighter Futures* is still targeting families who have high and complex needs but do not meet the risk of significant harm (ROSH) threshold. Lead agencies now make decisions about which families will be offered *Brighter Futures* and are working directly with a range of agencies and referral sources to ensure that the program is offered to very vulnerable families at high risk of entering the statutory child protection system. The Early Intervention Council (consisting of NGOs, Community Services and other government agencies) was established in January 2011 to help *Brighter Futures* and early intervention services more generally deliver better outcomes for vulnerable families.

<sup>165</sup> The transfer of out-of-home care to the non-government sector began in March 2012. It is anticipated that the transfer will take between five and 10 years to complete with up to 3,800 children and young people being cared for by NGOs by June 2014. The 10-year timeframe is to enable Aboriginal agencies adequate time to build capacity to support Aboriginal children and young people, and carers.

## 4.2 A new horizon

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Family and Community Services (FACS) has set out in a bold new direction. Future services will focus on people not programs, work with individuals and families as early as possible, harness community capacity, and drive a results-focused organisation and delivery system.

This vision includes an ambitious suite of integrated reforms in legislation, policy and practice that are necessary to place Community Services on a more sustainable footing and improve the outcomes for at-risk children and young people. It builds on strong foundations and the strength of community and government partnerships.

At the centre of *Community Services 2012-2014 Plan* are reforms that:

- increase capacity and transform the current focus on systems, paperwork and reporting into a focus on working with families
- localise the service system by harnessing the capacity of non-government and government partners to deliver services to the most vulnerable
- reduce the risks of significant harm to children by seeing more families earlier and better targeting early intervention to help families take responsibility and change
- seek permanency for children in care by making decisions quickly about a home for life and focusing on their education and health needs
- do better for vulnerable adolescents by getting policies and programs right and encouraging innovative new approaches for this previously neglected age group, and
- increase the interconnectedness between FACS services for highly vulnerable families who require the services of multiple agencies.

Getting things right in these areas will provide a solid foundation to reduce the number of children and young people at risk of significant harm and in state care. It will also enable the system to revolve around what is most important — providing children and young people and their families the support they need when they need it.

## 4.3 Addressing gaps identified in the *Child Deaths 2010 Annual Report*

The *Child Deaths 2010 Annual Report* analysed themes from Community Services' review work, and identified six key themes where practice and systemic improvement is needed. *Community Services 2012-2014 Plan* makes a major contribution to identifying and establishing projects to address these gaps.

### 4.3.1 Capacity

The *Child Deaths 2010 Annual Report* and the Ombudsman's Special Report to Parliament *Keep Them Safe?*<sup>166</sup> highlights the significant gap between the number of children reported as potentially at risk of significant harm, and the number of children who receive a face-to-face assessment from Community Services.

Community Services is implementing a range of initiatives to remove blockages to productivity so that caseworkers see and help more children and young people and reduce risks. There are still too many overly burdensome procedures and practices that stop caseworkers from spending time directly with families that need them. Through building Community Services' organisational capabilities, the full potential of staff will be realised, which will lead to improved services and lives.

Community Services is committed to delivering technology and systems solutions that support casework efficiency and simplifying policies and procedures that guide practice.

For example, administrative and financial tasks have been transferred to non-casework staff where possible, record keeping requirements have been audited with redundant ones removed and a standardised set of templates for forms, letters and reports developed to improve workload and responsiveness. These changes release caseworkers to do more hands-on work with families. Casework procedures are also being streamlined: allowing caseworkers to better respond to the individual needs of children, young people and families.

Community Services is also enhancing capabilities in financial management and developing better information and performance systems. This is reducing the administrative burdens caseworkers face and leading to improved practices, information sharing, recording and accountability.

As part of the process of enhancing capabilities, Community Services has developed measures of performance. One of the measures is 'the proportion of children and young people at ROSH with a face-to-face assessment of service'. This measure will count those children and young people reported at ROSH who received any face-to-face service from Community Services or a funded NGO.

Making the child protection system more efficient also includes working with the Children's Court to continue with reforms to allow it to deal with matters efficiently and expeditiously. Procedures that do not assist the

Court yet unreasonably increase the administrative burden on caseworkers are being examined.

For example, significant time is also spent preparing specific documents and material for Court proceedings that may not ultimately be relied upon by the Court. Community Services has re-commenced discussions with the Court and the Legal Aid Commission with the aim of making changes to documentation processes and requirements.

Through stronger, efficient systems and simplified procedures, caseworkers will be freed up, given time to work with more families; improve the quality of casework; and give Community Services Centres more responsibility and decision-making power, recognising they are the ones who know what is best for their communities.

A better-connected service system will also see NGOs delivering more services, allowing Community Services to better focus on its statutory role of seeing children who are at risk of significant harm and working directly with those families who are approaching the statutory threshold. This will better help to keep children safe and lower the risks of significant harm.

166 NSW Ombudsman (2011). *Keep Them Safe? A special report to Parliament under s31 of the Ombudsman Act 1974*. NSW Ombudsman: Sydney.

### **4.3.2 Assessing cumulative and changing risk**

The *Child Deaths 2010 Annual Report* identified assessing cumulative and changing risk as a key issue in casework practice, and as one of the enduring challenges of child protection work in all jurisdictions. Community Services has implemented or is implementing a number of new tools to improve practice.

#### ***Structured Decision Making***

Community Services has introduced the Structured Decision Making (SDM®) risk assessment system to help caseworkers at the Child Protection Helpline and in Community Services Centres to better assess cumulative and changing risk. SDM® helps caseworkers assess risk and guides them in the decisions and actions they need to take to keep children safe from harm and is bringing positive changes to the way caseworkers work with families.

SDM® requires caseworkers to consider cumulative risk of harm to children and young people by systematically reviewing the current situation in the context of each family's history of child protection reports. This is done to establish whether the whole of that information considered together suggests that risk of significant harm to the child is greater than the concerns expressed in any one report or is escalating.

#### ***Safety Assessment and Risk Assessment***

The Safety Assessment and Risk Assessment (SARA) tools require caseworkers to review the safety of a child or young person when there is a change of circumstances by conducting a new safety assessment. It is a key requirement for caseworkers in applying these assessments in their practice that the child is sighted and spoken with (where appropriate) to directly observe any changes that may reflect a decrease or increase in immediate safety or future risk of significant harm.

In a 2011 review of the SARA trial, caseworkers were asked about the impact on the way they work with families to keep children and young people safe. The majority indicated that this had changed for the better; SARA led to more agreement in decisions being made about the safety of children and young people, enabled caseworkers to better focus on critical safety and risk issues to ensure children and young people were safe, and was easier and quicker to complete, allowing caseworkers to have more face-to-face time with families. Seventy-five per cent of caseworkers reported that the SDM® system made their jobs easier. Additionally, many caseworkers have reported finding that developing a Safety Plan with families is a very useful and concrete strategy, completed at the first home visit if necessary, to reinforce what parents need to do to help keep their child/ren safe.

#### ***Family Strengths and Needs Assessment and Restoration Assessment***

Similarly, in a 2011 review of the six-month trial of the Family Strengths and Needs Assessment (FSNA) and Restoration Assessment, which are tools used by caseworkers to assess children's and families' strengths and needs in order to case plan and determine whether restoration should proceed, caseworkers reported that these enabled more transparency in working with families, more time to spend talking with families and changed practice to enable more focus on strengths. Fifty-six per cent of caseworkers said that these assessments improved their ability to have difficult conversations with a family, with 75% stating that they more clearly distinguished the concepts of safety and risk.

Following this review the Restoration Assessment tool was endorsed for state-wide implementation, with an emphasis on its role in promoting change in casework practice.

### 4.3.3 Engaging with parents, caregivers and children

A key finding of the *Child Deaths 2010 Annual Report* was the need for greater, and more focused engagement with parents, caregivers and children during assessment and intervention. Speaking to all family members, but particularly to children and to fathers or male partners, is a key factor in assessing risk of significant harm and supporting change.

#### Training

A number of training and practice initiatives are underway to improve the way we work with families.

The SARA assessment requires caseworkers to include face-to-face contact with the family, sighting all children and interviewing children who are old enough to participate as part of the safety and risk assessment process.

Training to help caseworkers and Child Protection Helpline staff work better with men who use violence in the home was rolled out across NSW between October 2011 and April 2012. A one-day Domestic Violence Engagement and Assessment workshop for Casework Specialists was held in April 2011 to discuss family dynamics, complex case studies and explore ways to better support and engage families experiencing domestic violence, based on the latest research findings.

A number of new training packages on safety planning and risk assessment in domestic violence have been developed to build caseworker engagement skills with mothers, fathers and children and young people in households where domestic violence compromises child safety. Caseworker training was provided in October 2012.

Refresher training on child sexual assault was rolled out state-wide from September 2012, focusing on child sex offender grooming tactics, the process of disclosure for a child, and the reactions of the non-offending parent. A training DVD is being developed to build the capacity of caseworkers when they are interviewing the non-offending parent.

#### Family Group Conferencing

During 2011, NGOs, Legal Aid and Community Services worked together to roll out a pilot of Family Group Conferencing in 11 Community Services Centres. Family Group Conferencing aims to resolve care and protection matters without families and Community Services having to go to court. To do this it empowers families, through conferences, to develop, implement and manage Family Plans that address identified child protection concerns and gives families greater participation in decision-making processes about keeping their children and young people safe. It has provided a unique vehicle to allow NGOs to participate developing Family Plans in a statutory child protection context. The pilot has been evaluated by the Australian Institute of Criminology.

### 4.3.4 Working with intergenerational risk factors

The *Child Deaths 2010 Annual Report* identified intergenerational child protection concerns including domestic violence, parental substance misuse and mental illness in the histories of many of the families. It can be difficult for people to care for their children when they themselves were abused and neglected during their childhood and have had no adult role models in their life to provide a healthy example of how to parent.

Complex families with intergenerational child protection concerns require the services of multiple agencies to keep their children safe. However, services to complex families are often fragmented efforts from individual agencies that are not always well directed or designed. The human and economic cost is a significant policy challenge. All government agencies and NGOs working with these families have a responsibility to stay child-focused and keep children safe.

Change is hard for many families, particularly those with entrenched intergenerational parenting problems. Understanding the importance of parental accountability for these families takes time. A seamless and collaborative effort from Community Services, the non-government sector and government agencies will be needed to drive the change that children in these families need. It will also require caseworkers to change the way they work with families.

A key goal of Community Services' reforms is to make the child protection system even more connected to remove blockages that stand in the way of helping families suffering intergenerational disadvantage.

### *Initiatives to improve the way we work with families*

Community Services has begun trialling *Practice First* — a new way for caseworkers to work with families. This is an innovative model that enables caseworkers to work in teams to share responsibility for assessing safety and risk and help families stay together. *Practice First* will be rolled out in 16 Community Service Centres by December 2012.

FACS is working to streamline its interactions with clients who have multiple and complex needs. An interagency case coordination framework, Integrated Case Management, is being developed specifically to address the needs of families with intergenerational parenting issues. Programs such as Family Case Management, Supporting Children Supporting Families and Complex Case Panels are being streamlined to ensure that coordinated case management can be delivered across all FACS divisions and with other government agencies and NGOs to families suffering the effects of intergenerational disadvantage and child protection concerns.

This work will help to bring together the right services (housing, disability services, family support and child protection services) for clients at the right time. It will also help to focus on improving services for homeless people, reducing domestic and family violence, and increasing the participation of people with a disability in employment and training.

### **4.3.5 Working with risk in early intervention**

One of the key issues that emerged in the *Child Deaths 2010 Annual Report* was a challenge in preventing cases from falling into a 'service gap'. This gap arose because the risks some families faced were too high to receive help from *Brighter Futures*, but capacity and program constraints in the statutory system did not allow these cases to be allocated to a child protection caseworker.

To address this, Community Services launched the *Strengthening Families* program. *Strengthening Families* is a statutory program focused on improving the long-term safety and wellbeing of children under nine years of age (including unborn children) who, following a risk of significant harm report to the Child Protection Helpline, are assessed as being at the highest risk of future abuse or neglect. *Strengthening Families* caseworkers engage with parents to seek their active involvement in case planning and decision making. Families are supported to reduce risks and achieve case plan goals in order for their children to continue to live safely at home for the long term.

At the same time, the government introduced a number of changes to *Brighter Futures* in January 2012.

*Brighter Futures* is now being wholly delivered by the non-government sector, and the program is better targeted to help complex families with children at high risk of entering the statutory child protection system. Child Wellbeing Units, individuals and other agencies are now also able to refer families directly to the program, and NGOs are able to determine eligibility. All non-government staff delivering *Brighter Futures* monitor risk and safety concerns for children participating in the program and report concerns where necessary to the Child Protection Helpline. Information can now also be more easily exchanged between *Brighter Futures* staff relating to the safety, welfare or wellbeing of a child.

### 4.3.6 Assessing risk from new partners or adult household members

The *Child Deaths 2010 Annual Report* identified that new partners are sometimes overlooked in risk assessments. In June 2012, Community Services developed a new practice tool to support frontline caseworkers in their work with families when new people join a household.

#### *New assessment tools and processes*

The New Partners and New Household Members Practice Tool, introduced in August 2011, is now used by caseworkers to review a child's safety when the composition of adult family members in a household changes, or a new adult enters the family. The tool also means that caseworkers now do not need to wait for a risk of significant harm report to be received prior to making enquiries about a new partner or adult household member.

As part of their assessment, caseworkers are guided to explore what experience the new partner/ household member has had with children, their understanding of children's needs and development, and what it may mean for the child if this person takes on or shares primary carer responsibilities. The tool includes strategies to promote engagement and disclosure by the family regarding new adult household members and a list of agencies that may provide additional information.

Community Services and the Association of Child Welfare Agencies co-hosted a series of cross-sector roundtables in March and May 2012 aimed at developing a shared approach to the assessment and probity checking of authorised carers and adult members of carer households, including new partners. The roundtable has proposed that there should be consistent cross-agency standards for probity checking and assessment of authorised carers and members of carer households, and that the arrival of a new partner in a carer household should trigger either review or reassessment.

#### *Information exchange with NSW Police Force*

Community Services has also been working with Corrective Services and the NSW Police Force to improve information exchange and collaboration when a child may be at risk of significant harm due to contact with a person on the Child Protection Register (registered persons with convictions for murder, kidnapping or sexual offences against children). This contact could come about when a person on the Child Protection Register starts or resumes a relationship with the mother of a vulnerable child.

An interagency working group is developing a range of practical strategies to ensure that Corrective Services can take into account information Community Services has when making decisions about the probation and parole of people on the Child Protection Register. The strategies are also designed to ensure that Community Services has comprehensive information when assessing risk to a child, and that police have the support of partner agencies for action they may take.

#### *Carers' Register*

The NSW Children's Guardian is developing a central Carers' Register of persons who have been authorised, or are applying for authorisation, to provide out-of-home care in NSW. The objective of the register is to reduce the risk of inappropriate authorisation of carers. To achieve this objective, the register is being designed to record the completion of minimum requirements for authorisation of carers, including requirements relating to household members, and to support information exchange between designated agencies. Designated agencies are the agencies which authorise and supervise carers in accordance with the *Children and Young Persons (Care and Protection) Act 1998* and the *Children and Young Persons (Care and Protection) Regulation 2012*.

#### *Working With Children Check*

Currently adult members of carer households are required to undergo a Working With Children Check to determine whether it is appropriate for the person to reside at the home of an authorised carer. The current requirement that these checks be undertaken on any adult household member if they have been residing in the carer, or prospective carer's home on a regular basis for a period of not less than three months may reduce to three weeks if the proposed Regulation commences.

## 4.4 Specific initiatives to support young parents

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Chapter 3 of this report indicated strengths and issues in supporting young parents. A number of the cases that were reviewed indicated that caseworkers need to get better at assessing a young parent's capacity to parent in the context of their own experiences of childhood abuse and neglect, working with young people leaving state care who have children, supporting young parents who are already showing signs of vulnerability with their parenting skills, and supporting young parents to continue a positive relationship with their child if the child has been removed.

These are significant challenges to break the cycle of disadvantage, and help young parents and their children realise their full potential. Community Services is already implementing a number of important reforms to begin the process of achieving this.

### Support for young parents

Young parents or pregnant young women in care or leaving care are now receiving priority access to both *Brighter Futures* and *Strengthening Families* to build their parenting capacity. This includes access to the full range of services provided in both programs including quality children's services, parenting programs, home visiting and casework focused on parent vulnerabilities to help address the issues which place their children at risk.

In July 2011, as part of the service system realignment, additional funding of over \$11 million per year was provided through Keep Them Safe to NGOs state-wide

to provide services under the new *Early Intervention and Placement Prevention Program*, which was developed to better reflect state plan priorities and Keep Them Safe directions. This program aims to provide an integrated system of appropriately targeted child, youth and family support services to reduce the likelihood of children and young people entering or remaining in the child protection and out-of-home care systems.

There is also significant work underway to improve the parenting capacity of young parents when risk of significant harm issues have been identified and reported to Community Services. The goal is to keep the children of young parents out of state care and at home safely.

Family Preservation and Restoration Services are being provided as part of a trial being conducted in close collaboration with NGOs to increase the use of short-term court orders while parents are supported through intensive casework and support services to improve their parenting skills and successfully resume the care of their children.

Social Benefit Bonds are also being trialled in the out-of-home care program. Social Benefit Bonds will bring a new source of funding to expand investment in early intervention and prevention services in a sustainable way. The pilots will focus on offering parents support to take care of children without the need for foster care. The first pilot is a consortium of the Benevolent Society, Westpac Corporation and the Commonwealth Bank of Australia, with a proposed bond of approximately \$10 million over five years.

The second pilot is with UnitingCare Burnside, which will work directly with families who have children aged zero to five years under the 'Newpin' program. This will occur in a number of locations, with a proposed bond of around \$10 million over seven years.

### Support for vulnerable teenagers

Throughout 2012, Community Services has led a review of all FACS policies and programs for highly vulnerable teenagers to identify reforms that will better support these young people. The review sought input from NGOs, external experts and young people.

A particular focus will be placed on identifying the factors that influence the early disengagement of teenagers from their families, communities and education, which is known to increase the risk that they will enter out-of-home care, become homeless, misuse drugs and alcohol, develop mental health problems, and participate in criminal activity.

In 2011, following consultation with the Early Intervention Council, the NSW Government decided that it would redirect \$10 million per year of Community Services early intervention funding to the non-government sector to trial innovative services for nine- to 15-year-old children and young people who are reported to Community Services as being at risk of significant harm. The services will prioritise Aboriginal children, young people and their families, and are intended to ensure that children and young people at risk of significant harm can stay safely at home.

As part of work to improve the lives of vulnerable adolescents, Community Services is currently implementing the Regional Child Protection Adolescent Response so that there will be an adolescent response and/or teams across all regions in NSW. This initiative aims to:

- increase the effectiveness of Community Services' response to risk of significant harm reports about adolescents
- enhance caseworker knowledge and skills in working effectively with adolescents and their families
- strengthen interagency partnerships with a focus on enhancing collaborative and coordinated service intervention in adolescent casework.

Strategies to meet these aims have been determined regionally, taking into consideration available resources and regionally specific priorities. In some regions, Child Protection Adolescent Teams' core functions will be to provide case management of children and young people aged 12 to 17 years who are at risk of significant harm. In other regions, strategies to meet the aims are being implemented across the existing structure of Community Services Centres and child protection teams. This will ensure that caseworkers across the state will be able to make well informed decisions to better support and improve services for young people.

### **Support for young people with complex needs**

A state-wide Adolescents with Complex Needs Panel has recently been established for young people aged from 12 to 18 years where the current service system has been unable to meet their complex needs. The panel will target adolescents who exhibit challenging/risk-taking behaviours of such intensity, frequency and duration that they place themselves or others at serious risk. Their behaviours may be life-threatening, or they may be at risk of their placement breaking down or have complex mental health presentations which impair their ability to participate in ordinary life.

The panel is currently chaired by Ageing, Disability and Home Care, and members include Community Services, Housing, Juvenile Justice, Aboriginal Affairs, the Department of Education and Communities, and the NSW Ministry of Health.

### **Support for young people leaving care**

It is important that all children and young people in out-of-home care, and particularly young parents, leave care with strong health and education outcomes that give them the best possible opportunity to lead a healthy adult life with stable employment. It is also vital that young parents are supported as much as possible to complete their schooling while caring for their children. Providing appropriate support to young people leaving state care, is a key area that will be improved through a number of specific initiatives.

From 2012, the NSW Government will provide primary health assessment referrals and health and education plans for all children and young people in out-of-home care to ensure that their health and

education needs are being met. The government has also introduced the Teenage Education Payment, which provides up to \$6,000 each year to carers of 16- and 17-year-olds in care who are at school or in training, to help with a range of costs.

Community Services will also continue to implement the Memorandum of Understanding it has with the Department of Education and Communities that governs the way the educational needs of children and young people in out-of-home care who attend government schools are met.

To provide out-of-home care, all agencies must be accredited by the Children's Guardian, or be participating in the Quality Improvement Program. These standards will demonstrate the ability and capacity of accredited NGO out-of-home care providers to manage young people who are leaving care. The implementation of NGO casework practice standards will facilitate integrated and flexible leaving care plans which will ultimately contribute to better outcomes for young people leaving care.

Through the government's reform agenda, the *Community Services 2012–2014 Plan* aims to address many of the challenges facing the child protection system that have been identified through the tragic outcomes presented in this report and reposition it to put families at the centre of attention to minimise the risks facing vulnerable children and young people.

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## WEBSITES

<http://www.sidsandkids.org>

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[http://www.marchofdimes.com/pregnancy/alcohol\\_illicitdrug.html](http://www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html)

[http://www.nspcc.org.uk/Inform/resourcesforprofessionals/children\\_under\\_one\\_statistics\\_wda79305.html#Homicide\\_statistics](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/children_under_one_statistics_wda79305.html#Homicide_statistics)

# Glossary

## **ABORIGINAL AND/OR TORRES STRAIT ISLANDER**

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

## **ABUSE**

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

## **ALLOCATED CASE**

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

## **AUTHORISED CARER**

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

## **BRIGHTER FUTURES**

Community Services' *Brighter Futures* early intervention program provides families with the necessary services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing. The transfer of the *Brighter Futures* program has been finalised, with Early Intervention and Prevention Services now delivered across NSW by non-government organisations.

## **CASE CLOSURE**

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

## **CASE PLAN**

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

## **CASEWORK**

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

## **CASEWORKER**

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

## **CASEWORK SPECIALIST (CWS)**

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

## **CHILD**

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

## **CHILD PROTECTION HELPLINE**

The Child Protection Helpline provides a centralised system for receiving reports about unborn children, children and young people who may be at risk of significant harm. It operates 24 hours a day, 7 days a week.

## **CHILD WELLBEING UNIT (CWU)**

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

## **CHILDREN'S COURT**

The court designated to hear care applications and criminal proceedings concerning children and young people in NSW.

## **COMMUNITY SERVICES CENTRE (CSC)**

The locally based Community Services offices. There are 82 CSCs across New South Wales.

## **DOMESTIC VIOLENCE**

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

## **DRUG AND/OR ALCOHOL ABUSE**

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

## **ENGAGEMENT**

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

## **FAMILY REFERRAL SERVICES**

Family Referral Services (FRS) assist children, young people and families who do not meet the statutory threshold for intervention, but would benefit from accessing specific services to address current problems and prevent escalation. FRS provides information and assists entry into a range of local support services. FRS is a referral service for use by government agencies and non-government organisations. Referral services may include case management, home visiting, intensive family support, quality child care, housing, parenting education, supported playgroup, drug and alcohol/mental health services, youth support services or respite care.

## **KEY INFORMATION AND DIRECTORY SYSTEM (KIDS)**

Community Services' electronic system for keeping records and plans about children, young people and their families.

## **MANAGER CASEWORK**

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

## **MANDATORY REPORTER**

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

## **MEDICAL EXAMINATION**

Pursuant with section 173 of the *Children and Young Persons (Care and Protection) Act 1998*, if the Director General or a police officer believes on reasonable grounds that a child is in need of care and protection, the Director General or the police officer may serve a notice naming or describing the child requiring the child to be forthwith presented to a medical practitioner specified or described in the notice at a hospital or some other place so specified for the purpose of the child being medically examined. The notice is to be served on the person (whether or not a parent of the child) who appears to the Director General or the police officer to have the care of the child for the time being.

## **MENTAL HEALTH CONCERNS**

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

**NEGLECT**

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

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

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

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

**ORDER**

An order of a court or an administrative order.

**OUT-OF-HOME CARE**

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

**PARENTAL RESPONSIBILITY**

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

**PARENTAL RESPONSIBILITY TO THE MINISTER**

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

**PHYSICAL ABUSE OR ILL-TREATMENT**

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

**PRENATAL REPORT**

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

**REMOVAL**

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

**REPORT**

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

**REPORTER**

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

## RESTORATION

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

## RISK OF HARM ASSESSMENT

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

## RISK OF SIGNIFICANT HARM (ROSH)

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

- (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met
- (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
  - (b1) in the case of a child or young person who is required to attend school in accordance with the *Education Act 1990* — the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act
- (c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated

- (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm
- (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm
- (f) the child was the subject of a prenatal report under Section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.

## RISK-TAKING BEHAVIOURS

Includes but is not limited to:

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

## SAFETY AND RISK ASSESSMENT (SARA)

SARA is a SDM<sup>®</sup> system for assessing risk. The goals of the system are to determine risk to children and young people through a structured process of information gathering and analysis. This is intended to produce more methodical and thorough assessments. SARA includes three distinct tools: Safety Assessment, Risk Assessment and Risk Re-assessment.

## SEXUAL ABUSE OR ILL-TREATMENT

This is any sexual act or threat to a child or young person which causes that child or young person harm, or to be frightened or fearful. Coercion, which may be physical or psychological, is intrinsic to child sexual assault and differentiates such assault from consensual peer sexual activity.

## STRENGTHENING FAMILIES

Community Services' established *Strengthening Families* program provides a differential child protection response to families where there are both high levels of long-term risk and the children are currently assessed as being at risk of significant harm. The *Strengthening Families* program is aimed at keeping these children living safely at home through effective interventions with the family. Where families seek to withdraw from the program, Caseworkers will conduct an assessment to determine the appropriate follow-up action required.

## STRUCTURED DECISION MAKING (SDM<sup>®</sup>)

SDM<sup>®</sup> aims to achieve greater consistency in assessments and support professional judgement in decision making. The SDM<sup>®</sup> process structures decisions at several key points in case processing through use of assessment tools and decision guidelines.

### **SUPERVISION (formal)**

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

### **SUPERVISION (informal)**

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

### **TASKS**

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

### **TRIAGE AND ASSESSMENT PRACTICE GUIDELINES**

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

### **WEEKLY ALLOCATION MEETING (WAM)**

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

### **YOUNG PERSON**

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



