



Family &  
Community  
Services

# Child Deaths 2013 Annual Report

Learning to improve services



## A note about this report

A number of stories, based on real cases, are used in this report to draw attention to important learning for practitioners and families about child safety. Names have been changed for privacy reasons. These stories might be confronting for readers. In particular, Aboriginal communities might find some of the report's findings and stories about Aboriginal and/or Torres Strait Islander children distressing. A list of support and counselling services is provided at Appendix 2 of this report.

# Contents

List of figures and tables	2
Minister's foreword	3
Secretary's foreword	4
Executive summary	5
Child deaths in 2013	5
Safer sleeping	6
Improving the way we work with children and families	7
<b>Chapter 1: Child deaths in context</b>	<b>8</b>
1.1 Child protection in NSW	8
1.2 Examining child deaths	8
<b>Chapter 2: Child deaths in 2013</b>	<b>14</b>
2.1 Child deaths in NSW in 2013	14
2.2 Circumstances of child deaths	15
2.3 Characteristics of the children	24
2.4 FACS response to the children who died	28
<b>Chapter 3: Safe sleeping</b>	<b>36</b>
3.1 SUDI and child deaths: 2008–12	36
3.2 Practice themes	45
3.3 Stories with good outcomes	47
3.4 Important final messages to remember	48
<b>Chapter 4: Progress in child protection reform</b>	<b>50</b>
4.1 The FACS Strategic Statement	50
4.2 Fewer children and young people are vulnerable to abuse and neglect	51
4.3 Children and young people at risk of significant harm are safer	51
4.4 Improving the future for children and young people in OOHC	53
4.5 A capable organisation and service system	53
4.6 Improving the way we work with children, young people and families	54
4.7 Conclusion	59
References	60
Appendix 1 Causes of death of children in 2013	63
Appendix 2 Counselling and support services	64
Glossary	65

# List of figures and tables

## List of figures

- Figure 1:** Circumstances of death for children and young people who died in 2013 and were known to Family and Community Services.
- Figure 2:** Children and young people who died in NSW, compared to children who died and were known to Family and Community Services, 2008 to 2013.
- Figure 3:** Circumstances of death for children and young people who died in 2013 and were known to Family and Community Services.
- Figure 4:** Age of children and young people known to Family and Community Services who died in 2013.
- Figure 5:** Number of Aboriginal and/or Torres Strait Islander and non-Aboriginal and Torres Strait Islander children who were known to Family and Community Services and died between 2008 and 2013.
- Figure 6:** Circumstances of death for children who died between 2008 and 2013 and were known to Family and Community Services, by Aboriginality.
- Figure 7:** Number of reports received for children and young people who died and their families.
- Figure 8:** Reported ROSH concerns for the families of the children and young people who died in 2013.

## List of tables

- Table 1:** Circumstances of death for children and young people who died between 2010 and 2013 and were known to Family and Community Services.
- Table 2:** Children and young people who were known to Family and Community Services and died from an illness and/or disease between 2010 and 2013.
- Table 3:** Babies who were known to Family and Community Services and died suddenly and unexpectedly between 2010 and 2013.
- Table 4:** Babies who were known to Family and Community Services and died from conditions related to their premature birth between 2010 and 2013.
- Table 5:** Children and young people who were known to Family and Community Services and died in a motor vehicle accident between 2010 and 2013.
- Table 6:** Children and young people who were known to Family and Community Services and died by suspected suicide between 2010 and 2013.
- Table 7:** Children and young people who were known to Family and Community Services and died after drowning between 2010 and 2013.
- Table 8:** Overrepresentation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures.
- Table 9:** Children and young people who were living in out-of-home care when they died between 2010 and 2013.
- Table 10:** Causes of death for children and young people who died in 2013 and were known to FACS via ICD code.

## Minister's foreword

The loss of a child's life is always a tragedy, no matter the circumstances. It is important that Family and Community Services (FACS) seeks answers to the understandable questions that may be asked by the families and communities of these children, as well as the public, about its role in the life of a child who died.

In doing so, there is a careful balance to achieve because we need to respect the privacy and confidentiality of these children and their families. This is why the *Child Deaths Annual Report* is such an important way to fulfill the government's commitment to be accountable and transparent about how FACS worked with these children.

The Child Deaths 2013 Annual Report is the fourth annual report about the deaths of children and young people who were known to FACS before they died. This report considers the cases of 75 children and young people who died in 2013 and were known to FACS (chapter 2), as well as 108 babies who died suddenly and unexpectedly between 2008 and 2012 (chapter 3).

This report also shares the learning from these cases, not just with FACS caseworkers, but with all practitioners who work with families, including those who work for other government and non-government organisations. This is one of many ways we improve the NSW child protection system.

During my first year as Minister for Family and Community Services, I have met with many caseworkers in the field. I am continually inspired by their commitment to keep children at the heart of their practice. I know this isn't always easy. It takes unwavering courage to advocate for children, and I'm grateful that our community has such a dedicated FACS workforce.

The 2014–15 State Budget delivered more support for children and young people in the child protection system. One of the NSW Government's priorities is building on the strengths of caseworkers by allowing them to be more mobile so they spend less time at their desks and more time with vulnerable families and children. In October 2014 a number of legislative changes commenced, which are designed to improve the NSW child protection system and provide permanency for those children who cannot live at home safely. Casework staff will now be better supported than ever before in their work with vulnerable families. This report is another way we can continue to strengthen the child protection system.



**Gabrielle Upton**  
Minister for Family and Community Services

## Secretary's foreword

It is difficult to make sense of the death of any child, no matter the circumstances. The sorrow and loss families experience is life changing and unimaginable to those not affected. Yet the distress is not just felt by families and communities. Our practitioners who had worked with the child and their family, those good men and women on our frontline, also commonly experience feelings of intense grief, alongside a natural response to reflect about how the system could have worked differently.

These reflections and questions can be difficult to answer, particularly in child protection work. Child deaths are not usually predictable or preventable. But they do present a rare opportunity for FACS to learn and improve. That is why we review each and every case where a child who has died was known to our department. Taking an honest look at our own practice is never easy, not for me as Secretary, and not for our caseworkers who do the testing job of trying to protect vulnerable children every day. Our staff are always willing to take part in child death reviews, to reflect on their own practice, and to talk openly about how the system may have helped or hindered their work. This is one of the many remarkable qualities of our courageous practitioners and my sincere thanks go to all of the caseworkers and managers who have actively participated in child death reviews over the years.

You will note that this report is slightly different from the reports in previous years. Instead of only talking about the deaths in data and statistics, we also tell the stories of some of the children. We've done this to better communicate that every child was an individual person with a life and story of their own. We also hope it will help to engage practitioners and the community, to highlight the complexities of child protection work and help practitioners learn from real practice examples.

This report also details how improving the quality of our practice remains a top priority for FACS. Legislative reform has laid the foundation for implementing Safe Home for Life – a range of initiatives to achieve better outcomes for children and young people through permanency planning, building parenting skills and strengthening our capacity for child-focused case work. FACS work on organisational design over the last 12 months has placed us in a strong position to tackle the challenges ahead. The publication of the FACS Strategic Statement, bedding down of the new district structure and significant work in the realignment of the central functions of the department, will all contribute to supporting localised, responsive service delivery. Finally, I would like to acknowledge that this report was written by the FACS Child Deaths and Critical Reports Unit. The unit is part of the Office of the Senior Practitioner and is made up of a small group of dedicated and passionate people who review the death of every single child known to FACS. I would like to thank the unit for their work that helps to improve our practice and make children safer.



**Michael Coutts-Trotter**  
Secretary, Family and Community Services

# Executive summary

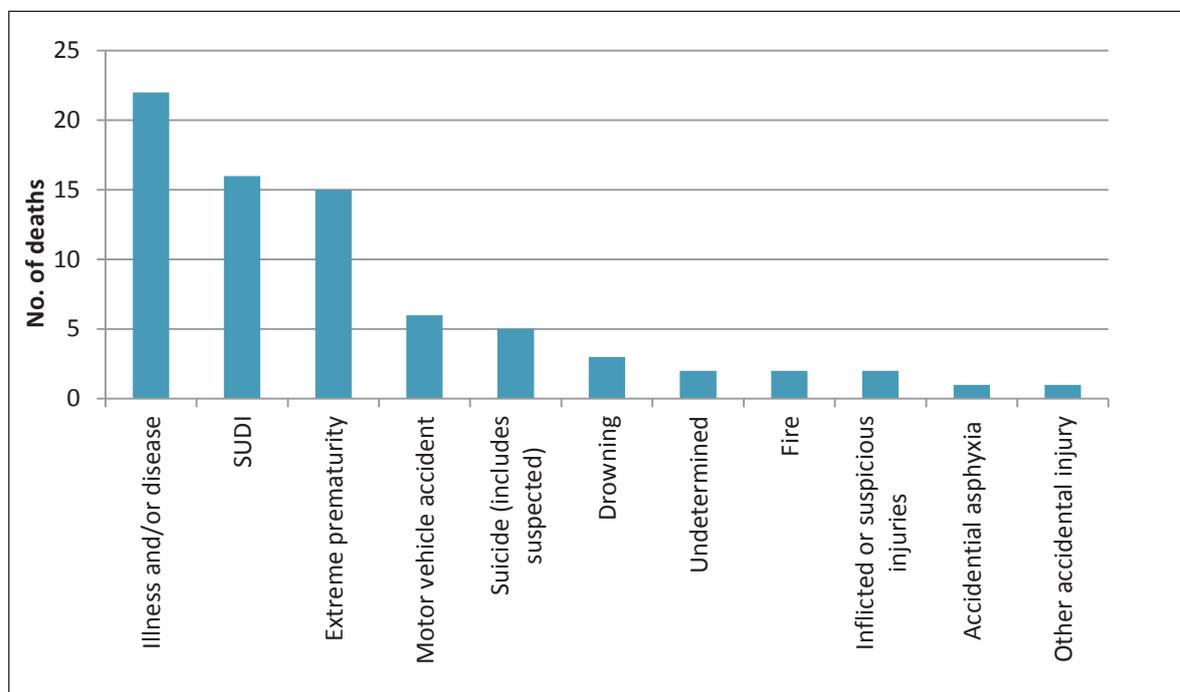
The *Child Deaths 2013 Annual Report* is Family and Community Services' (FACS) fourth public report examining our involvement with the families of children and young people who died and were known to FACS.

By providing contextual information about the deaths of children who were known to FACS, this report aims to provide learning opportunities for all practitioners who work with children, whether they are within the child protection system or providing other services to families. The report also aims to enhance the public's understanding of the complexities of child protection work and the underlying factors of disadvantage that affect so many families in NSW.

## Child deaths in 2013

Chapter 2 of this report summarises information about the 75 children and young people who died in 2013 who were known to FACS<sup>1</sup>. As outlined in Figure 1, most of these children died in circumstances related to illness, disease or extreme prematurity. Sixteen babies died suddenly and unexpectedly, meeting the criteria for Sudden and Unexpected Deaths in Infancy (SUDI). Five children and young people died by suicide and two children died of suspicious or inflicted injuries.

**Figure 1: Circumstances of death for children and young people who died in 2013 and were known to Family and Community Services.**



<sup>1</sup> 'Known to FACS' includes children and young people (or their sibling/s) who were the subject of a risk of significant harm report within three years of the death.

Almost half (47 per cent) of the children and young people who died in 2013 were Aboriginal and/or Torres Strait Islander, highlighting the concerning overrepresentation of Aboriginal children in child protection and child death figures. This overrepresentation has increased over the years – 30 per cent of children in 2011 and 32 per cent of children in 2012 who died and were known to FACS were Aboriginal and/or Torres Strait Islander.

Six children and young people were not living with their immediate families at the time of their deaths, including four children who were under the parental responsibility of the Minister.

Most of the children (48 children or 66 per cent) who died in 2013 were the subject of a Risk of Significant Harm (ROSH) report within three years of their death. The remaining children were not directly reported but their siblings were the subject of a report within three years of their death.

In 52 (69 per cent) of the cases, FACS completed a face-to-face assessment with the family before the child died. In 42 of the 52 cases, the assessment occurred within the three years prior to the child's death. Twenty three (31 per cent) families did not receive a face-to-face assessment due to the higher priorities of other matters (17 cases), the case still being open at the time of the child's death (four cases) or an assessment not being required (two cases)<sup>2</sup>.

Following the child's death, 33 (44 per cent) of the families received a face-to-face assessment by FACS, while 42 (56 per cent) did not due to no response being required<sup>3</sup> (40 cases) or the higher priority of other matters (two cases).

## Safer sleeping

FACS recently completed a cohort review of the deaths of 108 babies who died suddenly and unexpectedly, meeting the criteria for Sudden and Unexpected Death in Infancy (SUDI)<sup>4</sup>. Chapter 3 of this report provides a summary of the major findings of the review with a particular emphasis on how practitioners, both within and outside FACS, can improve their practice with families with young babies. The full report, *Safe sleeping: supporting parents to make safer choices when placing their baby to sleep*, can be found at [www.facs.nsw.gov.au](http://www.facs.nsw.gov.au)

While SUDI occurs in all families, sadly these deaths are more prevalent in families known to the child protection system. These families are often disadvantaged, poorly resourced and have a range of vulnerabilities including unemployment, lower parental educational achievement, transience, young parenting, domestic violence, parental mental illness and parental alcohol or drug misuse. These problems can impact on parents' abilities to make safe choices when they place their baby to sleep.

The *Safe sleeping* review builds on the substantial work already undertaken within FACS to support parents to make safer choices when placing their babies to sleep. The review found there was at least one modifiable risk factor known to increase the risk of SUDI in nearly all of the 108 deaths reviewed, and three or more modifiable risk factors were identified in over three quarters of the deaths reviewed. The majority of the 108 babies died while sleeping somewhere other than their cot. Many were sharing a sleep surface with a parent affected by drugs or alcohol. Others had loose bedding or were surrounded by cigarette smoke. In some cases all of these risk factors were evident at the time of the baby's death.

A number of de-identified stories, are used to highlight important themes for practitioners who work with families with young babies. These stories are not used with the intention of judging the actions or decisions of the people who were caring for the babies when they died. It is not just the role of the child protection caseworker or the midwife to make sure that

<sup>2</sup> FACS determined that an assessment was not required after further intake work at the CSC.

<sup>3</sup> FACS determined that a response was not required in these cases due to no siblings living in the same household (21 cases) and no risk issues being identified for the siblings (19 cases).

<sup>4</sup> These deaths were identified and provided by the NSW Child Death Review Team (CDRT).

parents can make informed decisions about safe sleeping; it is the job of every practitioner who has contact with families, regardless of their expertise.

Chapter 3 discusses the links between SUDI and child protection, then integrates information known about the characteristics of the babies (for example their ages, gender and cultural background) with observations made about the babies' sleeping arrangements. The chapter also discusses three key practice themes:

- assessing risk for unsafe sleeping
- working with parents who are reluctant to change unsafe sleeping practices
- the importance of not assuming prior knowledge and changed behaviour.

## Improving the way we work with children and families

Work to reform and improve the child protection system has progressed significantly since last year's 2012 *Child Deaths Annual Report*. Our partnerships with non-government organisations have continued to grow in the areas of early intervention, child protection and out of home care.

Significant legislative reform through the Safe Home for Life initiatives aim to strengthen the child protection system by giving parents, courts and caseworkers the tools they need to improve vulnerable children's lives. A range of other innovative initiatives were expanded and consolidated during the year, including:

- additional Practice First sites across the state (bringing the total to 24)
- ongoing capacity building around clinical issues that staff encounter in their day to day work with families
- the launch of a new Practice Framework and the re-alignment of our Care and Protection Practice Standards to reflect the framework.

These reforms are detailed in Chapter 4 of this report.

# Chapter 1: Child deaths in context

## 1.1 Child protection in NSW

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

Our caseworkers work with some of the most vulnerable children and families in our community. Many of these families are subject to social and environmental factors such as low socio-economic status, lack of access to services, parental unemployment, homelessness and social isolation. These problems can contribute to domestic violence, substance abuse and mental health issues in families, which are leading concerns in many of the risk of significant harm reports made about children in NSW and are clearly linked to child abuse and neglect<sup>5</sup>.

An intergenerational cycle of disadvantage commonly underpins the abuse and neglect of children, particularly for vulnerable groups such as young parent and Aboriginal and/or Torres Strait Islander families. For Aboriginal and/or Torres Strait Islander people, a history of trauma and dispossession has exacerbated these inequities, resulting in higher rates of disadvantage in these communities<sup>6</sup>.

## 1.2 Examining child deaths

### 1.2.1 Why review child deaths?

While most children die from causes or in circumstances that were not related to the reasons for their child protection reports, the fact remains that children in NSW with a child protection history have a higher mortality rate than children without this history<sup>7</sup>. This is one of many symptoms of the chronic disadvantage that many vulnerable children live with, and why it is important to review FACS involvement with the families of children who have died.

There is always the risk that child death reviews can be counterproductive. In a recent paper, leading child protection researchers Andrew Turnell and Eileen Munro discuss problems with the traditional approach to reviews that focus on finding 'lessons' and developing recommendations on how to avoid similar mistakes in the future. They discuss how child protection organisations can respond to child deaths in a more constructive way.

Western culture in general, and child protection agencies in particular, have been increasingly co-opted into the myth that every risk is calculable, every problem solvable and every death chargeable to some professional's account. This sensibility escalates blame and defensiveness<sup>8</sup>.

Turnell and Munro argue that an agency's focus on pursuing 'unattainable certainty' leads to practitioners protecting themselves defensively in all aspects of their work, rather than being able to focus on helping children and families. Our own review work has also highlighted this risk, particularly for staff involved with child death cases that receive extensive and critical coverage in the media. This type of defensive response is potentially dangerous for practice as it raises the risk that casework staff may be overly cautious, leading to them taking an

5 FACS, 2014a.

6 Australian Institute of Health and Welfare, 2014.

7 The NSW CDRT found that children with a child protection history had 1.4 times the mortality rate than children without a history (NSW CDRT, 2014b).

8 Turnell A, Munro E & Murphy T, 2013.

overly intrusive approach with families and not recognising opportunities to build safety for a child within their family. Defensive practice can also paralyse the judgement of a practitioner and reduce their belief that families can achieve positive change<sup>9</sup>.

Changing the way we work with families must start at an organisational level, where leaders need to acknowledge the uncertainty of the work and share the anxiety between workers and management. The FACS Care and Protection Practice Framework provides a foundation to support work with families and addresses core areas of practice including relationship-based practice, critical reflection, developing expertise and sharing risk. Within this framework, our child death review work acknowledges that reviews are one of many ways that we can create a culture of continual learning by encouraging caseworkers to reflect critically on how their own practice and the broader system impacts on the lives of children and families. Our review work also acknowledges two other important points; that child deaths are rarely predictable and that decisions about children are made within the context of resources, demand and culture.

The following case study is a good example of how FACS is working towards developing a learning culture, where workers are reflecting on their practice in a considered way and making decisions that are safe and child-centred, rather than making defensive decisions in response to crises.

case study

A report was made to FACS about Alyssa just after her birth because of concerns about how her older brother, Jack, had died the year before. There were suspicions that Jack had been shaken, although this was never confirmed by medical experts.

After Alyssa's birth, the casework team faced a long and complex process in trying to work out what risks she faced. It would have been easy to take the 'safest' option and remove Alyssa from her parents' care. Such a decision would have immediately removed one set of risks, yet brought with it another set – finding a secure long-term placement outside of Alyssa's immediate family. The casework team took the approach of establishing a shared goal with the family of a safe future for Alyssa. The team assessed the risk to Alyssa holistically, engaged services and made reflective and collaborative decisions. Caseworkers were open and upfront with the parents about their concerns without raising the parents' defensive barriers. A plan to support and monitor the family intensively was established. The caseworkers also relied on current research as an evidence base for setting up safety plans for Alyssa. For example, because of their engagement with theory, caseworkers were able to identify when there might be heightened periods of stress for the parents during Alyssa's first three months. The research was shared with the family, and safety plans were developed which enlisted extended family members to take a responsible, protective role during these risk periods.

Alyssa remains in her parents' care with a number of services supporting the family and monitoring her progress. After a period of intensive casework, FACS re-assessed the family, finding that the risk level for Alyssa had decreased significantly.

## 1.2.2 FACS child death reviews

The Child Deaths and Critical Reports unit reviews FACS involvement with the families of children and young people who have died and were reported in the three years prior to the death. Our unit also reviews cases where a child or young person was in care at the time of their death.

Internal child death reviews are constantly evolving. Our unit was previously part of the (then) Accountability and Review Branch of FACS, but in 2012, moved into the Office of the Senior Practitioner, which is responsible for strengthening child protection work in FACS through the promotion of best practice. Our first full year in the Office of the Senior Practitioner

<sup>9</sup> Turnell A & Edwards S, 1999.

has signified a shift in the focus of our reviews – while accountability to the public remains important, our work has a significant focus on improving practice and organisational learning. Our reviews focus on current practice and sibling safety and aim to provide timely information to all practitioners who work directly with families and children.

We undertake different types of reviews, depending on the nature of the department's involvement with a family and/or the circumstances of a child's death. We often work together with casework staff to understand vital contextual information, and to reflect critically on practice. Despite this being an understandably difficult process for staff, we are continually impressed and inspired by the courage and determination of casework staff to learn from the tragedy of a child's death.

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

Within the Office of the Senior Practitioner, we are identifying ways to enhance the connection with casework staff and promote practice development. The findings from child death reviews provide rich learning opportunities for practitioners, both within the organisation and externally. Each year, we undertake a state-wide rollout of the learning from the previous years Annual Report. In 2013, the findings from the *Child Deaths 2012 Annual Report* were presented to FACS staff at the first annual state-wide practice conference road show.

In addition to individual reviews, we also undertake cohort reviews where themes, trends or systemic issues are identified. This year, we finalised a review of the cases of 108 infants who died between 2008 and 2012, and whose deaths were attributed to Sudden Unexpected Deaths in Infancy (SUDI). The cohort review examines the risks, trends and patterns associated with the deaths of these babies. The review seeks to support staff to build on their existing knowledge and understanding of safe sleeping. A summary of this review can be found in Chapter 3 of this report.

### 1.2.3 Public and interagency understanding of child deaths

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

While we cannot report on individual cases, the department is committed to greater transparency and accountability about child deaths. The annual publication of this report is one of the best ways to meet this commitment. Annual reports provide an opportunity to further examine the complexities of child protection work and allow for the identification of crucial learning from these cases, especially for practitioners who work with families.

The *Child Deaths 2013 Annual Report* is our fourth publically available report, examining the deaths of children known to FACS. In order to formalise the government's commitment to transparency and accountability about child deaths, the *Children and Young Persons (Care and Protection) Act 1998* since 29 October 2014 requires the Minister of Family and

<sup>10</sup> This has been adapted from a case review model in England sourced from: Fish S, Munro E & Bairstow E, 2008.

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

<sup>12</sup> Although some of the stories of children and young people who died are told in this report, the identifying details of the families and cases have been changed to protect this privacy.

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

Community Services to present this report to Parliament annually. The relevant amendment was passed into law on 1 April 2014.

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

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

The media plays an important role in supporting this understanding, as well as holding agencies accountable for their involvement with families. But as Eileen Munro argues, if sensitive and balanced media coverage of child deaths is not achieved, it can have a considerable impact on vulnerable children:

A one dimensional view can impact on the child protection system in a way that makes it less safe for children. A lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among child protection workers can also be damaged, leading to more workers leaving the profession and making it more difficult for the profession to attract candidates and attract staff<sup>14</sup>.

#### 1.2.4 Child death oversight in NSW

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

##### **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 neglect or abuse 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 every two years. His last report was tabled in March 2013 and his next report will be tabled in the first quarter of 2015.

##### **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. The team includes the Commissioner for Children and Young People, the Community and Disability Services Commissioner, representatives from other government departments (including FACS), and individuals with expertise in relevant fields including health care, child development, child protection and research methodology. The CDRT reports annually to the NSW Parliament about its work, including research projects.

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14 Munro E, 2011.

The CDRT reported that the deaths of 587 children and young people were registered in NSW during 2013. Of these cases, the team identified the deaths of 112 children who a child protection history<sup>15</sup>. These figures differ from FACS data. This highlights important differences between the two categories:

- CDRT reports on the deaths of children and young people that were registered in a calendar year with the NSW Registry of Births, Deaths and Marriages while FACS reports on deaths that occurred in a calendar year<sup>16</sup>
- FACS may include cases where NSW children died in another state in its annual total of child deaths, while CDRT reports on those cases separately, 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>17</sup>
- CDRT reports on the deaths of children and young people who were reported to FACS, but whose reports did not reach the statutory threshold of Risk of Significant Harm (ROSH)
- in addition to reporting on the deaths of children who were known to FACS, CDRT also includes children who were known to Child Wellbeing Units<sup>18</sup>.

### **The NSW Police Force and the NSW Coroner**

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

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

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

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

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

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15 NSW CDRT, 2014a.

16 For example, a child who died in December 2013, but whose death was registered in January 2014, would be included in Family and Community Services 2013 figures and CDRT's 2014 figures.

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

18 Child Wellbeing Units (CWU) were established in NSW Health, NSW Police Force, Department of Education and Communities and Department of Family and Community Services to 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.

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths<sup>19</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 of a review by the team.

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

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

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

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

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

In response to the significant progress that has been achieved in transitioning the provision of statutory OOHC services from government to the non-government sector, we are working with our non-government partners to undertake reviews in certain circumstances. The collaborative model of review allows the opportunity for all services to reflect upon their involvement with children and young people, and share reflections and learning in order to improve service provision.

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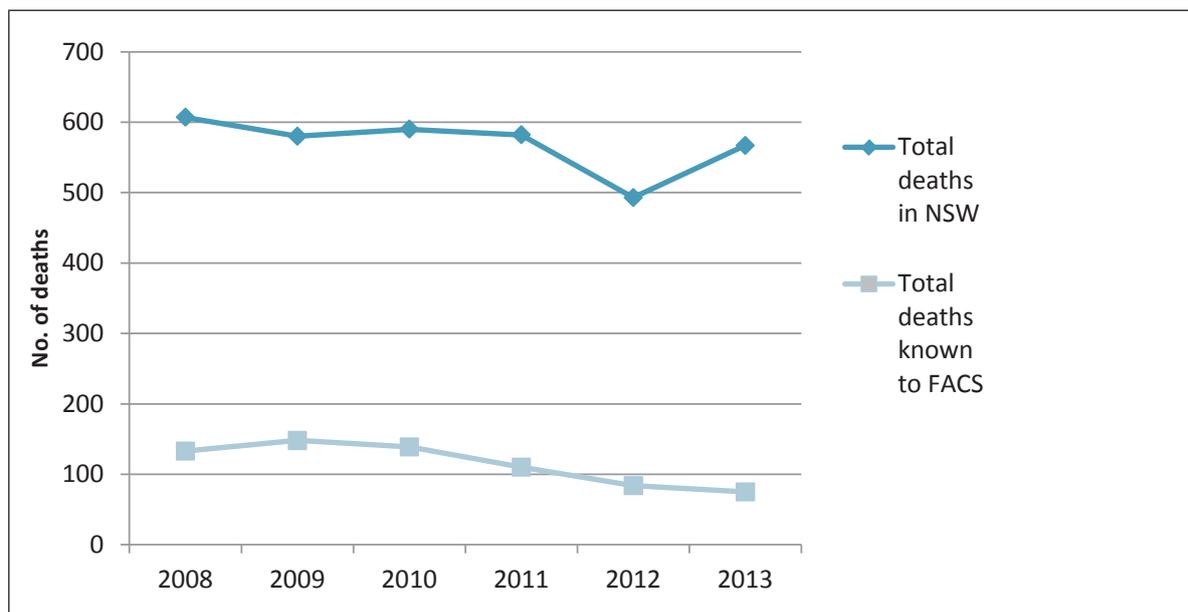
<sup>19</sup> Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as the death that is caused directly or indirectly by a person who was in a domestic violence relationship with the deceased person. This Act also provides that a domestic violence death is 'closed' if the coroner has dispensed with or completed an inquest concerning the death, and any criminal proceedings (including appeals) concerning the death have finally determined.

# Chapter 2: Child deaths in 2013

## 2.1 Child deaths in NSW in 2013

Between 1 January 2013 and 31 December 2013, the deaths of 567 children and young people were registered in NSW<sup>20</sup>. In the same period, 75 children and young people died who were known to FACS.

**Figure 2: Children and young people who died in NSW, compared to children who died and were known to Family and Community Services, 2008 to 2013.**



Source: Family and Community Services and NSW CDRT, 2014.

The number of deaths of children and young people who were known to FACS has steadily decreased since 2009. This is highly likely to be due to the introduction of the Risk of Significant Harm (ROSH) threshold in January 2010<sup>21</sup>, resulting in a lower rate for reports that meet this threshold, and therefore, a lower rate of deaths of children who were known to the department.

<sup>20</sup> NSW CDRT, 2014a.

<sup>21</sup> In January 2010, the threshold for reporting to FACS changed from 'risk of harm' (ROH) to 'risk of significant harm' (ROSH).

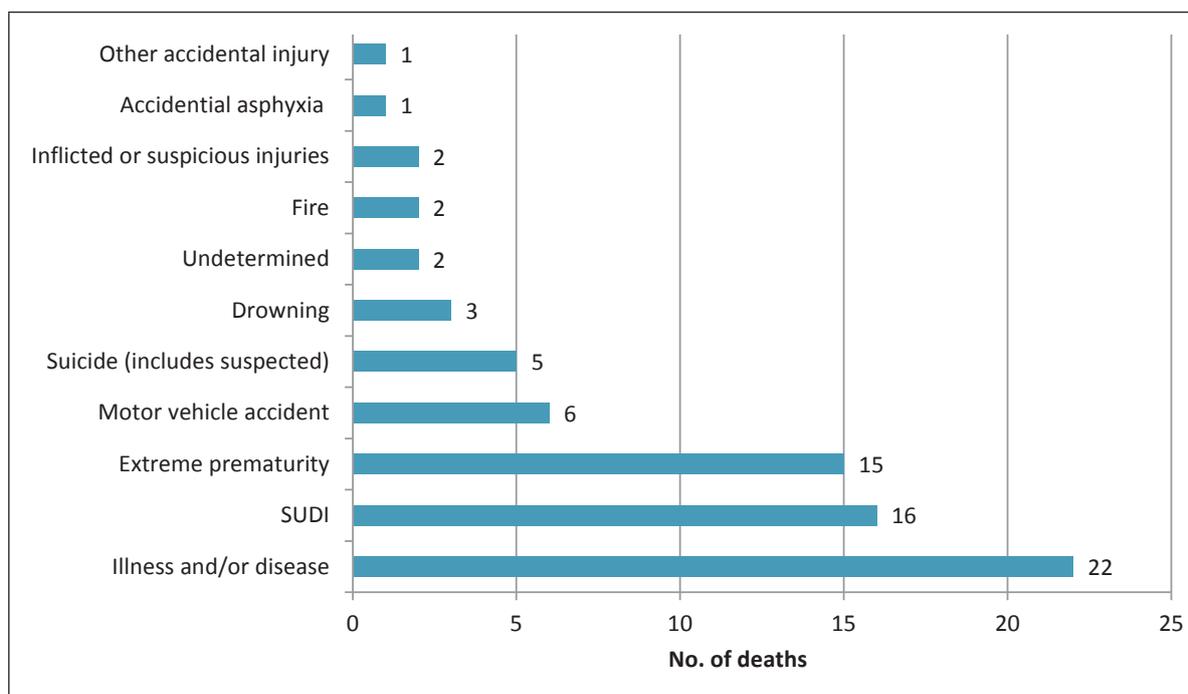
## 2.2 Circumstances of child deaths

We receive information about the medical cause and circumstances of a child's death from the State Coroner and the NSW Registry of Births, Deaths and Marriages (via the NSW Ombudsman). Based on this information, we report on the circumstances of the child's death. Understanding the circumstances in which a child died is far more relevant when considering the child protection history of the child's family and any opportunities that we may have had to intervene before the child's death. Reporting on the circumstances of death can provide important information for the child protection system as a whole, beyond the practice and systems relevant to the individual child who died.

Overall, most of the deaths in 2013 were associated with illness or disease, followed by infants who died suddenly and unexpectedly, meeting the Sudden and Unexpected Deaths in Infancy (SUDI) category.

The categories we use to describe a child's circumstances of death are outlined in Figure 3. These categories may be different from the cause of death. For example, the cause of death could be multiple injuries, but the circumstances of death could be a motor vehicle accident or an inflicted or suspicious injury<sup>22</sup>.

**Figure 3: Circumstances of death for children and young people who died in 2013 and were known to Family and Community Services<sup>23</sup>.**



<sup>22</sup> A summary of the cause of death for children known to Family and Community Services who died in 2013 is provided at appendix 1.

<sup>23</sup> The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

**Table 1: Circumstances of death for children and young people who died between 2010 and 2013 and were known to Family and Community Services<sup>24</sup>.**

Circumstance of death	2010		2011		2012		2013	
	no.	%	no.	%	no.	%	no.	%
Accidental asphyxia	0	0	0	0	0	0	1	1
Accidental choking	0	0	1	1	0	0	0	0
Drowning	3	2	7	6	5	6	3	4
Drug overdose (self administered)	3	2	3	3	2	2	0	0
Extreme prematurity	25	18	14	13	13	15	15	20
Fire	3	2	0	0	0	0	2	3
Illness and/or disease	51	37	38	35	25	30	22	29
Inflicted or suspicious injuries	5	4	7	6	2	2	2	3
Motor vehicle accident	10	7	8	7	7	8	6	8
Other accidental injury	4	3	4	4	1	1	1	1
SUDI	26	19	21	19	16	19	16	21
Suicide (includes suspected)	7	5	4	4	12	14	5	7
Undetermined	2	1	3	3	1	1	2	3
<b>TOTAL</b>	<b>139</b>	<b>100</b>	<b>110</b>	<b>100</b>	<b>84</b>	<b>100</b>	<b>75</b>	<b>100</b>

Table 1 compares the circumstances of death for children who died between 2010 and 2013 and were known to FACS. Despite a drop in the number of overall deaths, the percentage of cases in each category has remained largely consistent. As this table shows, a very small number of child deaths each year are considered suspicious by police or directly attributed to abuse or neglect. Regardless of this, the deaths of children known to FACS due to medical causes or accidental circumstances remain relevant issues within the child protection context. For example, child health issues may be exacerbated by socio-economic disadvantage and/or child protection concerns such as parental neglect. A parent's capacity to care for their children may also impact on the likelihood of their children dying in accidents. These factors are further explored in the following sections.

### 2.2.1 Deaths from illness and/or disease

**Table 2: Children and young people who were known to Family and Community Services and died from an illness and/or disease between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	52	38	27	22
% of deaths	37%	35%	32%	29%
Age range	0–17 yrs	0–17 yrs	0–16 yrs	0–17 yrs
Aboriginal and/or Torres Strait Islander	3	7	5	8

In 2013, 22 children and young people died from an illness and/or disease. The number of deaths due to illness and/or disease has dropped by over half since 2010. The percentage of these deaths during each year has also dropped, but at a lower rate.

<sup>24</sup> Note that this data may have changed from previous years reports due to new information and changes in reporting methods.

In 18 of the 22 cases, the child or young person had been diagnosed with a medical condition before their death<sup>25</sup> including eight cases where the child had a disability. While it is unlikely that FACS would have had an opportunity to prevent the deaths of these children, it is important to consider these cases through a child protection lens. In eight of the 22 cases, socio-economic factors, including poverty, homelessness, transience and/or geographical isolation were reported for the family prior to the child's death. In 12 of the 22 cases, reports about neglect were received about the family, including seven cases where medical neglect was a concern prior to the child's death.

Our child death reviews have identified consistently how the ongoing stressors associated with caring for sick children can exacerbate, or lead to other child protection issues such as domestic violence, parental mental health issues and parental drug and alcohol use. This is a critical issue for casework staff to monitor, and a focus on the safety of the children must be carefully balanced with a sensitive and compassionate approach, as demonstrated by the story below.

case study

Jonah was born with a rare genetic disorder which meant his life expectancy was considered to be short. He had significant care needs, weak muscle tone and was totally dependent on his mother, Amanda, for all his needs. Jonah was reported for concerns about medical neglect when Amanda had discharged him from hospital against medical advice. Amanda had been heard to say she didn't think she could continue caring for Jonah and she had 'had enough' and wanted his life to end.

There were other complicating factors; Amanda had other young children, a history of trauma, was the victim of violence and had been diagnosed mental health issues including depression and anxiety.

When we reviewed the case we found the caseworker took a holistic and thoughtful approach to the assessment of medical neglect, parenting capacity and attachment. The caseworker checked immediate safety concerns by talking to the paediatrician and confirming that it was not medically urgent for Jonah to return to hospital.

Although there were reports that Amanda had 'had enough', the caseworker acknowledged that these comments may have been made at a point of crisis. The caseworker was open to the possibility that these comments were taken out of context by the people who made the reports. The caseworker's assessment of Amanda's attachment and parenting capacity was holistic and found she was very attached to Jonah.

FACS involvement resulted in hospital staff becoming open to other hypotheses about their views on medical neglect, the mother's attachment, parenting capacity and working with the mother in a different way. Although Jonah eventually died from his illness, the collaborative approach between Amanda, the hospital, and the department meant Jonah received consistent care in the months leading up to his death.

<sup>25</sup> This figure is based on information known to Family and Community Services. It is possible that more children had an existing medical condition prior to their death that was not reported to the department.

## 2.2.2 Sudden and Unexpected Death in Infancy

**Table 3: Babies who were known to Family and Community Services and died suddenly and unexpectedly between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	26	21	16	16
% of deaths	19%	19%	19%	21%
Age range	0–10 mths	0–8 mths	0–5 mths	0–10 mths
Aboriginal and/or Torres Strait Islander	9	8	4	9

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

- unexpected or unexplained at autopsy (meeting the criteria for Sudden Infant Death Syndrome)
- an acute illness that was not recognisable by carers and/or health professionals as potentially life threatening
- an existing health condition that was not previously recognised by health professionals<sup>26</sup>.

These deaths usually occur after babies are put to sleep.

In 2013, the deaths of 16 babies were classified as SUDI<sup>27</sup>, comprising 21 per cent of deaths of all children known to FACS for the year. Post mortem reports were available for 15 of the 16 babies, and provide the following cause of death information:

- undetermined (8)
- SIDS or SUDI (3)
- illness or disease (3)
- possible asphyxiation (1).

Chapter three of this report provides a summary of FACS *Safe sleeping* review, which examined the deaths of 108 babies over a five-year period (between 2008 and 2012) that met the SUDI classification. The majority of these babies (103 out of 108) were found to have at least one modifiable risk factor that increases the risk of SUDI, consistent with other national and international research<sup>28</sup>. These risk factors include the baby sleeping with their parent at the time of death, the position the baby was placed to sleep, the baby sleeping with loose bedding, exposure to cigarette smoking or the baby being prop fed with a bottle.

Of the 16 babies who died suddenly and unexpectedly in 2013, one or more modifiable risk factors were found in 15 cases.

<sup>26</sup> NSW CDRT, 2012.

<sup>27</sup> These data are based on information provided to FACS by the NSW CDRT.

<sup>28</sup> NSW Family and Community Services, 2014c.

### 2.2.3 Deaths related to premature births

**Table 4: Babies who were known to Family and Community Services and died from conditions related to their premature birth between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	25	14	13	15
% of deaths/year	18%	13%	15%	20%
Age range	0–1yr	0–3wks	0–1mth	0–2mths
Aboriginal and/or Torres Strait Islander	8	4	8	10

In 2013, 15 babies died from conditions related to their premature birth<sup>29</sup>. The majority of these babies (11) died within the first 24 hours of their birth. Two babies died within their first week, one died within a month and one baby died within the first three months.

Ten of the 15 babies were identified as Aboriginal and/or Torres Strait Islander. This is consistent with broader research about poorer birth outcomes for Aboriginal babies, compared with non-Aboriginal babies. The NSW CDRT found that the mortality rate for Aboriginal and/or Torres Strait Islander babies who died from conditions originating in the perinatal period was more than double that of non-Aboriginal children<sup>30</sup>. Other research has identified that Aboriginal newborns are more likely to have higher rates of stillbirth, low birth weight, and are more than twice as likely to be born premature<sup>31 32</sup>. The reasons for these higher rates are complex. Aboriginal women giving birth are more likely to present late for antenatal care, be under the age of 20 years, experience disadvantage and live in a rural or remote location<sup>33</sup>. Previous studies have also found that approximately half of Aboriginal women reported that they smoked during pregnancy, which has previously been associated with poor perinatal outcomes, including preterm birth<sup>34</sup>.

Nine of the 15 babies who died in 2013 after their premature birth were reported to FACS during their mother's pregnancy with concerns about<sup>35</sup>:

- the mother's drug or alcohol use during pregnancy (7 cases)
- the mother being the victim of violence during pregnancy (6 cases)
- poor ante-natal care (1 case).

For a further three cases, the babies' siblings were reported due to similar issues about maternal drug or alcohol use and/or physical domestic violence against the children's mother.

These findings are consistent with a wide range of research about the risks of premature birth for the babies of women who use drugs or alcohol, or who are the victims of physical abuse<sup>36 37 38</sup>. While child protection practitioners have opportunities to work with pregnant women to achieve positive change, there are also challenges in engaging families with unborn children, as discussed in the next case study.

<sup>29</sup> Cases were included in this group when prematurity was recorded as either an underlying, associated or contributing factor in the death.

<sup>30</sup> NSW CDRT, 2013.

<sup>31</sup> Comino et al., 2012.

<sup>32</sup> AIHW, 2007.

<sup>33</sup> Ibid, 2007.

<sup>34</sup> Ibid, 2007.

<sup>35</sup> Six of these cases featured multiple concerns.

<sup>36</sup> Rodrigues T, 2008.

<sup>37</sup> Leone et al., 2010.

<sup>38</sup> Wendell A, 2013.

Jake died shortly after being born extremely prematurely. He was the youngest child in a large Aboriginal family. Jake’s mum, Sandy, was well known to a regional FACS community services centre (CSC) in Western NSW. All of his brothers and sisters were in care. Sandy had a significant child protection history as a child herself and had been struggling with chronic alcoholism and drug addiction for many years. Her own history of trauma and disadvantage was very much at the centre of her problems. Not long before her pregnancy with Jake, she had miscarried, after being kicked in the stomach by her partner.

When Sandy was pregnant with Jake, reports were made that she was still drinking heavily, was using drugs and was homeless and transient, having moved from regional NSW to various areas in Sydney.

FACS found it difficult to allocate the case because of Sandy’s transience – she kept moving between the catchment areas of each CSC. But our review found the regional caseworkers were very concerned about Sandy and her baby, so went out of their way to make sure she had support and was being monitored. Regional caseworkers contacted medical services in Sydney to increase Sandy’s support network and ensure they were aware of her history. They also arranged for a ‘high risk birth alert’<sup>39</sup> to be placed on the hospital system, so that FACS would be advised when Jake was born.

## 2.2.4 Motor vehicle accidents

**Table 5: Children and young people who were known to Family and Community Services and died in a motor vehicle accident between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	10	8	7	6
% of deaths	8%	7%	8%	8%
Age range	2–17 yrs	9–17 yrs	9–17 yrs	5–15 yrs
Aboriginal and/or Torres Strait Islander	4	3	1	4

In 2013, six children and young people died in motor vehicle accidents. As the above table shows, the number of deaths due to motor vehicle accidents has decreased since 2010 while the percentage of these deaths has remained relatively consistent.

Five of the children and young people were from regional areas in NSW. Road trauma in rural and remote areas of Australia is a major national road safety problem with studies finding that the rural road crash injury rate is almost double that of urban road injury crashes and a person involved in a rural crash is over ten times more likely to die than if they had been involved in a crash in an urban area<sup>40</sup>.

For the six children who died in motor vehicle accidents in 2013, risk-taking behaviours were linked to four of the cases, including:

- speeding and/or driver error in judgement
- substance use by the driver
- unregistered, unlicensed and underage driver
- no seatbelt or helmet.

39 A high risk birth alert allows Family and Community Services to provide information under the legislation to NSW Health and other services about an unborn child who has been the subject of a pre-natal report.

40 Tziotis et al., 2006.

Of the six children who died in motor vehicle accidents, two were driving the vehicle when they died. No specific reports about underage driving were received prior to the accident but both children had recent reports about supervisory neglect, running away and high risk behaviours including substance abuse, criminal behaviour, chronic school absence and violence.

### Motor vehicle accidents since 2006

The relationship between risk taking behaviours and motor vehicle accidents has been a common theme identified by our reviews. Between 2006 and 2013, 69 children and young people died in a motor vehicle accident. Of these 69 children and young people, over half (39) were in accidents linked to risk-taking behaviours by the driver. Of these 39 children and young people, 24 had been previously reported about their high risk behaviour, including criminal activity, substance abuse, self harm, challenging behaviour, school absence, violence and suicidal ideation.

## 2.2.5 Suicide

**Table 6: Children and young people who were known to Family and Community Services and died by suspected suicide between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	7	4	12	5
% of deaths	5%	4%	14%	7%
Age range	14–17yrs	14–17yrs	13–17yrs	13–16yrs
Aboriginal and/or Torres Strait Islander	2	1	4	0

In 2013 five children and young people died by suspected suicide, all by hanging. Three of the children and young people were girls. In four cases, the child or young person had made a previous suicide attempt, or had made threats to end their lives. One child had not previously threatened or attempted to end their life, but a close family member made a non-fatal attempt at suicide. All five children and young people were suffering from mental health problems prior to their death<sup>41</sup>. Prior suicide or self-harm attempts, the death of a parent or the suicide of a close friend or family member are all closely linked to suicide risks for children and young people<sup>42</sup>.

While there has been a large decline (41 per cent) in suicide mortality rates for NSW young people with a child protection history over the past ten years, the mortality rate for this group is still four times higher than for young people without a child protection history<sup>43</sup>. The child protection histories for four children who died by suicide in 2013 reflect strong themes of abuse. FACS received reports about exposure to serious physical violence in the home for three children, one who had also experienced sexual abuse. The fourth child was reported to be the victim of sexual abuse. Before their deaths, four of the children and young people had been reported about ongoing concerns for their mental health, risk-taking and violent behaviours, and involvement in criminal activity.

Working with adolescents can be extremely challenging, yet potentially rewarding work. The transition into adulthood can be tough for many young people, but this is especially hard for teenagers with a history of trauma, abuse and neglect. Our review of cases where children and young people have died by suicide consistently highlight the challenges of understanding what it must be like for a young person who has grown up in a home where child protection concerns overwhelm the family's functioning. Unfortunately, a common theme often emerges from these reviews about how vulnerable children and young people may ask for help, but

<sup>41</sup> This includes diagnoses of mental health issues and concerns about the child's mental health.

<sup>42</sup> Davidson L & Linnoila M, 2012.

<sup>43</sup> NSW CDRT, 2014b.

don't get it. These challenges are highlighted in the story about Joshua who was 16 years old when he took his own life.

**case study**

Joshua was first reported to FACS when he was six years old. The report was about physical abuse of Joshua and his siblings by their mother, and their mother's alcohol and drug use. The mother's abuse of her children had increased in severity following the death of their father.

FACS visited the family in response to some of the reports. Caseworkers would speak to mum, and then to Joshua and his siblings. Joshua always told caseworkers the same thing, 'Mum's really mean to me. I just want it to stop'. The caseworkers would tell Joshua, 'Your mum's trying really hard'. For Joshua, the visits by caseworkers didn't help. His mum became more abusive, especially towards him.

From the time Joshua turned 14, his behaviours changed. Reports to FACS about Joshua running away from home increased, and his behaviour at school had become a problem. He was suspended before eventually being expelled. Adults would talk to Joshua, and again he would tell them about his mum's cruelty, but nothing happened. They kept returning Joshua home, and Joshua kept running away.

FACS also received information that Joshua was connected to high-risk peer groups. His peers were much older than him, and were known to police for drug use. Joshua started to get into trouble for trying to pick fights. It was undeniable that Joshua's behaviours were linked to his experiences at home.

The year before Joshua's death, he was using and selling drugs, and was caught breaking into a car. Before too long, he was in the juvenile justice system. Joshua's mental health continued to deteriorate, and he was feeling more hopeless. Joshua told some people about his plans to end his life.

Supporting vulnerable young people is a priority for FACS, but it is an ongoing challenge that requires intensive and ongoing work. In addition to a range of other initiatives (discussed in Chapter 4) to improve our services to adolescents, we are undertaking a cohort review of vulnerable young people whose deaths were attributed to suicide, alcohol or drug misuse, or resulted from other risk taking behaviour. The findings from this review will be shared with FACS staff and the wider sector.

### 2.2.6 Drowning related deaths

**Table 7: Children and young people who were known to Family and Community Services and died after drowning between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	3	7	5	3
% of deaths	2%	6%	6%	4%
Age range	0–6 yrs	1–14 yrs	1–13 yrs	0–1 yr
Aboriginal and/or Torres Strait Islander	1	6	1	2

In 2013, three children died after drowning in a swimming pool or bath. All three children were under the age of two years and all three deaths occurred in the absence of parental supervision. Two deaths occurred in a backyard swimming pool, both of which were fenced inadequately. The other child drowned in a bathtub.

There are a range of factors associated with drowning in swimming pools including the adequacy of adult supervision and pool barriers to prevent unsupervised access. Children

under the age of five are most at risk of drowning<sup>44</sup>. Supervision is also a factor in the drowning deaths of children in bathtubs, particularly for children under the age of two years<sup>45</sup>.

Supervision is consistently promoted as the most effective preventative measure against drowning. The Royal Life Saving Society Australia promotes the 'active supervision'<sup>46</sup> of children around water. The use of older children to watch younger children is also discouraged as they are not equipped with the skills to perceive and respond to an emergency situation and should not be burdened with such responsibility.

The relevance of supervision is particularly significant for the work of FACS with the families of young children. This is also supported by the NSW Child Death Review Team's finding that children with a child protection history had 2.7 times the mortality rate for drowning than those without a child protection history. Inadequate supervision is a frequently reported issue for children who are at risk, and often occurs in the context of broader neglect concerns. For example, there may be other more complex and complicating facts that can affect supervision, such as a parent's use of drugs and alcohol or their mental health. Other more subtle factors can also have an impact, such as a parent placing inappropriate expectations on older siblings to supervise a young child, a parent being overly distracted by other concerns, or a foster carer having numerous children placed in their care who have significant supervision and support needs.

Kaylah's story below highlights how working with families to protect children is not just about addressing parental risk factors in the home, it is also about considering physical dangers to the children and how the family can be creatively supported to provide a safe environment.

case study

Kaylah drowned in the backyard swimming pool of her home. She was two years old when she died.

Kaylah was living with extended family in a property in Northern NSW. Caseworkers visited the home after reports were made with concerns about how her aunty (Barbara) was coping with the care of Kaylah and her siblings, including her brother, who had a disability. There were also concerns about Barbara's increased drinking, ongoing neglect and physical discipline of the children. Caseworkers referred the family to an early intervention service.

During a home visit, caseworkers remember seeing a swimming pool in the backyard, but couldn't remember if it had a fence. Police told FACS that Kaylah had accessed the backyard pool while Barbara was inside the house. While the pool had a fence and gate, it was not compliant with safety guidelines.

Our review found that while caseworkers could not predict Kaylah's death, the reported concerns of neglect, physical abuse and Barbara's increased drinking highlighted that Barbara was not managing with the children. Caring for a number of children would have been difficult in these circumstances, particularly as she was caring for young children, including a child with high needs.

44 NSW CDRT, 2013.

45 Ibid, 2013.

46 Active supervision means 'focusing all of your attention on your children all of the time, when they are in, on, or around the water. You must be within arms reach of your child and be ready to enter the water in case of emergency.' Royal Life Saving Fact Sheet 1 Supervise found at [http://www.royallifesaving.com.au/\\_\\_data/assets/pdf\\_file/0005/3956/RLS\\_FactSheet\\_1.pdf](http://www.royallifesaving.com.au/__data/assets/pdf_file/0005/3956/RLS_FactSheet_1.pdf)

## Drowning deaths since 2006

Between 2006 and 2013, 41 children and young people died from drowning in swimming pools, baths and other bodies of water. Five of these children and young people were under the parental responsibility of the Minister at the time of their death.

Lack of adequate supervision is consistently the most common theme we identify in reviews about drowning deaths. Most of the drowning deaths (35) were directly linked to an absence of parental supervision<sup>47</sup>. Of these 35 children, 28 had been previously reported for concerns about parental alcohol and drug use, parental mental health concerns or neglect including supervisory neglect.

Just over half (22) of the drowning deaths occurred in swimming pools, including underground, aboveground, temporary and inflatable pools. All 22 cases were linked directly to inadequate parental supervision. Of the 22 deaths in swimming pools, 16 highlighted issues relating to the pool barriers, including no fence and/or physical gaps in fencing, the gate not self closing and/or self locking, faulty and/or inappropriate locking mechanisms (padlocked, rope) or climbable materials close to fencing.

A number of these deaths have been of interest to the NSW Coroner who has conducted inquests into these deaths and made recommendations to government bodies, including FACS. The department is committed to continuing to address this issue, particularly in reducing the number of children in care who die from drowning.

## 2.2.7 Other circumstances of death

### Inflicted or suspicious injuries

Two children died in 2013 of suspicious injuries. A young child's father was charged with murder in one case, and in the other, both the mother and her partner have been charged with the child's murder.

Homelessness and transience were major themes in the child protection histories of both children. Reports were received about physical abuse for both families, but these reports did not indicate that either child was at risk of fatal assault. In one case, the information in the report was appropriately screened as not meeting the risk of significant harm threshold. In the other case, the child's siblings were reported two years prior to the death due to their father's physical abuse. FACS did not have contact with either family prior to the injuries that led to the children's deaths<sup>48</sup>.

### Fire

Two children died in a house fire in 2013. Both were Aboriginal children and their child protection histories featured themes of parental drug and alcohol use, domestic violence and neglect.

## 2.3 Characteristics of the children

### 2.3.1 Age and gender

In 2013, 42 (56 per cent) of the children and young people who died were male and 33 (44 per cent) were female. This gender difference is consistent with findings from previous years.

<sup>47</sup> The remaining six deaths were predominately teenagers swimming in lakes or rivers. The circumstances of one death are not known.

<sup>48</sup> Due to the small number of cases in this category, it is not possible to detail any further information about these children without identifying the children and their siblings.

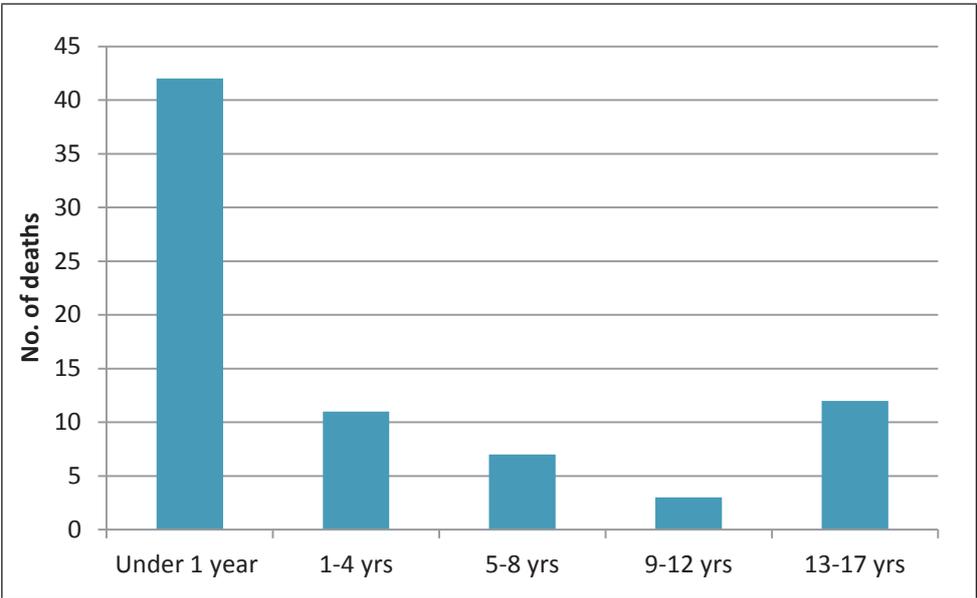
The majority of children (42 children or 56 per cent) who died in 2013 were under the age of one year, also consistent with findings from previous years. Of the 42 babies, 35 died within their first three months. The circumstances of these 35 deaths were related to:

- prematurity (15)
- SUDI (11)
- an illness or disease (8)
- undetermined causes (1).

The overrepresentation of young babies in child death figures is consistent with findings from the CDRT for all child deaths in NSW<sup>49</sup> and highlights the vulnerability of babies, both from a physiological and child protection perspective.

Twelve (16 per cent) adolescents died in 2013, which is a reduction from the 25 (30 per cent) adolescent deaths in 2012.

**Figure 4: Age of children and young people known to Family and Community Services who died in 2013.**



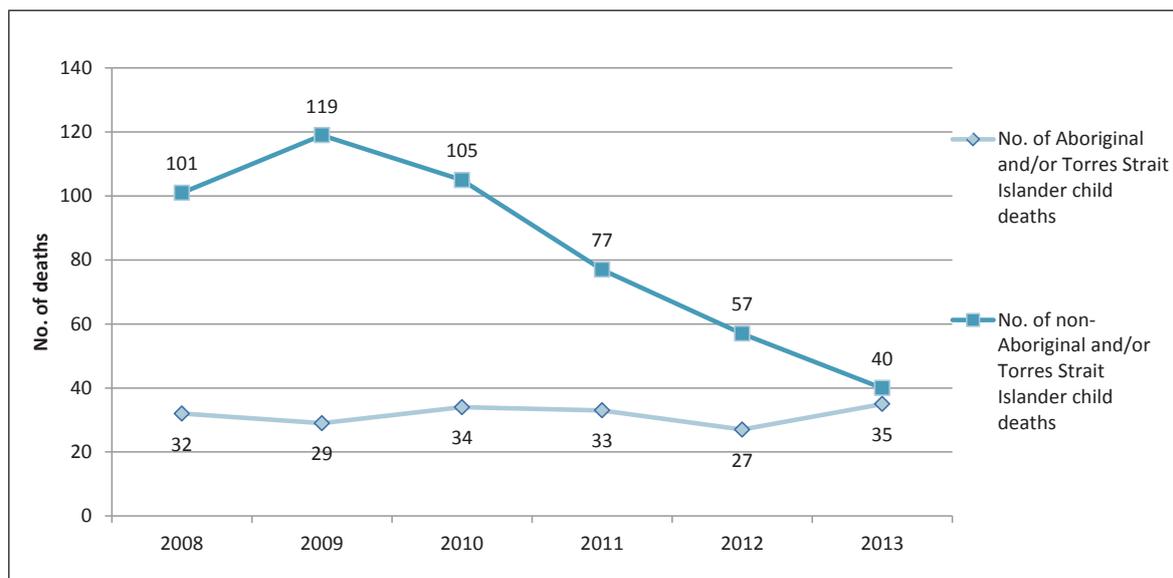
### 2.3.2 Aboriginal and/or Torres Strait Islander children

**Note:** The statistics and stories in this section may cause distress within Aboriginal communities. A list of contacts for support is provided at Appendix 2 of this report.

In 2013, 35 Aboriginal and/or Torres Strait Islander children who were known to FACS died, consisting of almost half (47 per cent) of all deaths for the year. Figure 5 shows a very concerning statistic; the introduction of the ROSH threshold has dramatically reduced the numbers of **non-Aboriginal** children who died and were known to the department, while the numbers of **Aboriginal** children who died and were known to FACS has remained relatively stable. This means that the proportion of Aboriginal children who died has risen from 24% in 2008 to 47% in 2013.

<sup>49</sup> In 2013, 63 per cent of children who died in NSW were under the age of one year (NSW CDRT, 2014a).

**Figure 5: Number of Aboriginal and/or Torres Strait Islander and non-Aboriginal and Torres Strait Islander children who were known to Family and Community Services and died between 2008 and 2013.**



These data confirm what is well known in the research – that Aboriginal children are one of the most vulnerable groups of children in Australia<sup>50</sup>. Aboriginal children who are reported are on the high end of the child protection risk spectrum, being 10 times more likely to be placed in care than non-Aboriginal children<sup>51</sup>. The number of Aboriginal and/or Torres Strait Islander children who are reported to FACS is also increasing at a higher rate than non-Aboriginal children<sup>52</sup>.

Table 8 outlines some very sobering statistics on the overrepresentation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures.

**Table 8: Overrepresentation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures.**

	%
Population of Aboriginal children in NSW <sup>53</sup>	4.9
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2013 <sup>54</sup>	14
Aboriginal and/or Torres Strait Islander children as a percentage of children who were the subject of a ROSH report in 2013 <sup>55</sup>	21
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2013 who were known to FACS	47

Source: AIHW (2014), NSW CDRT (2014) and Family and Community Services (2014).

<sup>50</sup> Australian Institute of Family Studies, 2013.

<sup>51</sup> Ibid, 2013.

<sup>52</sup> From 2010–11 to 2012–13 there was a 13.3 per cent increase in the number of Aboriginal and/or Torres Strait Islander children and young people involved in ROSH reports, compared to a 5.5 per cent increase for all children involved in ROSH reports (FACS, 2014a).

<sup>53</sup> Based on 2011 census data (NSW Commission for Children and Young People, 2011.)

<sup>54</sup> NSW CDRT, 2014a.

<sup>55</sup> Between 1 January and 31 December 2013 69,167 children and young people were the subject of a ROSH report to Community Services. Of these children, 14,438 (20.9 per cent) were identified as Aboriginal and/or Torres Strait Islander.

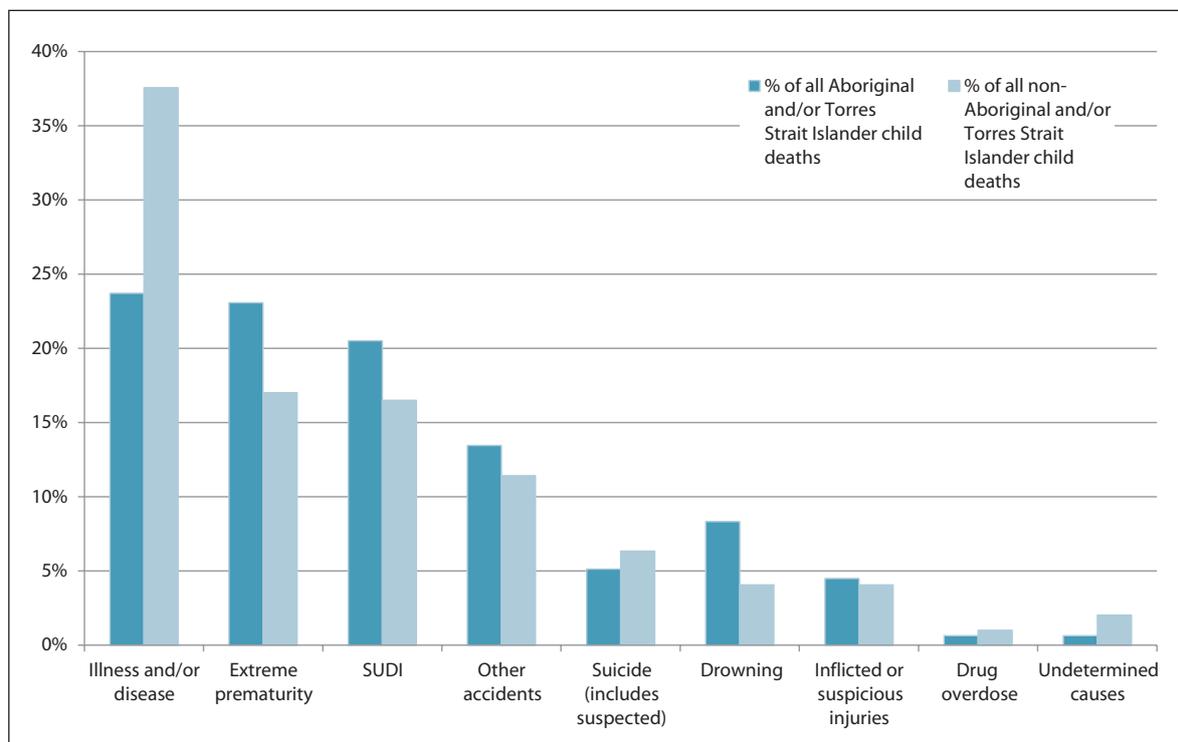
This overrepresentation is consistent with national research. The Australian Institute of Health and Welfare (AIHW) recently published a study<sup>56</sup> into Aboriginal child safety, which found that:

- Aboriginal and/or Torres Strait Islander children have higher hospitalisation rates than non-Aboriginal and Torres Strait Islander children, particularly for assault, which is more than five times the rate for non-Aboriginal and Torres Strait Islander children
- Aboriginal and/or Torres Strait Islander children are nearly eight times as likely as non-Aboriginal and Torres Strait Islander children to be the subject of substantiated child abuse or neglect
- the rates of sexual assault report to police for Aboriginal and/or Torres Strait Islander children aged 0–9<sup>57</sup> were two to four times higher than rates for non-Aboriginal and Torres Strait Islander children.

It is not only the comparative numbers of Aboriginal children in child protection and child death figures that are a concern, it is also how they are dying. The AIHW study found that more than a quarter of all deaths among Aboriginal and/or Torres Strait Islander children were due to external causes of injury, which is more than twice the rate for non-Aboriginal and Torres Strait Islander children. Also, external causes of death are more likely in Aboriginal and/or Torres Strait Islander children with a child protection history, compared to those without<sup>58</sup>.

FACS data (from 2008 to 2013) are also consistent with these findings. As Figure 6 shows, Aboriginal and/or Torres Strait Islander children had higher rates of death due to circumstances such as accidents, unsafe sleeping environments (in the SUDI category), extreme prematurity<sup>59</sup> and inflicted injuries, while there were lower rates of deaths due to illness or disease, suicide, drug overdoses and undetermined causes.

**Figure 6: Circumstances of death for children who died between 2008 and 2013 and were known to Family and Community Services, by Aboriginality<sup>60 61</sup>.**



56 AIHW, 2014.

57 In NSW, Queensland, South Australia and the Northern Territory.

58 AIHW, 2014.

59 See section 2.2.3 for more information on prematurity related deaths for Aboriginal and/or Torres Strait Islander children.

60 'Other accidents' including accidental choking, asphyxia, motor vehicle accidents and other accidental injuries.

61 Note that all children in the graph had received a report themselves or others in their family had, hence no family had received zero reports.

The reasons for these higher rates of preventable deaths are very complex. The AIHW found that they were attributable to a range of factors, including the ongoing effects of colonisation, social disadvantage, high rates of drug and alcohol misuse by adults, high rates of violence, high stress levels, residence in remote areas, poor safety standards, unsafe roads and poor access to primary health care<sup>62</sup>. Mothers of Aboriginal children are also more likely to be unsupported, and to report a history of mental health problems, childhood abuse and a history of domestic violence than mothers of non-Aboriginal children<sup>63</sup>.

Intergenerational abuse and neglect is another critical issue for FACS work with Aboriginal families, as detailed in Emily's case study below.

**case study**

Emily died when she was six months from a viral infection. Emily had not seen a doctor before she died.

Emily's mother Suzanne had two other children who were placed with Aboriginal kinship carers under the parental responsibility of the Minister when they were toddlers. FACS made a care application to the Children's Court after a number of concerns were reported about the children being neglected and Suzanne's heavy drinking and serious mental health issues.

Suzanne has an extensive history of involvement with child protection services as a child. Suzanne was part of a family of eight children and had been reported to FACS since she was a baby due to neglect and her mother's drug use. Throughout her childhood, Suzanne was the victim of sexual abuse from a number of offenders, which began at a very young age. Suzanne and some of her sisters and brothers were removed when she was 10 years old and placed with kinship carers. After she was removed Suzanne continued to be reported to FACS due to neglect and domestic violence.

Emily and Suzanne's story provides insight into the experiences of many vulnerable Aboriginal children in NSW. The statistics also show the serious disadvantage that Aboriginal children can face and our reviews often highlight systemic and structural problems with how the child protection system responds to Aboriginal children at risk. The agency's history of wrongful and forcible child removals means that caseworkers who are working with Aboriginal families try to balance carefully the child's safety with the need to provide a culturally sensitive service. Achieving this balance can be challenging.

A common theme in child death reviews is Aboriginal children who have been placed with kinship carers after being removed from a parent. Although the principle of placing Aboriginal children in a culturally appropriate placement is vital for a child's identity and future well-being, it is critical for caseworkers to carefully consider and understand any dynamics of intergenerational abuse and neglect in order to assess the placement and provide sufficient support to kinship carers to help support them to provide a safe home for the child. Aboriginal children deserve safety and protection, especially when the state has intervened in their lives by removing them from their parents. This is discussed further in section 2.4.2.

## 2.4 FACS response to the children who died

This section outlines FACS involvement with the families of the 75 children and young people who died in 2013. Information is provided about the number of reports received<sup>64</sup>, what the reports were about, the decisions made in response to the reports and whether the child or young person was living away from their family at the time of their death. This section also considers how FACS responded to the family after the child's death.

<sup>62</sup> AIHW, 2014.

<sup>63</sup> Comino et al., 2012.

<sup>64</sup> A report includes either a 'risk of harm' report received prior to January 2010, or a 'risk of significant harm (ROSH)' received after January 2010. Reports that were determined to be non-ROSH are not included in this count.

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

**Table 9: Children and young people who were living in out-of-home care when they died between 2010 and 2013.**

	2010	2011	2012	2013
No. of deaths	17	11	7	6
% of deaths	12%	10%	8%	8%
Age range	0–17 yrs	0–16 yrs	0–17 yrs	0–15 yrs
Aboriginal and/or Torres Strait Islander	4	7	2	1
Parental responsibility of Minister (any aspect)	12	9	4	4
Placed with a relative	5	4	5	3
Placed with authorised carers	7	5	1	3
Other (e.g. placed in residential care, hospital)	5	2	1	0

In 2013, six children and young people were not living with their immediate families at the time of their death. Four of these children were under the parental responsibility of the Minister. The remaining two were under the parental responsibility of relatives. Of the six children, three were placed with a relative and three with authorised carers who were not related to the children (two with FACS carers and one with a NGO carer).

The circumstances of death of the six children and young people who died in 2013 included illness or disease, SUDI, suicide and drowning. The circumstances of death for the three children and young people who were living with a relative were SUDI, suicide and drowning.

Our review work has found consistently that carer assessments for kinship placements, including for those cases where parental responsibility was being sought to be allocated to kin, were not as comprehensive as those completed for other authorised carers.

There are significant advantages to kinship care placements for children, including the reinforcement of a child's identity, self esteem, connection to culture, increased stability and reduced placement disruption<sup>65</sup>. However, detailed assessment and support of kinship carers is particularly important in families where intergenerational themes of neglect and abuse are evident<sup>66</sup>. Our reviews often find that kinship carers can experience the same issues as the parent who had their child removed, but this is not often understood sufficiently when decisions are being made about where a child who has been removed should live. The application of the Aboriginal Placement Principles should consider the child's safety as paramount, alongside a thorough understanding of that child's cultural needs.

Even when assessments are completed, a caseworker's attention may focus on how the children would be unsafe if they returned home to their parents' care rather than considering the potential risks in the kinship placement or the additional support needs for the relatives to take on the care of the children. Our review work also found that after children are placed with their relatives, their needs may not be appropriately identified or supported.

<sup>65</sup> Queensland Child Safety Services, 2011.

<sup>66</sup> Ibid, 2011.

Drake died at the age of 15 in an accident that involved risk-taking behaviours.

Drake had been living with his grandmother, Rosetta, on and off for about 10 years. Drake and his sister Gabby were under the shared parental responsibility of the Minister and Rosetta.

Drake was first reported when he was two years old about concerns that his parents, Latisha and Robert, were homeless and using speed. Drake was taken to the emergency department with a head injury but Latisha had no idea what had happened. Two years later Robert was charged with assaulting Drake and Latisha, and was imprisoned for several months.

FACS spoke to Rosetta who was willing to look after the children but was worried about Robert taking the children. FACS determined that the children were unsafe in the care of their parents, so sought legal orders due to a risk that the parents could remove the children from Rosetta.

After Children's Court orders were made, reports were received sporadically about Rosetta's care of the children, with concerns that she wasn't coping and was starting to drink more. Also, she didn't know how to handle Latisha and Robert, who were coming over whenever they wanted and having violent arguments with each other and Rosetta. Drake was also starting to miss school, was picking fights and being aggressive towards Rosetta and Gabby.

Our review found there were advantages to having the children live with their grandmother, who was clearly doing her best to provide a good home for the children. But the absence of assessment and support for Rosetta meant that the children continued to be at risk. When the children were placed with Rosetta, Latisha's own significant child protection history was not identified. This included reports about Rosetta's alcohol abuse and Latisha's father being very violent towards Rosetta. Latisha was also reported when she was a teenager for running away from home.

This was vital information to consider before the children were placed with Rosetta, and also during the placement, when reports were being received about Rosetta's ongoing alcohol use and concerns that she wasn't coping. Despite her efforts, Rosetta was unable to keep the children from being continually exposed to their parents' drug use and Robert's violence.

### Deaths of children in OOHC 2010–2013

Between 2010 and 2013, 41 children and young people died while they were not living with their family. Of these 41 children 17 were living with a relative, 16 were living in foster care and 8 were living in a residential setting or hospital.

The circumstances of death of these 41 children and young people included illness, disease or prematurity (19), SUDI (6), motor vehicle accidents (4), drowning (4), suicide (3), drug overdose (3) and undetermined causes (2).

## 2.4.2 Reports

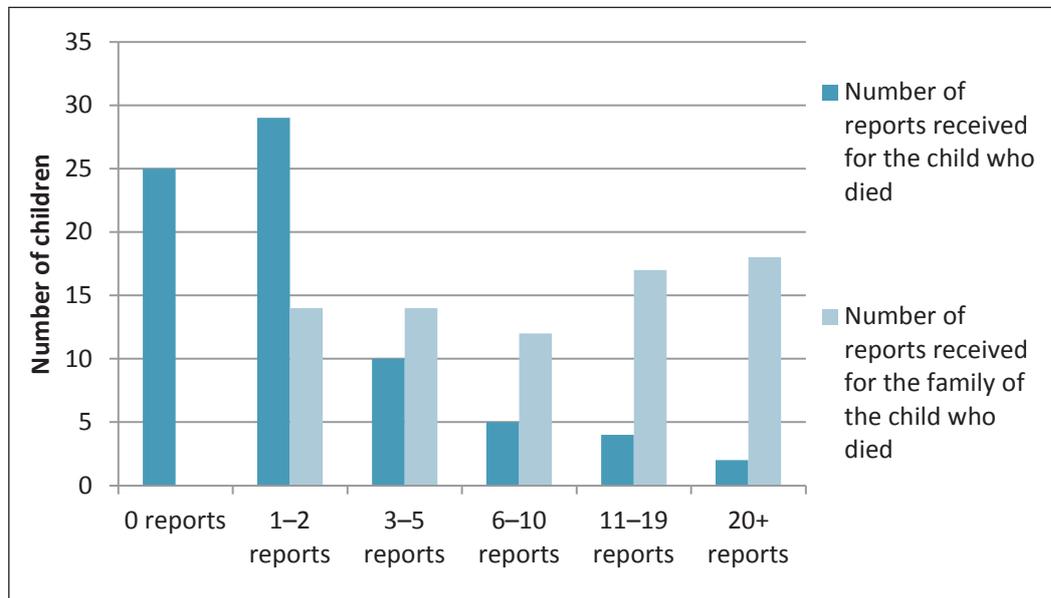
Of the 75 children and young people who died in 2013, 50 (67 per cent) were the subject of a report<sup>67</sup> to FACS prior to their death. Of these cases, 48 children and young people were the subject of a ROSH report before they died and in 42 of the 48 cases, the child or young person was reported within 12 months of their death.

The remaining 25 (33 per cent) children were not the subject of a report, but their siblings were the subject of a ROSH report prior to the death.

Most of the children and young people who died (54 children or 72 per cent) did not have lengthy child protection histories<sup>68</sup>. Eleven (15 per cent) children were reported to FACS on more than five occasions, including two adolescents who were reported 41 and 42 times respectively.

There was a higher rate of reports received for the families of the children who died, compared to reports only for the child<sup>69</sup>. This is highlighted in Figure 7 below.

**Figure 7: Number of reports received for children and young people who died and their families<sup>70</sup>.**



It should be noted that the number of reports about a family does not necessarily directly correlate with the level of risk for the children in that family. Some young families may only be reported once or twice, but the content of these reports are serious and indicate high risk. On the other hand, an extensive history of multiple reports can indicate chronic and ongoing risk issues in a family, but it also can apply to families with older children, where the majority of reports may have been received some years before the child's death.

67 A report includes either a 'risk of harm' report received prior to January 2010, or a 'risk of significant harm (ROSH)' received after January 2010. Reports that were determined to be non-ROSH are not included in this count.

68 This figure includes children who were not reported to FACS, or those who received one or two reports.

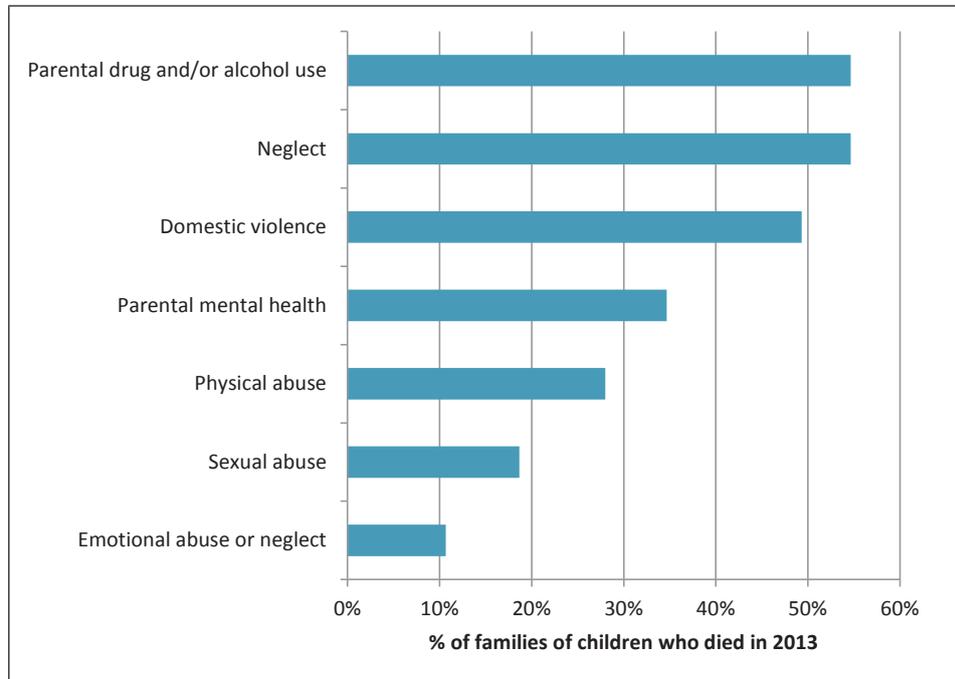
69 This is because these figures include reports received not only for the deceased child, but also for siblings of that child.

70 The 18 families who were reported over 20 times include four families who were the subject of over 50 reports.

### 2.4.3 Reported risk concerns

Parental drug or alcohol use and neglect were the primary reported issues that were identified from the ROSH reports received for the families of children who died in 2013, followed by domestic violence and parental mental health.

**Figure 8: Reported ROSH concerns for the families of the children and young people who died in 2013<sup>71</sup>.**



Of the 41 families who were reported to FACS due to ROSH concerns about neglect:

- 24 families were reported due to physical neglect
- 22 families were reported due to supervisory neglect
- 15 families were reported due to medical neglect
- 6 families were reported due to educational neglect<sup>72</sup>.

All practitioners who work with families need to acknowledge the interplay between co-existing risk factors in a family. For example, a mother's drug use may be exacerbated by domestic violence from her partner. The combination of these two issues can worsen or even create mental health problems for a parent. It is not uncommon for families who are involved with child protection services to have to deal with a combination of all three of these problems. Of the 75 children who died in 2013, 29 (39 per cent) of the families had a history of concerns about mental health, alcohol or drug use and domestic violence<sup>73</sup>.

The association between drug and alcohol use, mental health issues and domestic violence is significant, particularly in the context of child deaths. The Victorian Child Safety Commissioner<sup>74</sup> recently conducted a study of these three issues in child death reviews and found that the combined presence of substance misuse, parental mental illness and family violence had a 'snow-ball' effect on the lives of children that exceeded the individual effects of each risk factor. The study found that when these three problems were combined, the risk to a child's safety and ongoing development could be severe, especially as they are often associated with poverty, homelessness, unemployment and isolation, further adding

<sup>71</sup> Numbers do not add to 100 per cent as multiple risk factors are often present in one family.

<sup>72</sup> Numbers do not add to 41 as multiple neglect issues can be present in one family.

<sup>73</sup> This included any reports or information received about the family to indicate that these issues were present.

<sup>74</sup> Child Safety Commissioner, 2012 (Victoria).

to difficult experiences of the child. The Commissioner argued that the impact of these risk factors was not always well understood by practitioners, and that child protection services needed to work together with adult mental health, drug and alcohol and domestic violence services to address the risks holistically.

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

Our child death reviews examine all reports<sup>75</sup> received about the child and sibling/s prior to the death and what action was taken by the agency in response to these reports. As multiple reports can be received for a family, a range of different responses is also likely to have occurred.

Overall, of the 75 families of children who died in 2013, 52 (69 per cent) received a completed face-to-face assessment from FACS<sup>76</sup> and 23 (31 per cent) did not. Of the 52 cases where a face-to-face assessment was completed, 42 occurred within three years of the child's death (i.e. between 2010 and 2013).

For the 23 families who did not receive a face-to-face assessment:

- 17 cases were closed due to the higher priorities of other children at risk
- four cases had reports that were still open at the time of the child's death<sup>77</sup>
- two cases were closed after further intake work determined that an assessment was not required.

Managing the competing priorities within the context of finite resources is one of the most enduring challenges of child protection work, this is not unique to NSW<sup>78 79</sup>. Every day, managers at FACS CSCs receive a number of reports about children and young people who are at risk of significant harm. Ideally, they should be able to send caseworkers out to see all of these children. This then leaves managers with the immense task of trying to prioritise reports based on very limited information about each family.

This can be an even greater challenge where the child who has been reported has a complex, extensive child protection history. Managers should base decisions about whether to allocate reports within the context of this history, but this is not an easy task, particularly when quick decisions need to be made about families in crisis.

#### 2.4.5 FACS response after the child death

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

After being informed about the death of a child, an initial decision is made about whether a risk assessment needs to occur for any other children in that family.

Of the 75 families of children who died in 2013, 33 (44 per cent) received a face-to-face assessment by FACS and 42 (56 per cent) did not. Of the 42 families who did not receive a response, a decision was made that no response was required in 40 cases. The remaining two cases were not able to be allocated due to the priority of other matters<sup>80</sup>.

75 This includes reports received prior to the introduction of the risk of significant harm threshold in 2010.

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

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

78 Vincent S, 2009.

79 Bromfield L & Holzer P, 2008.

80 Both of these cases included children who had died from an illness or disease.

The reasons why FACS determined that no response was required for 40 families included:

- there were no siblings living in the same household who were under the age of 18 years (21 cases)<sup>81</sup>
- no risk issues were identified for the surviving siblings (19 cases)<sup>82</sup>.

Of the 33 families where a face-to-face assessment was completed, the following interventions occurred:

- FACS continued to provide ongoing case management to the family (22 cases)
- the family was referred to other services and the case was closed (six cases)
- the siblings were removed from the family home and assumed into care (five cases).

## Supporting vulnerable families following a child death

It can be a challenge to conduct a safety and risk assessment in a family after a child has died. Practitioners need to approach the family sensitively and work within the context of the family's significant grief. The dual roles of assessing safety and risk and supporting the family can often feel incompatible.

Our child death reviews have found that even the most experienced caseworkers can find it hard to visit a family straight after a child's death. These workers need to find a balance between how to engage a family who are grieving the loss of a child without compounding their grief further, alongside the need to conduct a quality assessment of risk for surviving siblings. These challenges were apparent in the story below, when caseworkers struggled to identify clearly their role following a child's death.

### case study

Jessica committed suicide at the age of 15 years. Jessica and her young sisters, Stephanie and Danielle, were the victims of serious physical abuse by their father, who had significant mental health and drug abuse problems.

After Jessica died, FACS visited the family and provided intensive assistance with funeral costs and referrals for grief and loss counselling for the parents and children. Caseworkers visited several times to ensure the family was well supported.

This was an important element of FACS casework with the family. But our review found that caseworkers became overly absorbed in supporting the family, without considering the very concerning risk issues that were still evident for Stephanie and Danielle. After Jessica's death, reports were made about the father's deteriorating mental health and escalating drug use. Despite this, caseworkers continued to maintain a supportive role in the family, without addressing what these risk issues meant for the children.

### guidance

Caseworkers require a combination of courage, skill, perseverance and compassion to stay focused on their role with in the family. Our reviews have found that the period following a child death can often present high risks for the siblings. Parents who are trying to manage grief and loss issues, potential feelings of blame and existing child protection issues (such as substance addiction, domestic violence or mental health), may find it difficult to meet the needs of other children in the family.

With this in mind, casework staff need to form a holistic judgement of the children's safety based on:

- any risk issues arising from how the child died (did the child die from abuse, neglect or in suspicious circumstances?)

81 This includes siblings who were in out-of-home care at the time of the child's death.

82 This includes cases where no ROSH concerns were identified by the helpline, or after further follow up by the CSC.

- the level and extent of the child protection history for the family (how can I support the grieving family so that existing risk factors don't get worse?)
- strengths in the family (where are the opportunities to build safety for the children?)

Critically, it is essential that practitioners identify, acknowledge and reflect on whether any judgements about a child's safety have been made in the context of defensive, reactive practice to the death, rather than a clear picture of risk in the family. Jayden's story (below) is a good example of how families can be supported through the grieving process, while still maintaining a focus on safety issues for the children. This case is also a good example of culturally responsive practice with an Aboriginal family.

case study

Jayden died when he was six weeks old, his death was classified as 'SUDI'. Jayden was sharing a bed with his mother at the time of his death.

Jayden was the youngest of four children. His brothers and sisters had been reported to FACS more than 30 times over seven years. Jayden's mum Sam had been the victim of violence from a number of partners and she was an alcoholic. There had been a lot of concerns about physical and medical neglect.

FACS had been in and out of the family's life – there always seemed to be a little progress, but never enough to sustain long term changes for the children. But since becoming pregnant with Jayden, Sam seemed to be trying to remain strong and be a good mum. Jayden's father was not living with the family, but lived in the same community.

FACS was informed that Jayden had died and there were also concerns about Sam smelling of alcohol and the house being in a poor state. Caseworkers completed an Aboriginal consultation and were guided about the family's sorry business<sup>83</sup>. Having made an appointment to see Sam, two caseworkers (one who was Aboriginal) visited the family about a week after Jayden's death.

These workers made a number of visits that week before Sam let them into the house. Over the next few weeks, the caseworkers completed a comprehensive risk assessment and started to put into place some supports for the family, particularly for the three children who were linked into medical services, grief and loss counselling and other general community services.

Our review found that caseworkers were able to support the family through the grieving process while still keeping the children at the centre of their practice. Caseworkers appropriately assessed Sam's alcohol use, considering what it might mean for the children after Jayden's death. They built rapport with Sam through perseverance and a culturally respectful response and also engaged Jayden's father, recognising that despite the fact that he was not living with him the home, he was still part of the family. Overall, caseworkers took an opportunity to carefully consider the needs of all the children in the family during a time of crisis. For the first time in many years, FACS was able to work with the family to create meaningful change and increase the safety of the children in difficult circumstances.

83 'Sorry business' is the term used by Aboriginal people to describe the death of a family or community member and the mourning process.

## Chapter 3: Safe sleeping

This chapter provides a summary of the major findings of the FACS cohort review of the deaths of 108 babies who died suddenly and unexpectedly, meeting the criteria for Sudden and Unexpected Death in Infancy (SUDI)<sup>84</sup>. The full report, *Safe sleeping: supporting parents to make safer choices when placing their baby to sleep*, can be found at [www.facs.nsw.gov.au](http://www.facs.nsw.gov.au)

### 3.1 SUDI and child deaths: 2008–12

#### 3.1.1 The links between SUDI and child protection

It is important to highlight that while babies in all families can die suddenly and unexpectedly tragically, families known to the child protection services are more vulnerable. Of the total number of SUDI deaths in NSW between 2008 and 2012, almost half of the infants were known to FACS over the same five year period<sup>85</sup>.

As discussed earlier, families known to child protection services are often some of the most vulnerable in the community. As well as child protection concerns, families may have complex needs and issues such as those arising from domestic violence, parental mental health problems, substance use, homelessness and transience. As our review found, these complexities

79 of the 108 babies (73%) had been reported to Family and Community Services prior to their death. The remaining 29 babies had a sibling reported prior to their death.

impact on parents' access to resources and ability to make safer choices for their babies. For instance, a parent may be more likely to sleep with their baby when affected by alcohol or drugs, and once asleep, the parent is likely to be less responsive to their baby's needs or distress. The review findings support the need for practitioners to continue to learn about safe sleeping, to be able to recognise risks in a baby's sleeping environment or sleeping arrangement, and to be able to provide an effective response when they observe unsafe practices.

#### 3.1.2 Characteristics of the infants

Infant characteristics – also described in the research on sudden infant death as 'non-modifiable' risk factors – are infant vulnerabilities that are linked to the risk of sudden infant death. These include the baby's age, gender, premature birth and low birth weight<sup>86</sup>.

The following are the key findings about infant characteristics from our review of the 108 babies who died suddenly and unexpectedly over the five-year period:

- SIDS<sup>87</sup> accounted for 46 of the infant deaths (43 per cent)
- 94 (87 per cent) babies died before the age of six months – peaking between two and three months
- the majority of the babies were boys (69 of the 108, or 64 per cent)
- 34 (32 per cent) Aboriginal and/or Torres Strait Islander babies died, representing a third of the infants known to FACS who died suddenly and unexpectedly over the five-year period<sup>88</sup>

84 These deaths were identified and provided by the NSW CDRT.

85 Data provided to FACS by the NSW Child Death Review Team.

86 Schnitzer et al., 2012.

87 Sudden Infant Death Syndrome (SIDS) is a sub category of SUDI used to describe the unexpected or unexplained deaths of babies under the age of one year.

88 Between 2008 and 2012 an average of 26 per cent of the children who died and were known to FACS were Aboriginal and/or Torres Strait Islander. Over the same five-year period 31 per cent of SUDI deaths were of Aboriginal and/or Torres Strait Islander infants.

- 37 (34 per cent) babies were born premature.

Other identified characteristics in the 108 babies were:

- the baby had an illness/medical condition in the two weeks prior to their death in 67 cases (62 per cent)
- one quarter of the babies who died were the second born in their family (28 babies or 26 per cent)
- 65 babies (60 per cent) died during the cooler months of autumn and winter
- 92 babies (85 per cent) died in their usual home environment
- 34 babies (32 per cent) were born to a young parent (a parent under the age of 22 years).

Although infant characteristics are linked to the risk of sudden infant death, it is important to note that they are not necessarily causal<sup>89</sup>.

A combination of infant characteristics (non-modifiable risks) and factors in the infants' sleep environments (modifiable risks) discussed in the next section, are linked to an even greater risk of infant death<sup>90</sup>.

### 3.1.3 Modifiable risks in the infants' sleep environment

This section draws attention to the risks identified in the babies' sleep environments. Aligned with the widely held view that sleep related infant deaths are potentially one of the most preventable deaths, this section emphasises the importance of safety in babies' sleep environments so that anyone – FACS staff, health professionals, police, NGOs or relatives – who visit a family where there is a baby in the home, can identify potential risks and help parents make safer choices for their babies.

The review found that at least one modifiable risk factor known to increase the risk of SUDI was observed in the sleep environments of 103 of the 108 babies (95 per cent) who died. Of greater concern is that three or more modifiable risks were found in 79 of the 103 (77 per cent) sleep environments. The following section discusses the risk factors identified in the babies' sleeping environments.

In 103 of the 108 baby sleep environments, at least one modifiable risk factor that increases the risk of SUDI was observed.

#### Inappropriate and unsafe sleeping surfaces

The risk to babies sleeping on surfaces other than those designed specifically for them significantly increases their risk of suffocating or asphyxiation<sup>91</sup>. Placing babies to sleep on inappropriate and unsafe surfaces such as a mattress, couch, lounge, beanbag, pram, and mesh sided cots, can present real threats to a baby's safety. It is important for practitioners to know that babies can become easily trapped:

- between a mattress and the bedhead or wall
- in between the backing of the lounge or sofa and the seating cushions
- between a mattress and the side rails of a cot
- between the slats of a crib
- in the side of a mesh cot, including becoming entangled in the mesh if it is torn.

In 82 of the 103 (80%) baby sleep environments, the baby was put to sleep, or had fallen asleep on a surface not designed or recommended for babies.

89 British Columbia Coroner's Service, 2009.

90 Trachtenberg et al., 2012.

91 Collins KA, 2001.

Babies do not have the ability to free themselves from these dangerous situations. Knowing the potential risks to babies who sleep on inappropriate and unsafe sleeping surfaces, and the reasons why this shouldn't happen, will help practitioners when raising the subject of safe sleeping with parents. For example, practitioners can explain why babies should not be put to sleep on a lounge or sofa, whether or not they are sleeping alone or with another person<sup>92</sup>. The risk of unsafe sleeping surfaces is demonstrated in Kelly's story, who was seven months old when she died after she was unable to breathe when she became trapped in between a mattress and the wall.

case study	<p>Kelly was picked up by her parents and brought home after having had a sleep-over at her grandma's house. Later that evening when Kelly's mum was getting Kelly ready for bed, she realised that they'd forgotten to pack the portable cot. The parents were tired, and grandma's home was a long distance away, so instead of going to get the cot, they made up a mattress for Kelly on the floor in the lounge room. They pushed the mattress up against the wall.</p> <p>Kelly was put down on her back near the middle of the mattress with a blanket on her. Her mum checked on Kelly several hours later, and found Kelly with her head facing down in the space between the mattress and the wall. Kelly had stopped breathing.</p>
reflection	<p>Kelly's death was a terrible accident. Kelly's parents were undoubtedly committed to making sure that Kelly slept in a cot – at home and away from home. It is understandable why the parents chose not to do the round trip to the grandmother's home to get the cot. Unfortunately, the parents' well-intentioned makeshift sleeping arrangements for Kelly had tragic consequences. It is not known if the makeshift sleeping arrangement was a one-off arrangement, or if it happened more frequently. FACS did have information that Kelly received regular respite at her grandmother's home.</p> <p>This case recognises that resources may be limited in some families and that practitioners should be aware of the unintentional risks of families sharing cots between households. Ideally, families should avoid sharing cots between homes, but in reality, this is not always possible.</p>
guidance	<p>When discussing safe sleeping with a parent or carer:</p> <ul style="list-style-type: none"> <li>● don't just focus on the baby's usual sleeping arrangements</li> <li>● ask questions about where else the baby might sleep and emphasise the importance of planning for safety in all situations</li> <li>● consider how you may help, or find help for the family if cots are being shared between households.</li> </ul>

<sup>92</sup> Byard et al., 2001.

## Shared sleep surface

The practice of adults sharing a sleep surface (also known as co-sleeping) with their baby can be controversial. Advice provided to parents about this practice is also mixed. Those in support of the practice argue that there are wide-ranging benefits for babies including that it can protect against sudden infant death by increasing the number of arousals in infants' sleep<sup>93</sup>. Parents may bring their baby into bed with them with all good intentions to help their baby to settle, to promote bonding or to feed the baby.

But research in this area is unequivocal in its findings that babies who sleep with another person are at increased risk of sudden infant death<sup>94 95</sup>. Parents may not be aware of the risk, or may have received inconsistent and ambivalent information about the safest way to sleep their baby. The message that needs to be given to parents – clearly and frequently – is that the safest place for babies to sleep is in a cot. This message is supported by the organisation SIDS and Kids NSW and Victoria. It is important to know that when babies sleep with another person, the risk of 'overlying' is increased. This means that a baby can be smothered from the larger person rolling on top of the baby during sleep. In this situation, the baby is unable to cry out because of the pressure exerted on his or her chest. It can cause the baby to stop breathing, as babies do not have the physical maturity to be able to free themselves<sup>96</sup>. These risks are reflected in Mason's story. Mason was eight weeks old when he died.

58 of the 103 (56%) babies were sharing a sleep surface (otherwise known as co-sleeping) with one other person.

case study	<p>Mason had a twin brother. The twins slept in separate cots in their parents' bedroom. Soon after the babies came home from hospital, the mother started to routinely take turns breastfeeding the twins in her own bed. She would breastfeed one baby, then their father would swap that baby for the other.</p> <p>On the morning of Mason's death, his mother had finished breastfeeding him at around 5am. She put Mason to her side, watched him fall asleep and then fell asleep too. When the father checked on them, he saw that they'd both fallen asleep next to each other. The father left the room without disturbing them. About an hour later, he returned to the room and noticed that Mason was still in the same position next to his mother. He was not breathing.</p>
reflection	<p>It is apparent that Mason's parents worked together as a team to establish a routine around feeding the twins. Given the exhausting task of looking after two newborns, it is no surprise that Mason's mum fell asleep next to him after his 5am feed.</p> <p>This case reflects the importance of both parents being aware of the potential risks of fatigue and exhaustion, and to avoid situations where a parent could find themselves unintentionally falling asleep during or after feeding their baby. Parents may worry about this risk more during the night but they need to be reminded of its potential consequences at any time of the day.</p>
guidance	<p>Encourage parents to feed their baby out of bed to avoid the risk of falling asleep and the risk of accidental smothering, particularly in the context of the potential dangers of fatigue or sedation.</p>

93 Carroll-Pankhurst C & Mortimer EA, 2001.

94 Busuttill A & Keeling J, 2008.

95 American Academy of Pediatrics, 2011.

96 Busuttill & Keeling 2008.

## Dangers with parental alcohol and drug use

The *Safe sleeping* review found that in 11 of the 58 families where the parent intentionally went to sleep with or had unintentionally fallen asleep next to their baby, the parent was observed (or told police) that they were under the influence of alcohol or drugs at the time. It is possible that the number may in fact be higher given that parental alcohol or drug use was a reported child protection concern in 44 of the 58 cases. There are many reasons why parents may not be open about their drug and alcohol use in these circumstances. They may fear the potential consequences of their drug use; they may feel guilt and distress about how their drug use may have contributed to their baby's death, and they may fear that this will become known to authorities.

In 11 of the 58 cases where the baby was sleeping with another person, that person was affected by alcohol or drugs

FACS is very clear in its message about how dangerous it is for babies to sleep with a parent who is affected by alcohol or drugs. The bottom line is that it is not safe to be in a situation where you are likely to fall asleep with your baby when you have consumed alcohol or drugs. Alcohol or drugs, including prescribed medications – and combinations of these – particularly depressants (e.g. cannabis, methadone and heroin), slow down a person's ability to react to situations, and can make people feel extremely tired, drowsy, and cause them to sleep in a much heavier state<sup>97</sup>. Parents affected by alcohol or drugs, who fall asleep with their baby, are at very real risk of being unable to be roused, to be unaware of the position of their baby and unable to respond to their baby's distress<sup>98 99</sup>. The risk of a parent rolling on top of their baby and the baby being smothered is increased significantly in these situations.

When assessing the risk of parental alcohol or drug use, it is important to keep in mind the way it impacts on behaviours and thinking and how it may affect the choices that parents will make for their baby. This risk is reflected in Jack's story. Jack was two weeks old when he died.

### case study

At 2pm, Jack's mum lay down on her bed with Jack for an afternoon sleep. She had taken her methadone and her anti-depressant medication. When she woke several hours later, she found Jack on his stomach. He was not breathing.

### reflection

FACS was not aware of the unsafe sleeping practices in this family but was aware of the mother's history of drug use. Practitioners must be alert to the risk of unsafe sleeping practices where one or both parents have a known history of alcohol or drug use. Once they have identified this potential risk, practitioners should think about how they are going to have conversations with parents about these risks.

This case serves as a reminder that babies can die suddenly and unexpectedly at any time – day or night. Jack's story highlights the danger of parents who are affected by alcohol or drugs who fall asleep with their baby. Practitioners need to be unequivocal in the messages that they give to parents about this risk.

97 The Royal Women's Hospital, 2012.

98 Mesich HM, 2005.

99 Dodd J, 2012.

Consider asking parents these questions:

- **How do you feel after you've been drinking or taking drugs?** Note that the effect of drugs vary on a range of factors, including the person's tolerance and the type of drug. Consult with an expert and visit <http://www.druginfo.sl.nsw.gov.au> for more information.
- **How long does this last for?**
- **How long does it take for you to come down?** For example, a person who has taken crystal methamphetamine, or 'ice', can sleep for days after coming down.
- (Depending on the length of time it takes for the effect of the drug to wear off)  
**Is the baby awake or asleep when this is happening?**
- **Is there another responsible adult in the home who can look after the baby?** Consider this in the context of how long the effects of the drugs or alcohol will last for.

**Make sure you always put the baby in the cot, as sleeping next to a baby while under the influence is dangerous and can lead to death.**

## Sleeping position

Placing babies to sleep on their stomach is identified as a major risk factor for sudden infant death. Public campaigns, in particular the 'Back to Sleep' campaigns throughout the 1990s, emphasised the importance of putting babies to sleep on their back. These campaigns have been credited with a reduction in the number of deaths of babies put to sleep on their stomach<sup>100</sup>. Our review found that 58 of the 103 babies were put to sleep in a safe position. Unfortunately, the co-existence of other risk factors, in particular the baby sharing a sleep surface with a parent, are possible contributing factors to the infant's death.

In 23 (22%) cases, the baby was put to sleep in an unsafe position – on their side or stomach.

Our review found an ongoing need to reinforce the message to parents that the safest position to put their baby to sleep is on their back. In some cases, we discovered that the parents intended to place their baby to sleep on their stomach. The review also found that parents need information about the risks associated with placing babies to sleep on their side. In a number of cases where the baby was sleeping on their side, the baby had also been sleeping with a parent. Research shows that the likelihood of a baby rolling from their side onto their stomach is significantly greater than rolling onto their back<sup>101</sup>. The risk is demonstrated in James' story, who was two months old when he died.

James was born six weeks premature. He had to stay in hospital for a while because it was hard for him to breathe. After he came home, his mum put him to sleep in his cot after breastfeeding him. James was put to sleep on his side. James' mother checked on him in an hour and found that he was still asleep and in the same position. In another hour, she checked on him again and saw that he was sleeping on his stomach with his head facing down. She did not change this position. The last time that James' mum checked on him, she found him not breathing.

<sup>100</sup> Edwin AM, Freemantle J, Young J & Byard RW, 2011.

<sup>101</sup> American Academy of Pediatrics, 2005.

reflection

James' mum did the right thing by moving him into his cot after she had finished breastfeeding him. As she was worried that James might stop breathing, she checked on him at regular intervals. It's not known what advice this mother had been given about safe sleeping and the safest position for James to be put to sleep. But the fact that James had been particularly difficult to settle that night may understandably be the reason why she didn't want to wake him when he rolled onto his stomach.

guidance

When working with families:

- ask parents what position they put their baby to sleep
- reinforce the message to parents that the safest position for their baby to sleep is on their back
- remind parents about success of the 'Back to Sleep' campaign in the 1990s.

### Loose bedding and objects in the baby's sleeping area

Loose bedding and other objects such as pillows, bed sheets, and toys can cause a baby's airways to become obstructed and increase their risk of suffocation. This is especially the case if the baby's head becomes covered by blankets or other objects. The risk of strangulation can also be increased from blind cords. In more than half of the cases where it was discovered that the baby was sleeping with loose bedding and other objects, the baby was sleeping with one or both parents or another sibling. The risk to a baby sleeping with loose bedding and objects in their sleeping area is demonstrated in Tom's story. Tom was nine months old when he died from accidental suffocation.

In 92 of the 103 (89%) cases there were hazards in the baby's sleeping environment.

case study

Tom lived with his mum who was 15 years old and her boyfriend who was 17. Tom's mum usually wrapped him in a blanket before putting him to sleep in a portable cot. On the night he died, Tom was put to sleep in the portable cot on his side. In the middle of the night, Tom was fed by his mum. She then wrapped him again and returned him to his cot. In the morning, Tom's mum asked her boyfriend if he could check on Tom. He found Tom cold to touch and blue in colour.

When police arrived at the home, they found that Tom's cot was full of doona covers, blankets and several stuffed toys. Police initially thought that the cot was used for storage because of the amount of objects in it. Tom's mum told police that the doona covers were at the bottom of the cot to make it comfortable for Tom, and the stuffed toys were there so that Tom had something to play with when he woke.

reflection

FACS and support services had been working with this young family before and after Tom's birth, and were gradually reducing their involvement. The parents had been doing a good job of raising their baby, so FACS and other services relaxed their views about the family and any potential risks to the baby. It is not known whether services were aware that the parents had started to collect things in Tom's cot.

Young parent families are particularly vulnerable to the risk of unsafe sleeping practices. It can be challenging for young parents to be confronted with the responsibility of caring for a baby who is totally dependent on them for their every need, particularly when there are strong themes of intergenerational abuse and neglect in their own history. Many of the young parents whose babies died did not have a suitable parental role model who they could seek support or advice<sup>102</sup>. This is likely to have contributed to choices that these parents made about their children.

<sup>102</sup> NSW FACS, 2012.

When working with young parents, consider:

- their previous experiences of parenting, including their own childhood experiences
- that the young parent may not have anyone or not know who they can call if they have a question about their baby
- how you as a practitioner can fill any gaps in support
- providing parents with contact details to support services e.g. Tresillian Family Care, Early Childhood Health Centres
- that they may be reluctant to ask practitioners for help in fear of being judged that they cannot look after their baby
- reassuring them that we share the same goal of making sure their baby is safe when being put to sleep.

## Exposure to parental cigarette smoking

Research has found an association between parental smoking and the risk of sudden infant death, in particular maternal smoking during pregnancy and after the birth of the infant (passive smoke)<sup>103 104 105</sup>. Babies exposed to cigarette smoke after birth are twice as much at risk of sudden infant death. If the mother smoked during pregnancy and after the baby's birth, the baby is three or four times at greater risk of sudden infant death<sup>106</sup>. Cigarette smoke, even after the cigarette has been put out, can be absorbed into clothes, couches, curtains, and bedding. Current research highlights the association between the co-existing risk factors of smoking and co-sleeping, and sudden infant death<sup>107</sup>.

In 51 of the 103 (50%) cases, the baby was exposed to cigarette smoking by one or both of its parents.

Some researchers have contended for some time that the most significant avoidable risk factor for sudden infant death is a reduction of parental smoking and that smoking parents should never sleep with their infant<sup>108 109</sup>. The *Safe sleeping* review found that in 31 of the 51 cases where the baby was exposed to cigarette smoking by one or both of their parents, the baby was also sharing a sleeping surface with a parent. The research also shows that smoking outdoors does not minimise risk as the issue of passive smoke is still there for the infant<sup>110 111</sup>. The heightened vulnerability of babies who are exposed to cigarette smoking is reflected in Chantelle's experiences. Chantelle was an Aboriginal girl who died when she was seven weeks old. Chantelle's vulnerability was increased because she was born premature.

103 Fleming PJ & Blair PS, 2007

104 Mitchell E, 2009.

105 Wilson et al., 2010.

106 Center for Disease Control, 2004.

107 American Academy of Pediatrics, 2011.

108 Sullivan FM & Barlow SM, 2001.

109 Vennemann et al., 2012.

110 Redacted Findings into the Death with Inquest into the Death of Baby K, in the Coroners Court Victoria at Melbourne, delivered on 6 July 2012 at the Coroner's Court of Victoria, Melbourne, <http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+340909+baby+k>

111 Baddock et al., 2007.

case study

Chantelle was born six weeks premature and had to spend quite a number of weeks in hospital before she could be discharged. She also had a cough in the two weeks prior to her death. On the evening before Chantelle’s death, her mum put Chantelle to sleep in her cot, before her parents also went to bed. The parents kept Chantelle’s cot next to their bed. Chantelle’s parents were smokers in the home, including the bedroom where Chantelle slept. When her mum woke the next morning, she went to get Chantelle out of the cot for her normal morning feed but found her not breathing. Police were called to the family home and could smell tobacco smoke in certain rooms including the room where Chantelle slept.

reflection

Chantelle was a highly vulnerable baby – she was born prematurely, had lung-related problems, and had been unwell prior to her death. Chantelle’s parents did the right thing by putting Chantelle to sleep in her cot. Unfortunately, it is likely that Chantelle’s vulnerability would have been further compromised by her sleeping in a room where there was cigarette smoke. Parental smoking had not been identified as a risk factor in this case by any services working with the family.

Practitioners may not feel comfortable or confident to raise smoking as an issue with parents or it might feel like a very low priority compared to other issues that need to be addressed in a family. But it is not about judging a parent’s choices. It is about making sure that families have all the information they need to make better decisions about their baby. All parents have this right, and we can provide a better service to families and children by having the courage to have these difficult conversations with them.

guidance

Practitioners should consider discussing the following points with parents if there is evidence of smoking in the home.

- There is a really high risk of babies dying from SIDS when they are exposed to smoke.
- Smoking is risky even if you smoke outside. Your baby will still be exposed to second-hand smoke and smoke on clothes, hair for example.
- Don’t be afraid to tell other visitors not to smoke in your house or car.

## Overheating

Thermal stress, in the form of overheating, is associated with sudden infant death<sup>112</sup>. Excessive clothing and/or bedding can contribute to the risk of the baby overheating by providing insulation. This prevents babies from losing heat and regulating body temperature<sup>113</sup>. This can be caused by an excessive amount of bedding, clothing, and poor ventilation. A baby can also overheat if their head becomes covered or while sharing a sleep surface with another person<sup>114 115</sup>. The risk of overheating is demonstrated in Jenny’s story. Jenny was 10 months old when she died. Jenny had a number of other vulnerabilities. She was born six weeks premature with severely underdeveloped lungs.

The possibility of a baby overheating from thermal stress was found in 38 of the 103 (37%) baby’s sleep environments.

112 British Columbia Coroner’s Service, 2009.  
 113 Ombudsman Western Australia, 2012.  
 114 British Columbia Coroner’s Service, 2009  
 115 Wailoo et al., 1989.

case study	The night before Jenny died, her mum put her to sleep in her cot. Jenny was dressed in a nappy and singlet, a woollen jumper, a jacket and pants. Jenny’s mum also covered her with a blanket, closed the bedroom window and turned on a heater. The bedroom door was also closed. Jenny’s mum checked on her the next morning and found her not breathing with the doona wrapped around her head and upper body. Jenny was lying on her tummy and face down. Police who arrived at the home described Jenny’s room as ‘hot’. Jenny’s death occurred in early spring.
reflection	Jenny’s mum might have been particularly worried about not wanting Jenny to be cold, or she may have had limited knowledge about the potential risk of babies overheating. Other risks in Jenny’s sleeping environment were the loose bedding, and the possibility that Jenny was placed to sleep on her side or tummy.
guidance	<p>Be aware of the potential risk of babies overheating by:</p> <ul style="list-style-type: none"> <li>• talking to early childhood professionals about appropriate layers of clothing and bedding for babies in all weather conditions</li> <li>• educating parents about not letting their baby get too hot when sleeping, and that babies should sleep at a comfortable room temperature</li> <li>• reminding parents to keep their baby’s cot away from heaters.</li> </ul>

## 3.2 Practice themes

FACS recognises the important and ongoing role caseworkers have in assessing safety in a baby’s sleeping environment. The department has undertaken significant work for a number of years to reduce the numbers of sleep-related infant deaths. The *Safe sleeping review* identified the need to continue this work. It is also important for other practitioners who work with families to give parents consistent messages about safe sleeping practices.

This section discusses three key practice themes: assessing risk for unsafe sleeping; working with parents who are reluctant to change unsafe sleeping practices; and the importance of not assuming prior knowledge.

### 3.2.1 Assessing risk for unsafe sleeping

Practitioners need to be able to give parents well-informed and consistent advice that will support them to make safer decisions for their baby. To do this they need to know the risks for unsafe sleeping discussed in section 3.1.2 and the reasons why parents may make particular decisions about their baby’s sleep.

Assessing the risk for unsafe sleeping and implementing strategies that support parents to change unsafe habits is not easy work. The challenges can be exacerbated in families where trauma and disadvantage have impacted on successive generations and where child protection issues overwhelm family experiences.

When there is a history of child protection involvement with families, parents may be less receptive to messages from FACS. Regardless, it is important that practitioners give parents the hard facts and engage them in frank conversations about the very real risk of their baby dying. Promoting safety for babies should be regarded as an ideal opportunity to build relationships with families based on the mutual goal to keep their baby safe.

Before the babies died, caseworkers were aware of risk factors in the sleep environments of 72 babies. In only 14 of these cases casework staff directly addressed the potential risks. This needs to improve.

## Engaging other adults in the home in safety plans

Education about the risk factors for unsafe sleeping should not be targeted at one parent alone – it is usually the mother who is most often engaged in the assessment process and/or is seen as the baby’s primary carer. Our review found that in 57 of the 103 unsafe sleep environments (55 per cent), there was at least one other adult living in the home (e.g. the father, a grandparent, other relative, or a family friend) who could have also been provided with educative information about safe sleeping. Understanding who is in the home and who may be in a position to help with safety planning could mitigate potential risk. Ask other adults in the home to participate in monitoring the baby’s sleeping arrangement and how safe it is.

In 57 of the 103 families (55%) there was at least one other adult living in the home that could have been provided with information about safe sleeping.

### guidance

- Know the potential risks to babies in their sleeping environment or sleeping arrangement and what impact other child protection issues in the family may have on a parent’s decision making (see section 3.1).
- Have respectful conversations with parents about any reported or observed risks.
- Explore with parents what they already know about safe sleeping.
- Be confident when talking about safe sleeping and what parents can do to promote safety.
- Develop plans with families that promote safe sleeping practices.
- Test and verify assertions made by parents – for example, if a parent tells you that they have a cot for their baby, it’s important to make further inquiries about this by asking to see the cot, asking when and/or for what purpose the cot is used, and does the baby sleep in the cot during night time sleep only or during the day as well.

### 3.2.2 Working with parents reluctant to change unsafe sleeping practices

Some parents will continue to make unsafe choices about where and how they put their baby to sleep, even when there are persistent efforts by practitioners to give safe sleeping messages. This is evident in Chloe’s story:

### case study

FACS caseworkers visited the family when Chloe was a week old. Caseworkers saw that Chloe was unusually red in the face and raised their concern with Chloe’s parents who said that they’d been sleeping next to Chloe. Caseworkers spoke to the parents about the dangers of co-sleeping and bought a cot for Chloe.

Caseworkers visited the family again several weeks later. During the visit, the parents told them that Chloe was asleep. When the caseworkers asked to see Chloe, the parents agreed after some reluctance. Caseworkers saw that Chloe was sleeping in the cot, but on her stomach. They encouraged the parents to move Chloe onto her back and reinforced the message to the parents about the dangers of babies sleeping on their stomach.

The next month, FACS was notified about Chloe’s death and that Chloe had been sleeping with her parents and was found lying on her stomach.

Realistically, it is not possible for any practitioner to monitor families 24-hours per day. When practitioners are speaking with parents about safe sleeping, they need to discuss with parents what is making it hard for them to adopt and maintain safer practices. Exhaustion, domestic violence, substance misuse and a lack of safe bedding are some issues that might impact on a parent's choice to continue an unsafe practice. There may be other, more practical reasons why families continue this practice too. For example, rather than buying two cots when there is more than one small child in the family, we found that parents will choose to place an older baby or toddler in the cot, and bring the younger, less mobile baby into their bed.

Keeping these issues in mind, it is important for practitioners and families to have an open, non-judgemental conversation about what the barriers are to making safer choices and what supports are needed to make their children safer.

### 3.2.3 The importance of not assuming prior knowledge and changed behaviour

It is important that practitioners do not assume that parents will retain prior knowledge or change their behaviour based on one conversation. In some of the cases reviewed, unsafe sleeping practices were long standing issues in the family. In one case where a baby died, the parents told caseworkers that they had shared a sleeping surface with all four of their children, and had experienced the previous death of a baby in the same circumstances.

For families living in poverty and disadvantage, often with unstable housing and stretched and limited resources, unsafe sleeping practices may be a pragmatic necessity rather than a choice because of the lack of availability of safer options, such as a cot. It can also be harder to convince experienced parents, and usually the mother, if she has co-slept with her other children without incident.

Practitioners should not rely on previous assessments completed on the family where safe sleeping issues have been discussed. A key learning from the *Safe sleeping* review is that parents may not change their practice even though they have been informed about the risks.

Any contact made with a family where there is a baby living in the home should be seen as an opportunity to have repeated conversations with parents about safe sleeping, exploring with the family what is preventing change in the parent's practices.

## 3.3 Stories with good outcomes

It is important to highlight stories reflecting good outcomes. These reassure that change is possible and that parents do listen to advice provided to them.

In the following case, the risk of co-sleeping was addressed successfully.

The mother was about to give birth to her second child and had not bought a cot for the baby. She had been co-sleeping with her older child and intended to also sleep with the newborn. Caseworkers spoke to her about the dangers of co-sleeping, and the risk that she or the three-year-old may accidentally smother the baby. Caseworkers bought the mother a cot which they set up and also worked with the mother on getting the three-year-old to sleep in her own bed.

The next story is about a young parent family:

case study

A caseworker accompanied the young parents to a parenting course to help them with advice on sleeping and settling techniques for their baby. The young parents took on board the information. The course was practical as it showed them how to wrap their baby. The caseworker's presence at the course allowed for further discussions about the risks of sudden infant death and ways to reduce the risks. When the young parents returned home, they removed the bumper padding that was in their baby's cot.

This story describes how a mother removed the risk to her baby sleeping with loose objects.

case study

One family used blankets to cover the top of the cot to block out the light. The mother wasn't aware of the risk this created – the blanket could fall or be grabbed in the night and fall on top of the baby. When caseworkers pointed out the risks to the mother, she removed the blanket. She also removed the blankets and pillow from the cot. During the next home visits, staff asked to have a look at the baby's cot. The cot was safe.

### 3.4 Important final messages to remember

Safe sleeping messages empathise that the safest way to sleep babies up to 12 months old is on their back, in a cot free of any loose objects, and in a smoke free environment. This chapter highlights that while all babies can be at risk of sudden and unexpected death, babies known to FACS are more vulnerable. Child protection issues, most particularly parental alcohol and drug use, family homelessness and transience impact on a family's functioning, access to resources and parents ability to make decisions that are safer for their baby. Three client groups are identified to be at particular risk: babies born to young parents; Aboriginal and/or Torres Strait Islander babies; and babies born into large sibling groups.

It is possible to prevent the sudden and unexpected deaths of babies by providing parents consistent messages from all practitioners about the risks.

The following are some simple yet key messages about safe sleeping for families, parents and anyone who has care of a baby:

- the safest place for babies to sleep is in a cot next to your bed
- make sure the baby is sleeping in a cot with nothing else in it. Babies can choke or suffocate on toys and pillows, or become tangled in loose blankets
- never sleep with a baby on a lounge, couch, mattress or sofa. Babies can roll, fall off or be suffocated
- never sleep with a baby if you have been drinking or using drugs because you could roll on them and suffocate them
- always put babies to sleep on their back. It is not safe for babies to sleep on their stomach because this can cause them to stop breathing. Babies should not be put to sleep on their side because they can roll onto their stomach and then stop breathing
- it is important not to smoke around babies or where they sleep as it makes it really hard for them to breathe.

FACS will continue to work towards supporting and educating parents to make safer choices when placing their baby to sleep. The report, *Safe sleeping: supporting parents to make safer choices when placing their baby to sleep*, details the steps we are taking to achieve this. But this work also extends beyond the involvement of FACS. A whole-of-community response and the efforts of partner agencies are needed to identify new and innovative ways to reduce these deaths.

While FACS is well placed to provide information to parents about safe sleeping, parents may be less receptive to these messages if conveyed in the context of statutory and involuntary intervention. A collaborative approach with our partner agencies is needed to ensure that consistent messages are given to parents about safe sleeping.

# Chapter 4: Progress in child protection reform

## 4.1 The FACS Strategic Statement

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

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

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

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

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

### 4.1.1 Improving the NSW child protection system

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

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

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

During 2013–14, staff at all levels of the department have worked hard to progress this challenging and complex agenda. The learning from child death reviews and critical reports have played a significant role in shaping improvements to our practice and the child protection system and will continue to inform the implementation of these changes during the next 12 months and beyond.

Some of the achievements during 2013–14 are highlighted below.

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

During 2013–14, FACS invested more than \$270 million in early intervention and community programs. Much of this funding was provided to other government agencies and non-government organisations to work with vulnerable children, young people and their families.

**The Brighter Futures Program** has continued to support up to 3,142 vulnerable families with complex needs at any one time. This service is delivered by 16 community organisations who are building the resilience of families and children considered at high risk of entering the statutory child protection system. There are now three Aboriginal Brighter Futures programs offered through Tharawal, Kari and Wandiyali. There is also a service for culturally and linguistically diverse families managed by the Metro Migrant Resource Centre.

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

Through the **Families NSW Program**, FACS has continued to work with other government and non-government agencies to assist vulnerable families who are expecting a child or have children up to eight years old. This work has included supported playgroups, family worker services, parenting programs and volunteer home visiting. Community capacity building initiatives to strengthen agency partnerships have also been a priority area during the last 12 months.

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

The NSW Government's OHCRE<sup>116</sup> **Plan for Aboriginal Affairs: education, employment and accountability** includes building the capacity of NGOs, including those delivering out-of-home care, child protection and family support services. FACS is leading this initiative to support Aboriginal NGOs to provide better services for families and communities involved in kinship care and in helping to provide support to Aboriginal parents and children.

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

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

This year saw the introduction of a package of legislative reforms designed to reduce the number of children and young people at risk of significant harm, improve the NSW child protection system and provide permanency for those children who cannot live at home safely.

The reform package was developed in consultation with other government agencies, non-government organisations and the broader community.

A key aspect of these reforms is the inclusion of the Permanent Placement Principle into the *Children and Young Persons (Care and Protection) Act 1998*. This Principle will guide decision making about the long-term placement of children and young people who are at risk of significant harm, placing a stronger emphasis on children remaining in or being returned to the care of their parent(s) or primary care giver(s) where it is safe to do so.

<sup>116</sup> OCHRE (Opportunity, Healing, Choice, Responsibility, Empowerment) is culturally significant for Aboriginal communities in NSW and is used in ceremonies to bind people to each other and their Country. [http://www.aboriginalaffairs.nsw.gov.au/wp-content/uploads/2013/04/AA\\_OCHRE\\_final.pdf](http://www.aboriginalaffairs.nsw.gov.au/wp-content/uploads/2013/04/AA_OCHRE_final.pdf)

Specific initiatives to be implemented during 2014–15 include an improved Parent Responsibility Contract Scheme, Parent Responsibility Agreements, Parent Capacity Orders, Family Group Conferencing and increased options for permanency planning.

Implementation of these reforms will commence in 2014–15 and will mean significant changes to practice. Additional tools and resources are being developed to support caseworkers make these changes in their everyday work with families.

### 4.3.2 Promoting good parenting to keep families together

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

During the review period, the **Strengthening Families Program** targeted families with children under nine years of age (or unborn) where there is a risk of significant harm involving specific issues relating to parenting capacity. Where these issues have been successfully addressed, the child has remained safely in the home.

Caseworkers build on existing family strengths through structured home visiting, parenting programs and casework focused on parent vulnerabilities. In many cases, this, combined with practical support (such as quality childcare), has eliminated the need for children to be placed in OOH. This program is now being integrated into mainstream child protection work.

The **Intensive Family Support and Intensive Family Preservation Programs** have continued to target families in crisis whose children and young people (aged zero to 15 years) are at risk/imminent risk of removal and placement in OOH. Following referral from FACS, NGOs provide case management and service delivery. Families have received an average of 12 weeks of intensive support (including 24-hour on call assistance) followed by up to 40 weeks of continuous and individually-tailored casework. In 2013–14, non-government service providers were contracted to provide 268 places in total.

**Intensive Family Based Services (IFBS)** for Aboriginal families in crisis continued during 2013–14. The program was delivered by a combination of FACS caseworkers and by Aboriginal NGOs. Each family received 12 to 16 weeks of intensive case management with caseworkers working with no more than two to three families at any time due to service intensity.

The pilot of IFBS in four Aboriginal non-government service providers located in Wagga, Clarence Valley, Kempsey and Wyong/Lakes continued, and has been extended until June 2016. The final evaluation is due to be completed by December 2014 and a small evaluation of the six internal IFBS services is currently being scoped.

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

Providing effective services and supports to adolescents has continued to be a challenge within our existing service system. There is a need to develop an evidence and skill base for working with this important group of vulnerable young people and their families.

Our **Youth Hope** program commenced as a trial in six districts during 2013 and will provide valuable insights into effective service models for adolescents. Five innovative early intervention and intensive services led by the non-government sector have been working with children and young people aged nine to 15 years who are deemed to be at risk of significant harm or likely to be so in the future.

## 4.4 Improving the future for children and young people in OOHC

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

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

The transition of statutory OOHC services from FACS to the non-government sector has been an important initiative to strengthen and expand the capacity of the system. Significant progress has been made in this area, with 53 per cent (6,456 of the 12,244)<sup>117</sup> children and young people in statutory OOHC now being case managed by non-government service providers.

A key driver of successful transition has been local implementation through dedicated Regional Implementation Groups (RIG)<sup>118</sup> consisting of government and non-government partners. Regional implementation plans have guided local implementation ensuring the best interests of children and young people are central to the process.

The process is supported by the Child Assessment Tool for placement matching and the online Referral Management System. As a result of capacity-building work with Aboriginal non-government service providers, there are now 10 accredited OOHC Aboriginal non-government service providers and nine partnerships between Aboriginal non-government services and non-Aboriginal services. **Raising Them Strong** has been delivered to more than 35 Aboriginal non-government and FACS staff to better support Aboriginal kinship and foster carers.

Stage 2 of the transition continues to focus on building service system capacity as well as establishing and improving systems and processes around governance, collaboration and carer support.

### 4.4.2 Accreditation of OOHC services

Accreditation of statutory OOHC services is an important process to ensure the safety and quality of care provided to children and young people who cannot live safely at home. It ensures we are held to the same high standards as our NGO partners. All six of our Intensive Support Services (ISS) and Sherwood House have received OOHC accreditation. FACS is currently subject to an Accreditation Program where it is being assessed by the Office of the Children's Guardian to provide statutory OOHC services across NSW.

This will complement the 52 non-government OOHC agencies that have been fully accredited, and a further 25 agencies have been provisionally accredited by the Office of the Children's Guardian. This means they have demonstrated their policies, procedures and practices meet the NSW Standards for Statutory OOHC.

## 4.5 A capable organisation and service system

To ensure FACS is well placed to deliver the planned reforms and improve outcomes for our clients, significant work has been occurring to realign and streamline the organisational structure.

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

Accordingly, resources have been concentrated at the local level, where they are needed, to work with our service and community partners to deliver innovative and flexible services.

<sup>117</sup> OOHC Transition Dashboard 2013–2014

<sup>118</sup> While FACS has been localised into 15 districts, out-of-home care transition continues to be managed according to former Community Services regions and led by hosting districts.

NSW is now divided into 15 districts and work is being undertaken to reconfigure and structure our central functions and culture to better support districts in this endeavour.

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

### 4.6.1 The Office of the Senior Practitioner

The Office of the Senior Practitioner (OSP) has maintained its passion for providing practice improvement leadership and support to caseworkers to achieve the best outcomes for children and young people.

The combined efforts of the units that make up the OSP<sup>119</sup> has provided the opportunity to promote best practice, undertake independent reviews of our practice and provide evidence based advice and guidance to casework staff during the year.

In 2013–14, **Practice First** and other family preservation and restoration strategies were allocated \$1.388M from Keep Them Safe funding. This additional funding has enabled us to provide greater support to caseworkers and build their capability in to work effectively with children and families. Some key initiatives are described below.

Practice First has now expanded to 37 sites around NSW with positive results. Practice First is now operational in 45 per cent of CSCs across the state. The three key goals of the Practice First approach are to:

- work closely with families to gain a more rounded understanding of their strengths and difficulties and to engage more collaboratively to build and sustain safety for children
- improve management of risks through greater emphasis on critical reasoning
- increase caseworkers' skills in helping families tackle their problems so that entry into care is a last resort.

Practice First sites have seen a decrease in reports about families who worked with FACS previously and an increase in the number of children and young people who have been able to safely remain at home with their families.

The first *Shining a light on good practice in NSW* report was published in December 2013. The second report was published in November 2014.

The reports highlight innovative practice across the broader child protection sector including our government and non-government partners.

Stories from individual practitioners demonstrate skilful innovative approaches to engage vulnerable children and families using respectful, transparent practices and articulating clear 'bottom lines' for child safety.

The stories provide an invaluable insight into the high quality of casework that is occurring across the sector and the importance of interagency relationships focused on shared goals.

Feedback on the reports has been positive with staff at all levels indicating it is an effective way to:

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

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<sup>119</sup> The OSP is made up of the Practice Quality Unit, Clinical Issues Unit, Child Deaths and Critical Reports Unit, Reportable Conduct Unit, Multicultural Services Unit, Systemic Review Team and the research team.

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

Along with legislation, policies and procedures, the Care and Protection Practice Standards are a core element of the framework. These standards were first introduced in 2007 and have now been updated to better align them with contemporary child protection practice; reflect the Family and Community Services Practice Framework; and bring the voice of the child to the forefront.

The role of the standards has also changed. They are now seen as a baseline for practice rather than a description of best practice. In other words, rather than being aspirational, they describe what is expected of practitioners in their everyday work.

The ten standards apply to all aspects of casework in child protection and OOHC and address the following core areas:

- 1 Practice leadership
- 2 Relationship-based practice
- 3 Holistic assessment and family work
- 4 Collaboration
- 5 Critical reflection
- 6 Culturally responsive practice with Aboriginal communities
- 7 Culturally responsive practice with diverse communities
- 8 Practice expertise
- 9 Sharing risk
- 10 Documentation in casework.

The key expectations based on the available evidence about what makes quality child protection practice are set out in each of the standards.

The first FACS Practice Conference was held in December last year. It was a joint initiative of the Office of the Senior Practitioner and Learning and Development, setting direction for our practice with children, young people and families, using the Care and Protection Practice Framework as the foundation.

The program from this conference was successfully delivered to a further 800 casework staff as a roadshow throughout NSW.

The feedback from the conference was really positive. Participants said they liked the range of sessions on offer and took away key messages about the value of relationship-based practice and the importance of hope. I think they found the commitment from the executive very motivating and valued the opportunity to reflect on their own work. It was a great event to be involved in, I really enjoyed working on it.

The second **Practice Conference** was held in November 2014. The conference aimed to build on the learning from the 2013 Practice Conference encouraging staff to explore and reflect on their practice with children, young people and their families. Feedback from participants has been overwhelmingly positive, with comments that the conference was inspiring and thought provoking. One participant commented on how attending the conference made her 'proud to work for FACS'. Another participant said that the conference was the best she had attended in her 30 year career in child protection.

During the year a **Research Team** was established within the OSP to promote and support evidence-informed child protection practice.

Knowledge from research is essential to help casework staff make difficult and complex decisions about the safety, health and development of children, young people and their families. The team is creating links between research and practice through the synthesis of literature; knowledge exchange via **Research to Practice** seminars and primary research with clients and caseworkers.

Their work over the last 12 months included a literature review on how children disclose sexual abuse. The key practice findings from this work are informing the development of a child sexual assault resource kit for all staff. Work also commenced on a review of the literature on open adoptions in OOHC to ensure our open adoption reforms are evidence based, and **Research to Practice** seminars were delivered on child sexual assault and attachment in practice.

Plans are well underway for a qualitative research project aimed at understanding and integrating the voices of children, young people and parents within our child protection quality assurance systems. This project commencing in early 2015 will include interviews with caseworkers.

## 4.6.2 Bringing clinical expertise to our casework

### Education program

In late 2013, FACS Clinical Issues Unit (CIU) worked with SIDS and Kids NSW and Victoria to develop a one-day training package for caseworkers to raise awareness and assist workers to identify the risks for Sudden Unexpected Deaths in Infancy (SUDI). The package is aimed at increasing caseworker knowledge, skills and confidence in delivering strong and consistent messages to families about safe sleeping and modifiable risk factors.

We know the rates of SUDI are higher for children from Aboriginal families and those from culturally and linguistically diverse backgrounds. The package was originally designed for these clients and two training pilots were delivered to Aboriginal caseworkers and managers. It quickly became apparent this knowledge and skill set would be valuable for all caseworkers. The training package was revised accordingly and will be rolled out across all districts in 2014–2015.

The CIU also developed a two-day training package on improving outcomes for vulnerable teens with a mental illness and/or substance use problem. This package will be available for all FACS staff in 2015.

### Delivering consultancy services

The CIU's clinical consultants directly support practice by providing case-specific information and advice to caseworkers on safety and risk assessment and case planning where there is domestic violence, parental mental health or substance misuse issues that are a risk to the safety and well being of children and young people. They provide consultations either by telephone, email or face-to-face, including in group supervision and other case discussions. The consultants also supply resources and information that assists caseworkers to integrate knowledge into their practice.

### Providing resource materials

In 2013, the CIU worked in partnership with NSW Ministry of Health and Community Services' Aboriginal Services Branch to develop a new range of safe sleeping resources for Aboriginal and non-Aboriginal families. Designed for use by caseworkers, health workers and community members, the resources provide simple, clear messages about safe ways for babies to sleep. The resources specifically focus on the risks associated with sharing a sleep surface with a baby when affected by alcohol or other drugs. In June 2014, the CIU distributed 150 safe sleeping resource kits to CSCs consisting of posters, door hangers

and wallet-sized cards. The resource kits were also distributed to non-government service providers and across NSW Health services.

An evaluation of the work of the CIU, published in August 2013, showed that staff feel the expertise the unit provides has increased their knowledge and skills and had positive impacts on practice and on outcomes for children and young people.

I have always found the CIU to be a very valuable resource to caseworkers. It is very likely the most valuable resource we have as we can access exactly the information we need very quickly.

*Caseworker*

It was just so valuable when you are really enmeshed deeply in a case and sometimes you can't see the next step, and so it was really good to have a consult, so we could actually look at, 'Okay where to from here? Who else do we need to get involved? You know, just looking at those really hands-on, practical things to do ... It is almost like when you hit a bit of a brick wall you can ring up the Clinical Issues Unit, have a discussion, and it will open up another step or another task that you can look at to work through those complex issues.

*Manager Client Services*

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

The **Child Deaths 2012 Annual Report** incorporated the learning from reviews of practice in relation to 466 children who died between 2007 and 2012 where domestic violence was a reported issue. While very few of the deaths were a direct result of to the violence, the cases highlighted the many risks violence poses to children and other victims in the household (usually their mothers) and the importance of child protection intervention in holistically addressing risks.

The review identified five key practice themes:

- getting the balance right – placing an equal focus on the impact of domestic violence on children and on assessing the capacity of both parents to keep their children safe
- recognising and working with periods of heightened risk and windows of opportunity
- incorporating knowledge about domestic violence dynamics and effects to enhance risk assessment and intervention
- recognising risk when multiple partners are a recurring dynamic
- understanding the importance of language.

The new domestic and family violence framework for reform, **It Stops Here: Standing together to end domestic and family violence in NSW**, was launched in early 2014. The framework will deliver a more integrated and coordinated state-wide system to ensure the safety of victims and their children.

Legislative change in mid-2013 improved information sharing between agencies in order to better support people experiencing domestic and family violence. Key priorities for implementation include:

- a common risk identification tool
- a central referral mechanism
- a network of local coordination points
- use of Safety Action Meetings.

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

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

The **Staying Home Leaving Violence** (SHLV) program worked with women and children escaping domestic violence supporting them to remain safely in their homes.

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

Last year, FACS committed \$31.2 million to the **Start Safely** program over three years to assist 3900 households who are escaping domestic violence and are homeless or at risk of homelessness to access safe, secure housing<sup>120</sup>. As part of the program, households received referrals to a range of support services (including domestic violence services) so they can receive the help they need. An evaluation of Start Safely by the Social Policy Research Centre in 2014 found that the program had become a valued option for providing assistance to those escaping domestic violence.

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

During the past 12 months the OSP CIU has built on the **Working with men who use violence in the home** training package, adding a suite of three safety and risk assessment training modules to enhance caseworker skills in holistic safety planning and risk assessment with families where there is domestic and family violence. The sessions focus on safety planning with the mother, with the child or young person, and working with the father or intimate partner. Casework specialists are delivering the training across NSW throughout 2014.

Linked to the Structured Decision Making tools (SDM<sup>®</sup>), the CIU developed a Safety Planning Resource to provide additional support to caseworkers developing SDM safety plans with families where there is domestic and family violence. In 2014 this valuable resource was made available to Brighter Future Program NGOs.

In 2014, the CIU is also developing a practice resource to assist caseworkers with case planning for families experiencing domestic and family violence, mental health, or drug and alcohol issues. It will provide guidance on how to develop realistic, time framed and measurable case plans based on a sound assessment of parental capacity to change. The resource is being developed with our NGO partners including domestic violence support services and men's behaviour change programs.

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<sup>120</sup> NSW Family and Community Services 2014b.

### Collaborating for better practice

Sarah and Toby were reported to FACS because their mother, Rhonda, had a history of mental illness and was showing signs of paranoia. Rhonda had married Sarah and Toby's father, Mark, two years after migrating to Victoria, Australia. Mark had been extremely violent towards Rhonda including breaking several bones. Rhonda had initially fled to a refuge and then moved interstate to Sydney with her children. Rhonda's experience of violence significantly impacted on her mental health, and since migrating to Australia Rhonda had limited access to supports and was socially isolated.

Justine (child protection case worker) had met with Rhonda but was struggling to make contact again. Rhonda's mental health appeared to be deteriorating with concerns that Rhonda's paranoia was escalating.

After Justine's home visit another report was received from Toby's school regarding his lack of attendance. Justine was concerned she couldn't contact Rhonda and couldn't check how the children were going, so she organised a consultation with the Clinical Issues Unit (CIU).

The CIU used their knowledge of the NSW mental health system to help Justine to make a referral for Rhonda to a community mental health team for an assessment. Justine arranged with the mental health team to conduct a joint home visit. Rhonda was assessed as not being a threat to herself or her children and was referred to the Transcultural Mental Health Centre for ongoing therapeutic support.

The CIU also provided information and advice to Justine about the potential impacts domestic violence has on the adult victim's mental health and the children. This resulted in the consideration of the ongoing impact of domestic violence on Rhonda and her children and how that was affecting the current situation.

Justine was also provided with resources and referral options by CIU for Rhonda and her children to support them to work through their experiences of domestic violence. Rhonda and her children are now receiving support from Mission Australia and a community support worker from Rhonda's country of birth.

## 4.7 Conclusion

Much was achieved during 2013–14 towards improving the way that we work and deliver services to our clients. Staff at all levels are to be congratulated on their ongoing efforts.

Significant funding for FACS over four years has been included in the 2014–15 NSW Budget. This investment is designed to better position caseworkers to work effectively with families and to ensure children are their primary focus. The major projects identified include:

- technology and innovative IT solutions to improve caseworker mobility so they can be more responsive to families. This is intended to reduce red-tape, freeing up time that can be spent with vulnerable families
- Safe Home for Life – Practice First has been expanded to an additional 13 sites and 73 new casework assistant positions will be created. This will free up caseworkers to spend more time working with families at risk. More face-to-face assessments will result in optimal outcomes for vulnerable children, young people and families
- additional non-government services to help build parenting skills in the families we work with so that children stay safely at home.

This additional funding is a real opportunity to consolidate the groundswell around reflective, relationship-based practice and realise our heartfelt commitment to better futures for the children, young people and families we are working with.

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## Appendix 1 Causes of death of children in 2013

This year, in addition to reporting on the circumstances of the deaths of children and young people, FACS has also published the causes of death using information made available by the NSW Child Death Review Team.

Reporting of cause of death is by the International Statistical Classification of Diseases and Related Health Problems (ICD) system, which is published by the World Health Organisation, and is the classification system used by most child death review teams both in Australia and internationally.

At the time of writing, information about cause of death was available for 58 children.

**Table 10: Causes of death for children and young people who died in 2013 and were known to FACS via ICD code.**

ICD Chapter	Total
External causes of morbidity and mortality (U50–Y98)	19
Certain conditions originating in the perinatal period (P00–P96)	14
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	10
Diseases of the nervous system (G00–G99)	5
Diseases of the respiratory system (J00–J99)	3
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)	3
Endocrine, nutritional and metabolic diseases (E00–E89)	2
Diseases of the circulatory system (I00–I99)	1
Diseases of the digestive system (K00–K93)	1
Total	58

Source: NSW CDRT, 2014.

## Appendix 2 Counselling and support services

Name	Description	Contact
Child Protection Helpline	Report suspected child abuse or neglect to FACS	132 111
Aboriginal Counselling Services (ACS)	Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	0410 539 905
Aboriginal Medical Service	Provides comprehensive health care to the Aboriginal community	Local contacts can be found at: <a href="http://www.ahmrc.org.au">www.ahmrc.org.au</a>
SIDS and Kids NSW and Victoria	Provides 24/7 bereavement support to families who have suffered the loss of a baby	1300 308 307
NALAG Centre for Grief and Loss	Provides free face-to-face and telephone loss and grief support	02 6882 9222
Lifeline	Provides 24/7 telephone crisis support and suicide prevention services.	13 11 44

# Glossary

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

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

## **Abuse**

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

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

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

## **Authorised carer**

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

## **Case closure**

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

## **Case plan**

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

## **Casework**

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

## **Caseworker**

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

## **Casework specialist (CWS)**

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

## **Child**

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

## **Child Protection Helpline**

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

### **Child Wellbeing Unit (CWU)**

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

### **Children's Court**

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

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

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

### **Domestic violence**

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

### **Engagement**

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

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

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

### **Manager Casework**

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

### **Mandatory reporter**

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

### **Medical examination**

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

### **Mental health concerns**

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

### **Neglect**

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

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

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

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

### **Order**

An order of a court or an administrative order.

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

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

### **Parental responsibility**

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

### **Parental responsibility to the Minister**

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

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

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

### **Prenatal report**

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

## **Removal**

The action by an authorised FACS officer or NSW Police Force officer to take a child or young person from a situation of immediate risk of serious harm and to place the child or young person in the care responsibility of the Secretary.

## **Report**

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

## **Reporter**

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

## **Restoration**

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

## **Risk of harm assessment**

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

## **Risk of significant harm (ROSH)**

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

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

## **Risk-taking behaviours**

Includes but is not limited to:

- suicide attempts or ideation
- self-harm
- engaging in criminal activities
- gang association and/or membership
- dealing drugs

- drug alcohol and/or solvent use
- engaging in unsafe sex
- prostitution.

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

SARA is a SDM<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 Reassessment.

### **Sexual abuse or ill-treatment**

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

### **Structured Decision Making (SDM<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**

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

### **Supported care allowance**

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

### **Tasks**

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

### **Triage and assessment practice guidelines**

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

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

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

### **Young person**

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

## NOTES

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