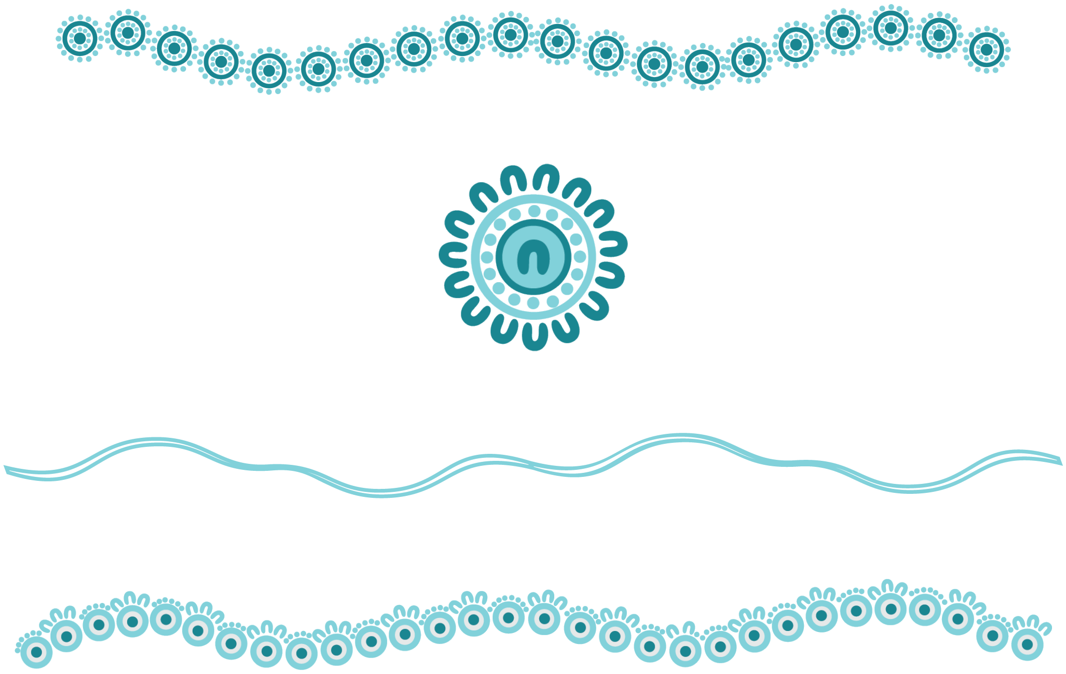
Child Deaths
2021 Annual Report

Learning to improve services

The original artwork in this report is a representation of the First Nations children who are on their spiritual journey to the dreaming. At the top of the artwork are stars to represent the spirits of our ancestors and the role they play in guiding our passed children to the dreamtime. The community circles in the centre represent the different communities that have been impacted by child deaths, but also represent the Department of Community and Justice staff and community members supporting our families during loss, grief and hardship. The lines between each yarning circle represent a sharing of knowledge and culture to ensure safe practice. This is about working towards a future where the percentage of First Nations child deaths in the system is reduced. At the bottom of the artwork are the children that have passed. This shares their journey to the dreamtime. They will forever be with us and will guide our practices moving into the future.



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Acknowledgement

The authors of this report would like to inform Aboriginal readers that it contains information about the very sad deaths of Aboriginal children and may cause distress to Aboriginal and Torres Strait Islander peoples. We wish to extend our deepest condolences to the children's families and communities.

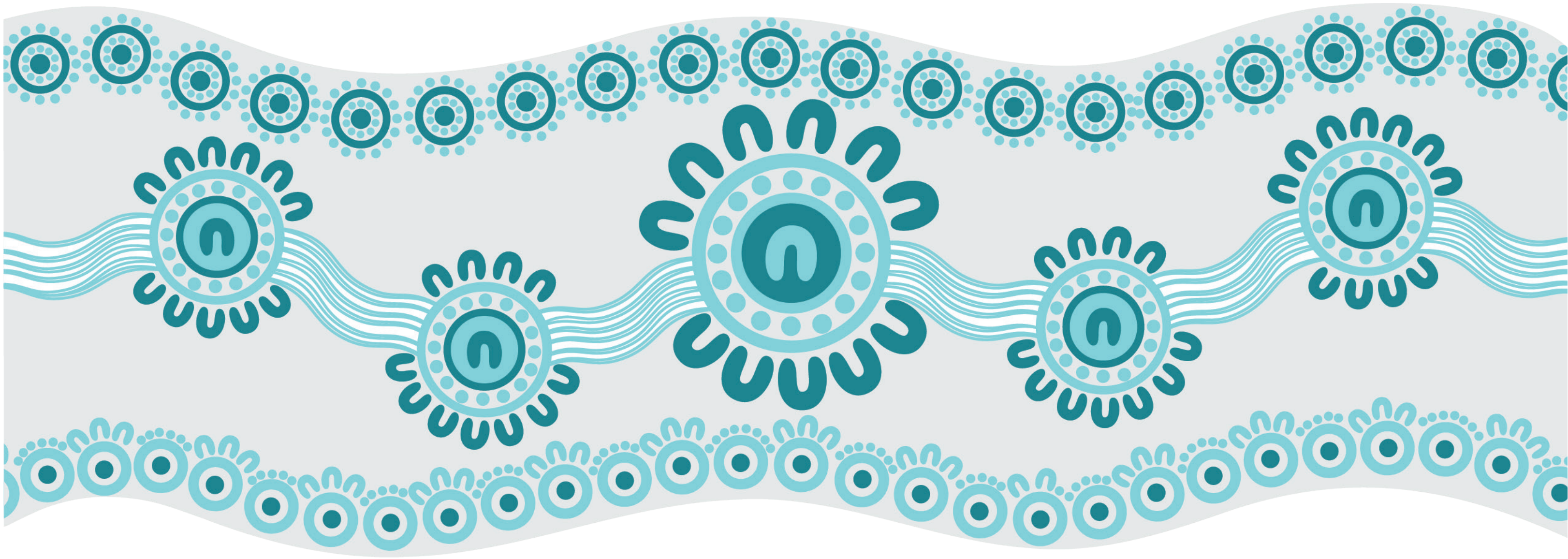
Sadly, Aboriginal children continue to be over-represented in the number of children who died in 2021 and who were known to the Department of Communities and Justice.

Past welfare policies and practices including the forced removal of Aboriginal children from their families, kin, Country and culture continue to impact Aboriginal children and their families today. This report acknowledges that Aboriginal people continue to resist the adverse consequences of these past practices and recognises the strength and resilience of Aboriginal children, families and communities across NSW.

The Department of Communities and Justice must not repeat the past and is committed to improving its practice with Aboriginal families and communities. Through policies and reforms, and in daily interactions with families, practitioners must always look for ways to understand and address the disproportionate number of Aboriginal children in the child protection and out of home care systems.

It is not the responsibility of Aboriginal people to drive this change but, rather, the entire child protection and out of home care sector. This can only be achieved by working in partnership with Aboriginal families and communities, and by taking the family's lead and fostering self-determination so that Aboriginal children are safe, connected and have a lived experience of their culture.

The Department of Communities and Justice acknowledges the impact that this report may have on Aboriginal families, practitioners and communities. A list of support and counselling services is provided at Appendix 1.



Minister's foreword

This report contains details about the 99 children who died in 2021 and were known to the Department of Communities and Justice (DCJ).

I extend my deepest sympathies to the families and communities who have lost children, and to those who have worked closely with these families during such distressing times. The death of any child is a tragedy and has broad implications for anyone who knew or loved them.

The safety of all children in the community is my highest priority. This report is essential to help us reflect on our work and consider how we can continue to strive to do better.

The *Child Deaths 2021 Annual Report* is DCJ's twelfth annual report about the deaths of children who were known to the department's child protection service. It provides details about the circumstances of these children's deaths and reviews DCJ practices with their families.

This report considers the lessons learned, as well as the initiatives being implemented to improve practice and the systems which support it. Sharing the learning with DCJ practitioners and our interagency partners will not only lead to improved service provision, and drive reform, but it will also motivate us all to do better to improve the lives of vulnerable children who are at risk.

While 2021 was a challenging year with the continued impact of COVID-19 restrictions, DCJ practitioners continued to focus on putting children first. I am inspired by the professionalism, dedication, resourcefulness and empathy of those who work in child protection and out of home care. Thank you to each of you who work tirelessly to protect children and keep them safe from harm.

Kind regards,

Natasha Maclaren-Jones

Minister for Families and Communities, and Minister for Disability Services

Secretary's foreword

As the Secretary for the Department of Communities and Justice (DCJ), I am humbled to present the *Child Deaths 2021 Annual Report*.

To the families and communities who have lost children, I convey my sincere condolences for your loss. The death of a child is deeply painful for all those who knew, cared for and loved them.

This is our twelfth consecutive report, demonstrating DCJ's ongoing commitment and accountability to continually improve child protection practice and responses to vulnerable families. This report provides the opportunity to consider the experiences of the 99 children known to DCJ who died in 2021, and the role DCJ, our interagency partners, and other services had to make a difference, and demonstrate the changes we are making.

DCJ is committed to critiquing its own work frankly and honestly. Our learnings help to answer the question 'what could, and should, have been done differently?'

Aboriginal children continue to be over-represented in the child protection and out of home care system and the number of children who died in 2021 reflects this unacceptable and alarming reality for Aboriginal children, families and communities.

Aboriginal children and families deserve far better and this a key priority for DCJ. We are focused on working in partnership with all parts DCJ, including the Transforming Aboriginal Outcomes division, to discharge our collective responsibility for improving outcomes for Aboriginal people in child protection, criminal justice, housing and the prevention of domestic violence, and transforming the way that government works with and for Aboriginal people. We work with our interagency partners, including the Office of the Children's Guardian, and are guided by the strengths and expertise of Aboriginal children, families, communities and organisations.

I am committed to continual improvement of our child protection practice and responses to families in need and being transparent and accountable. Since joining DCJ earlier this year, I have felt privileged to work alongside practitioners who prioritise the safety and wellbeing of children in their work every day. It is challenging and rewarding work.

Thank you to those who advocate on behalf of children and families and practitioners within DCJ and our partner government and non-government agencies, who continuously strive to improve the ways we work together to keep children and young people safe.

Michael Tidball

Secretary

Summary

The *Child Deaths 2021 Annual Report* is the twelfth public report from the NSW Department of Communities and Justice (DCJ).[1] It examines DCJ involvement with the families of children[2] who died and were known[3] to DCJ.

The report provides context about the children's deaths with the intention to strengthen the child protection system, improve child protection practice and support other services working with vulnerable children and families. It is the aim of the report to increase community understanding of the complexities of the work, including the widespread social disadvantage among families whose children are reported to the child protection system and the intricacy of the challenges they face.

A number of stories based on real families 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 who might find some of the report's findings and stories distressing. A list of support services and counselling services is provided at Appendix 1.

Child deaths in 2021

In 2021, 480 children aged from birth to 17 years died in NSW.[4] Ninety nine of these children were known to DCJ. Chapter 2 summarises information about these 99 children. As shown in Figure 1, and consistent with previous years, the most common circumstance of death was illness and/or disease.

Also consistent with previous years, infants under the age of 12 months and young people made up a significant proportion of the children who died. Thirty four of the children were infants under the age of 12 months, and 44 were young people aged 13 to 17 years.[5]

Aboriginal children continue to be disproportionately represented in deaths of children known to DCJ. In 2021, 37 of the children who died were Aboriginal. This report considers these 37 deaths, both within the larger cohort of the 99 children who died and separately, providing specific detail about the children's circumstances, age and gender.[6]

Seven of the children who died in 2021 were not living with their parents. The Children's Court had made an order allocating parental responsibility to the Minister for Families and Communities for five of these children. The Children's Court had allocated parental responsibility to a relative for two children.[7]

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[1] The Department of Communities and Justice (DCJ) commenced on 1 July 2019. It brings together the former departments of Family and Community Services, and Justice.

[2] The *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a 'child' as aged under 16 years, and a 'young person' as aged over 16 and under 18 years of age. In this report, the terms 'child' and 'children' are used to refer to both a 'child' and 'young person' as defined by the Act.

[3] 'Known' to DCJ includes children (or their siblings) who were the subject of a risk of significant harm report (ROSH report) within three years of their death. This also includes where a child was in out of home care at the time of their death.

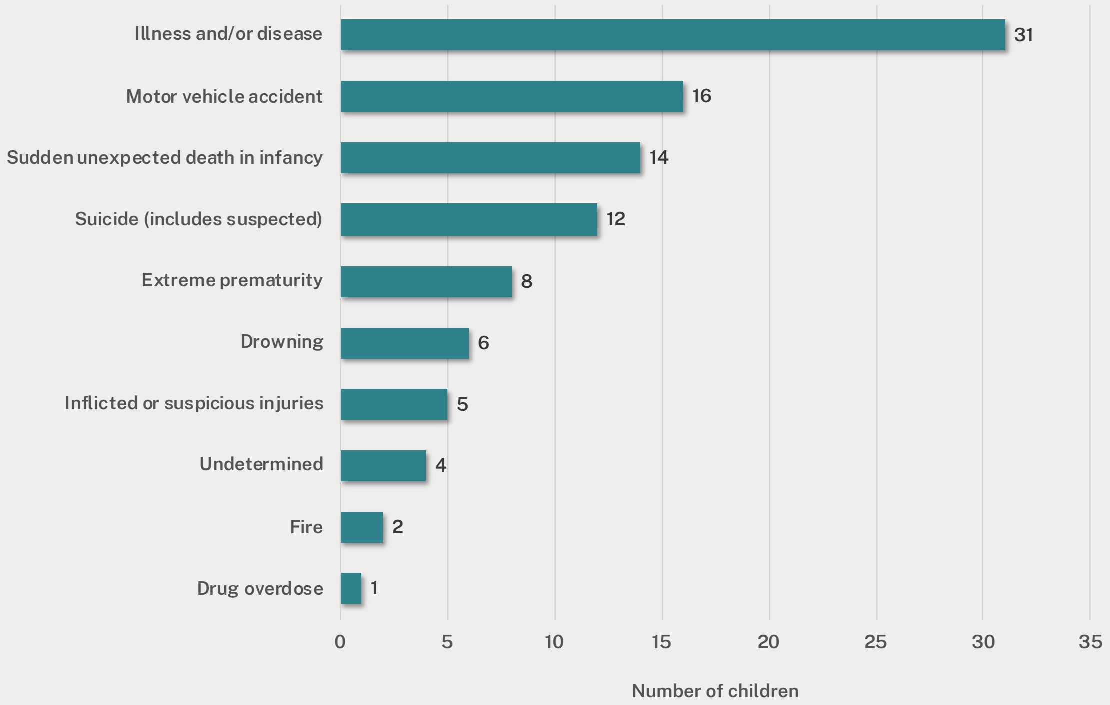
[4] Information provided by the NSW Ombudsman's Office on 31 August 2022. This information is subject to change due to subsequent reporting of deaths to CDRT.

[5] Fifteen children were aged one to eight years; and six children were aged nine to 12 years.

[6] The detail about the circumstances of these children's deaths is discussed in section 2.3.

[7] See Chapter 2 for information about the circumstances of the children's deaths. For one of these children who was living with a relative, the Minister only held parental responsibility for the child's visiting arrangements with their family.

Figure 1: Children who died in 2021 and were known to DCJ, by circumstance of death



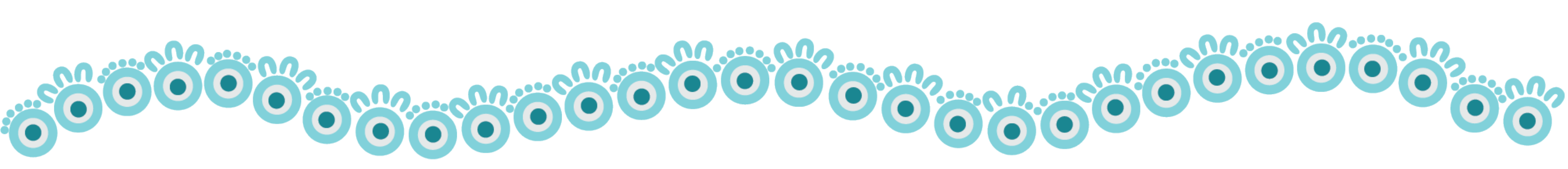
The 'undetermined' category includes cases where post-mortem information has not yet been received and where the NSW State Coroner has been unable to determine a cause of death.

Children with disability

The focus of Chapter 3 is the findings from a cohort review of 128 children who were known to DCJ and died between 2017 and 2021, and who had disability. The insights about the systems and practice in the reviews of these children is used to increase practitioner and sector understanding when working with families where a child has disability. The chapter also provides practice advice about support that can be used to make a difference when working with families who are caring for children with disability.

Improving the way DCJ works with children and families

Across 2021 and 2022, the NSW Government continued to implement reforms to the child protection and out of home care system. Chapter 4 includes a summary of how the child protection system has been strengthened as a result of recommendations made in DCJ internal child death reviews. The work of the Serious Case Review Panel is discussed, alongside key practice reform and changes that have taken place following recommendations made by the Panel in 2021.



Chapter 1: Child deaths in context

This chapter sets out the objectives of the report, and outlines the context of the child protection system and processes for child death reviews and oversight in NSW. This information is intended to help the public and other agencies understand the complex issues underlying child abuse at a societal level.

1.1 Child protection in NSW

DCJ was formed on 1 July 2019. It brought together the former departments of Family and Community Services (FACS) and Justice. DCJ is the statutory child protection agency in NSW and works with other government departments, non-government organisations and the community to support families to keep children safe from abuse and neglect. DCJ enables services to better work together to support individuals' rights to access justice and help for families, and promote early intervention and inclusion. DCJ is the lead agency in the Stronger Communities Cluster and brings together under one roof all government services targeted at achieving safe, just, inclusive and resilient communities.[8,9]

DCJ child protection practitioners work with some of the most vulnerable children and families in NSW. Many of these families live with extreme disadvantage because of poverty, past injustice, lack of access to services, unemployment, homelessness and social isolation. Often, families live with the impacts of problematic parental substance use, unaddressed mental health issues and domestic and family violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect and lead to many of the risk of significant harm reports (ROSH reports) made about children in NSW.[10]

Aboriginal families are resilient, and derive strength from their connection to Country, community and kin. Their connection to culture can be a great source of strength and protection for Aboriginal children. The challenges Aboriginal families face need to be understood in the context of a sustained history of oppression, paternalism and cruelty. Many Aboriginal families who are in contact with the child protection system have been adversely affected by intergenerational trauma and its compounding effects.[11]

DCJ has a mandated role in protecting children and is committed to a response that understands how social disadvantage and the stressors associated with it are related to child abuse and neglect. This understanding helps to improve long-term outcomes for children and their families. This report shares some of the stories of families whose children were known to DCJ and died, reflects on their experiences, and considers ways that practice could have been strengthened when working with these families to reduce risk and create safety.

Like other child protection jurisdictions worldwide, NSW faces challenges in responding to all children and young people reported at risk of significant harm. Over the last decade, the number of children seen and assessed by caseworkers has steadily increased, and the caseworker workforce has increased by 9 per cent. It is also worth remembering that a face to face assessment by a statutory child protection caseworker is one type of response available to a child

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[8] DCJ includes Courts, Tribunals and Service Delivery, Corrective Services NSW, Housing, Disability, Youth Justice and child protection services.

[9] Collaborative Practice in Child Wellbeing and Protection: NSW Interagency Guidelines for Practitioners 2021 is a resource for all government and non-government agencies working in the child and family services sector. The guidelines provide key information for interagency partners to work collaboratively to meet the safety, welfare and wellbeing needs of children. (NSW DCJ 2021b)

[10] NSW FACS (2016).

[11] Family Is Culture Review Report (2019).

reported to DCJ. Some children and families who don't receive a full child protection assessment can receive other supports that can improve safety within the home. This can happen through referrals to family preservation programs provided by non-government organisations, which can last up to 12 months or longer if necessary. In other cases, DCJ may coordinate extra support through local community partners, health, education and police to ensure a response is provided to children and families from a local service to meet immediate need and reduce risks where possible. Ensuring children are safe and families get the support they need is the priority. Just focusing on children receiving a full child protection assessment only tells part of the story and does not illustrate the fuller child protection and wellbeing system in NSW, where child protection is everyone's business.

It is important to note that the vast majority of children who die each year die from causes that were not directly related to the child protection concerns reported about them or their families. Caution should be exercised before drawing any conclusions about the children whose stories are told in this report.

1.2 Examining child deaths

1.2.1 DCJ internal child death reviews

Reviewing child deaths is a requirement in the *Children and Young Persons (Care and Protection) Act 1998*. Each year, DCJ is required to report on the number and circumstances of death of children who have died and were known to DCJ. This includes children and/or their siblings who were reported to be at risk of significant harm within three years before the death of the child, or a child who was in out of home care when they died.[12]

Children in NSW with a child protection history have a higher mortality rate than those not known to DCJ, and account for a greater relative proportion of the children who die from certain causes in NSW.[13] Other jurisdictions across Australia report similar findings.[14]

Each year the Child Deaths Annual Report has four objectives:

1. To promote transparency and accountability about child deaths by publicly reporting on DCJ involvement with the families of children who have died.
2. To increase public trust and confidence in DCJ by reporting on what has been learned from internal child death reviews, and the improvements to practice and systems made as a result of this learning.
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage that can impact on outcomes for families.
4. To share learning from internal child death reviews with practitioners and interagency partners in other government and non-government organisations.

Serious Case Review Unit

The Serious Case Review (SCR) Unit is part of the Office of the Senior Practitioner (OSP) within DCJ. The SCR Unit reviews DCJ involvement with all children who have died and were known to DCJ. These internal child death reviews consider how DCJ systems at a local and organisational level may have impacted on practice with the families of children who died. The reviews create learning opportunities for practitioners who work with families, by not only identifying areas for improvement, but also promoting positive practice. This in turn leads to broader system improvements.

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[12] Section 172A.

[13] NSW Ombudsman (2021).

[14] Previous contact with child protection services is often noted as a common factor in child death reviews. See AIFS (2017).

Practitioner support and consultation

When a child dies, the SCR Unit works to help practitioners so they can focus on providing direct support to families and assess the safety of any other children in the home. The role of the SCR Unit includes liaising with district leaders, permanency and practice managers, and casework specialists to ensure debriefing occurs with practitioners who may have been working with a family; and preparing briefings for senior officers about the circumstances of the child's death.

The SCR Unit frequently consults with practitioners to give them an opportunity to discuss their experience working with a family, including any contextual factors or systemic issues they consider relevant, and to reflect critically on practice. In some circumstances when an internal child death review is completed, the SCR Unit also provides practitioners with the opportunity to read the review, including critique of the practice, and provide feedback. Participating in an internal child death review can be a difficult process for practitioners. The SCR Unit is continually impressed by the courage and openness shown by practitioners in their willingness to reflect on their practice and learn from DCJ involvement with a family when a child dies.

An open and collaborative consultation process reduces the risk of the child's death negatively impacting future practice with other families. It encourages practitioner reflection and ensures accuracy of information and robust analysis. If reviews are to lead to genuine learning, practice and system improvement, and support practitioners to think and work differently with other children, then a process that gives them the opportunity to understand and contribute to the interpretation of their work is crucial. If practitioners have been consulted, they are more likely to accept the review findings, even those that are critical of practice. Consultation can also impact positively on the willingness of other practitioners engaging with the review process in the future.

Learning from internal child death reviews

Each internal child death review offers the possibility of considerable learning, and the OSP looks for opportunities to proactively share this learning with practitioners, program areas and policy makers across DCJ, to strengthen child protection practice and improve the services offered to vulnerable children and families.

Child Deaths Annual Report

This report is published at the end of each calendar year, and provides retrospective information about children who have died and were known to DCJ. This includes their demographic characteristics, the circumstances of their deaths, and how DCJ responded to the families of the children before and after their deaths. The report aims to engage practitioners and the community in the stories of the children who died, as well as highlighting the complexities of contemporary child protection work in NSW.

Included in the report is a cohort review that looks at a group of children who died and were known to DCJ who share some common characteristics. Previous cohort reviews have considered children who died:

- in circumstances of suicide or suspected suicide
- in circumstances related to premature birth
- and whose parents had a child protection history
- from illness and/or disease
- and who had experienced neglect
- suddenly and unexpectedly
- and who had young parents.

Other cohort reviews include responses to families of children who died, vulnerable teenagers, and children who were reported to be at risk of significant harm because of domestic and family violence.

Practice review sessions and other forums

The OSP often holds practice review sessions with practitioners, both internal and external, following a child death review. These sessions support practitioners to reflect on what worked, what could have been done differently and how learning could be applied to work with other families. The sessions also give practitioners an opportunity to share their expertise and insights about a family or about broader issues raised in a review. The stories of children who have died are also at the heart of many broader OSP learning forums, including the annual DCJ Practice Conference.[15]

1.2.2 Public and interagency understanding of child deaths

In providing public information about the circumstances surrounding children's deaths, DCJ is committed to protecting the privacy of vulnerable families who are impacted by the tragedy. The NSW Parliament has also responded by protecting privacy and confidentiality through a range of legislation that governs the disclosure of information on individual child deaths.[16] While DCJ cannot report publicly about individual children, it has a strong commitment to transparency and accountability. The publication of this report reflects this important and ongoing commitment.

Child deaths and the media

Drawing attention to the stories of vulnerable children and families through the findings of rigorous review can help the community to understand the nature of child protection work and some of the complexities involved in working with vulnerable families.

Most years a small number of child deaths are the subject of considerable media attention. These deaths often involve children who died as a result of abuse or neglect by a parent or carer. Child abuse injuries, severe neglect and deaths demand explication in the public domain and the impacts of this scrutiny can be severe and long lasting, to the families themselves and to the practitioners who worked with the family. The media can help to shape public and professional ideas of risk and it can be difficult to separate what is known about child abuse from the media as compared to theory, research and practice.[17]

While there are important and positive aspects to media coverage of child abuse such as raised public awareness and increased reporting of concerns, there are negative consequences of media coverage that is sensationalist and distracts from a solutions and a prevention approach. Recent literature about media reporting of child deaths advocates a more balanced approach that draws child protection risk to the public's attention, but then focuses on how the system could be improved.[18]

Review work by the SCR Unit has highlighted the impact that the death of a child can have on practitioners when there has been extensive coverage in the media. Practitioners may adopt a potentially unhelpful defensive response, leading them to become too cautious; or they may adopt an overly intrusive approach with families, and not recognise opportunities to build safety for a child within a family. The importance of the review process must not be understated and provides an opportunity to understand professional decision-making and focus on what can be learned and what could be done differently to support those children known to DCJ.[19]

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[15] Each year the OSP holds a conference and offers seminars to frontline workers and other professionals, to provide them with up to date research and information about current best practice. The content of these seminars, including online videos and conference papers, is available to practitioners on the Casework Practice intranet site.

[16] *Children and Young Persons (Care and Protection) Act 1998* (NSW); *Children (Criminal Proceedings) Act 1987* (NSW); *Privacy and Personal Information Protection Act 1998* (NSW); *Health Records and Information Privacy Act 2002* (NSW); *Privacy Act 1988* (Cwlth).

[17] Beddoe & Cree (2017).

[18] ibid.

[19] The review process used by the SCR Unit is described in a fact sheet available to staff on the DCJ intranet, 'Serious Case Review – who we are', and references the model from Fish, Munro and Bairstow (2008).

1.2.3 Child death oversight in NSW

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

NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the legislative requirements of the Ombudsman is the systemic review of deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths that have occurred in a care setting.[20] The purpose of this function is to prevent the deaths of children in circumstances of abuse or neglect.

The NSW Ombudsman also makes recommendations about legislation, policies, practices and services for implementation by government and non-government agencies and the community.[21] The recommendations are monitored and discussed in its biennial reports. The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in August 2021 and considered reviewable deaths of children in 2018 and 2019.[22]

NSW Child Death Review Team

Convened by the NSW Ombudsman, the NSW CDRT registers, examines, analyses and classifies the deaths of all children in NSW with the objective of preventing and reducing child deaths. The CDRT includes the Advocate for Children and Young People, the Community and Disability Services Commissioner, representatives from other government agencies,[23] and individuals with expertise in relevant fields including health care, child development, child protection and research methodology.

The CDRT also makes recommendations about legislation, policies, practices and services for implementation by government and non-government agencies and the community.[24] The CDRT reports biennially to the NSW Parliament about the causes and trends of deaths of all children that occurred in NSW, as well as annually in relation to its operations and activities, including research projects and progress on the implementation of the CDRT recommendations.

The CDRT advised DCJ that 480 children aged from birth to 17 years died in NSW in 2021.[25] Ninety-nine (21 per cent) of these children were known to DCJ because they and/or their siblings had been reported at risk of significant harm in the three years prior to their death. These figures can differ slightly from DCJ data, highlighting important differences between the CDRT and DCJ.

CDRT reports include the 'child protection history' of children who die in NSW but, unlike, DCJ:

- CDRT does not include children in care who died as having a child protection history unless the child and/or a sibling was the subject of a report to DCJ within the three years before their death
- CDRT child protection history includes children and/or their siblings who were the subject of a report (ROSH or non-ROSH) about their safety, welfare or wellbeing made to DCJ or a Child Wellbeing Unit.[26]

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[20] This may include children in care, in detention centres and correctional centres, or persons in residential care.

[21] Outlined in section 36(1)(b) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

[22] NSW Ombudsman (2021).

[23] Including from DCJ, NSW Police Force, the Department of Attorney General and Justice, Department of Education and NSW Health. For a full list of members see www.ombo.nsw.gov.au/about-us/who-we-are

[24] Outlined in section 34D(1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

[25] Information provided by the NSW Ombudsman's Office on 31 August 2022. This information is subject to change due to subsequent reporting of deaths to CDRT.

[26] The Child Wellbeing Units established in NSW Health, the NSW Police Force and the Department of Education help mandatory reporters in government agencies ensure that all concerns that reach the risk of significant harm threshold are reported to the Child Protection Helpline. They also help to identify other services that can support the child or family.

NSW Police Force and the NSW State Coroner

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

In addition, the NSW State Coroner has the power[27] to hold an inquest into a child's death where it appears to a senior coroner that:

- the child was in care, or
- the child and/or their sibling was reported to DCJ in the three years immediately preceding their death, or
- there is 'reasonable cause to suspect' that the child died in suspicious circumstances, or circumstances that may have been due to abuse or neglect.

DCJ is responsible for reporting the deaths of children known to the Department to the NSW State Coroner. DCJ and the State Coroner's office regularly share information about child deaths.

Following an inquest, a coroner may make recommendations to government and other agencies. These recommendations aim to improve public health and safety, and prevent similar deaths. Agencies are required to report to the Attorney-General about their responses to coronial recommendations, which are published on the DCJ website. Since July 2009, a consistent process for responding to and monitoring NSW State Coroner recommendations has been in place and a report is made public in June and December each year.

NSW Domestic Violence Death Review Team

The NSW Domestic Violence Death Review Team (DVDRT) is convened by the State Coroner. The team includes representatives from government agencies, including DCJ, Police and Health, and representatives from non-government sectors and academia. The core functions of the team are to review and analyse individual closed cases of domestic violence deaths;[28] to establish and maintain a database to identify patterns and trends relating to such deaths; and to develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths. The DVDRT reports to the NSW Parliament biennially, setting out findings from qualitative case analysis and recommendations from this analysis. The DVDRT undertakes public monitoring of its recommendations and responses to these in its tabled reports and on its website.

The death of a child in the context of domestic violence is also subject to review by the team. The team reports every two years, with the fifth DVDRT report (2017–2019) published in 2020.[29]

Joint Child Protection Response Program

The Joint Child Protection Response Program (JCPRP) provides a multidisciplinary response to child abuse by joining together DCJ, the NSW Police Force and NSW Health. The program operates statewide and provides a comprehensive and coordinated safety, criminal justice and health response to children alleged to have experienced sexual abuse, serious physical abuse and serious neglect that may constitute a criminal offence.

In September 2018, the Secretary of DCJ, the Secretary of NSW Health and the Commissioner of the NSW Police Force negotiated a Statement of Intent. The statement reflects an agreement between the agencies to foster cooperation and provide the best outcomes for children and their families in response to serious cases of child abuse. By working collaboratively, JCPRP staff from DCJ, Police and Health are able to coordinate agency-specific expertise around the child's needs.

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[27] *Coroners Act 2009*. https://legislation.nsw.gov.au/view/html/inforce/current/act-2009-041#sec.24

[28] Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as a death caused directly or indirectly by a person who was in a domestic relationship with the deceased person. The 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 been finally determined.

[29] NSW Domestic Violence Death Review Team (2020). A copy of this report is available on the NSW Coroners website.

Office of the Children's Guardian

The primary functions of the Office of the Children's Guardian (OCG) include:

- Working with Children Check (WWCC) – the OCG manages the WWCC processes, including applications, renewals, compliance, risk assessment and ongoing monitoring of WWCC holders.
- Oversight of organisations – the OCG implements the Reportable Conduct Scheme, Child Safe Scheme, accreditation and child safe practices in voluntary and statutory out of home care, children's employment and other child-related organisations.
- Capability building – the OCG aims to regulate, monitor and foster capability in quality child safe practices through free training and resources.

1.2.4 Reviewing the deaths of children in out of home care

NSW has a strong system of oversight into the deaths of children in out of home care. When a child who is living in out of home care dies, their death is reviewed by a number of different agencies. The SCR Unit reviews DCJ involvement with the child and their family, and the death is also reviewed by the NSW Ombudsman. The child's death is reported to the Coroner and the Children's Guardian, and may be investigated by the NSW Police Force and the Coroner.

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2021, this included children placed with carers authorised by DCJ or Permanency Support Program (PSP) providers, and children who died in a facility funded, operated or licensed by DCJ. These reviews consider the adequacy of the involvement of all agencies with the child and family up to the child's death.

Consistent with a growing non-government child and family services sector, the SCR Unit is working with non-government partners more often as part of its review process. The deaths of children in non-government out of home care settings have led to a broadening of review mechanisms, with some reviews being undertaken jointly. This flexible and collaborative model provides the opportunity for all services to consider their involvement with children and to share reflections and learning in order to improve service provision to benefit all children in care.

1.2.5 Making and monitoring recommendations following child deaths

The aim of internal child death reviews is to understand the opportunities for DCJ to work better or differently with families, while at the same time considering how the overall system can be improved. When practice and systemic issues are identified in a review, recommendations are made. Recommendations seek to strengthen the way DCJ works to support children and families, and further improve the systems that keep children safe. Making recommendations is complex and occurs both within DCJ as well as externally from other agencies. DCJ has a process in place to monitor the implementation of recommendations. The different mechanisms for making and monitoring recommendations are outlined below.

Making and monitoring recommendations within DCJ

Approximately 90 internal child deaths reviews are undertaken each year. Many of the reviews result in recommendations aimed at improving direct casework with families or about the unique needs of a Community Services Centre (CSC) or district. All reviews with recommendations are referred to the Executive District Director, Director Community Services and Director Practice and Permanency to consider the practice issues highlighted in the review and any need for a localised management response to those issues. The implementation of these recommendations is monitored closely through the DCJ Quarterly Business Review process, providing visibility of recommendations and ensuring accountability.

A small portion of the internal child death reviews completed each year have implications for statewide practice and organisational systems. These reviews are considered by the Serious Case Review Panel.

Serious Case Review Panel

The Serious Case Review Panel was established in June 2016. It meets quarterly to discuss complex practice reviews and consider the issues raised for child protection and out of home care practice within DCJ, as well as the broader relationships with other government and non-government services. The Panel is made up of senior executives from across DCJ, which ensures input from multiple perspectives and ownership of recommendations across DCJ.

This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. Chapter 4 of this report includes details of recommendations made from internal child death reviews considered by the Panel in 2021 and how these recommendations are progressing. The OSP maintains a secretariat role for the Panel and monitors the progress of recommendations. The Panel reports to the DCJ Executive Board on its work and the progress of systemic recommendations. When requested, the NSW Ombudsman and NSW Coroner are provided with a copy of the recommendations and DCJ responses in implementing them. This informs the NSW Ombudsman and Coroner’s broader role in overseeing the whole service system’s response to the learning from child death reviews.

Chapter 2: Child deaths in 2021

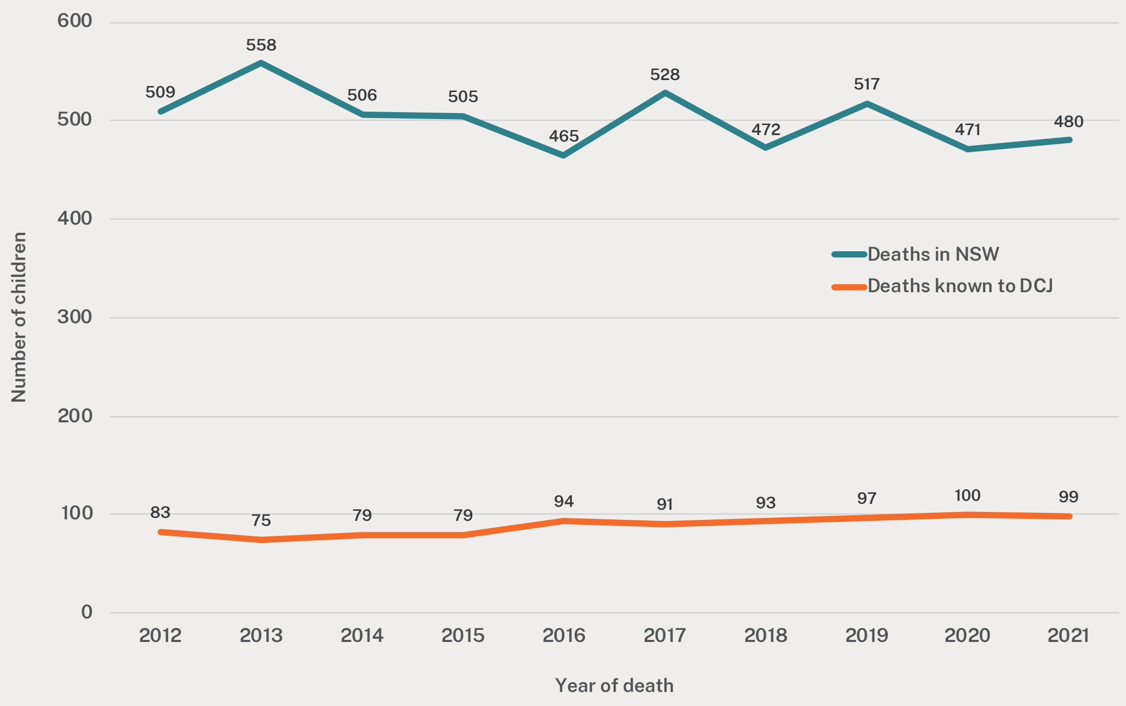
In 2021, 99 children died who were known to DCJ before their death.[30] Chapter 2 provides summary information about these children and their families, including the characteristics of the children such as their age and gender. The accompanying analysis considers the circumstances of the children's deaths, any known child protection history, and how DCJ responded to ROSH reports received before and after the children died. It also considers broad practice themes related to DCJ practice.

The purpose of the chapter is to reflect on DCJ responses to the children who died and their families, alongside that of other government and non-government services who may have been working with the child or family at the time of their death. To maintain confidentiality for the families, this chapter provides broad information that helps to describe the key themes of practice, both positive and in areas for strengthening practice.

2.1 Child deaths in NSW in 2021

Between 1 January 2021 and 31 December 2021, the deaths of 480 children were registered in NSW.[31] Of those 480 children, 99 were known to DCJ because they and/or their siblings had been reported at risk of significant harm in the three years prior to their death, or the child was in out of home care when they died.

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ, 2012–2021



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[30] Information correct as at 16 September 2022. This information is subject to change due to subsequent reporting of child deaths.

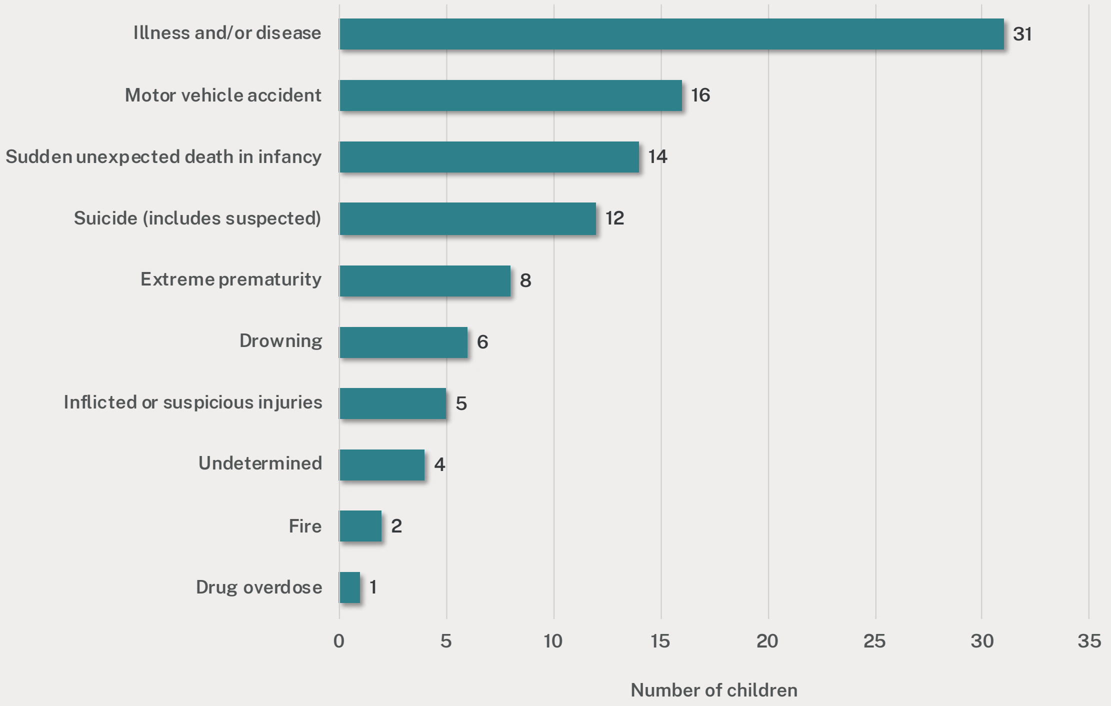
[31] Information provided by the NSW Ombudsman's Office on 31 August 2022. This information is subject to change due to subsequent reporting of deaths to CDRT.

In 2021, there was a very slight decrease in the number of children known to DCJ who died compared to 2020,[32] but the numbers have remained proportionally stable over the previous three years. The number of children who were known to DCJ and who died represent 0.1 per cent[33] of the total number of children reported to DCJ in 2021. This is consistent with previous years' findings.

DCJ receives information about the medical causes and circumstances of children's deaths from the NSW State Coroner and NSW Ombudsman's Office. The categories used to describe the circumstances of death can be different to the cause of death. For example, the cause of a child's death might be 'multiple injuries', while the circumstance of death may be from a motor vehicle accident.

Figure 3 (a repeat of Figure 1 in this report) again shows the circumstances of death for the children who were known to DCJ in 2021. Of the 99 children who died, 81 deaths were attributed to five main circumstances. The most common circumstance of death was illness and/or disease (31 children). This was followed by motor vehicle accidents (16 children), sudden unexpected death in infancy (SUDI) (14 children), suicide (12 children) and extreme prematurity (8 children).

Figure 3: **Children who died in 2021 and were known to DCJ, by circumstance of death**



The 'undetermined' category includes cases where post-mortem information has not yet been received and where the NSW State Coroner has been unable to determine a cause of death.

Over the five-year period 2017 to 2021, the number of deaths across each of the circumstances has remained relatively stable. Death from illness and/or disease has remained the most prevalent circumstance for all children who died and who were known to DCJ. This is consistent with the deaths of children in the general population.[34] However, this year saw the lowest number of deaths from illness and/or disease over the past five years. Although, this year, there was an increase in deaths as a result of motor vehicle accidents and from drowning.

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[32] When 100 children died.

[33] In 2021, DCJ received 246,326 ROSH reports involving 116,433 children (data extracted by the Child Protection Reporting Team, Organisational Performance, FACSIAR, 22 March 2022).

[34] NSW Ombudsman (2021) – section 3.2: Trends in natural cause infant and child deaths, 2005–2019.

Table 1: Children who died and were known to DCJ, by circumstance of death, 2017–2021

Circumstance of death	2017		2018		2019		2020		2021	
	No.	%	No.	%	No.	%	No.	%	No.	%
Illness and/or disease	46	50%	39	44%	32	33%	36	36%	31	31%
Motor vehicle accident	2	2	10	11%	6	6%	11	11%	16	16%
Sudden unexpected death in infancy	15	17%	10	11%	19	20%	16	16%	14	14%
Suicide (includes suspected)	4	4%	8	9%	8	7%	12	12%	12	12%
Extreme prematurity	13	14%	10	11%	10	10%	9	9%	8	8%
Drowning	1	1%	2	2%	3	3%	1	1%	6	6%
Inflicted or suspicious injuries	5	5%	8	9%	7	7%	3	3%	5	5%
Undetermined	2	2%	0	0%	2	2%	5	5%	4	4%
Fire	0	0%	1	1%	3	3%	2	2%	2	2%
Drug ovedose	1	1%	2	2%	2	3%	2	2%	1	1%
Accidental asphyxia	1	1%	1	1%	1	1%	2	2%	0	0%
Other accidental injuries	1	1%	1	1%	3	3%	1	1%	0	0%
Accidental choking	0	0%	1	1%	1	1%	0	0%	0	0%
Total	**91**		**93**		**97**		**100**		**99**	

2.2 Characteristics of the children

2.2.1 Age and gender

Consistent with previous years, infants under the age of 12 months and young people made up a significant proportion of the children who died and were known to DCJ. Thirty-four of the infants who died were under the age of 12 months. Forty-four were children aged 13 to 17 years.[35]

In 2021, 59 children who died were male, and 40 were female. This aligns with the CDRT *Biennial report of the deaths of children in NSW: 2018 and 2019*, which found that males had mortality rates 1.4 times higher than females (in 2018 and 2019).[36]

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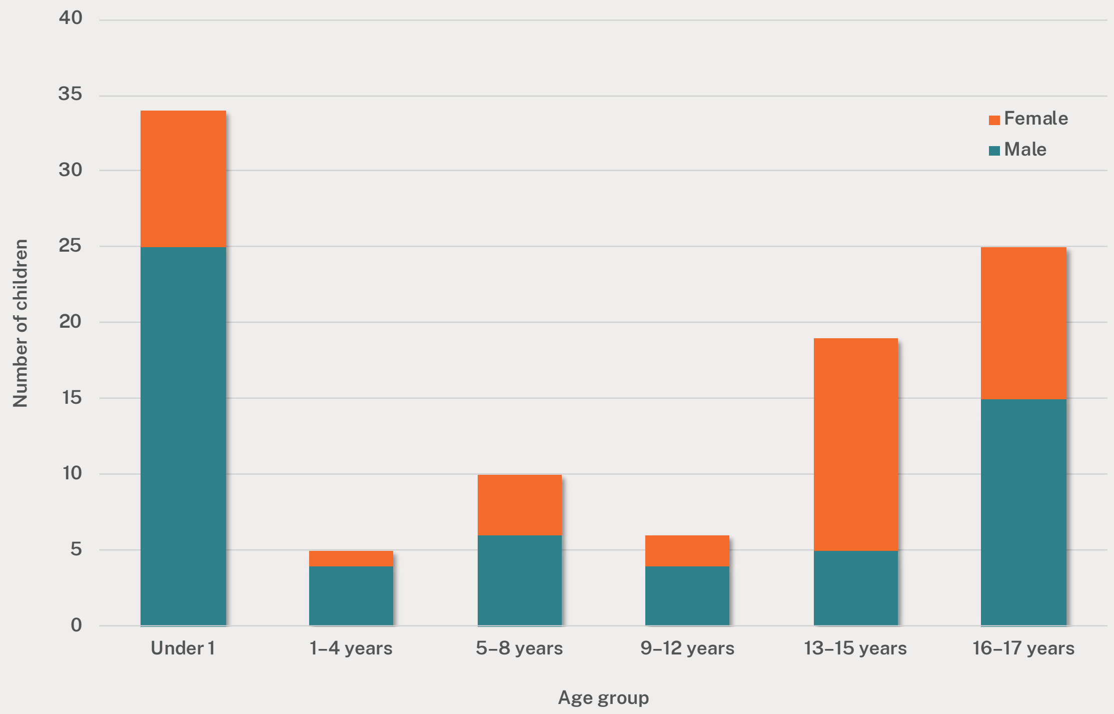
[35] Fifteen children were aged one to eight years; six children were aged nine to 12 years.
[36] NSW Ombudsman (2021).

Figure 4: Children who died in 2021 and were known to DCJ, by age and gender



Infants aged under 12 months

Of the 34 infants who died under the age of 12 months, 28 infants (82 per cent) died within three months of their birth. Twenty-five (74 per cent) were male and nine (26 per cent) were female.

The three main circumstances of death for infants under the age of 12 months were SUDI (14 infants, 41 per cent), extreme prematurity (8 infants, 24 per cent) and illness and/or disease (7 infants, 21 per cent).

Children aged one to eight years

Of the 15 children who died aged one to eight years, 10 (67 per cent) were male and five (33 per cent) were female.

The circumstances of death for children in this age group were motor vehicle accidents (7 children, 46 per cent), drowning (4 children, 27 per cent) and illness and/or disease (4 children, 27 per cent).

Children aged nine to 12 years

Of the six children who died aged nine to 12 years, four (67 per cent) were male and two (33 per cent) were female.

The circumstances of death for children in this age group were illness and/or disease (5 children, 83 per cent) and motor vehicle accidents (1 child, 17 per cent).

Teenagers and young people aged 13 to 17 years

Of the 44 young people who died aged 13 to 17 years, 20 (45 per cent) were male and 24 (55 per cent) were female.

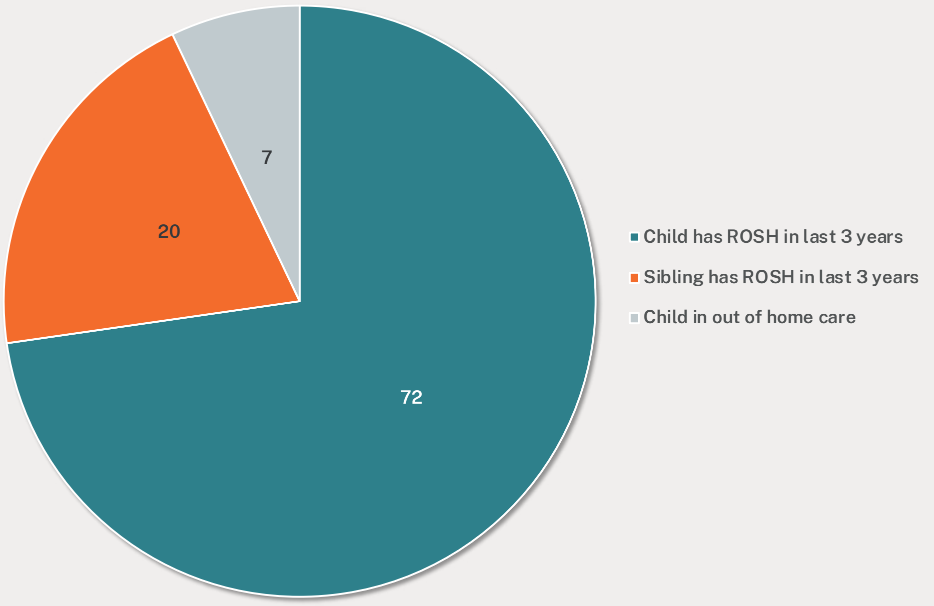
The three main circumstances of death for children in this age group were illness and/or disease (15 children, 34 per cent), suicide or suspected suicide (12 children, 27 per cent) and motor vehicle accidents (8 children, 18 per cent).

2.2.2 Reported child protection history

As seen in Figure 5, 72 (73 per cent) of the 99 children who died in 2021 were known to DCJ because a ROSH report had been made about them in the previous three years. Twenty children (20 per cent) were known to DCJ because a ROSH report had been made about their sibling/s in the previous three years. Seven of the children (7 per cent) were known to DCJ because they were living in out of home care.[37] These figures are similar to those for the children who died in 2020.

Of the 72 children who were known to DCJ, 44 (61 per cent) had five or fewer ROSH reports made about them before they died. Twenty-five (35 per cent) of the children were reported at risk of significant harm between six and 25 times, and three children (4 per cent) had more than 25 ROSH reports.

Figure 5: Number of children who died in 2021, and how they were known to DCJ



2.3 Aboriginal children who died in 2021 and were known to DCJ

The deaths of Aboriginal children continue to represent a higher proportion of children who died and who were known to DCJ. Of the 99 children who died in 2021 and were known to DCJ, 37 children (37 per cent) were Aboriginal. This represents an increase from previous years.[38]

Aboriginal children continue to be significantly over-represented in the NSW child protection system. Aboriginal children are reported to DCJ at a disproportionally higher rate and are three times more likely to be taken into care. The proportion of Aboriginal children in out of home care in NSW has continued to increase. In NSW, there were 6,829 Aboriginal children in out of home care as of 30 June 2021. This is an increase of 2.1 per cent from 30 June 2020.[39]

DCJ practitioners have a responsibility to work in partnership with Aboriginal families and communities to keep children safe. Caring about, respecting and understanding Aboriginal culture means acknowledging the trauma of past injustices that stripped Aboriginal families

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[37] The causes of these children's deaths are discussed in section 2.5.
[38] In 2020, 23 children (23 per cent) who died were Aboriginal; in 2019, 33 children (34 per cent) who died were Aboriginal.
[39] As at 30 June 2020, there were 6,688 Aboriginal children in out of home care. DCJ Annual Statistical Report 2021.

of basic human rights, their families and connection to Country. DCJ must ensure that current practice does not repeat the errors of the past. Culturally responsive practice involves acknowledging that Aboriginal children and families are the experts in their experiences, fostering self-determination and ensuring a child's culture is considered in every decision made about them. Connection to Aboriginal culture protects children, and provides belonging, understanding of identity and wellbeing.

The importance of purposeful cultural consultation for Aboriginal children and families cannot be overstated. Practitioners need to draw on the strength and support of communities, wisdom and leadership from Elders, and learn about the cultural practices, protocols and spirituality that supports healing and parenting. Guidance on how to work in these ways should come from cultural consultation with Aboriginal staff and community members. Consultation needs to be ongoing throughout the casework journey. It involves practitioners engaging genuinely in the process and seeking specific knowledge and skills, to help make sure DCJ practice meets the needs of Aboriginal children and their families.

CULTURAL PRACTICE WITH ABORIGINAL FAMILIES

Achieving better outcomes for Aboriginal children and families is a key priority for DCJ. To achieve this goal DCJ staff need to be equipped with the skills, knowledge and capability to engage with Aboriginal families in a respectful and culturally inclusive manner. DCJ practitioners can access internal Casework Practice advice on **Cultural practice with Aboriginal communities**, which provides information and resources for practitioners working with Aboriginal families.

Identity and culture for children in out of home care mandate

The **Identity and culture for children in out of home care** mandate was recently written in partnership with Aboriginal practitioners. The new mandate significantly strengthens case planning to meet a child's cultural needs, and maintain and enhance their connection to family, Country, community and culture (including language).

Aboriginal Case Management Policy

The **Aboriginal Case Management Policy**, developed in partnership with AbSec,[40] was introduced in 2019. The policy supports practitioners to engage early with Aboriginal families to shape case planning, and keep children safe with their family and community. The rules and practice guidance strengthen Aboriginal family led decision-making and the role of Aboriginal Community Controlled Organisations (ACCOs) in the provision of family preservation, out of home care and permanency services to Aboriginal children and families.

Aboriginal Cultural Capability Framework[41]

The **Aboriginal Cultural Capability Framework** (ACCF) is a strategy to help DCJ improve the cultural capability of individuals and teams, create a culturally safe

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[40] AbSec (formerly the Aboriginal Child, Family and Community Care State Secretariat) is the NSW Child, Family and Community Peak Aboriginal Corporation.

[41] The Aboriginal Cultural Capability Web App. See https://accf.facs.nsw.gov.au/

environment for staff and drive better engagement with Aboriginal people. The ACCF provides the tools needed to improve cultural capability and practice within DCJ. It provides strong leadership, localised training, access to cultural resources and an increased number of Aboriginal staff. The ACCF will benefit DCJ staff and clients by:

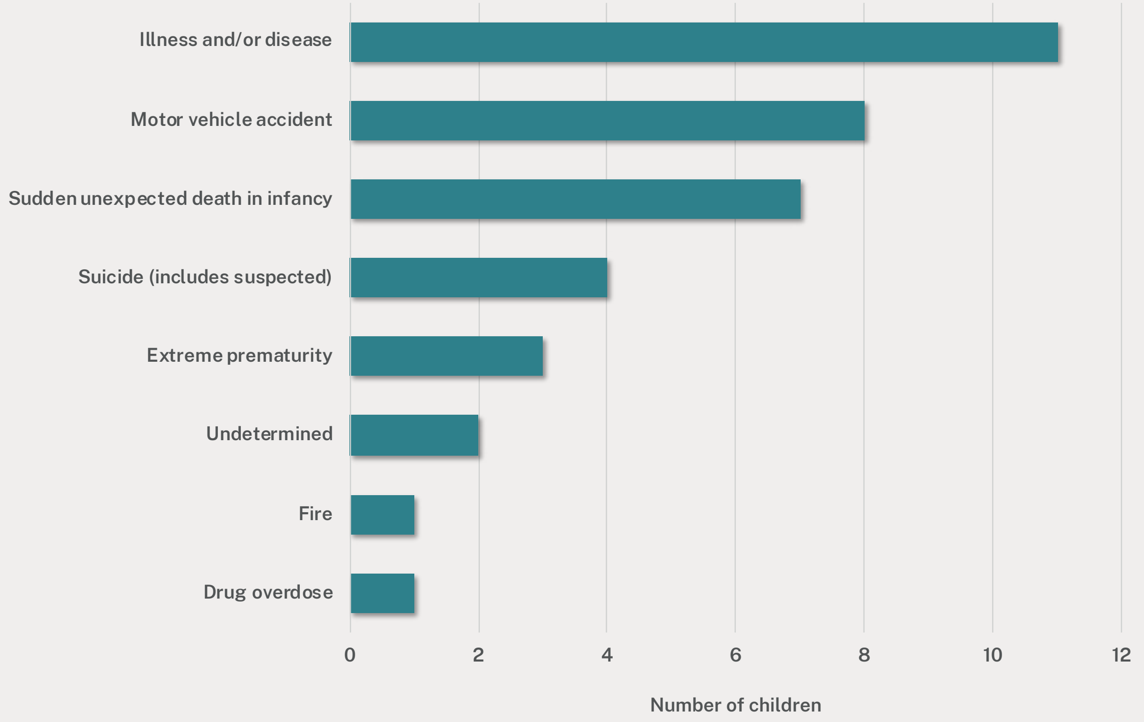
- making DCJ a culturally safe organisation for Aboriginal clients
- empowering all staff with the skills and capabilities to be more effective in working with Aboriginal clients and make better informed and culturally appropriate decisions
- breaking the cycle of poor interactions between DCJ and Aboriginal people to improve the likelihood of accessing DCJ services before they reach crisis point.

2.3.1 Circumstance of death

Consistent with previous years, a significant proportion of Aboriginal children's deaths were from illness and/or disease. As seen in Figure 6, of the 37 Aboriginal children who died in 2021, the three main circumstances of death were illness and/or disease (11 children, 30 per cent), motor vehicle accidents (8 children, 22 per cent) and SUDI (6 children, 16 per cent).

There was an increase from 2020 of children who died in motor vehicle accidents, with two sets of siblings who died in accidents likely accounting for this increase; and an increase in infants who died in circumstances of extreme prematurity. There was a decrease from 2020 in the number of Aboriginal children who died in circumstances of suicide.

Figure 6: Aboriginal children who died in 2021 and were known to DCJ, by circumstance of death



2.3.2 Age and gender

Of the 37 Aboriginal children who died, 25 were male and 12 were female.

Fourteen (38 per cent) of the 37 Aboriginal children who died were younger than 12 months. These children died primarily in circumstances of SUDI, extreme prematurity and illness and/or disease. For one death, the Coroner has not yet made a determination as to the final cause.

Nine Aboriginal children (24 per cent) were aged from five to 12 years, with most children aged from five to eight years. These children died in motor vehicle accidents and from illness and/or disease.

Fourteen Aboriginal children (38 per cent) who died were aged 13 to 17 years. These children died primarily from illness and/or disease, motor vehicle accidents or suicide.

BUILDING STRONG FOUNDATIONS

Building Strong Foundations (BSF) for Aboriginal Children, Families and Communities provides culturally safe child and family health services for Aboriginal children from birth to school age and their families.[42] Services are provided by teams of Aboriginal health workers and child and family health nurses. BSF services include regular child health checks (using the Blue Book); parenting information and support; health promotion and community activities; and appropriate referrals and support to access other services. Services are located in Albury Wodonga, Balranald, Bathurst, Eurobodalla, Gosford, Griffith, Kempsey, Lake Cargelligo and Murrin Bridge, Lithgow, Menai, Narrandera, Newcastle, Nowra, Penrith/Cranebrook, Tamworth, Taree and Wentworth.

2.3.3 Aboriginal children in out of home care

Four Aboriginal children were living in out of home care when they died in 2021, which is consistent with previous years.[43] The Minister had parental responsibility for three children. For one child, the Minister had parental responsibility for parent/child visiting arrangements only, with all other care aspects allocated to a relative.

The children were aged from 13 to 17 years; two were male and two were female.

For the four Aboriginal children who lived in out of home care the circumstances of death were illness and/or disease (2 children), fire (1 child) and undetermined (1 child). Two of the children were living with relative/kinship carers, one lived in a residential care setting and another in a long-term hospital facility.

DCJ response to the Aboriginal children who died and their families

Reported issues of concern

Of the 37 Aboriginal children who died, 23 had been reported at risk of significant harm fewer than five times. Five of these children had not been reported themselves, but their sibling had.

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[42] NSW Health (2022a).

[43] In 2020, no Aboriginal children in out of home care died. In 2019, five (15 per cent) of the 33 Aboriginal children who died were living in out of home care. In 2018, five (13 per cent) of the 36 Aboriginal children were living in out of home care.

Nine children had been reported to DCJ between five and 20 times. Four children had been reported more than 20 times; two of these children had been taken from their parents' care as children but later reunited. The most common concerns reported[44] about the families were:

- domestic and family violence (14 families)
- physical neglect (13 families)
- parental substance use (12 families)
- physical abuse (12 families).

DCJ response to ROSH reports received within 12 months of the child's death

Twenty-five of the Aboriginal children who died or their siblings had been reported to DCJ within 12 months of their death. DCJ responded to these reports in the following ways:

- Allocating eight of the reports for assessment:
    - DCJ was working with six of the families at the time the children died.[45]
    - DCJ had completed an earlier assessment about one child before closing the case,[46] when a new report was received that the child had died.
    - DCJ allocated another report, but the child died before the assessment started.
- Gathering information about two of the children to inform decision-making; however, during that time, the children died.[47]
- For one report (2 siblings), DCJ referred the families to a DCJ-funded program (Brighter Futures) to work with and support the family.
- For four reports, the siblings who had been reported were in out of home care.
- For five reports, confirming that the children were receiving support from other agencies such as Health before closing the report.

There were five reports that were not allocated by DCJ at the time of the child's death. The circumstances of these children's subsequent deaths were not related to the child protection concerns raised and included:

- one baby died due to extreme prematurity
- one baby died in circumstances of SUDI
- one child died following an illness (cancer)
- two young people died in motor vehicle accidents.

DCJ sibling safety response

Of the 37 Aboriginal children who died, for 27 of these families there were no other risks identified for the siblings or there were no siblings aged under 18 years living in the home. DCJ completed sibling safety assessments with five families. One of these cases was closed in line with closure guidelines;[48] the other four families were referred to DCJ-funded programs (Brighter Futures) and local services. DCJ was not able to allocate five of the families for further assessment.

Practice themes

Collaboration with services: A number of the reviews for Aboriginal children who died and were known to DCJ demonstrated a high level of collaborative practice with partner agencies and external services such as Aboriginal Maternal Infant Health Services and Aboriginal Medical Services.

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[44] In the last three years.

[45] Each of the six children died from separate causes or circumstances: SUDI, illness and disease, drug overdose, suicide, extreme prematurity and, in one case, the Coroner is yet to determine the child's cause of death.

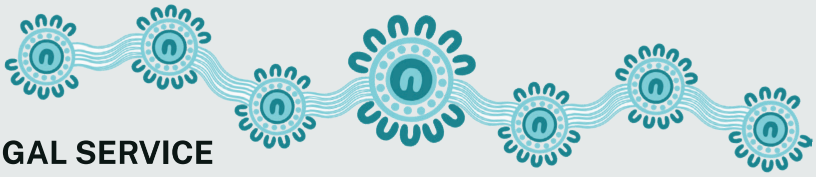
[46] In line with case closure guidelines.

[47] One child in circumstances of SUDI and one child died in circumstances of suicide/suspected suicide.

[48] A risk assessment indicating the child was at 'low or moderate' risk of future harm.

Aboriginal consultation: Many of the reviews showed that cultural consultation was being used to inform work with Aboriginal families, which was a strength in practice; however, reviews identified that for some children, not all suggestions from cultural consultations were being implemented, particularly around consultation with wider family and kinship networks.

Aboriginal Legal Service: A number of reviews identified families who were receiving support from the Aboriginal Legal Service (ALS) and missed opportunities for DCJ to actively involve the ALS in the child protection response to ensure that it could provide ongoing advocacy and support.



ABORIGINAL LEGAL SERVICE

The Aboriginal Legal Service (ALS) Care and Protection team provides culturally safe, expert legal and non-legal help to Aboriginal families who have had child protection involvement. The team helps families to understand the processes of child protection agencies and the Children's Court. It can also support families who want to change an order made by the court or ensure that Aboriginal children who have been taken into care by DCJ are placed with family or within their community.[49]

Other practice themes arising from the internal child death reviews of Aboriginal children were also noted in reviews of non-Aboriginal children who died. These themes have been included within the practice themes for each circumstance of death or within the common themes at the end of this chapter.

2.4 Circumstances of child deaths

This section of the chapter considers the circumstances of death for all of the 99 children who died in 2021.

2.4.1 Deaths from illness and/or disease

Consistent with previous years, child deaths from illness and/or disease accounted for the greatest number of deaths in 2021. Thirty-one children known to DCJ died from illness and/or disease in 2021, which was proportionally the lowest it has been over the past five years. Details of the numbers of child deaths from illness and/or disease over the past five years is provided in Table 2.

Of the 31 children who died from illness and/or disease, 14 were male and 17 were female. Nine of the children (29 per cent) were aged 16 to 17 years, seven (23 per cent) were aged under one year, and six (19 per cent) were aged 13 to 15 years. Four of the children were living in out of home care.

For most of the children (24) who died from illness and/or disease, their death was due to a chronic health condition,[50] with seven children dying from an acute illness.[51]

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[49] Aboriginal Legal Service (2022).

[50] Chronic diseases are long-lasting conditions with persistent effects. Many people with chronic conditions do not have a single condition, but rather experience the presence of two or more chronic conditions at the same time (AIHW 2021a).

[51] An acute illness is a medical condition that comes on suddenly and lasts for a limited time (AIHW 2021b).

Of the 24 children with chronic illnesses:

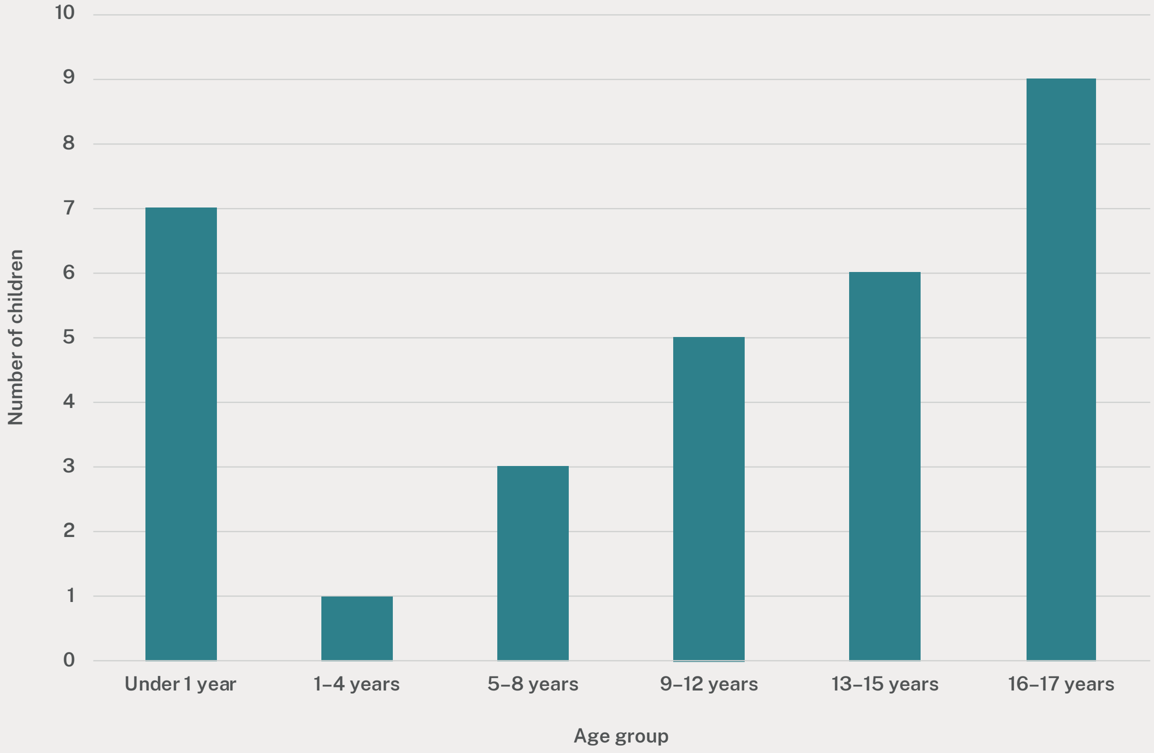
- 16 children had a congenital illness[52] including metabolic disorders, degenerative disorders, organ abnormalities (heart, brain, lungs and kidneys), autism, epilepsy, and brain injury causing cerebral palsy and multiple disabilities
- seven children had a form of cancer
- one child sustained a brain injury in early childhood
- eight of the children were receiving palliative care or end of life care.[53]

For six of the seven children who died from an acute illness, the cause of death was related to an infection.[54] One child died suddenly from a congenital condition that was not diagnosed until after their death. Three of the children lived in regional or remote NSW.[55] For two children there were delays in their families seeking medical assistance when the children first became unwell. There had been no prior reports to DCJ about medical neglect for these two children.

Table 2: Children who died due to illness and/or disease and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	46	39	32	36	31
% of total deaths	50%	44%	33%	36%	31%
Age range	0–17 years	0–17 years	0–17 years	0–17 years	0–17 years

Figure 7: Children who died in 2021 due to illness and/or disease and were known to DCJ, by age



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[52] A congenital disorder is a medical condition that is present at or before birth. These conditions can be acquired during the fetal stage of development or from the genetic make-up of the parents. Congenital disorders may also be caused by infections during pregnancy or injury to the fetus at birth (Spine-health n.d.).

[53] End of life care is the last few weeks of life in which a patient with a life-limiting illness is rapidly approaching death. The needs of patients and carers is higher at this time (Palliative Care Australia 2022).

[54] Either a bacterial or viral infection, and in one case it was due to sepsis.

[55] The Australian Statistical Geography Standard-Remoteness Area (ASGS-RA) is a tool that defines locations in terms of remoteness; that is, the physical distance of a location from the nearest urban centre. It divides Australia into five classes: major city, inner regional, outer regional, remote and very remote (Australian Government 2022).

DCJ response to the children who died from illness and/or disease

Of the 31 children who died from illness and/or disease, DCJ was working with eight of the families at the time of death. For four of these families this was because the child who died was in out of home care.

Reported issues of concern

Of the 31 children who died, 16 children had been reported at risk of significant harm fewer than five times. Eight children had been reported from five to 15 times, and two children more than 15 times. There were five children who had not been reported at risk of significant harm prior to their death. Three of these children were only known to DCJ due to reports being received about their siblings within three years of the children's deaths. Two of the children's deaths were reportable because they were in out of home care. The most common concerns reported[56] about the families were:

- physical abuse (13 families)
- domestic and family violence (11 families)
- emotional abuse (10 families).[57]

DCJ response to ROSH reports received within 12 months of the child's death

Three of the children who died from illness and/or disease had been reported to DCJ in the month before their death. For two of these children, DCJ was already working with the family at the time these reports were received. For eight of the children, DCJ had received reports about their families between one and six months prior to their death. DCJ responded by:

- allocating four of the reports for assessment
- referring one of the families to a counsellor for support
- closing the reports for three of the families; however, DCJ gathered further information from services or the family to ensure supports were in place before closing the reports.

For eight of the children, DCJ had received reports for their families between six and 12 months prior to their death. DCJ responded by:

- allocating two of the reports for assessment
- closing the reports for six of the families. For two of these families DCJ gathered further information from services or the family to ensure supports were in place before closing the reports. For the other four of these families DCJ determined that the family had adequate supports already in place.

DCJ sibling safety response

For 25 families, there were no other risks identified for the siblings or there were no siblings aged under 18 years living in the home. DCJ completed sibling safety assessments with four of the families where children had died from illness and/or disease. One child was considered 'unsafe' and the child was taken into care. DCJ continued working with the three other families, and the reports were closed in line with case closure guidelines.[58] DCJ was not able to allocate one of the reports for assessment and the case was closed.[59]

Practice themes

In reviewing DCJ practice where reports had been received about children who died from illness and/or disease, the following key themes were identified.

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[56] In the last three years.

[57] Some families were reported for more than one child protection concern.

[58] A risk assessment indicating the siblings were at 'moderate' risk of future harm.

[59] The child's circumstance of death was from chronic illness and was not unexpected. DCJ was not informed of the death until two months later.

Strong collaborative practice: Where children had chronic illnesses there were many examples of collaboration with doctors, health and therapy services, disability support services and extended family members to understand a child's complex needs and supports. This was beneficial to holistic practice.

Factors impacting on holistic assessment: In some families where a child had a chronic illness with significant medical needs there were additional risks due to the pressures their parents faced in caring for them. Some reviews identified that it was important for practitioners to spend time with families to understand the family dynamics and how the pressures of caring for the sick child impacted on the child and their family. Assessments needed to consider the holistic needs of the children who were unwell, such as education, physical safety and emotional wellbeing, rather than just their medical needs. In several cases the reported risks such as the presence of domestic and family violence were not sufficiently explored as the child's illness was the focus.

Responding to reports about children with medical and health needs: In several cases, including those where children with chronic illnesses became unexpectedly unwell, or previously well children developed an acute illness, there were concerns about delays in families seeking prompt health intervention due to a number of reasons. This highlighted the importance of DCJ practitioners responding with urgency to ROSH reports about children who are chronically or acutely unwell, particularly in regional areas.

Balancing a parent's need for support while assessing safety and risk to children: There were instances where practitioners played an important role in providing emotional support to families where children were unwell. For several families, children were receiving palliative care or end of life care. For one Aboriginal family support was provided to prepare for Sorry Business[60] in the knowledge that the child would soon die. This created challenges in performing the dual roles of supporting a family while assessing safety and risk.

2.4.2 Motor vehicle accidents

In 2021, 16 children known to DCJ died from injuries sustained in motor vehicle accidents. This is an increase from 2020 when 11 children died and is the highest number of deaths in motor vehicle accidents over the past five years. Of the children who died, there were two sets of siblings, which may account for the increase.

As shown in Figure 8, one child who died was aged one to four years, and another child was aged nine to 12 years. The age group with the highest deaths was children aged five to eight years, in which six children died; and children aged 16 to 17 years, in which six children also died. Ten of the children who died were male and six were female. Eight children were Aboriginal.

Table 3: Children who died from motor vehicle accidents and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	2	10	6	11	16
% of total deaths	2%	11%	6%	11%	16%
Age range	5–16 years	3–17 years	0–17 years	1–17 years	2–17 years

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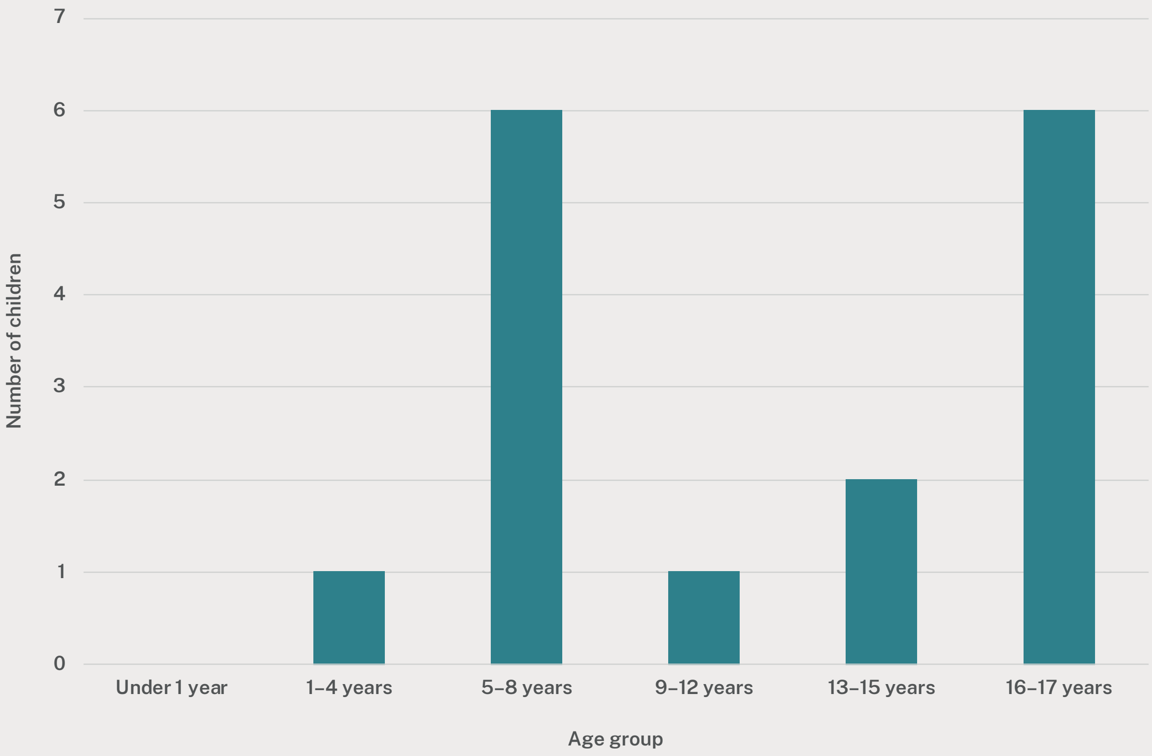
[60] Sorry Business is an important time of mourning that involves responsibilities and obligations to attend funerals and participate in other cultural events, activities or ceremonies with the community. This is a community and cultural tradition that is highly important for Aboriginal and Torres Strait Islander peoples (Australian Government Fair Work Ombudsman 2021).

Figure 8: Children who died in 2021 from motor vehicle accidents and were known to DCJ, by age



Twelve of the 16 deaths occurred in regional areas[61] of NSW. Five of these deaths included circumstances where a child was driving a car or riding a motorbike when the accident occurred. Another child also died while riding a motorbike in a major city. Only two of the children who died while riding a motorbike had been wearing appropriate protective clothing.

For three of the 16 deaths,[62] a parent or adult had been driving at the time of the accident. Alcohol and/or other substances were a contributing factor in one accident, which resulted in two deaths. Additionally, none of the three children were wearing a seatbelt or in an age-appropriate car seat restraint.

Six of the 16 deaths were pedestrian accidents such as crossing a road or walking on a footpath. These children were aged from two to 16 years. Four children were aged under seven years and were with a parent when the accident occurred. Two of the children were aged 15 years or older and were with friends when the accident occurred.

DCJ response to the children who died from motor vehicle accidents

Reported issues of concern

Of the 16 children who died from injuries sustained in motor vehicle accidents, one child had only been reported to DCJ due to the accident and their subsequent hospitalisation. Two children had not previously been reported to DCJ at risk of significant harm, however their siblings had been reported within three years of the child's death.

For the remaining 13 children, seven had been reported to DCJ fewer than six times, four of the children had been reported from 13 to 20 times, and two young people had been reported to DCJ

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[61] As previously noted, there are five classifications: major city, inner regional, outer regional, remote and very remote. Two of the children lived in inner regional areas and nine lived in outer regional areas.

[62] This included one sibling group of two children.

at risk of significant harm more than 20 times. The most common concerns reported[63] about the families were:

- sexual abuse (8 families)
- physical neglect (8 families)
- parental substance use (4 families)
- domestic and family violence (4 families)
- parental mental health (4 families).

DCJ response to ROSH reports received within 12 months of the child's death

Eight children had been reported to DCJ at risk of significant harm within 12 months of their death. DCJ was working with one family at the time of the child's death. DCJ allocated this report when the child sustained their injuries; however, the child died before the assessment could occur. One child died before DCJ could make a decision about allocating the report for assessment. DCJ closed one report[64] but referred the family to a DCJ-funded program (Brighter Futures). DCJ was not able to allocate the remaining five reports made about the children for assessment due to capacity issues that existed at the CSCs when reports were received.

DCJ sibling safety response

For 13 families there were no other risks identified for the children's siblings or there were no siblings aged under 18 years living in the home.[65] DCJ completed a sibling safety assessment with two families,[66] including one family that DCJ was already working with at the time of the child's death, and closed the reports in line with DCJ case closure guidelines.[67]

Practice themes

In reviewing DCJ practice where reports had been received about children who died from injuries sustained in motor vehicle accidents, the following key themes were identified.

Improving collaborative practice: For the children who died in motor vehicle accidents some were being supported by a number of services, such as Youth Justice and NSW Health. Some reviews found that collaborative practice was not as strong as it needed to be. It is important for DCJ practitioners to collaborate with other agencies to understand their respective roles in supporting the child, to ensure that each of the services are offering the child and their family the support that they need.

Referrals to services: Some reviews identified occasions when children were referred to similar services on multiple occasions. When DCJ practitioners make referrals to services, they should consider the appropriateness of the service to meet the child and family's needs, the eligibility requirements, and the service's capacity to provide support. Contacting the service first to discuss a possible referral may help to prevent the re-referring of families to multiple services when past referrals have not been successful.

Sharing of information between agencies: The importance of sharing child protection information with interstate partner agencies was highlighted in some reviews. Where families lived interstate for periods of time, or moved frequently, it was important for practitioners to use Connect for Safety to see if a child or adult was known in other Australian jurisdictions. Using this resource can help practitioners to understand risks to the child that may not be known to DCJ, and in turn inform decision-making when allocating reports for assessment.

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[63] In the last three years.

[64] This included a total of three children who died, as there was one sibling group who died.

[65] One additional death had only been reported at the time of finalising this report and has not yet been screened by the Child Protection Helpline.

[66] This included one family where two siblings had died.

[67] A risk assessment indicating the siblings was at 'low or moderate' risk of future harm.

≣ DCJ CASEWORK PRACTICE

If a family has no permanent address or moves frequently, DCJ practitioners can check **Connect for Safety** to see if a child or any persons related or caring for them is known in other Australian jurisdictions. **Connect for Safety** is an internal national child protection records information search tool, rolled out to DCJ in 2021, which helps to identify whether a person is known by any child protection agency across Australia. The **Connect for Safety** search uses matching technology to connect practitioners with possible records to follow up, even where there is only a small amount of information available. This helps practitioners to learn more about a child, or person and/or family's 'story', and their child protection history. This will also help to identify and provide the right supports at the right time, when reviewing available information, conducting assessments and developing support or intervention plans. Failure to find a match does not mean the person is unknown to other jurisdictions. If a potential match is identified, practitioners are required to follow the interstate child protection process[68] and make enquiries accordingly.

2.4.3 Sudden unexpected death in infancy

The NSW CDRT defines sudden unexpected death in infancy (SUDI) as the death of an infant younger than 12 months that is sudden and unexpected, where the cause is not immediately apparent at the time of death. Excluded from this definition are infants who died unexpectedly as a result of injury, and deaths that occurred in the course of a known acute illness in a previously healthy infant. Further classifications for SUDI are:

- Explained SUDI – a cause of death was identified following investigation.
- Unexplained SUDI – a cause was unable to be determined following investigation.

During 2021, the deaths of 14 (14 per cent) of the 99 children who died and were known to DCJ were sudden and unexpected. Post-mortem reports or a coronial certificate of death were available for nine of the 14 children. Once a final post-mortem is received for the other five children, the circumstances of death could change and the total number of SUDI deaths that occurred in 2021 may vary.[69]

Families known to the child protection system and Aboriginal infants are over-represented in SUDI deaths compared with the general population. Many of the risk factors associated with SUDI are modifiable, therefore the implementation of recommended safe sleeping practices may further reduce the incidence of SUDI.[70]

Table 4: Infants who died suddenly and unexpectedly and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	15	10	19	16	14
% of total deaths	17%	11%	20%	16%	14%
Age range	0–9 months	0–11 months	0–12 months	0–8 months	0–9 months

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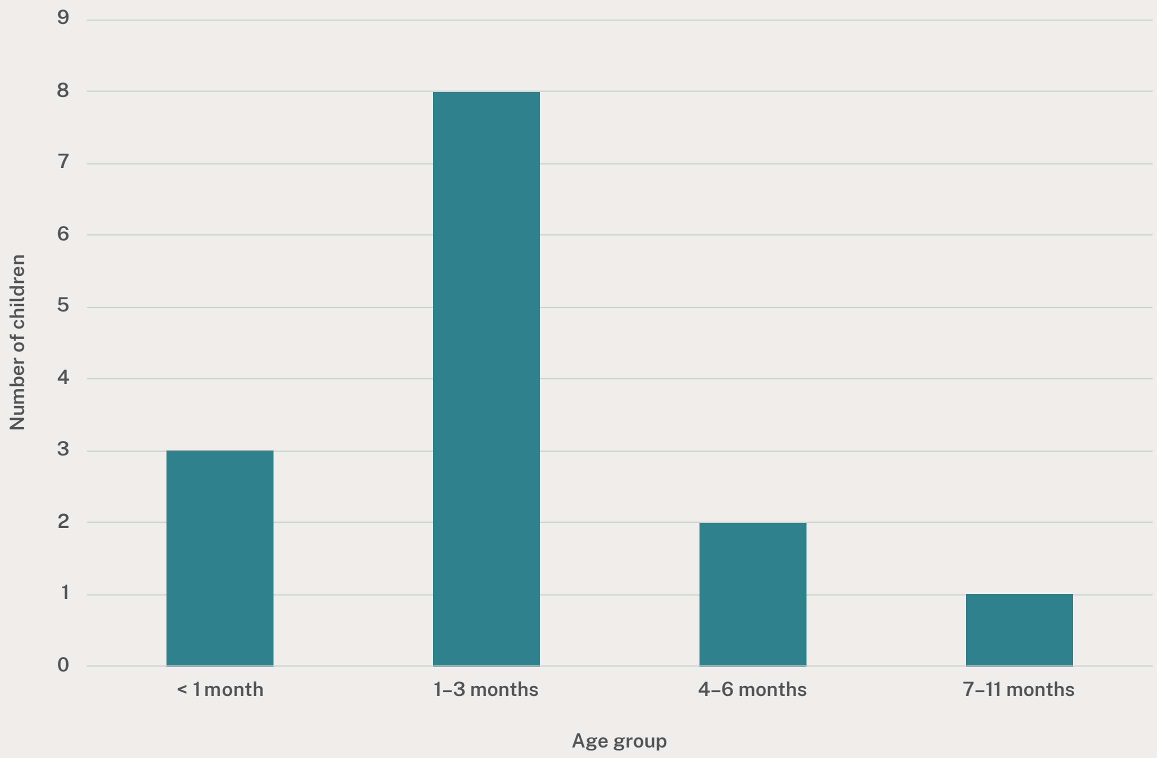
[68] NSW DCJ (2022).

[69] Once a post-mortem is received, the circumstances of death are updated and numbers are corrected for previous years. For example, a death classified as SUDI may be later confirmed to have occurred due to illness and/or disease.

[70] NSW Health (2021).

As shown in Figure 9, 11 (79 per cent) of the infants who died suddenly and unexpectedly were aged three months or less. In 2021, 10 of the infants were male and four were female. The age and gender of the infants who died suddenly and unexpectedly in 2021 were similar to those who died in 2020.[71]

Figure 9: Infants who died in 2021 suddenly and unexpectedly and were known to DCJ, by age



Risk factors associated with SUDI deaths

Risk factors associated with SUDI can be intrinsic and extrinsic. Intrinsic risks are individual factors that affect an infant's susceptiblity[72] and include things such as premature birth, low birth weight and prenatal exposure to smoking, drugs and alcohol. In its 2021 report,[73] the CDRT stated that 'intrinsic factors are generally not modifiable, except for exposure to maternal cigarette smoking (or other drug and alcohol consumption) during pregnancy'. Extrinsic factors are environmental and modifiable and can be avoided or changed. They include factors such as sleep position, sharing a sleep surface and overheating.

The majority of infants (12 out of 14) who died suddenly and unexpectedly were found to have modifiable risk factors present in their sleeping environment. For these 12 infants this included:[74]

- being placed to sleep somewhere other than a cot, bassinet or co-sleeper (4 infants)
- being placed to sleep in bed with a parent or sibling (4 infants) and for two of these infants the parents had consumed alcohol prior to going to sleep with the infant
- having soft objects such as pillows, clothes or blankets in the sleep environment (3 infants)
- the infant falling asleep with their parent on a lounge (2 infants).

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[71] In 2020, 75 per cent of infants who died suddenly and unexpectedly were aged three months or less.
[72] NSW Ombudsman (2021).
[73] ibid.
[74] Numbers do not add up to 12 as some infants had more than one modifiable risk factor present when they died.

SAFE SLEEPING[75]

Did you know?

- If you can slide a standard can of drink between the rungs of a cot, the cot is not built to Australian safety standards.
- The safest way to place an infant to sleep in a cot is with the infant's feet placed firmly at the bottom of the cot, with the blanket tucked in firmly.
- The safest position for an infant to sleep is on its back – infants should not be placed on their side or stomach.
- Baby carriers, slings and pouches can cause a suffocation risk for babies. The risk is highest for babies under four months old, and for babies who were born premature, had low birth weight or who are unwell.

DCJ response to the children who died suddenly and unexpectedly

Reported issues of concern

Of the 14 infants who died suddenly and unexpectedly, seven were known to DCJ because reports had been received about their older siblings in the three years before they died. The other seven infants were known to DCJ because a report was made about them before they died. Two infants had each been reported once, prenatally. One infant had only been reported about the circumstance which led to their death. Four infants had been reported between one and three times. The most common concerns reported[76] about the families were:

- domestic and family violence (6 families)
- physical abuse (5 families)
- physical neglect (5 families)
- parental mental health (5 families).

DCJ response to ROSH reports received within 12 months of the child's death

For two of the infants who died in circumstances of SUDI, a report had been received about their families in the month before the infant died. DCJ was already working with one of these families at the time the report was received. For the other family the report was made in relation to the incident which resulted in the infant's death and DCJ allocated the family for assessment.

For six of the infants, DCJ had received reports for their families between one and six months prior to their death.[77] For one of the families the infant died before a decision could be made about allocation. For the other families DCJ responded by:

- allocating two families for assessment
- referring one family to a DCJ-funded program (Brighter Futures) for further support
- closing the reports for two families without completing an assessment due to a lack of capacity at the CSC to respond.

DCJ sibling safety response

Sibling safety assessments were completed for 10 of the families (71 per cent) whose children died in circumstances that were sudden and unexpected. For one family, a sibling was found to be unsafe and taken into care. DCJ continued working with the nine other families, and the reports were closed in line with case closure guidelines. For four of the families a sibling safety assessment was not completed because there were no siblings aged under 18 years living in the home.

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[75] See Appendix 2 for a list of discussion points that practitioners should include when talking with parents and carers about safe sleeping.

[76] In the last three years.

[77] There were no families that received reports between six months and 12 months prior to the infant's death.

Practice themes

In reviewing DCJ practice where reports had been received about children who died suddenly and unexpectedly, the following key themes were identified.

Modifiable risk factors: The majority of infants (12 out of 14) who died suddenly and unexpectedly were found to have modifiable risk factors present in their sleeping environment. This highlights the need to have continued discussions with familes about safe sleeping for infants during assessments when families have or are expecting babies. Practitioners must understand and be aware of modifiable intrinsic and extrinsic risk factors, be clear in their advice about safe sleeping, and use language that is strong, clear and consistent.

Family action plans:[78] The development of these plans was a theme across the reviews where infants had died suddenly and unexpectedly. The reviews highlighted the benefit of developing plans in collaboration with families and service providers prior to closing cases for external case management.

Red Nose is Australia's leading authority on safe sleep and safer pregnancy advice, and bereavement support for anyone affected by the death of a baby or child. The Bereavement Support Service provides specialised support for anyone affected by the death of a baby or young child. The Red Nose website[79] also provides advice on various topics including safe wrapping, coronavirus and your baby, safe sleeping and cot to bed safety. It also provides Indigenous-specific resources developed by Aboriginal families such as the **Keeping Bub Safe** brochure to help families know how to sleep their baby safely to reduce the risk of SUDI.

2.4.4 Suicide

Suicide remains the leading cause of death of young people in Australia.[80] Suicide death is preventable, but the stigma associated with mental health and suicide often means that young people feel unable to seek help. In 2021, 12 children known to DCJ died in circumstances of suicide or suspected suicide. There has been a fluctuation over the past five years in the number of deaths in circumstances of suicide or suspected suicide. However, over the last two years the numbers have remained high.

Table 5: Children who died in circumstances of suicide or suspected suicide and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	4	8	8	12	12
% of total deaths	4%	9%	7%	12%	12%
Age range	10–17 years	14–17 years	13–17 years	14–17 years	14–17 years

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[78] These plans are used when case planning is needed to support a child to remain safely at home. It is a family led process centred on bringing together assessment and family work. It is based on a realistic assessment of capacity to change and must address the key child protection risks identified.

[79] See https://rednose.org.au/page/red-nose-today

[80] AIHW (2022b).

The 12 children who died in circumstances of suicide were aged from 14 to 17 years. Four of these children were Aboriginal. Of the 12 children, four lived in regional areas[81] of NSW, while another child lived in a remote area.

≣ DCJ CASEWORK PRACTICE

The *Child Deaths 2020 Annual Report* noted that the Centre for Rural and Remote Mental Health had found that people living in rural and remote Australia are up to twice as likely to die by suicide as people living in major cities. The more remote the community, the higher the suicide rate. Risk factors for people living in these communities include poor employment opportunities, lower levels of education, social isolation and reduced access to medical and health services. Families living outside large regional centres often wait many weeks and travel long distances to attend medical and health services. For small populations in rural communities, maintaining privacy while seeking support is more difficult. The lack of access to services and perceived risks to personal privacy can mean that families who need support may delay seeking help.

Local people and the community play a vital role in protecting children when there is limited access to services and formal support systems. The practitioner's understanding of the experience, challenges, history and culture of the community they work in is central to good child protection practice. The history and culture of Aboriginal people is linked, in its own unique way, into all rural and remote communities in NSW. Understanding this context is important with both Aboriginal and non-Aboriginal families.

DCJ practitioners can access the internal **Remote and rural casework** practice advice for additional learning and support.

Worldwide, suicide rates have been found to be higher in males aged 10 to 19 years than females of the same age.[82] However, in 2021 this was not reflected in the children who died in circumstances of suicide and were known to DCJ. Six of the children who died were female and six were male; this included two gender or sexually diverse children. Seven of the children had a diagnosed disability such as autism, a conduct disorder or a learning disability, or a mental illness such as depression, anxiety, post-traumatic stress disorder or borderline personality disorder.[83]

The children had earlier been, or were at the time of their death, receiving some level of support from services including private psychologists or psychiatrists, general practitioners, Child and Adolescent Mental health Services (CAMHS),[84] Headspace[85] and school counsellors. At least half of the children had experienced a recent hospital admission due to concerns about their mental health.

≣ DCJ CASEWORK PRACTICE

Suicide is a topic many people find difficult to talk about; with those who are at risk and with others who are affected by it. Understanding and responding to factors that increase risk for children is critical for preventing suicide. Deaths from suicide were explored in great detail in Chapter 3 of the *Child Deaths 2020 Annual Report*.

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[81] As previously noted, there are five classifications: major city, inner regional, outer regional, remote and very remote.
[82] ibid.
[83] Chapter 3 includes more detail about children with neurodevelopmental disorders or psychosocial impairments.
[84] CAMHS provides assessment and intervention for children and their families, for moderate to severe mental health disorders.
[85] Headspace is the National Youth Mental Health Foundation. It provides mental health services for 12 to 25 year olds.

The chapter provides clear practice advice to support practitioners in their casework with children and their families, and highlights that urgent, intentional support can and does make a difference. For further advice about responding to self-harm or suicidal behaviour, DCJ practitioners can also refer to the **Guidelines for risk assessment and management of suicide and self-harm**.

NSW Health has a range of new and improved service access points to support young people's mental health. These include the following services:

Safeguards: Child and Adolescent Mental Health Response Teams

Safeguards Teams are new dedicated Child and Adolescent Mental Health Services (CAMHS) across NSW designed to provide care to children and young people aged from birth to 17 years who are experiencing acute mental health distress. By the end of June 2025 there will be Safeguards Teams in every local health district. The teams will respond to children in schools, homes and communities and in hospital-based settings, through face to face, phone and telehealth appointments, and provide assessment and brief intervention to resolve immediate crises, build resilience and coping skills, and link children to ongoing mental health services if required.

The Youth Aftercare Pilot

The Youth Aftercare Pilot is a support service for children and young people aged under 25 following significant suicidal ideation, self-harm or a suicide attempt. The service, also known as **i.am**, is also available to carers and families. The pilot is run by New Horizons in Blacktown, Bankstown, Coffs Harbour and Tamworth.

GENDER OR SEXUALLY DIVERSE CHILDREN

Gender or sexually diverse children (often included under the description of LGBTQIA+)[86] experience poorer mental health and higher rates of substance misuse than their peers. Research indicates they are five times more likely to attempt suicide and nearly twice as likely to engage in self-harm than their similar aged peers.

In August 2021, the DCJ LGBTQIA+ consultation model went live. The **Working with LGBTQIA+ children and young people** practice advice provides online resources to help DCJ practitioners to support a child when they are coming out, respond to gender diversity, and support carers of an LGBTQIA+ child. A register of staff across DCJ who identify as LGBTQIA+ support the model and are available for consultation for practitioners. When working with gender or sexually diverse children in out of home care DCJ practitioners should refer to the **Identity and culture for children in out of home care** mandate to ensure the child's need for positive identity is upheld.

To achieve improved health outcomes for the diversity of LGBTQIA+ people and communities, NSW Health developed the NSW LGBTIQ+ Health Strategy 2022–2027.[87]

Some initiatives relevant to DCJ are:

- A partnership between Western NSW Local Health District (LHD) and The Gender Centre has enabled transgender and gender diverse people in Dubbo, Orange and surrounding areas to achieve specialist counselling support and services.
- Maple Leaf House, based in Newcastle, provides an integrated specialist transgender and gender diverse health service for children and young people up to age 24 years.

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[86] Lesbian, gay, bisexual, transgender, queer, intersex, asexual plus communities.
[87] NSW Government (2022).

- Maple Leaf House supports children and their families throughout their gender journey who are based in the Central Coast, Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW local health districts. A service is to be opened to meet the needs of families across the Sydney metropolitan area, to build on the support currently provided at the Children's Hospital Westmead.

DCJ response to the children who died in circumstances of suicide or suspected suicide

Reported issues of concern

Of the 12 children who died, five had been reported at risk of significant harm fewer than five times; one of these children had only been reported once before they died. One child was only known to DCJ because their sibling, who was in out of home care, had been reported to DCJ. Four children had been reported between five and 15 times. The two children who were reported more than 20 times had been taken from their parents' care as children and later reunited. The most common concerns reported[88] about the families were:

- the child's risk-taking behaviour[89] (11 families)
- sexual abuse (6 families)
- physical abuse (6 families).

DCJ response to ROSH reports received within 12 months of the child's death

Eight of the children had been reported to DCJ within six months of their death. DCJ responded to the reports in the following ways:

- Allocating two of the children for assessment: DCJ was working with one child at the time they died and had earlier completed an assessment about another child before closing the case.[90]
- Liaising with a DCJ-funded program (Youth Hope) that was already working with one child at the time the report was received.
- Referring one family to Family Connect and Support.[91]
- Closing one of the reports without further assessment, noting there were current Federal Circuit and Family Court of Australia proceedings underway.
- Confirming that another child was receiving treatment from an inpatient mental health facility before closing the report.
- Gathering information about two of the children to inform decision-making; however, during that time, both children died.

DCJ sibling safety assessment

Of the 12 children who died in circumstances of suicide or suspected suicide, for seven families there were no other risks identified for the siblings or there were no siblings aged under 18 years living in the home. DCJ completed sibling safety assessments with three families; all were closed in line with case closure guidelines.[92] DCJ was not able to allocate two of the families for further assessment; however, DCJ contacted the services working with one family to ensure they were being supported before the reports were closed.

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[88] In the last three years.

[89] Including substance use, threats to self-harm, unstable accommodation and school non-attendance.

[90] In line with case closure guidelines.

[91] Previously known as the Family Referral Service. Family Connect and Support is a NSW Government initiative that brings together families, support services and community resources so that children are safe and well.

[92] A risk assessment indicating the child was at 'low or moderate' risk of future harm.

Practice themes

In reviewing DCJ practice where reports had been received about children who had died in circumstances of suicide or suspected suicide, the following key themes were identified.

Collaboration with services: Many of the children had been or were currently receiving support from a mental health service. When allocation was not possible, DCJ could have strengthened practice by collaborating with services to obtain further information about its role with the child. When multiple services were involved with the child, DCJ could have considered using other available options in the **Triage assessment** mandate including facilitating Interagency Case Discussions[93] with all stakeholders to share information about the concerns held for the child.

Referrals to services: When DCJ practitioners made referrals to services to support the child, closer consideration was required to determine the appropriateness of the referral and the service's capacity to accept it. DCJ practice could have been strengthened by avoiding the re-referring of children to multiple services when previous referrals had not been accepted or had not achieved the goals of intervention. Contacting the service first to discuss a possible referral and to understand how the service could support the child's mental health needs may assist in a more successful referral.

The roles of other agencies: In some circumstances, the child's parents had been acting protectively by seeking help for their children to keep them safe, but were often turned away or discharged from the NSW Health system. When reports were received about these concerns, DCJ needed to advocate more strongly for the children and their families and encourage the health system to provide a more proactive and firmer approach to address the child's mental health.

2.4.5 Deaths related to premature births

In 2021, eight infants known to DCJ died from complications related to extreme prematurity,[94] including two sets of twins. As seen in Table 6, the number of infants who have died in these circumstances has gradually declined over the past five years.

Table 6: Infants who died in circumstances related to extreme prematurity and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	13	10	10	9	8
% of total deaths	14%	11%	10%	9%	8%
Age range	0–9 months	0–5 months	0–1 month	0–3 months	0–1 month

MULTIPLE PREGNANCIES

The Women and Infants Research Foundation of Australia reports that 'multiple pregnancies make up about 1.5 per cent of births in Australia, with about 4,300 sets of twins born each year. Overall, twin pregnancies are much more likely to be complicated by preterm birth (more than 50 per cent) than single pregnancies, and for the babies to be of low birth weight. The risk is increased even more in higher order multiple pregnancies.'[95]

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[93] An Interagency Case Discussion (ICD) is a meeting undertaken by the CSC with agencies that are (or could be) involved with a family, when a decision has been made to close the ROSH report.

[94] The World Health Organization distinguishes between three categories of premature birth: moderately premature (32–36 weeks), very premature (28–32 weeks) and extremely premature (27 weeks or less) (WHO 2018).

[95] Women and Infants Research Foundation Australia (n.d.).

Four infants died within 24 hours of their birth, three infants died within three days, and one infant lived for more than one week. Seven infants were male and one was female. The higher rate of male infants is consistent with international data, which suggests that male fetuses mature later than female fetuses, making them less resilient to stress in the womb.[96]

Three infants were Aboriginal. This over-representation is consistent with data for all children born in NSW, which indicates Aboriginal infants are more likely than non-Aboriginal infants to be born prematurely, and have significantly higher perinatal mortality rates.[97]

DCJ response to the infants who died in circumstances of extreme prematurity

Reported issues of concern

For all of the infants who died, DCJ was not aware of the mother's pregnancy, as no ROSH report had been received about them. The infants were only known to DCJ because their siblings or half-siblings had been the subject of a previous report. The most common concerns reported[98] about the siblings' families were:

- physical abuse (4 families)
- physical neglect (3 families)
- domestic and family violence (3 families)
- emotional abuse (3 families).

Seven of the infants' siblings or half-siblings had been reported to DCJ within 12 months of the infants' deaths. One other sibling was reported more than 12 months earlier. For four of the infants who died, the reports were about concerns for siblings or half-siblings who lived in a different household and the concerns did not directly impact the safety and wellbeing of children in the infant's household.

DCJ response to ROSH reports received within 12 months of the child's death

For two of the infants who died, the reports were about concerns for siblings or half-siblings who lived in the infant's household. For one report, DCJ gathered further information to help in decision-making and referred the family to a DCJ-funded program (Brighter Futures). DCJ was not able to allocate the second report for further assessment.

DCJ sibling safety response

For five families,[99] there were no other risks identified for the siblings or there were no siblings aged under 18 living in the home. DCJ completed a sibling safety assessment with one family and then closed the report in line with case closure guidelines.[100]

Practice themes

In reviewing DCJ practice where reports had been received about children who died in circumstances of extreme prematurity, the key theme was that DCJ had not received information that the family were expecting a baby. Although the families of the eight infants who died were known to DCJ, for six of these infants[101] this was because of child protection reports about siblings who lived in a different household.

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[96] DCJ Child Death Annual Report 2019, Chapter 3 cohort: Infants who died in circumstances related to premature birth.
[97] NSW Health (2022a).
[98] In the last three years.
[99] This includes two sibling groups of twins.
[100] Indicating the siblings were assessed as 'low or moderate' risk of future harm.
[101] This includes two siblings groups of twins.

PARTNERING WITH NSW HEALTH

Successful collaborative and client-centred approaches from government agencies and services may help to keep families safe, increase engagement and reduce risk of harm. NSW Health is a lead service for responding to and caring for pregnant women and their unborn children, including women who may be experiencing or are at risk of violence. NSW Health should play a key role in supporting the expectant mother with their health needs and in preventing and responding to violence occurring in pregnancy or early maternity, with joint involvement from DCJ practitioners. DCJ practitioners should help NSW Health engage the pregnant mother and make referrals to other services as needed. NSW Health can provide a range of services to support families including:

- Substance Use in Pregnancy and Parenting Service (SUPPS)
- Domestic Violence Routine Screening (DVRS) in maternity, Child and Family, Mental Health, and Alcohol and Other Drugs service streams
- Safe Start program and referral pathways such the Perinatal and Infant Mental Health Service (PIMHS)
- Pregnancy Family Conferencing
- Aboriginal Maternal and Infant Health Service.

2.4.6 Drowning

In 2021, six children known to DCJ died in drowning accidents. This is an increase from 2020, when one child drowned. While deaths from drowning increased in 2021 compared to 2020, the trend in deaths from drowning has remained relatively low over the past five years.

Table 7: Children who died in drowning accidents and were known to DCJ, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	1	2	3	1	6
% of total deaths	1%	2%	3%	1%	6%
Age range	4–5 years	0–3 years	0–15 years	16–17 years	1–16 years

Every year, Royal Life Saving produces a National Drowning Report, which examines the factors that contribute to drowning deaths in Australia.[102] The 2022 report highlights that there were 17 drowning deaths among children aged from birth to four years and 15 drowning deaths in children aged five to 14 years. The report noted that the number of drowning deaths of children has decreased. The report suggests that programs and campaigns targeted to children and their parents may be making an impact but emphasises the importance of a continued focus on drowning prevention efforts toward children.

All six children who died from drowning and were known to DCJ in 2021 were in the care of their parents or another adult at the time of the accident. Four children were aged one to six years; two children were aged 13 to 16 years. The four youngest children died in circumstances where an adult was not adequately supervising them. Two children accessed a pool or spa that had not

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[102] Royal Life Saving Australia (2022).

been fenced or secured; two children had wandered off and accessed open bodies of water.[103] Two children drowned while swimming with friends where adults were nearby.

Four of the children who died were male and two were female. Three of the children had disabilities: two were diagnosed with autism and one child had Down syndrome.

On average, 22 children aged from birth to four years drown each year in Australia. In addition, on average, 11 children aged five to 14 years drown, and 73 per cent in this age group are boys. Drowning in this age group most commonly occurs in open water environments such as rivers, creeks, oceans and harbours.

While some general principles of safety such as supervision remain constant through a child's life, Royal Life Saving's 'life-stage' approach addresses specific risks. By understanding a child's developmental stage parents and carers can be better prepared to deal with the various risks that impact specific age groups. Royal Life Saving recommends some level of supervision for all children under the age of 15. This ranges from being in the water, within arms' reach and actively supervising children aged from birth to four years; actively supervising from the water's edge for those aged five to 10 years; and regularly checking up on those aged 11 to 14 years.

Children with disabilities

International research indicates people with autism are at greater risk of premature death due to drowning compared with the general population. In Australia, between 2002/03 and 2017/18, 33 people drowned where autism was known to be a factor. Children aged from birth to nine years accounted for 70 per cent of autism-related drowning deaths. Inland waterways such as rivers, lakes and dams were the most common location for drowning in these cases.

People with autism are often drawn to water without understanding the risks it may present. People with autism may also have a greater tendency to wander – they may leave a safe area in search of a retreat from overstimulation and may naturally gravitate towards water as a means of alleviating their sensory needs. Close supervision, and water safety education, including exposure to different aquatic environments, is essential in preventing drowning among people with autism.

DCJ response to the children who died by drowning

Reported issues of concern

Of the six children who died, one child was only reported due to the drowning incident and their subsequent hospitalisation. For the remaining five children, three had only been reported to DCJ at risk of significant harm twice or less and for two of the children, ROSH reports had been received up to 15 times. The most common concerns reported[104] about the families were:

- inadequate supervision (4 families)
- domestic and family violence (2 families)
- parental mental health (2 families)
- parental substance use (2 families).

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[103] Open bodies of waters include rivers, creeks, lakes, dams, oceans and harbours.
[104] In the last three years.

DCJ response to ROSH reports received within 12 months of the child's death

Five of the children had been reported to DCJ within six months of their death. DCJ was not able to allocate all of the reports made about the children for assessment; however, DCJ gathered information to inform decision-making about allocation. This led to two reports being referred to a DCJ-funded program (Brighter Futures) and a local multicultural service. One child died before the report could be allocated for assessment. DCJ had been working with one of the families for less than two weeks at the time of the child's death.

DCJ sibling safety response

For four families there were no other risks identified for the children's siblings or there were no siblings aged under 18 years living in the home. DCJ completed sibling safety assessments with two families. This included the family that DCJ was already working with at the time of the child's death, and continued to work with. DCJ also completed a sibling safety assessment for a second family, with the report subsequently closed in line with case closure guidelines.[105]

Practice themes

In reviewing DCJ practice where reports had been received about children who died in drowning accidents, the key theme was lack of supervision, particularly for those children under six years old. Water safety continues to be an important area to raise with families during assessments and ongoing casework, particularly when families include young children who have access to outdoor water areas such as pools or dams.

DCJ CASEWORK PRACTICE

The *NSW Swimming Pools Act 1992* requires swimming pools to be surrounded on all sides by a fence and to have a child-resistant gate. Pool owners are required by law to conduct a self-assessment of the safety of their pool and to register their pool with the NSW Swimming Pool Register. In addition, a pool compliance certificate, which is valid for three years, must be obtained from the local council.

Swimming pool safety compliance continues to be monitored by the Office of the Children's Guardian as part of the Out of Home Care Standards for children living away from home. DCJ, Permanency Support Program (PSP) and other out of home care providers undertake compliance checks during foster or relative carer assessments as part of the home inspection checklist. There are a number of internal resources and fact sheets available to DCJ practitioners to provide to families, carers and the public to raise awareness about the importance of water safety.[106]

Advice that practitioners should provide to parents and carers about keeping children safe around water

- Have everything ready before placing your child anywhere near bath water; keep bath water to a minimum.
- Remove toys from water when not in use.
- Remain within arms' reach of your child and never leave a child alone around water.
- Ensure a pool fence is correctly installed around pools and spas, including a self-closing gate that is regularly checked, maintained and never left open.
- Never leave a young child in the care of older children.
- Enrol your child in water familiarisation lessons, and continue this for teenagers.

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[105] A risk assessment indicating the child was at 'moderate' risk of future harm.

[106] NSW DCJ (2019b). See also the swimming pool FAQs on the Casework Practice intranet site.

- Empty buckets/containers that can hold water; place mesh over water features/ponds.
- Empty portable pools when not in use; those with a depth greater than 30 cm need to be fenced by law.
- Enrol in a First Aid course and update CPR[107] skills annually.

2.4.7 Inflicted or suspicious injuries

In 2021, five children known to DCJ died from inflicted or suspicious injuries. Three of the children were aged 16 to 17 years, and two were under the age of 12 months. Four of the children were male and one was female. While this is an increase from 2020 when three children died, the number is still relatively low compared to the past five years.[108]

All five children had been reported to DCJ at risk of significant harm within 12 months of their death. One infant was reported to DCJ at risk of significant harm at the time of their injury, but was not known to DCJ before this. The Joint Child Protection Response Program had started an assessment of the child's safety in response to their injury before the child died. The other infant was reported to DCJ fewer than 10 times. DCJ had been working with this family for almost six months when the child sustained life-threatening injuries, was hospitalised, and later died. The three older children were reported to DCJ between 10 and 22 times. Two of the children died before DCJ could allocate them for further assessment; the report about the third child could not be allocated due to capacity issues that existed at the CSC.[109]

DCJ completed sibling safety assessments with two of the families. One report was closed in line with case closure guidelines[110] and one family was referred to a DCJ-funded program (Brighter Futures) for ongoing casework support. For the remaining three families, there were no other risks identified for the siblings or there were no siblings under 18 years living in the home.

At the time of publishing this report, all five of the children's deaths are still under police investigation, or are being investigated by the NSW State Coroner.

2.4.8 Other circumstances of death

Fire

In 2021, two children known to DCJ died in house or other fires. The number of children known to DCJ who have died in house or other fires has been consistently low over the past three years.[111]

Both children had been reported to DCJ at risk of significant harm fewer than 15 times. They were both reported to DCJ within 12 months of their death about concerns for their risk-taking behaviours, substance use and non-attendance at school. DCJ was not able to allocate the reports for assessment due to capacity issues that existed at the CSCs when reports were received, but the children were each being supported by various health and medical services for their mental health, substance use and behavioural concerns, as well as local non-government services such as a youth worker.

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[107] CPR (cardiopulmonary resuscitation) is an emergency life-support procedure that uses a combination of mouth-to-mouth resuscitation and external cardiac massage.

[108] In 2020, three children died from inflicted or suspicious injuries; in 2019, seven children died; in 2018, eight children died; and in 2017, five children died in these circumstances.

[109] The ROSH report about this young person was closed five months before their death. The reported concerns were not related to their cause of death (from an assault in the community).

[110] The risk assessment indicated the sibling was at 'low or moderate' risk of future harm.

[111] In 2020, two children died in fire-related circumstances; in 2019, three children died; and in 2018, one child died in these circumstances.

DCJ completed a sibling safety assessment with one of the families and the report was closed in line with case closure guidelines.[112] A sibling safety assessment was not required for the second family as there were no siblings aged under 18 years living in the home.

Drug overdose

In 2021, one child known to DCJ aged 13 to 15 years died from an overdose, after mixing multiple medications. This number is one fewer than in 2020, when two children known to DCJ died from accidental overdoses, and is the lowest number of deaths of children known to DCJ from accidental drug overdose in the past three years.[113]

The child had been reported to DCJ at risk of significant harm two times. The second report was made in the two months before the child's death with concerns about medical neglect, parental violence and substance use. DCJ allocated the report for assessment and was still working with the family at the time of the child's death. A sibling safety assessment was not required as there were no siblings aged under 18 years living in the home.

2.4.9 Undetermined deaths

At the time of writing this report, the causes of death for four children known to DCJ have not been determined by the NSW State Coroner and the circumstances of death cannot yet be reported. Three of these children were less than three months old. Two children were male and two were female. Three of the children who died had a pre-existing disability or illness.

2.5 Children in out of home care

In 2021, seven children were living in out of home care when they died, as shown in Table 8. This is higher than in 2020 when five children died, but is consistent with the past five years.

Table 8: Children who were living in out of home care when they died, 2017–2021

	2017	2018	2019	2020	2021
No. of deaths	9	8	7	5	7
Age range	0–17 years	0–17 years	3–17 years	0–9 years	0–17 years
Parental responsibility of Minister (any aspect)	8	7	7	5	6
Placed with a relative/kin carer	4	3	4	1	3
Placed with authorised carers	3	5	2	2	1
Other (independent living, residential care, hospital)	2	0	1	2	3
% of total deaths	10%	9%	7%	5%	7%

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[112] A risk assessment indicating the sibling was at 'moderate' risk of future harm.

[113] In 2020, two children died in circumstances of accidental overdose; in 2019, three children died; and in 2018, two children died in these circumstances.

When children cannot live safely at home, the Children's Court makes an order allocating parental responsibility. The Minister for Families and Communities had parental responsibility for five children who died in out of home care, and parental responsibility for one child for parent/child visiting arrangements only (all other care responsibility was allocated to a relative). One child was in a supported out of home care placement after the Children's Court reassigned parental responsibility to a relative.

At the time of their deaths, three of the children were living with relatives and another child lived with authorised carers. One child lived in a hospital and another child in a residential care setting. One child had been hospitalised just prior to their death.

Five of the children who died were aged 14 years or more; the two other children were less than seven years old. Of the seven children, four died from illness and/or disease, one died in a house fire, one died in circumstances of SUDI and one child died from undetermined circumstances.

Five of the children entered care before 2010, with one of these children referred to the Out of Home Care (OOHC) Health Pathway.[114] Another child who entered care after 2010 was appropriately referred to the Pathway. One child had been in care for less than two weeks, with their entry into care occurring while they were in hospital, and the referral process had not yet occurred.

Three of the children had life-limiting conditions, and where the Minister held full parental responsibility for them, they all had endorsed end of life plans.[115]

2.6 Practice themes

While each section above has provided information about practice themes specific to the circumstance of death, the following common practice themes were also identified across all reviews for children who died in 2021.

Reviewing a parent's history: Understanding a parent's history by speaking to them, reviewing child protection records, and obtaining information from partner agencies such as Health, Education and Police is critical. Gathering information about a parent's child protection history enables practitioners to better understand the risks to children in the household, and identify what support is most appropriate for families. Accurately capturing a parent's child protection history in the risk assessment may also avoid closing reports prematurely.

Working with all household and family members: It is important to work with all family members who live in the household or who have a significant role in children's lives. Reviews identified occasions when fathers and/or partners were not included in the assessment process. When men use violence, it is important to clearly document their use of violence and its impact on others, consider risks to women, children and others who may be harmed, and engage with specialist services (such as the Men's Referral Service) or referral pathways to help men to address their offending behaviour.

The impact of COVID-19: COVID-19 impacted usual casework practice. Although procedures were in place to ensure that essential home visits continued during the COVID-19 pandemic, there were occasions when home visits were rescheduled due to family members being unwell.

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[114] The OOHC Health Pathway is a joint initiative of DCJ and NSW Health aimed at ensuring that every child entering statutory out of home care receives timely and appropriate health screening, planning, monitoring and review of their health needs. All children who entered care after 2010 should be placed on the OOHC Health Pathway and referred when they turn 15 in line with leaving care planning. Children with a significant health need should also be referred regardless of when they entered care.

[115] See Chapter 3 for more information on end of life planning.

Having conversations with children, young people and young parents: Reviews identified missed opportunities to speak with children to understand their experiences. Reviews also identified challenges in engaging young people, particularly those with risk-taking behaviours. When working with young parents who experienced neglect and abuse themselves, it is important for practitioners to spend time with them to explore the impact of their experiences on their own parenting. This work needs to begin in the early stages of intervention in order to build rapport and trust, and to engage these young parents in ongoing casework.

Cultural consultation: Cultural consideration often occurred for Aboriginal and culturally and linguistically diverse families after a child had died, in order to determine the most appropriate way to engage with and support the family. The reviews highlighted the need to use meaningful cultural consultation during all aspects of casework to better understand a family's needs and reduce risks to the children.

Understanding Family Law Court proceedings: When DCJ receives information that there are Federal Circuit and Family Court of Australia proceedings underway, it is important for practitioners to understand the role DCJ has in responding to and sharing information with the Court.[116]

Using other available options to respond to reports: DCJ needs to prioritise reports, and is unable to allocate all reports received. In many cases, DCJ gathered additional information about families to ensure that supports were in place, or referrals were made to services to support the families. DCJ practice could have been strengthened by practitioners using other available options at triage such as Interagency Case Discussions to support positive outcomes for families when allocation was not possible.

Correct application of assessment tools: The Structured Decision Making (SDM) suite of tools is used to identify critical decision-making points and improve the structure and consistency of decisions made about and services provided to families. Assessment relies on respectful engagement with the family, bringing together all that is known about the family and linking this to our professional experience, knowledge and theory. Risk assessments look at the likelihood of future abuse or neglect to a child in the household. The risk level determines whether the case should remain open for ongoing casework or whether it can be closed. In some reviews, the incorrect application of the tool resulted in cases being closed prematurely.

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[116] See the section on mandates and legal options on the Casework Practice intranet site.

Chapter 3: Children with disability

The population of people with disability is diverse. It includes people with varying types and levels of disability across all socioeconomic and demographic groups. How people experience disability depends on environmental factors, including opportunities and access to services, personal factors and community attitudes. Therefore, people with similar health conditions may have different experiences of disability and the same health condition may contribute to disability in one person, but not another.[117]

Children with disability make up eight per cent of Australia's population.[118] Children with disability are often described as an especially vulnerable group. There is evidence that they experience abuse and neglect at rates considerably higher than children without disability and they are more likely to spend time in out of home care.[119] Despite this increased risk, research also notes that abuse of children with disability is likely under-reported.[120]

It is important to note that it is not a child's disability that makes them more vulnerable, but it could be an indicator that they might experience harm.[121] The causes of abuse and neglect of children with disability are the same as those for all children but individual, social and environmental factors may increase the risk of children with disability experiencing harm.[122]

This cohort review focuses on children with disability who were known to DCJ and died between 2017 and 2021. In the review period, there were 480 children who died and were known to DCJ. Of these, 128 (26 per cent) had disability and were included in this cohort.[123]

Children with disability are children first. Their disability is one aspect of their lives and does not define their life or identity.[124] Their need for safety and protection is a human right. Understanding and responding to the factors that increase risk for children with disability is important to ensure children and their families experience a positive social response and children remain safe.

> *It's about knowing the child, and then through that process, navigating the system and drawing on other supports. But the best asset ever is listening to the child, listening to the carers and understanding their needs without any labels.*
>
> **DCJ caseworker**

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[117] AIHW (2020a); AIHW (2022a).

[118] Wayland & Hindmarsh (2017).

[119] Legano et al. (2021); Maclean et al. (2017).

[120] Robinson (2012); Stalker & McArthur (2012).

[121] Lightfoot (2014); Robinson (2012).

[122] Legano et al. (2021).

[123] There were an additional 11 children who were born with disability but died shortly after their birth. These infants were born with significant congenital disabilities that typically lead to short life expectancies, and they were not discharged from hospital before their deaths. These children were not included in the cohort.

[124] Wayland & Hindmarsh (2017).

3.1 The cohort: Children with disability

3.1.1 Defining disability

There are several definitions of what it means to have disability. The different understandings of disability mean that data is not always consistently captured.[125] Historically, disability was viewed as a health condition to be treated or cured. This medical model of disability perpetuated the thinking that people with disability did not 'fit' into society and focused on what a person could or could not do.[126]

In recent years, there has been a shift in the way disability is understood. The social model of disability considers how a person interacts with their environment.[127] The term 'impairment' is used to describe a person's loss or limitation of bodily or cognitive functioning.[128] Disability is seen as the result of the interaction between people living with impairments and an environment with physical, communication, attitudinal and social barriers. The focus, then, is on removing barriers and implementing adjustments to ensure people with disability experience equitable participation in society.[129]

This cohort review has adopted the definition used by the United Nations Convention on the Rights of Persons with Disability.[130] The convention was signed in 2007 and ratified into Australian law in 2008. This was an important milestone in beginning to promote dignity and rights for Australians with disability.[131]

Therefore, the review includes children who had any kind of long-term physical, cognitive, sensory or psychosocial impairment that interacted with other factors in their life. DCJ does not always hold detailed information about a child's disability and its impact on their participation, and so the cohort includes children who lived with impairments that were likely to hinder their full participation in society on an equal basis with others.

3.1.2 The cohort

Between 2017 and 2021, 480 children known to DCJ died. Of them, 128 children had disability. This represents 27 per cent of all children who were known to DCJ and died during this period. This is consistent with research highlighting that children with disability experience abuse and neglect at higher rates than children without disability.[132] This percentage is especially significant when considering that children with disability are also less likely to have concerns for their safety and wellbeing reported when compared to children without disability.[133]

As shown in Table 9, the number of children with disability who died and were known to DCJ ranged from 23 children (2017 and 2019) to 32 children (2021). The proportion of children who died and had disability each year ranged from 24 per cent (2019) to 32 per cent (2021).

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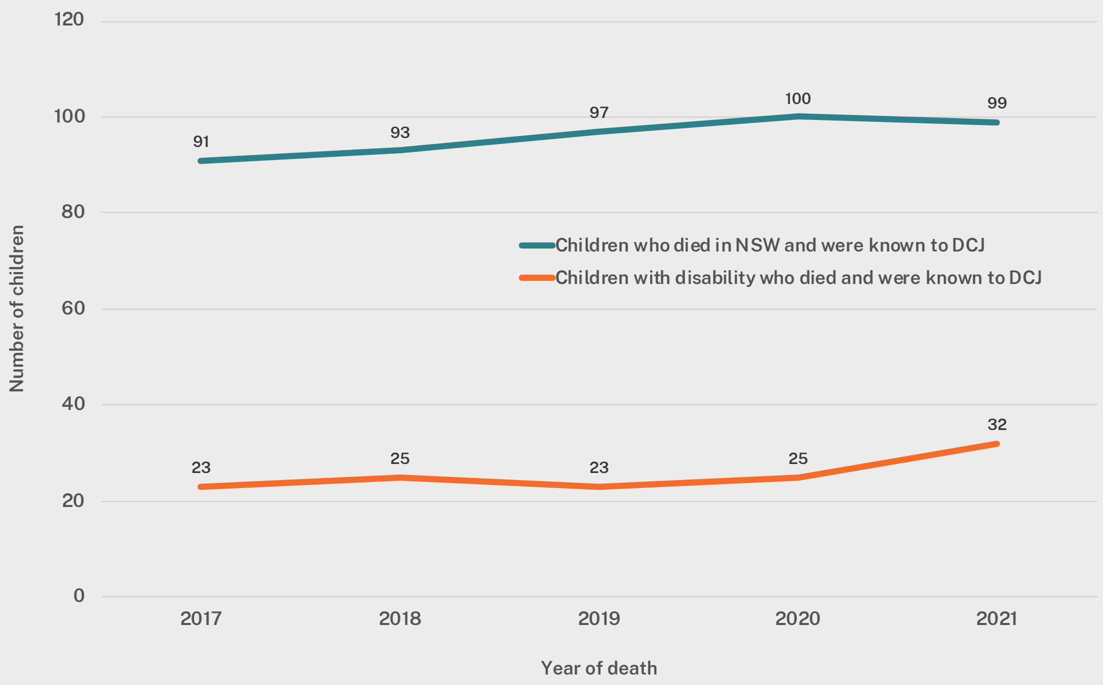
[125] AIHW (2022a).
[126] Wayland & Hindmarsh (2017).
[127] Australian Disability Network (2021).
[128] Taylor et al. (2015).
[129] Australian Disability Network (2021).
[130] UN General Assembly (2007).
[131] Small (2007).
[132] Legano et al. (2021); Maclean et al (2017).
[133] Robinson (2012); Stalker & McArthur (2012).

Table 9: **Children with disability who died between 2017 and 2021 and were known to DCJ, by year of death**

	2017	2018	2019	2020	2021
No. of deaths	23	25	23	25	32
% of total deaths for children known to DCJ	25%	27%	24%	25%	32%

Figure 10: **Children who had disability and died, by number of total deaths and whether they were known to DCJ, 2017–2021**



3.1.3 Age

In 2018, the prevalence of disability among Australian children increased with age, from 3.7 per cent of children aged from birth to four years to 9.6 per cent of children aged five to 14 years.[134]

Of the children with disability who died and were known to DCJ between 2017 and 2021, 23 children (18 per cent) were up to four years old and 63 children (49 per cent) were aged five to 14 years at the time of their death. There were also 42 children (33 per cent) aged 15 to 17 years when they died.

3.1.4 Gender

Recent Australian data suggests that boys are more likely than girls to have disability. In 2018, 9.6 per cent of boys, compared with 5.7 per cent of girls, in Australia had disability. For children known to DCJ who had disability and died between 2017 and 2021, 73 (57 per cent) were boys and 55 (43 per cent) were girls.

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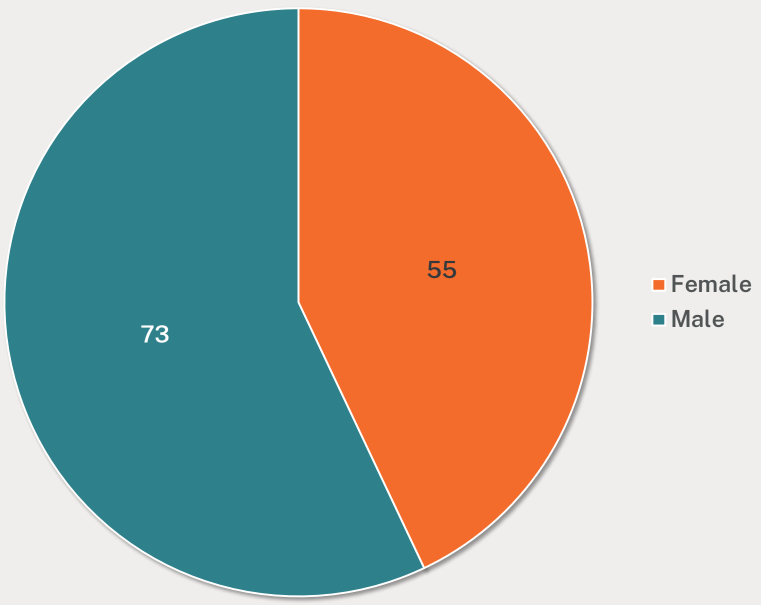
[134] Australian Bureau of Statistics (2018).

Where information is available, children have been categorised according to the gender with which they identify. It is acknowledged that this may not be an accurate representation of the gender for the children in this cohort. Many children are not afforded opportunities to discuss their gender identity openly, or they may feel unsafe or uncomfortable to do so. When speaking with children, it is important to normalise conversations about gender identity and record this information accurately. Always ask, then use the child's preferred gender and pronouns when talking with or about them, in a way that promotes their safety and psychological wellbeing.

≣ DCJ CASEWORK PRACTICE

In February 2022, ChildStory was updated to include new gender identifiers so that a child's gender identity can be accurately recorded. Identifiers now include male, female, not stated, unknown, non-binary, trans male, trans female and other gender identity. For further advice about working with children who identify as gender diverse, DCJ practitioners can refer to the **Working with LGBTQIA+ children and young people** practice advice topic.

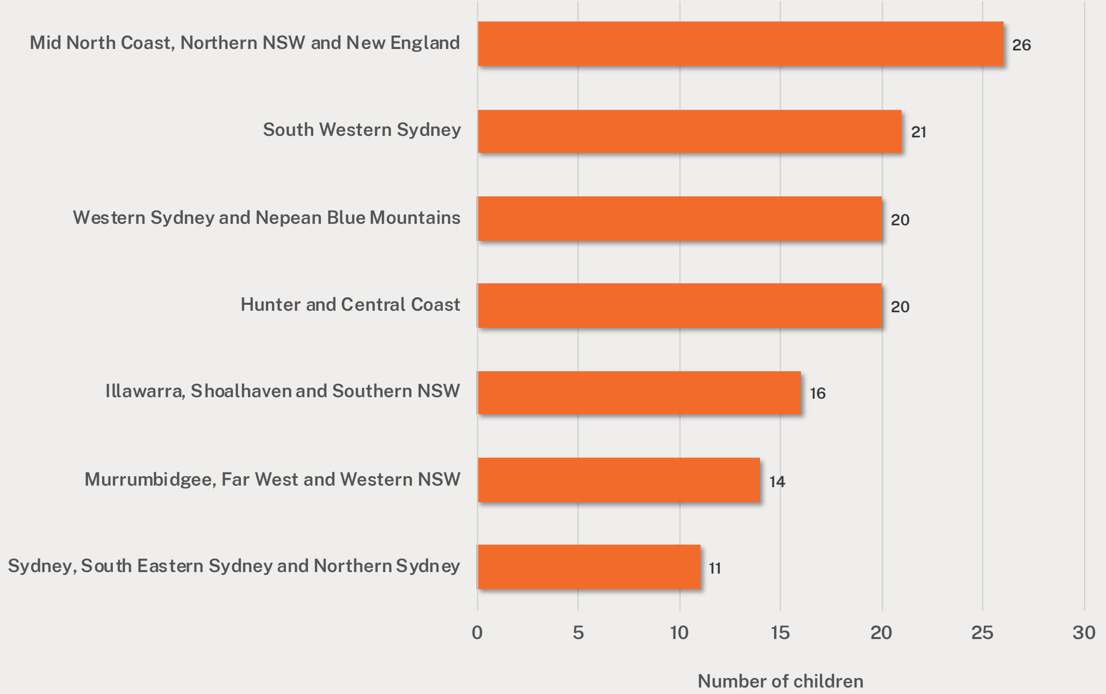
Figure 11: Gender of children who had disability and died and were known to DCJ, 2017–2021



3.1.5 Geographical distribution

As shown in Figure 12, the largest number of children in the cohort (26, 20 per cent) lived in Mid North Coast, Northern NSW and New England districts; and the fewest lived in Sydney, South Eastern Sydney and Northern Sydney districts (11 children, 9 per cent).

Figure 12: Children who had disability and died and were known to DCJ, by DCJ district, 2017–2021



It has been well established that there are fewer services in rural and remote areas, meaning people with disability are less likely to be able to access timely and effective support.[135] A 2011 study examining a rural town in NSW found the ratio of service providers to population decreases as rurality increases.[136] Another study (2013) considering the barriers experienced by people with disability accessing therapy services in rural and remote NSW found that excessive travel time, long waiting lists and limited access to therapy past early childhood all contributed to the difficulties experienced by people with disability living in rural and remote locations.[137] Additionally, the Australian early development census reported that children living in rural and remote communities are more likely to start school in the lowest 10 per cent in the developmental domains – social, emotional, physical, cognitive and language – when compared to children living in metropolitan areas.[138]

3.1.6 Circumstances of death

Each year, illness and/or disease is consistently the most common circumstance of death for children who die and are known to DCJ. For all children who died and were known to DCJ between 2017 and 2021, 39 per cent died from an illness and/or disease. Of the 128 children who died in the same period and who had disability, 78 children (61 per cent) died from illness and/or disease. Several children who had disability lived with multiple and complex impairments as well as comorbid life-limiting illnesses, which likely accounts for the increased number of children who died from illness and/or disease in this cohort. For the remaining 50 children, 23 died in accidents, including motor vehicle accidents, fires, drowning or other accidental injuries. Twenty-one children died by suicide. All of the children who died by suicide had either a psychosocial disability or a neurodevelopmental disorder. Three children died from inflicted or suspicious injuries. One child's cause of death is categorised as undetermined by the NSW State Coroner, and the cause of death for two children is still unknown.

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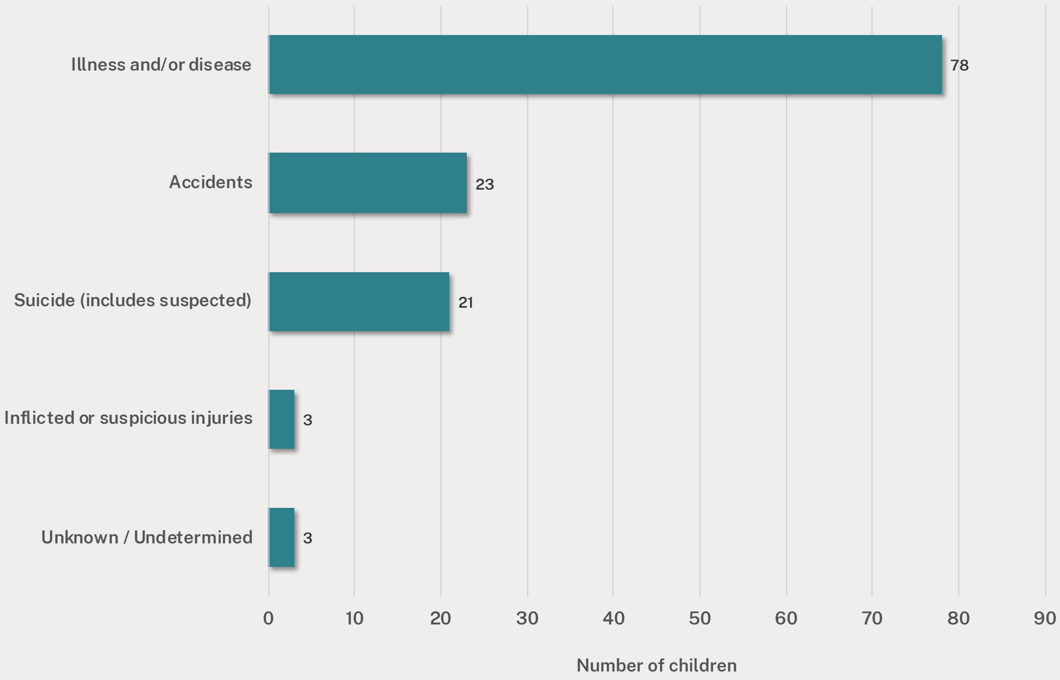
[135] Dew et al. (2013).
[136] Chisholm et al. (2011).
[137] Dew et al. (2013).
[138] Department of Education, Skills and Employment (2022).

Figure 13: Children who had disability and died and were known to DCJ, by cause of death, 2017–2021



3.1.7 Aboriginal children

The impact of colonisation of Aboriginal land has been devastating and long lasting. Past policy and legislation have seen the removal, dispossession and separation of Aboriginal families, and the intergenerational trauma experienced by Aboriginal people has been profound. Aboriginal people are resilient, and despite extraordinary adversity and oppression, Aboriginal people still have a strong connection to culture, kin, land and Country. Connection to culture provides safety and protection for Aboriginal children.

Sadly, Aboriginal children continue to be over-represented in all areas of disadvantage, including children who die and are known to DCJ. This disparity is reflected in this cohort of children who had disability. Of the 128 children who had disability, were known to DCJ and died between 2017 and 2021, 37 children (29 per cent) were Aboriginal. The children's age at the time of their death varied between 10 months and 17 years, with two children aged under 12 months when they died. Twenty-six of the Aboriginal children were male and 11 were female. Of the 37 Aboriginal children, seven also had a parent with disability. Thirteen of the Aboriginal children who died and had disability were living in out of home care at the time of their deaths.

Understanding disability in Aboriginal children

Aboriginal communities may speak about and respond to disability in ways different to non-Indigenous people. Many Aboriginal communities conceptualise disability as 'part of living' and rely on extended family and kin to care for the person with disability. This responsibility usually sits with the matriarch of a family, such as grandmothers or older aunts.[139] Aboriginal people are often private, and may not feel comfortable or safe to share details about their lives and challenges with other people, including with services. Others knowing about Aboriginal family business can bring about a sense of shame, and worry that if government services knew a family was struggling, they would be reported to DCJ and their children would be at real risk of being

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[139] Gilroy et al. (2016).

taken into care. It is uncommon for Aboriginal families to identify to statutory agencies that they are struggling and ask for help. This may mean that families are reported more often when their need for support is high, and the availability of support is low.

The 2012 Survey of Disability, Aging and Carers found that Aboriginal children are more than twice as likely to have disability compared to their non-Indigenous peers: 15.2 per cent of Aboriginal children had disability, compared to 6.6 per cent of non-Aboriginal children.[140] The additional stressors of caring for a child with disability can lead to environmental factors such as parental drug use, domestic and family violence or housing issues. Disability, compounded by social disadvantage, can increase health disparities and inequities for Aboriginal children.[141]

It is important for practitioners to understand how Aboriginal families view their child's disability, and what this means for the child and their family's participation in their own community. Service provision should focus on the whole family's experience of the child's disability, including barriers to their overall health and wellbeing, and connection to and participation in community.[142] Practitioners must think critically about how the child's disability may increase their vulnerability to abuse and neglect, and what other cultural, social, educational or financial factors provide protection or place the child at increased risk of harm.

Aboriginal children are cherished within their families. While disability may not be openly spoken about, a child's siblings, parents, grandparents and extended family all share a responsibility to love, care for and nurture children.

Access to disability services

Accessing support for Aboriginal children with disability is complex and requires practitioners to consider not only the child's disability needs – alongside holistic assessment as to how their disability intersects with the family's experiences of racism, poverty, connection to culture – but also any child protection risk issues. Despite being twice as likely to have disability, Aboriginal families are less likely to engage in disability services, because services often do not meet their needs in a meaningful and culturally competent way. Twenty of the 37 Aboriginal children in this cohort were known to be receiving support.[143]

Families experience several barriers to accessing disability-specific support. Most significantly, the experiences of institutionalised racism and government control may lead to fear and distrust of organisations. Often, access to appropriate services is made more difficult by lack of availability, and travel to and from services for multiple appointments can create a financial burden for families. Additionally, many children are being raised by family members and not a legal guardian, which leads to difficulties in applying for support.[144]

Access to essential funding, for example through the National Disability Insurance Scheme (NDIS), can bring about several challenges for Aboriginal families. Application processes are costly, lengthy, complicated and require a high level of literacy. In order to secure enough funding, applicants are required to describe their inability to meet the needs of themselves or their children without support, which may cause great distress to Aboriginal families who may have experienced racism and judgement from government services in response to traditional child rearing practices. Additionally, practical support such as in home and respite support requires Aboriginal people to trust strangers to come into their homes and provide care for their children.

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[140] Australian Bureau of Statistics (2012).

[141] DiGiacomo et al. (2013); Aboriginal Disability Network (2005).

[142] Aboriginal Disability Network (2005).

[143] Types of support included a National Disability Insurance Scheme (NDIS) package and specific disability support services; hospital, medical or palliative care services; in home care support (not disability specific); educational support; child and adolescent mental health services; and respite care. For the remaining 17 children, support was offered but not accepted by the family, no support was occurring, or DCJ was not aware of the support being provided.

[144] Aboriginal Disability Network (2005); Gilroy et al. (2016).

A lack of practical support to care for children with complex needs has been identified as a key factor in parents relinquishing care of their children.[145] As Aboriginal families are less likely to have access to appropriate services, they may also be at higher risk of relinquishing care, and need practitioners to advocate for urgent and culturally safe support.[146]

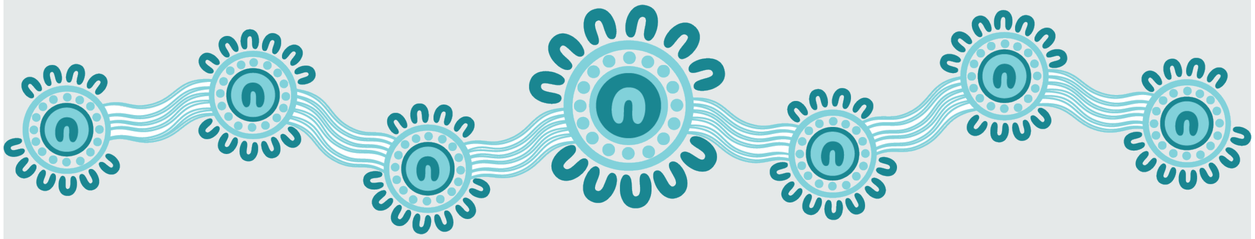
For Aboriginal families living in rural or remote communities, further barriers exist. Due to limited services being available, many families face the dilemma of moving to metropolitan areas to access better or culturally appropriate health and disability specific services, at the expense of health and wellbeing associated with leaving Country and community.[147]

DCJ CASEWORK PRACTICE

To support culturally safe practice with Aboriginal children and families, consider the following:

- Spend time with the whole family; take the time to listen to their story without judgement. This may need to happen over multiple visits, but it is important to be patient and build a trusting relationship with the family.
- Know the family, and know their child's diagnosis. Seek to understand what it means for the child individually and the family as a whole. Ask the family to explain what a day in their life looks like, and be sure to include parents, siblings and extended family and kin who play a significant role in the child's life. If a child does not have a diagnosis but you suspect there may be a developmental delay or disability, be curious when observing the child and listening to the family, and talk to them about exploring a diagnosis so that they can engage with early intervention and support.
- If a child with disability also lives with a parent with disability, consider how this impacts the family's access to services. Adapt the sharing of information and discuss strengths and worries with parents. Work with the family in a manner that is consistent with the parent's abilities, and link them with appropriate supports to help them to care for their child safely.
- Focus on informal supports, which can be explored through the use of Family Group Conferencing. Informal supports will be in the family's life longer than DCJ or other services. Invest time in helping parents and extended family to take on roles of supporting care, coordinating with services, and knowing when to ask for further help. This promotes self-determination and family led decision-making.
- Be guided by regular and purposeful Aboriginal consultation with staff and, where possible, community members.
- Consider what intervention the child and their family/carers need, and think critically about what barriers are getting in the way of the family accessing support.

For further advice about working with Aboriginal families, DCJ practitioners can refer to the **Cultural practice with Aboriginal communities** practice advice topic.



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[145] Ellem et al. (2016); Nankervis et al. (2011).
[146] Davis (2019).
[147] Dew et al. (2019).

JARROD'S STORY

Jarrod was a 17 year old Aboriginal boy who was taken from his parents and lived with extended family members from the time he was seven years old. He was under the parental responsibility of the Minister. Sadly, Jarrod died just before he turned 18.

When Jarrod could no longer safely live with his parents, DCJ authorised family members to care for him. This meant Jarrod could grow up in community and Country. Unfortunately, Jarrod's experiences of trauma and his neurodevelopmental disability meant he struggled to regulate his emotions and often behaved in ways that put himself and others in danger. Because of this, Jarrod became disconnected from his parents and siblings, and struggled to participate in school and community.

Jarrod's caseworker supported his family to apply for an NDIS support package. His caseworker asked questions in a way that honoured the family's strengths, so that they felt comfortable to share how they had tried to care for Jarrod and what help they needed. The caseworker helped to complete the NDIS application and worked with the NDIS to review the level of funding allocated to Jarrod. They also advocated for Jarrod to be allocated a culturally appropriate support coordinator.

Jarrod's caseworker also connected with his teachers to create a flexible and responsive plan for Jarrod to engage in school. This included helping in the library and at the school canteen. Jarrod's school community participated in his case plan meetings and frequently updated Jarrod's caseworker with information and ideas for how to best support him. This careful planning and collaboration meant that Jarrod remained engaged, and school was a positive experience.

LEARNING FROM JARROD'S STORY

DCJ did well to recognise the safety network within Jarrod's Aboriginal family. While Jarrod was sadly disconnected from his siblings, he was still able to be connected to his extended family and his Country.

DCJ had a strong partnership with Jarrod's school, which placed Jarrod's learning needs at the centre. The flexible and collaborative approach from Jarrod's school and caseworker meant that he was not excluded from education, and was given opportunities to learn that were suited to his abilities.

When DCJ supported Jarrod's family to apply for NDIS funding, it meant his family could speak openly about their challenges and needs. Jarrod's NDIS package was suited to his needs, and his family felt more supported to care for him. By helping Jarrod and his family to link in with a culturally appropriate NDIS support coordinator, Jarrod was supported to fully use his NDIS funding, and access service providers to meet his needs in a culturally appropriate way. Jarrod had many services involved in his life, but he needed more informal support. While casework with Jarrod included him and his carers in decision-making, it needed to extend to involving his parents and siblings. Reconnecting Jarrod to more of his extended family would have given them an opportunity to support not only Jarrod but his carers, and ensure he was surrounded by a lifetime network of people who loved and supported him.

3.1.8 Culturally and linguistically diverse children

Twenty-seven (21 per cent) of the children who had disability, were known to DCJ and died between 2017 and 2021 were identified as culturally and linguistically diverse. Of these 27 children, 14 were male and 13 were female.

Of the 27 children, 16 (60 per cent) had a combination of impairments that meant their disability and health care needs were complex. For 10 of these 16 children, their ability to communicate was impacted by their disability. Fifteen children were known to be receiving support for their disability or health conditions.[148]

Understanding disability within different cultures

Culturally and linguistically diverse children with disability and their families face unique challenges within the child protection and broader health systems. Many cultures view disability differently. Within some cultures, there is a significant stigma and sense of shame surrounding a child's disability. Some families believe their child's disability is a gift, while others perceive having a child with disability as a 'curse' or 'punishment' linked to religious or spiritual beliefs.

Some cultures do not have words in their language to describe or identify disability, making it difficult for families to talk about their child's disability and seek appropriate support. Research has found that culturally and linguistically diverse people in Australia access specialist disability services at a rate disproportionally less than their presence in the community, suggesting a clear gap in service accessibility for these communities.[149] It is important to consider how culturally and linguistically diverse families may face additional access or inclusion barriers as a result of language and cultural differences.[150]

Many families may have received negative social responses from their community about their child's disability which impacts their ability to access appropriate support and intervention. This may present as medical or other neglect. Additionally, some cultures view disability as limiting the child's potential to achieve goals in the way children without disability would be encouraged to do so, therefore restricting their participation in formal education or access to the larger social world.[151]

The disability service system is complex, and families who are not culturally or linguistically diverse struggle to navigate the services available in Australia and rely on word of mouth and internet searches to obtain information and support.[152] For culturally and linguistically diverse families experiencing social isolation or who have limited English, these barriers are likely to increase.

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[148] For the remaining 12 children, support was not adequate to meet the child's and family's needs, no support was occurring, or DCJ was not aware of the support being provided.

[149] Zhou (2016).

[150] Tsambouniaris (2016).

[151] Olivos et al. (2010).

[152] Ziviani et al. (2014).

DCJ CASEWORK PRACTICE

When working with culturally and linguistically diverse families where a child has disability, consider the following:

- Be curious and seek cultural consultations every step of the way.
- Ask questions to understand the child's full experience. Seek to understand how the family have tried to help their child, or what cultural, financial, social or other systemic barriers have prevented them from doing so.
- Understand how disability is viewed within the child's culture, and the way in which this will influence how parents see and respond to their child.
- Think creatively about communicating information with families. Ask open-ended questions from a strengths based approach.
- Recognise the impact of disability on the whole family. Some families may respond differently to their children without disability because they are viewed as having 'more chance at a normal life'. It is important to understand the family's views and intentions when assessing risk of abuse and neglect.
- Where possible, advocate for culturally specific services, or cultural support alongside disability services that can support families to navigate and engage with disability services for their child.
- Access to interpreters, multicultural respite care and bilingual health professionals is key to helping culturally and linguistically diverse children with disability to participate in services.[153]
- Foster collaborative relationships centred on the child's needs by upholding the child and family's right to equal participation in decision-making.[154]

Multicultural support services in NSW

Ethnic Community Services Co-operative (ECSC) provides multilingual/multicultural services and support to meet the needs of culturally and linguistically diverse people. ECSC can support families to understand NDIS plans, provide support coordination in their language, and promote participation within their community.

Multicultural Disability Advocacy Association provides various levels of advocacy for people, their family and carers who are culturally and linguistically diverse and from non-English speaking backgrounds to promote their rights and access to disability support.

Wesley Multicultural Services provides support services for mothers from a range of cultural backgrounds who have young children, children with special needs or teenagers.

Settlement Services International (SSI) is a community organisation that supports all people who have experienced vulnerability, including refugees, people seeking asylum and culturally and linguistically diverse communities. SSI provides services to people with disability such as helping them to access the NDIS, a multicultural peer network for culturally diverse people with lived experience of disability, and support to establish or expand their small business.

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[153] Tsambouniaris (2016).

[154] Olivos et al. (2010).

SRIYA'S STORY

Sriya, a 13 year old girl, was born with multiple and complex impairments. Sriya's family is Sri Lankan, and migrated to Australia when Sriya was four years old. Sriya could not speak and relied on her parents to manage her day to day care, including administering her prescribed medication.

When Sriya presented to hospital after an overdose of prescription medication, hospital staff were worried about the care and supervision at home and made a report to the Helpline. The report was allocated to a local office and a caseworker, Rebecca, who visited the family with the support of an interpreter. Rebecca spoke with Sriya's parents both at home and at the hospital, to ensure Sriya was included. Rebecca observed Sriya's body language and learned how Sriya communicated feelings of happiness, or distress, and how she communicated with her siblings. Sriya's parents told Rebecca they were not offered an interpreter when they had conversations with health professionals, which meant they did not understand that incorrect storage of her medication would strengthen the dose. They were distressed to learn that they had accidentally given Sriya too much medication. They spoke to Rebecca about feeling socially isolated because they did not speak to their extended family about Sriya's disability.

Prior to Sriya's discharge from hospital, Rebecca facilitated an interagency discussion with Sriya's parents, her doctors and NDIS workers. She advocated for an interpreter to be present, and encouraged Sriya's family to invite a friend from their community whom they trusted to participate in the meeting as a support person. Rebecca ensured Sriya's parents were informed about Sriya's medication plan and follow-up appointments, and knew how to ask for help or clarify information in future. Sriya's parents managed her care in line with her palliative care plan for another six months. Sadly, Sriya died from health complications associated with her disability.

LEARNING FROM SRIYA'S STORY

Rebecca's casework with Sriya and her family was respectful and responsive to their needs. Rebecca identified early on that the family needed an interpreter, which meant they could participate meaningfully in her first home visit and had the opportunity to explain their experiences of the hospital system. By observing Sriya's body language during the visit, and asking questions about how she communicated, Rebecca was able to include Sriya in the safety and risk assessment.

Rebecca understood Sriya's parents' intentions behind their care of her, including administering her medication. This helped to inform a holistic assessment and Rebecca knew what needed to happen to prevent an overdose from happening again. Rebecca's facilitation of an interagency discussion reflected the importance of collaborating with a child's family, and the services involved in supporting them. They were able to centre Sriya's needs and ensure everyone had equal access to information and could make informed decisions about her care.

3.2 Vulnerabilities related to a child's disability

There are distinct vulnerabilities relevant for children with disability and their contact with the child protection system. Their risk of abuse and neglect is generally considered higher than for children without disability. Research commissioned by the World Health Organization found children with disability experience harm at higher rates than children without disability. They are around three times more likely to experience physical violence and sexual abuse and over four times more likely to experience emotional abuse or neglect.[155] However, a child's impairment alone does not increase their vulnerability. Rather, other features in their environment, relationships, and the attitude and culture of their community more significantly influence their vulnerability.[156]

3.2.1 Disability types

Disability categories and publicly available prevalence data is inconsistent and sometimes not collected, making comparisons about disability types more difficult.[157] Defining and categorising disability is also complicated given a person may have more than one impairment, across different categories.

Disability is more than the presence or absence of physical, cognitive or mental health conditions. It occurs when impairments limit a person's ability to participate in a range of activities.[158] The categories used below are broad categories of disability, included to support practitioners working with children with disability and their families. They are not intended to be definitions of disability types.

It is important to note that information about a child's disability is not always known to DCJ. Some of the information reported below was not known to DCJ until after the child's death. Additionally, while details about a child's impairment and specific diagnoses may been known to DCJ, the impact an impairment had on a child's participation in the community is more difficult to quantify and is not always known to DCJ.

Intellectual disability

Intellectual disability is reported to be the most common type of impairment among Australian children. In 2015, an estimated 4.3 per cent of Australian children had intellectual disability.[159] The number of children with intellectual disability typically doubles at school age.[160]

Of the 128 children who were known to DCJ, had disability and died between 2017 and 2021, 57 (21 per cent) had intellectual disability. Almost half of the 57 children (25) were described as having an intellectual delay, and 19 children were diagnosed with a global developmental delay. Five children were diagnosed with Down syndrome and four children had an acquired brain injury. Of the 57 children with intellectual disability, 47 had an NDIS plan. Five of the 57 children with intellectual disability also had a parent with intellectual disability. Children with intellectual disability were most commonly reported to be at risk of significant harm due to neglect (32 children) and physical abuse (30).

Australian and international studies have reported that children with intellectual disability are more likely to be reported to child protection authorities and more than twice as likely to experience abuse and neglect.[161] Furthermore, children with intellectual disability have been

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[155] Jones et al. (2012).
[156] Robinson (2012).
[157] AIHW (2022a).
[158] ibid.
[159] ibid.
[160] Wayland & Hindmarsh (2017).
[161] De La Sablonniere-Griffin et al. (2021); Jones et al. (2012); McDonnell et al. (2019); Maclean et al. (2017).

found to experience a higher number of investigations by child protection authorities than children without intellectual disability, suggesting they experience recurring harm.[162]

Physical disability

A physical disability is characterised by the impact of a condition on a person's mobility or ability to perform physical activities.[163] For the 60 children (47 per cent) in the cohort with physical disability, this included diagnoses such as quadriplegia, cerebral palsy, congenital conditions that impacted physical mobility, spina bifida or other degenerative disorders. Forty-two of the 60 children with physical disability had multiple impairments. This was most commonly intellectual disability (31 children) or neurodevelopmental disability (29 children). Seven children with physical disability had an acquired brain injury.

Children with physical disability were most commonly reported to be at risk of significant harm due to neglect (37 children) and this usually related to their medical needs (33 children). One explanation for this is that these children likely attended regular medical appointments and treatment, and exposure to mandatory reporters. The next most frequently reported risk category was physical abuse (31 children), which correlates with research reflecting parents' likelihood to excessively discipline children with physical disability when compared to children who do not have disability.[164]

Neurodevelopmental disorders

Disorders impacting early brain development are often referred to as neurodevelopmental disorders. These conditions share three common characteristics: they begin in infancy or early childhood, disrupt brain development and do not show signs of worsening or improving.[165] Neurodevelopmental disorders impair motor, learning, language, non-verbal communication and sensory functions. Conditions included in definitions of neurodevelopmental disorders vary, but typically include autism, intellectual disability, motor disability, seizure disorders, learning disability, communication disorders and attention deficit hyperactivity disorder. Neurodevelopmental disorders often impact on personal, social, educational and occupational functioning due to cognitive delay, communication difficulties or challenges in emotional and behavioural regulation.

Of the 128 children in this cohort who died, 66 (52 per cent) had a neurodevelopmental disorder.[166] This included autism, epilepsy, attention deficit hyperactivity disorder, conduct disorder and fetal alcohol spectrum disorder. Children with these disorders are at increased risk of experiencing mental health conditions.[167] They often experience similar symptoms to those with mental health conditions, including increased impulsiveness and emotional instability. Of the 66 children with a neurodevelopmental disorder, 12 had a co-occurring psychosocial disability.

Several studies have investigated specific neurodevelopmental disorders and interaction with the child protection system. Studies consistently identify that children with neurodevelopmental disorders, problems with communication and challenging behaviours are more likely to experience abuse and neglect.[168] Of the 66 children known to DCJ with a neurodevelopmental disorder, 24 had difficulties with communication and 24 had challenging behaviour. Children with neurodevelopmental disorders were mostly commonly reported at risk of significant harm due to physical abuse (39 children), neglect (37 children) and domestic and family violence (36 children).

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[162] Paquette et al. (2018).
[163] National Disability Services (2022).
[164] Palusci (2017).
[165] Orygen (2019).
[166] This number does not include children in the cohort who had intellectual disability. These children have been included above under intellectual disability.
[167] Hansen et al. (2018).
[168] For example, Fisher et al. (2019), McDonnell et al. (2019).

DCJ CASEWORK PRACTICE

Disability, behaviour and safety

When conducting assessments, seek to understand each child's needs and behaviour. Behaviour may be linked to a child's disability, and require practitioners and families to work together to ensure short- and long-term safety. Behaviour may also be impacted by parental risk factors, and require rigorous safety discussions and planning to ensure that it is recognised and responded to. Engaging curiously with families and support networks helps practitioners to effectively understand a child's world. Look out for the following behaviour:

- 'Wandering' (or 'elopement') is the term used when a child leaves a safe area or responsible carer. It is common for children with autism or developmental delay. Children may wander away from a caregiver even with vigilant supervision. Often children wander into unsafe locations, increasing their risk of harm for issues such as drowning, abduction or physical injury.[169]
- Children with disability may experience issues with feeding, such as under- or over-eating, sensory issues with food intake, food refusal or generalised disordered eating.[170]
- Behaviours often associated with attention deficit hyperactivity disorder and oppositional defiant disorder include resistance to routine, decreased impulse control, poorer relationships with peers and emotional dysregulation.[171]

To gain a holistic understanding of how a child's disability influences their care needs, practitioners should:

- discuss the child's behaviour and presentation with their family and safety network to understand them in context (including whether siblings without disability have similar behavioural needs)
- consult with the child's treating medical or disability-based services
- consult with DCJ Psychological Services, the Engagement and Family Support team and casework specialists to further understand the disability type, and how their assessment can consider this information contextually
- research the disability using credible and reliable sources.

Psychosocial disability

A psychosocial disability occurs when a mental health condition interacts with external factors in a person's environment and impacts their ability to participate in society equally.[172] A psychosocial disability may impact a child's capacity to concentrate, interact with others, be in particular environments and manage stress.[173] Psychosocial disability is one of the most prevalent impairments among Australian children, at an estimated 2.7 per cent of children.[174]

The Young Minds Matter Survey[175] identified that anxiety and depressive and conduct disorders are the most common conditions that led to psychosocial disability, with teenagers experiencing

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[169] Pereira-Smith et al. (2019).

[170] Huke et al. (2013); Stiles-Shields & Holmbeck (2019).

[171] Miller (2022).

[172] NSW Health (2022b).

[173] ibid.

[174] Australian Bureau of Statistics (2018).

[175] Conducted by the Australian Government Department of Health in 2013 and 2014. It randomly selected and interviewed more than 6,000 Australian families in order to better understand the mental health and wellbeing of children aged four to 17 years. Almost 3,000 children aged 11 to 17 years participated directly.

these conditions more frequently than children aged under 12 years.[176] Children who experience adverse childhood experiences in their early developmental years are at greater risk of having a mental health condition progress to a psychosocial disability.[177] This risk is further heightened for children who had contact with a child protection service by six years of age, or for children in out of home care.[178]

Of the 128 children in the cohort who died, 33 (26 per cent) had a diagnosed mental health condition. Nineteen of these children were male and 14 were female. The majority of the children (31) were aged 12 years or over. The most commonly diagnosed condition among these children was depression (18 children). Eleven children were diagnosed with an anxiety disorder and 12 of the children had more than one diagnosed mental health condition. Eight of the children were in out of home care, and 15 children had received a child protection assessment at some point in their lives.

Psychosocial disability in children can mean a higher likelihood of negative adult outcomes, including disengagement with the workforce, substance use and interaction with the criminal justice system.[179] Of importance to casework practice are the factors that mitigate the likelihood of these continued challenges into adulthood, including permanency, safe connections and a sense of belonging, and early access to appropriate support services.[180]

≣ DCJ CASEWORK PRACTICE

Working effectively with a child with a psychosocial disability requires persistence and connection to safe and loving people. For further advice and support, DCJ practitioners can access the **Mental health** practice kit, which includes a chapter on working with children with mental health issues. **Cultural** and **psychological** consultation can also support practitioners in their dignity driven practice and holistic assessment for children with a psychosocial disability. For children with psychosocial disabilities who experience suicidal thoughts or behaviour, it is important for practitioners to collaborate with mental health services supporting the child and their family. Practitioners must ensure their assessments are holistic, the child's suicide risk is understood, and intervention is tailored to the child's individual needs.

3.2.2 Children in out of home care

Twenty-three children (18 per cent) who had disability, were known to DCJ and died between 2017 and 2021 were in out of home care at the time of their death. Of these 23 children:

- 11 were case managed by a Permanency Support Program (PSP) provider
- 11 were case managed by DCJ
- one child was case managed jointly between DCJ and a PSP provider.

The care arrangements for these children included:

- 10 children living with authorised carers
- eight children living with relatives who had been authorised to provide them with long-term care
- three children living in residential and/or disability care settings
- two children who had left their authorised placements and were living with their parents or other relatives.

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[176] Lawrence et al. (2015).
[177] Green et al. (2020).
[178] ibid.
[179] Singh (2009).
[180] Osborn & Bromfield (2007).

Of the 23 children, 12 were male and 11 were female. The children living in out of home care varied in age at the time of their deaths, from four months to 17 years.

Research suggests that children with disability are at higher risk of experiencing abuse and neglect, and are almost twice as likely to be taken from their family.[181] In particular, children with neurodevelopmental disability are more likely to experience earlier entries into care, have a parent or caregiver relinquish care, and be placed in a residential care setting than their peers without disability.[182] Additionally, some studies have found that older children with disability are more likely to stay longer in out of home care, and experience less placement stability than children who do not have disability.[183]

All of the 23 children in out of home care were offered or were receiving specialist support, either through NSW Health and hospital services, or from disability or other support services.

≣ OUT OF HOME CARE (OOHC) HEALTH PATHWAY

All children should be referred to the OOHC Health Pathway when they enter care. Children who are not on the Pathway should be referred when they turn 15 years old, in line with leaving care planning. Children with a significant health need should be referred regardless of when they entered care.

Health management plans

A health management plan is developed by NSW Health in consultation with DCJ, PSP providers, authorised carers and children. The plan is developed within 90 days of a child entering care and outlines their health needs and any required intervention to support their health and development.

End of life decisions

Children in care with life-limiting illnesses and disability may require an end of life plan. End of life decisions are complex and require significant planning with the child, their family, carers, and medical and support services. End of life planning must begin as soon as DCJ is made aware that a child's condition is life limiting, and must keep the child and their wishes at the centre of planning.

For more information on meeting health needs for children in care, and advice on developing an end of life plan, DCJ practitioners can refer to the **Health needs of children in out of home care** mandate.

Restrictive practices

Restrictive practices involve intervening to protect children or others from harm. Such practices must not be used as form of punishment, and should only be used as part of a formal behaviour intervention as set out in an approved behaviour support plan. Restrictive practices may include physical restraint or removing harmful items from the child. Some children may also require psychotropic medication, which affects their cognition, mood, level of arousal and behaviour. Children who require restrictive behaviour management are at higher risk of experiencing harm.[184] Four of the 23 children in out of home care required approval for use of restrictive practices as part of their DCJ behaviour support plan. Two children were diagnosed with mental health conditions and neurodevelopmental disorders and were prescribed psychotropic medication. The other two children were diagnosed with multiple disabilities and required the use of physical restraints to keep themselves and others safe.

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[181] Lightfoot et al. (2011).
[182] Baidawai & Piquero (2021).
[183] Hill (2012).
[184] Robinson (2012).

BEHAVIOUR SUPPORT PLANNING

Some children who live with neurodevelopmental disorders, acquired brain injuries or who have other complex behavioural needs may require a DCJ behaviour support plan (BSP). A BSP is required when a child who is living in out of home care is prescribed psychotropic medication, if their behaviour is a danger to themselves or others or is having a major impact on their day to day functioning, or if restrictive practices are recommended to keep themselves and those around them safe.

For further advice on developing a BSP, DCJ practitioners can refer to the **Behaviour support** mandate, and the **Behaviour support in out of home care guidelines**, available on the Casework Practice intranet site.

Children who require a DCJ behaviour support plan may also be eligible for an NDIS Behaviour Support Plan. DCJ practitioners can contact the **Engagement and Family Support** team for advice on how to advocate for children to access their NDIS Behaviour Support Plan and use their funding appropriately.

TOM'S STORY

Tom was born prematurely and had cerebral palsy, quadriplegia, a hearing impairment and microcephaly. As he grew up, he had limited verbal communication and needed a wheelchair to move around. When Tom was three years old, his mother told DCJ that she could not look after him anymore. DCJ assumed care of Tom and he went to live with his adult cousin. Tom's health began to decline as he grew older.

Tom's caseworker, Andy, arranged case planning annually and involved people and services that were most important to meeting Tom's needs. This included his parents, his cousin who cared for him, extended family, and his school, NDIS support coordinator, and various health and disability services. Andy visited Tom regularly, and clearly documented the love that Tom experienced from his family. By spending time with Tom and his family, Andy learned what made Tom laugh, saw how he smiled when a family member entered the room, and could observe his comfort within his environment. Tom had difficulty communicating, so Andy made sure he participated in his case plans and home visits by using tools like the Charter of Rights flash cards.

When Tom was 14 years old, he become critically ill. Andy involved Tom's family and the services around him in decisions about his care by holding a Family Group Conference. Tom's family was supported to take the lead in decisions about his end of life plan, which helped them to prepare for his death. Tom died at age 16, surrounded by those who loved him.

LEARNING FROM TOM'S STORY

Tom's presence was strong in all the records that were written about him. His caseworker, Andy, built a strong relationship with him and the important people in his life by consulting with his family and the services supporting him, and upholding family led decision-making. Tom's mother reached out to DCJ when she could no longer meet Tom's needs as a young child, but her role as Tom's parent was carefully considered by Andy and her involvement in his life was encouraged. Despite Tom's communication challenges, Andy did well to consider alternative ways to communicate with him and promote his participation. This meant the **NSW Child Safe Standards for Permanent Care** were upheld, and Tom was cared for with dignity and compassion.

3.2.3 Young people involved in the criminal justice system

Young people[185] with disability are over-represented at all points of contact with the criminal justice system, from initial police interaction to being in custody.[186] Often, systemic issues that young people with disability face contribute to this over-representation. This includes disengagement from school and education, unsupported needs related to their disability, and the intersection of trauma and disability.[187]

Overall, young people in contact with the criminal justice system are more likely to have speech and language disorders and dually diagnosed physical and mental health conditions.[188] The 2015 Young People in Custody Health Survey found that one in six young people surveyed had a potential intellectual disability, with 80 per cent having below average assessed language skills.[189] Young people who present with disability may be perceived as having challenging behaviour or as less willing to engage with intervention and support.[190]

Nineteen (15 per cent) of the 128 young people who were known to DCJ and had disability and died between 2017 and 2021, had had contact with the criminal justice system at some point before their death. Seventeen of these young people were known to Youth Justice, with two case managed by Youth Justice at the time of their death.[191] Their involvement included spending time in custody, subject to bail conditions or supervision orders, and receiving general casework support to increase education or employment engagement. Two of the 19 young people had recorded involvement with NSW Police but were not known to Youth Justice. This police involvement related to their behaviour towards others. Of the 19 young people, the majority were male (16 male; 3 female). Their ages ranged from 14 to 17 years. Twelve of the young people were Aboriginal. This correlates with a nationwide over-representation of First Nations young people in custody or involved with youth justice.[192]

Research highlights that young people with neurodevelopmental or intellectual disability are at higher risk of coming into contact with the criminal justice system.[193] Over half of young people surveyed in the 2015 Young People in Custody Health Survey met the criteria for an attention or behavioural disorder. The rate of attention deficit hyperactivity disorder for young people in custody was three times higher than the prevalence in the general population.[194] Additionally, young people involved in criminal activity have often experienced cumulative negative life experiences, making them more vulnerable to mental health issues or psychosocial disability.[195]

Neurodevelopmental or intellectual disability may lead to behaviour such as hyperactivity and impulsivity, which can contribute to increased interactions with police. For the 19 young people in this cohort who had contact with the criminal justice system, seven had neurodevelopmental disorders, six had diagnosed mental health conditions and two had intellectual disability. The remaining four young people had multiple impairments that were a combination of physical and intellectual disability, neurodevelopmental disorders and mental health conditions.

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[185] The *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a young person as aged over 16 and under 18 years of age. The term 'young people' is used in this section for ease of reading.

[186] Kincaid & Sullivan (2019).

[187] ibid.

[188] Dowse et al. (2014).

[189] Justice Health and Forensic Mental Health Network, and Juvenile Justice (2017).

[190] Chitsabesan et al. (2007).

[191] The causes of death for these 17 young people were: eight died by suicide, three died in motor vehicle accidents, two died from a drug overdose, two died in fires, one died from an illness and one died from an inflicted injury.

[192] National Children's Commissioner (2019).

[193] Hughes et al. (2012).

[194] Justice Health and Forensic Mental Health Network, and Juvenile Justice (2017).

[195] ibid.

DCJ CASEWORK PRACTICE

Working collaboratively with Youth Justice is critical to providing a cohesive systems response to young people who have disability and are interacting with both Youth Justice and Community Services. Consider the following in practice:

- Share risks, strengths and worries and develop next steps together. Use group supervision sessions to partner with purpose to develop a family action plan with young people and their families and collectively consider the required supports.
- An important time for collaboration is when a young person enters custody. This can present an opportunity to identify and assess disability and arrange for the right support by accessing NDIS or alternative services.
- When case planning to support leaving care, partner with Youth Justice, NDIS and DCJ-funded programs to ensure plans for support are decided and arranged early.
- Establish role clarity and responsibilities in service provision for young people who enter custody to ensure their needs are holistically met.

Collaboration between Youth Justice and Community Services

On 1 July 2019, the former NSW Department of Family and Community Services and NSW Justice merged to create the NSW Department of Communities and Justice. One of the purposes of this collaboration is to better meet young people's needs and work together to increase access to child protection support, justice, early intervention and general service delivery.

Youth Justice has developed a comprehensive plan to prioritise the service delivered to young people with disability. The **Youth Justice NSW Disability Action Plan 2021–2024** identifies actions to reform practice in the following areas:

- Strengthening partnerships with internal and external stakeholders.
- Early intervention and diversion from the criminal justice system.
- Developing the skills and capabilities of staff specifically in relation to working with young people who have disability.
- Improving the way that data is captured, recorded and reported on.
- Refining service delivery that is cohesive, collaborative and tailored to individual young people and families.
- Promoting the rights and inclusion of young people with disability in the community.

3.2.4 Parents with disability

Parents with disability can love and care for their children like any other parent, but they may need additional support to help them. One of the biggest challenges parents with disability face is overcoming the stigma and assumptions about their disability and capacity to parent. Studies suggest that parents with intellectual disability may be more likely to have involvement from child protection authorities.[196] Children who have a parent with intellectual disability also have a greater likelihood of having a case open longer and being taken from their parent's care.[197] Research about disability prevalence suggests that approximately 40 per cent of children who have a parent with intellectual disability have developmental delays and behavioural challenges.[198] When

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[196] Llewellyn & Hindmarsh (2015).
[197] Mayes et al. (2006); Llewellyn & Hindmarsh (2015).
[198] Llewellyn & Hindmarsh (2015).

these children have safe and supportive relationships with other family and community members, risk is lowered and their abilities are increased.[199]

For parents with physical disability, there is generally some reliance on other adults to support them with one or more elements of a child's care, which can impact how they are viewed as a parent, potentially increasing attention from child protection authorities.[200] Similarly, parents with physical or psychosocial disability face a higher likelihood of having their parenting practices reported to child protection services.[201,202]

Of the 128 children in this cohort, 20 (16 per cent) had a parent with known disability.[203] Four of these children lived with parents who both had disability. Children of a parent with disability in the cohort were most often reported to be at risk of significant harm for neglect (16 children) and physical harm (14 children). Half of the children who had a parent with disability had multiple or complex disability, which frequently means more demanding care needs[204] that can increase the demands on carers or parents who also have disability. Six of the children who had a parent with disability also had a sibling with disability, which further exacerbates care and support needs for the family.

DCJ CASEWORK PRACTICE

What do parents with disability need from practitioners?

- Be clear and direct about safety and risk issues.
- Plan your visits and think about who a parent might need there to support them in safety planning and case planning.
- Be guided by parents on how to best communicate with them. Check in with parents regularly to make sure they understand the worries, strengths and plans. Be creative about how you communicate and share information. Consider a parent's ability to remember and recall information, and ensure that a parent's responses to stressful situations is understood in the context of their disability.
- Use supervision or group supervision to reflect on your own biases, assumptions and beliefs about people with disability. The presence of disability for a parent should not be the only factor in assessing whether their child is safe. Be clear about behaviour and impact on children when determining safety and risk.
- Support parents to connect with disability advocacy organisations. Advocates can support parents to understand DCJ work and decision-making and ensure they are not unduly pressured into consenting to care arrangements for their children. Advocates can also support parents to participate in case planning for their children, particularly when the goal is restoration, to ensure actions for parents are realistic and achievable.[205]

Practitioners can search for federal and state disability advocacy organisations through the **Australian Federation of Disability Organisations**.[206]

For Aboriginal families, practitioners can support families to connect with the **First Peoples Disability Network Australia**.[207]

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[199] Campbell et al. (2012).
[200] Selander & Engwall (2021).
[201] Darlington & Feeney (2009).
[202] Dominiek (2017).
[203] The remaining children either did not have a parent with disability or information about a parent's disability was not known to DCJ.
[204] Cole (2020).
[205] Davis (2019).
[206] See www.afdo.org.au
[207] See https://fpdn.org.au

3.3 Child protection responses

Caring for a child with disability can create additional pressure and support needs for families. In the context of child protection work, it is important to remember that disability does not cause or warrant the harm a child experiences. The causes of abuse and neglect of children with disability are the same as those for all children but caring for a child with disability may place higher emotional, physical, economic and social demands on families.[208]

Experiences of invisibility or discrimination may bring shame and isolation, and can affect family relationships and support networks. This can limit a child's access to supports and create additional pressure on caregivers. A family's perception of the child's disability and associated behavioural needs can also mean that children with disability are at higher risk of being neglected or more harshly disciplined.[209]

Responses to reported child protection issues for children with disability may also place them at greater risk. Research indicates that practitioners are more likely to perceive that a child with disability is contributing to the harm they are experiencing.[210] Children with disability are also less frequently considered to need care and protection,[211] and are more likely to be under-reported than the general population.[212]

3.3.1 Reported risk of significant harm concerns

As stated, research suggests that children with disability are more likely to experience abuse and neglect when compared to children without disability.[213] The majority of children who were known to DCJ, had disability, and died between 2017 and 2021 had been reported at risk of significant harm. Twenty children had been reported once; for 66 children there were from two to nine reports; and for 35 children, more than 10 reports had been received. The remaining seven children were not reported to DCJ prior to their death, although reports had been received about their siblings.

The families of children in this cohort were reported at risk of significant harm due to the following categories of concern:[214]

- Neglect (79 families, 62 per cent)
- Physical abuse (73 families, 57 per cent)
- Domestic and family violence (63 families, 49 per cent)
- Sexual abuse (61 families, 48 per cent)
- Parental drug or alcohol use (59 families, 46 per cent)
- Child risk-taking behaviour (48 families, 37 per cent)
- Parental mental health (40 families, 31 per cent)

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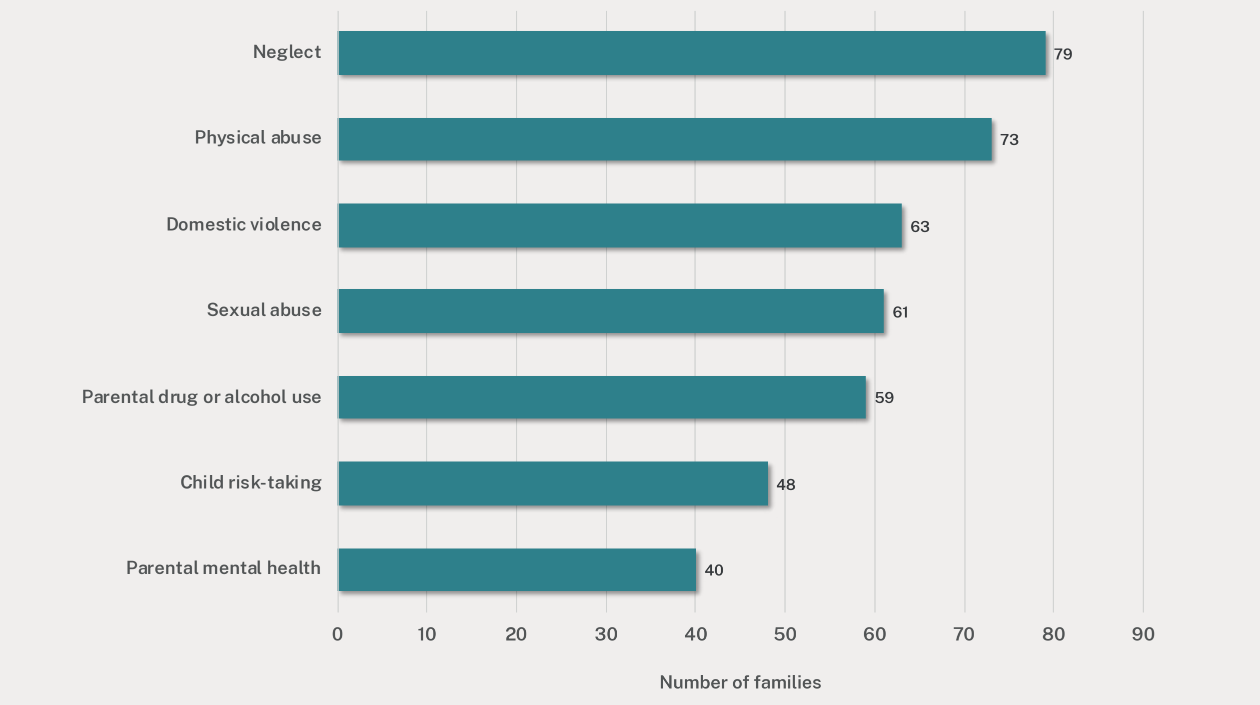
[208] Legano et al. (2021).
[209] Robinson (2012).
[210] Llewellyn et al. (2016).
[211] Wayland & Hindmarsh (2017).
[212] Stalker & McArthur (2012).
[213] Jones et al. (2012).
[214] Numbers do not add to 100 per cent as families can be reported multiple times for multiple concerns.

Figure 14: Reported risk of significant harm concerns, by number of families



Neglect

In Australia, neglect is one of the most common forms of child maltreatment but one of the most challenging to assess and address.[215] Neglect is also often the most commonly reported risk factor for all children who died and were known to DCJ.

Children with disability generally have higher care needs than their peers without disability, and are at heightened risk of each form of neglect, including emotional, medical, educational, supervisory and physical neglect. Research has identified a number of family factors that increase the risk of neglect for a child with disability. This includes a parent's understanding of their child's disability and care needs, a parent's own disability, drug or alcohol use, limited access to resources, management of a parent's own mental health condition or the number of children in a sibling group.[216]

As reflected in Figure 15, neglect related to supervision (56 families) and the medical needs of a child (55 families) were the most commonly reported neglect type for children who died between 2017 and 2021, were known to DCJ and had disability.

Medical neglect for children in this cohort was commonly related to missed medical appointments, and medications or therapies not being provided. For the 55 children reported to be at risk of significant harm due to medical neglect, more than half (31) had multiple impairments and likely had higher and compounding care needs. The increased needs of children with complex disability were also reflected in those reported because of concerns about appropriate supervision, with 19 of the 56 children having multiple impairments.

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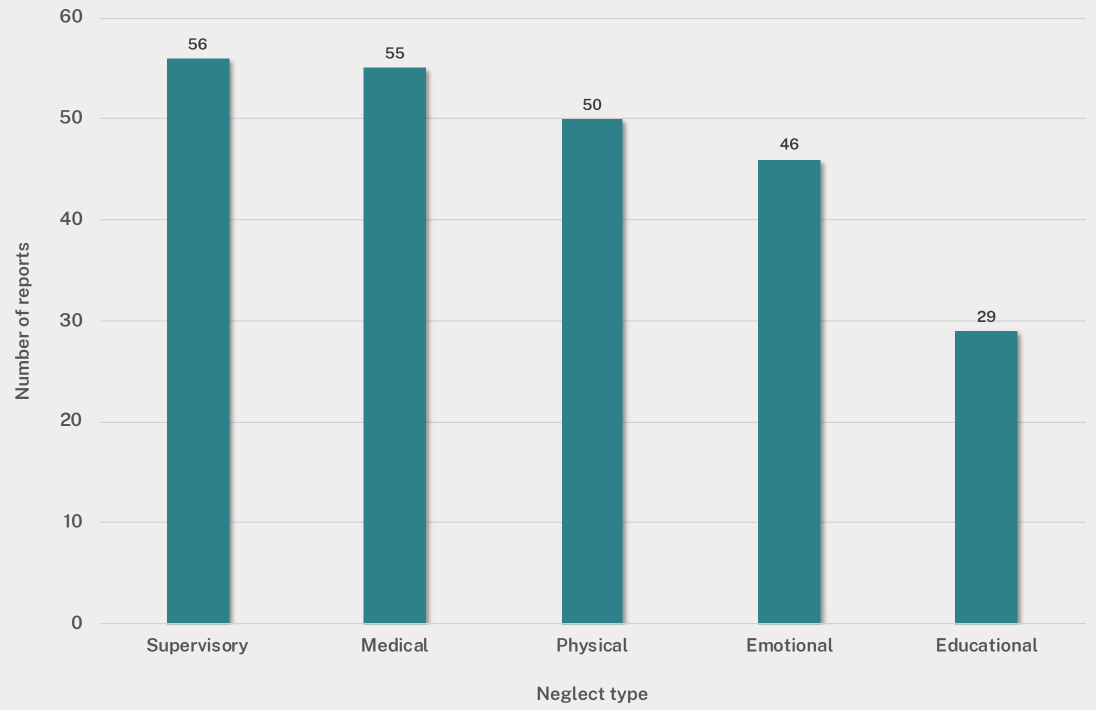
[215] Scott (2015).
[216] Leeb et al. (2012).

Figure 15: Number of reports about neglect, by neglect type



It is important to note that children with disability are not more vulnerable to neglect because of their own characteristics or diagnosis, but rather the interaction between their disability and external factors in their environment.[217] When considering this interrelationship in the context of neglect, children with disability are more likely to be reported at risk of significant harm because of factors such as heightened exposure to mandatory reporters, higher expectations on caregivers to meet their child's complex needs and the child's declining health being associated with parental care rather than prognosis.[218]

Physical abuse

Research shows that physical abuse is more likely for children who have disability than children who do not have disability.[219] Characteristics that make day to day care needs more difficult predispose a child to physical abuse.[220] This includes disability-related challenging behaviour, increased personal care needs and children with physical or intellectual disability.

Consistent with these findings, over half (73, 57 per cent) of the children who were known to DCJ and had disability and died between 2017 and 2021 were reported because of concerns about physical abuse. Of these 73 children, 32 had multiple impairments which likely increased their daily care needs, and 28 were known to have challenging behaviour. Fifteen children who had been reported to DCJ because of concerns about physical abuse were known to have physical disability and 16 children had intellectual disability. Fourteen children had both physical and intellectual disability.

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[217] Chu et al. (2011).
[218] Coller & Komatz (2017).
[219] Lightfoot (2014).
[220] Kauppi et al. (2012).

Domestic and family violence

For families who have a child with disability, the dynamics of domestic and family violence can be further complicated, and are experienced more frequently than by women and children without disability. There is often a reliance on the perpetrator of violence to help in meeting care needs and provide financial support to the family. Perpetrators of violence may exploit these roles to isolate and further control women and children, and women and children with disability may experience additional barriers to disclosing violence and accessing support. This can impact the severity and frequency of the violence, and the interaction of different forms of violence (e.g. physical, financial and emotional) may increase.[221] The correlation between complexity of care needs and increased risk of domestic and family violence is reflected in the cohort, with 28 of the 63 families reported to DCJ because of concerns about domestic and family violence also having a child with multiple or complex impairments.

≣ DCJ CASEWORK PRACTICE

The dynamics of domestic and family violence for families who have a child with disability require holistic assessment, critical reflection and analysis. It is important that practice seeks to hold perpetrators accountable for their violence, and that women and children with disability are involved in any decision-making about their safety. For further advice, DCJ practitioners can refer to the **Domestic and family violence** practice kit.

Sexual abuse

Research suggests that adult perpetrators of child sexual abuse are more likely to choose to groom and target children with disability.[222] The increased risk of sexual harm is compounded by the challenges children with disability face in disclosing sexual abuse, and the response they receive when they do.[223] Adult offenders of child sexual abuse are more likely to exploit their increased access to children with disability including in personal care, transport services or education in order to sexually abuse children. Adults who use grooming tactics are more likely to choose victims who cannot or are less able to disclose harm. These choices are intentional. Children with disability face specific barriers and challenges to disclosing sexual abuse, due to their reliance on adults to meet their care needs, communication difficulties, their understanding of abuse or protective behaviour, and the need to spend a significant amount of time in care settings where they are expected to be compliant and well behaved.[224] The combination of these factors means sexual abuse of children with disability is consistently under-reported.[225] Further, research has shown that when a child with disability does disclose the sexual abuse they have experienced, they are less likely to receive the therapeutic support they need.[226]

For children in this cohort, 61 families were reported to be at risk of sexual harm. In these 61 families, 13 children were known to have difficulties with communication, and 17 children likely required help with daily care needs either due to their young age (3 years or younger) or their diagnosed disability. Additionally, 18 children had multiple or complex impairments.

International studies have identified that children with learning disability are specifically at increased risk of sexual abuse and exploitation.[227] This is especially true for children with disability living in out of home care.[228] From the 61 families reported to be at risk of sexual harm, 12 of the children were in out of home care.

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[221] Robinson et al. (2020).
[222] Olafson (2011).
[223] Lemaigre et al. (2017).
[224] Llewellyn et al. (2016).
[225] Stalker & McArthur (2012).
[226] Esposito & Field (2016).
[227] Franklin et al. (2015); Jones et al. (2012).
[228] Euser et al. (2016).

DCJ CASEWORK PRACTICE

When working with a child with disability who may have been sexually abused, reflect on the following:

- How can I recognise the signs of sexual abuse and help this child to tell someone what has been/is happening to them, even when the child has difficulty communicating?
- Have I examined any potential ableism (my own and others) to ensure that I am not disbelieving or minimising potential child sexual abuse?
- Have I spoken with the child and communicated that they have been heard and believed?
- What actions can I take, in partnership with the child and their network, to ensure the child's safety within the scope of my role? Have I connected with the child's safety network and helped to build their capacity to keep the child safe? How can those who care about the child help the child to tell their story?
- What actions can I take, in partnership with the child and their network, to try to ensure that the perpetrator is held accountable? (e.g. reporting, information sharing with other services and NSW Police)

For further advice, DCJ practitioners can refer to the **Child sexual abuse** practice kit.

3.4 Learning from child death reviews

3.4.1 Children's participation

> *It's important to have a relationship with children as best you can … making sure that you're interacting with them in spaces that they're comfortable with and in things that they enjoy.*
>
> **Mathew, Youth consultant**

When reviewing children's deaths, DCJ often identified that children were not invited to participate in assessments about their safety and risk, and often there was no consideration about alternative methods to communicate with children who had limited verbal skills. Assessments also did not routinely focus on family strengths and protective factors.

For children in this cohort, in the three years before each child's death, DCJ completed assessments for families of 53 children (41 per cent). Sixteen of these 53 children were known to have difficulties with communication. From these 53 families, nine children participated in the assessments. Of the 44 children who did not participate in the assessments, 32 were aged five or over. Many of these children were observed but not spoken with, or only their siblings were spoken with.

Children perceive safety differently to adults and therefore it is essential that practitioners talk with children to understand what safety means to them, how they are experiencing safety, and how to act in a way that responds to their worries.[229] Participation in decision-

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[229] Moore (2017).

making is particularly important for children with disability, whose interests and voices are often overlooked.[230] Hearing and responding to the voices of children is crucial and should be prioritised. With purposeful planning, it is possible to have safe, creative conversations with children about sensitive topics in their lives.[231] Effectively supporting children with disability to share their experiences and build meaningful relationships with safe adults may help to reduce high rates of harm, and help children feel supported to identify and act on feelings and instincts, increasing their own protective behaviour.[232]

ADVICE FROM TARNIE AND MATHEW, YOUTH CONSULTANTS

- I have a right to participate in decisions about my life so help me to do this, even when talking to me and understanding my needs is hard.
- If I can't tell you directly, think of creative ways to ask me how I'm going and whether I'm safe.
- Get to know my non-verbal cues. Learn from those around me how I communicate my needs.
- Give me options about how and when we meet and talk. Find out where I'm usually most comfortable.
- Sometimes I might say I understand, even though I'm not sure. Check my understanding with me every step of the way.

DCJ CASEWORK PRACTICE

Having conversations with children about their experiences and feelings of safety helps practitioners to work collaboratively with children to respond to dangers, identify networks of safe people, and increase protective behaviour.

Practitioners can talk to the child's family network and learn how they communicate with their child. They may have communication aids the child is familiar with, or they may be able to describe the child's body language and how they communicate their needs. When completing assessments, it is important for practitioners to spend time with the child and observe their body language and responses to discussions happening with or around them. Observe the family dynamics and who in the household participates in the child's care. These observations need to be recorded and informed by ongoing home visits and communication with the child, their siblings, and parents or carers.

To encourage children's participation in casework, try the following approaches:

- Avoid making assumptions about a child's ability to communicate. Ask them first and offer them an opportunity to speak with you privately. Be guided by the child when assessing whether additional communication methods or aids are needed.
- Avoid only addressing a parent or carer if the child in the room. Include the child in the conversation, even if they seem distracted or are doing other things while listening.
- Seek out alternative communication aids, like visual aids such as symbols or picture cards, communication boards or technological devices (iPad and tablet apps).[233]

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[230] UNICEF (2007).
[231] Robinson (2016).
[232] ibid.
[233] Family Connect (2021).

- Consider the environment in which you are speaking to the child – where are they most comfortable? How do they prefer to communicate and who could be involved to support them?
- If the child would like to go somewhere specific to speak with you, make sure you know how to safely transport the child, and that you are going somewhere accessible. Advice for practitioners about transporting children safely can be found in the **Transporting a Child or Client Policy**.
- Be comfortable sitting in silence, allow extra time for conversations and ask the child to repeat themselves, or show you in a different way if you do not understand. Never pretend to understand if you do not.
- Record clear observations of the child's behaviour. Be curious about what their behaviour is telling others. Ensure the child's voice is considered in every assessment.
- Seek to understand how the child differentiates between 'being safe' and 'feeling safe'. It is possible to experience one without the other, or both at once. Critically reflect on what is needed to ensure a child is safe and feels safe.[234]

For further information and support, DCJ practitioners can refer to the **Working with children with disability** and **Talking to children and participation** practice advice topics on the Casework Practice intranet site.

3.4.2 Collaborating around a child

> *Caseworkers often fall into the trap of thinking 'I have to be the doer of all things', and that's where we get stuck. Sometimes the best role we can play is to be the lead agency in bringing together Health, Education and other services, and facilitating really strong collaborative meetings that help get everyone on the same page to strengthen what is happening for the child.*
>
> **DCJ caseworker**

The needs of families that have a child with disability are often complex. One of the greatest risk factors increasing the likelihood that a child with disability will experience abuse or neglect is that families do not have appropriate support to care for their child.[235] This was reflected in the internal child death reviews completed for the children in this cohort. When working with children who have disability and their families, the importance of purposeful partnerships with services supporting the child and family cannot be overstated. Good collaboration means that practitioners are working as a team with families, children and community partners, which leads to shared understanding of risk and keeps the child at the centre of decision-making.

Children with disability often have one or more services supporting them and their families, including disability or other health or support services. Of the 128 children in the cohort who died, 55 (43 per cent) were involved with support services, with 39 children (30 per cent) known to have more than one service involved.[236] Forty-six children (36 per cent) had an NDIS plan at the time of their death.

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[234] Moore (2017).
[235] Lightfoot (2014).
[236] This included a combination of health, disability or other family support services.

Collaboration is critical to facilitating information sharing, leading to appropriate care coordination and continuity.[237] Strong collaboration helps to ensure the child's and family's views are understood, and important information is shared between DCJ, the family, care providers and other support services. DCJ practitioners do not need to be experts on every type of disability. However, it is important to acknowledge that the child and their family are the experts on their experience and disability, and approach them with curiosity to understand the child's experience of their disability and the care they are receiving.

DCJ CASEWORK PRACTICE

Consider the following opportunities for purposeful collaboration:

- Identify opportunities to engage with services supporting the family.
- Connect with a service at the point of receiving a new report about a family, and plan a joint home visit.
- Invite services to participate in family group conferences, group supervision, case plan meetings or other interagency meetings.
- Gather and share information with the family and services in the process of completing safety and risk assessments and reassessments.
- Share information about DCJ decision-making with services, where appropriate, particularly when DCJ decides to stop working with a family because services are involved. Ensure the services DCJ is relying on to work with the family are aware of DCJ decisions and the expectation of support that will be provided.

Engagement and Family Support team

The DCJ **Engagement and Family Support** team provides tertiary level support to practitioners working with a family where a child or their parent has disability. The team can provide advice and support on accessing NDIS funding and understanding disability and the intersections with child protection issues.

Recording information about the NDIS

As part of a range of DCJ initiatives to better identify the needs, service responses, accessibility and inclusion of children with disability, in June 2022, ChildStory updated the way NDIS and Early Childhood Approach (ECA) information is recorded. Practitioners can now create records to include information such as whether the child is an NDIS participant or accessing support via ECA; details of the NDIS plan manager or NDIS support coordinator; involvement with the DCJ Engagement and Family Support team; and NDIS plan details such as plan information, funding support, duration of plan and payments claimed by service providers.

Cohesive collaboration that supports children's safety requires services to have clear roles and purposes in their work with families. When this becomes unclear or diluted, there can often be a misconception of safety due to service involvement, without clarity about a service's role in mitigating risk for children.[238] While keeping children safe is a shared responsibility held by families, communities and agencies, it is important for practitioners to obtain accurate and relevant information when making critical decisions about children, particularly at allocation, assessment and closure stages.

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[237] Green et al. (2018).

[238] Broadhurst et al. (2010).

Themes from serious case reviews for the cohort and consultation with practitioners emphasised the importance of curiosity and critical analysis in assessing whether involved services and circumstances contributed to a child's safety. The importance of not assuming that service involvement in itself constituted safety was stressed.

DCJ CASEWORK PRACTICE

Reflective prompts to consider when assessing safety and service involvement. Have I:

- Checked that the family understands why each service is involved and its role? Does the assessment consider the role of each service and how it is contributing to the child's safety and experience?
- Spoken directly to each service and requested information to inform the assessment?
- Shared enough information about the child protection concerns to help services to work effectively with the family?
- Considered other ways to share the family's strengths, worries and information, like group supervision or an Interagency Case Discussion?

3.4.3 Language matters

> *I need you to show me respect in the way you speak to and about me and those who are important to me. Be fair and honest with your words ... Remember every word you write will shape the perception of every person who reads it in days to come.*
>
> **Practice Framework Standard 4: Writing and talking with children and families**

When talking about disability, it is important to use the language chosen by the person or group being spoken with or about. Usually, this is either person-first language (such as 'people with disability') or identity-first language ('disabled people'). People who live with disability have personal preferences about how they choose to be described, and it is important to ask about what they prefer. If someone is unable to communicate verbally, check their preference with their family or support network.

Instead of	Try	Why it matters
Referring to someone as ‘being’ disabled (e.g. Ellie is autistic)	Describing the person as ‘having’ disability (e.g. Ellie has autism)	People are more than a diagnosis and it is important to reflect that it is only part of their identity. This needs to be led by each individual.
Using terms that evoke pity like ‘suffers from’	Using neutral language or the person’s own words to describe how the disability effects them	Language that evokes pity unnecessarily can impact a person’s sense of dignity and empowerment.
Describing someone as ‘wheelchair bound’ or ‘confined to a wheelchair’	Explaining that the person uses a wheelchair, or what the mobility aid helps with	Wheelchairs provide mobility and a level of independence for people who are unable to walk. They are not a limitation.
Identifying people without disability as ‘able bodied’, ‘healthy’, ‘normal’ or ‘well’	Using the person’s name, or clarifying that they are a person without disability	Using words like ‘healthy’ or ‘normal’ to refer to people without disability implies that people with disability are not.[239]

Tips for communicating with people who ...	
Are unable to communicate verbally	Do not shout or exaggerate your words. Make eye contact (where culturally suitable) and speak in an age appropriate manner. Consider using visual communication aids. Spend time with them to understand how their family or support network interacts with them.
Use mobility aids or wheelchairs	Do not touch or lean on mobility aids or wheelchairs; they are personal space and property. Do not move someone’s wheelchair or mobility aid without their express consent or at their request.
Have intellectual disability	Use short, clear sentences. Give them time to respond. Do not finish their sentences for them.[240]

ADVICE FROM TARNIE AND MATHEW, YOUTH CONSULTANTS

- Ask me how I want to be spoken with and about.
- Remember that I’m a person too. Don’t talk to me like a baby, or talk about me like I’m not there.
- Don’t make assumptions about what I can understand.

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[239] People with Disability Australia (2021).
[240] National Disability Coordination Officer Program (2021).

DCJ CASEWORK PRACTICE

Language is a powerful tool for practitioners to build relationships and set the tone of partnership with families. The words used to write and speak about disability may impact how a person feels, how they are seen and how they connect with others. Being conscious of language and how it is used to describe people and circumstances helps support inclusion and bring awareness to ableism. Consider the following reflections. Have I:

- Asked the child and family how they like to be spoken with and adapted my approach?
- Reflected that what I write and say may influence my own views and the views and decisions of others?
- Checked my language for bias, jargon or judgement?
- Spoken about the child, family and others with respect and fairness and as if they were in the room?
- Spoken with the child and family as whole people, rather than just about the challenges they face?

Chapter 4: Improving the way DCJ works with children and families

Chapter 4 outlines the learning that has come from child death reviews.[241] It also provides an overview of some of the practice initiatives and reforms that were underway in 2021 aimed at improving DCJ responses to vulnerable children and families.

Within DCJ, there are three types of recommendations that can be made in response to internal serious case reviews:

1. **Individual recommendations** can be made when safety and risk concerns are identified for the siblings of children who have died. Chapter 2 includes a summary of this information.
2. **CSC and district recommendations** can be made where learning or development needs are identified for a CSC or a district. Chapter 2 also includes a summary of this information.
3. **Systemic and statewide practice recommendations** can be made by the Serious Case Review Panel in response to issues identified about systems or statewide practice; these are considered in the context of broader responsibilities or reform work.

As noted in Chapter 1, the Serious Case Review Panel meets quarterly to discuss complex case reviews and consider the issues raised for child protection and out of home care practice within DCJ, as well as the broader relationships with other government and non-government services.

During 2021, the Panel met five times and considered 12 complex case reviews: 11 reviews were about DCJ involvement with a child and their family before the child died; one review examined a CSC's practice, systems and culture.

Reflecting the Panel's broad focus, not all reviews will have recommendations made in response to the concerns identified. Where the Panel identifies existing reform work underway that will address the issue of concern, such work will be noted and no new recommendation made. The information below summarises the key practice reforms and systems issues identified by the Panel in 2021.

4.1 Practice changes in response to recommendations made in child death reviews

Improving DCJ referral practices

During 2021, the Panel considered four reviews that identified a need to improve the way DCJ refers families to support services, to ensure referrals are purposeful and targeted to address the family's vulnerabilities and needs. The reviews showed that families were being referred to support services before a full assessment of the family's needs had been completed. In some of the cases, DCJ closed the case after the family was referred to a service, but before it had been confirmed the service had been able to meet with the family, gain their agreement and assess their willingness to participate in the program. In these cases DCJ did not confirm that the service had capacity or was able to engage with the family to reduce the risks and improve safety for the children.

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[241] S172A (3) of the Children and Young Persons (Care and Protection) Act 1998 requires the Child Deaths Annual Report to detail the implementation of any departmental practice changes in response to or resulting from reportable deaths (as defined by s172A (2) of the Care Act).

Actions to support change and systems improvement in 2021

On 26 July 2021, DCJ (child protection) published its revised **Triage and assessment practice** mandate. The mandate guides managers in the allocation of ROSH reports, so that the most urgent cases are prioritised for a response. It also allows for the consideration of alternative actions if a report cannot be allocated for a face to face assessment.

In November 2021, DCJ published a **Targeted referral fact sheet** to guide practitioners and managers on how to:

- prioritise family preservation services for children in need of care and protection
- correctly identify the right support for families
- ensure better uptake of the referral and service provided.

In July 2022, a universal referral form (with a supporting knowledge article) for family preservation services was embedded in **ChildStory** to help practitioners with referrals of families to the following programs: Family Preservation (formally Brighter Futures and Youth Hope), Intensive Family Preservation, MST-CAN®,[242] FFT-CW®,[243] Resilient Families and former non-placement support services (which now sit under either Family Preservation or Intensive Family Preservation).

The **Quality Service Review** project[244] is incorporating a Family Strengths and Needs Assessment (FSNA) into its review of DCJ SDM practice tools. The FSNA will be used to identify the child and parental strengths that provide resilience and protection against maltreatment, and to identify and prioritise the family's safety and wellbeing needs to inform a holistic and purposeful family action plan.

In 2021, DCJ started the **Family Preservation and Recommissioning** program[245] to deliver a new approach for family preservation. The revised program will integrate existing family preservation programs into a single continuum of care, to help vulnerable families access the right supports at the right time, and to respond to a range of needs across all areas of safety and wellbeing. The new program will provide evidence-based treatment that seeks to address trauma, and provide intensive family supports for parenting skills and child development. The new structure will bring together existing programs into a single structure with three key streams: family preservation, intensive family preservation and Aboriginal family preservation.

The recommissioning program is being phased in. The first stage, in 2021, involved recontracting and bringing together the existing suite of programs into a single system. DCJ is leading the next stage of system change, which is scheduled to occur in 2024. It is anticipated that further data evaluation and input from the **Quality Service Review** (into the use of SDM tools) and **Protecting our most vulnerable children** (the Premier's Priority targeting the reduction of re-reporting rates for children reported at risk of significant harm) will inform how to better target referrals and better match vulnerable families to available support services.

Noting the current work underway to reform the referral processes, the Panel did not make any specific recommendations, and referred these four reviews to the Quality Service Review project and Strategy, Policy and Commissioning division for consideration of the issues raised and to inform their future work.

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[242] MST-CAN®: Multisystemic Therapy for Child Abuse and Neglect.

[243] FFT-CW®: Functional Family Therapy through Child Welfare.

[244] The Quality Service Review project is discussed in more detail later in Chapter 4.

[245] See www.facs.nsw.gov.au/providers/children-families/family-preservation/family-preservation-recommissioning

Balancing the need for performance and completing quality assessments

One review considered by the Panel in 2021 identified a recurring theme in many child death reviews about the tension that exists in child protection districts of maintaining performance (seeing more children and families) and completing quality safety and risk assessments. The Panel has noted that this can lead to unintended consequences, such as superficial assessments, when the effort to see more children and families is prioritised.

In the case considered by Panel, the review had occurred after the district leadership had undergone a number of changes. While the review noted the change in leadership and the district's efforts to improve its systems and processes, in response to the concerns identified the new Executive District Director agreed to review the district's referral, engagement and transfer processes for child protection cases – particularly when families were being referred to an external support service and the CSC was ending its involvement with the family. The district also agreed to share the findings of its review with the DCJ Practice Framework Working Group, for consideration of statewide applicability and implementation. In this particular case, the district was also asked to report back quarterly to the Panel on the progress of its casework with the sibling of the child who died.

Actions to support change and systems improvement in 2021

In March 2021, DCJ established the **Re-reporting Taskforce**, under the **Protecting our most vulnerable children** project.[246] The taskforce is responsible for developing and implementing a number of strategies aimed at ensuring more families get the right support at the right time and not be re-reported to DCJ. The new initiatives are having a positive impact and recent data is indicating that performance is improving.

Supporting young people in out of home care who are pregnant

One review considered by the Panel in 2021 identified the need to improve the quality of the service response to young people who are in out of home care and pregnant. This young person's experience showed a fractured service response, where her unborn baby was the focus of intervention. While practical supports were provided, limited focus was given to the young person's experiences of living in out of home care, including violence, vulnerable mental health and concerns about problematic drug use.

Actions to support change and systems improvement in 2021

The Panel noted the following reform work currently would go some way to addressing the issues raised by this young person's experience, including:

- the Quality Service Review
- a review of the DCJ **Perinatal Policy**
- a review of the DCJ **Responding to Prenatal Reports Policy**
- enhanced funding for the development and expansion of Pregnancy Family Conferencing for vulnerable women and their partners as part of the Brighter Beginnings[247] initiative to support expectant parents and their families where there are concerns about the safety and wellbeing of an unborn child[248]
- as previously indicated, through the DCJ **Family Preservation and Recommissioning** program, which is examining the range of services available to support family preservation; this will include consideration of the types of services required by young women in care who are pregnant.

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[246] More information about the Re-reporting Taskforce is detailed later in this chapter.
[247] See www.nsw.gov.au/initiative/brighter-beginnings
[248] The 2022–2023 State Budget (BP2) allocated $5.1 million ($21.5 million over four years) to expand and develop this program.

While acknowledging the work that is currently underway, the Panel referred the review about this young person's experience to the Strategy, Policy and Commissioning division to inform its examination of overarching out of home care policy, strengthen guidance for young expectant parents who are in care, and consider any intersections with child protection responses. The Panel recommended consideration be given to an early intervention approach for the unborn child (unless safety and risk concerns are present) while simultaneously attending to the parent as a young person in care.

It was further recommended that the Quality Service Review team partner with Child and Family programs[249] to consider how the SDM tools and processes being developed can support a sound and holistic out of home care policy.

Improving our culturally responsive practice

One review in 2021 considered DCJ work with an Aboriginal family and found that there was an absence of culturally responsive practice with the family over a number of years, including limited consideration of maintaining the child's connections to family, culture and community.

Actions to support change and systems improvement in 2021

The Panel noted that DCJ cultural practice with Aboriginal families is developing and significant work has been undertaken to improve the way practitioners engage with and work with Aboriginal families.

The **Aboriginal Case Management Policy** was developed for DCJ by AbSec.[250] The policy encourages and supports practitioners to engage early with Aboriginal families and draw on their knowledge and expertise to inform case planning, and to develop solutions to keep children safe with their family and community. The policy is supported by the **Aboriginal Case Management Rules and Practice Guidance**, which sets out a continuum of support across universal services, family preservation, restoration, out of home care and aftercare support.

The revised **Caseworker Development Program** (2021) includes modules dedicated to ensuring practice with families is culturally responsive, such as Working with Aboriginal Families; Cultural Practice; Connection, Belonging and Felt Security; Family Finding; Cultural Consultation; and Relationship Based Practice.

In November 2021, DCJ created a new division, **Transforming Aboriginal Outcomes**, to focus on improving Aboriginal outcomes across the criminal justice system, child protection and housing, and on the prevention of domestic and family violence in line with NSW's commitments to the national agreement for **Closing the Gap**.[251] Wiradjuri man Brendan Thomas was appointed Deputy Secretary, Transforming Aboriginal Outcomes, and is leading this important work.

In March 2022, the OSP established a dedicated leadership position, the **Director Aboriginal Culture in Practice**, to lead and influence our practice with First Nations families, and to ensure that responses and decisions about Aboriginal and Torres Strait Islander children and families are culturally informed. During 2022, the Director Aboriginal Culture in Practice will work with the OSP and Transforming Aboriginal Outcomes to finalise the Aboriginal Culture in Practice unit's key responsibilities and priorities.

The DCJ **Practice Leadership Development Program** was launched in June 2022 and dedicates a number of places for emerging leaders, including a targeted number of Aboriginal emerging leaders. This aligns with the DCJ **Aboriginal Employment Strategy** to increase Aboriginal staff

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[249] Five program streams sit within Child and Family: Strategy; Intensive Supports; Family Preservation and Child Protection; Out of Home Care Program; and Early Intervention, Youth and Volunteering.

[250] AbSec (formerly the Aboriginal Child, Family and Community Care State Secretariat) is the NSW Child, Family and Community Peak Aboriginal Corporation.

[251] See www.closingthegap.gov.au

representation in leadership positions. The DCJ **Aboriginal Cultural Capability Framework** is a key component of the Practice Leadership Development Program.

Sharing learning to promote child safety

During 2021, a number of reviews considered by the Panel were referred to internal DCJ units to share the learning and to inform program design. In one case, the review was also shared with non-government partners who had provided case management to a child who was in care at the time of their death. As a result of work in 2021, reviews were shared (in part or whole) with the following external organisations:

- Office of the Children's Guardian
- two non-government out of home care providers – Anglicare and Creating Links.

Developing a joint review framework

In 2021, the Serious Case Review (SCR) Unit continued, in collaboration with non-government partners, to review the deaths of children who were in out of home care and case managed by non-government out of home care providers. The collaborative approach, informed by the Permanency Support Program (PSP) **Critical Events Policy**, allows for the SCR Unit to liaise with out of home care providers to arrange and undertake joint serous case reviews, where necessary. In 2021, the scoping paper described in the Child Deaths 2020 Annual Report was further developed and will be circulated internally for consultation and feedback in late 2022.

Holistic assessment practice advice

The revised **Holistic assessment** practice advice was published in Casework Practice in March 2022. The topic highlights the revised **Assessing safety and risk** practice mandate and helps practitioners lead quality assessment practice in real time across the casework continuum. The revised topic provides clarity and support to practitioners on how to:

- keep children at the centre of assessment practice with purposeful participation
- harness culture as a priority
- draw on multiple sources of information
- include those with caregiving responsibility, particularly fathers
- use the SDM and Alternate Assessment frameworks, and Practice Framework approaches, to strengthen assessment practice.

Mental health practice kit

In May 2022, DCJ included a new chapter in the **Mental health practice kit** to support practitioners working with children at risk of suicide and self-harm. The chapter was adapted from the new **Guidelines for risk assessment and management of suicide and self-harm** developed by DCJ Psychological and Specialist Services. An e-learning package was also developed for DCJ and non-government practitioners to support them in identifying and responding to children at risk of suicide and self-harm.

Casework journey guide

Launched in March 2021, the **Casework journey guide: Children safe or safe with plan** helps practitioners navigate the key activities children and families need along the casework journey to identify and mitigate dangers, reduce risk and support meaningful change. In late 2021, the **Casework journey guide** was updated to reflect the **Safety in care** mandate, which was introduced in October 2021 to help practitioners respond to reports about children in out of home care. The guide outlines the end to end process of responding, from allocation, through the assessment and then planning, monitoring and review. It covers non-allegation-based risks, assessments when there are reportable allegations and assessments when a PSP or other out of home care provider has primary case responsibility. The guide brings together current practice mandates, policies, approaches and standards to visually represent where they fit along the practice continuum and in case management.

Helping children in care achieve their potential practice advice

In April 2021, the **Helping children in care achieve their potential** practice advice was updated, following consultation with young people from the OSP Youth Consult for Change program. The Youth Consult for Change team provided input to this topic and have ensured the voices of children are central throughout the practice advice. The revised advice guides practitioners in how they can connect with children in care and shares the children's experiences through quotes, animation, voice clips and short videos. At the heart of this advice is the recognition that it is not enough for children to just survive the care system; practitioners should expect that children will thrive and succeed in life.

Permanency planning advice

Launched in August 2021, the revised **Permanency planning** practice advice provides practitioners with clear and useful advice on 'what, why and how' to create the foundations of security and permanency for children that lead to lifelong benefits. The improved **Permanency planning** advice:

- provides greater clarity about the legislation for permanency options for Aboriginal and non-Aboriginal children
- better reflects current practice and permanency reforms
- details the five legal permanency options including guardianship and adoption
- supports practitioners to use a children's rights based approach to decision-making and determining their best interests
- provides clear and practical advice on how to talk to children, their parents and carers about permanency
- highlights the importance of family led decision-making.

Transporting a Child or Client Policy

In July 2021, DCJ revised its **Transporting a Child or Client Policy** to better reflect all relevant parts of the DCJ work, health and safety policy framework, and to support DCJ employees to make safe decisions and arrangements when transporting a child or client. This policy arises from the recommendations of an internal child death review which identified the need for more guidance on the hazards and risks associated with transporting a child with high support needs and how to mitigate those risks.

4.2 Supporting child protection and out of home care practice in NSW

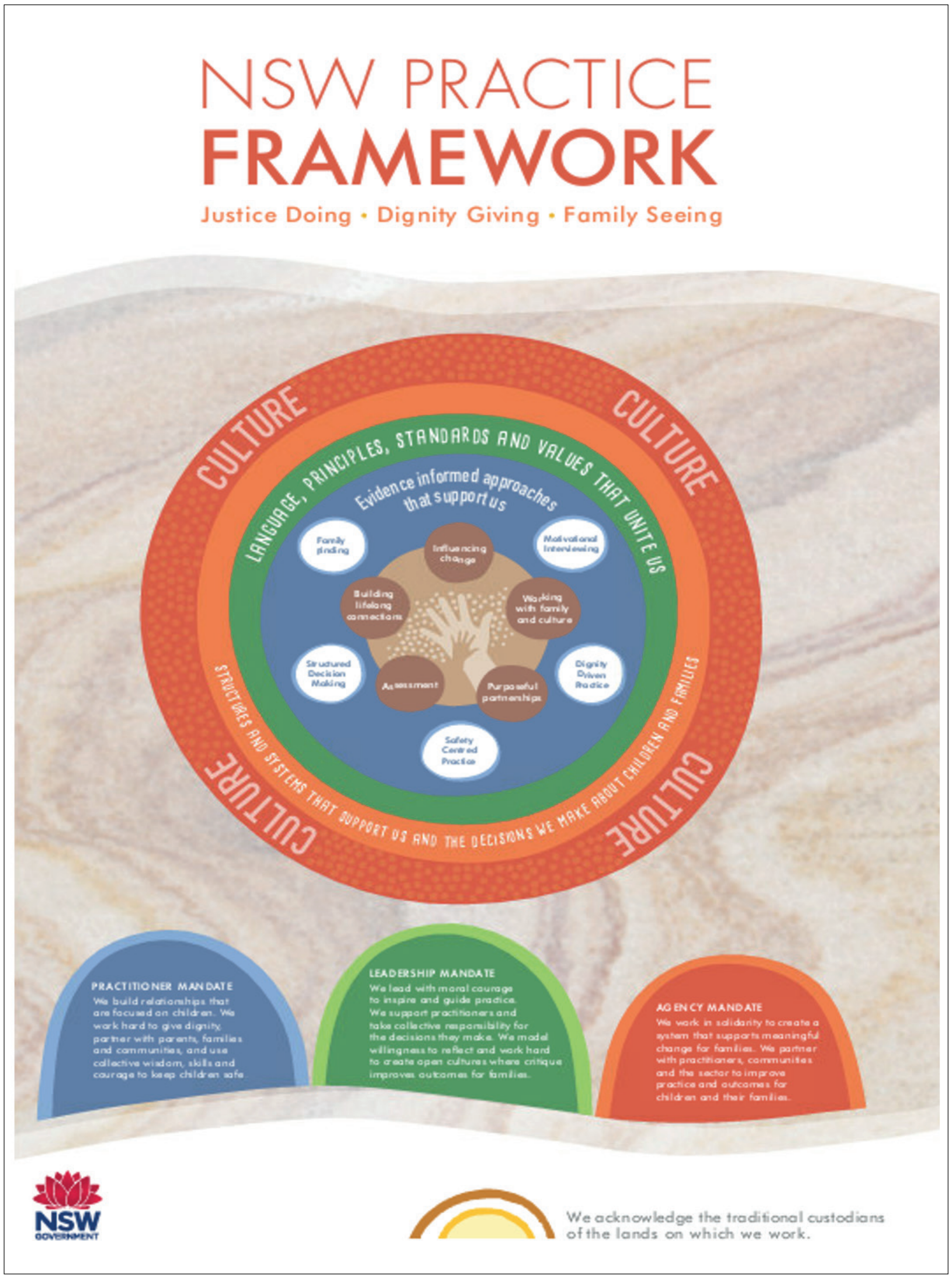
During 2021 and into 2022, DCJ started a range of activities aimed at improving child protection and out of home care practice in NSW.

4.2.1 NSW Practice Framework

Since its launch in 2017, the NSW Practice Framework has continued to guide and support child protection practice in NSW. The Framework shows how DCJ works with children and families in NSW, setting out the principles, values, mandates, approaches and systems that underpin our work.

United by principles,[252] language and standards, the Framework puts children and families at the centre of the work and is deliberately intentional about its child focus. Practitioners are helped to understand that all relationships they form with parents, carers and community partners must be built on common goals about improving safety to children.

Figure 16: NSW Practice Framework (launched September 2017)



PRACTITIONER MANDATE
We build relationships that are focused on children. We work hard to give dignity, partner with parents, families and communities, and use collective wisdom, skills and courage to keep children safe.

LEADERSHIP MANDATE
We lead with moral courage to inspire and guide practice. We support practitioners and take collective responsibility for the decisions they make. We model willingness to reflect and work hard to create open cultures where critique improves outcomes for families.

AGENCY MANDATE
We work in solidarity to create a system that supports meaningful change for families. We partner with practitioners, communities and the sector to improve practice and outcomes for children and their families.

We acknowledge the traditional custodians of the lands on which we work.

Since the implementation of the Framework, the OSP has continued to provide training to new practitioners about how to operationalise it in their everyday work. From 2021, training in the Framework has been delivered to DCJ staff virtually, through a series of e-learning modules, structured group supervision sessions and the following five remote learning modules:

- Dignity, safety and the path to meaningful change
- Belonging, permanency, connection: Helping kids reach their potential

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[252] Culture is ever-present; Language impacts on practice; Relationships create change and restore dignity; Critique leads to improved practice; Ethics and values are integral to good practice.

- Assessment: Seeing, noticing and responding to danger and risk
- Case planning: Creating change on purpose
- Restoration: Building safety at home

All CSC staff, inclusive of caseworkers, specialists, psychologists, casework support staff, managers casework and managers client services, are required to complete all aspects of the training.

Group supervision: A key component of the Framework

Group supervision is a formal and structured process that brings a team together to discuss a particular decision that needs to be made for a child and their family. While the discussion is centered on a particular family, the model encourages practitioners to explore practice themes that can be applied to other families, develop their practice skills, build their knowledge, and attend to the emotional aspects of child protection work. Group supervision sessions use an adaptation of the Minnesota model[253] and attend to all four aspects of professional supervision.

Since the launch of the Framework, weekly group supervision has been used by all casework teams and is now the established system to make collective decisions about children, build capability and practice skills, and draw on the support and knowledge of colleagues.

NSW Practice Standards

The NSW Practice Standards are a key component of the NSW Practice Framework.

The Practice Standards provide a set of expectations of practitioners, drawing on contemporary evidence and giving greater clarity. They bring together the components of the Practice Framework and make it clear how each component comes to life as expectations in daily practice with children.

The Practice Standards support greater clarity about the Practice Framework by articulating the knowledge, skills and behaviour that underpin how practitioners work within the systems, principles, approaches and capabilities of the Framework, while also considering the related Public Service Capability Framework.

Intended as both an organisational resource to benchmark expectations of practice and as a learning and development and planning tool, the Practice Standards support the improvement of practice through the continued implementation of the Practice Framework. The Standards improve practice as practitioners openly commit to working to them, and to being transparent with families about their rights.

The Practice Framework Standards – Family Resource

Launched in early 2022, the **Practice Framework Standards – Family Resource** is helping families understand the standard of practice they should expect from DCJ practitioners. The resource is a public DCJ webpage. Print resources (posters and wallet cards) have been designed with a QR code that families can use to access the page directly from their mobile phones.

Further information about the Practice Framework Standards – Family Resource can be found at: www.facs.nsw.gov.au/families/caseworker-visits/practice-framework-standards-family-resource

Evidence the Framework is changing practice for the better

An evaluation of the Framework has shown it has encouraged a more skilled workforce, and practitioners and practice leaders have reported positive changes in their approach to their work with children and families.[254] In particular, practitioners reported group supervision was helping

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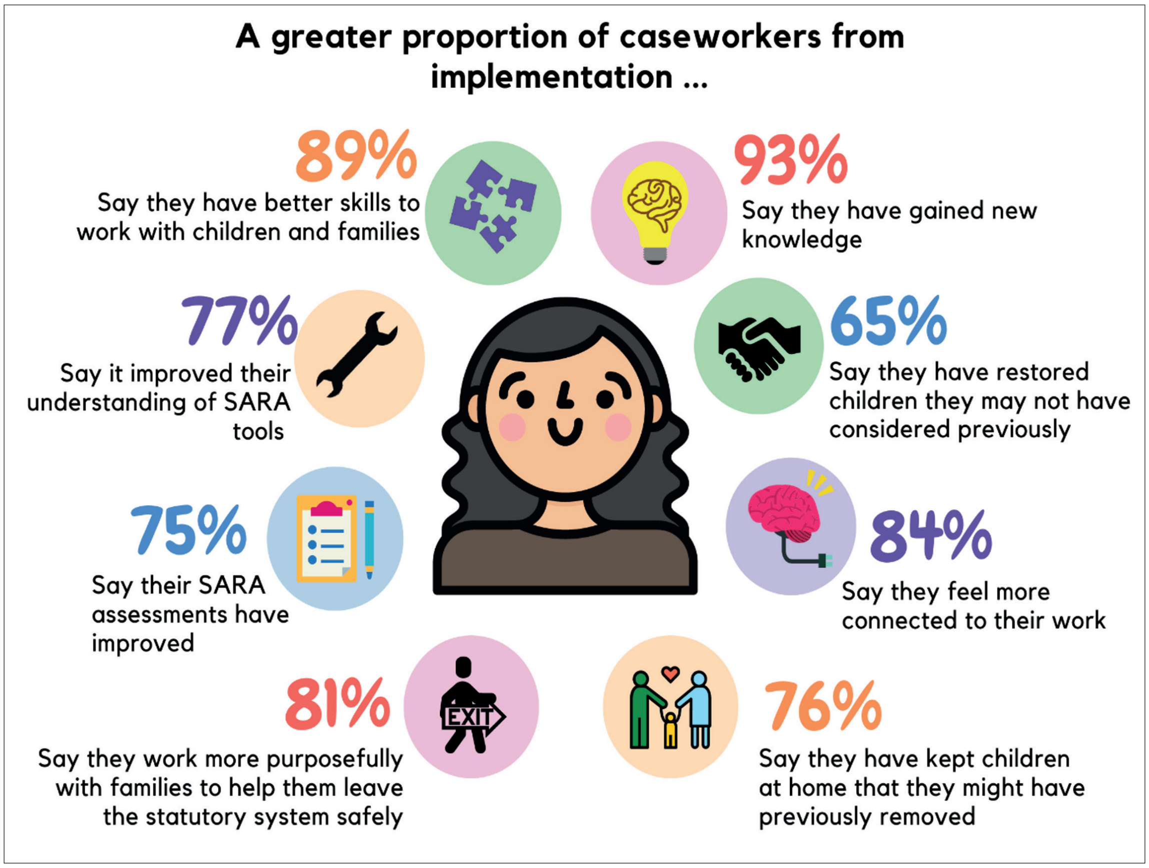
[253] Lohrbach (2008).

[254] Completed by the OSP in partnership with the DCJ Insight, Analysis and Research Statistical Analysis unit.

to change their practice, improve decision-making and knowledge, and build confidence in the decisions made for children and families. Some of the key findings from practitioners are shown in the following image.

Figure 17: Findings from practitioners in the Framework evaluation



4.2.2 Child Protection Assessment Review Project

In 2021, DCJ started the **Child Protection Assessment Review Project**, which aims to improve the quality, equity and accuracy of decisions made about children and their families through a full review of child protection decision-making tools, policies and practices.

Structured Decision Making Quality Service Review

The Structured Decision Making (SDM) tools have not been subject to a full review since implementation in NSW over a decade ago.

The **Quality Service Review** is reviewing SDM tools as well as leading the design of a new assessment model to assess the safety of children in care when there has been a report about them. The **Quality Service Review** is being led by the OSP in partnership with Evident Change.[255] This work involves strong consultation with Aboriginal people, community members, children and parents with lived experience, and sector partners, alongside DCJ operations and Strategy, Policy and Commissioning.

The project is integrating critical cultural practices, informed by the **Aboriginal Case Management Policy** and **Aboriginal Placement Principles**, into decision-making tools and policies. Lessons from the Family is Culture Review and family led decision-making are being

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[255] Evident Change is a US-based not for profit and the developer of SDM.

infused into assessment practice, to ensure the tools reflect current evidence and contemporary practice and service delivery settings.

The SDM tools prioritised for review include:

- **Mandatory Reporter Guide (MRG):** the MRG helps mandatory reporters decide whether to report their concerns of possible abuse or neglect of a child to the Child Protection Helpline. Where the MRG indicates that a concern does not warrant a report, it helps mandatory reporters to respond appropriately to children (e.g. referral to an appropriate service).
- **Screening Response and Priority Tool (SCRPT):** SCRPT is used by the Child Protection Helpline to determine if a concern report meets the risk of significant harm threshold and if so, a priority for response.
- **Safety Assessment:** the Safety Assessment is used to determine if a child is safe to remain living with their parents in the immediate period, or if protective measures are needed (this may be a safety plan, Temporary Care Arrangement or removal of the child).
- **Risk Assessment:** the Risk Assessment is an actuarial tool used to estimate the likelihood that the child will be reported at risk of harm over the next 18 months if purposeful supports are not put in place with a family.
- **Family Strengths and Needs Assessment (FSNA):** FSNA is used to identify strengths for children and parents that provide resilience and protection from maltreatment, and to identify and prioritise the family's needs in order to develop a holistic and purposeful family action plan. The FSNA is not currently implemented in child protection practice in NSW but will be implemented as a part of this project.

The review will involve remodelling tools as well as updating policy settings and service pathways (such as report pathways at the Helpline, and referral pathways) based on evidence and design processes.

Safety in Care assessment model

A new assessment model, **Safety in Care**, is being developed to guide the response to reports about children in care.[256] The model has six key components:

1. **Assessment approach:** principles, mindset, skills and key messages to anchor the approach to assessment of children in care.
2. **Policy settings:** organisational policy positions, mandated tasks and regulatory requirements articulated to support role clarity, scope and accountability.
3. **Assessment process:** the casework continuum of decision-making and casework activities from the point of allocation to assessment conclusion, including any pathways of response.
4. **Decision outcomes:** a defined purpose of the assessment and options of assessment decisions reached across the assessment continuum.
5. **Assessment tool:** the structure used to support information gathering, analysis and decision-making across the continuum of assessment, including templates and categories to identify and analyse.
6. **Practice guidance:** detailed tool definitions and practice guidance to support the application of the assessment tool.

To date the project has held extensive consultations to inform the changes to assessment practice that have included:

- 18 dedicated Aboriginal consultations that included three community consultations in partnership with AbSec, six meetings with the state Aboriginal Reference Group and three meetings with the Deputy Children's Guardian

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[256] This includes children in the care of the Secretary, or those in the parental responsibility of the Minister, or if there is shared parental responsibility for residency allocated to the Minister.

- briefings and consultations with the non-government sector, reaching 400 sector staff about the new Safety in Care model
- incorporating 600 individual pieces of feedback into the Safety in Care manual
- facilitation of five dedicated youth consultations and 14 sessions where youth representatives were directly involved in the design work for SCRPT, Safety Assessment and Safety in Care
- commissioning AbSec to facilitate community consultation about assessment practice, SCRPT, Safety Assessment and Safety in Care.

DCJ has started building the revised tools into ChildStory in late 2022 and this work will continue into 2023.

4.2.3 Practice Leadership Development Program

In 2021, the **Practice Leadership Development Program** was created to support the development of child and family focused practice leaders who are culturally capable in practice with children, families and communities, and Aboriginal staff; and who can operate effectively in the five public sector leadership impact areas of people, results, systems, culture and public value.

Participants develop the skills, knowledge and behaviours required for their leadership roles, with a focus on achieving better outcomes for children and families and improving staff wellbeing. These were identified as important areas of development through consultation with district staff. The program supports the continued implementation of the NSW Practice Framework and Practice Standards, the DCJ Aboriginal Cultural Capability Framework and the NSW Public Sector Leadership Framework.

The program has seven modules:

1. Leading self, others and practice
2. Leading advocacy in practice
3. Creating trust-based supervisory relationships
4. Leading for cultural capability
5. Developing staff and effective practice
6. Leading for resilience and adaptability
7. Leading for inclusion and collaboration

From June 2022, all managers casework and managers client services will undertake the program over a 12-month period. Each DCJ district has been allocated spaces for emerging leaders, including a targeted number of Aboriginal emerging leaders, to align with the DCJ Aboriginal Employment Strategy to increase Aboriginal staff in leadership positions.

The Practice Leadership Development Program will then be offered on an ongoing basis to new and emerging leaders in DCJ.

4.2.4 Change Together

During 2021, the OSP redesigned and released a training program to provide more contemporary learning opportunities for DCJ-funded non-government organisations that provide Targeted Earlier Intervention, Family Connect and Support or family preservation services across NSW.

Following a successful pilot, the **Change Together** program launched in November 2021 as an online resource with eight modules. Each module has three to four e-learning units and one online workshop. The eight modules are:

1. Foundations of child protection
2. Trauma responsive practice

3. Culturally responsive practice
4. Understanding and responding to commonly co-occurring issues in child protection
5. Mandatory reporting
6. Working with children and young people
7. Talking with families
8. Working with families for change

Those who have participated in the program have positively reported on its practical, informative and culturally responsive nature as well as the opportunity it provides to connect with diverse practitioners through workshops.

Change Together workshops are also available to DCJ practitioners via the DCJ internal learning management system. Participation in workshops has led to policy and program staff deepening their understanding of the NSW Practice Framework and the context in which child protection practitioners and practice leaders do their work with children and families; and opportunities to partner with non-government agencies to influence practice and strengthen interagency collaboration.

Further information about Change Together can be found at:
www.dcj.nsw.gov.au/service-providers/change-together.html

4.3 Improving responses to at risk children and families

4.3.1 Permanency Support Program

The Permanency Support Program (PSP) is a NSW Government initiative to support safety, wellbeing and positive life outcomes for children in the child protection and out of home care systems in NSW.

The PSP has three main goals:

- **Fewer entries into care:** by keeping families together.
- **Shorter time in care:** by returning children home or finding other permanent homes for more children through guardianship or adoption.
- **A better care experience:** by supporting children's individual needs and their recovery from trauma.

Four aspects of the program support children, young people and families to achieve permanency:

- Permanency and early intervention principles are built into casework.
- Working intensively with birth parents and families to support change.
- Recruitment, development and support of carers, guardians and adoptive parents.
- Intensive Therapeutic Care system reform.

The program funds services to support children through five different permanency pathways: preservation, restoration, guardianship, open adoption and long-term out of home care. These pathways reflect the permanent placement principles outlined in the *Children and Young Persons (Care and Protection) Act 1998*. The pathway chosen for a child will depend on their permanency goals. As per the legislation, adoption is the last permanency option considered for Aboriginal children after long-term foster care. This reflects the government's acknowledgement of the intergenerational trauma experienced by many First Nations people, caused by government policy which supported the systemic removal of their children.

DCJ expects that as a result of the PSP, fewer children will enter care each year. For children who do enter out of home care, the experience should be shortened and improved through more targeted services and supports that help children recover from trauma.

Further information about the PSP can be found at:
www.facs.nsw.gov.au/families/permanency-support-program

Family preservation

In 2021, DCJ started the **Family Preservation and Recommissioning** program to reform its family preservation services. The new program will increase safety and wellbeing of children by providing evidence-based treatment services to address the impacts of trauma, and intensive family support to promote parenting skills and child development.

Family preservation programs will be integrated into a single continuum of care, which aims to ensure families are provided with the right supports at the right time, and that the system can respond to needs across all areas of safety and wellbeing.

The new program will bring existing services into a single structure, with three streams:

1. Family preservation
2. Intensive family preservation
3. Aboriginal family preservation

This integrated system will better meet the assessed needs of vulnerable families. Eligibility will be less restrictive, with all programs offering services for children aged from birth to 17 years.

Recommissioning will occur in stages. During 2021, existing programs were recontracted and brought together under a single system, establishing a foundation for further change. Services recommissioned included those delivered under the following programs:

- Brighter Futures (including SafeCare, and Voices and Choices trial sites)
- Youth Hope
- Intensive Family Preservation
- Intensive Family Based Services
- Non-placement Services
- MST-CAN®
- FFT-CW®
- Nabu (Aboriginal Early Intervention)
- Resilient Families

PSP Family Preservation Packages will not be recommissioned through this process. Licenced or trial programs (MST-CAN®, FFT-CW®, Resilient Families and Nabu) will retain their current names and licencing/fidelity requirements.

The second stage will be completed by 30 June 2024 to fully implement the system vision.

The new program will be comprehensive. Over time, the integrated family preservation system will deliver tiered levels of intensive supports that can be selected and staged to meet the changing needs of families. It will offer standard core program components so that families who need these interventions can access them no matter where they live in NSW. These core components are:

- Engagement
- Case management
- Parent and family support
- Therapeutic support
- Child-focused support

A variety of program activities will be delivered under each core program component, tailored to the assessed needs of families. The benefits to families will include greater access to case management and the kinds of supports known to reduce the risks of abuse and neglect. Core program components may be delivered through multiple providers or a single provider. Opportunities for licenced programs to offer core program components will also be explored.

Further information about the Family Preservation Recommissioning program can be found at: www.facs.nsw.gov.au/providers/children-families/family-preservation/family-preservation-recommissioning

4.3.1 Premier's Priorities for child protection and out of home care

In 2019, the NSW Government committed to enhancing the quality of life for the people of NSW and set 14 'Premier's Priorities', two of which focused on improving the safety and wellbeing of vulnerable children, young people and families:

1. **Protecting our most vulnerable children:** decreasing the proportion of children and young people re-reported at risk of significant harm by 20 per cent by June 2023.[257]
2. **Increasing permanency for children in out of home care:** doubling the number of children in safe and permanent homes, for children in or at risk of entering out of home care.

The following section summarises these two key initiatives and has been included in this report as it links to the reforms underway and seeks to address practice themes identified in internal child death reviews completed in 2021.

Protecting our most vulnerable children

Once a child has been reported at risk of significant harm, child protection practitioners support families to create change and provide safer homes for their children. Reducing re-reporting is important because it shows the effectiveness of interventions to make vulnerable children safer, either through DCJ direct services, or through DCJ partnerships with the broader service system.

While DCJ has made progress to strengthen the services and supports provided to vulnerable children and their families, reports to the Child Protection Helpline have doubled over the last 10 years and ROSH report volumes continue to grow.

The core drivers of re-reporting are complex and interconnected, and relate to the effectiveness of DCJ interventions and the support of the broader service system, particularly NSW Health, Police, Education and (DCJ) funded service providers.

In March 2021, DCJ established the **Re-reporting Taskforce** to develop and implement a number of interconnected strategies that attempt to address these issues. These initiatives when fully employed should result in more families getting the right support at the right time, and prevent the likelihood of re-reporting to DCJ.

The three key strategies are:

1. **Improving assessments:** improving the accuracy of risk assessments through improved information gathering and practice so only families requiring a statutory response enter or remain in the child protection system.
2. **Targeted referrals:** prioritising funded family preservation services for children assessed as needing *care and protection*. This ensures tailored support for the families most in need. Creating targeted referrals will improve the uptake of a referral and result in a greater chance of the family sustaining ongoing change.

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[257] From a baseline of 40.4 per cent at June 2015, by June 2023.

3. **Enhancing future safety:** ongoing support for a family ensures mandatory reporters are aware of their role in helping the family and ensures that children and families have strong safety networks to protect against future harm. Engaging networks during and after closure through a 'no wrong door' approach reduces the likelihood of ROSH re-reporting.

Other DCJ initiatives implemented during 2021 and into 2022 to improve re-reporting include:

- Upgrading the eReport process and website for mandatory reporters who are worried about children suspected of being at risk of significant harm. The changes aim to improve the quality of information that is provided to the Helpline, which will then lead to improved accuracy of the assessments of which matters meet the risk of significant harm threshold.
- Extending to more CSCs the Child Protection Helpline's Advanced Screening Program, which involves additional follow-up and information gathering prior to the assessment.
- Re-launching the Protecting Our Kids training program at multiple CSCs, providing site-specific coaching on effective practices to reduce re-reporting.
- Implementing a peer review closing practice so that cases are closed correctly, with all relevant supports and risks considered beforehand.

Initial indicators show these strategies have served to change the trajectory of increasing re-reports; however, this will continue to be monitored to ensure the downward trend can be maintained and at a rate that will approach the target.

Increasing permanency for children in out of home care

All children deserve a safe and stable home. As noted, the first priority for DCJ is to keep families safely together and support them with the services they need. The Premier's Priority seeks to double the number of children in safe and permanent homes for those children in or at risk of entering out of home care. DCJ is targeting the following three key areas to build on effective practice and drive improvement.

Maximising supports to enable children to remain safely at home

To achieve this, DCJ has:

- started recommissioning all family preservation programs, which is expected to be finalised in 2024
- undertaken analysis of a number of families to understand the practice drivers that are impacting increased entries into care
- provided **Aboriginal Case Management Policy** information sessions to early intervention services.

Improving restoration practice

To achieve this, DCJ has:

- undertaken an analysis of restoration trends and worked alongside caseworkers to understand the challenges and opportunities to improve restoration outcomes
- developed and implemented statewide action plans to support each DCJ district to achieve its contribution to the statewide target
- targeted resources delivered via non-government workforce development strategy, through the PSP Learning Hub, on restoration during 2022.

Increasing permanency planning and timely decision-making for children

To achieve this, DCJ has:

- developed a permanency taskforce, and will implement a permanency dashboard to drive data led decision-making across DCJ and non-government practitioners
- presented to Children's Court clinicians on the benefits of permanency
- started a targeted awareness campaign for practitioners on the benefits of permanency.

Detail about DCJ progress against the Premier's Priorities targets is reported in the DCJ Annual Report. DCJ annual reports can be found at:
www.dcj.nsw.gov.au

Information about the Premier's Priorities can be found at:
www.nsw.gov.au/premiers-priorities

Glossary

Aboriginal

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

Abuse

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

Alcohol and/or drug use

Significant substance use that interferes with a parent’s daily functioning, and the substance use negatively impacts on their care and supervision of the child to the extent that there is risk of significant harm.

Alternative Care Arrangement

An alternative care arrangement (ACA) is an emergency and temporary fee for service arrangement for a child in, or entering, statutory or supported out of home care after every effort has been made to place them with relatives/kin, a foster carer, or contracted out of home care placement (e.g. accredited PSP provider). ACAs are subject to strict approval processes and ongoing review. ACAs are where the child is cared for in a hotel, motel or other temporary accommodation that can be terminated at short notice and/or directly cared for and supervised solely by sub-contracted staff from a non-designated agency who have been authorised to provide care under clause 31B of the *Children and Young Persons (Care and Protection) Regulation 2012*.

Authorised carer

A person who is authorised as a carer by an authorised provider.

Case closure

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

Case planning

Case planning is the core of purposeful work that supports families to make change. Case planning helps families to ‘connect the dots’ between their behaviours and what changes are needed to keep kids safe.

Casework

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

Caseworker

A DCJ officer responsible for working with children and their families, and other agencies in child protection, out of home care and early intervention. Caseworkers have day to day case coordination responsibilities. Caseworkers report to a manager casework.

Child

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) 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 children who may be at risk of significant harm. It operates 24 hours a day, seven days a week.

Children's Court

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

ChildStory

The DCJ electronic system for keeping records and plans about children and their families.

Child Wellbeing Unit (CWU)

Child Wellbeing Units (CWU) operate in NSW Health, NSW Police Force and the Department of Education. CWUs assist mandatory reporters to ensure that where a person has reasonable grounds to suspect risk of significant harm to a child, a report is made to the Child Protection Helpline. Where concerns do not meet a risk of significant harm, it is the role of CWUs to support mandatory reporters to better respond to concerns relating to the safety, welfare and wellbeing of children and young people. This may involve providing advice on referrals to appropriate services.

Culturally and linguistically diverse

The phrase 'culturally and linguistically diverse' (CALD) is a broad term used to describe communities with diverse languages, ethnic backgrounds, nationalities, traditions, societal structures and religions.

DCJ Community Services Centre (CSC)

Locally based community services offices. There are approximately 80 CSCs across NSW.

Domestic and family violence

Domestic and family violence is defined to include any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour.

Domestic and family violence is usually committed by men against women within heterosexual relationships, but can occur within any type of relationship. Domestic and family violence can have a profound negative effect on children.

Engagement

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

LGBTQIA+

'LGBTQIA+' is an inclusive term that includes people of all genders and sexualities, such as lesbian, gay, bisexual, trans, queer/questioning, intersex, asexual or any other term to express gender or sexual diversity. While each letter stands for a specific group of people, the term encompasses the entire spectrum of gender fluidity and sexual identities.

Manager casework

A manager casework provides direct supervision and support to a team of DCJ 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 DCJ 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* (NSW).

Medical examination

Pursuant to section 173 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), if the Secretary of DCJ 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 illness is a health problem that significantly affects how a person thinks, behaves and interacts with other people. It is diagnosed by a qualified health care professional according to a standardised criteria set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Common mental health issues experienced by people who are involved with child protection include anxiety, depression, psychotic disorders, psychosis, bipolar disorder, personality disorders, antenatal and postnatal anxiety and depression, and postnatal psychosis.

Neglect

Neglect means that the child's basic needs (e.g. supervision, medical care, nutrition, shelter) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to produce a substantial and demonstrably adverse impact on the child'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.

Order

An order of a court or an administrative order.

Out of home care

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

Parental responsibility

In relation to a child, 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 in the care and responsibility of the Minister under section 79(1)(b) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Permanency Support Program

The Permanency Support Program (PSP) provides services to vulnerable children so they can grow up in stable, secure and loving homes. A PSP service provider is contracted by the Department to arrange and supervise out of home care placements and/or exercise case responsibility for achieving children's case plan goals of preservation, restoration, guardianship, open adoption and long-term care. For definitions relevant to the PSP see the Permanency Case Management Policy (PCMP) Rules and Practice Guidance: www.facs.nsw.gov.au/providers/children-families/deliver-psp/permanency-case-management-policy/rules-and-practice-guidance

Physical abuse or ill-treatment

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

Practitioner

A DCJ employee who provides and supports direct child protection service delivery. DCJ practitioners include caseworkers, casework support officers, managers casework, casework specialists, managers client services, managers practice support, directors community services, and directors practice support.

Prenatal report

The *Children and Young Persons (Care and Protection) Act 1998* (NSW) allows for prenatal reports to be made to DCJ 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 DCJ officer or NSW Police Force officer to take a child from a situation of immediate risk of serious harm and to place the child in the care responsibility of the Secretary.

Report

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

Reporter

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

Restoration

Restoration is a process where families receive support to manage a child's safe journey home.

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.

Risk of significant harm (ROSH)

For the purposes of section 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) a child or young person is at risk of significant harm (ROSH) 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* (NSW) – 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

Risk-taking behaviours can include:

- suicide attempts or ideation; or self-harm
- engaging in criminal activities; or gang association and/or membership
- dealing drugs; or drug, alcohol and/or solvent use
- drink driving
- early or high risk sexual activity
- running away from home.

Safety and risk assessment (SARA)

SARA is an SDM® system for assessing risk. The goals of the system are to determine the safety of and risk to children 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 which causes that child harm, or to be frightened or fearful. Coercion, which may be physical or psychological, is intrinsic to child sexual assault and differentiates such assault from consensual peer sexual activity.

Structured Decision Making (SDM®)

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

Supervision

Supervision is the foundation of quality practice with children, young people and families. Contemporary child protection literature strongly supports the need for and benefits of professional supervision. The DCJ Supervision Policy for child protection practitioners sets out the expectations for and responsibility in delivering professional supervision to its child protection practitioners.

Supported care allowance

Financial support provided by DCJ to relative/kin carers when there is an order allocating parental responsibility (for at least the aspect of residence) to a relative/kin carer; or when there is no legal order, but DCJ has assessed the child as in need of care and protection. While some children in out of home care may still be in ‘supported care no order arrangements’, DCJ closed the pathway to these arrangements on 1 December 2016.

Triage and assessment practice guidelines

The practice guidelines describe the process of triaging risk of significant harm (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 statewide 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* (NSW) defines a young person as a person who is aged 16 years or above but who is under the age of 18 years.

Youth Justice

Youth Justice is a branch of DCJ that supervises young people in custody and in the community and is accountable for breaking the cycle of youth offending with a focus on intervening early, keeping them out of court and custody, reducing reoffending and ensuring community safety.

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Appendix 1: Counselling and support services

Service	Description	Contact
Child Protection Helpline	Report suspected child abuse or neglect to DCJ	132 111
Aboriginal Counselling Services (ACS)	Crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	0410 539 905
Aboriginal Medical Service	Comprehensive health care for the Aboriginal community	Find local contacts at ahmrc.org.au
Department of Forensic Medicine	Information, support and counselling for relatives and friends of the deceased person for deaths being investigated by the Coroner	(02) 8584 7800
Kids Helpline	Telephone counselling	1800 55 1800 or visit kidshelpline.com.au
Lifeline	24/7 telephone crisis support and suicide prevention services	13 11 14 or visit lifeline.org.au
My Forever Family NSW	The Care Support Team is available via phone or email	1300 782 975 or enquiries@myforeverfamily.org.au
NALAG Centre for Grief and Loss	Free face to face and telephone loss and grief support	(02) 6882 9222 or visit nalag.org.au
National Centre for Childhood Grief	Free counselling for bereaved children; counselling also provided for bereaved adults, parents and carers (fee involved)	1300 654 556 or visit childhoodgrief.org.au
Red Nose NSW and Victoria	24/7 bereavement support to families who have suffered the loss of a baby	1300 308 307 or visit rednosegriefandloss.com.au
Suicide Call Back Service	Free 24/7 phone, video and online counselling for anyone affected by suicide	1300 659 467
The Australian Child and Adolescent Trauma Loss and Grief Network	Resources to help carers understand and respond to the diverse needs of children and adolescents experiencing trauma, loss and grief	Visit tgn.anu.edu.au
The Compassionate Friends NSW	Self-help organisation offering friendship and understanding to bereaved parents, siblings and grandparents after the death of a child and fostering the physical and emotional health of bereaved parents and their surviving children	1800 671 621 or visit tcfnsw.org.au

Appendix 2: Safe sleeping messaging

DISCUSSION POINTS FOR PRACTITIONERS WHEN TALKING WITH PARENTS AND CARERS ABOUT SAFE SLEEPING

Ask to see the infant's cot

- Does it meet the Australian safety standard?
- Is the mattress in good condition? Is it firm, flat and the right size for the cot?
- Make sure there is nothing in the cot. Remove all loose/soft objects, including toys, pillows, bumpers and loose bedding. Talk to parents about the dangers of these items.
- Ask the parents to show you how they put their infant to sleep and, when appropriate, demonstrate safe sleeping positions.
- Reinforce that the safest place for an infant to sleep is in a cot next to their parents' bed.
- Explain to parents that covering an infant's head increases the risk of sudden infant death.

Assess the risk of substance use

- Reinforce the message to parents that sleeping with their baby under the influence of alcohol/drugs or prescribed medication is dangerous and increases the infant's risk of death.
- Ask parents about their alcohol and/or drug use. If they are using alcohol or drugs, what kind (including prescribed medication) and how much? When do they use and what impact does it have on them? When did they last use? What types of alcohol or drugs did they take, and did they feel sleepy or sedated?
- Ask parents about their infant's sleep routine. Does this routine coincide with their substance use? Is there another adult in the home who can care for or supervise the infant when they use?

Discuss sleep routines

- Discuss the benefit of establishing good sleep routines.
- Talk to parents about how and where they put their infant to sleep. Where do they sleep during the day and at night? Do they intend to sleep with their infant?
- Explain to parents that sleeping with their infant is dangerous and can be fatal.
- Reinforce that infants should never be left unsupervised on a couch, lounge or bed.
- If the family is away from their usual home, ask what temporary sleeping arrangements are in place.

Parents who smoke

- Explain the increased risk of sudden unexpected death in infancy (SUDI) for infants exposed to smoke, particularly if they share a sleep surface with a parent who smokes.
- Look for indicators such as ashtrays and a smell of smoke in the home.
- Remind parents to ask others in the home or visitors not to smoke in the home or car.

- Explain that even second-hand smoke or smoke on clothes is a risk.
- Talk to parents about wearing a ‘smoking shirt’ and hair covering, and removing them before coming inside, and washing their hands after smoking.

Talk to breastfeeding mothers

- Educate mothers so they are aware of the potential dangers of fatigue and sedation.
- Encourage mothers to breastfeed their infant out of bed to avoid the risk of falling asleep.
- If the mother is using substances, practitioners should refer to the breastfeeding advice in the **NSW clinical guidelines for the management of substance use during pregnancy, birth and the postnatal period** from NSW Health.

Published by

NSW Department of Communities and Justice

www.DCJ.nsw.gov.au

If you think a child or young person is at risk of significant harm, contact the Child Protection Helpline on 132 111.

ISSN 1839-8375

3393 DCJ 091222