NSW GOVERNMENT

Child Deaths
2019 Annual Report

Learning to improve services

A note about this report

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. In particular, Aboriginal communities might find some of the report's findings and stories distressing. A list of support and counselling services is provided at Appendix 1.

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Minister's foreword

Firstly, I extend my sympathies to the families and communities of the children who died and are included in this report, as well as to all those who have lost children. The death of a child is deeply distressing and has far-reaching implications for all those who knew and loved them.

The *Child Deaths 2019 Annual Report* is DCJ's tenth annual report about the deaths of children who were known to the department's child protection service. This report openly shares information about the details and circumstances of death for these children who were known to be at significant risk of harm or in out of home care.

This report contains details of the 97 children who were known to the Department of Communities and Justice (DCJ) and died in 2019.

2020 has been a challenging year for NSW, and none of us could have prepared for the measures and restrictions that came into place because of the COVID-19 pandemic. During this incredibly challenging time, DCJ practitioners have continued to focus on putting children first. Their work to protect children and keep them safe from harm has not stopped.

I remain committed to working with DCJ practitioners and our interagency partners to achieve better outcomes for the children and families of NSW.

Gareth Ward
Minister for Families, Communities and Disability Services

Secretary's foreword

The death of a child under any circumstances is always heartbreaking.

I offer my sincere condolences to the families, carers and friends of children who have died.

This report focuses on 97 children who died and were known to the Department of Communities and Justice (DCJ) in 2019. It also includes a review of 59 infants who died due to premature birth between 2015 and 2019.

To the families and carers of these children, I am deeply sorry for your loss.

When a child known to DCJ dies, we undertake a review. Reviewing our work allows us to consider these children's experiences and analyse what worked well and what we missed.

All these children have something to teach us about how we could have worked better to reduce risk and create safety.

2020 has been a year to remember. Staff in DCJ have navigated massive changes at work and in spite of the COVID-19 restrictions, continued to visit and work with hundreds of at risk children and families each week. As ever, I am inspired and encouraged by the creativity and persistence of our staff.

The *NSW Practice Framework* continues to guide our child protection work. You can read more about its implementation alongside information about the progress of other reforms and how recommendations made following child death reviews have been implemented in Chapter four of the report.

Working to keep children safe from abuse or neglect is a most difficult job. Each and every time I speak with practitioners, I am reminded of the challenges they face.

This report highlights these challenges and causes me to reflect about what we can change and improve.

I commend each and every one of you who can read this report with an open mind and reflect on what you can do differently in your own practice.

Michael Coutts-Trotter
Secretary

Summary

The *Child Deaths 2019 Annual Report* is the tenth public report from the NSW Department of Communities and Justice (DCJ)[1] examining DCJ involvement with the families of children[2] who died and were known to DCJ.

This report provides context about the deaths of children who were known to the department, with the intention to strengthen the child protection system, improve child protection practice and support other services working with vulnerable children and families. There is hope that it strengthens community understanding of the complexities of the work, including the widespread social disadvantage among the families who the child protection system comes into contact with, and it's very real consequences for children's experiences of abuse and neglect.

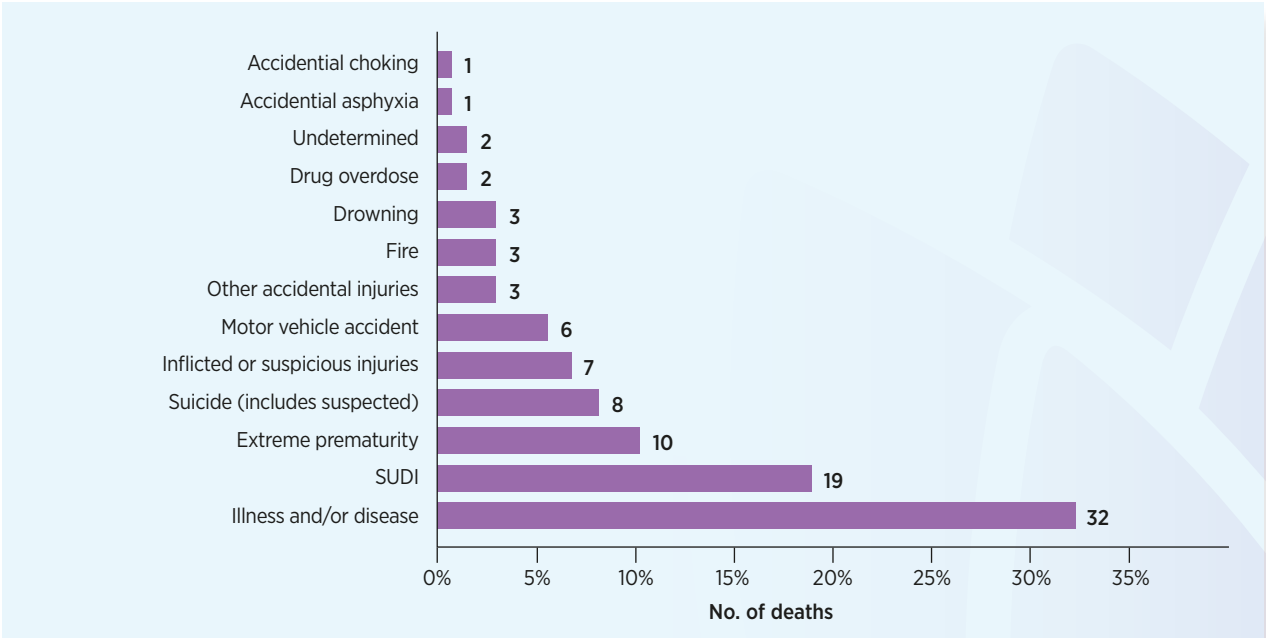
Child deaths in 2019

Chapter 2 summarises information about the 97 children who died in 2019 who were known to DCJ.[3] As shown in Figure 1, and consistent with previous years, the most common circumstance of death for these children was illness and/or disease. Almost half, 47 (48 per cent) of the children who died were under 12 months.

Aboriginal children continue to be disproportionately represented in deaths of children known to DCJ. In 2019, thirty-three of the children who died were Aboriginal. For the first time, this report considers these 33 deaths both within the larger cohort of 97 children who died and separately, providing specific detail about their circumstances, age and gender.

Seven of the children who died in 2019 were not living with their parents and the Children's Court had made an order allocating their care and responsibility to another person. One child had their care and responsibility shared between a relative and the Minister for Families, Communities and Disability Services (the Minister) and the other six children had their care and responsibility allocated solely to the Minister.

Figure 1: Children who died in 2019 and were known to DCJ, by circumstance of death[4]



1 The Department of Communities and Justice (DCJ) commenced on 1 July 2019. The new department 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 '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 (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 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.

Infants who died in circumstances related to premature birth

The focus of Chapter 3 is on the findings from a cohort review of 59 infants[5] who died between 2015 and 2019 because of their premature birth. Each year, infants who die in circumstances related to their prematurity account for one of the highest circumstances of death among children known to DCJ. Strong intersections exist between child protection concerns and the risk of prematurity.

Chapter 3 provides details about the circumstances in which the 59 infants died, why they had been reported to DCJ and other information about their families. The intersections between prematurity and child protection concerns are considered alongside research and practice examples that highlight the importance of prenatal casework and intervention.

It is hoped that learning from these deaths will improve DCJ work with all families, particularly with mothers and families with unborn children.

Improving the way DCJ works with children and families

Across 2019 and 2020, the NSW Government continued to implement reforms to the child protection and out of home care system in NSW.

Chapter 4 includes a summary of how the child protection system has been strengthened as a result of recommendations made in 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 in 2019.

The NSW Practice Framework, launched in 2017, creates a shared vision and guides all parts of the system in working together to achieve the best outcomes for children and families. More information about the Framework's implementation and the systems in place to support it are included in Chapter 4.

DCJ continues to implement reforms to the child protection and out of home care system. Chapter 4 describes the work of the Stronger Communities Investment Unit (SCIU) that leads and delivers the NSW Government's landmark reform, *Their Futures Matter*. Alongside information about the work of the SCIU are details of the Permanency Support Program, new Caseworker Development Program and other relevant reforms. Together, these reforms improve the department's approach and practice with vulnerable children and families.

5 The term 'infants' is used in this report when referring to the cohort of 59 children who died due to circumstances of premature birth. This term recognises the young age of this group of children who are considered in the cohort review.

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 review and oversight in NSW. This information is intended to help the public and other agencies to understand the issues underlying child abuse at a societal level.

1.1 Child protection in NSW

The NSW Department of Communities and Justice (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 (NGOs) and the community to support families to keep children safe from abuse and neglect. DCJ enables services to better work together to support everyone's right to access justice and help for families, and promote early intervention and inclusion, with benefits for the whole community. DCJ is the lead agency in the new Stronger Communities Cluster and brings together all government services targeted at achieving safe, just, inclusive and resilient communities under one roof.

DCJ child protection practitioners work with some of the most vulnerable children and families in NSW. Many of them live with extreme disadvantage because of poverty, 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 use of domestic 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 (ROSH) reports made about children in NSW.[6]

DCJ is committed to providing a child protection response that understands how social disadvantage, and stressors associated with it, are related to child abuse and neglect. DCJ has a mandated role in protecting children and young people and is committed to doing its best to influence and improve long-term outcomes for children who come into contact with the child protection system. This report shares some of the stories of families whose children known to DCJ have died, reflects on their experiences, and considers how DCJ could have worked with the families to reduce risk and create safety.

1.2 Examining child deaths

1.2.1 DCJ child death reviews

Reviewing child deaths is a requirement in the *Children and Young Persons (Care and Protection) Act 1998*.[7] 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 ROSH within three years before the death of the child, or a child who was in out of home care when they died.

Children in NSW with a child protection history have a higher mortality rate than those not known to DCJ, and have a higher rate of death from certain causes, including sudden unexpected death in infancy (SUDI) and unnatural causes such as fire or assault.[8] Other jurisdictions across Australia report similar findings.[9]

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 child death reviews, and the improvements to practice and systems made as a result of this learning

6 NSW FACS (2016).
7 Section 172A.
8 NSW Child Death Review Team (2014).
9 Previous contact with child protection services is often noted as a common factor in child death reviews. See Australian Institute of Family Studies (AIFS) (2017).

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 child death reviews with practitioners and inter-agency partners in other government and non-government organisations.

Serious Case Review Unit

The Serious Case Review Unit (SCR) is part of the Office of the Senior Practitioner (OSP) within DCJ. SCR reviews DCJ involvement with all children who have died and 'were known to DCJ'. These practice 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 practice improvement, but also promoting good practice.[10] This in turn can lead to broader system improvements.

Practitioner support and consultation

When a child dies, SCR works to support caseworkers so that they can focus on the important job of assessing the safety of any other siblings or children in the home and offering and providing support to families.[11] The support provided by SCR includes practical support such as debriefing practitioners who may have been working with a family recently, and preparing briefings for senior officers about the circumstances of the child's death. In many instances, SCR consults with casework staff to understand contextual information and to reflect critically on practice. Despite this being an understandably difficult process for staff, SCR is continually impressed by the courage and openness shown by DCJ practitioners in their willingness to learn from a child's death.

In some circumstances when a complex review is completed, practitioners are given an opportunity to discuss their work with a family, including any contextual factors or systemic issues they consider relevant. In these instances, SCR also provides practitioners with the opportunity to read the review and any critique of their practice.

An open and cooperative staff consultation process reduces the risk of the child's death negatively impacting future practice with other vulnerable children. It encourages staff reflection and ensures accuracy of information and robust analysis. If reviews are to lead to genuine learning, and practice and system improvement, and if they are to support staff to work differently with other children, then a process that gives staff the opportunity to understand what has been said about their work is crucial. If staff 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 openness of other staff engaging with the review process in the future.

Learning from child death reviews

Each child death review offers the possibility of considerable learning, and the OSP looks for opportunities to share learning proactively with practitioners across DCJ. Some examples of the ways DCJ learns from child death reviews are highlighted below.

Child Deaths Annual Report

The *Child Deaths Annual Report* (this report) is published at the end of each calendar year, and provides 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 child protection work in NSW.

10 Launched in 2017 the NSW Practice Framework encompasses timely and accurate decision making through safety and risk assessment, building strong relationships with families and working with family and culture, to partner with families for change.

11 Chapter three of the Child Death 2016 Annual Report outlines the key role child protection agencies play after the death of a child including supporting families in their grief and loss, and in completing sibling safety assessments with vulnerable families.

Cohort and other reviews

Each year, SCR undertakes a cohort review that looks at a group of children who died and were known to DCJ who share some common characteristics. In 2018, SCR completed a review of children known to DCJ who died and whose own parents were the subject of reports to child protection services. That cohort review provided important insights into how practitioners engaged with parents to understand their experiences as children, and how these experiences impacted on them in adulthood and in their role as parents.

Previous child deaths cohort reviews have considered:

- Children who died from illness and/or disease (2017)
- Responses to families of children who died (2016)
- Children who experienced neglect (2015)
- Vulnerable teenagers (2014)
- Babies who died suddenly and unexpectedly (2013)
- Children who were reported to be at ROSH because of domestic violence (2012)
- Children who had young parents (2011).

This year's cohort review (Chapter 3 of this report) presents findings about 59 infants who died in circumstances related to their premature birth.

Practice review sessions and other forums

The OSP often holds 'practice review' sessions with practitioners 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 staff 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 and are used to inform the OSP's Practice Conference and Research to Practice seminars.[12]

1.2.2 Public and inter-agency 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 death.[13] 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.[14]

While DCJ cannot report publicly about individual children, it has a strong commitment to transparency and accountability. The annual publication of this report reflects this 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,

12 Each year the OSP holds a practice conference and offers a program of Research to Practice seminars to frontline workers and other professionals, to provide them with up to date research and information about current best practice on a range of child protection areas. Details about the content of these and seminars, including online videos and conference papers, is available for practitioners on the Casework Practice intranet site.

13 Although information about children who have died is set out in this report, identifying details of families have been removed to protect their privacy.

14 *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).

deaths and severe neglect demand explication in the public domain and the impacts of this scrutiny can be severe and long lasting. The media helps 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.[15]

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 solutions and a prevention approach. An approach that draws child protection risk to the public's attention and then focuses on what should be done about it is advocated for in recent literature.[16]

Review work by SCR has highlighted the impact that the death of a child can have on staff 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 cannot be understated and provides an opportunity to understand professional decision-making and focus on what can be learned and what could be done differently.[17]

At an organisational level, the NSW Practice Framework[18] (see also Chapter 4) helps departmental and practice leaders acknowledge the uncertainty of work and share the risk between frontline workers and management. The Framework integrates the approach, values, standards, tools and principles that guide the NSW statutory child protection system. It clearly articulates mandates for how DCJ works and brings these together in one framework that is used by the whole department. Within it, information about DCJ child death review work acknowledges that reviews are one of many ways to guide practice. Internal child death reviews show DCJ willingness to reflect and maintain an open culture, where critique leads to improved outcomes and supports meaningful change for families.

NSW PRACTICE FRAMEWORK

To be the best we can be for families, we must invite and provide critique. We need to be open to hear and accept critique and willing to change our practice when required. Critique supports practice improvement, which ultimately leads to child safety.

NSW Practice Framework Principle – Critique leads to improved practice

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 Ombudsman, the NSW Police Force, the NSW State Coroner and the Office of the Children's Guardian all have responsibility for child death oversight, investigation and review.

NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths that have occurred in a care setting. The aim of this function is to prevent the deaths of children through the systemic review of deaths of children in circumstances of abuse or neglect, and the deaths of children in care or detention. The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in June 2019 and considered reviewable deaths of children in 2016 and 2017.[19]

15 Beddoe & Cree (2017).
16 ibid.
17 The process of review used by SCR is described for staff in a fact sheet available on the DCJ intranet, 'Serious Case Review – who we are' and references the model from Fish, Munro & Bairstow (2008).
18 NSW FACS (2017b).
19 NSW Ombudsman (2019).

NSW Child Death Review Team

Convened by the NSW Ombudsman, the NSW Child Death Review Team (CDRT) reviews 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,[20] and individuals with expertise in relevant fields including health care, child development, child protection and research methodology. The CDRT reports biennially to the NSW Parliament about the causes and trends of deaths of all children in NSW, as well as annually in relation to its operations and activities, including research projects and progress on the implementation of the CDRT's recommendations.

In 2020, the CDRT advised DCJ that 518 children aged from birth to 17 years died in NSW in 2019. Ninety-six of these 518 children were known to DCJ. These figures can differ slightly from DCJ data, highlighting important differences between the CDRT and DCJ:

- The deaths of children outside NSW are not included in CDRT data analysis or reporting
- CDRT reports include the 'child protection history' of children who die in NSW. Unlike DCJ, however:
  - 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 who were reported to DCJ but whose reports did not reach the ROSH statutory threshold, and also children who were known to Child Wellbeing Units.[21]

NSW Police Force and the NSW State Coroner

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

In addition, the NSW State Coroner has the power 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 was reported to DCJ in the three years immediately preceding their death, or was the sibling of a child reported to DCJ within three years 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.

Domestic Violence Death Review Team

The Domestic Violence Death Review Team is convened by the NSW 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;[22] 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 death of a child in the context of domestic violence is subject to review by the team. In 2016, the Domestic Violence Death Review Team moved to reporting every two years. The team's fifth report (2017–2019) was published in 2020.[23]

20 This includes representatives from DCJ, NSW Police Force, the Department of Attorney General and Justice, the Department of Education and the Sydney Children's Hospital. For a full list of members including independent experts see www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team/current-child-death-review-team-members

21 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 ROSH threshold are reported to the Child Protection Helpline. In other cases, they identify potential responses by DCJ and other services to help the child or family.

22 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.

23 NSW Domestic Violence Death Review Team (2020). A copy of this report can be accessed online via the Coroners Court New South Wales website.

Joint Child Protection Response Program (JCPRP)

The JCPRP provides for a multi-disciplinary response to child abuse by DCJ, the NSW Police Force and NSW Health. The program operates state wide and provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have experienced sexual abuse, serious physical abuse and extreme 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 (SoI). The SoI reflects an agreement between the agencies to foster cooperation and provide the best outcomes for children, young people and their families in response to serious cases of child abuse. By working collaborative, JCPRP staff from DCJ, Police and Health are able to coordinate agency specific expertise around the child or young person's needs.

Office of the Children's Guardian

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

- accredit and monitor designated agencies that arrange statutory out of home care in NSW
- maintain and monitor the NSW Carers Register, a database of people who are authorised, or who apply for authorisation, to provide statutory or supported out of home care
- register and monitor agencies that provide, arrange or supervise voluntary out of home care
- accredit non-government adoption services providers
- authorise the employment of children under the age of 15, and child models under the age of 16, in the entertainment sector
- administer the Working With Children Check and encourage organisations to be safe for children
- administer the Child Sex Offender Counsellor Accreditation Scheme – a voluntary accreditation scheme for counsellors working with people who have committed sexual offences against children
- administer the reportable conduct scheme.[24]

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

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. SCR reviews DCJ involvement with the child and their death may also be reviewed by the CDRT and the NSW Ombudsman. The child's death is reported to the Coroner and the Children's Guardian and may be investigated by 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 2019, this included children placed with DCJ or NGO carers, 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.

In response to the significant progress that has been achieved in moving statutory out of home care services from the government to the non-government sector, SCR 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 and others separately. 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.

24 From 1 March 2020, the Office of the Children's Guardian became responsible for administering the Reportable Conduct Scheme under the *Children's Guardian Act 2019*.

1.2.5 Making and monitoring recommendations following child death

Understanding what DCJ can do better and how the overall system can be improved is at the heart of child death reviews. When practice and systemic issues are identified in a review, recommendations are made. Recommendations seek to strengthen the way that 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 through the internal process of child death review as well as externally from other agencies. DCJ has a process in place to monitor the implementation of recommendations made. The different mechanisms for making and monitoring recommendations are outlined below.

Making and monitoring recommendations in DCJ

Approximately 90 serious case reviews are undertaken each year following a child's death. Many of the reviews result in recommendations aimed at improving direct casework with families or about the unique needs of a Community Service 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 casework 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 reviews completed each year have implications for state-wide practice and organisational systems. These reviews are considered by the Serious Case Review Panel.

Serious Case Review Panel

Established in June 2016, the Serious Case Review Panel 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 the department.

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 child death reviews considered by the Panel in 2019 and how these recommendations are progressing. The OSP maintains a secretariat role for the Serious Case Review 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 response to 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.

Making and monitoring recommendations about the broader service system

NSW Ombudsman

The CDRT makes recommendations about legislation, policies, practices and services for implementation by government and non-government agencies and the community.[25] These aim to prevent and reduce the likelihood of child deaths. The CDRT monitors these recommendations and reports on them in its annual report to Parliament. In their 2018–2019 annual report, the CDRT was monitoring 19 open recommendations.

NSW State Coroner

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,

25 This function is outlined in section 34D (1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

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 as provided in Premier's Memorandum M2009-12 Responding to Coronial Recommendations.

DCJ received two recommendations from a coronial inquest held in 2019.[26] These are being considered by the relevant area of DCJ and a progress update will be provided to the Attorney-General before the end of 2020.

26 The coroner's findings in this case were handed down on 1 June 2020.

Chapter 2: Child deaths in 2019

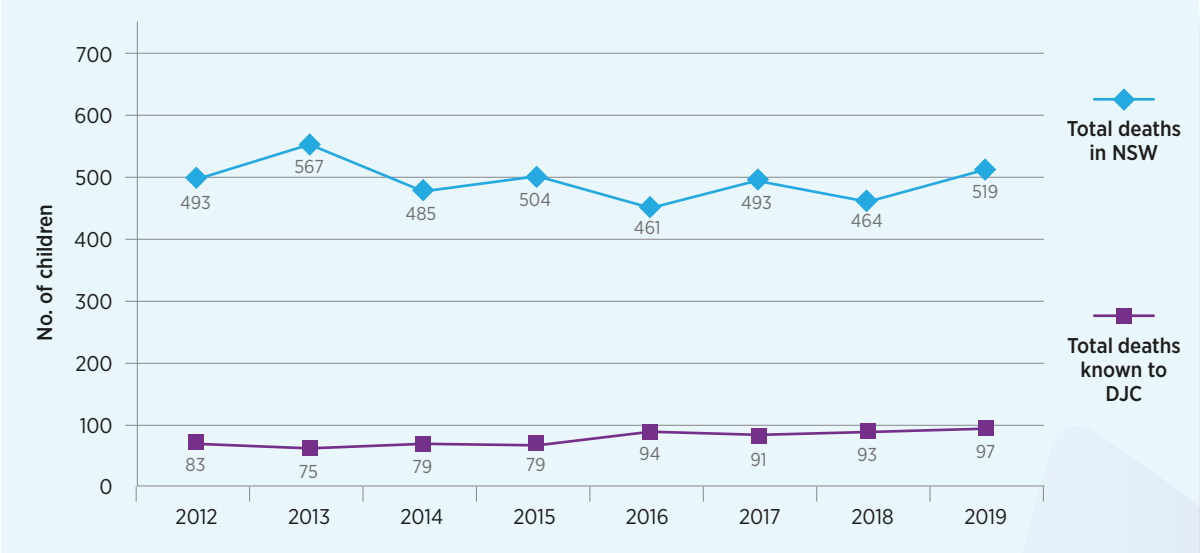
Chapter 2 provides a summary of information about the children who died in 2019 and who were known to DCJ before their death. It includes characteristics of the children such as their age, gender and Aboriginality. The analysis in this chapter also considers the circumstances in which the children died, the children's child protection history, as well as DCJ responses before and after the child's death.

To maintain confidentiality, this chapter only provides broad information about the 97 children who died in 2019 and their families. It also provides an opportunity to reflect on DCJ responses to these children, young people and their families and consider improvements to practice or policy.

2.1 Child deaths in NSW in 2019

Between 1 January and 31 December 2019, the deaths of 519 children occurred in NSW.[27] Ninety-seven children (19 per cent) of the 519 children who died in NSW were known to DCJ because the child who died and/or their sibling/s had been reported as at risk of significant harm (ROSH) in the three years before their death, or the child was in out of home care.

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ, 2012–2019 [28]



In 2019, the number of deaths of children known to DCJ remained relatively stable at 97 compared to 93 in 2018. The 97 children who were known to DCJ and who died in 2019 represented less than 0.1 per cent of the total number of children reported to DCJ in that year.[29] This rate is marginally lower than in previous years due to a greater increase in the number of children known to DCJ in 2019.

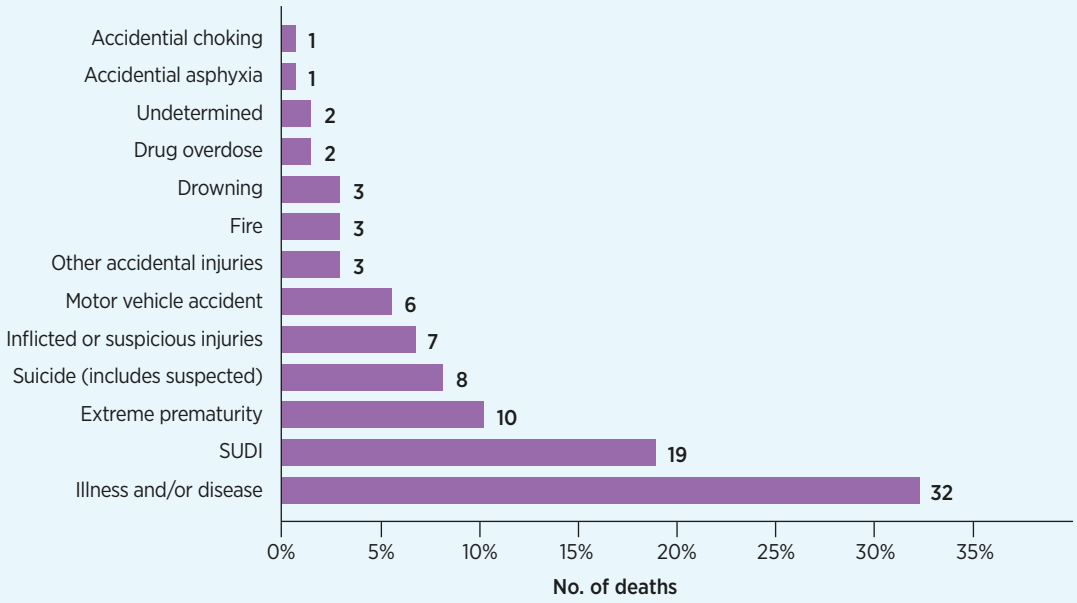
DCJ receives information about the medical causes and circumstances of children's deaths from the NSW State Coroner and NSW Ombudsman. DCJ relies on these sources to report on the circumstances of the child's death.

Figure 3 (a repeat of Figure 1 in this report) shows the circumstances of death for the children known to DCJ in 2019. The categories used to describe the circumstance of death can be different from those used for the cause of death. For example, the cause of a child's death may be listed as 'multiple injuries' but the circumstance of death may be a motor vehicle accident.

Further details about each of these circumstances of death and the groups of children known to DCJ who died in these circumstances is provided later in this chapter.

27 Information provided to DCJ in 2020 from the NSW Child Death Review Team. Note that one additional child death was reported after the NSW Ombudsman finalised its reporting data. It has been included in DCJ data but not NSW Ombudsman data.
28 ibid.
29 In 2019, DCJ received 226,561 ROSH reports, involving 110,998 children (data was extracted on 5 May 2020).

Figure 3: Children who died in 2019 and were known to DCJ, by circumstance of death[30]



2.2 Characteristics of the children

2.2.1 Age and gender

Table 1 provides further detail about the number of children in each age group who died due to each circumstances of death.

Table 1: Children who died in 2019, by age and circumstance of death

	< 12 months	1-4 years	5-8 years	9-12 years	13-15 years	16-17 years
Accidental asphyxia	1	0	0	0	0	0
Accidental choking	0	1	0	0	0	0
Drowning	1	0	0	1	1	0
Drug overdose	0	1	0	0	1	0
Extreme prematurity	10	0	0	0	0	0
Fire	0	0	2	1	0	0
Illness and/or disease	10	4	6	2	7	3
Inflicted or suspicious injuries	4	2	1	0	0	0
Motor vehicle accident	1	1	0	1	0	3
Other accidental injuries	0	1	1	0	0	1
SUDI	19	0	0	0	0	0
Suicide (includes suspected)	0	0	0	0	3	5
Undetermined	1	1	0	0	0	0
Total	**47**	**11**	**10**	**5**	**12**	**12**

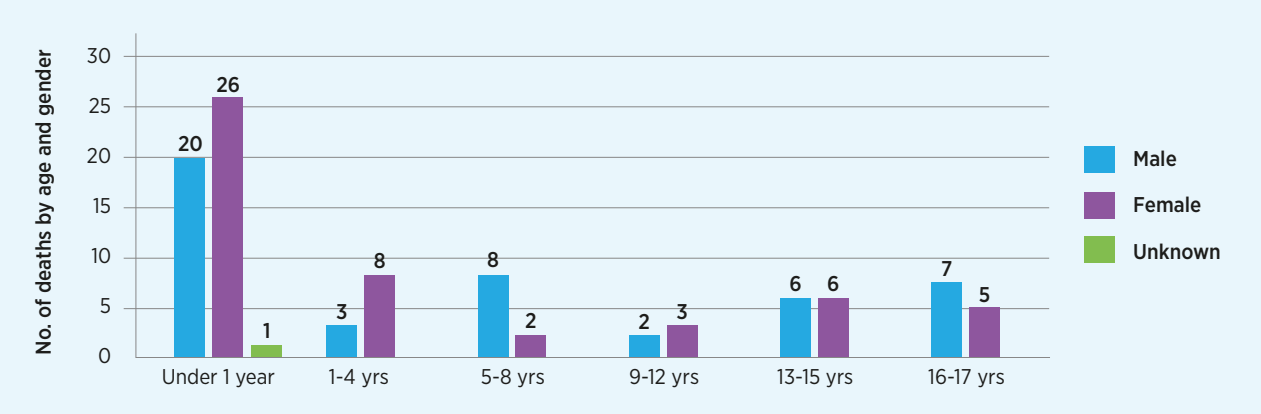
30 The 'undetermined' category includes cases where post-mortem information has not yet been received and where the NSW State Coroner has not yet been unable to determine a cause of death.

A significant proportion of the children known to DCJ who died in 2019 were under the age of 12 months (47 children; 48 per cent). This represents an increase from 2018 when only 36 children were under the age of 12 months. There was an increase in the deaths of children aged between five to eight years, from five children in 2018 to 10 children in 2019. These deaths occurred across a range of circumstances outlined in more detail later in this chapter.

There was also a slight increase in the number of young people who died between the ages of 16 and 17 years in 2019 (12 young people), compared with 2018 (10 young people). This increase is largely attributed to an increase in young people who died from suicide (2 in 2018; 5 in 2019).

In 2019, 50 (52 per cent) of the children who died were male and 46 (48 per cent) were female.[31] In contrast to previous years, the deaths of males versus females was not significantly higher (in 2018, males accounted for 61 per cent of the deaths of children known to DCJ). As seen in Figure 4, the male to female difference is most pronounced in the under one, one to four and five to eight age categories.

Figure 4: Children who died in 2019 and were known to DCJ, by age and gender



Children younger than 12 months

Of the 47 infants who died and were younger than 12 months, 37 died within three months of their birth. The circumstances of these deaths were predominantly sudden unexpected death in infancy (SUDI), extreme prematurity, and illness and/or disease.

Of the 47 infants who died, 24 were reported to DCJ, either before or after their birth. For the other 23 infants, a report was made to DCJ about their sibling/s at some point in the three years before their death. For all of the 47 infants, the ROSH concerns raised with DCJ[32] were:

- Parental drug and/or alcohol misuse (20 reports)
- Neglect (23 reports)
- Domestic violence (24 reports)
- Parental mental health (16 reports)

Children aged 1–4 years

Of the 97 children who died, 11 were aged between one and four years. Illness and/or disease and inflicted or suspicious injuries were the most frequent circumstances of death for this age group.

Teenagers

There was an increase in the number of young people who died aged 16 to 17 (12 young people; 12 per cent) compared with 2018 (10 young people; 11 per cent). The circumstances of these 12 deaths were from suicide (5 young people), illness and/or disease (3 young people), motor vehicle accidents (3 young people) and accidental injuries (1 young person).

31 One child's gender was identified as 'indeterminate'.
32 Numbers do not add up to 47 because of multiple reported issues.

2.3 Aboriginal children who died in 2019 and were known to DCJ

The deaths of Aboriginal children continue to represent a significant proportion of children who died and who were known to DCJ. Of the 97 children who died in 2019 and were known to DCJ, 33 children (34 per cent) were Aboriginal. This is lower than the proportion and number of Aboriginal children who died in 2018 however represents an overall increase from previous years.[33] This section includes specific information about these 33 children and their families.

2.3.1 Circumstance of death

Consistent with previous years, a significant proportion of Aboriginal children's deaths were from an illness or disease. There was an increase of infants who died in circumstances of SUDI in 2019 compared with 2018.[34]

The circumstances of death for the 33 Aboriginal children who died were:

- Illness or disease (10 children)
- SUDI (8 children)
- Inflicted or suspicious injuries (4 children)
- Suicide (3 children)
- Extreme prematurity (3 children)
- Drug overdose (2 children)
- Motor vehicle accident (1 child)
- Other accidental injuries (1 child)
- Undetermined (1 child).[35]

Aboriginal children continue to be grossly over-represented in the child protection and out of home care systems in NSW and the number of children who died reflects this ongoing and troubling over-representation.[36] The underlying systemic factors which continue to contribute to the disproportionate number of Aboriginal children who die and who are known to DCJ include the lasting ramifications of colonisation, forced removals of Aboriginal children from their families and the continued impact of intergenerational trauma.[37]

Included in the NSW Government reforms are several programs and services dedicated to working with Aboriginal families which are outlined in more detail below and in Chapter 4. The reforms also include the development of partnerships with Aboriginal communities and organisations to explore specific supports for Aboriginal children, young people and their families.

In addition to the broader reforms in place, DCJ practitioners have a responsibility to work in partnership with Aboriginal families and communities to keep children safe, while working towards understanding and addressing the disproportionate number of Aboriginal children in the system.

Culturally responsive practice involves acknowledging that Aboriginal children and families are the experts on their experiences, fostering self-determination and ensuring a child's culture is considered in every decision made about their care. Connection to Aboriginal culture protects children. Practitioners can 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 do so should come from cultural consultation with Aboriginal staff and community members.

33 In 2018, 36 Aboriginal children died, representing 39 per cent of children who died and were known to DCJ. In 2017, 29 Aboriginal children died, representing 32 per cent of children who died and were known to DCJ. In 2016, 26 Aboriginal children died, representing 27 per cent of children who died and were known to DCJ.
34 In 2018, three Aboriginal children died in circumstances of SUDI.
35 One child's cause of death was unable to be determined by the NSW State Coroner before publishing this report.
36 In 2019, DCJ received 62,201 ROSH reports about 23,227 Aboriginal children. Aboriginal children made up 21 per cent of the children who were reported at ROSH to DCJ in 2019.
37 See Human Rights and Equal Opportunity Commission as cited in Australian Institute of Health and Welfare (2015).

The importance of purposeful cultural consultation for Aboriginal children and families cannot be overstated. Cultural consultation needs to be an ongoing process and not a one-off event. It involves practitioners engaging genuinely in the process and seeking specific knowledge, skills and assistance to make sure DCJ practice meets the needs of the child and their family.

2.3.2 Age and gender

Of the 33 Aboriginal children who died, 19 were male and 14 were female. Twenty-three children were aged five years or under when they died, with 17 children under one year. This is consistent with 2018.[38] The circumstances of death for the 17 children who died under the age of one year were:

- SUDI (8 children)
- Illness or disease (4 children)
- Extreme prematurity (3 children)
- Inflicted or suspicious injuries (2 children).

In Australia, the mortality rate for Indigenous children between birth and four years is almost twice that of non-Indigenous children; however, the mortality rate has improved by 7 per cent since 2008.[39] The factors that influence birth outcomes and deaths for Indigenous children include various health and social determinants, such as maternal health, birth trauma, complications of pregnancy and risk factors in pregnancy (e.g. smoking and alcohol use). Protective factors like access to quality medical care, public health initiatives and safe living conditions can improve the chances of having a healthy baby.[40]

ABORIGINAL CHILD AND FAMILY CENTRES

Since 2008, nine Aboriginal Child and Family Centres (ACFC) have been established across six DCJ districts, from Minto, Mount Druitt, Nowra, Doonside and Toronto, to Brewarrina, Lightening Ridge, Gunnedah and Ballina. ACFCs provide integrated services for children aged 0–8 years and their families.

The centres were designed by Aboriginal people, for Aboriginal people. They put culture front and centre and provide quality early childhood education and care and integrated health and family services to Aboriginal children, families and communities. The centres also offer tailored, person-centred support to children and families and collectively offer 68 different wraparound services, including:

- Early childhood education and care
- Maternal and child health
- Parenting support groups
- Supported playgroups
- Adult education opportunities
- Paediatricians
- Psychologists
- Counsellors
- Disability screening and support
- Speech therapists
- Occupational therapists
- Referral coordination

An evaluation of the ACFC program in 2014 found that the proportion of Aboriginal children receiving all relevant health checks had increased from 81 per cent to 95 per cent. As of July 2020, more than 3,000 children and young people have accessed services, along with more than 2,200 parents, carers and families. An outcomes evaluation is underway and will be completed by June 2021.

38 Of the 36 Aboriginal children who died in 2018 and were known to DCJ, 23 were aged under five years.
39 According to the 2020 Closing the Gap Report, the Indigenous infant mortality rate has improved by 7 per cent since the baseline in 2008. However, the mortality rate for non-Indigenous children has improved at a faster rate. As a result, the gap is widening.
40 Closing the Gap Report (Australian Government, 2020).

2.3.3 Aboriginal children in out of home care

Of the 33 Aboriginal children who died in NSW in 2019 and were known to DCJ, five (15 per cent) were in out of home care at the time of their death.[41] This is consistent with previous years.[42]

Four of the children who died were living with relative/kinship carers, with three children case managed[43] by DCJ and one case managed by an NGO. One child was living with non-Aboriginal authorised carers and case managed by an NGO. Of the five children who died, four children died from an illness or disease and one child died by suspected suicide.

The proportion of Aboriginal children in out of home care in NSW has continued to increase. In 2018–2019, 41 per cent of children who entered out of home care in NSW were Aboriginal. As of 30 June 2019, Aboriginal children made up 39 per cent of all children in out of home care in NSW.[44]

WORKING WITH ABORIGINAL CHILDREN WITH AN ILLNESS

Of the four Aboriginal children who died from an illness or disease while in care, DCJ knew about their medical conditions before their deaths. Two of the children were born with significant medical conditions and two of the children developed an illness while they were in care. Practitioners worked with these children's parents and carers to include them in planning for the child's medical treatment. Three children had an end of life plan in place,[45] developed in collaboration with their parents, carers, health staff and caseworkers. DCJ supported the families to access grief and loss support and pay for funeral costs after the child's death.

Good practice with children with life limiting illnesses involves the participation of children, their parents and carers in decisions about medical treatment and end of life planning. When working with Aboriginal children with life limiting illnesses, the importance of Aboriginal consultation at all stages of this work is vital. Practitioners need to be guided by Aboriginal families and communities when considering medical treatment and intervention, and death and funeral arrangements, so they can be mindful of cultural practices, customs and traditions which may influence how the family or child wishes to proceed. Aboriginal consultation can help practitioners to understand how 'Sorry Business' may impact their work with the child's siblings and family after the child's death.

Family is Culture review

In 2016, the NSW Government commissioned an independent review of Aboriginal children and young people in out of home care. The Family is Culture: *Independent Review of Aboriginal Children and Young People in Out of Home Care* was completed and released in 2019. The NSW Government responded to the recommendations from this review with a clear commitment to building a child protection system that is more responsive to the needs of Aboriginal children, families and communities.[46] The NSW Government has committed to the following changes:

- Establishing a Deputy Children's Guardian for Aboriginal Children and Young People within the Office of the Children's Guardian, to elevate the rights and wellbeing of Aboriginal children

41 An additional five Aboriginal children who died were not in out of home care, but had at least one sibling who was in out of home care at the time of the child's death.

42 In 2018, five (13 per cent) of the 36 Aboriginal children who died were living in out of home care. In 2017, five (17 per cent) of the 29 Aboriginal children who died were living in out of home care.

43 Case management refers to an agency's responsibility for financial costs, decision-making and day to day care for children in care. Case management can either sit with DCJ or with a non-government agency.

44 In 2017–2018, Aboriginal children made up 38 per cent of children in out of home care in NSW, and in 2016–2017 Aboriginal children made up 37 per cent of children in out of home care.

45 The fourth child had a known health condition that DCJ was aware of but was not considered life limiting. While in out of home care, DCJ managed this with the child's relative/kinship carers. The child's death was related to their illness but occurred suddenly.

46 As stated in the NSW Response to the Family is Culture Review at https://www.facs.nsw.gov.au/families/out-of-home-care/nsw-response-to-the-family-is-culture-review/nsw-response-to-the-family-is-culture-review

- Establishing an Aboriginal Knowledge Circle to provide independent advice to the Minister
- Establishing an Aboriginal Outcomes Taskforce to drive improvements in services and supports for Aboriginal families, data collection and reporting, casework policy and practice, and inter-agency coordination.

SUPPORTING ABORIGINAL YOUNG PEOPLE IN OUT OF HOME CARE

ID Know Yourself is one example of an initiative for Aboriginal young people (aged 15 to 18) and provides a cultural mentoring program for young people leaving care in the Redfern/Waterloo area. The program focuses on establishing a sense of belonging, discovering purpose and empowering positive choices. ID Know Yourself connects young people to culture and community and prepares them with essential life skills for life after care. ID Know Yourself is one of the initiatives funded by the *Their Futures Matter* reforms. Chapter 4 of this report includes information about ID Know Yourself and other programs that support Aboriginal children, young people and families.

See https://idknowyourself.com/the-mentoring-program/

LISTENING TO ABORIGINAL YOUNG PEOPLE IN OUT OF HOME CARE

Youth Consult for Change is a youth advisory and leadership program within DCJ. The program engages young people aged 14–25 years from across NSW who have a lived experience of out of home care. The youth consultants meet every six weeks in Ashfield and have continued to meet virtually during the COVID-19 pandemic.

The young people consult on a number of programs, initiatives and services designed or reviewed by DCJ for the sector. The program also produces a project each year that aims to create change and improve the experience of other children and young people in care.

Currently, six of the 19 youth consultants are proud Aboriginal young people. They provide insight, expert advice and critique to the department which helps strengthen the way DCJ understands, supports and responds to the needs of Aboriginal children and young people, especially those experiencing out of home care.

Recent initiatives

The youth consultants developed a **Care Leavers' Charter of Rights**, which was launched in November 2019. The Charter outlines the ways practitioners can more meaningfully support and prioritise connection to culture and community.

See a Charter of Rights poster at www.facs.nsw.gov.au/families/out-of-home-care/children-in-oohc/rights-in-care

Through the podcast ***More than just a kid in care*** a number of the Aboriginal youth consultants provided insight and critique to the department about the challenges they experienced staying connected to culture and community while in out of home care. This podcast is available publicly and feedback has been used to inform practice advice and caseworker training.

Find the podcast at https://player.whooshkaa.com/shows/more-than-just-a-kid-in-care

CULTURALLY RESPONSIVE PRACTICE

The **Aboriginal Case Management Policy**, introduced in 2018, is a landmark policy written by AbSec[47] in consultation with Aboriginal communities, children and families. The rules and practice guidance developed from this policy provide detailed support for practitioners to be culturally responsive when working with Aboriginal children at all stages of DCJ work. This practice guidance includes cultural support for casework during triage, Aboriginal family-led field assessments, Aboriginal family-led case planning, decisions about placement, and preserving an Aboriginal child's relationships and connections while in care.

In line with the Aboriginal Cultural Capability Framework,[48] **Connecting with Aboriginal Communities** training began rolling out in DCJ districts in 2018 and will continue until 2022. The training is co-facilitated with the Aboriginal Education Consultative Group, the Aboriginal Outcomes Cross Division and local Aboriginal organisations. The training is held on Country and aims to improve cultural competency of DCJ staff, to deliver better outcomes for Aboriginal people.

Practitioners can get further support and learning from the Aboriginal Cultural Capability Framework through the web app at accf.facs.nsw.gov.au/#/home

NSW PRACTICE FRAMEWORK

We must not repeat the past. Through our approaches and daily work with families, we must always be looking for ways to understand and address the disproportionate number of Aboriginal children in our system. We can do this by working in partnership with Aboriginal families and communities, 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.

NSW Practice Framework Principle – Culture is ever-present

47 AbSec, the NSW Child, Family and Community Peak Aboriginal Corporation, works to empower Aboriginal children, young people, families and communities impacted by the child protection system. See absec.org.au

48 Australian Public Service Commission (2020).

2.4 Circumstances of child deaths

The section of the chapter considers the circumstances of death for all the 97 children who died in 2019. Consistent with previous years, the most common circumstance of death for the children who died in 2019 and were known to DCJ was illness and/or disease. Figure 5 shows and compares the number of children known to DCJ who died in each circumstance of death in 2018 and 2019.

Figure 5: Children who died in 2018 and 2019 and were known to DCJ, by circumstance of death[49]

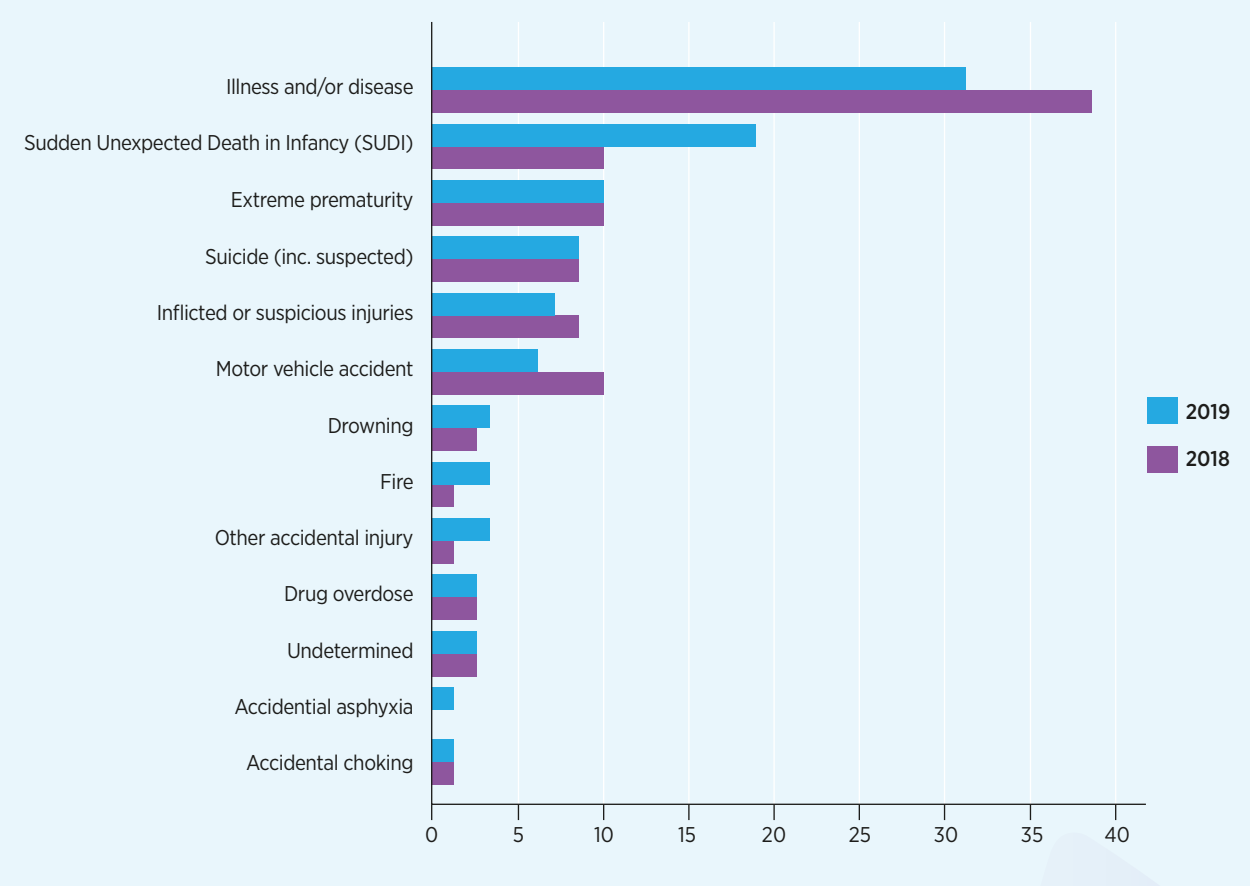


Table 2 compares the circumstance of death for children who were known to DCJ and who died between 2016 and 2019.[50] While the number of deaths in each category has remained relatively stable, there were a few notable changes between 2018 and 2019. These include:

- a decrease in the number of deaths from illness and/or disease
- an increase in the number of deaths classified as SUDI
- an increase in the number of deaths from fire
- an increase in the number of deaths from accidental injuries.

49 The numbers for some circumstances of death in this table have varied from reports in previous years. This is due to updated information from the NSW State Coroner or NSW Ombudsman about causes and circumstances of death. In particular, deaths that were once classified as 'undetermined' or 'SUDI' have been confirmed to be from illness and/or disease. Percentages may not add up to 100 due to rounding.

50 Figures are subject to fluctuation across years due to the small numbers. Conclusions should not be drawn about the changes.

Table 2: Children who died and were known to DCJ, by circumstance of death, 2016–2019

Circumstance of death	2016		2017		2018		2019	
	No.	%	No.	%	No.	%	No.	%
Accidental asphyxia	0	0	1	1	1	1	1	1
Accidental choking	0	0	0	0	1	1	1	1
Drowning	5	5	1	1	2	2	3	3
Drug overdose	1	0	1	1	2	2	2	2
Extreme prematurity	11	12	13	14	10	11	10	10
Fire	2	2	0	0	1	1	3	3
Illness and/or disease	34	36	46	50	39	44	32	33
Inflicted or suspicious injuries	4	4	5	5	8	9	7	7
Motor vehicle accident	9	10	2	2	10	11	6	6
Other accidental injuries	2	2	1	1	1	1	3	3
SUDI	15	16	15	16	10	11	19	20
Suicide (includes suspected)	11	12	4	4	8	9	8	8
Undetermined	0	0	2	2	0	0	2	2
Total	**94**	**100**	**91**	**100**	**93**	**100**	**97**	**100**

2.4.1 Deaths from illness and/or disease

Consistent with previous years, illness and/or disease accounts for the greatest proportion of child deaths in 2019. Thirty-two children died from illness and/or disease, which is a decrease from the previous two years and similar to 2016. Table 3 provides further detail.

Table 3: Children who died from illness and/or disease and were known to DCJ, 2016–2019

	2016	2017	2018	2019
No. of deaths	34	46	39	32
% of total deaths	36	50	44	33
Age range	0–17 years	0–17 years	0–17 years	0–17 years

Of the 32 children who died from illness and/or disease, information provided to DCJ indicates that 25 were diagnosed with a medical condition[51] before their death and 13 had a diagnosed disability before their death.

Of the 32 children who died from illness and/or disease, infants younger than one year (10 children) made up the largest group. This was followed by children aged 13–15 years (7 children) years and those aged 5–8 years (6 children).

51 This figure is based on information known to DCJ. It is possible that more children had an existing medical condition before their death that was not reported to the department.

Infants who died from illness and/or disease

The high number of children known to DCJ who die from illness and/or disease is consistent with findings by the CDRT, which has identified that most of the deaths of children in NSW are due to natural causes. In 2016 and 2017, 75 per cent of children died from natural causes; most of these children were infants in their first weeks of life.[52] Of the 32 children known to DCJ who died from illness and/or disease in 2019, 10 children were younger than 12 months; and six died at birth or in the first month after their birth.

While it is unlikely that DCJ could have prevented the deaths of these children, it is important to view these deaths through a child protection lens, to identify the opportunities that DCJ had to work with the parents and carers of these children to create safety.

Of the six infants under the age of one month who died from illness and/or disease, five had a ROSH or prenatal report[53] made about them before their death raising concerns about:

- the child's siblings having current child protection concerns and the mother's impending pregnancy (5 infants)
- the child's mother having a child protection history that may increase the risk to the child once born (4 infants)
- the child's mother using drugs and/or alcohol during pregnancy (4 infants)
- the child's mother not accessing antenatal care (2 infants)
- the child's father's use of drugs and/or alcohol, use of violence and mental health impacting on the child's mother and causing risk of significant harm to the child (3 infants)
- the child's father using violence against the child's mother placing the child at significant risk of harm (1 infant).

DCJ CASEWORK PRACTICE

Engaging and supporting at risk families is crucial to reduce the risk to children in utero and at risk of harm following birth. The DCJ Casework Practice mandate **Assessing and case planning with expectant parents (prenatal)** provides practitioners with information and skills for engaging parents following a prenatal report, and when carrying out casework with a child or young person in out of home care who is pregnant or is a parent.[54]

Shining a light on good practice tells the real stories of children, young people, families and their work with DCJ child protection practitioners. These stories are available on the DCJ website. Included in these are many positive examples of prenatal casework as well as other stories of skilled and compassionate casework that has changed the lives of children and their families.

Stressors for parents and carers of a child with an illness or disease can lead to and exacerbate other child protection concerns, such as parental mental health issues, domestic violence, problematic drug and alcohol use, and the neglect of the child or young person's medical, physical and emotional needs. Recognising the challenges faced by parents and carers of a child with an illness or disease is critical to understanding and better supporting families, and assessing safety and risk for children.

Serious case reviews have found that even experienced parents and carers face challenges in meeting the emotional and physical needs of children with complex health issues. Ongoing case management and support for parents and carers is important to ensure that a child's medical needs do not prevent them from receiving the love, nurturing and stimulation they require for quality of life. Careful case management and strong partnerships with families and other agencies such as NSW Health can help with case planning for children with complex medical needs.

52 NSW CDRT (2019).
53 Children can be reported for multiple risk factors in the one report.
54 See a list of DCJ Casework Practice intranet URLs in the reference section of this report.

2.4.2 Sudden unexpected death in infancy

The 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.

Table 4: Infants who died suddenly and unexpectedly and were known to DCJ, 2016–2019

	2016	2017	2018	2019
No. of deaths	15	15	10	19
% of total deaths	16	16	11	20
Age range[55]	0–11 months	0–9 months	0–11 months	0–12 months

As shown in Table 4, there has been an increase in the number of SUDI deaths compared to previous years. Nineteen infants died suddenly and unexpectedly in 2019, accounting for 20 per cent of the deaths of children known to DCJ in 2019. Post-mortem reports were available for 11 of the 19 infants and provided the cause of death as 'SUDI unexplained'. Once a final post-mortem is received for the other eight infants, the circumstances of death could change and the total number of SUDI deaths for 2019 may vary.[56]

The CDRT in their 2018–2019 annual report[57] identified a disproportionate number of infants who died suddenly and unexpectedly in disadvantaged families – including Aboriginal families, families with a child protection background, families from areas of greater socioeconomic disadvantage, and families living in more remote locations.

Of the 19 infants who died suddenly and unexpectedly in 2019, nine had a report made about them before their death (3 prenatal, 6 ROSH). The remaining infants were known to DCJ because their sibling had been reported at ROSH in the three years before the child's death. The issues reported to DCJ[58] were:

- Father's use of violence toward the child's mother (10 infants)
- Parental mental health (7 infants)
- Parental drug and/or alcohol use (6 infants)
- Cumulative harm due to neglect (13 infants)

Modifiable risk factors

Of the 19 infants who died suddenly and unexpectedly in 2019, one or more modifiable risk factors (characteristics in an infant's sleep environment) were found in 14 (78 per cent) of the families. A modifiable risk factor increases the risk of SUDI and includes:

- the infant being placed to sleep with a parent or sibling (10 infants)
- soft objects or other objects in the sleep environment (3 infants)
- the infant being placed to sleep somewhere other than their cot/bassinet (3 infants)
- the infant being prop fed (1 infant).[59]

55 The age range shown reflects the actual age in months of the infants who died each year.
56 Once a post-mortem is received, the circumstances of death are updated and numbers are corrected for previous years. Occasionally, deaths classified as SUDI may be later confirmed to be from illness and/or disease.
57 NSW CDRT (2019).
58 Numbers do not add up to 19 because of multiple reported issues.
59 Prop feeding is when an infant's bottle is positioned or propped up beside a pillow, rolled-up blanket or something similar instead of the infant being held to feed.

The number of children who die suddenly and unexpectedly in infancy highlights the need for practitioners to understand and be aware of modifiable risk factors. Practitioners must be clear in their advice to parents about safe sleeping when they are speaking with families. To enable this, practitioners need to be supported to keep their skills and knowledge up to date.

An ongoing challenge for practitioners working with families who experience a range of vulnerabilities is that advice to parents about safe sleeping are not always received, understood or adopted. In some instances, safe sleeping arrangements may need to be assessed over time as part of the safety and risk assessment process. Practitioners need to build relationships with families and communities, and support families to find ways to keep their infants safe. It is important that practitioners are consistent, persistent and non-judgemental when talking to families about safe sleeping arrangements. Where appropriate referrals to other family support services including Tresillian or Karitane may be needed.

SAFE SLEEPING AND COT-TO-BED SAFETY

A study into SUDI-related deaths of children identified at high risk of significant harm by the Child Safeguarding Practice Review Panel in the UK found that concerns around domestic violence, neglect, parental mental health and substance misuse – which can make co-sleeping dramatically more risky – were common across the case studies of infants that had died suddenly and unexpectedly.[60] The study pointed toward the need for a flexible and tailored approach to prevention which recognises and is responsive to the reality of people's lives, and is linked to plausible and understandable mechanisms for protection.

NSW Health has several resources for families that provide clear messages around safe sleeping. These include a Safe Sleep Cot Card and a safe sleeping brochure for Aboriginal families. NSW Health also provides information for professionals on its website.[61]

The Red Nose Foundation has developed two mobile phone apps – called **Red Nose Safe Sleeping** and **Red Nose Cot-to-Bed Safety** – for expectant mothers, carers and professionals, aimed at providing vital educational information on topics such as safe sleeping, tummy time, safe wrapping, when to move a child from their cot into a bed, what type of bed to use and how to provide a safe environment for a child.[62] These apps are helpful resources for practitioners to use when working with families when assessing the safety of infants in their parent's care including dangers, current protective abilities and safety interventions and safety planning. While they enable families to readily access information on safe sleeping practices in their home, for parents who do not have access to online resources, practitioners can take hard copies of advice, to provide parents as part of the safety and risk assessment process.

Download **Red Nose Safe Sleeping** and **Red Nose Cot-to-Bed Safety** through the Apple App Store or Google Play.

The *Child Deaths 2013 Annual Report* included a cohort review of 108 infants who died suddenly and unexpectedly between 2008 and 2013. In 2015, the findings from this review were used to develop a training package that was delivered across DCJ. Helpful practice tips for talking with parents about safe sleeping, taken from this review are included below.

The practice tips below are intended to be used alongside the structured decision making (SDM) safety and risk assessment framework.

60 Child Safeguarding Practice Review Panel (2020).
61 NSW Heath (2017).
62 Red Nose Foundation (2020).

SAFE SLEEPING

Ask to see the infant's cot

- Does it meet the Australian safety standard?[63]
- 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, and talk to parents about the dangers of these items.
- Ask the parents to show you how they put their infant to sleep and where appropriate demonstrate safe sleeping positions.
- Reinforce to parents that the safest place for their infant to sleep is in a cot next to their bed.
- Explain to parents that covering an infant's head increases the risk of sudden infant death.
- Is the bedroom free of other risks, including cigarette smoke?

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 drug use. Do they use drugs and alcohol? If so, what alcohol and drugs (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 drugs or alcohol 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 sleeping routines.
- Talk to parents about how and where they put their infant to sleep. What is their infant's sleep routine? 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 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.

63 All infant's cots must meet Australian and New Zealand Standard AS/NZS 2172:2003 Cots for household use – safety requirements.

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: www.health.nsw.gov.au/aod/professionals/Pages/substance-use-during-pregnancy-guidelines.aspx

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.

SUPPORTING PARENTS IN THEIR GRIEF AND LOSS

The Red Nose Foundation has a grief and loss program to support grieving individuals and families with the sudden and unexpected death of their infant or young child. Their website offers individuals and families a range of supports, resources and information.

Go to rednosegriefandloss.com.au

2.4.3 Deaths related to premature births

In 2019, 10 infants died from conditions related to their premature birth (10 per cent of all deaths of children known to DCJ) as shown in Table 5. All of the 10 infants died within four days of their birth, with seven infants dying within the first 24 hours.

Table 5: Infants who died from conditions related to their premature birth and were known to DCJ, 2016–2019

	2016	2017	2018	2019
No. of deaths	11	13	10	10
% of total deaths	12	14	11	10
Age range	0–1 months	0–3 months	0–6 months	0–4 days

Of the 10 infants who died from conditions related to their premature birth in 2019, three were reported to DCJ prenatally. Their reports raised concerns about:

- Their mother's drug and alcohol use (1 infant)
- Their father's use of violence towards their mother (1 infant)
- Parental mental health (2 infants)
- Physical abuse (1 infant)
- Their mother's homelessness (1 infant)
- Older siblings being in care (1 infant)

Understanding the factors that may have contributed to the premature deaths of these 10 infants can lead to greater insights about the support needs of families. Chapter 3 focuses on infants who died

from conditions related to their premature birth between 2015 and 2019. It provides the latest research and guidance to practitioners on how to engage families during pregnancy and to support them where there are problems associated with poor mental health, alcohol and/or drug use and domestic violence.

2.4.4 Suicide

Suicide remains a leading cause of death for young people in Australia.[64] Suicide death is preventable, but the stigma associated with mental health and suicide means that often young people feel unable to seek help.[65]

In 2019, eight children known to DCJ died as a result of suicide or suspected suicide (8 per cent of all deaths of children known to DCJ). Of the eight children and young people who died from suicide, all had experienced mental health issues, including suicidal thoughts or self-harming behaviour before their deaths.

Of the eight children who died, all were aged between 13 and 17 years. Three of the children were female and five were male. Three children were Aboriginal.

Table 6: Children who died by suspected suicide and were known to DCJ, 2016–2019

	2016	2017	2018	2019
No. of deaths	11	4	8	8
% of total deaths	12	4	9	8
Age range	13–17 years	< 10–17 years	13–17 years	13–17 years

Two of the eight children were under the care and responsibility of the Minister and living in out of home care. Research indicates that children and young people in out of home care are three times more likely to attempt suicide.[66] For the two children who died by suicide while in out of home care, both experienced a profound lack of connection to family and sense of belonging. Both had experienced significant abuse and neglect and their mental health issues and complex trauma required an urgent, collaborative response from DCJ.

Research also suggests that children who experience abuse (in particular, physical and sexual abuse) and neglect are at greater risk of developing mental health issues, including attempting and completing suicide.[67] Early childhood experiences of abuse and neglect have also been associated with increased prevalence of depression, anxiety and aggression as children grow older, which in turn heightens the risk of self-harming and suicidal behaviour.[68]

Of the eight children who died by suicide in 2019 all had been reported to the Helpline at ROSH. The concerns about each of the children were varied and included neglect, domestic or family violence, physical abuse and sexual abuse. Concerns about mental health, self-harming behaviour or suicidal thoughts were reported to DCJ for four of the eight children. For the other four children, only after their deaths did DCJ learn that their families had been worried about the child's mental health and risk-taking behaviour.

Of the eight children, DCJ completed field assessments for four of them. When reviewing these children's deaths, SCR found that DCJ did not seek to understand the children's full experiences in the care of their parents or authorised carers. Information about their mental health was either not identified during assessment, or identified but not responded to with enough urgency.

DCJ needs to respond to information about children's mental health, complex trauma and risk-taking behaviour with urgency and partner with health services to ensure that children receive both urgent

64 Health Direct (2019).
65 World Health Organization (2014).
66 Evans et al. (2017).
67 Miller, Esposito-Smythers, Weismoore & Renshaw (2013).
68 Paul & Ortin (2019).

mental health support where needed and ongoing support to address the underlying issues impacting on their mental health. With the right support, suicide is preventable. When working with children who have experienced abuse and neglect, holistic assessments are vital in capturing the impact of early childhood maltreatment on a child's mental health and identifying the specialist mental health support needs of the child and their family. Partnering with health services to ensure that assessments are informed by the expertise of mental health professionals is critical.

HOLISTIC ASSESSMENT OF CHILDREN AND YOUNG PEOPLE

The following points should always be considered when working with children and young people holistically.

What to do now

- Look for warning signs, such as the young person expressing feelings of hopelessness or worthlessness, drastic changes in mood or behaviour, aggression and irritability, talking about dying, self-harming, and/or using a lot of alcohol or other drugs.
- If you are worried that a child is in immediate danger, call triple zero (000) or go to the nearest hospital emergency department. Do not leave the child alone or with any sharp objects, weapons, drugs, medication or a car.
- Make sure that you have made a suicide safety plan with the child or young person before leaving them alone.
- Talk to the child or young person about your worries and do not keep it a secret. Share with them that you will support them to find help.

What to do while completing an assessment

- Speak to children to understand their full experiences in the care of their parents or authorised carers and how they are experiencing their mental health issues.
- Consider the need for a cultural consultation: Aboriginal and Torres Strait Islander children are four times as likely to die by suicide.[69] Positive cultural identity and connection to community and kinship networks increases resilience for Aboriginal young people.[70] Consultation can help practitioners to identify and build on Aboriginal children's connections in community and search for culturally appropriate health services.
- Consider any history of reported concerns and how a child's experience of trauma might be impacting their mental health.
- Acknowledge where risk-taking behaviour may be a child's act of resistance. Do we see the child's behaviour as oppositional or aggressive, or is the child trying to hold onto some control or dignity when someone is threatening to take it? Keep in mind that acts of resistance are not always safe behaviours and urgent safety planning with the child and their parents may be required.
- Consult with appropriate mental health services to understand risk factors of suicide and how to plan with parents to mitigate this risk.
- Seek to understand experiences of mental health, drug use or violence for the child's parent or carers and how this may affect their capacity to help the child to access appropriate mental health support and treatment.

BeyondNow is a suicide safety planning app for smartphones, developed by Beyond Blue.

The **Headspace National Youth Mental Health Foundation** website offers information, support and resources about mental health and wellbeing that may also be useful.

See https://headspace.org.au/

69 Australian Bureau of Statistics (2018).
70 University of Western Sydney and Black Dog Institute (2018).

DCJ CASEWORK PRACTICE

The practice kit ***Mental health: Working with young people and children with mental health issues*** provides practitioners with information on mental health issues and key risk factors in children and young people, and guidance for talking to children and parents and supporting children in out of home care.

The NSW Premier's Priority Towards Zero Suicides aims to reduce the rates of suicide in NSW by 20 per cent by 2023. Since 2018, a number of the initiatives to address the priority have been implemented to improve systems approaches to suicide prevention and are outlined in more detail below.

A STRATEGIC FRAMEWORK FOR SUICIDE PREVENTION

In October 2018, the NSW Government launched the *Strategic Framework for Suicide Prevention in NSW 2018–2023*. The framework recognises that individuals who are at the highest risk of suicide and suicidal behaviour include children in out of home care, adults who spent time in care as a child, children and young people in the justice system, people who do not have strong connections to their culture or identity, and survivors of sexual abuse and domestic violence.

The framework launch was accompanied by an investment in the Towards Zero Suicides initiative, which involves eight main priorities:

- After-care services for people who have made a suicide attempt
- Alternate services for people presenting to emergency departments in distress
- Support services for people bereaved by suicide
- More counsellors for regional and rural communities
- Expanded community mental health outreach teams
- Strengthening practices in the mental health system to eliminate suicides and suicide attempts among people in care
- Resilience building in local communities
- Improvements to the collection and distribution of suicide data in NSW

As of July 2020, the following actions have been taken in line with these priorities:

- The introduction of **Safe Haven Cafes** in pilot sites, a redirection from emergency departments for people presenting with suicidal thinking
- Increased funding to Beyond Blue's **The Way Back Support Service**, a three-month after-care program currently piloted in Newcastle, Murrumbidgee and North Coast NSW
- The development of a new **Post Suicide Support** service for people bereaved by suicide
- Support for mental health staff together with the **Zero Suicide Institute of Australasia** to redesign procedures, reduce risks and build skills to prevent suicide for people in acute and community mental health services
- Funding for 12 culturally appropriate suicide prevention programs in Aboriginal communities

See health.nsw.gov.au/mentalhealth/Pages/Services-Towards-Zero-Suicides.aspx

LIFE SPAN FOR SUICIDE PREVENTION

The *Child Deaths 2018 Annual Report* provided information about the Black Dog Institute trial program, LifeSpan. **LifeSpan** is an integrated framework for a systems approach to suicide prevention. The LifeSpan program aims to be community-led, involving health, education, frontline services, businesses and the community.

As of March 2020, LifeSpan's four trial sites (Newcastle, Illawarra Shoalhaven, Central Coast and Murrumbidgee) have involved services and a significant number of community members in work towards suicide prevention. This has included training:

- 12,724 high school students in Youth Aware of Mental Health program
- 2,674 individuals working with young people in suicide prevention
- 5,146 community members to recognise and respond to people who may be at risk of suicide

See blackdoginstitute.org.au/research-centres/lifespan-trials/

2.4.5 Motor vehicle accidents

In 2019, six children died from injuries sustained from a motor vehicle accident. This is a decrease from 2018 where 10 children died in motor vehicle accidents. As noted in previous reports, the number of children who die in motor vehicle accidents fluctuates from year to year.

Of the children who died in 2019, four were male and two were female. Their age range varied from less than one year to 16–17 years. Two of the children were hit by a motor vehicle; two were in a car that was involved in an accident; and two young people were involved in separate accidents where they were driving another motorised vehicle that was involved in an accident.

2.4.6 Inflicted or suspicious injuries

In 2019, seven children died from inflicted or suspicious injuries (7 per cent of all deaths of children known to DCJ). This was a reduction from 2018, but is an increase on previous years.[71] One of the seven children was not known to DCJ before the report about their injuries.

Of the seven children who died, three were female and four were male. Their age range was between 10 weeks and six years, with six children under two years of age and one child aged six years. The six children under two years of age were allegedly harmed by their parent or their parent's partner.

At the time of publishing this report, three of the children's deaths are before the criminal court, two of the deaths are still under police investigation and two are being investigated by the NSW State Coroner.

2.4.7 Other circumstances of death

Fire

In 2019, three children died in house fires. This is an increase from 2018 when only one child died. The number of children who die in house fires has remained consistently low.

71 Eight children died in 2018 from inflicted or suspicious injuries. In both 2017 and 2016, four children died.

Fire and RESCUE NSW

Fire prevention information

Fire and Rescue NSW offers fire prevention and support to families where a child has a fascination with lighting fires. Information on the program is available at fire.nsw.gov.au under 'Fire safety' then 'Educational resources'.

Fire safety awareness

Fire and Rescue NSW also provides a range of resources for households about fire safety awareness at fire.nsw.gov.au under 'Fire safety' then 'Community fire safety'.

Home fire safety checks

NSW fire stations can conduct voluntary home fire safety checks in households where fire risks might be identified as part of a holistic safety and risk assessment. Find local fire stations at fire.nsw.gov.au under 'Contact us' then 'Find a fire station'.

Drowning

In 2019, three children died from drowning. This is a slight increase from 2018 when two children drowned. One of the children was under the age of 12 months and two were between nine and 15 years. The deaths of children from drowning from year to year continues to fluctuate.[72]

Drowning deaths are tragic but preventable. The NSW Government continues to invest significant resources to educate the public about the dangers associated with water, and to inform parents and carers about how to keep children and young people safe around water. Attentive supervision continues to be promoted as the most effective preventative measure.

Most child drownings occur at home, most commonly in a backyard swimming pool. A lack of adult supervision is the most common factor leading to these deaths. Swimming is a vital skill for all ages to learn. It is important for children to learn from a young age and continue until they reach a competent level.

Swimming lessons are no substitute for adult supervision. Parents and carers should always be expected to keep watch of children and weak swimmers when they are in and around water.[73]

BE WATER SAFE, NOT SORRY

The NSW Government, in partnership with Surf Life Saving NSW, Royal Life Saving Society Australia and Marine Rescue NSW has launched the **Be Water Safe, Not Sorry**[74] water safety campaign in response to the number of drownings that occur in NSW throughout summer.

Always supervise children in or near water

- Do not get distracted by phone calls, a visitor at the door or attending to other children
- If you have friends over, designate a supervisor that so an adult is always watching
- Ensure the pool fence meets safety standards and the pool gate is closed, not propped open

72 In 2017, only one child drowned compared to five children in 2016.
73 https://www.watersafety.nsw.gov.au/Pages/swimming-safety/swimming-safety
74 Water Safety NSW (NSW Government, 2019a).

Don't drink or take drugs and swim

- If you drink or take drugs and swim you are putting yourself at risk of drowning
- Don't drink or take drugs and go swimming or participate in water-based activities
- Be aware that rivers, lakes, streams and dams can be isolated and are not manned by lifesavers
- Keep an eye out for your mates

No flags means no lifesavers

- Nearly 36 per cent of people who drowned last summer drowned at the beach, frequently at unpatrolled locations or outside of patrol hours.
- Swim at patrolled beaches, where possible
- Don't swim outside of lifesaver hours at patrolled beaches
- Don't swim beyond your abilities, particularly in unfamiliar waters

Practitioners can enhance children's safety by undertaking holistic assessments that consider how issues such as substance use, domestic violence and mental health problems impact a parent or carer's ability to supervise a child around water, and having conversations with parents and carers about the need for ongoing and attentive supervision around water.

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. DCJ and funded service providers undertake compliance checking for children's access to water during foster or relative carer assessments, as part of the home safety inspection checklist. There are a number of resources and fact sheets available to practitioners to provide to families, carers and the public to raise awareness about the importance of water safety.

Drug overdose

In 2019, two children died from accidental drug overdoses – one after they ingested their parent's prescribed drugs and one from a methamphetamine overdose.

The child who died after ingesting their parent's prescribed drugs was aged under two years. When working with parents who use prescribed drugs, particularly drugs such as methadone, fentanyl or other codeine or opioid-based drugs, it is important to talk to parents about how and where their prescription drugs are stored. There is no safe dosage of methadone for children and it must be stored out of reach from any children. Practitioners should advise parents to store prescription drugs in a childproof medicine cabinet or locked in a high location and not in the fridge, in a handbag or anywhere accessible to a child. If prescribed methadone, parents should not take their methadone dose in front of their children.

DCJ CASEWORK PRACTICE

METHADONE: SAFETY TIPS FOR PARENTS AND CARERS

Casework Practice has an advice sheet for parents and carers on common risks to infants, including storing methadone, safe sleeping and settling infants. This advice sheet was designed for caseworkers to have on hand when visiting families. It includes signs that a child has ingested methadone, such as the child:

- turning pale
- developing a cold, sticky sweat
- becoming unconscious or unable to wake up
- making unusual snoring/gurgling noises or breathing with difficulty.

It also includes advice that if a parent believes a child has ingested methadone, they need to call an ambulance immediately. If a child is being transported to hospital, the methadone container should be provided to hospital staff as well as information on what time the child swallowed the methadone and the amount, if known.

FENTANYL USE AROUND CHILDREN

Fentanyl is a highly potent opioid, which can be taken in the form of patches placed on the skin. Fentanyl patches are often used to treat chronic pain.[75] Infants and children are at higher risk of accidental exposure to fentanyl as they explore their world by touching and tasting things within their reach. Fentanyl patches can be fatal if they are ingested or accidentally attach to a child's skin.[76]

For the child who died from a methamphetamine overdose there had been previous reported concerns about this child's drug use before their death.

Children who have experienced trauma are at high risk of misusing drugs in adolescence.[77] It is important when working with teenagers who are using drugs to acknowledge their child protection history and whether their drug use is an act of resistance, and consider how to talk to them about how they can minimise risk while working to control or stop their drug use. This could include talking about risk of accident or injury and the risk of overdose.

Other accidental circumstances

Two children died from hyperthermia and one young person died from a fall.

2.4.8 Undetermined deaths

At the time of writing this report, two of the children's causes of death have not been determined by the NSW State Coroner and their circumstances of death are unable to be reported.

75 NPS Medicine Wise (2006).
76 NPS Medicine Wise (2015).
77 Carliner et al. (2016).

2.5 DCJ response to the children who died in 2019

This section provides a brief overview of DCJ involvement with the families of the 97 children who died in 2019. It discusses information about the number and nature of reports received, whether an assessment was undertaken for the child or their sibling before the child's death, and whether the children were living with family at the time of their death. This section also considers how DCJ responded to families after their child's death to assess the safety of siblings and offer support to the family.

2.5.1 ROSH reports

Of the 97 children who died in 2019, 63 (66 per cent) were reported at ROSH in the three years before their deaths and of those, 53 (55 per cent) were reported at ROSH in the 12 months before they died. This is fewer than in 2018, where 70 children (75 per cent) were the subject of a ROSH report in the three years before their death.

Twenty-seven (28 per cent) of the 97 children who died in 2019 were not reported to DCJ at ROSH, but their sibling was reported before the child or young person's death.

In 2019, 58 children (60 per cent) who died did not have a lengthy child protection history, with between zero and two ROSH reports received before their death. Eighteen (19 per cent) of the children were reported at ROSH three to five times. Seventeen (18 per cent) of the children were reported at ROSH more than five times with four having more than 25 ROSH reports.

Seventy (72 per cent) of the children who died, or their siblings, had a face to face assessment with DCJ before their death. Forty-one of the children or their siblings received the assessment in the 12 to 18 months before their death.

For some of the children who died in 2019 where assessments had been undertaken, a number of reviews identified learning about the quality of safety and risks assessments and case closure decisions. This resulted in recommendations for some districts to provide refresher training in Structured Decision Making tools and case closure decision making.

A number of cases considered by the Serious Case Review Panel have also identified issues around decision making for case allocation and case closure, resulting in a recommendation for the agency to review its guidance on case allocation and case closure.

As noted from the data above, many of the children who died and who were known to DCJ received a practitioner response to assess safety and risk, and a plan was developed with the child's family to address the identified concerns. Regular assessments and case plan reviews help to identify the changing needs of children and families, and to adapt plans to meet those changing needs. Establishing realistic goals and plans to address those goals in consultation with families can create change and lead to improved child safety. The NSW Practice Framework is designed to enable practitioners to partner with families, understand the worries and risks for children and be agents of change.

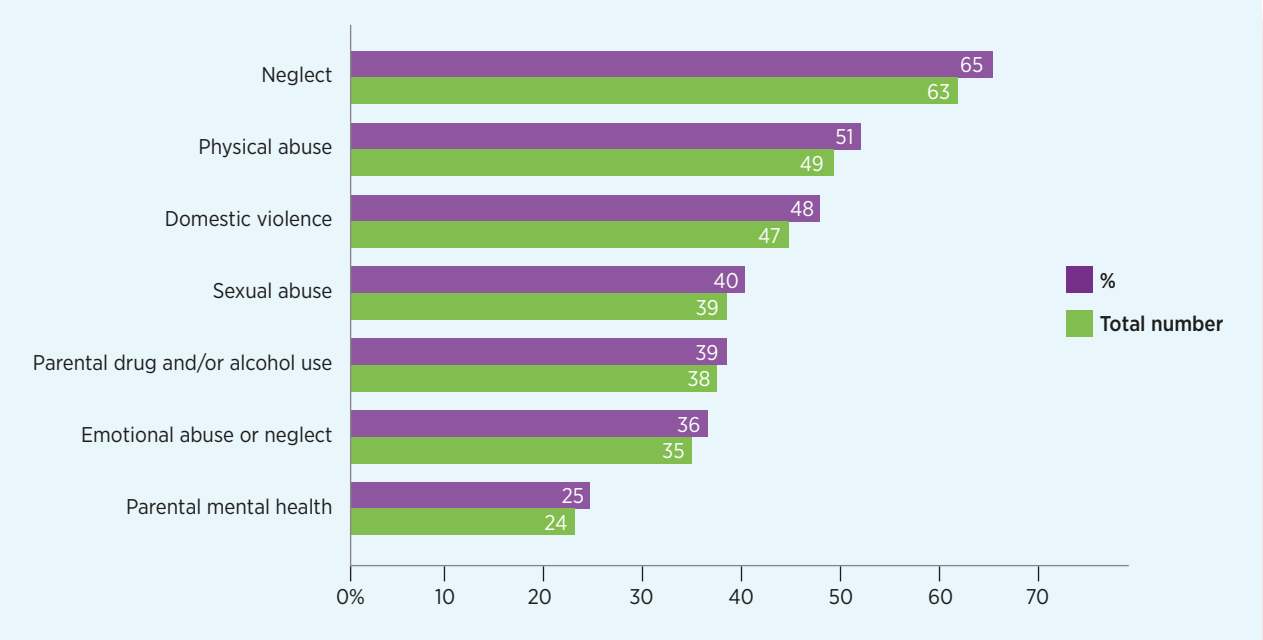
DCJ CASEWORK PRACTICE

The Casework Practice topics **Case planning for change** and **Holistic assessment and family work** provide useful guidance for practitioners when case planning.

2.5.2 Reported risk factors

Neglect, physical abuse, domestic violence and sexual abuse were the highest reported issues identified from the ROSH reports received for children who died in 2019 and their siblings.

Figure 6: Children who died in 2019 and were known to DCJ, by selected reported issues in ROSH reports received about them and their families[78]



A total of 63 children (65 per cent) and their families were reported to DCJ due to ROSH concerns about neglect. These families were reported for one or more types of neglect:

- Supervisory neglect (40 families)
- Physical neglect (33 families)
- Emotional abuse/neglect (35 families)
- Medical neglect (24 families)
- Educational neglect (14 families)

The main risks reported for children who died in 2019 rarely occurred in isolation. Practitioners often work with families where co-existing conditions[79] are present. A practitioner's role is to assess how the issues reported may impact on parenting and, in turn, the child's safety. A parent who is experiencing multiple challenges will often have a number of vulnerabilities and factors that influence this, including:

- current or past experience of trauma or childhood abuse
- social disadvantage, living in poverty, family breakdown, intergenerational abuse or trauma
- early school failure, social isolation, peers involved with alcohol and/or drug use
- a community with disadvantages and a lack of social resources, or a neighbourhood characterised by high crimes or low employment rates
- unemployment, trauma (physical, emotional or sexual abuse), isolation, disconnection and family breakdown.[80]

Quality, holistic safety and risk assessments are essential to understanding children's and families' experiences of violence, mental health and drug and alcohol misuse. Practitioners need to prioritise children within families and support parents to make and sustain change that ensures the safety of children. This can best be achieved by timely risk assessment, quick and effective access to Family Group Conferencing, and referrals to the most appropriate services to effect change and mitigate risk.

78 Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.
79 Previously known as dual diagnosis or comorbidity.
80 NSW DCJ Casework Practice kit: Alcohol and other drugs.

SUPERVISION AT DCJ

The goal of professional supervision in child protection work is to improve practice, strengthen the decision-making process, and sustain an effective, hopeful and skilled workforce. The DCJ **Supervision Policy for Child Protection Practitioners** sets out how group and individual supervision is used in DCJ to guide decision-making.

Group supervision is a key formal process through which supervision is delivered to child protection practitioners in NSW. Current evidence highlights that group supervision in child protection work benefits practitioners, children and families because it:

- allows practitioners to share the risk in decision-making
- provides practitioners with multiple perspectives to support decision-making
- promotes ethical, transparent and dignity driven practice
- supports workers collectively to manage uncertainty
- supports practitioners to identify feelings arising from the work and draw on each other for structured emotional support
- develops important group work skills
- is a forum for learning and professional development.

There is a strong and emerging evidence base[81] about the value of group supervision in child protection. Well delivered, it supports strength-based, family focused child protection practice. Group supervision helps practitioners, practice leaders and DCJ to fulfil our mandate to embed principles, approaches and capabilities into practice with children and families.

In addition to group supervision, the supervision policy requires all DCJ employees to participate in individual supervision a minimum of nine times per year. This includes bi-monthly supervision and three Personal Development Program supervision sessions.

2.5.3 Children in out of home care

As shown in Table 7, seven children were in out of home care when they died. This represents 7 per cent of all the children who died and were known to DCJ in 2019.

Table 7: Children who were living in out of home care when they died, 2015–2019

	2015	2016	2017	2018	2019
No. of deaths	9	10	9	8	7
Placed with a relative	1	4	4	3	4
Placed with authorised carers	7	4	3	5	2
Other (e.g. independent living, residential care, hospital)	1	2	2	0	1
% of total deaths	11	11	10	9	7
Age range	0–17 years	0–17 years	0–17 years	0–17 years	3–17 years
Parental responsibility of Minister (any aspect)	9	8	8	7	7

Four of these children died from an illness and/or disease. Two young people died by suicide and the other young person died in a motor vehicle accident.

When children cannot live safely at home the Children's Court makes an order allocating their care and responsibility. Of the seven children in out of home care who died in 2019, one child had their care and

81 DeWane (2013); Hawkins & Shohet (2000); Lohrback (2008).

responsibility shared between a relative and the Minister for Family, Communities and Disability Services (the Minister) and the other six children had their care and responsibility allocated solely to the Minister.

Four children were living with their family when they died. Two children were living with non-government authorised carers at the time of their death. Five of the children were Aboriginal.

2.5.4 How DCJ responded after the child's death

When a child dies due to abuse, neglect or in suspicious circumstances, or the child is in out of home care, DCJ has a legislative responsibility to assess the safety of other children living in the household, including unborn children. DCJ has a sibling safety mandate[82] to guide practitioners when responding to a report about sibling safety after the death of a child.

Of the 97 children who died and were known to DCJ in 2019, practitioners completed a safety assessment for siblings of 39 of these children (40 per cent) after their death. The work with these 39 children's siblings involved:

- assessing that the children were safe and ceasing involvement
- providing ongoing case management
- making referrals to other services for the family to access support
- siblings being taken into care.

For the remaining 58 children (60 per cent), their siblings did not receive a face to face assessment by DCJ after the child's death. The decision to not complete a sibling's safety assessment was due to:

- no risk issues being identified for their siblings
- a child's death being screened as non-ROSH at the Helpline
- no siblings or other children under 18 years old in the household
- information gathered through phone calls and other ways indicated the family had adequate support and a sibling safety assessment was not required.

Responding to a family after a child has died is challenging. This work requires practitioners to be sensitive and empathetic, while carefully assessing and planning for dangers. When visiting a family to complete a sibling safety assessment, practitioners need to clearly understand the purpose of their visit and be able to articulate this with families.[83]

NSW PRACTICE FRAMEWORK

Practitioners who are required to visit a family after a child has died can feel understandably worried about how their intervention will be experienced by the family. They may feel challenged about how they can assess safety and risk and have difficult conversations with a grieving family. These worries are important to address before the first visit to the family.

Families need us to be able to tell them what we are worried about and why, particularly in the context of a crisis such as the death of a child where families will be particularly vulnerable, grieving and may see the caseworker as a threat. Using the right words at this time will help make connections with children and parents and will make them more likely to be open to sharing their stories. Thinking about the words that will be used before visiting the family is important so that the caseworker can achieve the right balance between showing empathy, expressing sorrow and condolences, offering support, and being clear about the purpose of the visit including talking to parents about child protection concerns.

NSW Practice Framework Principle – Language impacts on practice

82 A response to assess the safety of siblings should happen when the death is due or may be due to abuse, neglect or suspicious circumstances and there are siblings, unborn children or other children and young people living in the household.

83 Practitioners need to be aware that a number of other government agencies have key roles to play in responding to child deaths. Importantly, police provide an investigative response in cases where a child's death is sudden and/or unexpected. Child protection practitioners need to keep in mind that it is not the role of the child protection practitioner to investigate the cause of a child's death, but to assess the safety and wellbeing of the other children living in the same household. For more information about responding to a child death see Chapter 3 of the Child Deaths 2016 Annual Report.

Practice leaders hold a crucial role in safeguarding practice and supporting caseworkers to assess sibling safety after a child has died. Research indicates that effective supervision increases the efficiency and quality of decision-making, therefore supporting practitioners to provide a service for families with complex needs.[84] Practice leaders can use supervision, both individual and group, to encourage critical reflection when preparing to respond to a child death. Critical reflection at this stage can help practitioners to:

- acknowledge the emotional intensity of responding to a child death and consider how the practitioner is feeling, before and after visiting the family
- think about any biases or assumptions they may be holding about the family, their child protection history, the circumstances of the child's death or the family's experience of grief
- plan for how they will balance assessing safety and risk for the surviving siblings while sensitively supporting the family through their grief and loss.

DCJ CASEWORK PRACTICE

Practitioners should refer to the **Sibling safety** mandate when responding to a family after the death of a child.

Chapter 3 of the *Child Deaths 2016 Annual Report*[85] focused on responses to a child's death and highlights key considerations when completing a holistic safety assessment with a family.

Practice leaders should refer to the **Facilitating assessment consultations** section of the **Practice Leadership Portal**. This provide managers with guidance about how to be an effective leader when planning to see a family and making decisions about the approach taken and outcome of an assessment.

84 Warren (2018).
85 NSW FACS (2017a).

Chapter 3: Children who died in circumstances related to premature birth

Introduction

Pre-term birth complications are the leading cause of death for children under five years.[86] Each year, infants who die in circumstances related to their prematurity account for one of the highest circumstances of death among children known to DCJ.

In order to understand the factors that contribute to the deaths of infants born prematurely, it is necessary to consider the issues associated with their premature birth. Premature labour can occur in any pregnancy but there are health and social factors that may make this more likely. The quality of health care for women and appropriate care in the neonatal period are often reflective of infant mortality.[87] Additionally, broader social factors such as domestic violence, smoking and drug use, poor maternal health, maternal age and socioeconomic disadvantage may also contribute to premature births.

The implications of prematurity are far-reaching. Infants born prematurely often require special care and are at greater risk of serious health problems, intellectual disability, chronic lung disease and vision and hearing loss.[88] Prematurity has also been identified as a risk factor for childhood abuse and neglect.[89]

The NSW Health First 2000 Days Framework highlights the importance of the first 2000 days in a child's life (from conception to five years) for physical, cognitive, social and emotional health. Exposure to stressors before birth and in early childhood increases the probability of poor health and wellbeing later in life.[90]

This cohort review focuses on infants, aged up to one year, who were known to DCJ and died between 2015 and 2019 in circumstances related to their premature birth. In the review period, 59 (17 per cent) of the 357 deaths of children known to DCJ were premature babies.

The prenatal period offers a critical window of opportunity to provide effective intervention to reduce the risks that contribute to preterm birth and death. This chapter describes the intersection between the risk of prematurity and child protection concerns to improve understanding of this risk and support effective and purposeful practice with families during the prenatal period. The practice learning from this review is relevant for all unborn babies known to DCJ.

Section 3.1 introduces and defines the cohort and provides details about the circumstances in which the 59 infants died. It also provides an overview of the demographic profile, family characteristics and reported concerns for these infants and their families, drawing links to research about relevant risk factors.

Section 3.2 considers the intersection between prematurity and reported child protection issues among the cohort and highlights relevant practice points for practitioners working with expectant parents and their families.

Section 3.3 discusses child protection responses for good prenatal casework and uses a case study example to highlight quality practice when working with expectant parents.

86 Liu et al. (2016).
87 Australian Government (PMC) (2014).
88 World Health Organization (2012).
89 AIHW (2017).
90 NSW Health (2019).

3.1: The cohort: Infants who died in circumstances related to premature birth

3.1.1 Defining the cohort

The World Health Organization distinguishes between three categories of premature births:

- Moderately premature – between 32 and 36 weeks gestational age
- Very premature – between 28 and 32 weeks
- Extremely premature – 27 weeks gestation or less[91]

As stated in Chapter 2, DCJ receives information about the medical cause and circumstances of a child's death from the NSW State Coroner and NSW Ombudsman. This information is used to report on the circumstances of a child's death. Between 2015 and 2019, 52 babies were reported to have died in circumstances of 'extreme prematurity'. Forty-seven were born before 28 weeks gestation. Five were born after 28 weeks. In order to understand the common risk factors leading to deaths related to premature births among children known to DCJ, these five babies have been included in the cohort. Including these infants shifts the focus of this chapter from 'extreme prematurity' to 'prematurity'.

A further seven babies who were reported to have died from illness or disease have also been included because prematurity was identified as an antecedent cause of death or a condition that significantly contributed to their death. This includes babies born with congenital conditions that may have caused both their premature birth and death, as well as infants whose premature birth exposed them to deadly infections.[92] Including these babies allows for a broader understanding of the circumstances in which premature deaths occur.

It is important to note the cohort excludes stillbirths – babies born after 20 weeks gestational age or over 400 grams birth weight with no sign of life.[93] The vast majority of deaths during the perinatal period (before and after birth) are stillbirths. Therefore, these deaths are not included in DCJ reporting. While not included in this cohort review, many of the risk factors contributing to stillbirths and premature infant deaths are the same and the prenatal practice advice captured in this chapter is still relevant when working with families who are expecting a baby.

3.1.2 The cohort

Between 2015 and 2019, 59 infants who were known to DCJ died in circumstances related to their premature birth. This represents 17 per cent of all children who died during this period. The proportion of infants whose death was linked to their prematurity ranged from 12 per cent to 16 percent over the five years of this cohort review. In 2015, there were 10 deaths (13 per cent), in 2016 there were 12 deaths (13 per cent), in 2017 there were 15 deaths (16 per cent) and in both 2018 and 2019 there were 11 deaths (each 12 per cent).

Table 8: Infants in the cohort, by year of death

	2015	2016	2017	2018	2019
No. of deaths	10	12	15	11	11
% of total deaths	13%	13%	16%	12%	12%

91 World Health Organization (2012).
92 Swanson & Sinkin (2013).
93 AIHW (2019).

3.1.3 Infant's age and degree of prematurity

There is a strong correlation between gestational age and perinatal death: the earlier a baby is born, the less likely it is to survive.[94] A study of premature babies born in NSW and the Australian Capital Territory (ACT) from 2007 to 2012 found that 95 per cent of those born between 28 and 32 weeks survived, but these rates drop rapidly in the 'extremely premature' range: from 91 per cent at 27 weeks to only 28 per cent at 23 weeks.[95]

Given these numbers, the NSW and ACT Perinatal Care at Borderline Viability Consensus Workshop Committee determined that any baby born up to 25 weeks would be treated according to parents' wishes and in consultation with the neonatologist and obstetrician.[96] Sadly, babies born at up to 22 weeks gestation rarely survive because their organs are not sufficiently developed and, therefore, they are not provided with intensive treatment. Instead, these 'pre-viable' babies are provided 'comfort care' until they die, which usually happens within a few hours of birth.

As indicated in Table 9, 26 of the 59 infants in the cohort (44 per cent) were born at a pre-viable gestational age and all of these infants died within 24 hours of birth. Another 28 (47 per cent) were born between 23 and 27 weeks and most of these babies (71 per cent) lived for less than a month. Three infants were born very premature (5 per cent) and two were born moderately premature (3 per cent).

Table 9: Gestational age, level of prematurity and age at death of infant

Degree of prematurity			Age at death					
Category		Gestation (weeks)	< 24 hours	1 day – 1 week	1 week – 1 month	1–3 months	4–6 months	Total
Extremely Premature	Pre-viable	< 23	26	0	0	0	0	26
	Peri-viable	23–27	8	8	4	6	2	28
Very premature		28–32	1	0	2	0	0	3
Moderately premature		33–37	1	1	0	0	0	2
Total			**36**	**9**	**6**	**6**	**2**	**59**

3.1.4 Causes of premature birth and infant death

It is difficult to draw strong conclusions about the circumstances surrounding these premature deaths because available information about cause of death is not always consistent. In cases where the direct cause of death was described, the most common cause was the infant's underdeveloped organs, which led to respiratory problems, brain haemorrhages, infections or bowel issues. Three of the infants in the cohort also had congenital conditions and for two infants, their premature births were medically induced because of diagnosed health complications for the infant.

The most common factor reported as causing the premature birth was chorioamnionitis – a bacterial infection of the uterus. Any pregnant mother can experience this condition, and risk factors include smoking, alcohol and drug use and untreated urogenital infections (including urinary tract infections and bacterial vaginosis).[97]

94 AIHW (2020a).
95 Bolisetty et al. (2019).
96 Lui et al. (2006).
97 Tita & Andrews (2010).

3.1.5 Gender

The gender of 58 of the 59 infants in the cohort could be identified.[98] Of these 58 infants, 26 (45 per cent) were female and 32 (55 per cent) were male. The slightly higher rate of male infants in the cohort is consistent with international data, which suggest that male foetuses mature later than female foetuses, making them less resilient to stress in the womb.[99]

3.1.6 Aboriginal status

Of the 59 infants in the cohort, 22 (37 per cent) were Aboriginal. This alarming 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.[100]

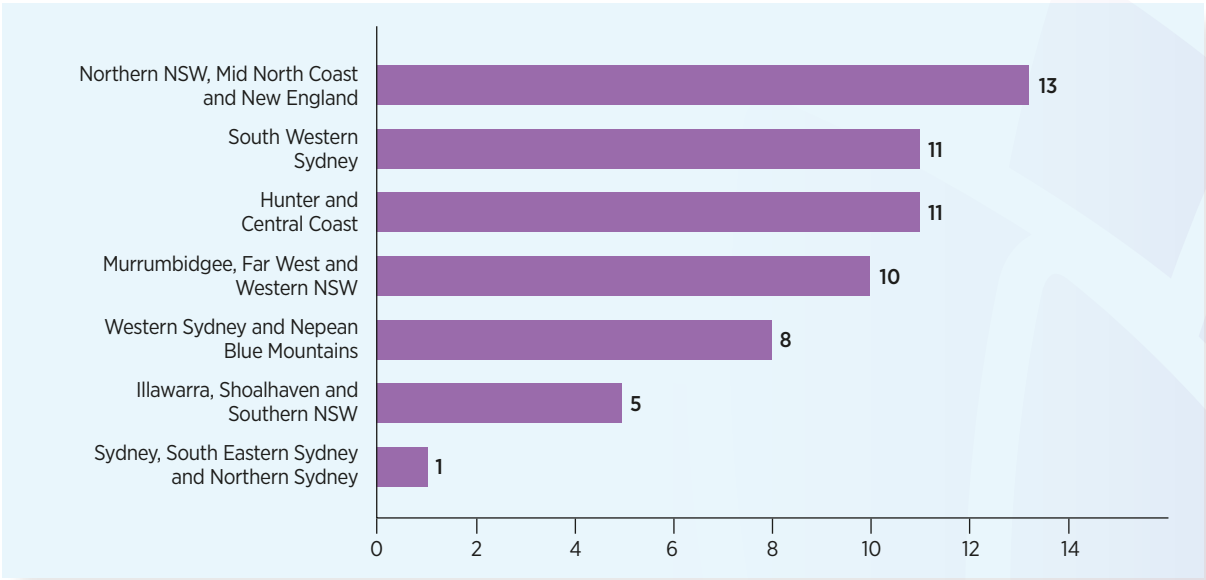
The mothers of 10 infants in the cohort (16 per cent) were Aboriginal. This is a significant percentage, given only 3.9 to 4.5 per cent of all mothers in NSW identified as Aboriginal between 2015 and 2018.[101] Of these 10 mothers, nine had been reported to DCJ during their own childhood, and four were less than 20 years old.

These sobering statistics highlight the continued impact of past government practice and policy on Aboriginal people. Aboriginal women are more likely to experience violence, poor health and substance misuse than non-Aboriginal women, and are less likely to seek out antenatal care early in their pregnancy.

3.1.7 Geographic distribution

As indicated in Figure 7, the largest proportion of infants in the cohort (20 per cent) were born in the Northern NSW, Mid North Coast and New England district. This was followed by Hunter and Central Coast and South West Sydney districts, which both had 11 infants (19 per cent); and Murrumbidgee, Far West and Western NSW district with 10 infants (17 per cent). The Sydney, South Eastern Sydney and Northern Sydney district had the lowest number, with just one infant in the cohort. These numbers are consistent with state-wide trends in preterm births. In 2018, NSW Health reported that mothers in outer regional, remote and very remote areas were more likely to give birth prematurely compared to mothers in major cities and inner regional areas.[102]

Figure 7: Infants who died in circumstances related to premature birth and who were known to DCJ, by DCJ district, 2015–2018



98 At the time of birth, the sex of one infant was not able to be determined.
99 Zeitlin et al. (2002).
100 AIHW (2020).
101 ibid.
102 HealthStats NSW (2019).

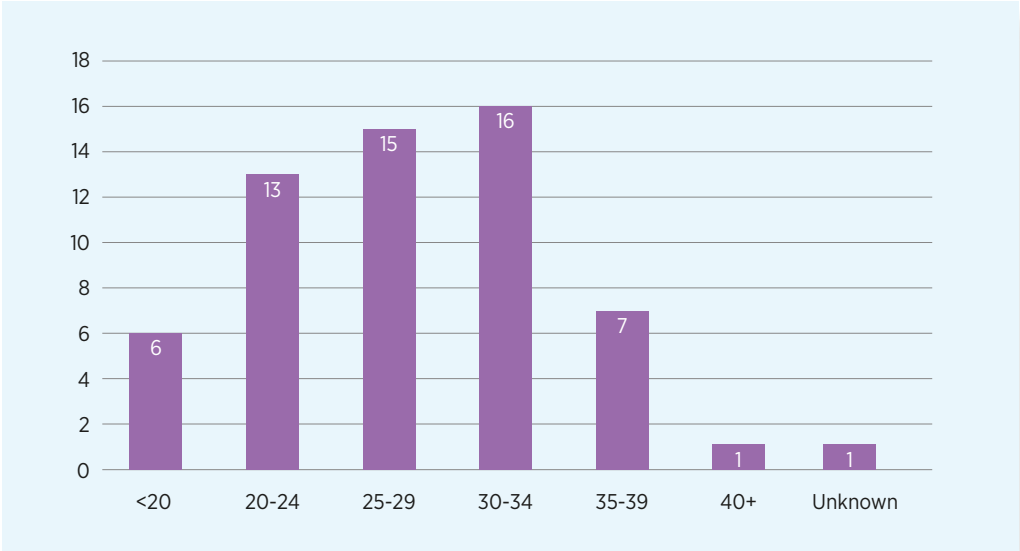
3.1.8 Family characteristics

Mothers

The mothers of infants in the cohort ranged in age from 16 to 40 years. The average age of mothers at the time of their baby's death was 28 years.

Australian data indicates that pregnant women under 20 years of age are at increased risk of experiencing premature birth.[103] Of the 59 infants in the cohort, six mothers (10 per cent) were under 20 years old at the time of the infant's birth. In comparison, in NSW in 2018 only 1.9 per cent of mothers were under 20 years old.[104]

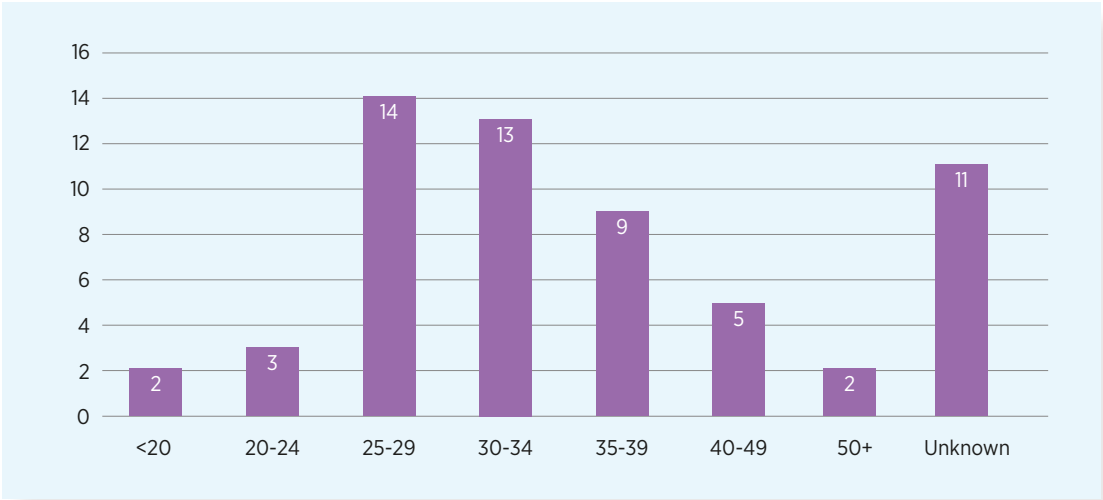
Figure 8: Age of infant's mother at time of infant's death



Fathers

Where information was available the average age for fathers when their baby died was 32 years.[105] Fathers ranged in age from 17 to 52 years.

Figure 9: Age of infant's father at time of infant's death



103 AIHW (2019).
104 Centre for Epidemiology and Evidence (2019).
105 There were 11 fathers whose age was not known to DCJ.

Parents' child protection history

For infants who died in circumstances of prematurity between 2015 and 2019, 41 (70 per cent) had a least one parent either reported to child protection services as a child or who lived in out of home care as a child, or both.

For the 59 families of this cohort, 40 (68 per cent) of the children's mothers were known to child protection services. Three of these mothers lived in out of home care as a child. The details of two fathers were not provided to DCJ when a report about their baby was made. Of the fathers of infants in this cohort identified in DCJ records, 19 were reported to child protection services as a child. None of the fathers in this review cohort lived in out of home care as a child.

Figure 10: Mothers with child protection history

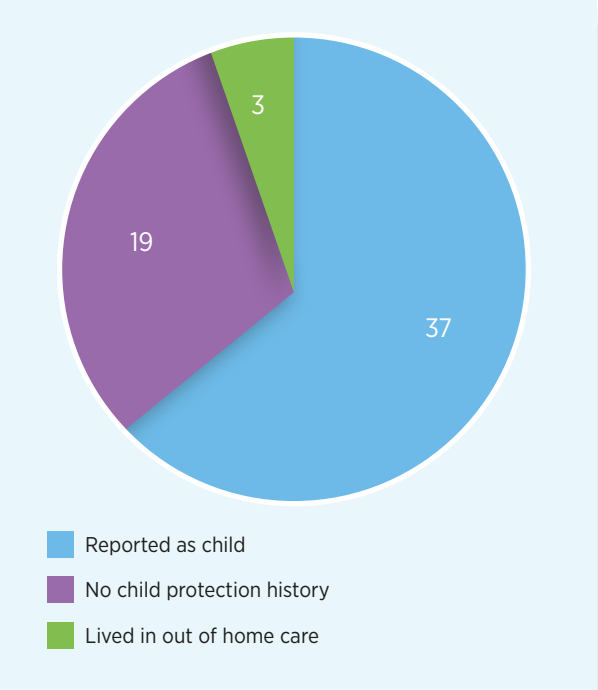
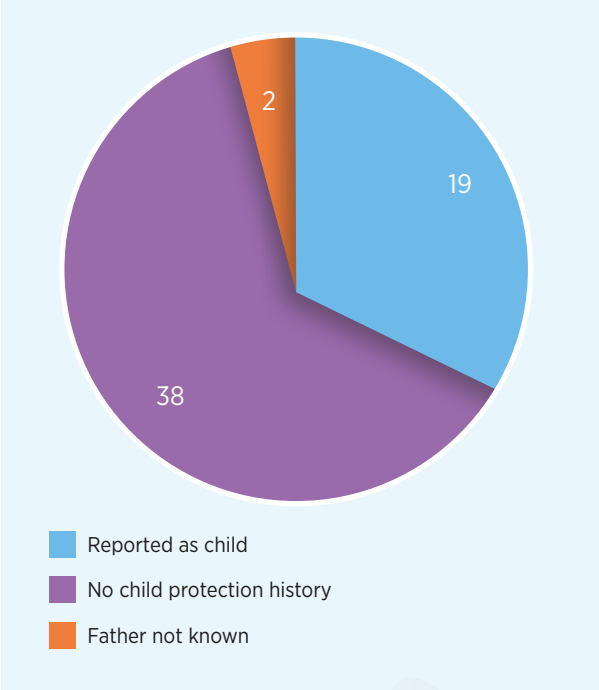


Figure 11: Fathers with child protection history



3.1.9 Reported risk of harm concerns

The infants in this cohort were known to DCJ because they and their families had been reported at risk of significant harm for the following child protection concerns (see also Figure 12):

- Parental alcohol and/or drug use (40 families; 68 per cent)
- Domestic violence (40 families; 68 per cent)
- Physical abuse (25 families; 42 per cent)
- Parental mental health (24 families; 41 per cent)
- Sexual abuse (18 families; 31 per cent)[106]

It is interesting to note how these percentages compare to the larger cohort in Chapter 2 of this report that considers all children who died and were known to DCJ in 2019 (see Figure 6). The families of the 59 infants in this cohort had a greater percentage of reports received for domestic violence (68 per cent here compared to 48 per cent in the larger cohort), parental alcohol and/or drug use (68 per cent compared to 39 per cent) and parental mental health (41 per cent compared to 25 per cent). However, the cohort here had smaller percentages of reports for physical abuse (42 per cent here compared to 51 per cent in

106 Numbers do not add to 100 per cent because families can be reported multiple times for multiple concerns.

the larger cohort) and sexual abuse (31 per cent compared to 40 per cent). When analysing these issues it is important to remember that they are about reported concerns and not what was found during an assessment.

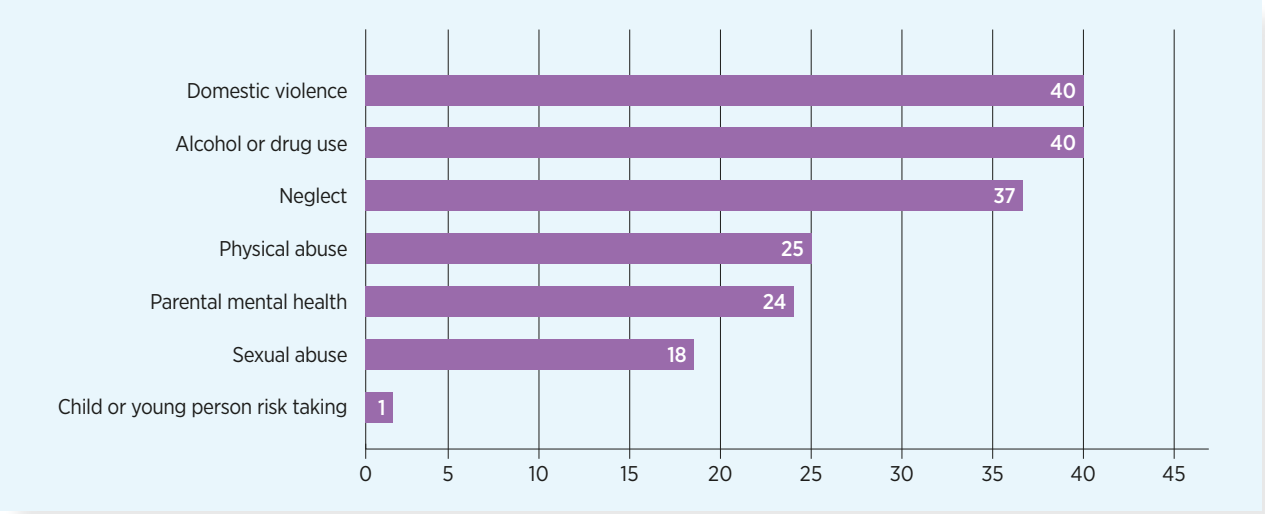
The over-representation of families reported for drug and alcohol misuse and domestic violence in the cohort is consistent with research that reports these issues contribute significantly to poor pregnancy outcomes for vulnerable mothers.[107]

For over half of the infants who died in circumstances related to their prematurity (37 families; 63 per cent), DCJ had received reports about at least one child in the family experiencing neglect before the baby's death. The reports about neglect included:

- Physical neglect (19 families; 32 per cent)
- Supervisory neglect (18 families; 31 per cent)
- Medical neglect (15 families; 25 per cent)
- Emotional abuse/neglect (13 families; 22 per cent)
- Educational neglect (4 families; 7 per cent)
- One child was reported for a child's own risk-taking behaviour.

The high number of families reported because of concerns about neglect is consistent with the data more broadly and with the data collected on the children known to DCJ who died in 2019. In Chapter 2 of this report, Figure 6 showed that 65 per cent of the 97 children who died in 2019 were reported for neglect concerns. Neglect is often the most common reported risk factor for all children who died and were known to DCJ. This is also consistent with national trends of children who are reported to child protection services across Australia.[108]

Figure 12: Reported ROSH concerns, by number of families



Of particular interest in this cohort, 23 (34 per cent) of the 59 infants were reported to DCJ at ROSH. Twenty-two infants were reported during the pregnancy, offering an opportunity for support during the prenatal period. One baby was first reported after their birth but before their death. These babies were reported to DCJ for the following risk of harm concerns:

- Alcohol and drug use (13 families)
- Mental health (10 families)
- Domestic violence (7 families)
- Neglect (4 families)
- Sexual abuse (1 family)

107 Gibberd et al. (2019).
108 Scott (2014).

Most of these infants were reported only once, but seven were reported between two and four times and one was reported seven times.

Thirty-six babies had never been reported to DCJ at ROSH. Their death was reviewable because a sibling had been reported within the three years before the infant's death.

3.1.10 Case allocation

DCJ was working with the families of 17 (29 per cent) of the 59 infants in the cohort when they died. This information was examined in more detail to understand the support being provided to families.[109]

In addition, there was an open child protection report (and DCJ was working with the families) for 13 (22 per cent) of the 59 infants in the cohort. The reports which led to the allocation raised the following concerns:

- Alcohol and drug use (7 families)
- Domestic violence (5 families)
- Mental health (5 families)
- Neglect (4 families)[110]
- Sexual abuse (2 families)
- Physical abuse (1 family)

Nine of the 59 infants had siblings in out of home care at the time of their death. Of these nine, seven had an order from the Children's Court allocating their care and responsibility to the Minister, with four receiving casework support from DCJ. Three were receiving casework and being supported by a non-government agency. One sibling was in the care and responsibility of a relative and another was in a supported care arrangement.

A further six families had open reports but these were not allocated to a caseworker. For four of these families the decision about allocation had not been made when the infant died. The remaining two families were awaiting an assessment at the time of the infant's death.

Thirty-three families of infants in this cohort had previous casework intervention but the cases were closed before the baby's birth and death.

DCJ CASEWORK PRACTICE

The period leading up to and immediately following the birth of a baby is one of the most vulnerable periods in human development. For this reason, it is crucial that unborn babies who are reported prenatally and their families receive purposeful and timely intervention.

Engaging expectant parents during pregnancy can improve the health outcomes of newborn babies and decrease the likelihood of future harm. The **Prenatal Policy: Responding to Prenatal Reports** was updated in 2020 and outlines the main objectives for DCJ practitioners when responding to prenatal reports at the triage, early intervention and child protection stages.

Prioritising prenatal reports for allocation as early in pregnancy as possible acknowledges the risks that exist for unborn babies and capitalises on a point in life when parents are often most motivated to make changes.

The **Prenatal Policy: Responding to Prenatal Reports** provides practitioners with clear advice regarding what information and circumstances should be considered when triaging prenatal reports.

109 Allocated families were receiving out of home care casework support for siblings of infants in the cohort, and the family of the unborn infant was receiving prenatal casework support, meaning numbers do not add to 17.

110 Two families were reported for emotional neglect and two families for physical neglect.

3.2 Prematurity and child protection issues

This section considers the child protection issues most commonly linked to risk of premature birth, including drug and alcohol use, domestic violence, mental health and neglect. It also highlights learning from reviews of practice with the families of infants who died.

3.2.1 Alcohol and/or drug use

Forty (68 per cent) of the 59 families of infants who died in circumstances of prematurity between 2015 and 2019 had been reported to DCJ because of concerns about a parent's drug and/or alcohol use. Of relevance to the infants in this cohort, concerns about parental drug and alcohol use were identified for 22 families (37 per cent) in the 12 months before the infant's death.

Without further information it is not possible to draw definite links between a mother's drug use and her infant's premature birth and death; however, it is widely known that substance use during the prenatal period is associated with adverse infant outcomes, including low birth weight, preterm birth and death.[111] For this reason, it is critical to understand and assess a mother's substance use during pregnancy.

While the issues relevant to working with all parents are applicable to working with expectant parents, there are some unique challenges to be considered. Pregnancy can be a great catalyst for positive change. It is a time when both expectant mothers and fathers may be more prepared to look at their substance use and take steps to ensure their unborn baby's healthy delivery and ongoing safety. Therefore, it is important that practitioners partner with appropriate support services and use this opportunity to support change.

However, pregnancy can also be a time of fear for expectant parents, especially fear that their baby may be taken from them. This fear can mean that some parents hide their substance use or avoid interactions with DCJ and others who may be trying to support them, causing further isolation. For practitioners, creating an environment that acknowledges this fear and is flexible and caring will help to provide the space for a parent to talk openly about their substance use.

An assessment of an expectant parent's drug use should also consider the possibility of co-occurring mental health problems.

DCJ CASEWORK PRACTICE

Substance use by a parent can impact a baby before birth and has been linked to a higher risk of preterm birth and death. The prenatal period offers a unique opportunity to assess the impact of substance use and link expectant parents with the right support.

Practitioners can use the practice kit **Alcohol and other drugs** (working with expecting and new parents chapter) for advice on supporting expectant parents at this critical time.

111 Wiencrot, Nannini, Manning & Kennelly (2012).

PARTNERING WITH NSW HEALTH

NSW Health Substance Use in Pregnancy and Parenting Service (SUPPS)

Babies are safer when their parents are getting both antenatal care and treatment for alcohol and drug use. When an expectant parent is using substances during pregnancy, it is important that they are connected to the right support to address their substance use and improve the perinatal outcomes for their unborn baby. Expectant parents need DCJ and NSW Health practitioners to work together and plan for how the parent will be supported.

NSW Health Substance Use in Pregnancy and Parenting Service (SUPPS) provides supportive counselling, referrals to other specialist services, advocacy and crisis intervention for expectant mothers who are using substances. SUPPS, available in most health districts, offers intensive clinical and case management to pregnant women who use substances, from the antenatal period up to five years post-delivery. Through these services, key partnerships are formed between maternity, child and family health, child protection and alcohol and other drug services.

The following case study supports learning about how best to support pregnant woman who are using drugs.

Sally and Noah

Noah was reported to DCJ when his mother, Sally, was pregnant. Sally was using ice and cannabis and there were concerns about the impact of this drug use on Noah's health, and Sally's ability to care for him when he was born. Similar concerns had been raised in the past about Sally's other children, Charlie (7 years) and Tom (3 years).

DCJ began working with Sally again when she was pregnant with Noah. Caseworkers learned that Sally had been using drugs since she was a teenager. She had tried several times to stop but found it hard, and her attempts had been unsuccessful. Sally and the children's father, Jack, had recently separated and Sally did not have close family or friends who could help her.

Caseworkers identified that this change in circumstances for Sally posed risks for her and the children and talked to Sally about how her drug use might be harming her unborn baby. While Sally knew that using drugs was not good for her baby and wanted to stop, she was daunted by the prospect of stopping her drug use suddenly. Sally was also worried about going to any long-term rehabilitation program because she needed to be home to look after Charlie and Tom.

Caseworkers concentrated their search for rehabilitation services that would allow Charlie and Tom to go with Sally, knowing that this may be the best way to keep Sally safely connected to a program. These kinds of services were limited and caseworkers did not have any success finding a vacancy that would cater for Sally and her children's needs.

Even though Sally had been open with caseworkers about her drug use and how she struggled with it, caseworkers organised for Sally to attend drug testing, which confirmed what they already knew – that Sally continued to use ice and cannabis. Before any other supports were discussed with Sally, she went into premature labour and Noah was born.

What could DCJ have done differently?

Caseworkers worked well to engage Sally. She was open to support and motivated to make changes to keep her unborn baby and her children safe. Engaging Jack during the pregnancy, despite their separation, would have acknowledged his role as the children's father and enabled him to be included in the assessment and planning for his children's safety. Including Jack could have helped to identify who else in the family could help care for the children while Sally received support, as well as assess Jack's capacity to provide for their care, when needed.

Exploring Sally's drug use with her and acknowledging the difficulty she experienced in stopping or getting control over her use would have allowed practitioners to understand the triggers for her drug use and build on her motivation and the strengths that had already been identified: that she wanted to reduce her drug use and that it was important for her to be available to her children while she did so. Working closely with a local drug and alcohol service, for example, NSW Health Substance Use in Pregnancy and Parenting Service (SUPPS), would have enabled support for Sally to address both the immediate risk of her drug use on her unborn baby, while planning for longer term support.

Talking with Sally about her life experiences may have helped DCJ to understand how adverse experiences such as abuse as a child, domestic violence or mental health contributed to her dependency. This would have enabled caseworkers to holistically assess any future risks to the children and make a plan with Sally and Jack about how those risks could be minimised and addressed over time.

3.2.2 Domestic violence

The families of 40 infants (68 per cent) had been reported because of concerns about domestic violence. Twenty-seven infants or their siblings were reported because of worries about domestic violence in the 12 months before the infant's death. For three infants, reported information included that the mother's partner or ex-partner had assaulted her while she was pregnant. While DCJ does not hold information that suggests domestic violence caused the preterm births and deaths, the risks during pregnancy are clear. Women are at an increased risk of domestic violence during pregnancy, and for women already experiencing violence it is likely to become more severe. This is especially true for women aged up to 24 years.[112] Research also highlights that domestic violence during pregnancy increases the chance of a baby being born prematurely.[113] Women who experience violence during their pregnancy are also at an increased risk of postnatal depression, which can impact on the bond between a mother and her baby.[114]

While fathers who use violence may not have contact with health professionals, it is imperative they are included in the child protection assessment and provided support to change their behaviour. Practitioners should acknowledge fatherhood roles while also holding men accountable for their behaviour. Men often do not connect that their violence towards their partner impacts on their child. It is possible that they will need support to understand how their violence affects their unborn baby.

Understanding the impact domestic violence can have on a mother's ability to care for and bond with her child is fundamental in child protection work. Extending this understanding to consider how domestic violence affects a mother and unborn baby is crucial to good prenatal casework. When domestic violence is suspected, pregnancy is an opportunity for intervention and support as women are likely to have regular contact with health professionals. It is also important to understand that coercive control

112 AIFS (2015).
113 Shah & Shah (2010).
114 AIFS (2015).

tactics used by partners may prevent some pregnant women from accessing antenatal care. Practitioners should look for ways pregnant mothers may be actively resisting violence and use pregnancy as an opportunity to build on these acts of resistance to increase safety.

DCJ CASEWORK PRACTICE

Practitioners can use the **Domestic and family violence** practice kit for further advice on understanding, assessing and supporting families experiencing domestic violence during the prenatal period.

PARTNERING WITH NSW HEALTH

Domestic Violence Routine Screening (DVRS) Program

Since 2004, NSW Health has been undertaking Domestic Violence Routine Screening (DVRS) for women accessing maternity, child and family health services, and for women 16 years and over, accessing mental health or alcohol and other drug services. DVRS provides a critical opportunity to women to talk about their experiences of domestic violence and be supported to access appropriate services.

3.2.3 Mental health

Perinatal mental health and the psychological wellbeing of pregnant women and their babies has been recognised as important in the literature. Pre-existing poor mental health in women has been identified as an independent risk factor for adverse birth outcomes such as low birth weight and prematurity.[115] There is also evidence that women are vulnerable to the recurrence or emergence of mental health problems during the perinatal period.[116]

Furthermore, research has highlighted that pregnant women with co-occurring substance use and mental health problems are at increased risk of poor birth outcomes.[117]

There were 24 families (41 per cent) of infants in the cohort who were reported due to concerns about a parent's mental health. For 17 families, worries about mental health were reported within 12 months of the infant's death.

A person's mental health can improve when they feel connected and empowered, and have hope about the future. Instilling hope is a tool for engagement and a catalyst for change.

For prenatal assessments, practitioners need to assess a parent's mental health and have an understanding of how it affects an unborn baby and co-exists with other risk factors, such as alcohol and drug use. Several reviews about infants in this cohort identified the need for assessments to be holistic and seek information from a variety of sources that had been tested for accuracy, and captured the family's history to understand what was happening for an unborn baby or child. When assessing a parent's mental health, strong collaborative relationships with inter-agency partners are essential to inform quality assessments. These partnerships should focus on understanding how a parent's mental health affects their parenting and develop plans to support recovery.

115 Witt, Wisk, Cheng, Hampton & Hagen (2012).
116 Glover (2014).
117 Zhao, McCauley & Sheeran (2017).

DCJ CASEWORK PRACTICE

Practitioners can use the **Mental health** practice kit in Casework Practice for further advice on understanding, assessing and supporting parents with mental health problems during the prenatal period.

PARTNERING WITH NSW HEALTH

Safe Start and referral pathways

Emotional and psychological screening is included as a mandatory part of perinatal care for pregnant women (the SAFE START program). This ensures the early identification of family, social and mental health vulnerabilities during the pregnancy and early postnatal period. When vulnerabilities are identified, options for support are discussed with and offered to the family. SAFE START meetings provide a forum for multidisciplinary case discussions and a platform for appropriate mental health referrals, including to the NSW Health Perinatal and Infant Mental Health Service (PIMHS), if available in that area.

Expectant parents need DCJ and NSW Health practitioners to develop strong inter-agency relationships and partner in supporting an expectant parent with their mental health issues. Information sharing and clear communication is key to an effective partnership. A clear plan to support an expectant parent's mental health should be jointly developed so that everyone knows how this will be achieved.

3.2.4 Neglect

Neglect is one of the most common forms of child maltreatment but it is also one of the most challenging to assess and address.[118] It is more likely to be overlooked than other forms of maltreatment because each episode may not appear to reflect high risk.[119] However, neglect rarely occurs in isolation and is strongly linked to other forms of maltreatment, for example, alcohol and drug use, domestic violence and poor mental health.

This cohort review found that 37 infants and their families (63 per cent) had been reported as being at risk of neglect. These reports covered all of the neglect categories: physical, supervisory, medical, emotional and educational.

When considering neglect, it is important to acknowledge the context of poverty. While poverty may not directly cause neglect, there are many families known to DCJ who experience poverty. This is likely to be associated with higher levels of parent stress, inadequate housing, lack of access to basic needs, low socioeconomic status, young maternal age and low levels of educational achievement – all of which are associated with neglect.[120] Studies have also identified that a mother's experience of domestic violence and history of abuse or neglect in her own childhood is a strong predictor for neglect in parenting.[121] For practitioners, assessments in the prenatal period should consider neglect alongside other risk factors and recognise that neglect cannot be addressed without considering the underlying cause.

A mother's perceived unwillingness to access prenatal services can often be judged as a form of medical neglect. Understanding the underlying issues that prevent her from accessing services is essential. The key to understanding context is the quality of the practitioner's relationship with a parent. This is achieved

118 Scott (2014).
119 NSW Department of Community Services (2006).
120 Scott (2014).
121 Dafour, Levergne, Larrivee & Trocme (2008).

through empathy, openness and trust, which allows parents to share intimate aspects of their lives. Women are at increased risk of domestic violence during pregnancy and restricting a women's access to prenatal services is one form of power and control. Other barriers to mothers accessing services could be the fear of losing custody of her baby, transport, homelessness and transience.[122]

The following case study is included to highlight common risk factors identified in prenatal casework.

Courtney, Daniel and Ruby

When Courtney was pregnant with her second child, Ruby, she went to hospital because she had sharp pains in her stomach and she was worried about her unborn baby. Courtney told medical staff that her partner, Daniel, had been violent. She also said that two years ago her first child, Jacob, had been taken by DCJ soon after he was born because of worries about the impact Courtney's mental health was having on her parenting. Courtney talked about her mental health and that she struggled to get out of bed most days.

After she was discharged, caseworkers visited Courtney and Daniel at their home. They talked about Daniel's violence. Caseworkers explained the ways violence can harm children, including unborn babies. Courtney said that Daniel was not violent and had been really supportive, especially since she was experiencing depression. She said when she was a child, her father used violence and that she was sexually abused by a cousin. Courtney said that she tried to forget about these times by staying in bed and sleeping a lot.

Caseworkers suggested Courtney visit her GP for a mental health assessment. When they visited again a week later and Courtney said she had missed her appointment because she slept in.

In the weeks that followed, caseworkers visited Courtney and Daniel regularly. They helped them to prepare for the birth of their baby by ensuring they had the practical things they needed like a cot, clothes and nappies. Courtney said Daniel had been helping her feel better in her mental health and she was no longer oversleeping or choosing to stay in bed.

When she was 27 weeks pregnant, Courtney went into labour and Ruby was born. Sadly, she died from health complications at five days old.

What could DCJ have done differently?

Creating opportunities for Courtney to talk with caseworkers without Daniel would have allowed her to share her experiences of Daniel's violence, the ways she resisted it, and how it impacted her mental health, without further compromising her safety. A strong partnership with NSW Health would have provided an opportunity for practitioners to meet with Courtney away from Daniel. This partnership would also have allowed practitioners to link Courtney with mental health support, for example, through the Perinatal Infant Mental Health Service (PIMHS) so that she had opportunities to talk about her past experiences of abuse, how these might have been impacting her now, and what she needed to support her mental health once Ruby was born.

Talking separately with Daniel, exploring his awareness about how his violence impacted on his family, including his unborn baby, and encouraging him to take responsibility for his behaviour, could have helped him to realise the impact of his actions. This would have allowed caseworkers to support Daniel to consider whether his violence aligned with the kind of father he wanted to be and plan for how he could be supported to change his behaviour.

122 Flaherty (2016).

3.3 Child protection responses

A holistic child protection response to prenatal reports is crucial. It allows practitioners to support expectant parents to reduce risks to their unborn baby while building their skills and networks to prepare them to keep their baby safe once born.

While pregnancy can be a time of fear for many parents, it can also be a powerful motivator for parents to make behavioural change. To make these changes, parents need the right support. This begins with building on support that already exists so that expectant parents feel positive during the prenatal period and intervention is purposeful and effective.

DCJ CASEWORK PRACTICE

The **Prenatal Policy** and **Assessing and case planning with expectant parents (prenatal)** practice mandate are useful resources that provide guidance for practitioners working with expectant parents.

3.3.1 DCJ prenatal caseworkers

There are designated prenatal caseworkers in each district across DCJ. Their role is consistent: to support expectant parents to reduce risk during pregnancy and build safety for the baby once born.

While this role can be challenging, particularly when prenatal reports are allocated late in a mother's pregnancy or if a family's previous experiences of DCJ have led to their children entering care, the following benefits have also been reported:

- The prenatal caseworker can attend specific training about risk issues that are prominent in prenatal reports and be best positioned to support expectant parents
- The prenatal caseworker can build strong relationships with NSW Health staff and professionals from other antenatal services, which assist in information exchange and collaborative intervention.

3.3.2 Pregnancy Family Conferencing

The Pregnancy Family Conferencing program is a collaborative model of care between DCJ and NSW Health, aimed at promoting early engagement and inter-agency planning with expectant parents. Some local health districts, including Central Coast, Sydney and Western Sydney, offer this. The program is voluntary and aims to support expectant parents and their families as early as possible to develop clear, coordinated plans that increase the likelihood of babies being able to remain safely in the care of their parents once born.

No infants in this cohort review were referred to Pregnancy Family Conferencing.

HOW IS PREGNANCY FAMILY CONFERENCING BEING USED ACROSS DCJ?

DCJ practitioners across NSW report that Pregnancy Family Conferencing helps to promote family-led planning during pregnancy and build strong relationships with NSW Health and other relevant antenatal services.

The Pregnancy Conferencing annual report indicates that in 2018 and 2019, 96 per cent of infants born to families referred to Pregnancy Family Conferencing remained in their parents' care following birth. Of the Aboriginal families referred, 100 per cent of the infants remained in their parents' care.

While Pregnancy Family Conferencing is not available in all local health districts, practitioners can use Family Group Conferencing as an alternative.

continued over...

Did you know?

In 2019, DCJ and Sydney Local Health District secured funding for a 12-month pilot program to employ four parents who had previously participated in Pregnancy Family Conferencing to act as 'Parent Supporters'. The program acknowledges that many expectant parents feel nervous or fearful when participating in Pregnancy Family Conferencing. The aim of the 'Parent Supporters' is to reduce this fear by linking expectant parents and their families with someone who has gone through the process before.

Mothers reported at Risk of Significant Harm (ROSH) with unborn children continue to be referred to the PFC program, with 11 active referrals underway this financial year. Annual reports have been prepared in 2018 and 2019 which have documented the program's success at supporting mothers with high risk birth alerts to keep their babies, following birth. The decision has been made not to prepare an annual report for 2020 given the successful outcomes previously identified. The program has not been independently evaluated.

As the Parent Supporters element of the program has only recently commenced and the sample of mothers who have been exposed to the initiative is still low. The research evaluation has not been concluded at this point. Research exploring the impact of the initiative is scheduled for completion in 2021.

3.3.3 High risk birth alerts

The *Children and Young Persons (Care and Protection) Act 1998* allows DCJ to provide information to NSW Health and other prescribed bodies about an unborn child who has been the subject of a prenatal report. This information can be recorded as a High Risk Birth Alert, which is shared to allow NSW Health workers to make a report to the Helpline when the risk issues identified in the prenatal report remain unaddressed once the baby is born.

Of the 59 infants in the cohort, a High Risk Birth Alert had been created for two before their birth. Both infants had been reported because of concerns about alcohol and drug use and mental health; one had been reported because of domestic violence. Both infants had siblings living in out of home care and both had open but unallocated reports with DCJ.

DCJ CASEWORK PRACTICE

It is important for practitioners to have a comprehensive and holistic understanding of a family's circumstances when considering whether to issue a High Risk Birth Alert. This can help ensure that any reluctance or fears are spoken about and understood.

Practitioners can gain an understanding of an expectant parent's circumstances by identifying barriers that may make engaging in support and intervention more difficult, such as geographical location, access to culturally safe services, and previous experiences and social responses from DCJ or other services.

Practitioners can find further information about High Risk Birth Alerts and how they can be used in prenatal casework in the practice mandate **Assessing and case planning with expectant parents (prenatal)**.

3.3.4 Working with fathers

While interventions during the prenatal period are heavily focused on women, assessments must include fathers and support must also address a father's behaviour to reduce risk of harm to their unborn baby, during the pregnancy and beyond. This chapter has already highlighted the importance of engaging fathers who use violence because of the very real risk this poses to their unborn baby, but other risk issues should not be ignored.

Practitioners should actively and purposefully engage expectant fathers in prenatal assessments and casework and make targeted plans to support them and their parenting skills. It is important that practitioners challenge myths that fathers do not want to be an involved parent and hold fathers to the same standard as mothers by including them in visits, assessments, safety plans and case plans. Where violence by the father is identified as a danger or risk, casework should focus on increasing a father's awareness of how his behaviour impacts on his family, including his unborn baby, and encourage sustained behaviour change that affirms his contribution to providing a loving, safe home.

DCJ CASEWORK PRACTICE

Fathers have an integral role to play in their family and can help a child develop their sense of self, cultural identity and connections in the community.

Practitioners can refer to **Working with fathers to keep children safe** for more advice on including fathers in assessments and casework.

3.3.5 Working with Aboriginal families

Practitioners must seek to understand and address the disproportionate number of Aboriginal children in the child protection system. This cohort review highlights that, tragically, unborn babies are no exception.

Government policies that were unjust stripped Aboriginal people of their rights. This injustice continues to have a devastating impact on Aboriginal families and communities. When working with Aboriginal families, especially during the prenatal period, the legacy of past policies will be present in every interaction. Many Aboriginal families may be fearful of DCJ and other government services. Casework must acknowledge this injustice, recognise the impact on Aboriginal families and intentionally harness the inherent strength and resilience in communities so that Aboriginal children can remain safely at home. Practitioners should work in partnership with Aboriginal families and communities, fostering self-determination so that Aboriginal children are safe, connected and able to experience their culture within their family.

DCJ CASEWORK PRACTICE

The **Prenatal Policy: Responding to Prenatal Reports** provides advice about working with Aboriginal families during pregnancy.

Cultural practice with Aboriginal communities also provides practice advice for understanding a family's culture, values and beliefs to ensure practice is responsive and tailored to a child and family's needs.

PARTNERING WITH NSW HEALTH

Aboriginal Maternal and Infant Health Service

The Aboriginal Maternal and Infant Health Service (AMIHS) is a NSW Health program to improve the health of Aboriginal women during pregnancy and decrease perinatal morbidity and mortality for Aboriginal babies.

The service is delivered through a continuity-of-care model where midwives and Aboriginal Health Workers collaborate to provide a high quality maternity service that is culturally safe, women-centred, based on primary healthcare principles and provided in partnership with Aboriginal people. AMIHS acknowledges and builds on the awareness, knowledge and understanding of Aboriginal families and communities about pregnancy and child health and the relationship to lifelong health.

There are over 40 AMIHS sites in NSW, delivering services to mothers of Aboriginal babies in over 80 locations.

AMIHS midwives and Aboriginal Health Workers provide antenatal and postnatal care, from as early as possible after conception up to eight weeks after birth.

3.3.6 Working with young parents

The risk of premature birth is increased for young mothers.[123] Children living in young parent families can be particularly vulnerable when the family is living with disadvantage, there are intergenerational risks, parents have a child protection history or there are poor family and professional networks. This vulnerability begins in the prenatal period. When working with young parents, practitioners must balance the support needs of young parents, who are often children themselves, with the care and protection needs of their unborn babies and children.[124]

Teenagers are still developing physically, cognitively and emotionally at a time when they also need to learn about the responsibilities and skills required to be a parent. Risk-taking is an expected part of a young person's development but this can be worrying when a young parent must also focus on the safety, welfare and wellbeing of their child. Adapting practice to understand and meet the needs of young parents is important to reduce the risk to their unborn baby.

The social response a practitioner provides a young parent sets the tone for engagement and helps to shape a more positive transition to parenthood. Practitioners can achieve this by being honest, transparent and patient; including young parents in decision-making; and building on the parents' strengths. This helps young parents to feel valued and develops trust. Practitioners should develop a relationship with young parents that:

- allows them to share their motivations, goals and aspirations for their unborn baby
- seeks to understand both young parents' developmental stage, their childhood experiences and how this impacts their parenting capacity
- acknowledges the social stigma attached to being a teenage parent, and then make referrals to prenatal services that are non-judgmental and understand the realities of young parenthood.[125]

This will allow practitioners to develop prenatal interventions with young parents that are tailored to their developmental capacity and linked to their goals and aspirations for their child. When the right balance is achieved, it can be the catalyst for growth and positive life outcomes.

123 AIHW (2019).
124 Price-Robertson (2010).
125 ibid.

DCJ CASEWORK PRACTICE

The practice advice topic Assessing and case planning with expectant parents (prenatal) includes a chapter on supporting a pregnant child or young person in out of home care.

3.3.7 Asha's story: Learning from DCJ prenatal practice

Asha's story is inspired by a true example of prenatal casework. It is included to demonstrate quality casework with expectant parents. The casework support provided to Asha's family was skilful, reflective and responsive. The DCJ caseworker showed the power of a response attuned to the needs of the family. Reflections and practice prompts are included to enable practitioners to incorporate this into their own practice. The names of family members and staff have been changed.

Asha's Story

Asha was first reported to DCJ when her mother, Tegan, was 29 weeks pregnant. Until then, Tegan and her partner, Kyle, had been avoiding antenatal appointments because they were afraid DCJ would find out about the pregnancy and take Asha away from them. Both Tegan and Kyle had had children taken into care by DCJ in the past. Kyle's children were taken five years earlier because his drug use meant their needs were not being met, and Tegan's daughter had been taken two years earlier because her drug use and poor mental health impacted on the care she provided. At the first antenatal appointment, Tegan was incoherent and said she had been hearing voices.

When Kate (DCJ caseworker) first met Tegan and Kyle she knew they were worried that their baby would be taken from them. She explained her role as a prenatal caseworker and was clear about what was needed for Asha's safety. Kate told Tegan and Kyle she would work with them to try to keep Asha safely in their care and invited them to talk about their previous experiences with DCJ caseworkers.

Tegan talked about the changes she had made since her daughter had been taken. She said she no longer used drugs and until recently had been feeling well in her mental health. Tegan said she had been hearing voices again and thought this was probably because she was worried about her baby. Kyle said he had been in jail for drug-related offences. He said he still used drugs most days – cannabis and ice – and did not know how he would cope if he stopped.

REFLECTIONS

Children need practitioners to approach their work with families with the belief that change is possible. This starts from the very first meeting with a family.

Kate recognised that her relationship with Tegan and Kyle could influence positive change that would allow Asha to be raised in safety. She engaged in an honest and respectful conversation with them from this first meeting. It was important that Kate explored the previous social responses Tegan and Kyle had experienced and communicated that she believed that they were capable of caring for their baby safely. This was the beginning of a positive social response and meaningful relationship that lay the foundation for collaborative, relationship-based practice.

PRACTICE PROMPT

First impressions are important. Be intentional about the way the family is initially approached. This sets the tone for future interactions.

Casework practice: to learn more about social responses and dignity driven practice with children and families see the practice advice topic **Dignity driven practice**.

Kate talked to the casework specialist in her office about the meeting. They talked about the worries that led to Tegan and Kyle's children being in care and the casework specialist helped Kate prepare to talk further with Tegan and Kyle by practicing motivational interviewing techniques. They also discussed ways to learn more about Tegan and Kyle's drug use and Tegan's mental health. Rather than drug testing, the casework specialist suggested Kate engage Tegan and Kyle in a conversation about their drug use to understand their triggers, the times when they did not use and their children's experiences of their drug use. To understand Tegan's mental health, they developed a plan to talk to Tegan about her experiences of poor mental health, how this related to her drug use, and what it meant for her parenting.

REFLECTIONS

Harnessing the expertise in colleagues helps practitioners draw on specialist knowledge and experience and apply tools skillfully so that casework is purposeful and effective.

By seeking consultation with the casework specialist, Kate was able to use the expertise of her colleague to critically reflect on her meeting with Tegan and Kyle and guide her practice with the family. Practicing her skills before meeting with Tegan and Kyle again meant that Kate was confident and competent in her practice approach with the family. This ensured that she was at her best to help the family create safety for Asha.

PRACTICE PROMPT

Casework specialists support quality practice and building practitioner skills through consultations and coaching.

Casework practice: use the **Getting help with your practice** support page for more information about how casework specialists can support practice.

Tegan and Kyle are Maori. Kate consulted with a multicultural caseworker who helped her understand the Maori practice of shared child rearing and the strong role of women in Maori families. With this in mind, Kate contacted Asha's two grandmothers, Gail and Sue. Kate told them she knew the best place for Asha was with family but that Tegan and Kyle needed help to be able to safely care for her. A Family Group Conference was planned and Gail and Sue agreed to make sure the family attended.

A week later, 12 relatives attended a Family Group Conference. Kyle opened the meeting with the Karakia Timatanga – a traditional Maori prayer. Kate was open with the family about her lack of cultural knowledge and encouraged the family to tell her if she needed to do things differently. Kate was also clear about her worries for Asha.

REFLECTIONS

When practitioners seek to understand a family's values and beliefs, practice will be more responsive and tailored to the child and family's needs.

Kate knew that understanding Asha's family in their cultural context was important to achieving safety for Asha. Kate sought consultation and applied what she had learnt to her practice so that casework and decision-making was in Asha's best interests.

PRACTICE PROMPT

Take the time at the beginning of your work with a family to seek cultural advice. This early understanding will reduce the risk of culturally inappropriate approaches harming your progress with the family.

Casework practice: for guidance, see the practice advice topic **Culturally responsive practice with diverse communities**.

The family worked together to develop a plan so that Tegan and Kyle would have ongoing support. Tegan said that although she had not used drugs for three months, she would need help so that she did not relapse. Kyle also agreed that he needed help to stop using drugs but did not know where to start. On the same day, Kate sat with Tegan and Kyle while they called the NSW Health social worker to find out more about how to get help. After hearing their circumstances, the social worker talked about the support available in their local area. Tegan chose to be referred to the Perinatal and Infant Mental Health Service (PIMHS) and Substance Use in Pregnancy and Parenting Service (SUPPS); Kyle decided to seek support through the local drug and alcohol counselling service.

Kate consulted with her team through group supervision. The group identified the family's strengths but also worried that there were serious risks given both Tegan and Kyle had had children taken in the past; Kyle was still using drugs and Tegan had only recently stopped. It was agreed that the best place for Asha was at home with her parents and that they needed support so they could safely care for their daughter.

REFLECTIONS

Children need practitioners to be curious, creative and reflective so that the work they do is ethical, thoughtful and in children's best interests.

Group supervision was a useful way for Kate to consult with her team, share risk and develop practice. Through shared decision-making Kate and her team were able to balance the strengths and risks while keeping focused on Asha's safety and ensuring they made the right decision for her.

PRACTICE PROMPT

Use group supervision to intentionally consider the strengths in a family so they become the foundation of the support provided to help them grow, develop and make change.

Casework practice: for further advice and guidance see the **Group supervision leadership resource**.

At 36 weeks pregnant, Tegan and Kyle met with Kate and others from the services supporting them. The group came together to develop a birth plan. Everyone agreed that Tegan was making positive progress. Tegan's PIMHS worker told the group that although she missed the first two appointments, she was now engaged in improving her mental health. Tegan's SUPPS worker said Tegan had been very open about her past drug use, had attended all appointments and was being supported to remain drug free. Kyle's drug and alcohol worker said that Kyle was due to attend his first appointment in two weeks. It was agreed that rather than Kate visiting the hospital, she would visit the family at home to assess Asha's safety once she was born. Since the plan was jointly developed, a High Risk Birth Alert was not needed.

REFLECTIONS

Strong collaborative relationships with inter-agency partners sets a working alliance with the family and creates a team of effective support.

Kate's partnership with NSW Health colleagues built trust and shared responsibility. Bringing together those supporting Tegan and Kyle helped to develop a shared understanding of the family's circumstances, a support network with a shared vision and more informed decision-making about how to ensure Asha would be safe once born.

PRACTICE PROMPT

Consider agency partners not just as points of referral, but also as valuable sources of consultation. Intentionally connect with inter-agency partners to build a network of local professionals for information, advice and to offer a different perspective.

Casework practice: for further advice on building purposeful inter-agency partnerships see the **Collaboration** practice advice topic.

As promised, once Asha was at home, Kate visited the family. Asha was cherished by her parents and her extended family from the moment she was born. This was evident in the interactions with the family, regular feedback from the services supporting them and in the assessments that showed that the risk for Asha had reduced.

Kate visited the family weekly, then fortnightly until Asha was five months old. Mental health and drug and alcohol support services also worked with Tegan and Kyle. During one of Kate's visits, Tegan said she knew she was doing well in her recovery because whenever she felt stressed or overwhelmed, she no longer thought about using drugs. Instead, she would go to her mum or call her aunty for help. Tegan and Kyle continued to be supported by their family. Kate was satisfied they had sustained the changes and DCJ closed the case.

LEARNING FROM ASHA'S STORY

Kate believed that Tegan and Kyle were capable of change that would allow them to safely care for Asha once she was born and was intentional about letting Tegan and Kyle know this to empower and motivate change. While holding hope, Kate also recognised the risk. She sought to understand this risk and its impact on Asha through skillful conversations with Tegan and Kyle and through group supervision. To create safety, Kate brought together a network of support to ensure Tegan and Kyle had the right people around them as they worked towards change.

WORKING WITH EXPECTANT PARENTS

For practitioners working with expectant parents, consider have I / have we:

- Acted like I believe in the possibility of change?
- Harnessed the expertise of others by consulting with DCJ colleagues such as casework specialists, permanency coordinators and psychologists?
- Sought to understand how a family's connection or resistance to services and other professionals has been shaped by social responses?
- Proactively participated in group supervision to partner and share risk?
- Included everyone that needs to be involved?
- Engaged proactively in strategies to enhance the knowledge and skills I need to do my job well?

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

Across 2019 and 2020, the NSW Government continued to implement vital reforms to the child protection and out of home care system in NSW. The work of DCJ in this sector has been informed especially by the redeveloped NSW Practice Framework[126] (launched September 2017), the Stronger Communities Investment Unit (previously called Their Futures Matter, launched November 2016)[127] and the Permanency Support Program (launched October 2017).

The NSW Practice Framework, Stronger Communities Investment Unit and the Permanency Support Program have been essential in guiding the department's approach and practice with vulnerable children and families. These strategies together promote a smart, connected system that provides evidence-based and needs-based supports to create meaningful relationships that sustain change and improve life outcomes. In 2020, the new Caseworker Development Program was implemented, refining the DCJ approach to training new child protection caseworkers. This will lead to a more skilled and confident workforce who can make decisions to improve safety and outcomes for children and their families.

Every child deserves to experience safety, permanency, and a home where they can develop strong relationships and a sense of belonging for the best start in life. The NSW Government continues to provide vital services and additional frontline workers to support the most vulnerable members of our communities.

NSW State Budget

The Stronger Communities Cluster delivers community services that support a safe and just NSW. It aims to support safer, stronger communities through the protection of children and families; build resilience to natural disasters and emergencies; promote public safety; break the cycle of reoffending; and promote physical activity and participation in organised sport, active recreation and sporting events.

In 2019–2020, specific state budget expenditure relevant to DCJ protecting children and families included:

- $30 million to help support the health and wellbeing of vulnerable children with complex needs in out of home care
- $16.8 million to support the delivery of child protection services through the continuation of funding for 45 Child Protection Helpline workers and 66 case support workers
- $5.6 million to reduce domestic and family violence reoffending and support victim safety through the continuation of Men's Behaviour Change programs in NSW.

Due to the COVID-19 pandemic, the NSW budget process was deferred and specific information was not available at the time of publication for the 2020–2021 financial year.

4.1 Departmental practice change in response to recommendations made in child death reviews

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

1. **Individual recommendations:** When reviews identify concerns for the siblings of children who have died, recommendations are made that address identified safety and risk concerns.
2. **CSC and district recommendations:** Some reviews make recommendations about learning and development needs of CSCs and districts.
3. **Systemic and state-wide practice recommendations:** A number of reviews are considered by the Serious Case Review Panel (SCR Panel). These reviews are chosen for the Panel because their findings reflect broad practice and systemic themes. Panel recommendations are considered in the context of broader responsibilities and DCJ's reform agenda.

126 NSW FACS (2017b).
127 NSW Government (2016).

4.1.1 Recommendations to improve practice

The information below summarises key practice reforms and changes arising from child death reviews completed in 2019.

Sharing reviews to assist current casework

A recommendation 'to provide the review to staff at the relevant CSC to consider the practice issues raised and inform current work with the family' is often made. Each child death review contains a chronological overview of reports that have been received and DCJ responses. This overview is about not only the child who died, but their siblings, and parents if relevant. This summary and any commentary by the review team can be useful to caseworkers who work with a family after a child has died.

New ChildStory Alert

In June 2020, a new alert was created in ChildStory for serious case reviews, critical incidents and child death reviews. Such alerts can only be created by staff from the Serious Case Review Unit but will be seen by all staff. They are added to the record of the child who died, but link to all existing relationships and any future children of the deceased child's parents. The alert indicates that a case review has been done and who to contact for more information.

Ongoing casework with siblings

Many of the reviews in 2019 contained recommendations focused on the siblings of the child who died. These recommendations included:

- Reassessment of children's permanency goals including care arrangements, contact with parents and siblings and assessment of possible restoration to parents
- That cases be allocated at a CSC for a face to face assessment
- That casework specialist support be used to complete risk assessment or review case planning
- Identifying that children had not been directly involved in decisions about them and development of their case plans, and recommending that visits happen more regularly and new case plans be developed
- Requesting a paediatric and psychological assessment for siblings to inform development of a tailored treatment plan
- Asking a district to share information with external agencies and non-government partners to inform their ongoing work with a family
- Using Family Finding[128] to build a child's support network and connect them with their Aboriginal culture and community.

Group supervision to facilitate learning and strengthen decision-making

Several reviews recommended the use of group supervision to enhance learning. The purpose of recommending group supervision was often to enable reflection on the commentary and practice analysis in a review, but some specified a focus for group supervision, such as:

- Reflecting on the impact that allocation to a caseworker and engagement would have had for a child and their family
- Involving specific groups of practitioners such as those involved in weekly allocation meeting decision-making, or across CSCs and practice units
- Inviting external services also involved with a family to participate in a case discussion about how to strengthen collaboration to improve future outcomes
- Considering how to better work with parents with intellectual disability.

128 Family Finding is a model developed by Kevin Campbell in the US. The model seeks to connect children with family and other supportive adults who will love and care for them now and throughout their life.

Sharing lessons learned

Several child death reviews were not taken to the SCR Panel but identified insights and lessons to be shared with areas of DCJ or other external agencies working with families. These recommendations included:

- Sharing reviews that contained lessons to be considered when DCJ practice mandates or practice advice topics are being updated
- Sharing a review that contained lessons about staff obligations as mandatory reporters with another government agency
- Sharing commentary about the need to consider a family's grief when managing other issues that the department is responsible for and how these competing demands can be balanced.

Decision-making and policy application

Other key themes for recommendations about improving practice included:

- For the leadership team at a CSC to develop clear processes around the induction of new staff and consider how cases are reallocated between staff
- Holding refresher training in Structured Decision Making tools and decision-making about case closure decisions
- Asking the Child Protection Helpline to re-screen reports and consider the practice issues highlighted in a review, whether all information was considered and if the screening criteria and response priority tools had been correctly applied
- Identifying policy and practice where language needs to be updated to reflect contemporary practice advice and the Practice Framework.

ChildStory

Child death reviews in 2019 included many recommendations about correcting records in ChildStory. For example, records about a person's date of birth, cultural identity and relationship links, along with improving other information. These recommendations are important and contribute to any future involvement DCJ has with a family, to understand and know them.

4.1.2 Recommendations by the Serious Case Review Panel

The information below summarises the key practice reforms and changes arising from the SCR Panel in 2019.

Objectives and membership

In 2019, the Panel discussed and revisited the SCR Panel objectives and membership. As an outcome of this discussion, the terms of reference were amended to strengthen the emphasis on practice improvement, membership was broadened to include representatives from other areas of DCJ including Youth Justice and Housing and it was agreed that updates from the SCR Panel would be provided to the Operations Executive and the DCJ Executive Board.

End of life planning

To continue the work started in 2018 by the SCR Panel about end of life planning, in 2019 the Panel considered a review about a girl who died from a known degenerative disease. As a result, a new end of life planning mandate was published on 8 May 2020. The mandate includes clear guidelines for DCJ to complete end of life planning before transferring case management to a non-government agency, and that the child or young person must be included in this process.

The findings from this review are also being used by DCJ to inform contract and program management with agencies providing out of home care.

Assessment of physical injuries

A review about a child who died from non-accidental injuries highlighted a common theme of caseworkers prioritising the opinions and advice of health professionals above their own child protection expertise when assessing the safety of children reported with physical injuries. In the case considered, this impacted on decision-making. As a result, a training package focused on assessing physical injuries was developed by the OSP and delivered through group supervision sessions to caseworkers and managers between January and March 2020.

Leadership

Several reviews considered by the SCR Panel highlighted the critical role of leadership in safeguarding child protection practice. In response, the Panel agreed that the OSP should prepare a discussion paper considering leadership in child protection practice. The DCJ Executive Board endorsed this recommendation and the Secretary has since approved the OSP's proposal for a leadership model, aligned to the Practice Framework, and focused on management and practice leadership skill development. The new leadership program is expected to start in early 2021.

The Director Child Safety and Review has facilitated group supervision sessions during the Director Community Services Operations Forums.[129] The discussions have focused on promoting leadership to enable staff to respond with urgency and appropriately challenge decisions that do not appear to be in a child's best interests.

In 2020-2021 all Directors Community Services and Executive District Directors with a role in child protection will undertake the *Leading Assessment Capability* program. The program is a professional development opportunity for Community Services executive leadership during which participants will deepen their knowledge and understanding of child protection assessment tools, processes, and skills. Executive leaders undertaking *Leading Assessment Capability* will complete the program with a baseline knowledge of DCJ assessment frameworks, a clear picture of what makes a quality assessment, and an understanding of their role in safeguarding quality assessment practice. As part of the program, executive leaders will be required to develop a plan for influencing change or safeguarding practice to improve assessment capability in the teams they lead.

Sharing learning to promote child safety

A number of reviews considered by the SCR Panel were referred to internal DCJ units and external agencies to inform program design.

When appropriate, reviews have also been shared with non-government partners that provide case management to children in out of home care.

Modifications to systems and tools used in decision-making

One review identified a systems error in ChildStory – when a ROSH report was referred by the Helpline and diverted to the wrong CSC. ChildStory was subsequently modified in June 2020 to allow any manager to change the location of a ROSH report immediately, to enable rapid response by the closest CSC.

The Panel considered two reviews in 2019 that contained examples of errors made by casework staff when using the Screening Criteria Response Priority Tool (SCRPT). The Panel agreed that further consideration of SCRPT is needed to determine whether errors are occurring because of how the tool is used or whether the tool needs to be modified.

The issues noted in these case reviews will be included in a strategic review of the SCRPT assessment and other Structured Decision Making tools (to be scoped in late 2020).

129 These have also included directors from Housing.

4.2 NSW Practice Framework: Implementation and progress

4.2.1 Overview of the Framework

Launched in September 2017, the redeveloped NSW DCJ Practice Framework (the Framework) seeks to improve the quality of child protection practice in NSW – to provide consistency, shared identity and direction on the basics of good child protection practice and the systems that support this.

The Framework brings together practice approaches, reforms and priorities to guide DCJ child protection work. United by principles, language and standards, the Framework puts children and families at the forefront and holds everyone at DCJ accountable for the decisions made about them. The Framework creates a shared vision for the interconnectivity of DCJ systems, people and culture. It gives explicit role clarity to everyone within the organisation, ensuring that all parts of the system work together to create the best outcomes for children their families.

The Framework is overtly and deliberately intentional in its child focus. It encourages DCJ staff to see that all of their work with a family needs to align with a constant responsibility to improve safety and outcomes for children. Staff 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 13: NSW Practice Framework (launched September 2017)

4.2.2 Implementing the Framework

The Practice Framework was developed by the OSP, and implementation in districts and head office, plus resource development, is led by the OSP. Day to day implementation and promotion of the Framework is the responsibility of districts. Implementation of the Framework has required all districts to participate in launch activities and to implement group supervision.

A staged district by district approach for full implementation of the Framework is underway. Implementation has followed an implementation science approach, with three phases, named simply as:

- Phase one – Get ready, go
- Phase two – Keep going
- Phase three – Staying on track

Phase one is a 12-month program during which districts receive skill-based training and leadership coaching. During this phase, governance structures are introduced to each CSC and district. These structures, known as Practice Implementation Teams and District Implementation Teams, enable local units and districts to align their systems, workforce and leadership drivers to the Framework. These teams report to a Central Implementation Team in the OSP. The Central Implementation Team supports the other teams to develop implementation plans and works at the broader system level to create opportunities to align the Framework to DCJ policy, reforms, projects and priorities.

Phase two of implementation focuses on embedding the learning derived in phase one into day to day practice. Local implementation plans are brought to life in this phase and group supervision is used as a key driver to embed practice change. During this phase, participants complete a range of skill extension modules to build on their existing knowledge and skills.

Phase three includes the introduction of an end to end quality assurance program – this phase has not yet started.

Training and implementation teams

To date, a key part of the implementation process has been nine days of skill-based Practice Framework training delivered over five to eight months. The training modules are:

- Dignity, safety and the path to meaningful change (2 days)
- Belonging, permanency, connection: Helping kids reach their potential (2 days)
- Assessment: Seeing, noticing and responding to danger and risk (2 days)
- Case planning: Creating change on purpose (2 days)
- Restoration: Building safety at home (1 day)

All CSC staff – that is, caseworkers, specialists, psychologists, casework support staff, manager's casework and managers client services – must participate in the five training modules.

As of July 2020, the OSP has delivered Framework training to 875 staff. Post-training surveys have been overwhelmingly positive and suggest that this training has been highly valued by the majority of caseworkers and practice leaders.

Group supervision: State-wide implementation and ongoing support

The OSP has adapted the DCJ group supervision model to incorporate the Framework's principles, approaches and capabilities. In 2018, the OSP delivered over 100 one-day group supervision introduction sessions to 2,400 caseworkers across the state, and three days of facilitation training to leaders. Post-training surveys suggest that both group supervision training packages were well targeted, engaging and enhanced learning.

To further support group supervision, the OSP led the development of the DCJ **Supervision Policy for Child Protection Practitioners**. This new policy provides clarity about supervision in a child protection context and, importantly, differentiates and mandates the delivery of group and individual supervision.

Given that group supervision is a key pillar upholding the Framework, Relationships Australia NSW (RANSW) was contracted to coach DCJ managers across NSW in group supervision to enhance skills in leadership and ethical, child and family-centric decision-making. The DCJ Coaching Project delivered by RANSW provided monthly coaching sessions to almost 900 DCJ managers in 86 locations across NSW.

Group supervision training for leaders continues to be delivered as needed to ensure new leaders are trained to facilitate sessions. On average, one training session per month is delivered to groups of 15–20 participants.

Quality assurance program[130]

The quality assurance program is being developed and managed by the OSP. It will incorporate all DCJ performance measures across child protection and out of home care and will include the addition of quality measures. These quality measures will include regular practice audits and, importantly, capture feedback from children, families, carers and agency partners. Work to scope the model has begun and it will launch in 2021. Put simply, a quality assurance program will enable the department to not only know what it's doing, but how well it's doing.

The program provides an opportunity to better understand what an effective intervention looks like, particularly in DCJ work responding to ROSH reports and completing safety and risk assessments. It will provide insights about the quality and amount of work required between a safety and risk assessment, and then again between the risk assessment and risk reassessment stage. Informed by real-time data that counts all activity, the quality assurance program will help the department better understand how much time is required to successfully exit a family from statutory services, and importantly what casework activities predict increased likelihood of success. Once implemented, the quality assurance program will remain and will provide a constant and consistent measure of practice for DCJ.

Practice Framework Working Group

The Practice Framework Working Group (the Working Group) was established to support the whole of agency Framework approach. Its purpose is to provide a focused, accountable governance structure to coordinate all work developed centrally that will impact on DCJ child protection practice. In essence it functions as a gatekeeper, ensuring that any new initiatives are aligned and understood within the broader operational context and that training and implementation are coordinated and planned.

The Working Group has an established Terms of Reference. It meets quarterly (four meetings have occurred to date). To strengthen the Working Group, it is intended that it will report into the Operations Executive Group from August 2020. The Executive Group will provide further guidance on what and when new initiatives will be introduced, ensuring increased support and knowledge at the district level of implementation plans and clarifying what is needed to support the implementation of new pilots, programs and policy in local CSCs.

4.2.3 Evaluation and future implementation

A mid-term evaluation has been conducted by the OSP research team, in partnership with the DCJ Insight, Analysis and Research Statistical Analysis unit. The mid-term evaluation focused on four questions:

1. Is the Practice Framework being implemented as intended?
2. How is the Practice Framework changing practice?
3. Are there differences between implementation and non-implementation sites?
4. What systems and structures support or hinder embedding the Practice Framework?

In addition, Relationships Australia completed an evaluation of a group supervision coaching program it provided to managers throughout 2019.

The OSP research team's evaluation contained many positive findings. On average, practitioners reported an increase in skills and knowledge, an increased connection to their work, greater role clarity and more

130 The quality assurance program is an evolution of the quality improvement model that was mentioned in the *Child Deaths 2018 Annual Report*.

purposeful assessments and use of group supervision. The evaluation also found a positive difference between non-implementation and implementation districts. Overall, a clear majority of caseworkers and practice leaders reported that they have changed or are changing how they work with children and families because of the Framework. Specifically, the majority of practice leaders and caseworkers who responded to a workforce survey for the evaluation strongly agreed, agreed or somewhat agreed that:

- they integrate the Framework into their daily work (97 per cent)
- they have gained new knowledge because of the Framework (88 per cent)
- the Framework has made a difference to their / their team's practice (87 per cent).

When asked about the role that group supervision was having in changing practice, caseworkers and practice leaders strongly agreed, agreed or somewhat agreed that:

- group supervision improves decision-making and practice (98 per cent practice leaders / 80 per cent caseworkers)
- group supervision is time well spent (96 per cent practice leaders / 76 per cent caseworkers)
- group supervision had resulted in improved knowledge and skills (98 per cent practice leaders / 78 per cent caseworkers)
- they were confident in the decisions made about children (100 per cent practice leaders / 88 per cent caseworkers).

Coinciding with this evaluation period, COVID-19 restrictions halted the delivery of face to face training. While COVID-19 has caused an unprecedented interruption to standard work practices, this also provides a unique opportunity to review the existing implementation model and develop a new model that harnesses the best of what DCJ was doing and introduce new elements to better meet the needs of districts.

The new model includes a combination of learning strategies. Moving away from a program of nine days of face to face training, the new action learning model includes online learning (to transfer knowledge), peer to peer learning (to explore values and ethics) and the strategic use of group supervision (to build skills).

As with the existing model, the new model involves the same five learning modules but also harnesses existing systems (group supervision, unit meetings and day to day casework activities), resulting in less time away from casework duties and improved potential to immediately transfer learning into practice. The new action learning model commenced in September 2020.

4.3 Their Futures Matter: Implementation and progress

4.3.1 Overview of the reforms

In July 2019, the Hon. Gareth Ward, Minister for Families, Communities and Disability Services, announced the transition of the *Their Futures Matter*[131] implementation unit to the NSW Stronger Communities Investment Unit.

The NSW Stronger Communities Investment Unit (SCIU) is a new entity in DCJ that will lead and deliver cross-government strategies to improve outcomes for vulnerable children, young people and families. It's work is underpinned by an investment approach, which uses a comprehensive human services dataset and investment modelling to determine population groups most in need, in order to guide investment and social policy decision-making.

In July 2020, the NSW Auditor-General released a report examining DCJ delivery of the *Their Futures Matter* reforms. The audit assessed the effectiveness of the governance and partnership arrangements in place to enable an evidence-based early intervention investment approach for vulnerable children and

131 *Their Futures Matter* was a set of reforms born out of recommendations made in David Tune's review into the out of home care system in NSW in 2015.

families in NSW. The Auditor-General made four recommendations to DCJ. DCJ has formally responded to these recommendations, noting that some of the recommendations made have already been completed and work has commenced on the remainder.

In response to the Auditor-General's Report, SCIU has developed a revised Governance Framework which will strengthen cross-government relationships to support implementation of the investment approach. At the time of this report the Governance Framework is still being finalised. The revised Governance will facilitate participation of relevant Ministers and Departmental Secretaries in investment decisions to support vulnerable groups identified in the *Forecasting Futures Outcomes: Stronger Communities Investment Unit – 2018 Insights Report*.[132]

4.3.2 Forecasting Future Outcomes

In 2018, the SCIU, in collaboration with other NSW human service agencies, compiled the first comprehensive human services cross-agency dataset in NSW – the TFM Human Services Dataset.

The TFM Human Services Dataset contains anonymised linked data on all children and young people born in NSW on or after 1 January 1990 until 30 June 2017 and the key government services they and their families have engaged with. This includes child protection, housing, justice, health and education.

The SCIU released the *Forecasting Future Outcomes: Stronger Communities Investment Unit – 2018 Insights Report* on 5 July 2019. The report presents findings from the first modelling undertaken on the TFM Human Services Dataset and highlights the high service usage and poor social outcomes for vulnerable groups of children and young people in NSW. As such, the report provides NSW with crucial evidence to help build a service system that intervenes early, prevents harm and focuses on those with the greatest need.

The analysis in this publication helped define six vulnerable groups that would benefit greatly from development of new support systems:

- **Vulnerable young children aged five or younger:** children with identified risk factors relating to their parents, perinatal factors or significant involvement in the child protection system
- **Children and young people affected by mental illness:** children and young people up to the age of 18 who, in the last five years, have experienced mental illness or whose parents have experienced mental illness
- **Vulnerable young adolescents:** children aged between 10 and 14 with identified risk factors in the last five years relating to their parents, significant involvement in the child protection system or interaction with the criminal justice system
- **Vulnerable young people transitioning to adulthood:** young people aged between 16 and 18 who, in the last five years, have had significant involvement in the child protection system or have interacted with the criminal justice system
- **Young mothers and their children:** mothers up to the age of 21 and their children
- **1000 individuals** with the highest estimated future service cost.

The first two of these groups have been prioritised for the development of state-wide strategies aimed at addressing their vulnerabilities and poor social outcomes.

The SCIU has developed a series of DCJ district and local government area information packs, which provide insights into the two priority groups at a regional level to inform planning and design of supports and services.

The SCIU is also working towards refreshing and expanding the TFM Human Services Dataset to include more recent and additional data, in preparation for the next round of investment modelling.

132 Stronger Communities Investment Unit (SCIU) (2018).

System Transformation

System Transformation (formerly known as Access System Redesign) recognises the importance of a multi-agency transformation of the child and family service system that aims to give children and families the support they need at the right time. This includes strengthening intake, assessment and referral pathways before children and families require a statutory intervention. Over time, this approach will help to redirect service interventions and investment from crisis-driven responses towards prevention and early intervention.

System Transformation is intended to be a more holistic approach, with the goal to design a child and family system where child wellbeing and protection is delivered in the context of family and community, and vulnerable children and families are connected with the services and supports they need at the earliest opportunity.

A number of pilots are supported as part of the SCIU principles of 'try, test and learn':

- **Collaborative Support Pathways Pilot** in South Western Sydney provides for all children and young people assessed as at ROSH to be referred early to support matched to their individual circumstances. To date over 4,000 children and young people have been referred in this way. Phase 2 of this pilot will see referral pathways strengthened and priority access for children and young people to key cross-government services.
- Similarly, the **Helpline and Northern NSW Streamlined Response Pilot** provides for improved assessment of Helpline reports and more targeted access to supports and services for children and young people. The next phase of this work will focus on Helpline operations. The **Helpline Pilot** team undertakes triage functions for reports relating to Ballina, Tweed Heads and Clarence Valley CSCs. The resulting benefit is that these CSCs are able to divert their triaging resources into seeing more children and families that require statutory intervention, in a time frame that meets their needs. The pilot has also provided opportunities for the Helpline to work with key stakeholders such as Child Wellbeing Units (CWUs) to enhance a culture of collective responsibility for child protection through the referral of non-ROSH reports to CWUs for a non-statutory response. This prevents matters from entering the child protection system where possible, as opposed to closing reports at the Helpline which results in no further contact or support being provided to children and families.

Redesign and reprioritisation activities are also underway as part of the System Transformation changes:

- Redesign of the Family Referral Service (FRS) program is underway. FRS is a partnership between NSW government agencies to support families early, including those with complex needs, and prevent them from entering the statutory child protection system. The redesigned service, **Family Connect and Support** (FCS), is a whole of family state-wide service aligned to the Human Services Outcomes Framework.[133] FCS embeds the priority groups identified by the Stronger Communities Insights Report and ensures that priority is given to Aboriginal families and communities. The service also builds on the strengths of the current FRS program, including service features like outreach into universal services and the use of active holding to prevent vulnerable families from falling through gaps. The new service will incorporate a cross-government, cross-sector leadership and governance framework and evidence-informed practice through action learning.
- **Child Wellbeing Units** will also be reviewed and redesigned to enable outcomes measurement through effective governance, identification of target outcomes, high quality data collection and formal evaluation.

133 The NSW Human Services Outcomes Framework is an overarching, cross-agency framework of seven wellbeing outcomes for all people in NSW, covering safety, home, economic, health, education and skills, social and community, and empowerment. These outcome domains were designed by agencies and NGOs and informed by a review of national and international research on what determines a person's wellbeing. The Outcomes Framework provides a way to understand and measure the extent to which DCJ makes a lasting positive difference to people's lives, and allows DCJ to assess what works in improving wellbeing. See facs.nsw.gov.au/resources/human-services-outcomes-framework

4.3.3 Programs and achievements

Since the implementation of the Their Futures Matter reforms in 2016, investment has been focused on intervention strategies that provide children with the best start; keep families together; reduce the number of children entering out of home care and where appropriate, prevent escalating risk.

Results so far for the evidence-based programs are described below.

Family preservation and restoration programs

Two evidence-based family preservation and restoration programs are underway, called Functional Family Therapy through Child Welfare[134] (FFT-CW®) and Multisystemic Therapy for Child Abuse and Neglect[135] (MST-CAN®). Both have been shown internationally to be successful with families.

Functional Family Therapy through Child Welfare

FFT-CW is a home-based family therapy treatment model for families where there has been physical abuse and/or neglect of a child or young person aged 0–17 years. FFT-CW works with families for an average of six to nine months and is provided to families in their homes or a suitable community setting.

Multisystemic Therapy for Child Abuse and Neglect

MST-CAN is a home-based intensive therapeutic treatment model for families where there has been substantiated physical abuse and/or neglect of a child or young person aged between six and 17 years. MST-CAN is delivered in the home by skilled psychologists, who are available 24 hours a day, seven days a week, and who can work with the family for up to nine months.

FFT-CW and MST-CAN are helping to reduce the need for children to be taken into care and away from their parents, increase the number of children who are returned to their parents or families, and respond to trauma and underlying causes of child abuse and neglect.

Where it is suitable to restore a child or young person to their family, intensive support will be provided through FFT-CW and MST-CAN or other services to ensure the pathway home for children is successful. Step-down support will also be provided at the completion of the programs following the return of a child or young person to their family.

By reducing the number of children in out of home care – that is, by preserving and restoring families – funds can be invested into services that strengthen the capacity of families to care for their children. This creates a stronger long-term service system.

Service delivery and outcomes

Home-based FFT-CW and MST-CAN services are being delivered by practitioners in over 15 priority locations across the state.

As at 30 June 2020, more than 2,800 families (239 in MST-CAN and 2,635 in FFT-CW) have been accepted into the programs. This translates to at least 9,599 siblings and other family members receiving benefits from the service.

Cumulative to the end of June 2020, some 1,194 families have completed the programs, including 315 Aboriginal families.

Preliminary findings of the independent program evaluation show:

- high completion rates across all programs
- substantially lower entries to out of home care than control groups for families who have successfully completed programs
- lower re-report rates than control groups for families who successfully completed the programs

134 Functional Family Therapy (2017).
135 Developed at the Medical University of South Carolina. See Global Family Solutions (2017).

- the target for Aboriginal families continues to be on track for MST-CAN (46 per cent of Aboriginal families being referred to the program) but not for FFT-CW (28 per cent)
- that Aboriginal families are at least as happy to commence FFT-CW as non-Aboriginal families but they are being referred to FFT-CW by DCJ at a disproportionately lower rate.

Thriving Families NSW

Thriving Families NSW provides targeted support to meet the needs of vulnerable young parents aged 25 years and under, and their children up to the age of five years (including unborn children). It aims to align resources across and within the Western Sydney Local Health District and Department of Education to respond adequately to the health, accommodation and safety needs of vulnerable children and families with support from DCJ. It also aims to intervene before vulnerable families reach crisis point by considering earlier indicators of vulnerability. The initiative does this by ensuring young parents have access to age-appropriate, strengths-based wraparound services which meet the needs of the whole family. This approach enables Thriving Families NSW to engage with this cohort and address their identified needs.

Thriving Families NSW is funded by the Stronger Communities Investment and Inclusion Directorate, Department of Communities and Justice (formerly Their Futures Matter). See the section below on 'Aboriginal children and their families' for information on the associated Aboriginal Thriving Families initiative.[136]

Service delivery and outcomes

Thriving Families NSW has exceeded its key performance indicators for 2019–2020:

- The initiative supports about 20–25 families at any given time
- Long-term support is provided
- In total, 53 families have received support.

In addition, clients have presented with increased risk and complexity due to the COVID-19 pandemic. The Thriving Families NSW multidisciplinary team has developed virtual modes of service delivery and modified in-person support in response. In addition, there has been an increase in the need for support through brokerage funding and material aid in this time.

A formative review of Thriving Families NSW found that the initiative is well designed to meet the needs of the young parents with young children who have been engaged in the program. The most commonly identified success factors included:

- Engagement methods with clients
- Family meetings
- Flexibility and autonomy with home visits
- Flexible brokerage
- Tailored support via multidisciplinary teams (e.g. midwife, child and family nurse, education coordinator).

An outcomes evaluation is underway and findings are due in late 2020.

Aboriginal children and their families

Their Futures Matter acknowledges and supports the cultural needs of Aboriginal people and communities. The reforms aim to intervene early to give Aboriginal children, young people and their families the support they need so that children can stay at home when it is safe to do so.

136 Aboriginal families are not excluded from Thriving Families NSW, and approximately 25 per cent of families seen through Thriving Families NSW identify as Aboriginal.

DCJ has invested in several evidence-based programs aimed at supporting Aboriginal children, young people and families. The principle of co-design ensures programs and services are designed, led and run with local Aboriginal communities, consistent with the right to self-determination.

A summary of these programs and their achievements is detailed below.

Aboriginal Child and Family Centres

The department funds nine Aboriginal Child and Family Centres (ACFCs) in NSW to provide quality wraparound services for Aboriginal children, families and communities including early childhood education and care, school readiness programs, coordinated child and family health services, and integrated family supports such as parenting groups, counselling and men's/women's groups.

Two ACFCs received funding under *Their Futures Matter* for the Thriving Aboriginal Families program, to improve the experience of wraparound service provision for Aboriginal children and families, increase support and advocacy for families including children with disabilities, and to increase service access for families.

ID Know Yourself

ID Know Yourself is a cultural mentoring program for Aboriginal young people aged 15 to 18 years in the Redfern/Waterloo area. The program aims to support Aboriginal young people in out of home care to become strong and resilient and prepare them to reach their full potential in life.

The Nabu Demonstration Project

The Nabu Demonstration Project is a First Nations evidence-based early intervention and intensive family support program for Aboriginal families in the Illawarra Shoalhaven and Southern NSW districts. The project aims to ensure Aboriginal and Torres Strait Islander children and young people remain safe and well cared for within their family (preservation), and that Aboriginal and Torres Strait Islander children and young people in the care of the Minister return safely home wherever possible (restoration).

From the program start in August 2019 to the end of June 2020, Nabu has helped 50 Aboriginal families from an annual target of 64 families.

Nabu provides wraparound services including case management, counselling, cultural mentoring and support from community Elders, practical family support, fitness, boys' and men's groups and therapy for children and young people. These are provided by 20 staff, the majority of whom are Aboriginal and from the local community.

Alongside their engagement with Aboriginal families, Nabu staff are working to influence and resolve some of the systemic issues that deny more respectful and culturally appropriate services to Aboriginal people. For example, Nabu has provided cultural immersion workshops to all staff at the Ulladulla and Nowra CSCs. Nabu staff have been working closely with the CSC staff, which has seen a review of the DCJ Family Action Plan for Change, leading to a significant improvement in how DCJ staff complete these plans and affidavits.

In turn, families have reported to Nabu that DCJ staff have been more supportive and respectful since their involvement with Nabu.

Data and qualitative information indicates that the model is effective in strengthening the capacity of vulnerable Aboriginal families to maintain or resume the care of their children, and improving the relationship between DCJ and families.

An independent formative evaluation of Nabu, commissioned by SCIU, is underway and a report is due by the end of 2020.

Aboriginal Evidence Building in Partnership

The SCIU is also partnering with Aboriginal communities to develop a strong evidence base of what works for Aboriginal children, young people, families and communities. The Aboriginal Evidence Building Partnership Project (AEBP) has been established to ensure that the broader NSW child protection service system is culturally appropriate and supports the needs of Aboriginal children, families and communities.

The AEBP does this by linking Aboriginal organisations with partnered consultants, to work together to build data collection and evaluation capabilities. The data helps organisations to understand their outcomes, make improvements to service delivery, and build the evidence base about 'what works' for improving outcomes for Aboriginal communities. AEBP has been largely successful in showing how validated assessment tools are improving service performance and improving outcomes for Aboriginal people accessing those services.

Under 12s

In September 2017, *Their Futures Matter* launched the first elements of a wraparound service solution for children under the age of 12 in residential care without an older sibling. This cohort of children was identified in March 2016 by the interim report of the *Their Futures Matter* review as needing immediate action and investment in a range of initiatives to improve life outcomes.

Service delivery and outcomes

The initiative has a number of key elements, but is founded on the principles of a shared understanding of need for children and young people who have experienced trauma and disrupted attachment, and leverages the expertise of professionals to share responsibility and create a consistent care approach.

As of December 2019:

- The number of children in this cohort in residential settings had fallen by 47 per cent (from 68 to 36 children)
- 10 children had been restored to their parents' care and one child transitioned to guardianship
- 90 per cent of the cohort have health plans or have left care so do not require one (up from 45 per cent)
- 43 of 49 children identified as requiring trauma treatment are accessing a service
- 23 of 31 children identified as requiring an NDIS plan have one.

Conclusion of trial

The Under 12s cohort initiative ended in January 2020. The young people in the initiative continue to receive multidisciplinary support, through the cross-agency coordination pathways developed through the pilot. The professional relationships built through the pilot have created opportunities for cross-agency collaboration to better support other young people across NSW. DCJ will use the lessons from the trial to explore opportunities for local practice improvements to better support vulnerable children and young people in alternative care arrangements or interim care.

Achievements

A review of the Under 12s initiative found that Team Around the Child (TAC) meetings were an improvement to previous agency coordination, with a multidisciplinary approach that supported better outcomes for children and young people. With an array of health and other specialists at the table, information sharing and coordination in the TAC led to more effective service responses and improved outcomes for children's health. A key focus of the TAC was ensuring a consistent approach to care for children at home, school and in the community, with behavioural support co-developed and reviewed regularly by the team.

Positive and effective relationships have developed for TAC participants, particularly between DCJ, Education and Health. Each district has had the opportunity to continue to grow these relationships for the benefit of the children in this cohort but also other children and young people in their district. There has been a consistent improvement in the number of children placed in the care of their parents, relatives or kin and a reduction in the number of children in residential care – this was achieved through good communication and collaboration between agencies.

OurSPACE

Implemented in December 2018, OurSPACE is a tailored trauma therapeutic intervention for children and young people aged 15 years and under who are in statutory foster and kinship care and experiencing placement instability. The goal of the initiative is to stabilise placements.

The provider and the Aboriginal partner organisation, Ngaoara, work together to identify a cohort of Aboriginal children and carers with complex and intensive needs who are evaluated by trauma assessment, referral and rehabilitation outreach teams (TARROT).[137] TARROT is an Australian first approach to assessment using traditional Aboriginal and western conceptualisations of trauma.

OurSPACE also works closely with care teams for children and young people to develop trauma-informed educational plans so school staff can understand the impact that trauma has on behaviour and learning ability. These plans have been positively received by Department of Education staff.

OurSPACE provides two services streams:

- **Comprehensive assessment and therapeutic support (CA&TS):** in-home therapeutic specialist planning and direct counselling using evidenced-based treatment
- **Consultation and support (C&S):** short-term telephone, video call or face to face advice and support to stabilise placements and provide education about impacts of trauma.

Referrals come from multiple pathways including NGOs, out of home kinship care providers, DCJ caseworkers, kinship and foster carers, school teachers, juvenile courts and other professionals.

Referrals are made through a centralised intake number: 1300 381 581.

Service delivery and outcomes

Since December 2018 OurSPACE has provided:

- support and consultation to 1,991 children and young people[138]
- comprehensive assessment and therapeutic support for 244 children and young people.

The program has also accepted 46 children and young people who live in alternative care arrangements.

Since implementation, Ngaoara has changed its role to focus on consultation for Aboriginal children and young people and their carers referred into the program, and supervision for Aboriginal staff. The program has employed six full-time Aboriginal staff, including a team leader, who are all enrolled in a Graduate Certificate of Developmental Trauma. The Australian Childhood Foundation has also offered a number of scholarships to NGO out of home care Aboriginal staff to complete the Graduate Certificate in Developmental Trauma.

The active outreach service has been well received in rural, remote and regional areas. The service has a strong relationship with Aboriginal communities and services and many referrals are for Aboriginal children and young people. For example, OurSPACE has been working closely with Maranguka Hub in Bourke to provide services to children, young people and carers in that community.

Evaluation

A preliminary process evaluation has been received from the National Drug and Alcohol Research Centre (NDARC) that identifies that more than 50 per cent of children and young people in the comprehensive assessment and therapeutic intervention are Aboriginal and there is a very low withdrawal rate for all accepted referrals.

A preliminary outcome and economic evaluation from NDARC is pending.

LINKS Trauma Healing Service

The LINKS Trauma Healing Service delivers trauma-focused evidence-based support to children and young people aged 16 years and under who are in statutory foster or kinship care where there have been two or more placements in the past six months and there is high risk of entering residential care or a high use of respite. The program is specifically for children and young people living in out of home care within 60 minutes of Penrith or Newcastle.

137 See ngaoara.org.au/tarrot

138 This reflects the number of children who were helped via the supports and services around them, for example, a school or carer. The same child may be counted multiple times.

LINKS aims to help children and young people decrease their trauma symptoms, feel better about themselves and improve their behaviour. It's delivered by a range of specialists including mental health clinicians, Aboriginal mental health clinicians, occupational therapists and speech pathologists.

The evidence-based support includes trauma-focused cognitive behaviour therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), Parent–Child Interaction Therapy (PCIT)[139] and Tuning into Kids/Teens.[140]

Service delivery and outcomes

- Between October 2017 and June 2020, LINKS supported 423 children and young people
- 48 per cent of these children and young people have been Aboriginal.

Evaluation

The final report of the independent evaluation of LINKS found evidence that the program has achieved placement stability for children and young people compared to business as usual; and there is a statistically significant improvement for children and young people with post-traumatic stress (for younger children), behavioural problems, emotional symptoms and social skills. The evaluation also reported that carers have felt a greater sense of personal wellbeing throughout the program.

A Place to Go

This initiative aims to improve supports and deliver a better response for 10–17 year olds entering and exiting the youth justice system, with a focus on young people in remand. It draws on NSW Government and non-government providers to deliver a coordinated and multi-agency service solution that can support a young person to change their life trajectory.

A Place to Go (APTG) focuses on using a young person's contact with police and/or the Children's Court as an opportunity to intervene and provide the supports they need to reach their potential. APTG is being implemented in the Nepean Police Area Command and the Parramatta Children's Court, with a trial that will run until 30 June 2021.

The initiative is funded by the Stronger Communities Investment and Inclusion Directorate, Department of Communities and Justice (formerly Their Futures Matter).

Achievements

A formative review of APTG found that the initiative is well designed to meet the needs of the target cohort and has great potential to make a significant positive impact for young people. Key to this is cross-agency collaboration and coordination, and the flexibility needed to deliver a holistic multidisciplinary service response for young people. The most commonly identified success factors included:

- Key worker function provides a single point of contact for young people to navigate the service system
- Multidisciplinary approach to the cohort's complex needs
- Effective needs assessment
- Flexible brokerage (using designated funds to purchase goods or services to meet the individual needs of young people)
- Therapeutic, trauma-informed short-term accommodation.

An outcomes evaluation of APTG is underway and findings are expected in late 2020.

Plans for further implementation

APTG has been expanded to a second site, the Broadmeadow Children's Court Pilot (BCCP) Project in the Newcastle/Hunter area. Launched on 1 July 2019, the BCCP brings together a team of government

139 Therapy developed to treat children with disruptive behaviour issues aged two to seven. See pcit.org

140 Evidenced-based parenting programs that focus on the emotional connection between parents and carers and their children. See tuningintokids.org.au

agencies and NGOs to provide wraparound supports to young people presenting to the court. This collaborative way of working has increased referral pathways, prevented duplication of services, and coordinated resources and actions between government and non-government service partners.

Treatment Foster Care Oregon

Treatment Foster Care Oregon (TFCO) is a treatment model developed to create opportunities for children and young people to successfully live in a family setting as an alternative to institutional, residential and group care placements. TFCO also coaches parents (or other long-term family relationships) to provide effective parenting in order to support sustainable placement stability over time.

TFCO is for children and young people in out of home care with severe emotional and behavioural disorders. There are two programs: TFCO-Children, for children aged 7–12 years; and TFCO-Adolescent for young people aged 12–17 years. The model is offered across the Sydney metropolitan area, and the majority of the children and young people have been referred from an alternative care arrangement.

Children and young people are placed with a specifically trained TFCO foster carer for approximately nine months. At the end of the placement the children and young people are reunified with their biological family (including kinship) or placed in lower intensity long-term foster care with support provided to maintain stability for approximately three months.

TFCO is an intensive program, and carers must be able to participate in rigorous contact, such as daily phone calls, and be willing to receive and implement instructions in working with complex children and young people. Carer recruitment carefully ensures that participants can support children and young people in the program effectively. Carers are supported and trained by OzChild.

Achievements

- Since becoming operational in 2019, 15 children and young people, including six Aboriginal children and young people, and 10 from alternative care arrangements have entered the program
- Four children and young people have graduated from TFCO (one each in March, April, May and June 2020)
- One young person moved from TFCO-C to TFCO-A.

4.4 Permanency Support Program

The Permanency Support Program (PSP), which started on 1 October 2017, is a key reform to the child protection and out of home care system in NSW. It represents a philosophical shift from a 'placement-based service' to a 'child and family centred service system'. The program supports children to find permanent, safe and loving homes.

The PSP has three 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 orders or adoption
- **A better care experience:** by supporting children's individual needs and their recovery from trauma.

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

- Permanency and early intervention principles 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 Care Act). 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 is due to the intergenerational trauma experienced by the Aboriginal community, caused by government policy which supported the systemic removal of their children.

The *Children and Young Persons (Care and Protection) Amendment Act 2018* was passed in Parliament in November 2018 and came into effect on 4 February 2019. It amends the Care Act and the Adoption Act 2000 to support current child protection reforms, including the PSP.

The amendments also support the NSW Practice Framework and further align practitioners and others around the goal of keeping children safe at home or, if that is not possible, working with urgency to find permanency.

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.

DCJ POLICY

The **Permanency Case Management Policy: Rules and Practice Guidance** was released in 2018 and updated in November 2019. This policy sets out the minimum expectations of DCJ and funded service providers in working collaboratively to deliver the PSP.

4.4.1 PSP implementation

In 2019–2020, PSP implementation continued, with a budget of $665 million. More than 8,000 children and young people were supported by NGOs with case management responsibility. Fifty-five service providers including 13 Aboriginal providers partnered with DCJ to deliver the program, including 10 service providers contracted to deliver Intensive Therapeutic Care (more on this below).

Family preservation packages

Under the PSP, flexible funding packages enable service providers to deliver tailored services and supports to address the needs of children and their families. PSP Preservation services provide evidence-based wraparound supports and services to safely sustain a child or young person in their home environment to avoid the need to enter out of home care.

On 1 October 2018, 190 PSP Family Preservation packages became available across NSW, with 37 per cent dedicated to Aboriginal children and families. In the 2019–2020 financial year an additional 190 packages were allocated, with 180 targeted for delivery by Aboriginal services.

The PSP Preservation program has maintained a significantly higher proportion of participation from Aboriginal families than the initial target of 37 per cent. Aboriginal families make up the majority of families who have achieved permanency.

In the 2019–2020 financial year, 274 families entered a PSP Preservation service; 208 (76 per cent) were Aboriginal families. A total of 50 families achieved their permanency goal and remained safely together; 33 (66 per cent) were Aboriginal families.

PSP Learning Hub

In 2019–2020, the NSW Government committed to invest $3 million over three years (2019–2022) for a new workforce development and training service, the PSP Learning Hub, which began operating in late November 2019. The Hub supports skill development for service providers in order to achieve permanency for children and young people.

My Forever Family NSW

Under the PSP, My Forever Family NSW has received $7 million over three years to provide recruitment, training and education, support and advocacy services for foster, relative and kin carers as well as guardians and out of home care adoptive parents.

Intensive Therapeutic Care

DCJ is continuing to implement Intensive Therapeutic Care (ITC), the component of the PSP replacing residential care. Some of the outcomes of ITC support include:

- By end of June 2020, 317 children and young people had been provided with placements in ITC homes
- 105 children and young people were in less intensive placements with ITC providers, such as carer-based placements and Therapeutic Supported Independent Living, which assists young people to successfully transition to adulthood
- Seven Intensive Therapeutic Transitional Care Units provide upfront intensive support for children and young people as they enter the ITC service system.

Permanency coordinators

DCJ has 52 permanency coordinators based across our districts supporting DCJ and NGO practitioners to achieve permanency for children. These vital roles provide advice on all permanency options, including making recommendations on the permanency option that is in the best interest of the child. They monitor and track progress towards achieving permanency outcomes for children and young people within two years.

Permanency coordinators have expertise across the child protection and out of home care systems, but are not caseworkers and don't make decisions about individual cases. They advise DCJ and non-government caseworkers on services in the local area that can best help meet the needs of each child and their family.

Permanency coordinators have recently joined the newly formed Practice and Permanency Unit in the OSP. This move allows the coordinators to work closely with casework specialists in each district and ensure the principle of permanency is embedded into practice.

4.5 Other relevant reforms in DCJ

4.5.1 Redesigned Caseworker Development Program

In July 2020, DCJ launched the new Caseworker Development Program. This redesigned program is a new approach to training child protection caseworkers in DCJ. The foundational program runs over 17 weeks and is mandatory for all new caseworkers.

The redevelopment of the Caseworker Development Program is underpinned by the NSW Practice Framework. It includes a substantial orientation in DCJ and training in:

- the NSW Practice Framework
- relevant NSW legislation and human rights conventions
- policies and guidelines for practice
- contemporary child and family research.

The program consists of workshops, online courses, on-the-job activities, marked assessments, weekly group coaching sessions via videoconference and work-based tasks designed to embed knowledge into demonstrable skills. The program is designed using blended learning and adult learning principles. Managers and CSC staff will help bring theory to life and embed a caseworker's new skills. The OSP is providing close support to the program via casework specialists and new practice coaches who will provide one-on-one support to caseworkers and their supervising manager.

Two hundred caseworkers are expected to complete the new program by the end of 2020.

4.5.2 ELVER Trauma Treatment Service

The ELVER program was established as a joint initiative between Community Services Statewide Services and South Western Sydney Local Health District Infant Child and Adolescent Mental Health Services (iCAMHS). It provides specialist multidisciplinary, trauma-informed assessments and interventions for children and young people in out of home care with complex developmental and mental health needs. ELVER started in September 2018 and is managed by the Director Intensive Support Services.

ELVER targets the following groups across NSW:

- Children with complex needs in individualised placements
- Children in Intensive Therapeutic Care (ITC), particularly those who need specialist intervention to avoid moving to a more intensive placement or care model
- Children under the age of 12 with assessed high needs who are ineligible to enter ITC.

The program has been commissioned to provide services to:

- Up to 50 children and young people in year one (2019)
- 75 children and young people in 2020
- 75 children and young people in 2021
- Up to 100 children and young people in 2022

Targets in years one and two have been exceeded.

4.6 Improving our responses to children reported in the prenatal period

This section describes current and future initiatives that focus on increasing casework knowledge and improving practice and outcomes for children who are reported to DCJ in the prenatal period.

4.6.1 Caseworker Development Program

The redesigned Caseworker Development Program includes a focus on prenatal casework and intervention with families in three key areas:

- Families where there may be mental health issues (prenatal and postnatal)
- Families where there may be problematic substance use, including during pregnancy
- Young parent families.

4.6.2 Updated Prenatal Policy

During 2019–2020, Strategy, Policy and Commissioning undertook a review of the **Prenatal Policy: Responding to Prenatal Reports** and corresponding practice mandate. The updated policy and practice mandate were released in November 2020.

Redeveloping this policy included consultation with a number of internal and external stakeholders, including other parts of DCJ, NSW Health, community legal centres, Legal Aid and the Family Action Centre.

The main changes and updates to the policy include:

- Imminent birth is now defined as 32 weeks gestation (reduced from 37 weeks gestation)
- A major emphasis on early intervention, as working with families during the gestation period can result in major and lasting change
- Articulating the need for effective and regular communication with NSW Health
- De-gendering language from ‘pregnant woman’ to ‘expectant parent’; encouraging the inclusion of fathers/co-parents where appropriate

- Changes in line with DCJ domestic violence policy, including domestic violence with high levels of coercion and control as a high risk factor (previously only related to physical abuse resulting in serious injury)
- Documents brought in line with the Practice Framework, including dignity driven practice and holistic practice
- Additional practice advice, including when and how to make appropriate referrals to NSW Health, obtaining early legal advice, and working with incarcerated expectant parents
- Updated information on working with Aboriginal families, shaped by advice from stakeholders
- Updated terminology for Structured Decision Making assessments and ChildStory
- Updates to reflect the PSP and permanent placement principles; case planning for permanency and permanency coordinator consultations
- The requirement to access Family Group Conferencing, or Pregnancy Group Conferencing where available; caseworkers must record reasons why this is not completed.

4.7 Premiers Priorities

The NSW Premier's Priorities[141] is a reform program that sets out ambitious targets to tackle issues of significant concern to improve the quality of life for the people of NSW. There are key reforms for which DCJ is responsible that focus on breaking the cycle of disadvantage. A number of these reforms impact on child safety.

The Protecting our Most Vulnerable Children Priority aims to decrease the proportion of children and young people re-reported at ROSH by 20 per cent by 2023. Focusing on how many children who receive a face to face assessment are later re-reported at ROSH tells DCJ whether it is creating sustainable change and safer homes.

DCJ is working to achieve this target through three main areas of focus to ensure better outcomes for our most vulnerable children:

- **Better support for caseworkers:** More effective support, including supervision, training and coaching programs, will allow caseworkers to improve practice and achieve better outcomes for families.
- **Reducing re-reporting for Aboriginal children:** Aboriginal children are over-represented in the child protection system and re-reported more often. DCJ is improving the services offered to Aboriginal families and working better with communities to reduce the number of Aboriginal children re-reported.
- **Driving continuous improvement in practice quality:** Implementing ways to measure, assess and improve practice and the quality of casework to get better outcomes for vulnerable children.

DCJ is also responsible for the Reducing Domestic Violence Reoffending Priority, which aims to reduce the number of domestic violence reoffenders by 25 per cent by 2023. Domestic violence has a significant impact on child protection. DCJ is working on a broad program of initiatives to support this ambitious target by:

- ensuring that perpetrators receive the right intensity of behaviour change intervention
- increasing its focus on family violence, including supporting young people using violence
- responding effectively to the needs of diverse cohorts of offenders.

Other Premier's Priorities focused on breaking the cycle of disadvantage will also have an impact on keeping children safe. DCJ is also responsible for, and working towards:

- increasing permanency for children in out-of-home care
- reducing homelessness
- reducing recidivism in the prison population.

141 Read more about the Premier's Priorities at 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 or young person can refer to different types of maltreatment. It includes assault (including sexual assault), ill-treatment, neglect and exposing the child or young person to behaviour that might cause psychological harm, whether or not, in any case, with the consent of the child.

Alcohol and/or drug misuse

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

Alternative Care Arrangement

An alternative care arrangement (ACA) is an emergency and temporary accommodation option for a child in out of home care when a preferred foster, relative/kin or Intensive Therapeutic Care (ITC) placement is not (yet) available. ACAs are subject to strict approval processes and ongoing review. The Office of the Children's Guardian considers ACAs a form of non-home-based emergency care. They include circumstances where a child in out of home care is accommodated in a serviced apartment, hotel/motel or other short-term arrangement.

Authorised carer

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

Case closure

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

Case plan

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

Casework

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

Caseworker

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

Child Wellbeing Unit (CWU)

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

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 violence is usually committed by men against women within heterosexual relationships, but can also be committed by women against men, and can occur within same-sex relationships. Domestic violence can have a profound negative effect on children.

Engagement

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

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

Neglect

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

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

Parental responsibility

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

Parental responsibility to the Minister

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

Physical abuse or ill-treatment

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

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 (ROSH) after birth.

Removal

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

Report

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

Reporter

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

Restoration

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

Risk of harm assessment

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

Risk of significant harm (ROSH)

For the purposes of section 23 of the *Children and Young Persons (Care and Protection) Act 1998* (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 include:

- Suicide attempts or ideation
- Self-harm
- Engaging in criminal activities
- Gang association and/or membership
- Dealing drugs
- Drug, alcohol and/or solvent use
- Engaging in unsafe sex
- Prostitution.

Safety and risk assessment (SARA)

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

Structured Decision Making (SDM®)

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 use of assessment tools and decision guidelines.

Supervision

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

Supported care allowance

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

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. DCJ is currently reviewing the triage mandate. This work will strengthen the triage process, particularly with families experiencing high levels of risk, by clarifying the management of reports.

Weekly allocation meeting (WAM)

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

Young person

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

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DCJ resources

NSW Practice Framework

https://caseworkpractice.intranet.facs.nsw.gov.au/our-approach/practice-framework

Aboriginal Case Management Policy Statement

https://www.facs.nsw.gov.au/providers/children-families/deliver-psp/aboriginal-case-management-policy/policy-statement2

Permanency Case Management Policy: Rules and Practice Guidance

https://www.facs.nsw.gov.au/families/permanency-support-program/permanency-case-management-policy

Prenatal Policy: Responding to Prenatal Reports

http://docsonline.dcs.gov.au/__data/assets/pdf_file/0012/286779/responding_prenatal_reports_policy.pdf

Supervision Policy for Child Protection Practitioners

https://intranet.facs.nsw.gov.au/__data/assets/pdf_file/0007/438811/Supervision-policy-for-child-protection-practitioners.pdf

Practice kit: Alcohol and other drugs

https://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/alcohol-and-other-drugs

Practice kit: Domestic and family violence

https://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/domestic-and-family-violence

Practice kit: Mental health

https://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/mental-health

Assessing and case planning with expectant parents (prenatal)

https://caseworkpractice.intranet.facs.nsw.gov.au/mandates/child-protection/assessing-and-case-planning-with-expectant-parents-prenatal

Case planning for change

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/permanency/case-planning-for-change

Collaboration

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/partnerships/collaboration

Cultural practice with Aboriginal communities

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/cultural-practice-with-aboriginal-communities

Culturally response practice with diverse communities

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/culturally-responsive-practice-with-diverse-communities

Dignity driven practice

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/dignity-driven-practice

Facilitating assessment consultations

https://caseworkpractice.intranet.facs.nsw.gov.au/leadership/managing-systems/consultations

Getting help with your practice

https://caseworkpractice.intranet.facs.nsw.gov.au/support/getting-help-with-your-practice

Group supervision

https://caseworkpractice.intranet.facs.nsw.gov.au/leadership/group-supervision

Holistic assessment and family work

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/holistic-assessment-and-family-work

Leadership

https://caseworkpractice.intranet.facs.nsw.gov.au/leadership

Methadone: Safety tips for parents and carers

https://caseworkpractice.intranet.facs.nsw.gov.au/download?file=334212

Serious Case Review – who we are

https://caseworkpractice.intranet.facs.nsw.gov.au/__data/assets/pdf_file/0017/421712/Serious-Case-Review-who-we-are-fact-sheet.pdf

Sibling safety

http://docsonline.dcs.gov.au/__data/assets/pdf_file/0011/286787/sibling_safety.pdf

https://caseworkpractice.intranet.facs.nsw.gov.au/mandates/child-protection/sibling-safety#section-365263

Swimming pools: Frequently asked questions

https://caseworkpractice.intranet.facs.nsw.gov.au/__data/assets/pdf_file/0011/338456/Swimming-Pools-FAQ.pdf

Working with fathers to keep children safe

https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/working-with-fathers-to-keep-children-safe

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)	Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	**0410 539 905**
Aboriginal Medical Service	Provides comprehensive health care to the Aboriginal community	**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 caregivers (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 caregivers 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**

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

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