



# Child Deaths 2017 Annual Report

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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 about Aboriginal children distressing.

A list of support and counselling services is provided at Appendix 1 of this report.

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# Minister's foreword

The *Child Deaths 2017 Annual Report* is the Department of Family and Community Services (FACS) eighth annual report about the deaths of children who were known to FACS. In 2017, 91 children died. Details about the circumstances of their deaths and FACS involvement with them are contained in this report.

While this report can be difficult to read, it is a publication I am proud of. It demonstrates our government's continued commitment to transparency and accountability. This report openly shares specific information and details about the deaths of children who were known to be at risk of significant harm or in out of home care. I extend my sympathy to the families and communities of those children discussed in this report and all those persons who have been affected by the loss of a child.

Most importantly, this report provides an opportunity for FACS to share details about the lessons we have learned from the 91 children who died in 2017. Child death reviews focus our attention on what can be done differently. This information can be used by FACS and our inter-agency partners to improve practice and the lives of children, young people and their families. FACS cannot do this work alone. The *Their Futures Matter* reforms are landmark reforms that will deliver improved outcomes for vulnerable children, young people and families in NSW.

FACS work with interagency partners is particularly relevant when reading chapter three of this report. It considers the impact of child protection issues on families who care for a child with an illness or disease, who are often reliant on health services for support. FACS will continue to strengthen interagency work to ensure families receive the services they need across government agencies, particularly when children's health and safety needs are evident.

I am continually inspired by the practitioners who work every day in the challenging area of child protection. They are dedicated, hardworking, passionate about families and committed to protecting the rights of the children they work with. This government is committed to supporting this workforce and has allocated funds to employ more casework staff over the next 12 months. I am grateful for every practitioner at FACS, our interagency partners and the non-government workforce. Thank you for the work you do each day to keep children safe.

**Pru Goward**

Minister for Family and Community Services

# Secretary's foreword

Each year, this report challenges me to stop and think about the children whose lives are spoken about in the pages of this review - the children whose voices can no longer be heard and whose stories are shared. To those who knew and loved these children, I am deeply sorry for your loss. It is important that we continue to reflect deeply on the work of the Department of Family and Community Services (FACS) for those children who have died, and the opportunities that we had to make a difference.

For each of the 91 children who were known to FACS and died in 2017, FACS reviews their experiences and our involvement with them and their families. These reports are not focused on the circumstances of death – most deaths are not predictable or preventable. Instead, the reviews provide an opportunity to look closely at our practice, reflect upon what could have been done better and how we can improve the services we offer.

Chapter 3 of this year's report focuses specifically on children who died from an illness or disease. Information about 165 children who died over a five year period has been collected and analysed. This group of children consistently make up the largest group of children known to FACS who die each year. Many of these children were diagnosed with an illness or disability from a young age. The impact that this has on a child or young person and those caring for them is significant. We need to work together across the government and non-government sector to care for and support these families.

This year's report also provides an update about *Their Futures Matter*. I am proud of FACS involvement in this cross government collaboration. These reforms and the services they are designing and delivering are making a positive difference to vulnerable children and their families. By working together, NSW government agencies can help families to be their best and thrive.

None of this work would be possible without our staff. I am constantly encouraged by the passion, skill and thoughtful work that FACS practitioners do every day. Their care for the children and families we work with is inspiring. I hope that the information and practice insights in this report will help practitioners to continue to make a positive difference to the children and families we work with.

**Michael Coutts-Trotter**  
Secretary

# Summary

The *Child Deaths 2017 Annual Report* is the NSW Department of Family and Community Services (FACS) eighth public report examining FACS involvement with the families of children<sup>1</sup> who died and were known to FACS.

This report aims to provide context about the deaths of children who were known to FACS, with the intention to strengthen the child protection system, improve child protection practice, and support other services working with vulnerable children and families. As this report is publicly available, there is hope that it enhances community understanding of the complexities of the work, including how widespread social disadvantage is among the families that the child protection system comes into contact with, and the very real consequences of this for children's experiences of abuse and neglect.

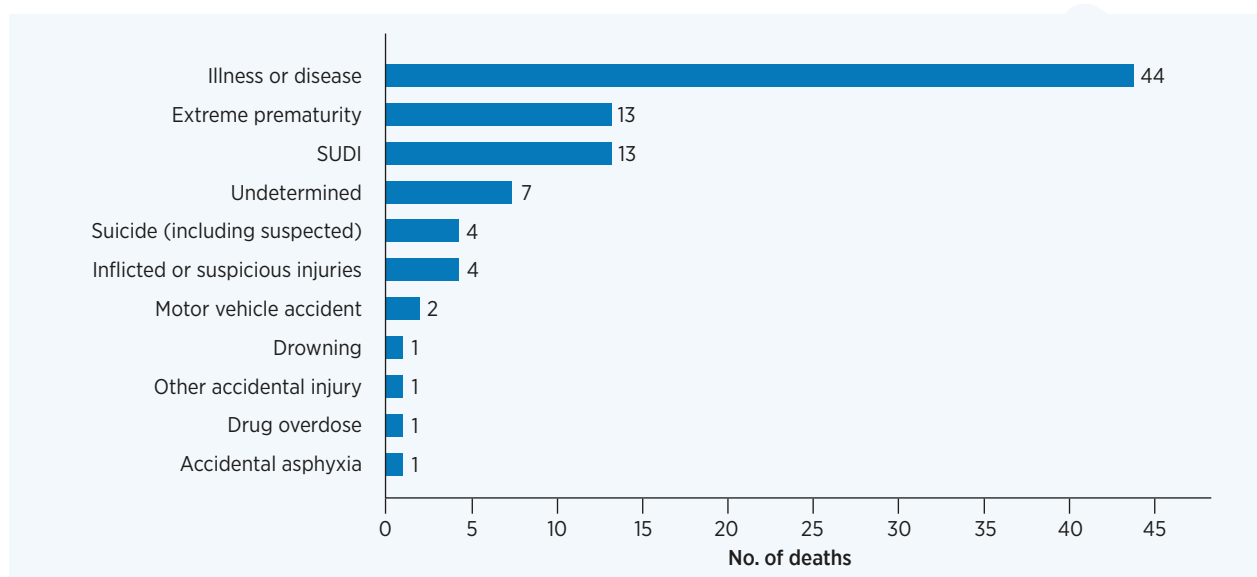
## Child deaths in 2017

Chapter 2 of this report summarises information about the 91 children who died in 2017 who were known to FACS.<sup>2</sup> As shown in Figure 1, most of the children died in circumstances related to illness and/or disease, from extreme prematurity or suddenly and unexpectedly in infancy (SUDI)<sup>3</sup>.

Each year, deaths from illness and/or disease consistently account for the greatest proportion of children who die and were known to FACS. In addition, 2017 saw a significant *increase* in the number and proportion of children who died from illness and/or disease. Consequently, the proportion of children known to FACS and who died from external causes (for example, suicide, motor vehicle accident and drowning) significantly decreased.

Nine of the children who died in 2017 had their parental responsibility reallocated through the Children's Court. The parental responsibility for one child was allocated to a relative, one child had parental responsibility shared between a relative and the Minister for Family and Community Services and seven children had their parental responsibility allocated to the Minister. Of these seven children, three had been living with relatives, three were placed with authorised carers and one was in residential care.

**Figure 1: Children who died in 2017 and were known to FACS, by circumstances of death<sup>4</sup>**



1 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.

2 'Known to FACS' 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.

3 For further information about SUDI, see Section 2.3.3.

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

## Children who died from illness and/or disease

The focus of Chapter 3 in this year's report is on the findings from a cohort review of 165 children who died from illness and/or disease from 2013 to 2017. Focusing on this group of children is important because illness and/or disease is consistently the highest circumstance of death for children who die and are known to FACS.

Caring for a sick child who requires additional support because of their health and physical needs can place extra strain on any family. The children included in the cohort review were either living in families where child protection concerns existed, or were in out of home care when they died. Chapter 3 considers these children's experiences, why they were known to FACS and what we can learn from the reviews of our work with them and their families.

Our analysis and findings have been written to inform future practice. It is hoped that learning from these deaths can improve FACS work with children who have an illness and/or disease, their families and those who are working to support them.

## Improving the way FACS works with children and families

Across 2017 and 2018, the NSW Government continued to implement reforms to the child protection and out of home care system in NSW. More information about these reforms is outlined in Chapter 4.

The NSW Practice Framework, launched in 2017, continues to bring together practice approaches, reforms and priorities to guide FACS child protection work across systems, policies and practice. The Framework unites FACS through shared principles, language and standards, and keeps children and families at the forefront of our thinking and action. More information about the implementation and rollout of the Framework is included in Chapter 4.

*Their Futures Matter* is the NSW Government's long-term strategy for improving outcomes for vulnerable children and families. It brings all areas of government together to deliver a more cohesive and accountable system. Chapter 4 provides an update about the implementation of the *Their Futures Matter* reforms, and details achievements that have occurred since implementation began. Together, the NSW Practice Framework and *Their Futures Matter* have been essential in guiding our approach and practice with vulnerable children and families.



# 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 helps 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 Family and Community Services (FACS) is the statutory child protection agency in NSW. FACS works with other government departments, non-government organisations (NGOs) and the community to support families to keep children safe from abuse and neglect.

FACS practitioners work with some of the most vulnerable children and families in the community. Many of these families live with extreme disadvantage because of poverty, lack of access to services, parental unemployment, homelessness, social isolation and reduced access to education. Often, families live with the effects of problematic parental substance use, unaddressed mental health issues and 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.<sup>5</sup>

FACS is committed to achieving child protection practice that understands how social disadvantage, and stressors associated with it, are related to child abuse and neglect. This report shares some of the stories of families whose children have died, reflects on their experiences and considers how FACS could have worked with the families to reduce risk and create safety.

## 1.2 Examining child deaths

### 1.2.1 FACS child death reviews

Children in NSW with a child protection history have a higher mortality rate than those not known to FACS.<sup>6</sup> Other jurisdictions across Australia have similar findings.<sup>7</sup>

While most children die from causes or in circumstances not related to the reasons for their child protection reports, the fact remains that children who have been reported to FACS at ROSH are at greater risk.

Each year the *Child Deaths Annual Report* has four objectives:

1. To promote transparency and accountability about child deaths by publicly reporting on FACS involvement with the families of children who have died.
2. To increase public trust and confidence in FACS by reporting on what has been learnt from child death reviews, and the improvements to practice and systems made as a result of this learning.
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage that can impact on outcomes for families.
4. To share learning from 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)<sup>8</sup> is part of the Office of the Senior Practitioner (OSP). SCR reviews FACS involvement with all children who have died and 'were known to FACS'. This includes children and/

<sup>5</sup> NSW FACS (2016b).

<sup>6</sup> NSW FACS (2017a).

<sup>7</sup> Previous contact with child protection services is often noted as a common factor in child death reviews. See Australian Institute of Family Studies (AIFS) (2016a).

<sup>8</sup> Formerly known as the Child Deaths and Critical Reports Unit.

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.

These often difficult reviews consider how FACS systems at a local and organisational level impacted on practice with the families of children who died. The reviews examine learning opportunities for practitioners who work with families by not only identifying areas for practice improvement, but also promoting good practice.<sup>9</sup> This in turn can lead to broader system improvements.

## **Making recommendations from serious case reviews**

The Serious Case Review Panel meets quarterly to discuss complex reviews and make recommendations. The panel is made up of the Senior Executive from across FACS, which ensures input from multiple perspectives and ownership of recommendations across FACS. The panel is overseen and monitored by the FACS Executive Board.

This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. On average, the OSP reviews FACS practice with more than 200 families each year. Approximately 90 of these are serious case reviews following a child's death, and more than 100 are practice reviews by casework specialists. Many of the reviews result in recommendations by the OSP aimed at improving direct casework with families; however, a small portion are complex reviews that also have implications for state-wide practice and systems.

## **Practitioner support and consultation**

When a child dies, SCR provides practical support to practitioners straight away. This enables practitioners to focus on the important job of offering and providing support to families, and assessing the safety of other children in the home. 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 FACS practitioners in their obvious willingness to learn from a child's death.

In some circumstances when a complex review is completed, practitioners are given an opportunity to talk about 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.

The staff consultation process is essential because, when done well, it reduces the risk of the child's death negatively impacting future practice with other vulnerable children. It can also reduce staff defensiveness and ensure accurate 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 feel they 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.

## **Turning child death reviews into learning**

Each child death review offers the possibility of considerable learning, and the OSP looks for opportunities to share learning proactively with practitioners across FACS. Some examples of the ways FACS 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 FACS. This includes their characteristics, the circumstances of their deaths, and how FACS responded to the families of the children before and

<sup>9</sup> While child protection is what we do, practice is how we do it. Practice is the relationships, the conversations, the thinking and the care. When it works, practice is the magic that keeps children with family, connected to culture and cherished by those who love them best. See NSW FACS (2017b).

after their deaths. The reports aim 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.

### Cohort and other reviews

Each year, SCR undertakes a cohort review that looks at a group of children who died and were known to FACS who share some common characteristics. In 2016, SCR completed a review of FACS responses to families when a child dies. That review focused on assessing the safety of the child's surviving siblings and supporting the family.

Previous cohort reviews include an analysis of the deaths of:

- 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 165 children who died from illness and/or disease from 2013 to 2017. This group of children is important, as illness and/or disease is the highest circumstance of death for children who die and are known to FACS.

### 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 often inform the OSP's Research to Practice seminars.<sup>10</sup>

## 1.2.2 Public and inter-agency understanding of child deaths

In providing public information about the circumstances surrounding individual children's deaths, FACS is committed to protecting the privacy of vulnerable families who are impacted by the death of a child.<sup>11</sup> 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.<sup>12</sup>

While FACS cannot report publicly about individual children, we have a strong commitment to transparency and accountability. The annual publication of this report reflects this commitment.

### Child deaths and the media

Every child death should be the subject of scrutiny and review. Drawing attention to the stories of vulnerable children and families can help the community to understand the nature of child protection work and some of the complexities involved in working with vulnerable families. If people have a better understanding of what life could be like for a child at risk, they may be more aware of and better able to help the child and report their concerns.

Every year 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 by a parent or carer. Understandably, these stories spark strong reactions from the community. The media plays an important role in supporting the

<sup>10</sup> Each year the OSP offers a program of Research to Practice seminars to frontline workers and other professionals, to provide them with up to date research and the best of current practice on a range of child protection areas.

<sup>11</sup> Although information about children who have died is given in this report, identifying details of families have been removed to protect their privacy.

<sup>12</sup> *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 (Cwth).*

community to gain a better understanding of child deaths. The media can increase awareness in the general population about child protection issues, increase the level of vigilance and sensitivity to signs of abuse and affect the likelihood that professionals suspecting abuse will report it.<sup>13</sup>

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.

At an organisational level, the NSW Practice Framework<sup>14</sup> (see also Section 4.1) helps departmental and practice leaders to acknowledge the uncertainty of our 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 FACS works and brings these together in one framework that is used by the whole department. The Framework is available to all the employees, community partners and families with whom FACS works. Within it, information about FACS child death review work acknowledges that reviews are one of many ways to guide practice. Internal child death reviews show FACS willingness to reflect and maintain an open culture, where critique improves outcomes and supports meaningful change for families.

### 1.2.3 Child death oversight in NSW

FACS 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 review the causes and patterns of those deaths and identify ways they can be prevented or reduced. The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in July 2017 and considered reviewable deaths of children in 2014 and 2015.<sup>15</sup>

#### 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 (including FACS), and individuals with expertise in relevant fields including health care, child development, child protection and research methodology. The CDRT reports annually to the NSW Parliament about its work, including research projects.

<sup>13</sup> Ayre (2013).

<sup>14</sup> NSW FACS (2017b).

<sup>15</sup> NSW Ombudsman (2017).

In 2018, the CDRT advised FACS that 493 children aged from birth to 17 years died in NSW in 2017. These figures differ from FACS data, highlighting important differences between the CDRT and FACS:

- CDRT data may also include children who reside in NSW but died in another state. However, where a child's death is registered interstate, the identity of the child may not be provided to the team and these deaths may be reported separately.
- CDRT reports include the 'child protection history' of children who die in NSW. Unlike FACS, however:
  - CDRT does not include children who died in care as having a child protection history unless the child and/or a sibling was the subject of a report to FACS within the three years prior to their death.
  - CDRT child protection history includes children who were reported to FACS but whose reports did not reach the ROSH statutory threshold, and also children who were known to Child Wellbeing Units.<sup>16</sup>

## 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, a senior coroner has the power to hold an inquest into a child's death where it appears to the coroner that:

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

FACS is responsible for reporting the deaths of children known to the department to the NSW State Coroner. FACS 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 11 government agencies, including Police, Justice, Health and Social Services, and representatives from the non-government and academic sectors.

The core functions of the team are to review and analyse individual closed cases of domestic violence deaths;<sup>17</sup> 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 (2015–2017) was published in 2017.<sup>18</sup>

<sup>16</sup> The Child Wellbeing Units established in NSW Health, the NSW Police Force and the NSW 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 NSW FACS and other services to help the child or family.

<sup>17</sup> Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as a death that is 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.

<sup>18</sup> NSW Domestic Violence Death Review Team (2017).

## 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.

FACS 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 particularly strong system of oversight into the deaths of children in out of home care. Where a child dies in out of home care, SCR reviews FACS involvement, the CDRT may look at the child's death, the death is reported to the Coroner and the Children's Guardian, and the death may be investigated by NSW Police and the Coroner, and reviewed by the NSW Ombudsman.

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2017, this included children placed with FACS or NGO carers, and children who died in a facility funded, operated or licensed by the Ageing, Disability and Home Care division of FACS. 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 our 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.

## Chapter 2: Child deaths in 2017

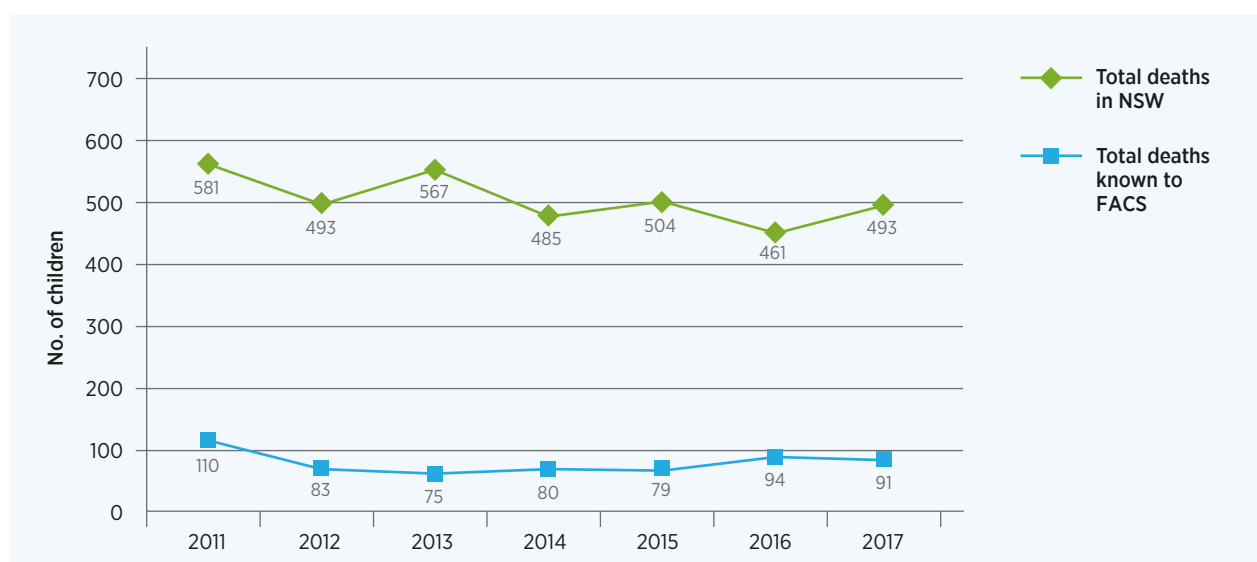
Chapter 2 provides a summary of information about the children who died in 2017 and who were known to FACS prior to their death. It includes characteristics of the children such as their age, gender and socioeconomic background. Analysis considers the children's child protection history, FACS responses before and after the child's death, as well as the circumstances in which the children died.

This chapter can only provide a broad background to the 91 children who died in 2017 who were known to FACS. The information provides a picture of the circumstances in which the children died and, where appropriate, an opportunity to reflect on and improve FACS responses to these children, young people and their families.

### 2.1 Child deaths in NSW in 2017

Between 1 January 2017 and 31 December 2017, the deaths of 493 children were registered in NSW.<sup>19</sup> Ninety-one of the 493 children who died in NSW were known to FACS because they and/or their siblings had been reported at risk of significant harm (ROSH) in the three years prior to their death, or they were in care.

**Figure 2: Children who died in NSW, by number of total deaths and whether they were known to FACS, 2011–2017**<sup>20</sup>



In 2017, the number of deaths of children known to FACS decreased compared to 2016.<sup>21</sup> The number of children who were known to FACS and who died in 2017 (91) also represented 0.1 per cent of the total number of children reported to FACS in that year. This is consistent with previous years' findings.<sup>22</sup>

<sup>19</sup> Information provided to FACS in 2018 from the NSW Child Death Review Team.

<sup>20</sup> *ibid.*

<sup>21</sup> There were 95 deaths of children known to FACS in 2016. The published figure was 94, but FACS was notified of one additional death after publication of the *Child Deaths 2016 Annual Report*.

<sup>22</sup> In 2017, FACS received approximately 165,000 ROSH reports, involving approximately 89,000 children.

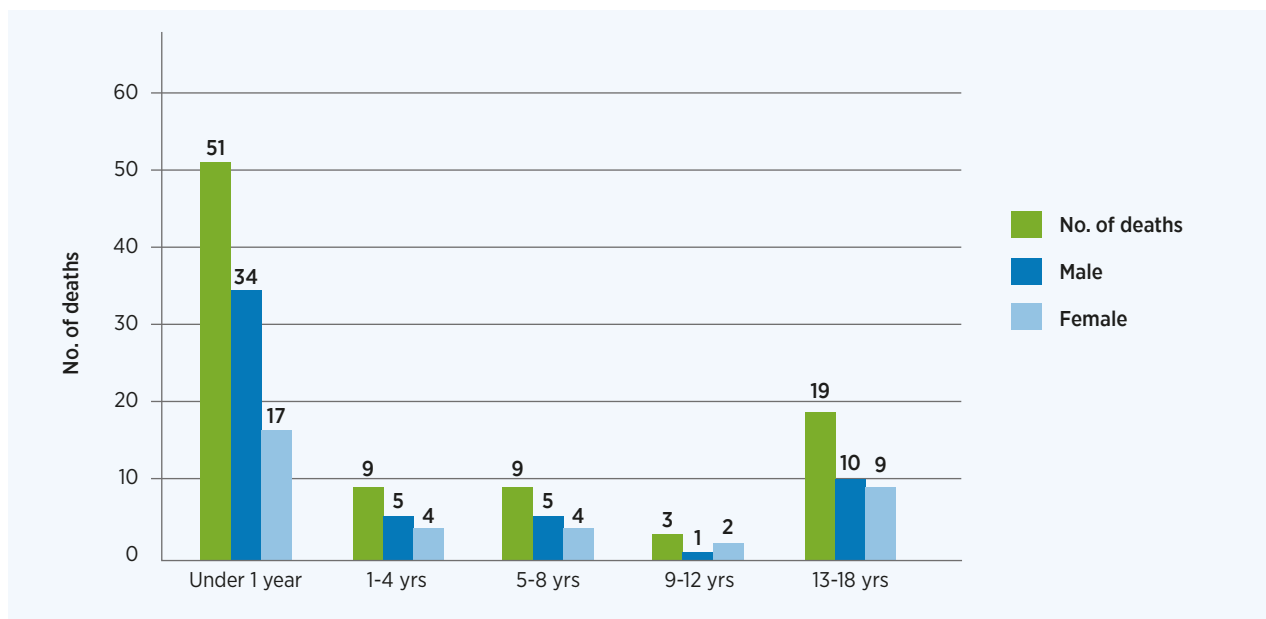
## 2.2 Characteristics of the children

### 2.2.1 Age and gender

Consistent with previous years, the majority of the children known to FACS who died in 2017 were less than 12 months old (51 children; 56 per cent). This number increased from 37 children in 2016 to 51 children in 2017. There was also an increase in the deaths of children aged between five and eight years, from four children in 2016 to nine children in 2017. This increase was largely due to an increase in the number of children who died from illness and/or disease in 2017. There was a decrease in the number of children who died who were aged between nine and 17 years.

In 2017, 55 (60 per cent) of the children who died were boys and 36 (40 per cent) were girls. Males died in higher numbers in almost all circumstances of death.

**Figure 3: Children who died in 2017 and were known to FACS, by age and gender**



### Children younger than 12 months

Of the 51 children aged under 12 months who died, 45 (88 per cent) died within three months of their birth. The circumstances of these children's deaths were:

- Illness and/or disease (17 deaths)
- Extreme prematurity (13 deaths)
- SUDI (11 deaths)
- Accidental asphyxia (1 death)
- Undetermined (3 deaths).

In addition, of the 51 babies who died:

- 38 had been reported for parental drug and/or alcohol misuse
- 33 had been reported for neglect
- 32 had been reported for domestic violence
- 27 had been reported for parental mental health.



## Teenagers

Nineteen (21 per cent) of the 91 children who died and were known to FACS were teenagers aged between 13 and 17 years. This is slightly lower than the number reported in 2016.<sup>23</sup> The circumstances of these 19 deaths were:

- Illness and/or disease (12 deaths)
- Suicide (3 deaths)
- Inflicted or suspicious injury (1 death)
- Motor vehicle accident (1 death)
- Other accidental injury (1 death)
- Undetermined (1 death).

There was a significant reduction in the number of teenagers who died from suicide<sup>24</sup> from 2016 to 2017, but there was an increase in the number of teenagers who died from an illness or disease.<sup>25</sup>

### 2.2.2 Aboriginal children

The deaths of Aboriginal children continues to represent a significant proportion of all children who died and were known to FACS.

Of the 91 children who died in 2017, 29 (32 per cent) were Aboriginal. This was a slight increase from 2016, where 27 per cent of children who died and were known to FACS were Aboriginal. Eleven of these 29 children were female and 18 were male. Twenty-five of the 29 Aboriginal children who died in 2017 were aged five years or under and four children were older than five years.

#### CULTURALLY RESPONSIVE PRACTICE

Practitioners have a responsibility to work to keep children safe, and should always be looking for ways to understand and address the disproportionate number of Aboriginal children in the child protection and out of home care systems. Practitioners need to work in partnership with Aboriginal families and communities to foster self-determination, so that Aboriginal and Torres Strait Islander children are safe and have a connection to their culture.

Practitioners need to take the time to understand the stories and cultural context of the Aboriginal families we work with, while maintaining a focus on the safety and wellbeing of children.

The principles of self-determination and participation are enforced through the *Children and Young Persons (Care and Protection) Act 1998* and must be promoted when working with Aboriginal families and communities. Participation is an important way to empower Aboriginal families and communities to help make decisions that affect the care and protection of their children.

Cultural consultation is a key step in obtaining greater insight and engagement with a family. Consultation is not just about looking for information to identify services. It involves practitioners engaging genuinely in the process and seeking specific knowledge, skills and assistance to make sure our practice meet the needs of the family.

Purposeful cultural consultation for Aboriginal children and families needs to be an ongoing process and not a one-off event.

Practitioners can refer to the Casework Practice topic **Cultural practice with Aboriginal communities** for more information.<sup>26</sup>

23 Chapter 3 of the *Child Deaths 2014 Annual Report* highlighted the vulnerability of adolescents and the behaviours that can enhance their vulnerability.

24 There were 11 deaths of children in 2016 from suicide.

25 There were nine deaths of children in 2016 from an illness or disease.

26 Intranet URLs for FACS Casework Practice resources can be found in the references section of this report.

## LIVING THE PRACTICE FRAMEWORK

Being curious about people's diverse cultural backgrounds can help to build trust and respect, which creates safety and belonging for children.

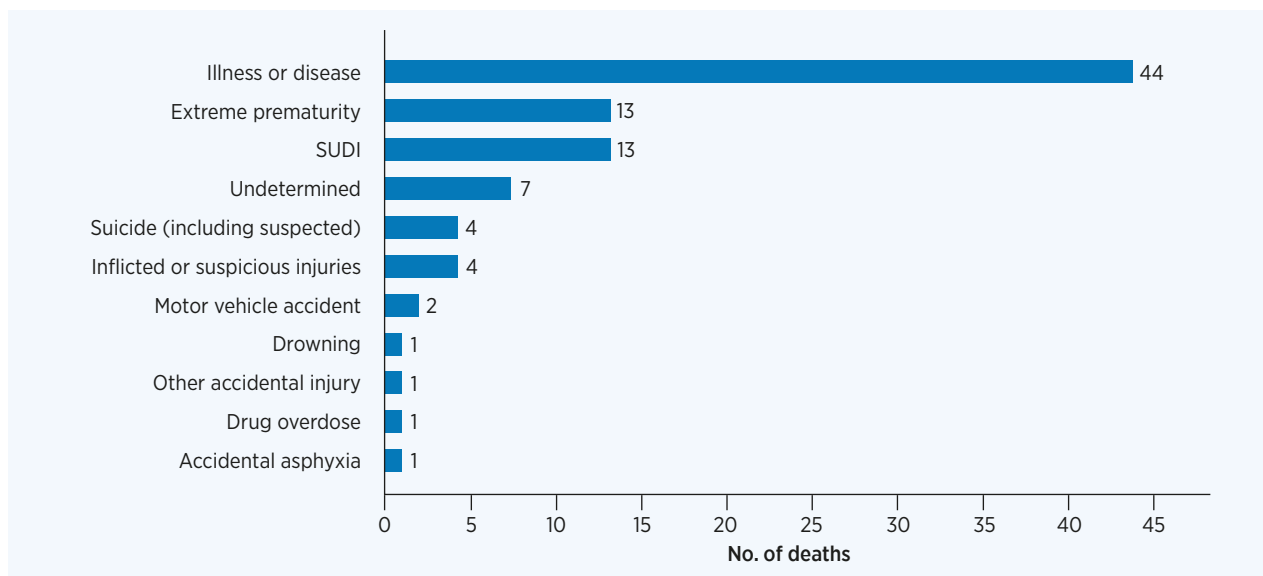
**NSW Practice Framework: Principle 1 – Culture is ever present**

### 2.3 Circumstances of child deaths

FACS receives information about the medical cause and circumstances of children's deaths from the NSW State Coroner and NSW Ombudsman. We rely on this information in our subsequent reports on the circumstances of the child's death. Following a child's death, FACS completes a review of the department's work with the child or young person and their family, including information from their child protection history and the work completed by practitioners. These reviews, along with the circumstances in which the child died, provide a context for FACS responses to the family.

Figure 4 shows the circumstances of death for the children known to FACS in 2017. Similar to previous years, most deaths in 2017 were from illness and/or disease, extreme prematurity and sudden unexpected death in infancy (SUDI).<sup>27</sup> This year, there were seven deaths where the circumstance of death is listed as 'undetermined'. These include two cases where FACS has not received post-mortem information and five cases where the Coroner has listed the cause of death as 'undetermined' or 'unascertained'.

**Figure 4: Children who died in 2017 and were known to FACS, by circumstances of death**



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 death could be multiple injuries, but the circumstance of death may be suicide, motor vehicle accident or an inflicted or suspicious injury.

<sup>27</sup> For further information about SUDI, see Section 2.3.3.

Table 1 compares the circumstances of death for children who were known to FACS and who died from 2014 to 2017. Despite little change in the overall number of deaths in 2016 and 2017, the percentage of children who died in each category has changed in some areas.<sup>28</sup> These changes include:

- an increase in the number of child deaths from illness and/or disease
- an increase in the number of child deaths as a result of extreme prematurity
- a decrease in number of child deaths related to SUDI
- a decrease in number of child deaths from suicide
- a decrease in the number of children dying in a motor vehicle accident
- a decrease in the number of children who drowned.

**Table 1: Children who died and were known to FACS, by circumstance of death, 2014–2017<sup>29</sup>**

Circumstance of death	2014		2015		2016		2017	
	No.	%	No.	%	No.	%	No.	%
Accidental asphyxia	0	0	1	1	0	0	1	1
Accidental choking	1	1	0	0	0	0	0	0
Drug overdose	1	1	0	0	1	1	1	1
Drowning	5	6	1	1	5	5	1	1
Extreme prematurity	17	20	8	10	11	12	13	14
Fire	0	0	1	1	2	2	0	0
Illness or disease	28	35	33	42	34	36	44	48
Inflicted or suspicious injuries	3	4	4	5	4	4	4	4
SUDI	14	18	13	16	15	16	13	14
Suicide (including suspected)	6	8	4	5	11	12	4	4
Motor vehicle accident	3	4	10	13	9	10	2	2
Undetermined	2	3	4	6	0	0	7	8
Other accidental injury	0	0	0	0	2	2	1	1
<b>TOTAL</b>	<b>80</b>	<b>100</b>	<b>79</b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>91</b>	<b>100</b>

### 2.3.1 Deaths from illness and/or disease

In 2017, 44 children (48 per cent) who were known to FACS died from illness and/or disease. Deaths of children from illness and/or disease accounted for the greatest proportion of deaths in 2017. The number of children who died from illness and/or disease increased from 2016 (from 34 deaths to 44 deaths). Table 2 highlights the deaths of children who died from illness and/or disease and were known to FACS.

**Table 2: Children who died from illness and/or disease and were known to FACS, 2014–2017**

	2014	2015	2016	2017
No. of deaths	28	33	34	44
% of total deaths	37	42	36	48
Age range	0–17 years	0–17 years	0–17 years	0–17 years

While it is unlikely that FACS could have prevented the deaths of these children, it is important to view these deaths through a child protection lens, to identify the ongoing stressors parents and carers of a child or young person with an illness or disease experience and how these stressors can exacerbate and

<sup>28</sup> Figures are subject to fluctuation across years due to the small numbers. Conclusions should not be drawn about the changes.

<sup>29</sup> 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 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.

lead to other child protection concerns, such as parental mental health, domestic violence, problematic drug and alcohol use, and the neglect of the child or young person’s medical, physical and emotional needs. Chapter 3 of this year’s report includes a cohort review of children who died between 2013 and 2017 from illness and/or disease and considers these issues and others in more detail.

Recognising the challenges faced by parents and carers of a child or young person with an illness or disease is critical to understanding and better supporting families and assessing safety and risk for children. SCR findings 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 to parents and carers is important to ensure that a child’s medical needs do not prevent them from receiving the love, nurture and stimulation they require for quality of life. Careful case management and support for parents and carers allows for work with families and other agencies to be organised and undertaken, and helps to case plan for children with complex medical needs.

### 2.3.2 Deaths related to premature births

In 2017, 13 babies died from conditions related to their premature birth, accounting for 14 per cent of all deaths of children known to FACS. There were seven babies who died at birth, four babies who died within the first month of their birth, and two babies who died within three months of their birth

**Table 3: Babies who died from conditions related to their premature birth and were known to FACS, 2014–2017**

	2014	2015	2016	2017
No. of deaths	17	8	11	13
% of total deaths	21	10	12	14
Age range	0–3 months	0–1 months	0–1 months	0–3 months

Understanding the factors that may have contributed to the premature deaths of these 13 babies in 2017 can lead to greater insights about the support needs of the families we work with. The health status and health care of the general population of women, their access to and the quality of preconception, reproductive, antenatal and obstetric services, and health care in the neonatal period are often reflective of perinatal mortality.<sup>30</sup> Broader social factors such as domestic violence, maternal education, nutrition, smoking, substance use in pregnancy and socioeconomic disadvantage are also significant factors that may have contributed to these premature deaths.

Of the 13 babies<sup>31</sup> known to FACS who died from conditions related to their premature birth, FACS received reports with concerns about:

- the mother’s drug and/or alcohol use during pregnancy (10 babies)
- mother experiencing violence during pregnancy (7 babies)
- a parent suffering from or experiencing a mental health condition (6 babies).

#### Substance use in pregnancy

Problematic substance use during pregnancy can lead to many potential risks for a baby, including low birth weight and premature birth. It is important to recognise that substance dependence is an illness and not just a behaviour. A dependency on alcohol and other drugs is linked to social stressors and physical and mental health.

While not all women who use substances during their pregnancy experience problems with their physical and mental health, many women experience poverty, encounter social disadvantage, face unemployment,

<sup>30</sup> Department of Prime Minister and Cabinet (2014).

<sup>31</sup> The numbers do not add to 13 because issues reported to FACS for some babies during the mother’s pregnancy included concerns about drug and/or alcohol use and domestic violence.

are young parents, have poor health and miss out on antenatal care. Mental health issues are common when there is an alcohol or drug dependency, with depression and anxiety the most common diagnoses.<sup>32</sup>

Pregnancy can be a time when many women are motivated to change their substance use. However, some women may not be ready to change. Creating new patterns of behaviour or finding new ways to manage emotional and physical needs can be extremely challenging.

Whether a woman is ready to change or not, her pregnancy is an opportunity. It is often the first time a woman will come into contact with health and child protective services and this provides practitioners with the opportunity to offer the supports needed. Pregnancy should be seen as a crucial time for readying women, and their partners, for change.

### **FACS CASEWORK PRACTICE**

The FACS Casework Practice **Alcohol and Other Drugs Practice Kit** provides practitioners with information and skills for engaging women and men where substance use poses concerns for their unborn child.

### **LIVING THE PRACTICE FRAMEWORK**

Motivational interviewing is a practice approach that uses genuine and curious conversations with families to encourage reflection about risks to a child. This approach could be used when working with families when a new baby is expected.

**NSW Practice Framework: *Practice approach – Motivational interviewing.***

## **Domestic violence in pregnancy**

Research suggests that domestic and family violence often begins during pregnancy or, if violence already existed, gets worse during pregnancy and into the first month of motherhood.<sup>33</sup>

Women who experience violence during pregnancy are at an increased risk of postnatal depression, which can impact on the bond and attachment between a mother and her baby. Violence during pregnancy can lead to babies having a low birth weight or being born prematurely.

Pregnancy and early parenthood are good opportunities for intervention if violence is suspected, as women and children are likely to come into contact with health and social services.<sup>34</sup> Expecting and new mothers may also be in a good place to be motivated towards change. If possible, engaging men at this stage can also help to keep the child and mother safe. A man's role as a father and carer needs to be recognised, while keeping him accountable for his behaviour. A father who is expecting a new baby may also be motivated to change his behaviour.

### **FACS CASEWORK PRACTICE**

The FACS Casework Practice **Domestic and Family Violence Kit** provides practitioners with information and skills for engaging women and men where domestic violence poses concerns for unborn children.

<sup>32</sup> National Drug and Alcohol Research Centre (NDARC) (2018).

<sup>33</sup> Australian Institute of Family Studies (AIFS) (2016b).

<sup>34</sup> *ibid.*

### 2.3.3 Sudden unexpected death in infancy

The CDRT defines SUDI as the death of an infant aged less than 12 months that is sudden and unexpected, where the cause is not immediately apparent at the time, and where the cause:

- is found after investigation (explained SUDI)
- remains unexplained after complete investigation (unexplained SUDI); this includes deaths classified as sudden infant death syndrome (SIDS).

**Table 4: Babies who died suddenly and unexpectedly and were known to FACS, 2014–2017**

	2014	2015	2016	2017
No. of deaths	14	13	15	13
% of total deaths	18	16	16	14
Age range	0–6 months	0–11 months	0–11 months	0–9 months

As shown in Table 4, the deaths of 13 babies in 2017 were classified as SUDI<sup>35</sup> and accounted for 14 per cent of the deaths of children known to FACS in 2017. Post-mortem reports were available for four of the 13 babies and provided the cause of death as ‘SUDI as a result of co-sleeping’.<sup>36</sup>

Of the 13 babies who died suddenly and unexpectedly in 2017, one or more modifiable risk factors (characteristics in an infant’s sleep environment) were found in 11 of the families. A modifiable risk factor increases the risk of SUDI and includes:

- the baby sharing a bed with a parent (7 babies)
- soft objects or other objects in the sleep environment (1 baby)
- the baby being breastfed and their parent falling asleep (3 babies).

Five of the 11 babies (38 per cent) who died in circumstances of SUDI were from Aboriginal families. Over the past few years, the number of children from Aboriginal families who have died in circumstances of SUDI has fluctuated. The number of children from Aboriginal families who died from SUDI-related circumstances in 2017 decreased by five per cent from 2016.

In 2017, the CDRT published the findings of its review of the deaths of 42 infants whose deaths were sudden and unexpected. The review<sup>37</sup> found that:

- almost all the infants were exposed to one or more modifiable risk factors, such as being placed face down to sleep, being placed to sleep in a bed with an adult, and being exposed to tobacco smoke
- on average, a cause of death is able to be determined in only one quarter of SUDI cases<sup>38</sup>
- SUDI in 2015 and in previous years disproportionately affected families in areas of socioeconomic disadvantage, families with a child protection history and Aboriginal families
- six infants died in circumstances where an adult unintentionally fell asleep while feeding or caring for them; across the five years from 2013–2017, 18 infants died in these circumstances.

Families known to FACS are more likely to experience a child dying in sudden and unexpected circumstances. The SUDI mortality rate is higher for children with a child protection history.<sup>39</sup> When working with families that are known to FACS, practitioners should promote that the safest place for a baby to sleep is in their own safe sleeping place in the same room as an adult carer.

<sup>35</sup> Information provided to FACS in 2018 from the NSW Child Death Review Team.

<sup>36</sup> The Coroner provided FACS with the final cause of death for an additional three children; however, their post-mortem reports were not available. These deaths were classified as undetermined or unexplained SUDI.

<sup>37</sup> NSW Child Death Review Team (2017).

<sup>38</sup> The NSW Department of Premier and Cabinet and the Deputy State Coroner are working with NSW Health and NSW Police on a clearer and more coordinated approach to responding to incidents of SUDI. This work aims to achieve greater alignment across policy directives, improve guidance for investigators and establish clear protocols for information sharing. These actions intend to increase the proportion of explained SUDI and ensure all families affected by SUDI receive follow up support. A final report will be provided to the NSW Ombudsman by the end of 2018.

<sup>39</sup> NSW Child Death Review Team (2015).

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 messages about safe sleeping when they are speaking to families. Practitioners should also participate in ongoing training 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 messages about safe sleeping are not always received, understood or adopted. Practitioners need to build relationships with families and communities, and support families to find ways to keep their babies safe. It is important that practitioners are consistent, persistent and non-judgemental when talking to families about safe sleeping.

## SAFE SLEEPING AND COT-TO-BED SAFETY

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 their website.

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.<sup>40</sup>

These apps are helpful resources for practitioners to use when working with families, and they allow families to readily access information on safe sleeping practices in their home.

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

The *Child Deaths 2013 Annual Report* included a cohort review of 108 babies 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 FACS. Helpful practice tips from this training package to consider when talking with parents about safe sleeping are included below.

## SAFE SLEEPING

### Ask to see the baby's cot

- Does it meet the Australian safety standard?<sup>41</sup>
- 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 baby to sleep.
- Reinforce to parents that the safest place for their baby to sleep is in a cot next to their bed.
- Explain to parents that covering a baby's head increases the risk of sudden infant death.
- Is the bedroom free of other risks, including cigarette smoke?

*continued over page...*

<sup>40</sup> See also Red Nose Foundation (2018).

<sup>41</sup> All baby cots must meet Australian and New Zealand Standard AS/NZS 2172:2003 *Cots for household use – safety requirements*.

### **Assess the risk of substance use**

- Ask parents about their substance use. Do they use drugs? If so, what drugs (including prescribed medication) and how much? When do they use and what impact does it have on them?
- Ask parents about their baby'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 baby when they use?
- Explain to parents the risks associated with sleeping with their baby while under the influence of substances.

### **Discuss sleep routines**

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

### **Parents who smoke**

- Explain the increased risk of SUDI for babies exposed to smoke, particularly if they share a sleep surface with a smoker.
- 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 jacket' and washing their hands after smoking.

### **Talk to breastfeeding mothers**

- Educate mothers so they are aware of the potential dangers of fatigue and sedation.
- Encourage mothers to breastfeed their baby out of bed to avoid the risk of falling asleep.

### **Did you know**

- If you can slide a drink can between the rungs of a cot, the cot is not built to Australian safety standards.
- The safest way to place a baby to sleep in a cot is with the baby's feet placed firmly at the bottom of the cot, with the blanket tucked in firmly.
- The safest position for a baby to sleep is on their back – babies should not be placed on their side or stomach.

The OSP Clinical Issues Team provides consultations to support practitioners to have conversations with families about co-sleeping. They can provide advice about how to assess safety for a child when there are unsafe sleeping practices.

## **SUPPORTING PARENTS IN THEIR GRIEF AND LOSS**

The Red Nose Foundation also has a grief and loss program aimed at supporting grieving individuals and families with the sudden and unexpected death of their baby or young child. A website offers individuals and families a range of support, resources and information.

Go to [www.rednosegriefandloss.com.au](http://www.rednosegriefandloss.com.au) for more information



## 2.3.4 Suicide

In 2017, four children died as a result of suicide or suspected suicide (4 per cent of all deaths of children known to FACS). All four children who died were male and aged between 10 and 17 years. One of the four children was in out of home care.

**Table 5: Children who died by suspected suicide and were known to FACS, 2014–2017**

	2014	2015	2016	2017
No. of deaths	6	4	12	4
% of total deaths	8	5	13	4
Age range	< 13–17 years	13–17 years	13–17 years	< 10–17 years

Of the four children who died from suspected suicide, all experienced trauma in their childhood. This trauma included neglect, physical abuse, exposure to domestic violence, parental mental health and parental drug and/or alcohol use. Two of the four children were reported to be at risk of sexual harm. FACS received ROSH reports for three of the four children in the 12 months prior to their death. Reported concerns were about the child or young person’s risk-taking behaviour, alcohol or drug misuse and problematic sexual behaviour.<sup>42</sup>

The four children who died by suspected suicide did not have any diagnosed mental health problems prior to their death; however, there were concerns about their emotional wellness. One of the four children had been involved with Juvenile Justice and another had previously attempted suicide.

### A PLACE TO GO

The *Their Futures Matter* whole of government reforms include newly designed ‘wraparound’ supports<sup>43</sup> for groups that have been identified as vulnerable. **A Place to Go** focuses on working with young people aged 10 to 17 years who are involved with the justice system.

Chapter 4 of this report includes more information about *Their Futures Matter* reforms.

In 2015, FACS completed a cohort review of vulnerable teenagers who died between 2009 and 2014. This revealed that those who died from suicide faced multiple individual, social and contextual risk factors<sup>44</sup> that heightened their vulnerability and compromised their safety. For children known to FACS, it is often the combination of these factors that poses the greatest risk for suicide.<sup>45</sup> Risk factors can relate to events or triggers; for example, sexual assault or bullying. The cumulative effect of neglect is likely to increase a child or young person’s vulnerability over time.<sup>46</sup>

In 2015, the NSW Child Death Review Team Report identified that suicide was the leading cause of death for 15–17 year olds and that:

- coordination of care and treatment for young people in contact with health services was not always optimal
- some young people who died by suicide did not present with suicidal behaviours or signs of intent

<sup>42</sup> Other reported ROSH concerns related to parental risk factors such as mental health, domestic violence, neglect, inadequate shelter or homelessness.

<sup>43</sup> ‘Wraparound’ refers to supports that are intended to wrap around a child to support them in all aspects of their life. Alongside services, wraparound supports can also include family, extended family, other carers, teachers and health care professionals.

<sup>44</sup> Individual risk factors include mental health problems, alcohol and substance use, previous suicide attempts and self-harm. Social risk factors include childhood adversity, such as a child protection history, bullying and social exclusion; sexual identity issues; and family factors, such as parental loss, divorce or discord and family depression and suicide history. Contextual risk factors include socioeconomic disadvantage, suicide in family or friends, homelessness and detention or contact with police.

<sup>45</sup> The suicide of young people was considered in detail in Chapter 3 of the NSW FACS *Child Deaths 2014 Annual Report*. The report highlighted a number of themes from reviews to help in understanding the risks associated with suicide.

<sup>46</sup> NSW Child Death Review Team (2014).

- young people often told their friends about their thoughts of self-harm or intent to suicide
- there is no focused suicide prevention plan for young people in NSW.<sup>47</sup>

Supporting vulnerable children is a continuous priority for FACS, and an area of child protection that requires intensive, skilful and sensitive casework.

### LIFE SPAN FOR SUICIDE PREVENTION

NSW Health, in collaboration with the Black Dog Institute, has developed **Life Span**, a systems approach to suicide prevention, incorporating health, education, frontline services, business and the community. Life Span aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis. Life Span is currently being trialled in four sites in Newcastle, Illawarra/Shoalhaven, Central Coast and Murrumbidgee.

Go to [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au) for more information.

### 2.3.5 Inflicted or suspicious injuries

In 2017, four children died due to circumstances of death that were from suspicious or inflicted injuries (4 per cent of all deaths of children known to FACS). Of these four children, one child's injuries were inflicted by a parent, one child's injuries were caused by a person unrelated to the family, and the person responsible for the other two children's deaths has not yet been determined.

Of the four children, three were male and one was female. Three of the children were aged six years and under and one child was under the age of 16.

For two of the four families, there was an allocated FACS caseworker involved with the family at the time of the child's death.

The number of children known to FACS who have died from an inflicted or suspicious injury has remained consistent over the last three years.<sup>48</sup>

### 2.3.6 Motor vehicle accidents

In 2017, two children died in motor vehicle accidents (2 per cent of all deaths of children known to FACS). This is significantly less than the nine children who died in motor vehicle accidents in 2016.<sup>49</sup>

One child was male and was eight years old, and one child was female and 16 years old. One of the two children was in out of home care.

Of the two children who died, one died in a motor vehicle accident and the other died from being hit by a car.

<sup>47</sup> NSW Child Death Review Team (2015).

<sup>48</sup> There were four child deaths in 2015 and 2016 from an inflicted or suspicious injury.

<sup>49</sup> There were three deaths of children known to FACS in 2014, 10 deaths of children known to FACS in 2015 and nine deaths of children known to FACS in 2016.

## 2.3.7 Other circumstances of death

### Drowning

In 2017, one child died from drowning (1 per cent of all deaths of children known to FACS). This child was female and was four years old. This is a decrease from 2016, when five children died from drowning.<sup>50</sup>

The NSW Government launched a water safety campaign, *Be Water Safe, Not Sorry*, in response to the increased number of drownings in 2016 and 2017. The campaign aims to educate people on the dangers associated with water and what they can do to stay safe.

Research to inform the campaign found that 15 per cent of all drowning deaths in 2016 and 2017 were children aged from birth to four years old. These deaths all occurred at home and lack of adult supervision was the most common factor leading to the deaths. One of the campaign's key water safety tips is 'always supervise children in or near water'. Key points to remember include:

- Don't get distracted
- Designate a supervisor so an adult is always watching
- Ensure pool fences meet safety standards
- Ensure the pool gate is securely closed.<sup>51</sup>

Supervision is promoted as the most effective preventative measure against drowning. Practitioners need to be aware of the risks of drowning and have conversations with parents and carers about the need for ongoing and attentive supervision around water, as well as how issues such as substance use, domestic violence and mental health problems may impact on a parent or carer's ability to supervise a child.

#### SAFETY AROUND WATER

Royal Life Saving Australia provides information on water safety as well as programs available to children and their families aimed at increasing children's safety around water.

Go to [www.royallifesaving.com.au](http://www.royallifesaving.com.au) for more information.

FACS and NGOs now include compliance checking for children's access to water during foster or relative carer assessments. Additionally, 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.

#### FACS CASEWORK PRACTICE

FACS caseworkers can access **Swimming pools: Frequently asked questions** via Casework Practice. This contains information about the requirements for pool safety at residential homes. Before being authorised, FACS foster, relative and kinship carers must provide a pool compliance certificate. When completing a home inspection, caseworkers must check that a swimming pool:

- has a child resistant pool fence/barrier that meets legal requirements
- is registered with the NSW Swimming Pool Register
- has a valid pool compliance certificate.

Caseworkers must review this along with all requirements of the Home Inspection Checklist during carer annual reviews and five yearly carer authorisation reviews.

<sup>50</sup> There were five deaths of children known to FACS in 2014, one death of a child known to FACS in 2015 and five deaths of children known to FACS in 2016 as a result of drowning.

<sup>51</sup> NSW Government (2017).

## Other accidental circumstances

In 2017, there were three child deaths due to other accidental circumstances. This represented 3 per cent of all deaths of children known to FACS. One child died as a result of an accidental overdose, one child died as a result of accidental asphyxia, and one child died of a head injury that occurred in a tragic accident.

## 2.4 FACS response to the children who died in 2017

This section outlines FACS involvement with the families of the 91 children who died in 2017. It discusses information about the number of reports received, what the reports were about, what decisions were made in response to reports, and whether the children were living with their family at the time of their death. This section also considers how FACS responded to families after their child's death to ensure that any siblings were safe.

### 2.4.1 ROSH reports

Of the 91 children who died in 2017, 58 (63 per cent) were the subject of a ROSH report to FACS in the three years prior to their death. Forty-five (77 per cent) of these children were reported at ROSH in the 12 months before they died. This is less than in 2016, when 74 children (79 per cent) were the subject of a ROSH report three years prior to their death.

Twenty-four (26 per cent) of the 91 children who died in 2017 were not reported to FACS at ROSH, but a sibling was reported prior to the child or young person's death. This was slightly higher than in 2016, when 20 siblings (21 per cent) were the subject of a ROSH report rather than the child who died.

Sixty-two of the children who died (68 per cent) did not have a lengthy child protection history, with between zero and two ROSH reports received prior to their death.<sup>52</sup> Fifteen (16 per cent) of the children were reported at ROSH three or four times. Fourteen (15 per cent) of the children were reported at ROSH more than five times, with one child having 15 ROSH reports. Of the 91 children who died, 28 (31 per cent) were allocated to a caseworker at the time of the child's death.

Before working with a family, caseworkers need to know what 'safety' will actually look and feel like, and what needs to be different for children. If parents do not understand our concerns, or disagree with the reasons for child protection intervention, it can be difficult to find agreement on what needs to change and what needs to happen next.

### LIVING THE PRACTICE FRAMEWORK

A relationship that honours the experiences of a family, and acknowledges any power imbalances between FACS and families allows families to feel safe enough to share intimate aspects of their lives.

**NSW Practice Framework: *Principle 3 – Relationships create change and restore dignity.***

### FACS CASEWORK PRACTICE

The Practice Advice topics **Relationship-based practice**, **Collaboration** and **Respectful partnerships with families** can support practitioners to build relationships with families that create change.

<sup>52</sup> This figure includes children who died and who were not reported to FACS but their sibling or siblings were, or those who received one or two reports.

Case planning is the core of purposeful work that supports families to make change. Case planning helps practitioners support families to change, while also balancing risk and holding hope. The quality of the relationship between the practitioner and the family is one of the single biggest influences for change.

It is important to monitor and review case plans in order to provide ongoing and meaningful casework to families. Regular reviews allow practitioners to clarify the purpose of their involvement, and make sure casework remains focused and supports change.

### FAMILY ACTION PLAN

FACS has a new case plan template. The **Family Action Plan** is a tool to support children to stay safely at home. It documents the family goals, necessary changes and supports required for a child to stay safely in the home.

The **Family Action Plan** is built into ChildStory and can be found on Casework Practice.

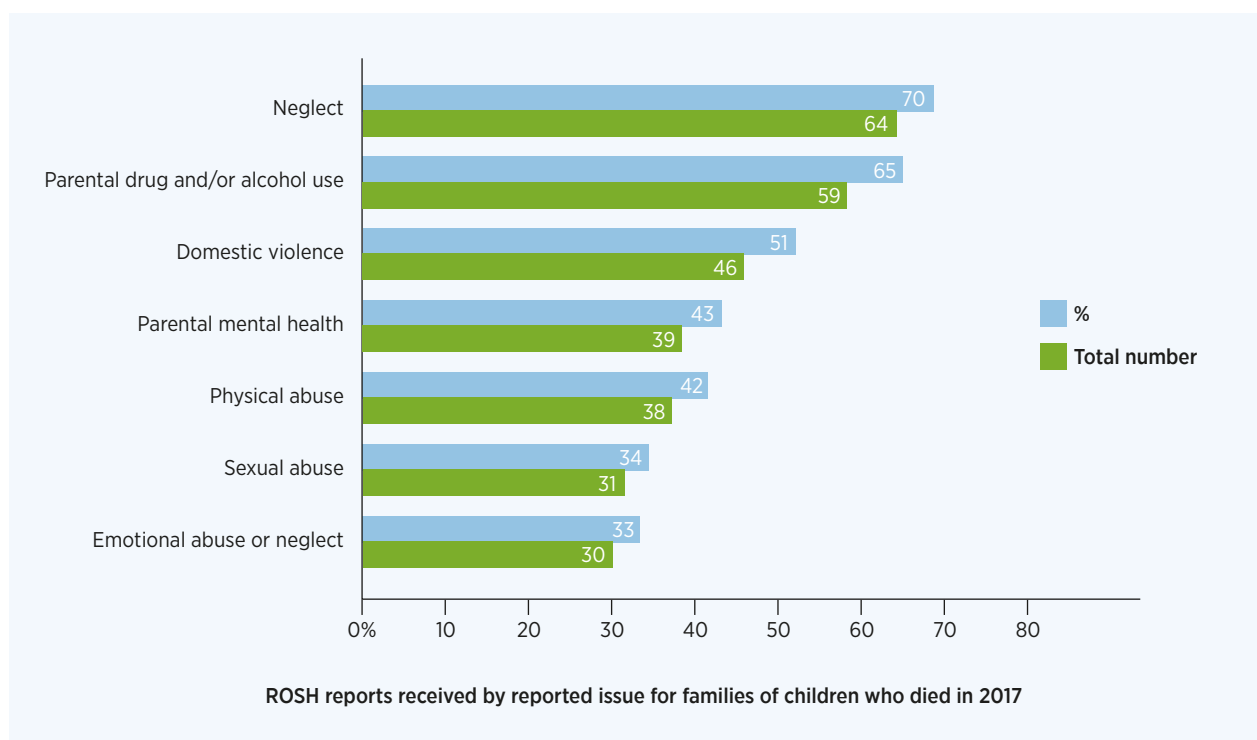
### FACS CASEWORK PRACTICE

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

## 2.4.2 Reported risk concerns

Neglect, parental drug and/or alcohol use and domestic violence were the primary reported issues identified from the ROSH reports received for children who died in 2017 and their siblings.

**Figure 5: Children who died in 2017 and were known to FACS, by selected primary reported issues in ROSH reports received about them and their families**<sup>53</sup>



<sup>53</sup> Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.

A total of 64 children (70 per cent) and their families were reported to FACS due to ROSH concerns about neglect. These families were reported for one or more types of neglect,<sup>54</sup> including:

- Supervisory neglect (37 families)
- Physical neglect (36 families)
- Emotional abuse/neglect (30 families)
- Medical neglect (26 families)
- Educational neglect (5 families).

While neglect, parental drug and/or alcohol use and domestic violence were the main issues reported for children who died in 2017, they rarely occurred in isolation.

Practitioners often work with families where co-existing conditions<sup>55</sup> are present. A practitioner's role is to assess how the co-existing conditions impact on parenting and, in turn, the child's safety. A parent with a co-existing condition 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.<sup>56</sup>

Quality and holistic safety and risk assessments are essential to understanding child and family experiences where more than one condition is present. Practitioners need to work in partnership with children and families, to support them to make and sustain change that ensures the safety of children.

## LIVING THE PRACTICE FRAMEWORK

Thinking about your own privilege, and others' disadvantage, helps develop empathy and is the start to building strong relationships that create change.

**NSW Practice Framework: Principle 5 – *Ethics and values are integral to good practice.***

## FACS CASEWORK PRACTICE

The Practice Advice topic **Social justice and human rights** can help practitioners to consider these issues when completing safety and risk assessments.

<sup>54</sup> Numbers do not add to 70 as multiple neglect issues can be present in one family.

<sup>55</sup> Previously known as dual diagnosis or comorbidity.

<sup>56</sup> Commonwealth of Australia (1996), Dadds et al. (2003), Durlak (1998), Durlak & Wells (1997a) and Loxley et al. (2004) as cited in the NSW FACS Casework Practice topic *Alcohol and other drugs: Risk assessment*. See a list of FACS Casework Practice intranet URLs in the reference section of this report.

## GROUP SUPERVISION AT FACS

Group supervision is the key formal process through which supervision is delivered to child protection practitioners in NSW.

Current evidence confirms the importance of group supervision in child protection work. It benefits work with children and families because it:

- shares risk in decision-making, so it does not just sit with one individual
- provides practitioners with multiple views and perspectives to support decision-making
- promotes ethical, transparent and dignity driven practice
- keeps managers close to 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 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 FACS to fulfil our mandate to embed principles, approaches and capabilities into practice with children and families. See Chapter 4 for more information about the NSW Practice Framework practice mandates.

### 2.4.3 Children in out of home care

As shown in Table 6, nine children were in out of home care when they died. This represents 10 per cent of all the children who died and were known to FACS in 2017.

**Table 6: Children who were living in out of home care when they died, 2014–2017**

	2014	2015	2016	2017
Number of deaths	10	9	10	9
Placed with a relative	2	1	4	4
Placed with authorised carers	7	7	4	3
Other (e.g. independent living, residential care, hospital)	1	1	2	2
<b>Other data</b>				
% of total deaths	12	11	11	10
Age range	0-15 years	0-17 years	0-17 years	0-17 years
Parental responsibility of Minister (any aspect)	9	9	8	8

Six of these nine children died from illness and/or disease. The other three deaths were from suicide, accidental injury and a motor vehicle accident.

Of the nine children who died in out of home care, seven were in the parental responsibility of the Minister for Family and Community Services. One child had their parental responsibility shared between the Minister and a relative, and one child had their parental responsibility allocated to a relative.

Of the nine children, four were living with relatives, two were living with FACS authorised carers, one was living with authorised non-government carers, one was living in a residential care setting, and one young person had been staying with a relative in an unauthorised placement, while still being supported by their FACS caseworker.

Five of the children were of Aboriginal descent. Five were female and four were male.

## 2.4.4 How FACS 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, FACS has a responsibility to assess the safety of other children living in the household, including unborn children. FACS has a sibling safety practice mandate<sup>57</sup> to guide practitioners when responding to a report about sibling safety after the death of a child.

Chapter 3 of the 2016 *Child Deaths Annual Report* focused on responding to a child's death and highlighted the following key areas of practice involved in completing holistic safety assessments with vulnerable families. These are:

- understanding the impact a child death has on a family as well as practitioners
- assessing other children's safety following a child death
- understanding the role of key agencies such as NSW Police, NSW Health, coronial services and FACS in a child death investigation.

It is important to focus on what practitioners need to do, including:

- working alongside families to assess the safety and wellbeing of children in the household
- assessing a family's support needs, while making a decision about future FACS involvement
- learning about and considering the family's history
- talking with services that may already be involved with the family
- talking with practice leaders about the impact the child's death has had on the family
- raising any concerns or worries they may have with the family
- working with the family to identify supports that can help in their time of grief
- being conscious of not looking for culpability or blame when responding to a child death where there are suspicious or unknown circumstances
- remembering that the focus is on the children's safety and wellbeing.<sup>58</sup>

Of the 91 children who died and were known to FACS in 2017, 33 (36 per cent) received an assessment from FACS following the child's death. This is consistent with findings from the cohort of families considered in the *Child Deaths 2016 Annual Report*, for children who died in 2015 and 2016. Typically, these assessments involve:

- FACS providing ongoing case management to families
- families being referred to other appropriate support services
- siblings being taken into care
- FACS ending its involvement because siblings were assessed to be safe in their circumstances.<sup>59</sup>

The remaining 58 (64 per cent) of the 91 families did not receive an assessment by FACS after the child's death. The decision not to complete a sibling safety assessment is usually made due to:

- no risk issues being identified for the siblings
- no children or young people living in the household who are aged under 18 years<sup>60</sup>
- FACS already being involved, working with the family and considering the information alongside existing casework
- a child or young person's death being screened as non-ROSH at the Helpline.

<sup>57</sup> The sibling safety policy states that 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.

<sup>58</sup> NSW FACS (2017a).

<sup>59</sup> *ibid.*

<sup>60</sup> This includes where the child who died did not have any siblings or the child had siblings who were in out of home care at the time of the child's death.



# Chapter 3: Children who died from illness and/or disease

## Introduction

Deaths from illness and/or disease consistently account for the greatest single circumstance of death for children known to FACS. In the five years from 2013 to 2017, 420 children known to FACS died. Of these, 165 (39 per cent) died from illness and/or disease. This chapter contains the findings from a cohort review of these 165 children. The practice learning from this review is relevant to all children known to FACS who are living with an illness and/or disease.

**Section 3.1** introduces the cohort and provides details about the characteristics of the children who died, and their families. This information is compared with all children who were known to FACS and died in the same five-year period. The similarities and differences between children who died from illness and/or disease and other external circumstances of death are also considered.

**Sections 3.2 and 3.3** have been informed by qualitative analysis of the internal serious case reviews completed for each of the children in the cohort. Such reviews include information about the circumstances and situation of each of the children before they died, and practice learning. Section 3.2 considers the intersection of childhood illness and/or disease with other child protection issues. The data is used to highlight those child protection issues most prevalent for children in the cohort and reveal the importance of holistic assessment. Section 3.3 considers how practitioners can work better with children, families and carers to assess children's safety and work together to keep them safe. This part of the report outlines common barriers and obstacles to working holistically and in partnership with families and provides suggestions for improving practice.

**Section 3.4**, the final part of this chapter, considers children who died from illness and/or disease while in out of home care. It focuses on end of life planning and includes discussion about the legal and practical considerations that need to happen when a child in out of home care requires palliative care.<sup>61</sup>

A number of de-identified case studies have been used in this chapter to highlight practice themes. These studies are based on details from the reviews of children included in the cohort. Reading these stories can be confronting and can bring up unexpected emotions, particularly if you have experienced a child death in your personal or professional life. Please be mindful of this when reading these stories and use the resources listed in Appendix 1 if needed.

## 3.1 The cohort: Children who died from illness and/or disease

One hundred and sixty five children who were known to FACS died from an illness and/or a disease from 2013 to 2017. This represented 39 per cent of all children who died during that period. More recently, FACS review of child deaths in 2017 has identified that the proportion of children who died from illness and/or disease has increased, representing just under half of all child deaths (48 per cent).

Deaths from an illness and/or a disease include those instances where the child died due to complications arising from a diagnosed medical condition or disability. Deaths may also have been from an acute illness.

The high number of children known to FACS who die from illness and/or disease is consistent with findings by the NSW Child Death Review Team (CDRT). The CDRT separates causes of death into 'natural' and 'external (injury-related)' causes and consistently identifies that most of the deaths of children in NSW are due to natural causes.<sup>62</sup> This cohort review excludes children who died from extreme prematurity.<sup>63</sup>

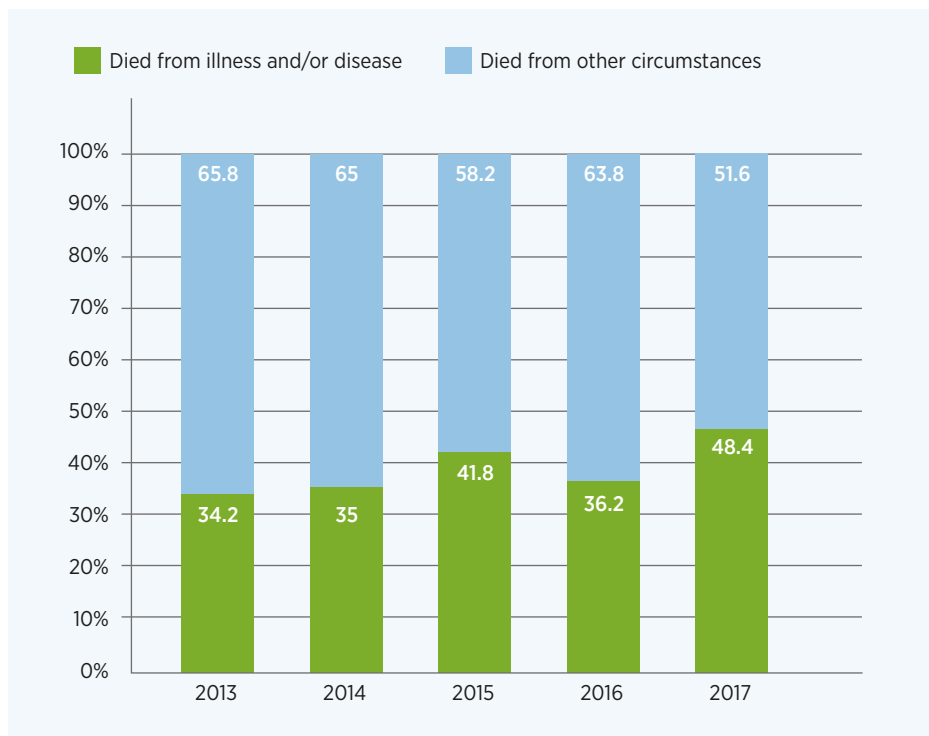
61 Palliative care is person and family centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life. Learn more at <http://palliativecare.org.au/>

62 In 2015, 81 per cent of children died from natural causes. In 2014, the figure was 78 per cent and in 2013, 85 per cent.

63 Extreme prematurity is also a 'natural' cause of death. However, FACS considers these deaths separately to the category of illness and/or disease.

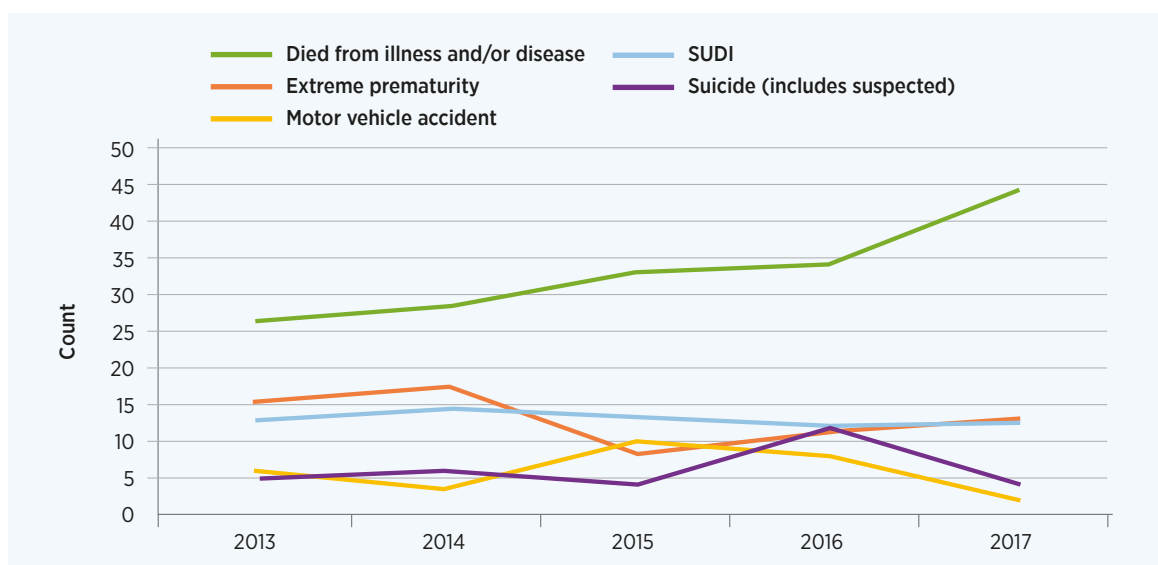
While the majority of child deaths in NSW are from natural causes, and children known to FACS are not over-represented in that group, children with a child protection history have a higher mortality for certain types of death due to natural causes<sup>64</sup> This includes meningococcal infection (3.4 times the mortality rate), influenza and pneumonia (2.2 times the mortality rate) and epilepsy (2.0 times the mortality rate).<sup>65</sup>

**Figure 6: Proportion of children known to FACS who died from illness and/or disease or in other circumstances, 2013–2017**



The deaths of children known to FACS from illness and/or disease are consistently higher than all other single circumstances of death. The deaths of children from the second highest other circumstance of death varies and includes extreme prematurity, SUDI, suicide and motor vehicle accident. Figure 7 shows that over the past five years the number of children known to FACS who died from illness and/or disease increased compared with the other highest circumstances of death. In 2017, there was a significant increase in the number and proportion of deaths from illness and/or disease.

**Figure 7: Number of children known to FACS who died from illness and/or disease or in other circumstances (top 5 circumstances), 2013–2017**



64 NSW Child Death Review Team (2014).

65 *ibid.*

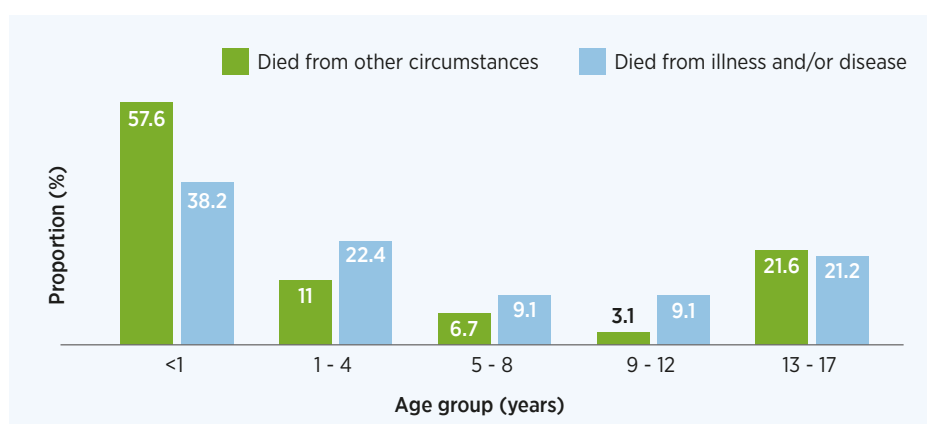
### 3.1.1 Age of children

Of the 165 children who died from illness and/or disease between 2013 and 2017, 100 children (61 per cent) were younger than five.

Infants younger than one year (63 children) made up the highest age group of children who died from illness and/or disease. This was followed by children aged one to four years (37 children) and children aged 13–17 years (35 children). Figure 8 compares the age grouping of child deaths from illness and/or disease with other circumstances of death.

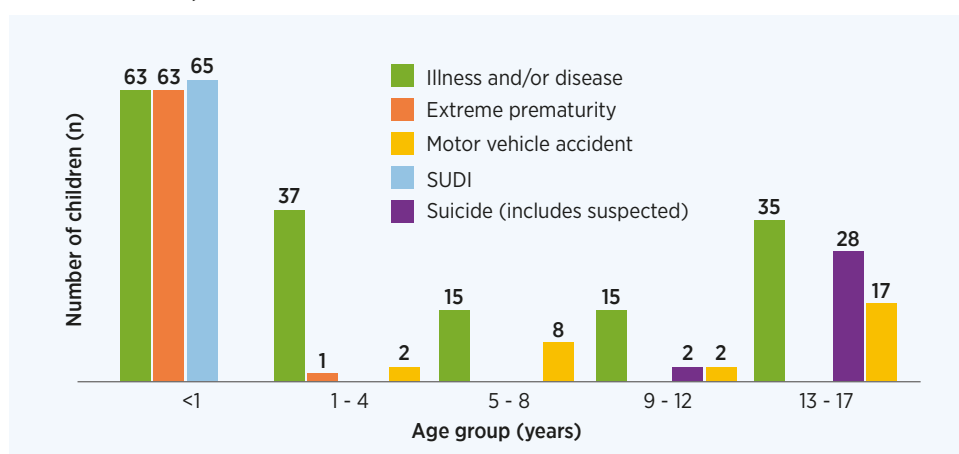
Recent research by the CDRT has identified that age presents particular vulnerabilities for some children.<sup>66</sup> For instance, compared with all children who die in NSW, certain age groups of children were more vulnerable to certain causes of death, particularly if the child is known to child protection services. For instance, infants aged under one year with a child protection history have higher rates of death from SUDI and extreme prematurity than infants without a child protection history.<sup>67</sup>

**Figure 8: Children known to FACS who died from illness and/or disease or in other circumstances by age group at time of death, 2013–2017**



When comparing deaths from illness and/or disease with other circumstances of death, the number of infant deaths from illness and/or disease is similar to deaths from SUDI and extreme prematurity (see Figure 9).

**Figure 9: Circumstances of death (top 5 with highest prevalence) by age group of child at time of death, 2013–2017**



Of the children who died and were younger than one year, a large proportion (56 per cent; 35 children) died in the neonatal period (from birth to 28 days).

Consistent with this review, the CDRT has found that the majority of children who die each year in NSW are infants younger than 12 months.<sup>68</sup>

<sup>66</sup> *ibid.*

<sup>67</sup> *ibid.*

<sup>68</sup> NSW Child Death Review Team (2016). NSW Child Death Review Team (2015).

**Figure 10: Infants aged less than 12 months who died from illness and/or disease, extreme prematurity and SUDI, 2013–2017**



### 3.1.2 Gender

The gender breakdown of children who died from illness and/or disease was similar to children who died from other circumstances. In the five years considered, 59 per cent of children who died from illness and/or disease and were known to FACS were male, and 41 per cent were female. For children who died from other circumstances, 60 per cent were male and 40 per cent were female. These findings are consistent with the CDRT, who also note a higher overall mortality rate for male children than for female children.<sup>69</sup>

### 3.1.3 Aboriginal status

Of the 165 children who died from illness and/or disease, 46 (28 per cent) of the children were recorded as being Aboriginal. Sometimes information about a child's Aboriginal status is not known or recorded, so this figure could be higher. In comparison, of the 255 children who died in other circumstances, 96 (38 per cent) were recorded as being Aboriginal.

Research from Canada (completed in 2009) shows that in countries such as Australia, New Zealand, the US and Canada, Indigenous status is a risk factor for childhood mortality due to a complex interplay of factors, including remoteness and access to health care, and socioeconomic and educational resources.<sup>70</sup>

Infant mortality is the death of a child younger than one year and is a long established measure of child health, as well as the overall health of the population and its physical and social environment. Both child and infant Indigenous mortality rates in Australia are declining.<sup>71</sup> Between 2011 and 2015 the mortality rate for Indigenous infants in Australia was 1.9 times the non-Indigenous rate. This has more than halved since 1998 and the gap between Indigenous and non-Indigenous infant mortality rates is narrowing, although there is still significant variation between jurisdictions.<sup>72</sup>

Without specific research, it is difficult to analyse how or if Aboriginality was a contributing factor to the deaths of children in this cohort. The proportion of Aboriginal children who are known to FACS and die from illness and/or disease is lower than for other circumstances of deaths.

<sup>69</sup> NSW Child Death Review Team (2016).

<sup>70</sup> Smylie & Adomako (2009).

<sup>71</sup> Australian Health Ministers' Advisory Council (AHMAC) (2017).

<sup>72</sup> *ibid.*

### 3.1.4 Prior diagnosis of illness or disability

From the information known to FACS, 113 (69 per cent) of the children in the review were diagnosed with an illness before they died and 68 (41 per cent) of the children had a diagnosed disability before they died.

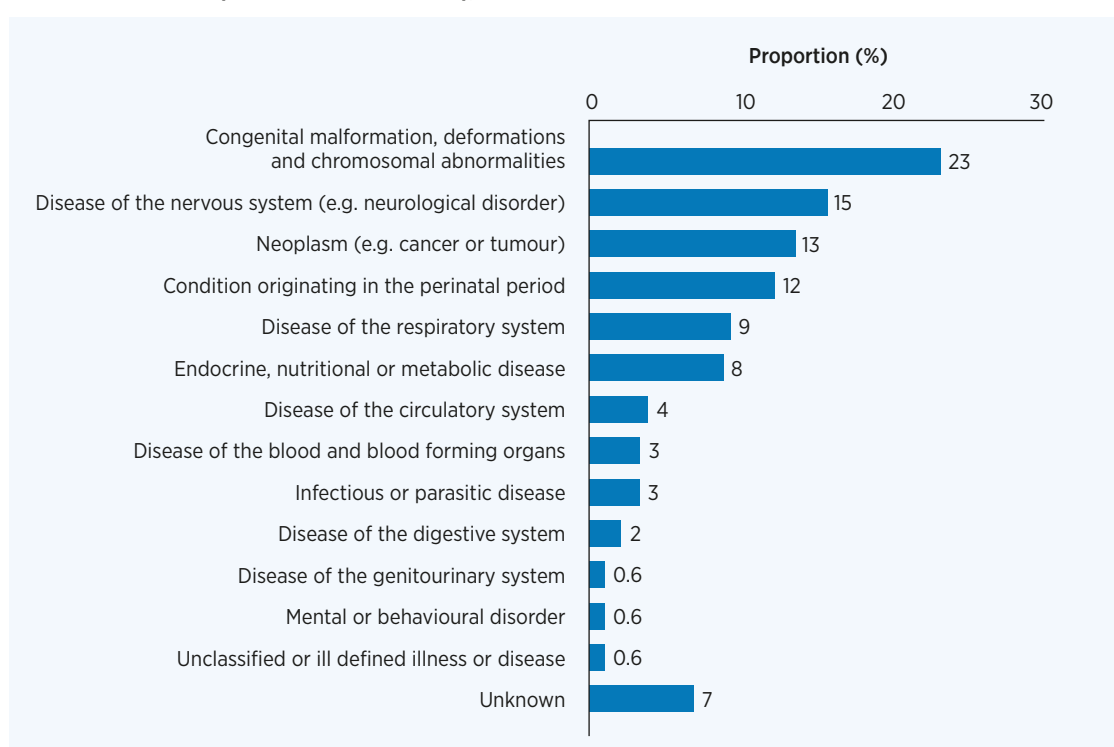
### 3.1.5 Classification of diseases and health conditions

Deaths from illness and/or disease can be classified further using the International Classification of Disease (ICD).<sup>73</sup> The World Health Organization (WHO) publishes the International Statistical Classification of Diseases and Related Health Problems (10th revision, ICD-10), the international standard for reporting diseases and health conditions for clinical and research purposes.

Within the cohort of children known to FACS who died from illness and/or disease, the largest proportion of children (23 per cent; 38 children) died from congenital malformation, deformations and chromosomal abnormalities. Examples of these deaths include children who were born with defects to their major organs or who had chromosomal abnormalities (often diagnosed in pregnancy). The findings from this review are similar to CDRT reviews, which have consistently found that deaths from congenital and chromosomal conditions are a leading natural cause of death for all children, after deaths from conditions arising in the perinatal period (which FACS includes as a separate circumstance of death, ‘extreme prematurity’).<sup>74</sup>

This review has already highlighted that children with a child protection history have a higher mortality rate. For deaths from natural causes including meningococcal infection, influenza, pneumonia and epilepsy, this increases further. For children who died and were known to FACS, post-mortem information indicated that for 34 of the children (21 per cent) these conditions were listed as contributing to the child’s death.<sup>75</sup>

**Figure 11: Proportion of children known to FACS who died from illness and/or disease by cause of death (ICD-10 classification), 2013–2017**



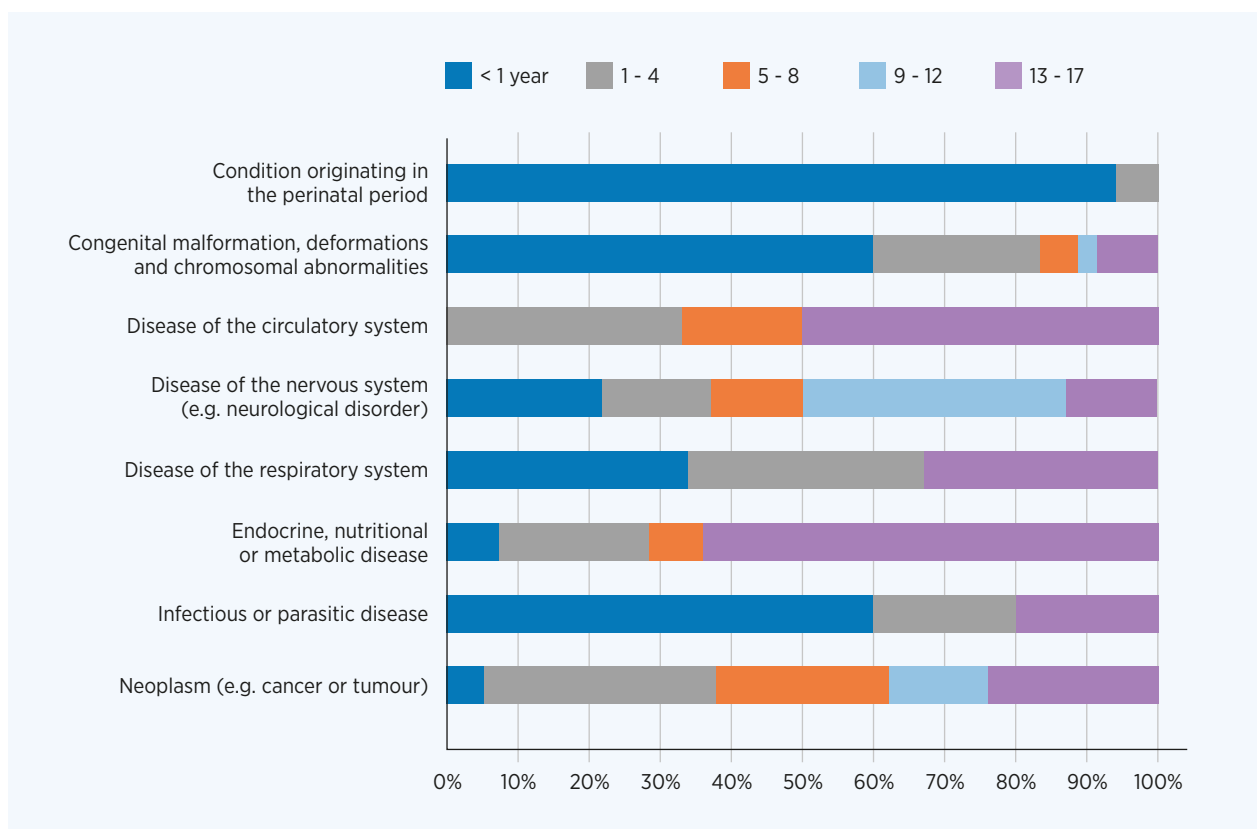
73 The ICD is a global foundation for the identification of health trends and statistics and is the diagnostic classification standard for all clinical and research purposes. ICD-11 was released 18 June 2018.

74 NSW Child Death Review Team (2016).

75 This included the primary cause as well as any listed antecedent causes on the post-mortem report.

Figure 12 reveals differences in cause of death by age group. Children aged less than one year died mainly from conditions arising in the perinatal period (extreme prematurity), a congenital malformation or an infectious disease. Children aged 13–17 years died mainly from circulatory system diseases (e.g. heart disease) or endocrine, nutritional or metabolic diseases (e.g. diabetes or cystic fibrosis).

**Figure 12: Cause of death by age group (%)**



### 3.1.6 Remoteness of child's residence

Just under two-thirds of children (64 per cent) in the review who died from illness and/or disease lived in the major cities of NSW.

**Table 7: Residence remoteness of children who died from illness and/or disease**

		Died from illness/disease			
		NO		YES	
		Count	%	Count	%
Residence and remoteness	Major cities	143	57	105	64
	Inner regional	78	31	42	26
	Outer regional	26	10	14	9
	Remote and very remote	4	2	2	1
Total		251	100.0	163	100.0

Note: Residence areas are grouped according to Australian Statistical Geographic Standard (ASGS) remoteness categories on the basis of their Accessibility/Remoteness Index for Australia score.

### 3.1.7 Family characteristics

#### Age of parents

Where information was available about a parent's age, the average age of mothers when their child died was 31 years. The average age for fathers was 35 years.

#### Parents' child protection history

For this cohort of 165 children and families, 60 mothers (36 per cent) had a child protection history or were known to FACS, while 32 fathers (19 per cent) had a child protection history or were known to FACS.

When looking at the parents' child protection histories together (Table 8), 25 families (15 per cent) had parents who both had child protection histories or were known to FACS. In comparison, 93 families (56 per cent) had parents who were both not known to FACS before the child's death.

**Table 8: Parents' child protection history: Number and proportion of mothers with child protection history, by fathers with child protection history**

		Father CP history			Total
		Unknown	No	Yes	
Mother CP history	Unknown	3 (1.8%)	-	-	3 (1.8%)
	No	2 (1.2%)	93 (56.4%)	7 (4.2%)	102 (61.8%)
	Yes	1 (0.6%)	34 (20.6%)	25 (15.2%)	60 (36.4%)
TOTAL		6 (3.6%)	127 (79.9%)	32 (19.4%)	165 (100%)

Note: Three children were excluded due to missing information on both their mother's and father's child protection histories.

### 3.1.8 Previous child death in the family

Within this cohort, 14 children (9 per cent) who died from illness and/or disease were in a family that had previously experienced the death of another child. Of the 14 deaths in the current cohort, three occurred in the perinatal period, three were an endocrine, nutritional or metabolic disease (e.g. a hormonal disorder) and two were from a congenital malformation (e.g. a physical defect present from birth).

### 3.1.9 Reported risk of significant harm concerns

While the children in this review died from illness and/or disease, they were also known to FACS and either living in families where there were reported child protection concerns, or living in out of home care when they died. The 165 children and families in this cohort had been reported to FACS for the following concerns:

- 54 per cent (89 families) for parental drug and/or alcohol misuse
- 52 per cent (86 families) for domestic violence
- 45 per cent (75 families) for physical abuse
- 39 per cent (64 families) for concerns about their parents' mental health
- 28 per cent (46 families) for sexual abuse.<sup>76</sup>

<sup>76</sup> Proportions do not add to 100 per cent and numbers do not add to 165 as families can be reported multiple times with multiple concerns.

For a large proportion of children who died from illness and/or disease (70 per cent; 115 children), FACS had received reports concerning neglect in the family prior to the child's death. Specifically, these reports for children and families about neglect included:

- 44 per cent (72 children) for physical neglect
- 39 per cent (65 children) for medical neglect<sup>77</sup>
- 34 per cent (56 children) for supervisory neglect
- 24 per cent (40 children) for emotional neglect
- 10 per cent (16 children) for educational abuse/neglect.<sup>78</sup>

Only 19 of the children in the cohort were reported for risks due to their own behaviour and risk-taking.

### 3.1.10 Allocation of cases

FACS was working with the families of 53 of the 165 children in the cohort when they died. The information known about these 53 children and their families was examined to understand why FACS was involved for such a significant proportion (32 per cent) of this cohort of children at the time of their death.

Seventeen of the 53 children were in out of home care and receiving regular casework. The other 36 children had open child protection cases.

For the 36 children with open child protection cases, reports had been reported for the following concerns:

- 83 per cent (30 families) for a form of neglect (including physical, supervisory, emotional and educational)
- 80 per cent (29 families) for parental drug and/or alcohol misuse
- 78 per cent (28 families) for domestic violence
- 61 per cent (22 families) for concerns about parental mental health
- 55 per cent (20 families) for physical abuse
- 50 per cent (18 families) for medical neglect
- 31 per cent (11 families) for sexual abuse.

Of the 165 children in the cohort, there were a further 10 children who had open cases with FACS when they died, but these cases were not allocated to a caseworker. Of these children:

- 6 had open cases for the purpose of providing a relative with a supported care allowance or were in out of home care, case managed by a non-government agency.
- 4 had been reported at ROSH before they died and FACS had not yet responded (one of these children died the same day the report was received and for the other three, a response was planned but had not started).

The remaining 102 children in the cohort were not receiving casework from FACS when they died. Of these 102 children:

- 29 had never been reported to FACS, but their death was reviewable due to a sibling having been reported for ROSH concerns
- 76 had been reported for ROSH concerns within the previous three years
- 49 of the children and their families had received previous casework intervention, but the cases were closed before the child died.

<sup>77</sup> For more information about medical neglect, see Section 3.2.1.

<sup>78</sup> Proportions do not add to 100 per cent and numbers do not add to 115 as families can be reported multiple times with multiple concerns.



### 3.1.11 Care arrangements and living circumstances

Twenty-three of the children in the cohort had had their parental responsibility arrangements changed by the Children's Court. For these 23 children:

- 17 had their parental responsibility allocated to the Minister for Family and Community Services
- 4 had their parental responsibility allocated solely to a relative
- 2 had their parental responsibility shared between the Minister and a relative.

Of the 17 children whose parental responsibility was allocated to the Minister, three were placed with family members, 12 were living with foster carers and two children were in a residential or group home.

There was one child in the cohort who was living with their grandparent, who was receiving a supported care allowance from FACS.

## 3.2 Intersection with other child protection issues

This section of the review of children who died from illness and/or disease considers what can be learned about practice with families.

Research suggests that children with a disability are at an increased risk of experiencing abuse or neglect.<sup>79</sup> They are also more likely to be abused by someone in their family when compared with children who do not have a disability.<sup>80</sup>

The overall finding of this review is that practitioners can become overly focused on a child's illness and/or disease at the exclusion of other child protection issues. The safety needs of children are often missed over the complexity of other issues happening in the home. The importance of holistic assessment cannot be understated and will be discussed in the following sections.

### 3.2.1 Medical neglect

Medical neglect is characterised by a carer's failure to provide adequate medical care. This can occur through a failure to acknowledge the seriousness of an illness or condition, or by deliberately withholding appropriate care.

Sixty-five of the 165 children who died from illness and/or disease between 2013 and 2017 had been reported to FACS for concerns about medical neglect. FACS practitioners have a critical role in responding to ROSH reports and assessing safety and risk. Good casework practice involves an awareness that neglect can be life-threatening and needs to be treated with as much urgency as other types of child abuse.

The *Child Deaths 2015 Annual Report* included a cohort review focused on neglect and found that eight children<sup>81</sup> who died from illness and/or disease had experienced medical neglect. A key finding of the 2015 cohort review was the need for practitioners to understand that safety concerns about a child's health are a child protection issue. Risks for these children require joint child protection and health service intervention to be managed effectively.

### 3.2.2 Neglect

As well as medical neglect, there were many reports for physical neglect (44 per cent), supervisory neglect (34 per cent) and emotional neglect (24 per cent) for the 165 children in the cohort. The harm that children experience as a result of neglect can be easily overlooked. Our reviews of children who were reported for various forms of neglect highlighted how easily casework became focused on the child's illness or disease, rather than responding to the neglect the child was experiencing.

<sup>79</sup> Maclean et al. (2017); Miller & Brown (2014); Algood et al. (2011).

<sup>80</sup> Miller & Brown (2014).

<sup>81</sup> These eight children died between 2010 and 2015. NSW FACS (2016a).

Physical neglect is characterised by a carer's failure to provide the basic physical necessities required by a child. Concerns experienced by children in our cohort included dirty home environments, inadequate sleeping arrangements and bedding, and a lack of appropriate clothing or food. There were also concerns related to health needs, such as feeding or medical equipment not being clean, suggested equipment not being purchased, medication needs not being fulfilled or a lack of prenatal care during pregnancy.

Supervisory neglect is the absence or inattention of a parent or carer that can lead a child to physical harm. As difficult and tiring as it can be for a parent or carer, they are responsible for a child's supervision. In one review, a young child was repeatedly found outside their home in dangerous situations. Our review noted that while his mother was initially held responsible, there was a slow shift of language by professionals over time, attributing the child's lack of safety to their own behaviour. This shift in language minimised the risks to the child, discounted their vulnerability and resulted in a changed perception of the dangers they faced.

While the number of children in the cohort who were reported for emotional neglect (24 per cent) was not as high as other forms of neglect, their experiences stood out in reviews. For instance, one child (aged four years) was reported to lie flat in his cot all day, bang his head against the mattress and not interact with people. There were also several examples of children, who were often non-verbal, witnessing significant violence by their fathers toward their mothers.

Ten per cent of children in the cohort were reported to FACS for concerns about educational neglect. Ensuring children with an illness and/or disease receive quality education in an inclusive environment should always be a priority. Education is vital for participating in later employment and also for social activity.<sup>82</sup> Research has shown that including children with different disabilities in inclusive educational settings from an early age can lead to positive effects on a child's social play and behaviour.<sup>83</sup> Research has also shown that inclusive education results in a more positive sense of self and self-worth for all children.<sup>84</sup> Caseworkers can help to uphold the rights of children with a disability and ensure education is inclusive. This involves challenging false assumptions and low expectations about children with disabilities or complex health needs.<sup>85</sup>

## THE IMPACT OF NEGLECT

Practitioners must assess the impact of all forms of neglect. They need to understand a child's health and medical needs and consider how these are impacted by the child's experience of neglect.

Building relationships with children is the key to understanding the impact of various forms of neglect. Caseworkers should seek support from those with expertise in working with children with disabilities and consider what behavioural indicators a child uses to communicate.

The *Child Deaths 2015 Annual Report* includes a chapter focused on neglect and provides information to support practitioners to respond to families with confidence and compassion where neglect is present.

### 3.2.3 Domestic violence

Eighty-six of the 165 children in this cohort were reported due to having experienced domestic violence. The impact and effects of domestic violence are well documented. Understanding the impact that being a victim of domestic violence can have on a mother's ability to care for and bond with her child is fundamental in child protection work. When assessing safety, practitioners should be attuned to the bonding and attachment that exists between a parent or carer and their child. A secure attachment to a primary carer is vital for healthy child development and provides strong protection for children.

82 World Health Organization (2011).

83 NSW Government (2014).

84 Cologon (2013).

85 *ibid.*

Understanding a child's attachment to inform decision-making is no different when working with a family where a child also has an illness and/or disability, and should inform a practitioner's assessment of the relationship between the child and their parent and/or carer.

In several reviews, practitioners identified that there had been a pattern of violent behaviour in the home but did not identify any danger to children due to the violent parent having left the home. This approach minimises the effect that the violence may have already had on the child. Whether violence happened in the past or is current, a comprehensive assessment is needed to understand the impact it has on those who experience it. This should include the adult who was a victim of the violence, and all children in the home. Positive practice was observed in a number of reviews, where practitioners kept the ongoing impact of the child's experience of violence at the centre of casework, despite the perpetrator having left the home.

Across those cases where domestic violence was a concern, there was a tendency for FACS interventions to focus primarily on the health and care needs of the child with the illness and/or disease, and not consider the safety implications of the violence in the home and the trauma that the child was experiencing as a consequence.

### **LIVING THE PRACTICE FRAMEWORK**

Response based practice is important when working with families where violence is present. Response based practice is about recognising people's inherent ability to respond to adversity. In the context of violence, acts of resistance are often hidden. Response based practice can help a practitioner to focus on a victim's response to an adverse situation and recognise their dignity and how it is being upheld.

**NSW Practice Framework: *Practice approach – Dignity Driven Practice***

### **3.2.4 Alcohol and/or drug use**

Eighty-nine of the 165 children in the cohort were reported to FACS due to concerns about parents' substance (alcohol or drug) use.

In the case reviews considered for the cohort, there were many examples of parents using substances to cope with the challenges they faced in caring for a child with illness and/or disease. Challenges included single parents caring for a child with little support, issues related to a parent's own disability, financial struggles and limited support networks. The high care needs of the child often resulted in sleep deprivation, exacerbation of the parent's own mental health issues and isolation from community or friendship networks, as parents focused on meeting the significant care needs of the child.

Alcohol and/or drug use by a parent or carer can often cause or exacerbate existing mental health problems. Problematic substance use by a parent places all children at risk. For children with specific health requirements, complex needs and possibly communication difficulties, problematic parental substance use increases their vulnerability and places them at high risk. Substance use can affect a parent's ability to recognise and meet a child's needs, supervise them and provide safety. These issues need to be considered in a holistic assessment.

### **CLINICAL ISSUES UNIT**

Practitioners can consult the Clinical Issues Unit if they have specific questions about substance use and its effects.

## FACS CASEWORK PRACTICE

Substance misuse by a parent or carer can impact parenting capacity. The extent of this impact and how it affects children in the home needs to be assessed. Practitioners should consider disruption to routine, the financial impact of the substance misuse, the capacity of the parent or carer to provide supervision and protection, how a parent's emotional and mental health is impacted and what affect this has on their attachment with their children.

Practitioners can use the **Alcohol and Other Drugs Practice Kit** in Casework Practice for more advice on assessing the impact of a parent or carer's substance misuse on children and young people.

### 3.2.5 Physical abuse

Seventy-five of the children in the cohort (45 per cent) were reported to FACS for concerns about physical abuse. Children with an illness and/or disability are at an increased risk of all forms of abuse. Physical abuse is any behaviour or omission that causes a child physical harm or places them at risk of harm. This also includes any inadvertent inflicting of injury resulting from physical punishment or aggressive treatment. Research shows that children with behaviour disorders, conduct disorders, an intellectual disability or health-related conditions are consistently more likely to experience physical violence and various forms of abuse.<sup>86</sup> Many of the children in our cohort required help with their physical care and daily needs; this can place them in vulnerable situations involving family members or those responsible for their care.

### 3.2.6 Sexual abuse

Forty-six of the 165 children (28 per cent) were reported to be at risk of significant harm (ROSH) due to concerns about sexual abuse. There is clear evidence that children with disabilities are more likely to experience sexual abuse than children without disability. According to the literature, the relative risk of child sexual abuse varies according to the type of disability the child experiences. In one study, children with speech and language impediments were three times more likely to be sexually abused, children with intellectual disability were four times more likely to be sexually abused and children with behavioural disorders were five to six times more likely to be sexually abused.<sup>87</sup>

Disclosure of sexual abuse can take time for any child who has been sexually harmed. For children with an illness or disability, this process can be further impacted by behavioural or communication difficulties. Practitioners need to be attuned to signs of sexual abuse and aware of reasons why a child may be reluctant to disclose. For a child with a disability, this may include having a lack of words or ability to name and describe the abuse. Children may also be reliant on their abuser for some or all of their needs and may have fewer people to support them and help them speak out about the abuse they are experiencing.

The recently concluded Australian Royal Commission into Institutional Responses to Child Sexual Abuse was an exhaustive five year inquiry which highlighted that children who have a disability, or who are in out of home care or cared for in institutional settings, are more vulnerable to abuse.

A literature review by FACS has noted that there is often a higher threshold for triggering child protection responses for children with a disability and that risk and interventions may be minimised because of a belief that supports are already in place for children and parents living with a disability.<sup>88</sup> These are important considerations for practitioners when working with children who have a disability and have been reported to FACS because of concerns about sexual abuse.

<sup>86</sup> Miller & Brown (2014).

<sup>87</sup> Sullivan & Knutson (2012) cited in Esposito & Field (2016).

<sup>88</sup> Esposito & Field (2016).

### 3.2.7 Intergenerational issues

A parent's own experience of being cared for is important to consider when assessing a family where a child has an illness or disability. Within this cohort, 60 of the mothers and 25 of the fathers were known to have a child protection history.

Across the case reviews of the 165 children who were part of this cohort, there was a strong focus on providing professional and casework intervention for mothers. There was a clear sense of mothers being held accountable for meeting the medical needs and care requirements of children with illness and/or disease.

It is important that practitioners understand and assess the role of all the people involved in caring for a child. If a child's father is involved in their life, their role must be recognised and they should be included in visits, assessments, and safety and case planning.

#### FACS CASEWORK PRACTICE

- Recognise the different roles of people involved with a child.
- Ensure that all those responsible for caring for a child have clear expectations of what they are responsible for.
- Include all persons with caring responsibilities in all casework.

Practitioners can refer to the Casework Practice topic **Working with fathers to keep children safe** for more advice on including fathers.

#### LIVING THE PRACTICE FRAMEWORK

**Family Finding** is an approach in the NSW Practice Framework that seeks to build a network around a child. This network is especially important for supporting children with illness and/or disability.

**NSW Practice Framework: *Practice approach – Family Finding***

### 3.2.8 Mental health

There were 64 children in the cohort who were reported due to concerns about a parent's mental health. In our reviews of FACS practice with these children, we found that consideration was not always given to how a parent's mental health affected their parenting and the safety of children in the home. We found that, too often, practitioners relied on a parent's own description of their mental health, their ability to recognise their mental health triggers and becoming unwell, and their need to seek support.

Practitioners need to assess a parent's mental health and have a deep understanding of how it affects children, and the parent's ability to provide safety for them. Several reviews identified the need to speak to a parent's doctors or psychologist specifically and not rely on information from a parent or other services about how mental health issues are being controlled and managed.

Inter-agency work with mental health services should focus on understanding how a parent's mental health affects their ability to parent.

#### THE EFFECTS OF MENTAL HEALTH

Where possible, speak to the child and their siblings about what life is like for them and their experiences at home to assess how a parent's mental health is affecting them. Develop a safety plan with them about who to call and how to get help if a parent becomes mentally unwell.

### 3.2.9 Ethical considerations

When the concerns about a child or young person who are reported to FACS meet the ROSH threshold, we have a statutory responsibility to assess whether the child is at ROSH.<sup>89</sup> Within this cohort review there were several examples of situations where culture or religion made an assessment of safety and risk to a child challenging. These examples included parents who:

- were unable to consent to a medical procedure, for example, a blood transfusion, due to religious beliefs
- were using cannabis oil to treat their child's illness
- were unable to provide personal care for their children due to cultural beliefs and expectations about gender roles.

These situations are complex and can challenge a practitioner's own beliefs and values. Ideally, we work with parents and help them to make choices that protect their children and ensure their safety. Protecting a parent's right to practice self-determination can be complicated when there are specific cultural or religious beliefs that influence this.

Practitioners need to work with and take time to understand and respect the culture, values and beliefs of children, young people and their families. Practitioners should use their creativity and, where possible, advocate for families so that their religious and cultural beliefs can be upheld.

#### ORDERS FOR MEDICAL DECISIONS

If all casework attempts have been unsuccessful and medical treatment is believed necessary, an application to the NSW Supreme Court can be made for an order to override a parent's decision.

Contact the **Child Law team** for advice and assistance.

#### FACS CASEWORK PRACTICE

See the Practice Advice topic **Culturally responsive practice with diverse communities**. FACS also has a **Multicultural Support Unit (MSU)** that provides consultation and support to practitioners to navigate cultural considerations and sensitivities.

## 3.3 Supporting children, young people and their families and working well with those who care for them

### 3.3.1 Working with the child or young person

Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously. This right applies at all times.<sup>90</sup> Children with a disability are particularly vulnerable. Their rights are given specific protection in the United Nations Convention on the Rights of a Child (CRC)<sup>91</sup> and Article 7 of the Convention on the Rights of Persons with Disabilities (CPRD)<sup>92</sup>. Australia ratified the CRC in 1990, the CPRD in 2008 and the Optional Protocol to the CPRD in 2009.

<sup>89</sup> Caseworkers respond and take action in accordance with the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

<sup>90</sup> Article 12 of the United Nations Convention on the Rights of the Child (CRC) (1989). UNOHCR (2018).

<sup>91</sup> Article 23 states that children who have any kind of disability should receive special care and support so that they can live a full and independent life. UNOHCR (2018).

<sup>92</sup> Article 7 states that state parties should take all necessary measures to ensure the full enjoyment of life by children with disabilities, that the best interests of the child should be a primary consideration and that children with disabilities have the right to express their views freely on all matters affecting them.

All children, particularly those who are younger, are reliant on a parent or carer for their physical needs. Children with a disability may be non-verbal or have limited language skills and be unable to communicate easily, creating barriers for them to be heard. For children who are reported to FACS as being at ROSH and who also have a disability or illness their vulnerability is heightened.

Research about children who have died has identified that social workers and other health professionals do not always relate to children effectively, which leads to assessments that lack a child focus.<sup>93</sup> This common phenomenon, known as the 'invisible child', is not well understood, but research suggests that the 'emotional intensity' of child protection work, 'complex interactions' with families and organisational issues can affect the ability of workers to think clearly and maintain a focus on children and their safety.

This cohort review found a number of practice examples where the child's illness or disease received more focus from parents, practitioners and other health professionals than the safety needs of the child. This led to practice where the child's opinions were not sought and participation in decision-making was overlooked. Barriers identified in this review that prevent effective participation for children include:

- caseworkers lacking specialist skills in working with children with illness and/or disability and an understanding of their complex needs and the services needed to support them
- the additional time needed to work with children with complex medical needs not being considered
- the competing demands of trying to address other concerns in the family
- a narrow focus on the parent and their experience of caring for the child.

Talking to children about their experiences, opinions and feelings is an essential part of holistic assessment. There are different levels at which children can participate, including being informed, expressing a view, influencing decision-making and being the main decider. For children with a disability who also have a cognitive impairment, their participation can be as simple as choosing between two carefully considered and clearly presented options. Such choices, where relevant, can be a valid and simple pathway to participation.<sup>94</sup> An assessment that considers the views of the child and their lived experiences can bring a new perspective to understanding a child or young person's situation or behaviour.

For some of the children who had disabilities, this review found that they also had behaviours that were perceived as challenging. The review found that in some cases this led to an 'attitudinal' shift where children were not viewed as a person with a significant health condition who had experienced trauma and abuse, but rather were only known for their 'challenging', 'difficult' behaviour. The review found that this type of labelling can negatively influence practitioners and cloud their understanding of a child's needs and vulnerability.

## FACS CASEWORK PRACTICE

Use language and communication styles that support the child to express their views for themselves. If needed, consider involving a disability support worker or someone who is familiar with the child and who understands their communication style and preferences.

Practitioners should seek to understand the child's level of comprehension and expression. This could be achieved through speech pathology reports or a referral to a speech pathologist.

It is important to consider whether the child is eligible for support from the National Disability Insurance Scheme (NDIS) and whether they are receiving this support and have a plan in place. If needed, a referral for support or for a review of supports should be made.

Building self-esteem, assertiveness, communication and relationship skills for all children is crucial. This will help to give them confidence and ultimately keep them safe.

Practitioners can refer to the Casework Practice topic **Talking to children and participation** for more considerations and ideas about preparing to talk to a child and seeking their views.

93 Ferguson (2016).

94 Franklin & Sloper (2009).

## Working with teenagers

Thirty-five children in the cohort were aged between 13 and 17 years. Working with teenagers who have an illness or disease presents different challenges to working with infants or children. While still dependent on a carer for many of their needs, a teenager also has independence and can be involved in decision-making. For example, a child aged 14 years and over can provide valid consent<sup>95</sup> for medical or dental treatment.

Teenagers face the usual challenges of adolescence alongside their health needs. Within this cohort, we saw examples of teenagers being expected to manage their own health and medical appointments, and situations where teenagers purposefully avoided health advice and medical care. Teenagers may be responsible for their own medications and will make their own decisions about compliance.

The *Child Deaths 2014 Annual Report* included a cohort review of 111 vulnerable teenagers who died between 2009 and 2014. Nineteen of these teenagers died from illness or disease, and SCR reviews found that parents or carers were often unable to provide for teenagers' medical needs. Three of the teenagers died from asthma.<sup>96</sup>

The following case study highlights how a child's illness can impact their self-esteem, family relationships and attitude towards their own care.

### CASE STUDY

Ella was 15 years old when she was first reported to FACS. She had been in hospital for treatment relating to her type 1 diabetes, diagnosed when she was nine years old. While in hospital, Ella was found self-harming. She told medical staff she was using cannabis and 'did not belong in her family'. Hospital staff told FACS that Ella had a poor history of diabetes control and multiple presentations to hospital.

Caseworkers met with Ella and her mother and learned that Ella had been living at different friends' houses for several months. Ella's mother described Ella as 'difficult' and said she was 'nothing but a burden' and that she had 'tried everything'. Ella's mother also told caseworkers she loved Ella and wanted her to be healthy and happy.

Ella told caseworkers that her mum was living with 'another boyfriend' that would 'treat her no good' and indicated she had witnessed a lot of violence from different men towards her mother. Ella said she was tired of all the medical appointments and having to be different from her friends. The hospital made a referral for Ella to a counselling service. FACS closed the case based on the involvement of other services.

Three months later, Ella died in hospital from acute complications relating to her diabetes. She had not been taking her medication, and wasn't attending appointments or following advice from professionals. She had continued to move between different friends' homes and had been engaging in risk-taking behaviour (sexual exploitation, and drug and alcohol use).

#### What could we have done differently?

Ella needed support to remain linked with specific services to address her diabetes, mental health and substance issues. Type 1 diabetes is a health condition that can be managed well with daily care. Ella needed someone to build a relationship with her, take time to listen to her and understand what she was feeling and what impact diabetes had on her. She needed support to reconcile with her mum, so they could build their relationship and understand each other's concerns. Ongoing case management to ensure these changes took place, and involvement with Ella until she was managing her health better, could have made a difference.

<sup>95</sup> Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW).

<sup>96</sup> NSW FACS (2015).



### 3.3.2 Siblings

Of the 165 children in our cohort, 146 had other siblings in the home. When working with families where child protection concerns exist and there is a child with a disability and/or illness or disease, the needs of other siblings in the family must also be considered and included in a holistic assessment.

Several of the reviews for our cohort noted instances where:

- siblings were required to take on a caring role
- the needs of siblings were excluded from assessments
- opportunities to work with a parent and help them to understand the needs of all their children were missed
- the impact of the behaviour of the child with a disability on siblings in a home was not always considered or understood
- other children in the home were at risk of physical abuse from a sibling with a disability because of their behaviours.

It is understandable that a child with significant medical needs may take the focus of a parent or carer's attention, with the potential to impact the whole family. A parent's interactions with their other children can be affected, routines become disrupted and a parent or carer may not be as available as they usually are. These dynamics should be considered by practitioners when working with families and included in assessment.

Children with disabilities influence their siblings in unique ways. A paper written to help school counsellors to work with siblings of children who have disabilities reminds us that siblings of a child with a disability have their own unique needs and experiences. For instance, the paper highlights that siblings may experience higher levels of empathy and share very close bonds.<sup>97</sup> However, the paper also finds that siblings can experience increased stress in comparison to other children of the same age who do not have siblings with a disability. The paper's findings note the potential for siblings to have low self-esteem, an increased risk of behavioural problems, the tendency to experience anger toward their sibling and a heightened sensitivity to typical family stressors.<sup>98</sup>

#### The importance of holistic assessment

The families that FACS practitioners work with have been reported due to child protection concerns and there are likely to be various forms of trauma and/or abuse happening in the home. If this is considered alongside findings from research, it is likely that specific interventions and work will need to be in place for siblings of children with a disability or with complex health needs, particularly if challenging behaviours are present. A FACS practitioner will be well positioned to do this through the process of holistic assessment.

#### FACS CASEWORK PRACTICE

Family systems theory is a useful tool to better understand the influence of a child's disability on the family.<sup>99</sup> The theory argues that no individual can be understood in isolation from their family unit because of the family's interconnectedness.

The Casework Practice topic **Holistic assessment and family work** includes other important prompts and considerations for assessment of the whole family.

<sup>97</sup> *ibid.*

<sup>98</sup> Hannon (2012).

<sup>99</sup> *ibid.*

### 3.3.3 Parents

Parents of children with an illness or disability have been found to experience higher levels of stress when compared with the parents of children with no health needs.<sup>100</sup> As well as worrying about their child's needs, parents and carers may face unexpected economic and financial costs associated with the care needs of the child, or caused by their inability to work if providing extended care for the child. Other stressors include social stigma and feelings of isolation.

When working with parents of children who have high health and medical needs, it is important to spend time understanding the needs of the child and their specific care requirements. Parents often have to juggle complex care and medical appointments while still looking after other children in the family. Understanding what a parent is facing, and recognising their experience, will help practitioners to better support parents to keep children safe.

Several of our reviews highlighted the importance of practitioners assessing information before allowing it to influence their perceptions of and views about a parent. Information provided to FACS often included comments that a parent had made while stressed or at a crisis point. While often not appropriate, these comments did not always reflect how a parent felt about their child. For example, in one review, a parent had brought their child to the hospital for treatment and told a hospital worker that they 'had had enough' and 'wanted it all to end'. When caseworkers met with the parent, they explained that the hospital admission was not medically urgent and described an alternate approach to the child's treatment, which focused on quality of life and the comfort of treatments. Caseworkers assessed that the parent knew their child well, was prioritising their care, and had made the comments when they felt frustrated by health professionals. In this case, the thoughtful and careful approach taken by caseworkers enabled the parent to feel heard, and the caseworker was able to advocate on their behalf to other health professionals.

This finding from our review supports Eileen Munro's research about common errors of reasoning in child protection practice.<sup>101</sup> The example highlights how practitioners were able to revise their judgement and consider how new information impacted their assessment of a parent.

For several children, our review found that information was reported about the child being 'difficult to manage', and parents were using inappropriate strategies to manage this 'difficult' behaviour. These inappropriate strategies included locking a child in their room, tying them to furniture and using medication inappropriately. While these practices are not appropriate, the reasons for why parents were using them needs to be listened to and understood. Practitioners must remain child-focused while also developing a relationship with a child's parents. Using empathy when working with parents can help practitioners to create strong relationships with families, which allows families to feel safe enough to share their struggles and challenges. Practitioners can then use this information to plan and work out the best ways to support a parent or carer while also keeping the child safe.

Research has shown that the quality of a parent's support network can influence the quality of their relationship with their child and moderate the effects of stress.<sup>102</sup> Social support can help a parent cope with stress and has been found to be the most crucial predictor of adjustment amongst mothers of children with disabilities.<sup>103</sup> Practitioners should consider this when working with parents of children who have an illness and/or disease and assess a family's current support network. If the support network is lacking, casework should build this to ensure parents feel supported.

### 3.3.4 Working with other services

Effective child protection practice depends on strong partnerships with wider service systems. Practitioners need to consider the involvement of services carefully and how they will create safety for children. Services should not be relied on or allowed to create a sense of security for FACS.

Our reviews noted multiple examples where FACS ended its involvement with a child and their family based on the involvement of other services. Reviews often found that little changed for families when FACS ended its involvement and the safety of children did not improve. Meaningful and sustained change

<sup>100</sup> Hannon (2012); Plant & Sanders (2007).

<sup>101</sup> Munro (1999).

<sup>102</sup> Plant & Sanders (2007); Algood et al. (2011).

<sup>103</sup> Findler, Jacoby & Gabis (2016).

takes time, particularly for families who are caring for a child with an illness, disability or disease and where child protection concerns are present.

Our reviews found that practitioners need to focus on purposeful case planning with families, with plans that describe clear and measurable goals towards increasing safety for children. Caseworkers need to avoid being distracted by the complex health needs of children, and should develop strong partnerships with families, NSW Health and other services to ensure that the health care and complex needs of children are understood and managed by the right professionals at the right times, and that each services is clear about its role.

In the case reviews for the 165 children in this cohort, several challenges associated with working with other agencies were identified. These included:

- getting all services and agencies involved with a child to be at case meetings and involved in case planning
- relying too heavily on other services' involvement
- over-reliance on other services to assess and monitor a child's safety when often these services are primarily focused on health care
- lack of coordination and clear division of responsibilities amongst the services involved
- lack of understanding by practitioners about what services were being provided by another service and what its role with the child and their family was
- lack of escalation of child protection concerns to FACS
- lack of understanding by FACS caseworkers to identify and respond to health risks.

The following case study highlights how effective inter-agency work can lead to an improvement in a child's care, quality of life and experiences.

## CASE STUDY

Jenny was born with a congenital condition that resulted in a shortened life expectancy. She required the use of a wheelchair and needed help with her personal care and eating. Her older sister Bree had the same condition and died when she was 13 years old. There were also two younger siblings in the family.

FACS began receiving reports for Jenny when she was nine. Her school reported that Jenny smelt, was in dirty clothes and did not have food for her lunch. FACS confirmed that other services were involved with Jenny and her family and closed the report.

When Jenny was 10, the school made another report with similar concerns about her hygiene and appearance. FACS also received a report from a speech therapist working with Jenny. The speech therapist said Jenny was not being fed the right foods and that her parents were not following the instructions they had been given to help Jenny use her communication tools. Around this time, Jenny was admitted to hospital because of poor weight gain and infection. The social worker reported that Jenny's parents were not visiting and were not attending Jenny's medical appointments.

FACS became involved and went to see Jenny's parents at home. Caseworkers took Jenny's parents to the hospital and met with Jenny, using this as an opportunity to observe their interactions and relationship. After spending time with Jenny's parents, the caseworker learned about financial difficulties the family was facing (both parents worked shift jobs), the grief they felt about Jenny having the same condition as their older daughter who had died, and the pressure they felt to care for their other children. FACS spoke to the other services involved and arranged a case conference.

At the meeting, the FACS caseworker advocated for the parents and explained why they had not been able to visit Jenny or always attend her medical appointments. The outcomes of the meeting included that:

- Jenny's parents would receive training from hospital staff on how to care for Jenny's specific personal care needs

*continued over page...*

- the family would be referred to a disability support service for case management
- new arrangements were put in place for communicating with the school and ensuring Jenny had the correct food
- FACS agreed to stay involved for three months and support the parents to meet all Jenny's requirements.

Six weeks later another case meeting was held between all services. Doctors said there had been a 'huge improvement' in Jenny and were impressed by her weight gain, personal care and the involvement of her parents. FACS remained involved for a further six months until a case management service could take over with coordination between Jenny's family and the services involved.

Jenny was 12 years old when she died as a result of complications from her illness. FACS had not received any more reports about her, or her family, until she died. From what we know, Jenny's quality of life improved after FACS became involved and she continued to be well supported. FACS active engagement with Jenny's family led to transparent discussions between all the agencies involved and, most importantly, Jenny's parents. The engagement was respectful and created the opportunity for services to work together to support Jenny's family.

## 3.4 Issues for children in out of home care

### 3.4.1 Involving parents

What is clear from the reviews for the children in this cohort is that, in most cases, children want to maintain a relationship with their parents, and parents want to see their children and be involved in decisions about their care. This can help children to retain and have a sense of their identity. The agency with case management has responsibility for helping children in care to develop and maintain relationships with their family and other significant people in their lives.

Among the children who died in out of home care, there were several whose parents had been caring for them, struggled to meet their high care needs and asked FACS for help. Within these reviews, we saw different responses to these parents and found that there were times when parents could have been provided with more support. For instance, at the point when parents were requesting help, they were tired, experiencing financial difficulties and had spent several years providing care for their child. These children were known to FACS because of child protection concerns, such as a parent's lack of supervision or substance use. The response given to the parent's request for help was often about child protection concerns and not a response that considered the parent's experience of caring for their child and the challenges they faced. Within reviews, we also found evidence of good practice that demonstrated respect, compassion and empathy. One of these is highlighted in the following case study.

#### **CASE STUDY**

David's parents were given information about David's health, poor prognosis and high care needs soon after his birth. They did not think they would be able to meet his needs and contacted FACS. The caseworker spent time observing David's care, and talking to David's parents to understand their concerns. David's parents told the caseworker they would like to remain involved and be able to see David regularly and make decisions about his medical care.

FACS applied to the Children's Court for an order allocating David's parental responsibility to the Minister for Family and Community Services, but asked that medical aspects of parental responsibility remain with the parents. An order that reflected this was made by the Children's Court. A carer was found who was happy for David's parents to have regular contact. David died when he was nine years old, and knew his carers and parents well.

## COMPASSION AND EMPATHY

Use a compassionate and empathetic response when making an assessment of parents who have children with an illness or disability.

Where possible, involve parents in decision-making and ensure arrangements are in place to support ongoing contact with children.

### 3.4.2 Maintaining sibling relationships

Practitioners should ensure that all children in out of home care are connected to their family. The NSW Charter of Rights for children in care states that 'you have the right to have contact with your family and community'. A measure of wellbeing within the case planning framework is to support and build the capacity of a child or young person to maintain positive relationships with family and significant others.

Research suggests that where sibling bonds are maintained, this connection can reduce the impact of some of the negative occurrences while in care and provide a valuable support well into adulthood.<sup>104</sup> Individuals who experience strong sibling relationships while in care have often been shown to have greater levels of social support, self-esteem, income and continuing adult sibling relationships.<sup>105</sup>

### 3.4.3 Caring for a child with specific health needs

The majority of children in out of home care have a history of complex trauma and need intervention to address this. Children in out of home care with an illness and/or disease will have even more specific health needs and requirements. The complexity of their requirements requires a coordinated response from FACS, health services and other professionals. This requires particular planning and thought when placement changes occur and a child moves between different health areas or between services.

FACS and NSW Health support all children in out of home care via the Model Pathway for the Comprehensive Health and Developmental Assessments for all Children Entering Out of Home Care (the **OOHC Health Pathway**). This is offered and supported by an OOHC Health Coordinator in each Health/FACS district. The OOHC Health Pathway aims to improve short and long-term health, development and wellbeing outcomes for children in out of home care, as well as supporting carers and placement stability. Chapter 4 of this report includes more information on the OOHC Health Pathway.

### 3.4.4 End of life planning

End of life planning takes place when a child in out of home care has a poor life expectancy or their condition is palliative. End of life decisions are complex and require significant planning. They involve careful consideration of medical needs, consultation with all significant people in a child's life and relevant health professionals, and clear documentation about decisions made.

There are many practical steps to be considered, as well as significant administration requirements such as consideration of victims compensation, the need for a will, advanced care planning, an ambulance care plan and funeral planning.

## DID YOU KNOW

Inter-agency partnerships and the inclusion of birth families, foster carers and out of home care agencies leads to better end of life decisions being made about children in care.

<sup>104</sup> McDowall (2015).

<sup>105</sup> *ibid.*

## Involving the child

Throughout end of life planning, the child must remain at the centre of all planning and decision-making. With consideration of the child's age, their understanding about their illness and the concept of death, a child should participate in their end of life planning. A practitioner should plan carefully and speak to the child about their wishes, the type of funeral they would like, who they wish to see before they die and the medical decisions being made about them.

## Legal considerations

A Children's Court order ceases on the death of a child and the legal authority to make decisions after death revert to the next of kin (this will usually be the child's parents) or the executor of the child's estate (if there is a will). When a child in out of home care dies, many people are affected and there can be multiple people wanting to be involved in decision-making about funeral and burial arrangements. If the child's death was anticipated, good end of life planning can help this process and prevent conflict.

Despite the child's legal status changing, the role of a FACS caseworker can be important after the death of a child in out of home care; caseworkers can often take on a lead coordination role. Managing communication, different family roles and the expectations of significant people in a child's life is complex and challenging, and FACS is often well positioned to do this. Again, much of this work can happen before a child dies, if their death was known or anticipated.

## Consideration of assets

It is important to consider planning needs for a child in out of home care who has financial or property assets. Children in out of home care are vulnerable. If a child dies without a will and has money or other assets, then the intestacy rules<sup>106</sup> dictate who inherits the child's assets. This is usually the child's parents as the closest next of kin. This may be appropriate, particularly in cases where parents continue to care for other siblings of the child. However, there may be circumstances where it would be inappropriate for a child's parents to inherit their assets; for example, in circumstances where the child's assets include money awarded by Victims Services as a result of injuries to the child caused by their parent or parents.

The NSW Supreme Court can approve the making of a will by a child under the age of 18 if the court is satisfied that the child understands the nature and effect of the proposed will. If a child does not have capacity to make their own will (because they do not understand the nature and effect of a will), an application can be made to the Supreme Court for a statutory will for the child. It is important to consider these applications, but you need to take into account the size of a child's estate<sup>107</sup> and be able to clearly articulate why intestacy rules should be disturbed.

### CHILD LAW LEGAL ADVICE AND SUPPORT

End of life planning and legal considerations are a complex area of our casework practice, and performed at sad and stressful times.

Liaise with a **Care Legal Support Officer** for advice and assistance.

<sup>106</sup> These are outlined in Chapter 4 of the *Succession Act 2006* (NSW).

<sup>107</sup> The costs of bringing an application to the Supreme Court are significant and should not exceed the size of a child's assets or estate. An application in relation to a very small estate is unlikely to succeed.

The following case study highlights some of the planning and considerations that may need to take place when a child in out of home care is nearing the end of their life and in palliative care.

## CASE STUDY

When Robert was born he was diagnosed with a condition that had a toxic effect on his brain and nerves. This resulted in severe physical and intellectual disabilities. In the first three years of Robert's life, FACS received reports about his father's verbal aggression and physical assault of his mother, both parents' drug use, and missed medical appointments for Robert. Caseworkers assessed that Robert could not stay with his parents and an order from the Children's Court was made allocating Robert's parental responsibility to the Minister. Robert went to live with his grandmother.

When Robert was 14 years old, he became very sick and was admitted to hospital. Doctors said his body was wearing out.

Caseworkers consulted with FACS Legal and confirmed that when Robert died his Children's Court order would end and parental responsibility would revert to his parents. FACS Legal supported Robert's caseworker to apply for a statutory will on behalf of Robert. This was important, as Robert had received money through a victims compensation claim.

Robert's caseworker organised a medical case meeting to discuss Robert's medical needs with NSW Health and Robert's grandmother. They carefully considered and agreed to a palliative care plan. Following the meeting, the caseworker travelled interstate to meet Robert's parents and discuss Robert's end of life planning. The caseworker spoke to Robert's parents about the palliative care plan and explained what would happen when Robert's condition deteriorated. Robert's parents agreed to the plan and were supportive of the decisions that had been made. The caseworker, Robert, his grandmother and parents planned Robert's funeral arrangements and supported Robert to make a decision about the donation of his organs. This information was all used in Robert's end of life plan, which was endorsed by the FACS Deputy Secretary.

Robert received in-home nursing and respite care, and continued to attend school until he was 17 years old. The caseworker visited Robert and his grandmother regularly. The caseworker got to know Robert and his grandmother well and learned to use the communication tools that had been developed for Robert, was involved in medical appointments, organising equipment and ensuring Robert's grandmother was well supported. The trust the caseworker developed with Robert and his grandmother contributed to maintaining a positive placement and Robert's health outcomes.

At 17, Robert passed away at home from health complications. FACS paid for Robert's parents' flights and accommodation to attend Robert's funeral. One funeral was held for Robert and attended by all of his family, and the professionals who had known and cared about him.

### 3.4.5 Planning for leaving care

While all the 165 children in this cohort died before they reached 18 years, there are specific considerations when working with a child or young person who has an illness and/or disability and is approaching the time when they will leave out of home care.

Upon entering out of home care, all children are referred to the OOH Health Pathway. A comprehensive health assessment is completed and a health management plan developed. More information on the OOH Health Pathway can be found in Section 4.3.1.

### National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is the new support pathway for Australians with disability, their families and carers. It provides individualised support to help people manage their needs and achieve their goals.

If, in the process of assessment and case planning, a practitioner identifies that a child is eligible to be supported by the NDIS, the practitioner should make a referral for the child so that an ‘access decision’ can be made. The practitioner should support the family through the assessment process and help with any required documentation.

A child with a disability who meets the eligibility criteria should have an NDIS plan as part of their out of home care case plan. Their disability needs should be described in their NDIS plan and complement their leaving care plan.

FACS practitioners should work with the child’s NDIS support coordinator or planner to develop the NDIS plan. It should consider:

- whether the young person has additional needs for where they can live or how they can travel
- how the young person will care for themselves day to day, make decisions, and manage their money, health and medication
- the young person’s needs for clinical therapy, counselling and behaviour support
- how the young person will be supported to stay connected to family and culture, and be included in their community
- the young person’s other needs related to their disability
- the young person’s goals and aspirations.

## ADVICE AND SUPPORT

Practitioners can contact the Engagement and Family Support Team for help referring a child to the NDIS and gathering evidence to support their requests.

Young people with chronic physical or mental health needs may require specific supports when leaving care to transition their health care to a primary care provider or adult health service. FACS practitioners should consider transition services such as Trapeze<sup>108</sup> that are available through the NSW Health Transition Care Network. Transition coordinators can work with a young person to facilitate their effective transition from paediatric to adult health services.

## Guardianship and power of attorney

If a child’s illness or disability impacts their ability to make their own health and lifestyle decisions, planning for leaving care should consider the appointment of a guardian. A guardian can be appointed by the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT) and will usually be authorised to make decisions on behalf of another person for a certain length of time. This may include decisions about where to live and consenting to medical or dental treatment. Ideally, a guardian can be a family member, friend or carer. If none of these are available, a public guardian can be appointed by NCAT.

FACS is responsible for identifying that a young person under the parental responsibility of the Minister requires an application to the Guardianship Division of NCAT and making the application.<sup>109</sup> This application process should happen two years before the young person leaves the care of the Minister for Family and Community Services and after they turn 16 years old.

A guardian is different to a financial manager, whose role is to make decisions about finances, assets and property. Practitioners should consider whether a child or young person needs to have a financial manager appointed to act for them when they leave out of home care.

<sup>108</sup> Trapeze is part of the Transition Care Network and supports young people aged 14 to 25 years. It enables current and past patients from the Sydney Children’s Hospital or the Children’s Hospital at Westmead to make a seamless transition to an adult based health care facility.

<sup>109</sup> Protocol between NSW FACS and the NSW Trustee and Guardian, Version 2, effective from 2015.



## Chapter 4: Improving the way FACS works with children and families

Across 2017 and 2018, the NSW Government continued to implement vital reforms to the child protection and out of home care system in NSW. The work of FACS in this sector has been informed especially by the redeveloped NSW Practice Framework (launched September 2017)<sup>110</sup> and *Their Futures Matter* (launched November 2016).<sup>111</sup>

The NSW Practice Framework and *Their Futures Matter* have been essential in guiding our approach and practice with vulnerable children and families. The 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.

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 2018–2019

In 2018–2019 the FACS cluster of departments and organisations will spend \$6.8 billion supporting children, adults, families and communities, and focus on breaking disadvantage to improve lives. Overall state budget expenditure relevant to FACS work includes:

- \$1.2 billion in targeted support for vulnerable people in our communities
- \$339.7 million in prevention and early intervention for individuals, children and families to enable them to live independently
- \$2.2 billion on sustained and ongoing support for individuals, children and families
- \$3.2 billion supporting the transition of clients to the NDIS.<sup>112</sup>

FACS is also contributing to the NSW Premier's and NSW official state priorities of:

- **Protecting our kids:** by aiming to decrease the percentage of children re-reported at risk of significant harm by 15 per cent by 2020
- **Reducing youth homelessness:** by aiming to increase the percentage of young people who successfully move from specialist homelessness services to long-term accommodation to more than 34 per cent by 2019
- **Reducing domestic violence re-offending:** by aiming to reduce the percentage of domestic violence perpetrators re-offending by 25 per cent by 2021
- **Creating sustainable social housing:** by aiming to increase the number of households successfully transitioning out of social housing by 5 per cent over three years
- **Successful transition** of participants to the NDIS.<sup>113</sup>

Newly announced funding in the 2018–2019 budget that will directly and indirectly affect the work of FACS includes:

- \$59.1 million over four years to support better safety, permanency and wellbeing outcomes for children, young people and their families, with funding for 100 additional workers for the child protection system and investment in the open adoption program, with a goal of 1000 open adoptions over the next four years

<sup>110</sup> NSW FACS (2017b).

<sup>111</sup> NSW Government (2016).

<sup>112</sup> NSW FACS (2018).

<sup>113</sup> *ibid.*

- \$61.7 million over four years to implement the NSW Homelessness Strategy 2018–2023 to support programs including Staying Home Leaving Violence, sustaining tenancy supports, social impact investment and transitional accommodation
- \$44.1 million over three years to support people impacted by domestic violence, and reduce reoffending and re-victimisation.

Already announced funding and new funding specific to the work of FACS across the current period and forward estimates is shown in Table 9.

**Table 9: NSW State Budget period and FACS program funding**

2018–19 >>	2019–20	2020–21	2021–22
	\$63 million for additional caseworkers and support workers to improve child protection casework practice (3rd of 4 years funding)		
	Under <i>Their Futures Matter</i> , \$39.2 million to help keep families together and deliver improved outcomes through evidence based models. These include Multisystemic Therapy for Child Abuse and Neglect and Functional Family Therapy for Child Welfare Services (FFT-CW® and MST-CAN®) which will help at least 900 families per year (see Section 4.2.7). (2nd of 4 years funding)		
	\$95 million <sup>114</sup> for targeted early intervention to support parenting, youth and family support programs (2nd of 4 years funding)		
	\$148 million to support children with high needs in out of home care (2nd of 4 years funding)		
	\$59.1 million to support better safety, permanency and wellbeing outcomes for children, young people and their families; 100 additional workers in the child protection system; a goal of 1000 open adoptions (new funding)		

<sup>114</sup> This figure covers some of the targeted early intervention programs. The full budget for targeted early intervention is \$149.5 million.

## 4.1 NSW Practice Framework: Implementation and progress

### 4.1.1 Overview of the Framework

In 2012, the Office of the Senior Practitioner (OSP) introduced the NSW FACS Care and Protection Practice Framework, at that time the first document of its kind in NSW. This provided FACS staff with a shared identity and direction on the basics of good child protection practice.

In 2017, the OSP revised the care and protection framework. The OSP worked with the Centre for Evidence and Implementation, and consulted with central office and district staff in the development of the new NSW Practice Framework.

Launched in September 2017, the redeveloped NSW Practice Framework (Figure 13) brings together practice approaches, reforms and priorities to guide FACS child protection work across systems, policies and practice. It aims to improve the quality of FACS child protection practice to generate the best outcomes for children and families across NSW.

The Practice Framework asks practitioners to treat families with dignity and view their problems through a social justice lens. It is bold and contemporary and draws together a world class, practical evidence base. The Framework combines the best of the Practice First model with national and international evidence to support the skill development of practitioners so that they can be their best for children and their families. It provides an integrated reconceptualisation of the approaches, values, standards, tools and rules that guide the NSW statutory child protection system. The Framework also provides role clarity for practitioners, their leaders and system developers through three clear practice mandates.

#### **NSW PRACTICE FRAMEWORK MANDATES**

##### **Practice mandate**

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

##### **Leadership mandate**

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

##### **Agency mandate**

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

The NSW Practice Framework forms the practice base for our organisation, towards integrated, quality, sustained family work. It shows in detail how we underpin our work by using language, principles, standards and values that unite us, supported by informed practice approaches (motivational interviewing, dignity driven practice, safety centred practice, Structured Decision Making and Family Finding) and skilful practice (influencing change, working with family and culture, purposeful partnerships, assessment, and building lifelong connections).

Figure 13: NSW Practice Framework (launched September 2017)



## 4.1.2 Implementing the Framework

### Introduction to staff

To launch and introduce the new NSW Practice Framework, the Deputy Secretary Northern Cluster and Senior Practitioner provided a series of briefings across NSW to district and central office staff, from late 2017 to mid 2018.

All Community Services Centre (CSC) staff also received framework materials, including posters, a flip chart that summarised the principles, approaches, mandates and values of the organisation, and a series of supporting communications which included ideas about team activities designed to help staff connect to the five principles of the Framework. A Practice Framework hub, available to all staff via the FACS internal Casework Practice website, provides practitioners with more detailed information about the Framework, including how it supports the system to attain priorities.

### Implementation

The OSP leads the overall implementation of the new Framework, but all practice leaders share responsibility to promote and support the guidance, principles, values, skills, mandates, approaches and systems that underpin our work.

As part of the initial implementation, practice leaders across the state received a briefing pack with guidance on how to facilitate a Framework familiarisation session for their teams. This session included the discussion and development of team-level practice commitments. All districts were asked to collate and report on the practice commitments developed for their individual units.

### Resource redevelopment

As we continue to implement the Framework, the OSP is threading the Framework's principles into revised and new resources. This includes the redevelopment of training modules, continuing professional development content, practice kits and practice advice.

The OSP has also adapted the FACS group supervision model to incorporate the Framework's principles, approaches and capabilities. Training in the adapted group supervision model has been delivered to more than 2400 practitioners across NSW in the past eight months. The revised Framework has been integral to this ongoing professional development for practitioners.

The OSP is also developing five short videos to demonstrate the five Practice First principles: **culture** is ever-present, **language** impacts on practice, **relationships** create change and restore dignity, **critique** leads to improved practice, and **ethics and values** are integral to good practice. These videos feature caseworkers and the families they work with telling raw and honest accounts of the work of child protection. The videos were launched in September 2018.

Integral to the implementation of the Practice Framework is the delivery of a series of skill building training modules. The modules contained in this training series include:

- Dignity, safety and the path to meaningful change
- Belonging, permanency and connection. Helping kids reach their potential
- Seeing, noticing and responding to danger and risk
- Case planning – creating change on purpose
- Restoration – building safety at home.

These training sessions support practitioners to build their skill and confidence by demonstrating how the five evidence informed practice approaches can be applied to direct work with children and their families. This training is delivered over 10 weeks.

## Quality improvement

The NSW Practice Framework also includes a quality improvement model that will be implemented over three years. An extensive evaluation will also occur over the same period. This evaluation will assess the utility of training and aspects of practice not currently measured by FACS. The evaluation started with a Readiness Assessment, which shows that FACS staff overwhelmingly accept the Practice Framework and believe it will make a difference to children and their families.

The quality improvement model and evaluation will be informed by FACS data (quantitative and qualitative) as well as feedback from practitioners, agency partners and children and families. Four outcomes will be measured at the end of these processes, which will consider how:

- Children experience safety
- Children, young people and families are connected to family and community
- Children, young people and families reach their potential
- Children, young people and families experience FACS as helpful.

## Practice Framework Board

To ensure that FACS practice and systems are aligned, a Practice Framework Board will be implemented. The Board will have oversight over all initiatives that impact on the work of a practitioner and their work with children and families. The Board will oversee the effective and timely implementation of initiatives and ensure their synergy.

## 4.2 *Their Futures Matter*: Implementation and progress

### 4.2.1 Overview of the reforms

*Their Futures Matter*,<sup>115</sup> launched in November 2016, is the NSW Government's long-term strategy for improving outcomes for vulnerable children and families. It's a landmark reform, designed to anticipate the needs of and deliver improved outcomes for vulnerable children, young people and families. It brings together all areas of government to align investment and the best evidence to deliver a more cohesive and accountable system.

The *Their Futures Matter* vision is to create a service system that delivers coordinated, wraparound<sup>116</sup> and evidence-based supports for children and families to improve their health, education, wellbeing and life course. Central to this vision is a targeted investment approach, which directs and prioritises whole of government funding to deliver solutions that achieve measurable and meaningful outcomes.

Ultimately, *Their Futures Matter* helps vulnerable children and their families by placing them at the centre of service delivery.

### 4.2.2 The three pillars of *Their Futures Matter*

The overall strategy for *Their Futures Matter* is driven by a central commissioning entity, the *Their Futures Matter* Implementation Unit, which drives the reform process. Strategy is supported and delivered through three reform pillars:

- **A smart system:** to draw together data, evidence and investment in order to build an integrated and accountable service system
- **One connected system:** to provide vulnerable children, young people and families with easy to navigate access to the services they need to improve their lives
- **Needs-based supports:** to deliver services designed to address the needs and goals of children, informed by the risks to their wellbeing and futures.

<sup>115</sup> NSW Government (2016).

<sup>116</sup> 'Wraparound' refers to supports that are intended to wrap around a child to support them in all aspects of their life. Alongside services, wraparound supports can also include family, extended family, other carers, teachers and health care professionals.

### 4.2.3 Cross-government leadership

*Their Futures Matter* takes a whole of government approach to service reform. The *Their Futures Matter* Implementation Unit works with leaders from multiple government departments including Education, FACS, Health, Justice, Treasury and the Department of Premier and Cabinet. Each of these departments is represented on the *Their Futures Matter* Implementation Board, which is responsible for leading cross-government collaboration and driving reform progress.

### 4.2.4 Integrated data and analysis

As part of its investment approach, *Their Futures Matter* gathers and analyses vital information to better understand the needs and aspirations of vulnerable children, young people and families.

For the first time, data from across NSW Government agencies will be integrated to form a single, holistic service information view. This will provide a more comprehensive understanding of what drives vulnerability and how to achieve lasting change.

Insights gathered from the data will result in significant improvements to service design and delivery, and allow for better planning of future resource needs. Over time, the service system will become more responsive to the needs and aspirations of children and families, to better support their health, education, wellbeing and life outcomes.

Data will be integrated and analysed to:

- identify areas of greatest need
- identify gaps and improvements
- coordinate resources and prioritise investment
- design and deliver wraparound support services
- understand service interaction patterns
- create an integrated service system
- optimise whole of government investment
- provide effective solutions for children, young people and families
- promote continuous improvement.

### 4.2.5 Cohort approach

*Their Futures Matter* establishes smart, connected and needs-based supports for vulnerable children and families through a cohort approach that uses cross-agency data to identify and understand groups of vulnerable children and families with similar experiences and needs.

A coordinated, wraparound service solution is then designed and implemented to meet the needs and goals of each identified cohort. This includes implementing services where support is currently missing, or failing to meet individual needs.

Wraparound supports for highly vulnerable cohorts are designed to prevent escalating contact with the child protection and justice systems and improve life trajectories by breaking the cycle of disadvantage.

#### Current targeted cohorts

The Independent Review of Out of Home Care in NSW, which led to the *Their Futures Matter* reforms, identified that services weren't always addressing the complex needs of young people, or the devastating effects of intergenerational abuse and neglect, particularly for Aboriginal children, young people and families.

As such, *Their Futures Matter* is designing wraparound service supports for targeted cohorts, identified by data as being vulnerable, and therefore prioritised for assessment and service implementation. Implementation of service solutions started in 2018 for three cohorts:

- **Thriving Families** (two cohorts) are non-Aboriginal vulnerable young parents aged 25 and under, and their children (aged 0–5 years).
- **A Place to Go** represents young people aged 10 to 17 years entering and exiting the juvenile justice system, with a focus on children in remand.

## 4.2.6 Impact on practitioners

### Consultation and awareness

Practitioners are becoming aware of the *Their Futures Matter* reforms thanks to extensive and fruitful consultation between cross-agency leadership and stakeholders across the sector, leading to promising developments in our approach to everyday practice.

For example, consultation has led to the development of a business case for the Futures Planning and Support Project ('Aftercare'; see the next section), looking at ways to improve outcomes for children as they transition out of care. In addition, practitioners across NSW have been made aware of the *Their Futures Matter* reforms through the rollout of new evidence-based programs.

These collaborative efforts, development processes and subsequent programs have enabled practitioners to refer vulnerable children and their families to services that are genuinely improving life outcomes.

## 4.2.7 Program implementation and achievements

*Their Futures Matter* is researching, designing and implementing evidence-based programs to improve outcomes for vulnerable children and families. The evidence-based approach supports the three reform pillars, by helping to develop and sustain a smart, connected and needs-based system that fosters meaningful change.

*Their Futures Matter* has led to significant program implementation and achievements since November 2016. These include:

- progress on the **high-level redesign of the child wellbeing intake, assessment and referral system**; this will deliver a multi-agency and evidence-based system that enables children and families in NSW to access the right supports and services at the right time
- new evidence-based services for **family preservation and restoration** that will help 900 families each year
- **trauma healing services** to improve psychological wellbeing for children under 15 years of age who are in out of home care and whose placements are unstable
- a **treatment program** delivering an alternative to institutional, residential and group care placements for children and young people in OOHC with severe emotional and behavioural disorders
- **evidence-building partnerships** with Aboriginal communities and organisations to explore and support what works for Aboriginal children, young people and families
- a **cross-agency service solution** for vulnerable children under the age of 12 years in residential out of home care
- **new service solutions** under design and development for three currently identified vulnerable cohorts
- **widespread consultation** with cross-agency leaders and stakeholders to inform a proposed new operating model for out of home care and transitions out of care
- a Public Interest Direction from the Privacy Commissioner that will pave the way for an **integrated, secure human services dataset** for deeper analysis.



## Access system redesign

This key initiative of *Their Futures Matter* aims to devise an evidence-based, integrated and multi-agency system where all vulnerable children, young people and families can access and connect with timely supports to improve outcomes across all areas of safety, health and wellbeing. The access system includes processes for intake, assessment and referral for child protection and child wellbeing.

The first stage of the access system redesign produced an evidence-led identification of key design features that work in NSW and internationally. The next stage focused on testing options from the evidence review and gaining inputs from NSW perspectives through targeted consultations and multi-agency workshops.<sup>117</sup>

The access redesign team has been working with expert academics, consultants and key stakeholders, conducting deep dives into high level design features, as well as cross-cutting work streams. Consultations have focused on workforce, technology enablers, governance, system performance and continuous improvement. We reached an important milestone on 20 September 2018 when the *Their Futures Matter* Board endorsed in principle the high level vision and design features for system access. The redesign team will submit a strategic business case to the *Their Futures Matter* Board by the end of November 2018.

## Family preservation and restoration programs

In 2018–2019 the NSW Government committed \$39.2 million to help keep families together through evidence-based models as part of *Their Futures Matter* reforms.

Two evidence-based family preservation and restoration programs are currently underway, called Functional Family Therapy through Child Welfare<sup>118</sup> (FFT-CW<sup>®</sup>) and Multisystemic Therapy for Child Abuse and Neglect<sup>119</sup> (MST-CAN<sup>®</sup>). Both have been shown internationally to be successful with families.

### FUNCTIONAL FAMILY THERAPY THROUGH CHILD WELFARE

FFT-CW<sup>®</sup> is a home-based therapy-focused treatment model for high-risk families where physical abuse or neglect has been experienced. FFT-CW<sup>®</sup> is provided to families in their homes or by other services in the community.

### MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT

MST-CAN<sup>®</sup> provides intensive therapy to children and families, in cases where children aged six to 17 are at high risk of being removed, or where the child has been recently taken and there is a plan to restore them to their parents. MST-CAN<sup>®</sup> is delivered in the home by a highly skilled psychologist, who is available 24 hours a day, seven days a week, and who can work with the family for up to nine months.

FFT-CW<sup>®</sup> and MST-CAN<sup>®</sup> are helping to reduce the need for children to be taken 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<sup>®</sup> and MST-CAN<sup>®</sup> or other services to ensure the pathway home for children is successful. Step-down support will also be provided following the return of a child or young person to their family.

<sup>117</sup> Agency and NGO service providers and practitioners met in metropolitan, regional and remote locations.

<sup>118</sup> Functional Family Therapy (2017).

<sup>119</sup> Developed at the Medical University of South Carolina. See Global Family Solutions (2017).

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<sup>®</sup> and MST-CAN<sup>®</sup> services have been delivered by practitioners in priority locations across NSW since August 2017. These services have also been contributing to one of the 12 priorities of the NSW Premier, Protecting our kids, which aims to decrease the percentage of children re-reported at risk of significant harm by 15 per cent by 2020 (based on the 2019 cohort of children).

As of 31 July 2018, 134 families have completed family preservation and restoration programs, with another 488 families active in the services.

Preliminary data indicates that primary carers who complete the family preservation and restoration programs experience improved wellbeing and empowerment, and less psychological distress.

In addition, 50 per cent of places in these preservation and restoration programs are dedicated to Aboriginal families. FACS continues to monitor and evaluate the models to understand Aboriginal families' access, engagement and outcomes.

## **LINKS Trauma Healing Services**

*Their Futures Matter* has commissioned FACS Statewide Services (Psychological Services) to deliver the LINKS Trauma Healing Service program to children in out of home care from two locations: Charlestown (Hunter New England) and Penrith (Nepean Blue Mountains).

LINKS was established to address trauma symptoms and improve psychological wellbeing for children under 15 years of age who are in out of home care and whose placements are unstable.

Childhood trauma in the form of child abuse and neglect can result in complex emotional and behavioural symptoms, including problems with mood regulation, impulse control, self-perception, attention, memory and somatic (body) disorders. These symptoms have been shown to increase carer stress and decrease placement stability.

### ***Service delivery and outcomes***

LINKS provided services to 70 children in the first half of 2018.

Baseline measures at program entry showed that 58 per cent of children recorded a 'clinical symptoms' score on at least one of the trauma symptoms checklist scales, including 37 per cent for anger/aggression, 32 per cent for post-traumatic stress and 23 per cent for anxiety. These scores highlight the need for trauma-focused services and the widespread experience of trauma for children in out of home care.

As a result of the initial program implementation and supporting data, *Their Futures Matter* will implement more trauma-focused, evidence-based programs in 2018–2019 for children and young people in foster and kinship care.

## **Aboriginal Evidence Building in Partnerships**

*Their Futures Matter* is leading the Aboriginal Evidence Building in Partnerships project.<sup>120</sup> This project will support organisations to build an evidence base to demonstrate what works for Aboriginal children, young people and their families.

These evidence-building partnerships will help participating organisations to:

- embed data collection and analysis practices that will improve future service delivery
- demonstrate the value of their program and the effect it has on their community
- be better placed to gain funding and expand programs.

<sup>120</sup> NSW Government (2018).

*Their Futures Matter* has matched experts in data collection and evaluation with five Aboriginal organisations and one non-Aboriginal organisation, each of which is showing promising signs of generating improved outcomes for vulnerable Aboriginal children, young people, families and communities.

The Aboriginal Evidence Building in Partnerships project will also demonstrate the effectiveness of solutions designed by and for Aboriginal communities, and potentially allow for a replication of culturally informed programs that aim to keep Aboriginal children and families safely together.

## Cross-agency service solution for children under 12 in residential care

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.

**Professional Individualised Care (PIC)** is a new model of foster care under trial for children with complex needs and trauma. The model places these children with foster carers who have tertiary training and experience in human services, with the aim of increasing placement stability.

### Service delivery and outcomes

In the 10 months to June 2018, the number of children in this cohort in residential settings has fallen by 41 per cent (from 68 to 40 children).

## CASE STUDY

### Professional Individualised Care

Tom has had 38 placements since entering statutory care. In September 2017, he moved from residential care to a placement with Professional Individualised Care (PIC). Maintaining routine, de-escalating crisis and reinforcing consistent relationship responses have been the key priorities for supporting Tom in his PIC placement. Jill, Tom's professional carer, has reported that 'trust is building', despite Tom displaying behaviours that appear to 'test' the placement.

Christmas marked the longest time Tom had lived with a carer, and was an emotional time for him. He tested the relationship he had formed with his carer through disruptive behaviour. However, with a high level of support from Tom's PIC caseworker, and because he had a carer that understood the drivers of his behaviour, Tom remained secure in his placement and Jill remains committed to his care. Tom has now been with Jill for eight months, his longest placement since entering care. Tom's key worker<sup>121</sup> believes that if not for PIC, the placement would have broken down.

## New services for identified vulnerable cohorts

The three cohorts identified by evidence as vulnerable and therefore prioritised for assessment and service implementation are (i) non-Aboriginal vulnerable young parents aged 25 and under; (ii) their children (aged 0–5 years) (**both Thriving Families**); and (iii) young people aged 10 to 17 years in the juvenile justice system, with a focus on children in remand (**A Place to Go**).

Initial implementation of wraparound services for these targeted cohorts began in July 2018, with a focus on locations where services will have the greatest immediate impact. This will allow FACS to assess the initial implementation, and expand what has worked across NSW. The two Thriving Families cohorts are also undergoing extra assessment to ensure that services are culturally appropriate before and during implementation.

<sup>121</sup> A key worker often works with families or carers when a child has difficulties in more than one developmental area. Key workers are early childhood intervention professionals and become the main contact for the family or carer's needs and the person whom carers see and talk to most often.

## Aftercare project development

The development of the Aftercare project, the aim of which is to undertake widespread consultation with cross-agency leaders and stakeholders to inform a proposed new operating model for out of home care and transitions out of care, has so far involved meetings with 152 stakeholders. This has included care leavers, out of home care service providers, service providers for young people after they have left care, NGO and FACS caseworkers, peak bodies and a wide range of state government agencies (Education, Health, Justice, Legal Aid, NSW Police, the Office of the Children's Guardian, and the Department of Premier and Cabinet). Out of home care and aftercare caseworkers were the largest group represented (72 out of 152) across a four-month consultation period.

### 4.2.8 Other relevant reforms within FACS

#### ELVER Trauma Treatment Service

The ELVER Trauma Treatment Service is being established as a joint initiative between CS Statewide Services and South Western Sydney Local Health District, Infant Child and Adolescent Mental Health Services (iCAMHS).

The program started in September 2018, and is being managed by the Director Intensive Support Services. It will target the following groups of children in out of home care across NSW:

- children in residential/intensive therapeutic care (ITC) who could move to a less intensive model of care or return home
- children in residential/ITC who need specialist intervention to avoid moving to a more intensive care model
- children with complex needs who will need to move into new placements as a result of service recommissioning.

#### Permanency Support Program

The Permanency Support Program supports children to secure permanent, safe and loving homes.

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.

Since it began in October 2017, the Permanency Support Program has implemented a number of initiatives, including:

- transferring close to 7500 children to the program so that they can access more targeted support geared towards them securing permanent homes
- training more than 1000 caseworkers across FACS and funded service providers in restoration work to increase the numbers of children returning home after short periods of time in care
- training more than 700 caseworkers in understanding and facilitating the use of guardianship as a permanency option
- funding and establishing My Forever Family NSW, an organisation dedicated to recruiting, training and supporting carers from a broad range of backgrounds to offer care that will better support permanency
- contracting nine organisations to provide the Intensive Therapeutic Care service system for children with complex needs
- offering, for the first time, a suite of family preservation packages that support children continuing to live at home safely if they have been identified as being at risk of significant harm.

In the coming years, FACS expects that successively lower numbers of children will enter care each year. For children who do enter out of home care, the care experience should be shortened and improved through more targeted services and supports that help children recover from trauma.

## 4.3 Improving our responses to children living with illness and/or disease

This section describes current and future initiatives that focus on increasing casework knowledge and improving practice and outcomes for children living with illness and/or disease. This cohort of children was discussed in detail in Chapter 3 of this report.

### 4.3.1 OOHC Health Pathway

In 2010, FACS and NSW Health partnered to develop an inter-agency framework to support health assessment, called the Model Pathway for the Comprehensive Health and Developmental Assessments for All Children Entering Out of Home Care (the **OOHC Health Pathway**). Children's needs are at the centre of this model.

The OOHC Health Pathway aims to improve short and long-term health, development and wellbeing outcomes for children in out of home care, as well as supporting carers and placement stability. The Pathway acknowledges that children in out of home care are highly vulnerable, with increased rates of physical, developmental, emotional and mental health problems compared to the general community.

The OOHC Health Pathway is offered across all Health/FACS districts in NSW, and is supported by OOHC Health Coordinators in each local health district.

To be referred to the OOHC Health Pathway, children aged 0–18 years must have entered care after July 2010 and currently be in statutory out of home care. The program also targets young people aged 15–17 years who may be leaving or transitioning from care within the next 18 months.

#### Assessment, health planning and review

In the Pathway program, all children have a primary health assessment within 30 days of entering statutory out of home care. The assessment can be done by a range of health care providers, including general practitioners (GPs), Aboriginal medical services and child and family health nurses. If the screening identifies particular health needs, the child or young person receives a comprehensive health assessment from appropriate clinicians and other health professionals.

Based on these assessments, and in partnership with the child, their carer and their caseworker, a health management plan is developed for each child. The plan identifies their state of health and recommends suitable interventions and reviews. At minimum, children under five years of age must have a health review at least every six months; children over five must have an annual review.

#### Increasing caseworker knowledge

The OOHC Health Pathway program aims to improve the health knowledge of caseworkers. They are actively engaged in implementation of the Pathway and are responsible for:

- initiating timely health screen referrals to NSW Health for children entering out of home care to enable health assessment to be completed within 30 days of entering care
- providing or arranging information to inform screening and assessments
- supporting carers to ensure children attend scheduled health assessments and interventions
- participating in the development of health management plans
- working with carers to ensure all treatments and interventions take place, including those provided according to NDIS plans
- requesting periodic health management plans reviews
- providing information about health issues affecting children in their care
- encouraging children to participate in health-related decisions.

#### Improving collaboration across systems

The OOHC Health Pathway promotes collaboration between health and child protection practitioners across both service systems to improve outcomes for children in out of home care. The Pathway provides clear, consistent processes for caseworkers and health practitioners regarding referral, communication and sharing information about children across departments and systems.

## Helping children

Many children who leave care can be impacted by trauma, abuse and neglect for many years. Research shows that adverse childhood experiences increase the chance of developing lifelong health conditions such as diabetes and heart disease.

The Pathway program has increased the number of children who have had their physical, developmental, psychosocial and mental health needs assessed within a specified period of entering out of home care. The development and implementation of health management plans has resulted in improved responses to children's health needs across their lifespan. The Pathway also empowers children to participate in decision-making around their health. They are encouraged to express their views and take part in the process according to their level of understanding.

For young people, the program also provides increased health literacy, links with general practice and primary health care services, and better access to their personal medical records in the lead up to leaving care. Once a child or young person leaves care, they will continue to access public and private health services, for which ongoing positive relationships with services are essential in order to address the ongoing impacts of trauma, abuse and neglect.

### CASE STUDY

#### Regional Local Health District

Sophie is two years old and entered out of home care in February 2017 when she commenced living with her maternal grandmother. She has a FACS case manager, and on entering care had a primary health assessment with an early childhood nurse. Sophie scored poorly in the Ages and Stages Questionnaire, and was experiencing complex issues, including:

- appearing not to know how to interact with people
- an inability to walk or stand alone
- below average fine motor skills
- difficulty reaching and grasping, with consequent frustration
- possible developmental speech delay.

Sophie was initially referred to the Pathways program for speech and occupational therapy, and her referral meant she received prioritised and collaborative service.

Due to Sophie's ongoing challenges, a multidisciplinary case review was organised, involving Sophie and her carer, the OOH Health Pathway liaison nurse, child family nurse, GP liaison nurse, child counsellor, occupational therapist, speech therapist and the early childhood nurse who conducted Sophie's primary assessment. This care team developed a health management plan with recommendations for ongoing early childhood clinic and community paediatric reviews, and a referral to an audiometry clinic.

Sophie's grandmother received support and advice on how to manage and follow-up on Sophie's issues, including about such things as play stimulation, crawling practice, walking, squatting and supportive shoes. Sophie continued to have bi-weekly and sometimes shared therapy visits, and the speech and occupational therapists work together to observe her speech and play when she goes to kids' gym.

This collaborative approach to Sophie's care has allowed for effective communication and jointly managed support across three disciplines (speech, occupational and physiotherapy), which has reduced stress for Sophie and her grandmother. Sophie's Pathway access keeps her and her carer engaged with the community health system, and able to navigate services more easily. Sophie's grandmother is also building relationships with clinicians that will help to maintain better ongoing health and outcomes for this family. Ongoing updates for the FACS caseworker also support the caseworker's knowledge and capacity to make meaningful contributions.

### 4.3.2 OSP Neglect Kit

The OSP is currently developing a Neglect Kit that will include a section on how to respond to medical neglect. The kit will also incorporate practice advice on neglect and working with parents with a disability, and a topic on neglect and working with children with a disability.

These practice advice topics will provide vital information about how to communicate with children with a disability, alongside ideas about what to consider in assessments for children struggling with illness and/or disease. The OSP Neglect Kit will be launched in November 2018.

# Glossary

## **Aboriginal**

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

## **Abuse**

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

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

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

## **Authorised carer**

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

## **Case closure**

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

## **Case plan**

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

## **Casework**

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

## **Caseworker**

A FACS officer responsible for working with children, young people and their families, and other agencies in child protection, out of home care (OOHC). 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 unborn children, children who may be at risk of significant harm (ROSH). It operates 24 hours a day, seven days a week.

## **Child Story**

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

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

CWUs were established in NSW Health, the NSW Police Force, the NSW Department of Education and Communities and the NSW Department of Family and Community Services. CWUs assist mandatory reporters in government agencies to ensure all concerns that reach the threshold of risk of significant harm (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.

## **Children's Court**

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

## **Domestic violence**

Violence between two people who are, or have been in the past, in a domestic relationship. The perpetrator of this violence can cause fear, and physical and psychological harm. Domestic violence is usually committed by men against women within heterosexual relationships, but can also be committed



by women against men, and can occur within same-sex relationships. Domestic violence can have a profound negative effect on children.

### **Engagement**

An ongoing and dynamic process of attracting and holding the interest of a person in order to build an effective and collaborative relationship. Locally based community services offices. There are 82 CSCs across NSW.

### **Manager casework**

A manager casework provides direct supervision and support to a team of FACS caseworkers.

### **Mandatory reporter**

A person who, in the course of their professional or other paid employment, delivers health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children, or a person who holds a management position in an organisation, the duties of which include direct responsibility for or direct supervision of the provision of health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children. If a mandatory reporter has reasonable grounds to suspect that a child is at risk of significant harm (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 FACS as soon as practicable, the name or a description of the child and the grounds for suspecting that the child is at risk of significant harm (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 FACS or a police officer believes on reasonable grounds that a child is in need of care and protection, the Secretary or the police officer may serve a notice naming or describing the child requiring the child to be forthwith presented to a medical practitioner specified or described in the notice at a hospital or some other place so specified for the purpose of the child being medically examined. The notice is to be served on the person (whether or not a parent of the child) who appears to the Secretary or the police officer to have the care of the child for the time being.

### **Mental health concerns**

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

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

### **Parental responsibility**

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

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

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

### **Prenatal report**

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

### **Removal**

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

### **Report**

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

### **Reporter**

Any person who conveys information to FACS concerning their reasonable grounds to suspect that a child, young person or unborn child (once born) is at risk of significant harm (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 a SDM<sup>®</sup> 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<sup>®</sup>)**

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

### **Supervision**

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

### **Supported care allowance**

Financial support provided by FACS to a relative/ kin carer after an order has been made by the Children's Court reallocating parental responsibility. The allowance is a contribution towards the cost of caring for a child or young person who is in supported care and helps to maintain the child or young person in a relative or kin placement and prevent them from entering statutory out of home care.

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

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

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

Weekly allocation meetings (WAM) are a 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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## FACS Casework Practice intranet resources

### **Alcohol and Other Drugs Practice Kit**

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

### **Alcohol and Other Drugs: Risk Assessment**

<https://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/alcohol-and-other-drugs/modules/risk-assessment>

### **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 responsive practice with diverse communities**

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

### **Domestic and Family Violence Practice Kit**

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

### **Holistic assessment and family work**

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

### **Relationship based practice**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/partnerships/relationship-based-practice>

### **Respectful partnerships with families**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/partnerships/respectful-partnerships-with-families>

### **Social justice and human rights**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/ethics-and-reflection/social-justice-and-human-rights>

### **Talking to children and participation**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/talking-to-children-and-participation>

### **Working with Aboriginal people and communities: A practice resource**

[http://caseworkpractice.intranet.facs.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0011/334289/Working-with-Aboriginal-people-a-practice-resource.pdf](http://caseworkpractice.intranet.facs.nsw.gov.au/__data/assets/pdf_file/0011/334289/Working-with-Aboriginal-people-a-practice-resource.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
<b>Child Protection Helpline</b>	Report suspected child abuse or neglect to FACS	<b>132 111</b>
<b>Aboriginal Counselling Services (ACS)</b>	Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	<b>0410 539 905</b>
<b>Aboriginal Medical Service</b>	Provides comprehensive health care to the Aboriginal community	<b>Find local contacts at <a href="http://ahmrc.org.au">ahmrc.org.au</a></b>
<b>Red Nose NSW and Victoria</b>	Provides 24/7 bereavement support to families who have suffered the loss of a baby	<b>1300 308 307 or visit <a href="http://rednosegriefandloss.com.au">rednosegriefandloss.com.au</a></b>
<b>NALAG Centre for Grief and Loss</b>	Provides free face-to-face and telephone loss and grief support	<b>(02) 6882 9222 or visit <a href="http://nalag.org.au">nalag.org.au</a></b>
<b>Lifeline</b>	Provides 24/7 telephone crisis support and suicide prevention services	<b>13 11 14 or visit <a href="http://lifeline.org.au">lifeline.org.au</a></b>
<b>National Centre for Childhood Grief</b>	Free counselling for bereaved children; counselling also provided for bereaved adults, parents and caregivers (fee involved)	<b>1300 654 556 or visit <a href="https://childhoodgrief.org.au">https://childhoodgrief.org.au</a></b>
<b>Department of Forensic Medicine</b>	Provides information, support and counselling for relatives and friends of the deceased person for deaths being investigated by the Coroner	<b>(02) 8584 7800</b>
<b>Suicide Call Back Service</b>	Free 24/7 phone, video and online counselling for anyone affected by suicide	<b>1300 659 467</b>
<b>The Compassionate Friends</b>	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	<b>1800 671 621 or visit <a href="http://tcfnsw.org.au">tcfnsw.org.au</a></b>
<b>The Australian Child and Adolescent Trauma Loss and Grief Network</b>	Resources to help caregivers understand and respond to the diverse needs of children and adolescents experiencing trauma, loss and grief	<b><a href="https://tgn.anu.edu.au">https://tgn.anu.edu.au</a></b>
<b>Kids Helpline</b>	Telephone counselling	<b>1800 55 1800 or visit <a href="https://kidshelpline.com.au">https://kidshelpline.com.au</a></b>

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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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