Communities and Justice

NSW GOVERNMENT

Child Deaths

2022 Annual Report

Learning to improve services

Acknowledgement of Country

The Department of Communities and Justice acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW. We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this annual report.

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Acknowledgement

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

Sadly, Aboriginal and Torres Strait Islander children continue to be over-represented in the number of children who died in 2022 and who were known to the Department of Communities and Justice.

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

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

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

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

Minister's foreword

It's with a heavy heart that I present the *Child Deaths 2022 Annual Report*.

I have no doubt that, like me, you will be moved by the tragic loss of life described in this report. Behind the statistics reflected in this year's report are the stories of 111 children and young people who died in 2022 and were known to the NSW child protection system. To the families and communities who knew and loved these children, I am deeply sorry for your loss.

The NSW child protection system and our community will always seek to make sense of what has happened when a child tragically dies. It is a critical government responsibility to report on the deaths of all children and young people and to find answers. I am committed to being open and honest about the challenges our child protection system faces, and to work hard to reshape the system to achieve real change for families in NSW.

I am proud to lead the Department of Communities and Justice (DCJ) and acknowledge its commitment to transparency. DCJ recognises it doesn't always get things right and is willing to reflect on its own practice and systems with a genuine desire to learn what it can do better to support the children and families it serves.

Child protection is an essential service in our society. For more than a decade, it has partnered with key services across health, education, justice and the non-government sectors to implement a shared approach; recognise harm being caused to children; and to try and address it early. While most child deaths are not predictable, when they do occur DCJ acts responsibly by examining where things could have been done differently and where systems can be improved. I know that everyone who works in this sector will embrace the lessons from this report and continue to strive to do better together.

Since being sworn in as Minister for Families and Communities in April 2023, I have had the privilege of meeting many impressive child protection staff working right across the child protection system. I continue to be struck by the dedication and passion they bring to keeping children safe and improving outcomes for families. I am grateful to this professional and resilient workforce, who give their all to improving outcomes for vulnerable children and families.

Kind regards,

Kate Washington

Minister for Families and Communities, and Minister for Disability Inclusion

Secretary's foreword

Of the many things I do in my role as Secretary, presenting the DCJ Child Deaths Annual Report to the Minister always causes me to pause and reflect on the lives of the children whose stories and circumstances fill its pages and to consider whether we are getting it right.

To the families and communities who cared for, and loved, the children whose deaths feature in the following pages, I offer my deepest condolences. They are the saddest of stories.

DCJ has a statutory obligation to review the circumstances of children who die and were known to our department. Examining our work with families allows us to better understand the children and their families' experiences of us as an essential service. It guides us to consider what we are doing well and what we can do better.

This year's report focuses on the 111 children who died in 2022 and were known to DCJ. It also includes information about what DCJ learnt and the actions it took in response to some of those children's deaths.

Sadly, there are some hard truths we must face. The over-representation of Aboriginal children in child deaths continues to be a source of deep sorrow here in NSW, as it is for our child protection, health and justice colleagues in other states and territories. It is a strong call to do more for Australia's First Nations peoples.

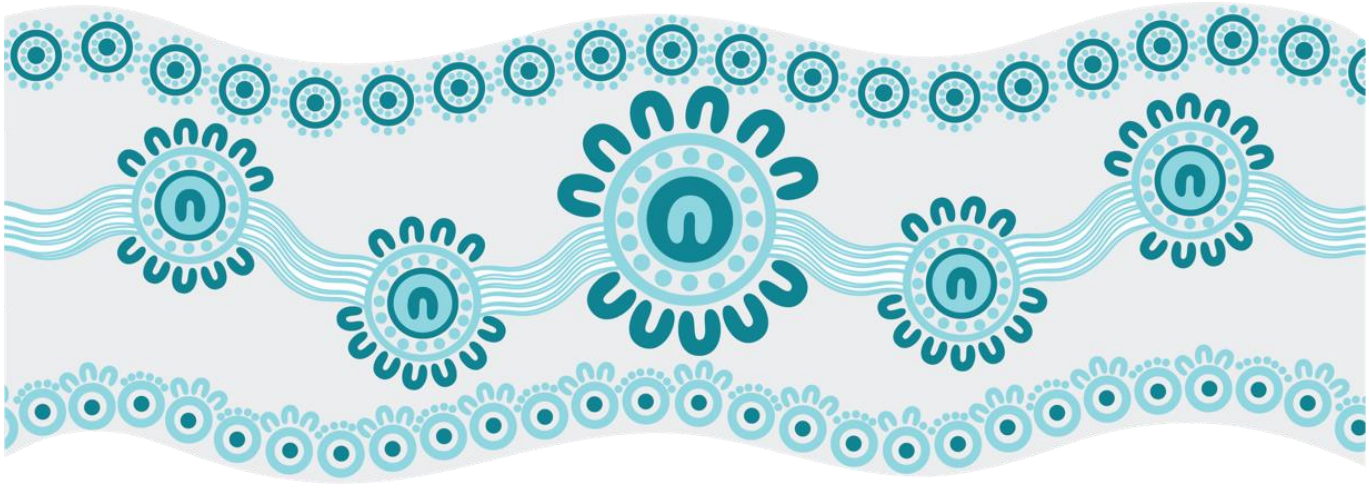
I am committed to partnering with my colleagues and interagency partners at a state and national level to improve how we work with, and alongside, Aboriginal and Torres Strait Islander families and communities. Our Transforming Aboriginal Outcomes team is working with the non-government sector to drive key reforms to lead our commitments to the National Agreement on Closing the Gap. We in DCJ are also continuing to implement the recommendations from the *Family is Culture* review and related legislative reforms.

It is my fervent hope these broader system reforms will steer us in the right direction towards improving the outcomes for Aboriginal and Torres Strait Islander children and families living in NSW.

I want to extend my gratitude to all child protection practitioners who work tirelessly to keep vulnerable children safe. I am grateful for the courage, skills and resilience of our caseworkers who persevere in what is rewarding and challenging work. May this report guide us to continue to do better, together.

Michael Tidball

Secretary



Summary

The NSW Department of Communities and Justice (DCJ) has reported publicly on child deaths since 2010. This is the thirteenth report that examines DCJ involvement with the families of children who died and were known to DCJ. The report provides context about the children's deaths with the intention to strengthen the child protection system, improve child protection practice and support other services working with children and families who have complex needs. It is the aim of the report to increase community understanding of the complexities of the work, including the widespread social disadvantage among families whose children are reported to the child protection system and the intricacy of the challenges they face.

DCJ acknowledges the grief and loss experienced by families and communities when a child dies. 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 some readers, who may find the report's findings and content distressing. A list of support and counselling services is provided at Appendix 1.

Considerations when reading this report

In this report, unless otherwise specified:

- The *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a 'child' as aged under 16 years and a 'young person' as aged over 16 and under 18 years of age. In this report, the terms 'child' and 'children' are used to refer to both a 'child' and 'young person'.
- 'Known to DCJ' includes children whose deaths met the criteria of 'reportable deaths' as defined in section 172A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This includes children (or their siblings) who were the subject of information that met the risk of significant harm threshold within three years of their death. This also includes those deaths where a child was in out of home care at the time of their death.

The numbers and information provided in this report about the deaths of children in 2022 who were known to DCJ reflect what was known at the time of writing. This information is subject to change due to subsequent reporting of child deaths. Information was also provided by the NSW Ombudsman's Office on 29 August 2023 about the total number of children who died in NSW in 2022. This is also subject to change due to subsequent reporting of deaths to the NSW Child Death Review Team.

Child deaths in 2022

In 2022, 463 children aged from birth to 17 years died in NSW; 111 of these children were known to DCJ. Chapter 2 summarises information about these 111 children. As shown in

Figure 1, and consistent with previous years, the most common circumstance of death for all children was illness and/or disease.

Also consistent with previous years, infants under the age of 12 months made up a significant proportion of the children who died and who were known to DCJ. Forty-six of the children were infants under the age of 12 months. Thirty-one children were aged between 1 and 12 years and 34 children were aged 13 to 17 years. Sadly, the number of children who were known to DCJ and who died from suicide remains high, with suicide the leading circumstance of death for children aged 13 to 17 years.

Aboriginal children continue to be disproportionately represented in deaths of children known to DCJ. In 2022, 38 of the children who died were Aboriginal. This report considers these 38 deaths, both within the larger cohort of the 111 children who died and separately, providing specific detail about the children's circumstances, age and gender and the practice learning that has emerged from review of these children's deaths.

For nine of the children who died in 2022, the Children's Court had made an order allocating parental responsibility to the Minister for Families and Communities. Six of these children were Aboriginal.

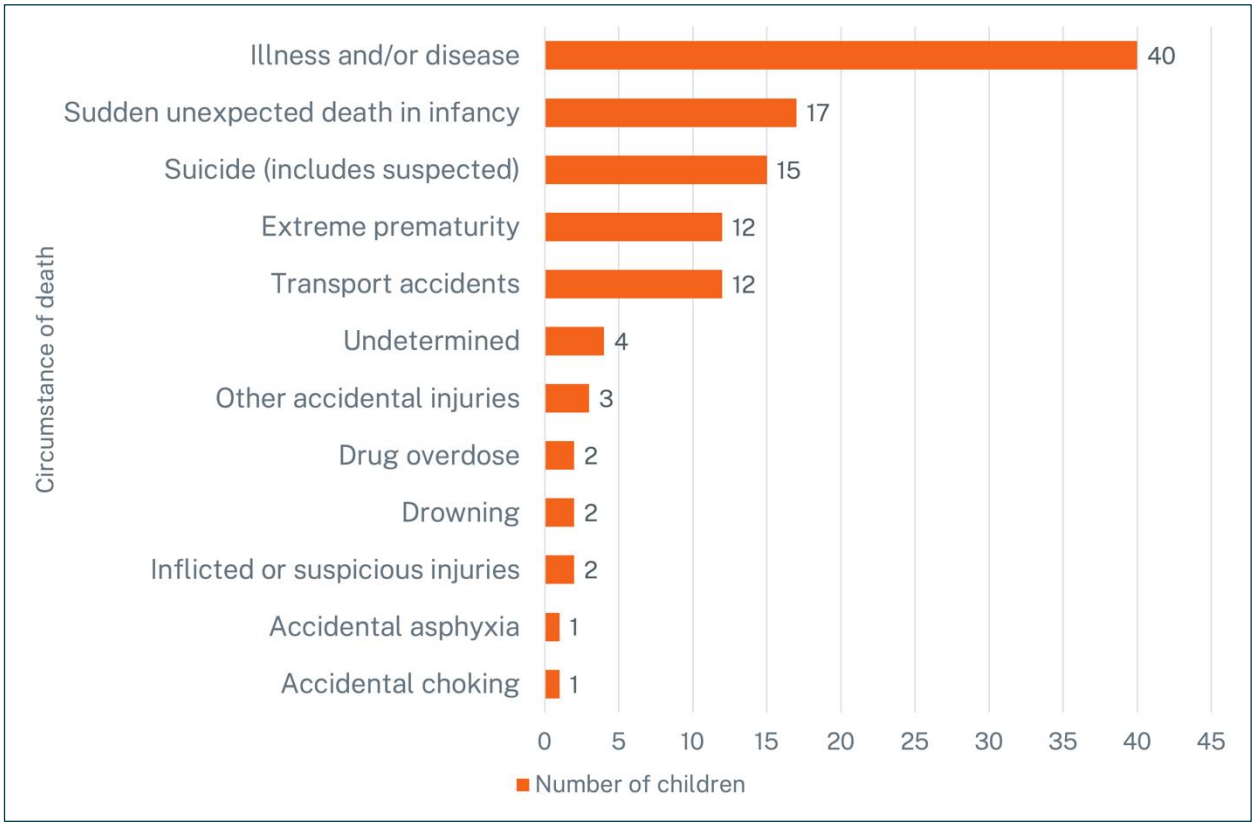


Figure 1: Children who died in 2022 and were known to DCJ, by circumstance of death

Figure note: the 'undetermined' category includes cases where post-mortem information has not yet been received and where the NSW State Coroner has been unable to determine a cause of death. The information in Figure 1 is also shown numerically in column '2022 No.' of Table 1.

Improving the way DCJ works with children and families

Chapter 3 outlines responses from DCJ to the learning that has come from child death reviews completed in 2022. It discusses the work of the Serious Case Review Panel and provides details about practice and policy changes that are taking place in response to recommendations made in child death reviews. Throughout 2022 and into 2023, DCJ continued to implement reforms to strengthen the child protection system and improve DCJ responses to vulnerable children and families. These are also described in Chapter 3.

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Child deaths in context

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

1.1 Child protection in NSW

DCJ commenced on 1 July 2019. It brought together the former departments of Family and Community Services (FACS) and Justice and includes Courts, Tribunals and Service Delivery, Corrective Services, NSW Housing, Disability, Youth Justice and child protection services, forming the Stronger Communities Cluster. DCJ is the statutory child protection agency in NSW and works with other government departments, non-government organisations and the community to support families to keep children safe from abuse and neglect. DCJ enables services to better work together to support an individual's right to access justice and help for families and promote early intervention and inclusion. DCJ is the lead agency in the Stronger Communities Cluster and brings together government services targeted at achieving safe, just, inclusive and resilient communities.

DCJ and non-government child protection practitioners work with children and families in NSW that have complex needs. Many of these families live with extreme disadvantage because of poverty, past injustice, discrimination, trauma, lack of access to services, unemployment, homelessness and social isolation. Often, families live with the impacts of problematic parental substance use, unaddressed mental health issues and domestic and family violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect and lead to many of the risk of significant harm reports made about children in NSW.[1]

Aboriginal families are resilient and derive strength from their connection to Country, community and kin. Their connection to culture can be a great source of strength and protection for Aboriginal children. The challenges Aboriginal families face need to be understood in the context of a sustained history of oppression, paternalism and cruelty. Many Aboriginal families who are in contact with the child protection system have been adversely affected by intergenerational trauma and its compounding effects.[2]

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

It is important to note that the majority of children who die each year die from causes that were not directly related to the child protection concerns reported about them or their families. We urge readers and agencies to exercise caution before drawing any conclusions about the children whose stories are told in this report.

1.2 Examining child deaths in DCJ

1.2.1 Internal child death reviews

Reviewing child deaths is a requirement under section 172A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Each year, DCJ is required to report on the number and circumstances of death of children who have died and were known to DCJ.

Children in NSW with a child protection history have a higher mortality rate than those not known to DCJ and account for a greater relative proportion of the children who die from certain causes in NSW.[3] Other jurisdictions across Australia report similar findings.[4]

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

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

Serious Case Review Unit

The Serious Case Review (SCR) Unit is part of the Office of the Senior Practitioner (OSP) within DCJ. The SCR Unit reviews DCJ involvement with all children who have died and were known to DCJ. These internal child death reviews rely on a systems approach that is based on a case review model developed in England.[5] The reviews consider how DCJ systems at a local and organisational level may have impacted on practice with the families of children who died. The reviews create learning opportunities for practitioners who work with families by not only identifying areas for improvement but also promoting positive practice. This in turn leads to broader system improvements.

Practitioner support and consultation

When a child dies, the SCR Unit and the Practice and Permanency Unit undertake collaborative work that enables practitioners to provide direct support to families and to assess the safety of any other children in the home. The role of the SCR Unit includes liaising with district leaders and practice managers to prepare briefings for senior officers about the circumstances of the child's death. The role of the Practice and Permanency Unit involves casework specialists partnering with practitioners to undertake sibling safety assessments. Managers practice and permanency often consult on the pre-assessment consultation and help plan for the difficult conversations needed, attend the assessment consultation and coordinate appropriate services to debrief casework teams. When a child who is in out of home care dies, permanency coordinators support non-government organisations to navigate the process.

The SCR Unit frequently consults with practitioners to give them an opportunity to discuss their experience working with a family, including any contextual factors or systemic issues they consider relevant, and to reflect critically on practice. Throughout this process, the focus of review work remains on the broader systems that impact on practice and not the work of any one individual practitioner. In some circumstances when an internal child death review is completed, the SCR Unit also provides practitioners with the opportunity to read the review, including critique of the practice and provide feedback. Participating in an internal child death review can be a difficult process for practitioners. The SCR Unit is continually impressed by the courage and openness shown by practitioners in their willingness to reflect on their practice and learn from DCJ involvement with a family when a child dies.

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

Learning from internal child death reviews

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

Child Deaths Annual Report

This report is published at the end of each calendar year and provides retrospective information about children who have died and were known to DCJ. This includes their demographic characteristics, the circumstances of their deaths and practice reflections and learning that arises from internal child death reviews completed by SCR. The report aims to engage practitioners and the community and share the learning that can come from the stories of the children who died, as well as highlighting the complexities of contemporary child protection work in NSW. Chapter 3 of the report provides an overview of key practice reform and changes that have taken place in response to the learning from reportable deaths.

Cohort reviews

Cohort reviews look closely at a group of children who died, were known to DCJ and share some common characteristics. In the last five years, cohort reviews have considered children who died:

- and had a diagnosed disability
- in circumstances of suicide or suspected suicide
- in circumstances related to premature birth
- and whose parents had a child protection history
- from illness and/or disease.

Other previous cohort reviews include responses to families of children who died, children who had experienced neglect, vulnerable teenagers and infants who died suddenly and unexpectedly.

Practice review sessions and other forums

The OSP coordinates many broad learning forums, including practice review sessions and an annual DCJ Practice Conference, and offers seminars to frontline workers and other professionals to provide them with up-to-date research and information about current best practice. The stories of children who have died are often at the heart of many of these learning forums.

Practice review sessions are held with practitioners, both internal and external, following a child death review. These sessions support practitioners to reflect on what worked, what could have been done differently and how learning could be applied to work with other families. The sessions also give practitioners an opportunity to share their expertise and insights about a family or about broader issues raised in a review.

1.2.2 Making and monitoring recommendations following child deaths

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

Making and monitoring recommendations within DCJ

Approximately 100 internal child death reviews are undertaken each year. Many of the reviews result in recommendations aimed at improving direct casework with families or are about the unique needs of a Community Services Centre (CSC) or district. All reviews with recommendations are referred to the Executive District Director, Director Community Services and Director Practice and Permanency to consider the practice issues highlighted in the review and any need for a localised management response to those issues. The implementation of these recommendations is monitored closely through the DCJ Operational Business Review process, providing visibility of recommendations and ensuring accountability.

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

Serious Case Review Panel

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

This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. The OSP maintains a secretariat role for the Panel and monitors the progress of recommendations. Since the end of 2022, the Panel has reported to the Operations Governance Committee on its work and the progress of systemic recommendations. Before this, the Panel reported to the DCJ Executive Board.

The NSW Ombudsman is provided with a copy of the recommendations and DCJ responses in implementing them. This informs the broader role of the NSW Ombudsman in overseeing the whole service system's response to the learning from child death reviews.

1.3 Child death oversight in NSW

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

1.3.1 Oversight bodies, agencies and teams

NSW Ombudsman

The NSW Ombudsman is an independent and impartial integrity agency that watches over most NSW public sector agencies and some community service providers. As part of his legislative responsibilities, the Ombudsman is required to conduct in-depth reviews of children who died in circumstances of abuse or neglect, and deaths of children in care or detention. These deaths are known as 'reviewable deaths'. The purpose of this function is to prevent or reduce the likelihood of reviewable child deaths.

The NSW Ombudsman also makes recommendations about legislation, policies, practices and services for implementation by government and non-government organisations and the community. The recommendations are monitored and discussed in its biennial reports. The Ombudsman must report to Parliament every two years. The most recent report considered reviewable deaths of children in 2020 and 2021 and was tabled in late 2023.

NSW Child Death Review Team

Convened by the NSW Ombudsman, the NSW CDRT registers, examines, analyses and classifies the deaths of all children in NSW with the objective of preventing and reducing child deaths. The CDRT includes the Advocate for Children and Young People, the Community Services Commissioner, representatives from other government agencies,[6] and individuals with expertise in relevant fields, including health care, child development, child protection and research methodology.

The CDRT also makes recommendations about legislation, policies, practices and services for implementation by government and non-government organisations and the community. The CDRT reports biennially to the NSW Parliament about the causes and trends of deaths of all children that occurred in NSW, as well as annually in relation to its operations and

activities, including research projects and progress on the implementation of the CDRT recommendations.

The CDRT advised DCJ that 463 children aged from birth to 17 years died in NSW in 2022. One hundred and eleven (24 per cent) of these children were known to DCJ because they and/or their siblings had been reported at risk of significant harm in the three years prior to their death. These figures can differ slightly from DCJ data, highlighting important differences between the way CDRT and DCJ report on child deaths. For example, the CDRT reports on the deaths of children with a child protection history if, within the three years before their death, the child and/or their sibling was the subject of a risk of significant harm report or a non-risk of significant harm report made to DCJ or a Child Wellbeing Unit, while DCJ only examines the deaths of children who meet the risk of significant harm threshold. Both the CDRT and DCJ report on deaths that occurred in a calendar year.

The CDRT reports on all children who died while in out of home care, but only refers to these children as having a child protection history if the child and/or their sibling was the subject of a risk report within three years of the death. As the jurisdiction of the CDRT primarily relates to the deaths of children that occur in NSW, deaths of NSW children who die outside of the state are not included in its biennial reports. DCJ reviews the deaths of children who were known to DCJ regardless of where they died.

NSW Police Force and the NSW State Coroner

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

In addition, as outlined in the *Coroners Act 2009* (NSW), the NSW State Coroner has the power to hold an inquest into a child's death where it appears to a senior coroner that:

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

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

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

NSW Domestic Violence Death Review Team

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

The NSW Domestic Violence Death Review Team (DVDRT) is convened by the NSW State Coroner. The team includes representatives from government agencies, including DCJ, police and health, and representatives from non-government sectors and academia. The team undertakes comprehensive analyses of deaths occurring in a context of domestic violence to identify issues arising in individual cases or across cases, identify trends and patterns in quantitative data, highlight limitations or weaknesses in service delivery from its qualitative analysis and make recommendations.

The DVDRT aims to develop and promote domestic and family violence intervention and prevention strategies to reduce the likelihood of deaths occurring in similar circumstances in the future, and to improve the response to domestic violence more generally. The death of a child in the context of domestic and family violence is also subject to review by the team.

The DVDRT reports to the NSW Parliament biennially, setting out findings from qualitative case analysis and recommendations from this analysis. The DVDRT undertakes public monitoring of its recommendations and responses to these in its tabled reports and on its website. The fifth DVDRT report, the *NSW Domestic Violence Death Review Team Report 2019–21*, was published in 2022.

Office of the Children's Guardian

The Office of the Children's Guardian (OCG) oversees organisations to uphold children's rights to be safe. The primary functions of the OCG include:

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

1.3.2 Reviewing the deaths of children in out of home care

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

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2022, this included children placed with carers authorised by DCJ or Permanency Support Program (PSP) providers, and children who died in a facility funded, operated or licensed by DCJ. These reviews consider the adequacy of the involvement of all agencies with the child and family before the child's death and the support and actions taken following the child's death.

In response to the significant progress that has been achieved in moving statutory out of home care services from government to the non-government sector, the SCR Unit is working with PSP providers and non-government organisations more often as part of its review process. The deaths of children in non-government out of home care settings have led to a broadening of review mechanisms, with some reviews being undertaken jointly. This flexible and collaborative model provides the opportunity for all services to consider their involvement with children and to share reflections and learning to improve service provision to benefit all children in care.

1.4 Public and interagency understanding of child deaths

In providing public information about the circumstances surrounding children's deaths, DCJ is committed to protecting the privacy of families who are impacted by the tragedy. The NSW Parliament has also responded by protecting privacy and confidentiality through a range of legislation that governs the disclosure of information on individual child deaths.[7] While DCJ cannot report publicly about individual children, it has a strong commitment to transparency and accountability. The publication of this report reflects this important and ongoing commitment.

1.4.1 Child deaths and the media

Child abuse and neglect is a problem for the whole of society, and the media plays a key role in the way it is portrayed in the public domain. Drawing attention to the stories of children who have died and their families through the findings of rigorous review can help

the community to understand the nature of child protection work and some of the complexities involved in working with children and families.

Most years a small number of child deaths are the subject of considerable media attention. These deaths often involve children who died because of abuse or neglect by a parent or carer. Child abuse injuries, severe neglect and deaths demand explication in the public domain, and the impacts of this scrutiny can be severe and long lasting. The media can help to shape public and professional ideas of risk, and it can be difficult to separate what is known about child abuse from the media as compared to theory, research and practice.[8]

Media attention also has negative consequences. Understandably, the death of a child, particularly in circumstance of abuse or neglect, will provoke strong emotion, and in turn, the need for an explanation or someone to be held accountable can result. This can lead to the increasing politicisation of child abuse, often responded to by political decisions to hold public inquiries, which in turn have contributed to systems becoming risk averse and punitive in their orientation.[9] Recent literature about media reporting of child deaths advocates a more balanced approach that draws child protection risk to the public's attention, but then focuses on how the system could be improved.[10]

Review work by the SCR Unit has highlighted the impact that the death of a child can have on practitioners when there has been extensive coverage in the media. Practitioners may adopt an 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.

On the positive side, media coverage can raise public understanding and increase community awareness about the need to report concerns about children. It can educate about the reality of the work, and it can challenge attitudes. Balanced reporting can lead to compassionate understanding about the impacts of trauma, disadvantage, addiction and family violence. Other positive benefits can include an increased understanding that child protection is a shared responsibility and that a joint approach is needed by all agencies to address the complex problems that impact child abuse and neglect.

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Child deaths in 2022

In 2022, 111 children died who were known to DCJ before their death. Chapter 2 provides summary information about these children and their families, including the characteristics of the children such as their age and gender. The accompanying analysis considers information that is known about the circumstances of the children's deaths, alongside relevant information about their child protection history. Practice reflections and learning are included to strengthen current practice and future work with children and their families.

To maintain confidentiality for the families, this chapter provides broad information that helps to describe the key themes of practice, both positive and in areas for strengthening practice.

2.1 Child deaths in NSW

Between 1 January 2022 and 31 December 2022, the deaths of 463 children were registered in NSW. Of those 463 children, 111 were known to DCJ because they and/or their siblings had been reported at risk of significant harm in the three years prior to their death, or the child was in out of home care when they died. Of these 111 children, 38 were Aboriginal.

Figure 2 shows the number of children who died in NSW and the number of children who died and were known to DCJ, across a 10-year period. The number of children who were known to DCJ and who died in 2022 represent 0.1 per cent[11] of the total number of children reported to DCJ in that year. This is consistent with previous years' findings.

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

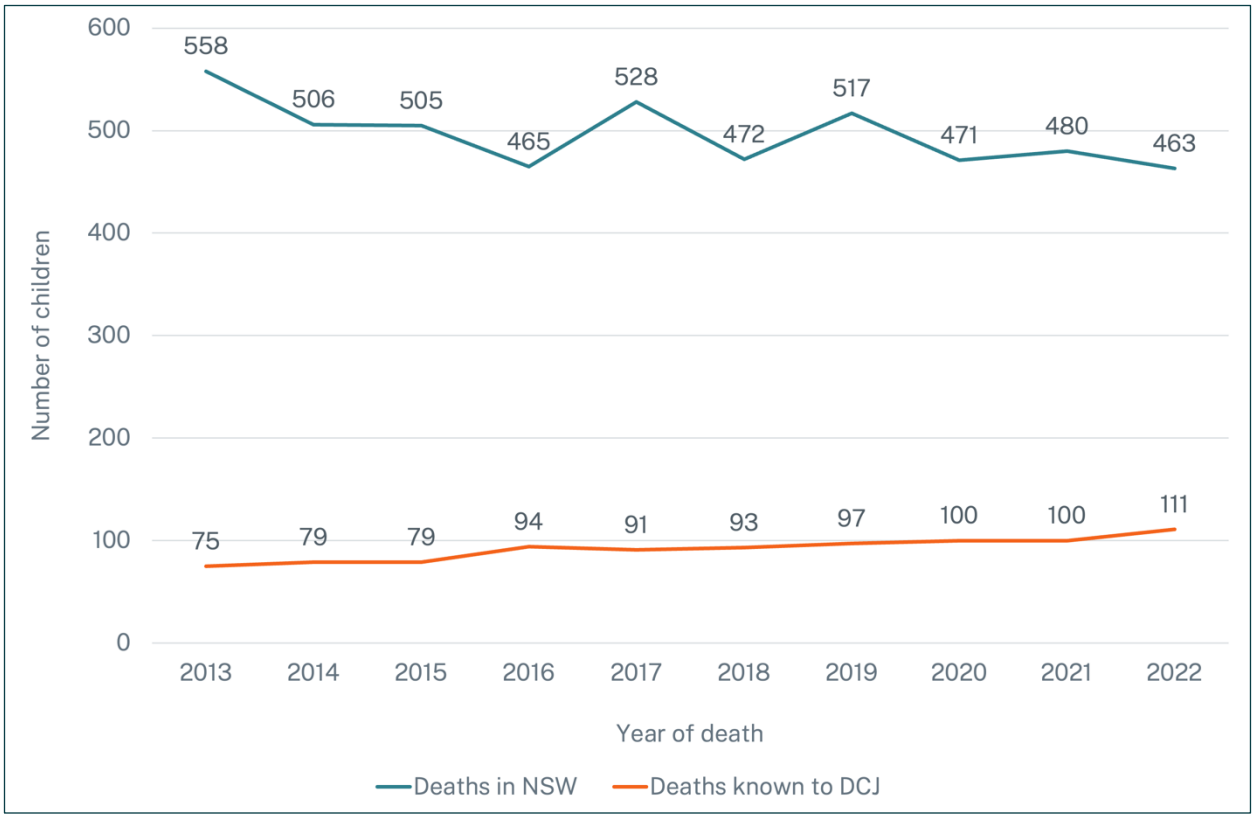

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ

Figure note: the information in Figure 2 is also shown numerically in Appendix 2, Table A2.

Figure 3 (a repeat of Figure 1 in this report) again shows the circumstances of death for the children who were known to DCJ in 2022. Of the 111 children who died, 96 deaths were attributed to five main circumstances. The most common circumstance of death was illness and/or disease (40 children). This was followed by sudden unexpected death in infancy (SUDI) (17 children), suicide (15 children), transport accident (12 children) and extreme prematurity (12 children). The remaining circumstances of death included accidental injuries (3 children), drug overdose (2 children), drowning (2 children), inflicted or suspicious injuries (2 children), accidental asphyxia (1 child), accidental choking (1 child) and those where the circumstance of death remains undetermined (4 children). The 'undetermined' category includes cases where post-mortem information has not yet been received and/or where the NSW State Coroner has not yet been able to determine a cause of death.

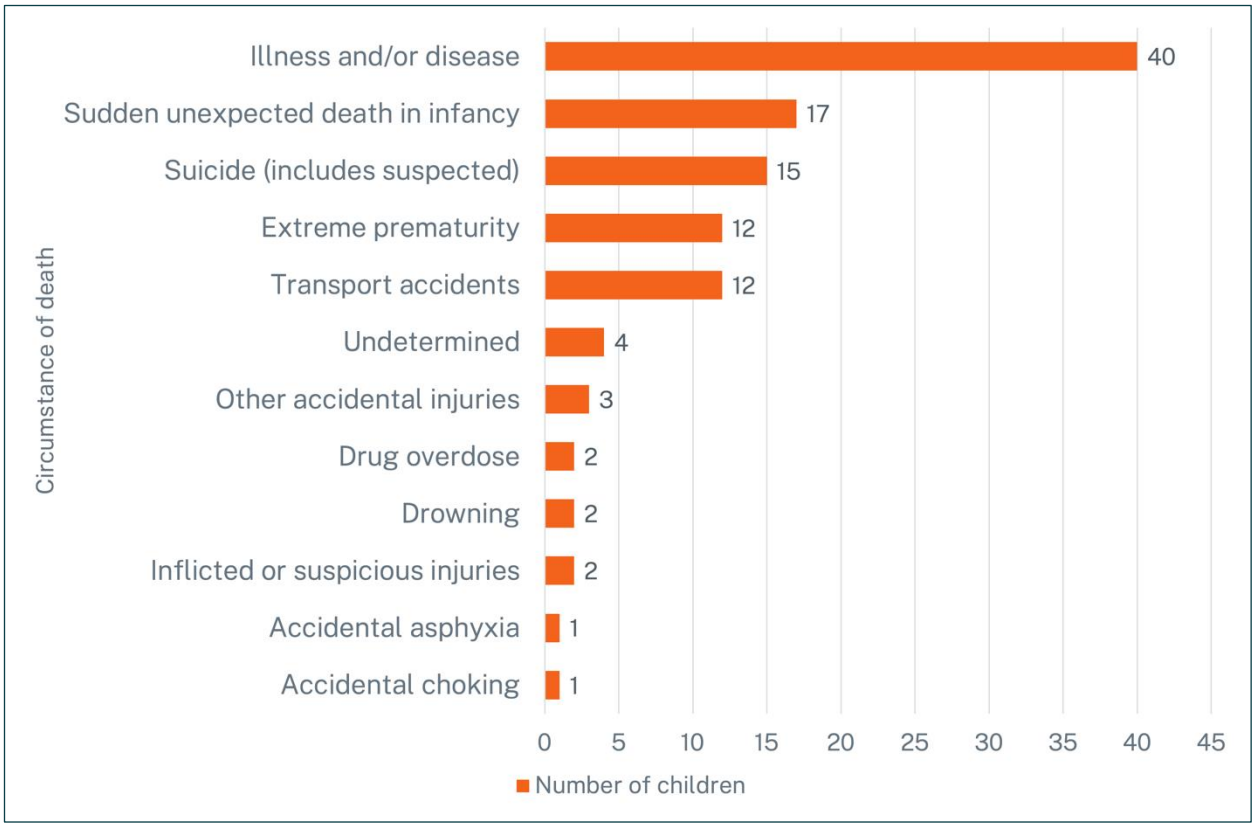

Figure 3: Children who died in 2022 and were known to DCJ, by circumstance of death

Figure note: the information in Figure 3 is also shown in column '2022 No.' of Table 1 in the content immediately following.

Table 1 shows the numbers and percentages of children who died and were known to DCJ by circumstance of death for the years 2018 to 2022.

Table 1: Children who died and were known to DCJ, by circumstance of death, 2018–22

Circumstance of death	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %	2021 No.	2021 %	2022 No.	2022 %
Illness and/or disease	39	44%	32	33%	36	36%	32	32%	40	36%
Sudden unexpected death in infancy	10	11%	19	20%	15	15%	14	14%	17	15%
Suicide	8	9%	8	7%	12	12%	12	12%	15	14%
Extreme prematurity	10	11%	10	10%	9	9%	8	8%	12	11%
Transport accident	10	11%	6	6%	11	11%	16	16%	12	11%
Undetermined	0	0%	2	2%	6	6%	4	4%	4	4%
Other accidental injuries	1	1%	3	3%	1	1%	0	0%	3	3%
Drug overdose	2	2%	2	3%	2	2%	1	1%	2	2%
Drowning	2	2%	3	3%	1	1%	6	6%	2	2%
Inflicted or suspicious injuries	8	9%	7	7%	3	3%	5	5%	2	2%
Accidental asphyxia	1	1%	1	1%	2	2%	0	0%	1	1%
Accidental choking	1	1%	1	1%	0	0%	0	0%	1	1%
Fire	1	1%	3	3%	2	2%	2	2%	0	0%
Total	**93**	**100%**	**97**	**100%**	**100**	**100%**	**100**	**100%**	**111**	**100%**

Figure note: percentages may add to more than 100 per cent due to rounding. The data for 2020 in this table is also shown graphically in Figure 1.

2.2 Characteristics of the children

2.2.1 Age and gender

Consistent with previous years, infants under the age of 12 months made up a significant proportion of the children who died and were known to DCJ. As shown in Figure 4, 45 of the children (41 per cent) who died were under 1 year of age, 16 of the children (14 per cent) were 1 to 4 years of age, eight of the children (7 per cent) were 5 to 8 years of age, eight of the children (7 per cent) were 9 to 12 years of age, 19 of the children (17 per cent) were 13 to 15 years of age and 15 of the children (14 per cent) were 16 to 17 years of age.

In 2022, 60 children who died were male, 50 were female and one was non-binary. As in previous years, the male mortality rate for children known to DCJ was higher than for females. The higher number of male deaths is consistent with Australian child deaths data. When compared to data from children living in Australia in 2021, the death rate was higher for boys than girls (84 and 70 deaths per 10,000 population, respectively).[12]

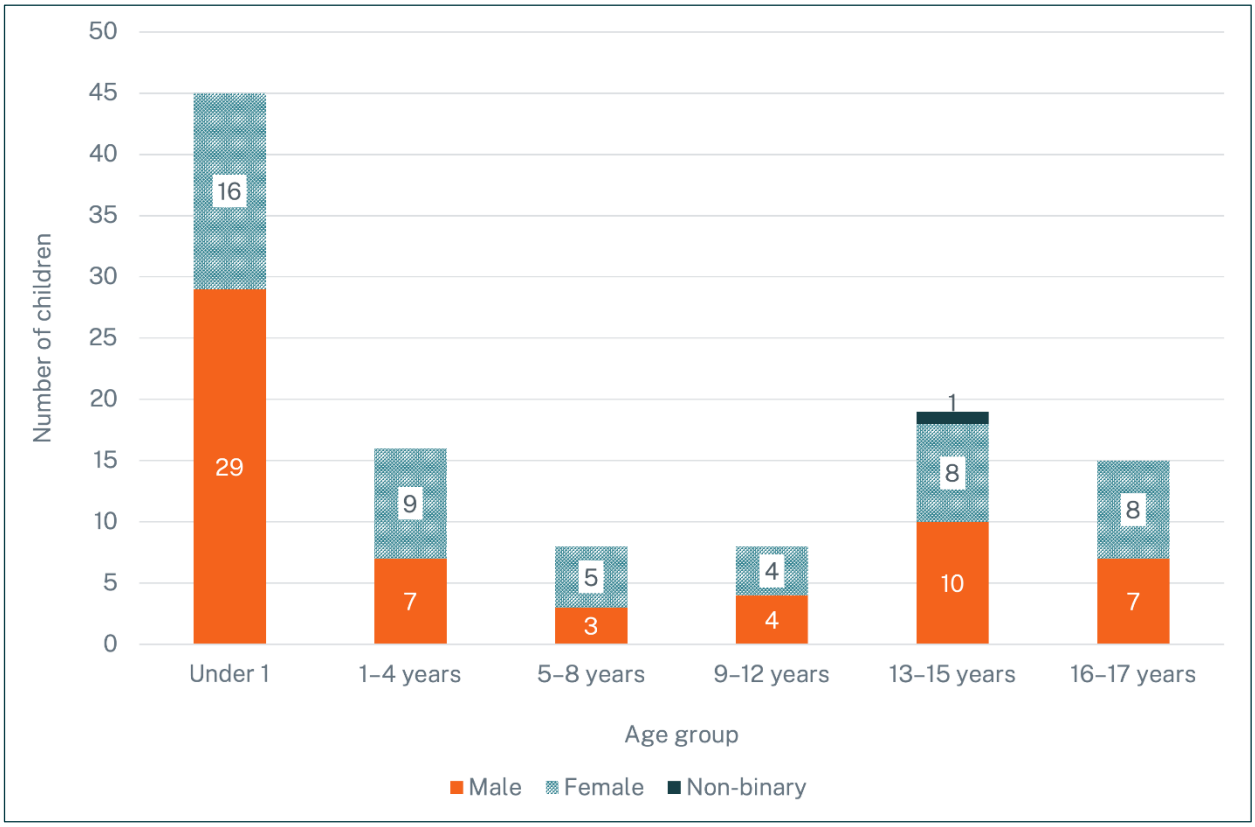

Figure 4: Children who died in 2022 and were known to DCJ, by age and gender

Figure note: the information in Figure 4 is also shown numerically in Appendix 2, Table A3.

2.2.2 Age, gender and circumstances of death

Infants aged under 12 months

Twenty-nine of the 45 infants (64 per cent) who died under the age of 12 months were male and 16 (36 per cent) were female. Thirty-three of the children (73 per cent) died within three months of their birth.

As shown in Table 2, the three main circumstances of death for infants under the age of 12 months were SUDI (17 infants, 38 per cent), illness and/or disease (13 infants, 29 per cent) and extreme prematurity (12 infants, 27 per cent). One child in this age group died of accidental asphyxia while the circumstances of two children's deaths remain undetermined.

Children aged 1 to 12 years

Thirty-two children who were known to DCJ were aged 1 to 12 years when they died in 2022; 18 were female and 14 were male.

As shown in Table 2, over two-thirds (21 children, 66 per cent) of the children died from one main circumstance of death: illness and/or disease. The other children died in circumstances of transport accidents (3 children, 9 per cent), other accidental injuries (3 children, 9 per cent), inflicted or suspicious injuries (2 children), drowning (1 child) or accidental choking (1 child), and the circumstances of one child's death remain undetermined.

Teenagers aged 13 to 17 years

Thirty-four of the children who died in 2022 were aged 13 to 17 years; 17 were male, 16 were female and one was non-binary.

As shown in Table 2, the three main circumstances of death for this age group were suicide (15 children, 44 per cent), transport accidents (9 children, 26 per cent) and illness and/or disease (6 children, 18 per cent). The four other children in this age group died in circumstances of drug overdose (2 children) or drowning (1 child), and one child died in circumstances which are still undetermined.

Table 2: Children who died in 2022 and were known to DCJ, by age and the most common circumstances of death

Age group	Most common circumstance	Second most common circumstance	Third most common circumstance
Infants under 12 months	SUDI (17 infants, 38%)	Illness and/or disease (13 infants, 29%)	Extreme prematurity (12 infants, 27%)
Children 1 to 12 years	Illness and/or disease (21 children, 66%)	Transport accidents (3 children, 9%)	Other accidental injuries (3 children, 9%)
Children 13 to 17 years	Suicide (15 children, 44%)	Transport accidents (9 children, 26%)	Illness and/or disease (6 children, 18%)

2.2.3 Cultural and linguistic diversity

Nineteen of the children who died in 2022 and were known to DCJ were identified as culturally and linguistically diverse. Among these 19 children there was a diverse range of ethnicity, languages and backgrounds. The predominant cultures represented by the children who died and were known to DCJ in 2022 included those of Māori and other Pacific Islander countries. This information was obtained from what was known about the children and their families at the time they died and the documents available to DCJ. This does not preclude that other children who died were culturally and linguistically diverse.

Additionally, 38 of the children who died and were known to DCJ in 2022 were Aboriginal. These children are discussed in section 2.4 of this chapter, along with the importance of identifying and recording a child's Aboriginal status and undertaking cultural consultation.

DCJ casework practice

Recognising that **Culture is ever-present** is a principle of the NSW *Practice Framework*.

Culturally responsive practice with diverse communities – key messages

- Accept and respect cultural differences.
- Cultural consultation is an ongoing process, not a one-off event.
- Speak to a child, their family and extended family about their culture and what it means to them.
- Be aware of cultural beliefs, biases and assumptions and the impact of these on practice.

- Model respectful engagement, including the use of appropriate language and awareness of cultural sensitivities.
- Show commitment to ongoing professional and personal development of cross-cultural knowledge and skills.
- Understand the family's culture and migration or refugee experiences and consider this in assessment and family work.
- Carry out regular and meaningful cultural planning and quality life story work.

Aboriginal consultation

Aboriginal consultation is an exchange or two-way flow of information. It is an important process that empowers Aboriginal families and communities to help make decisions on matters that affect the care and protection of their children. Aboriginal consultation provides guidance, advice and support through decision-making and should occur at all stages of involvement in the life of an Aboriginal child.

The **Aboriginal Consultation Guide** is available to DCJ practitioners on Casework Practice and provides a practical framework to enable practitioners to consult consistently, effectively and sensitively with Aboriginal children, families and communities.

Multicultural consultation

Multicultural practitioners are the primary DCJ resource for cultural consultation. They can help practitioners to understand the cultural background and practices of a family. Cultural consultations are also organised and provided by practitioners, or agencies outside of DCJ, with knowledge of the family's culture. Since mid-July 2022, requests by DCJ practitioners for multicultural consultation are made in ChildStory.

Interpreter services

Language barriers have an immense effect on a child's and family's ability to access basic services, information and support. This can lead to isolation, discrimination and disadvantage. DCJ practitioners should always offer children, families and communities who do not speak English or have difficulty speaking English a telephone or face-to-face interpreting service. Casework Practice includes information for DCJ practitioners about when and how to access interpreting services.

2.3 DCJ response to the children who died

This section of the report outlines DCJ involvement with the 111 children who died in 2022 and their families. Information is provided about why their deaths met the reportable deaths criteria, the number of reports that had been received and what the reports were about.

A report is created when the information reported to DCJ about a child meets the risk of significant harm threshold. This information is later assessed alongside professional experience, knowledge and theory by DCJ practitioners during engagement with a child and their family. When reading the information in the next few sections, it is important to remember that the figures presented are about information that met the threshold for risk of significant harm before it had been assessed by DCJ.

This section also includes information about the sibling safety policy and how the need for a sibling safety response after a child dies is identified. Details of how DCJ responded to the families of the children who died in 2022 and whose families required a sibling safety response is included.

2.3.1 Reported child protection history

Reportable deaths are defined in section 172A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

As shown in Figure 5, 85 (77 per cent) of the 111 children who died in 2022 were known to DCJ because they were the subject of a risk of significant harm report in the three years immediately preceding their death. Seventeen (15 per cent) children had not been reported to DCJ, but their sibling/s had been the subject of a risk of significant harm report in the three years before they died. Nine (8 per cent) of the children were living in out of home care.

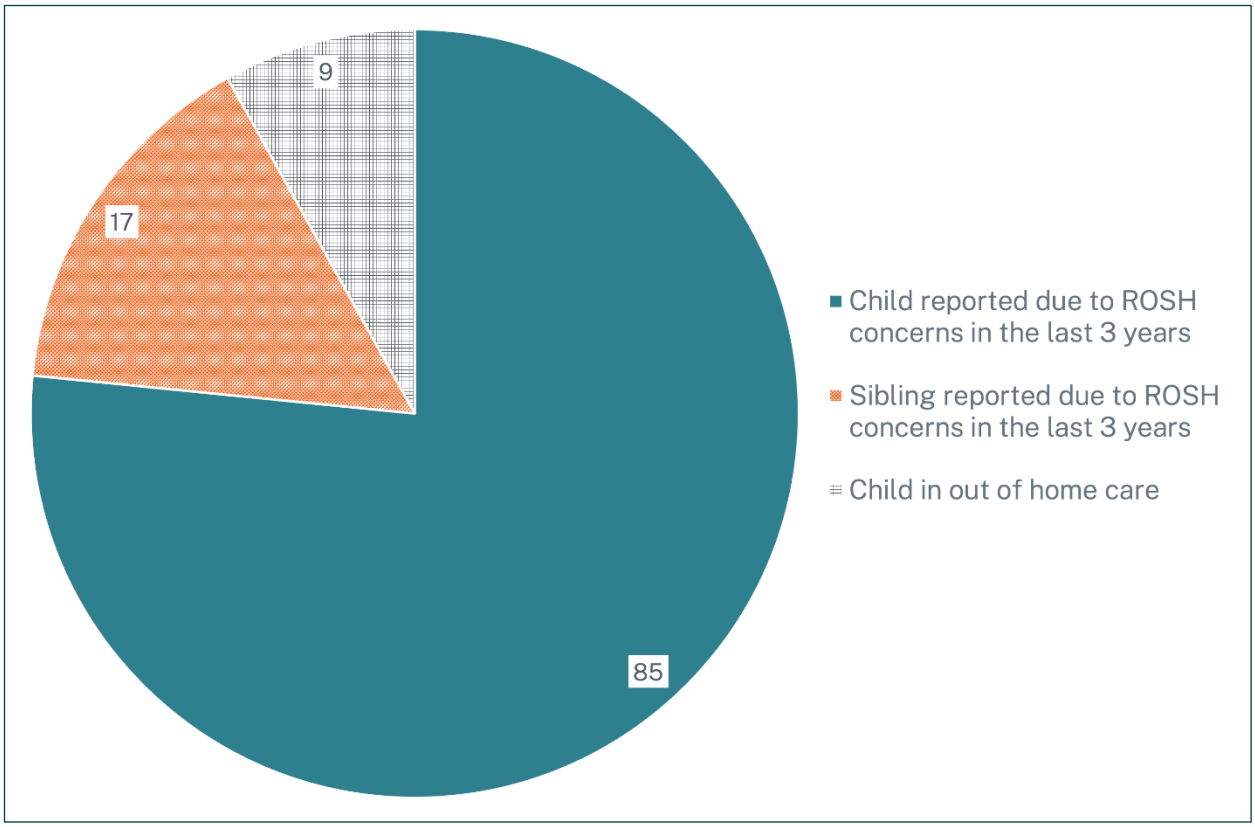

Figure 5: Number of children who died in 2022, and how they were known to DCJ

2.3.2 Reported issues of concern

Physical abuse and domestic violence were the main issues reported for the children who died in 2022. These issues did not occur in isolation. Only nine of the 111 children who died in 2022 were reported because of only one type of harm. Most children were reported to DCJ because they were suspected to be at risk from and/or experiencing multiple types of harm. Practitioners are required to explore all the reported concerns when planning for an assessment and consider any other types of abuse, harm and risk that a child is exposed to.

For the 111 children and their families, the most common issues they were reported as experiencing or being at suspected risk of experiencing were:

- physical abuse (66 children)
- domestic violence (60 children)
- physical neglect (59 children)
- emotional abuse or neglect (55 children)
- parental alcohol or drug use (52 children)
- sexual abuse (49 children).

2.3.3 Decisions made in response to risk of significant harm reports

When a report is made to DCJ about a child being at risk of significant harm, the child has a right to responsive assessment and casework that keeps them safe.

Urgent reports that contain information indicating imminent risk to the child are prioritised to be allocated for a field assessment immediately. A field assessment includes either a safety assessment and risk assessment or an alternate assessment. It involves meeting with the child and members of their family, usually at the child's home. Practitioners will often speak with extended family members, community and professionals involved in providing care and/or support to the family to help inform the assessment. The practitioner will consult with their manager at key decision-making points in the assessment process.

If a risk of significant harm report cannot be allocated for a field assessment, Community Service Centres (CSCs) are guided by a triage process to make decisions. This includes collaboration with other services and/or the family to gather further information, where required, to ensure that appropriate action is taken and children at the highest level of risk are given priority for a field assessment. An assessment takes place at the CSC of the incoming reports to determine the most appropriate response. Considerations include:

- child factors such as their age, development, functioning and vulnerabilities
- the cultural and other specific or unique needs of the family
- the support networks and visibility of the family within the community and any observations from these networks
- the type of abuse and neglect, including any patterns known or multiple risk factors
- strengths and protective factors known
- the child protection history of the family
- the parents and/or caregivers own child protection history and experience.

Most reports are considered as part of the triage process, either at a weekly allocation meeting (WAM) or equivalent peer review process. The report is discussed in detail and the CSC management team prioritises reports for a field assessment. Decisions can be made to refer a child and their family to another agency who is able to address the reported concerns or to hold an interagency case discussion (ICD). An ICD meeting allows DCJ to bring together agencies which are (or could be) involved and supporting a family to collaborate and agree on ways to achieve the best possible outcomes for children and their families.

Following the triage process, some reports about risk of significant harm may be closed. This decision is based on consideration of all information known at the time of closure, and reasons may include that the family was referred to another agency for support or the report had not been able to be allocated for more than 28 days and other reports at the CSC awaiting allocation had a higher priority.

DCJ response to risk of significant harm reports for the children who died in 2022

In the three years before they died, 66 children and their families received an assessment from a DCJ practitioner. For the 45 families who had not received an assessment in the three years before the child died, the reasons included that:

- DCJ had not received any prior risk of significant harm reports about the child who died, or the child was known to DCJ because of reports received about their siblings that had previously been assessed by DCJ
- the child who died was in out of home care, and no new assessments had been completed in the three-year period before they died
- the triage process was open and DCJ was gathering information to inform decision-making, but the child died before the report was allocated for assessment
- DCJ had referred the child and their family to a DCJ-funded program for support to address the reported concerns before closing the report
- capacity issues at the CSC prevented allocation of the report; however, further information was gathered from services or the family to ensure supports were in place before closing the report.

Open DCJ cases for the children who died in 2022

DCJ had an open case for 34 of the children and their families when they died in 2022. Eighteen of the 34 children with open cases were Aboriginal. Nine of the 34 children were in out of home care with open cases and ongoing casework, five children were case managed by DCJ, and four children's case management had been previously transferred to a non-government agency.

DCJ was in the process of assessment, or providing ongoing casework aimed at addressing identified needs, for 17 families when the child died. For these families, casework involved the completion of safety and risk assessments and ongoing review of the child's safety when new information was received, regular visits to the home, family meetings and family group conferences, the development of family action plans for change, referrals to Intensive Family Preservation programs and joint work with other agencies. When DCJ learned that the child had died, practitioners worked to support the family and assessed the safety for siblings and other children in 13 of these families. The other four families did not require sibling safety assessments. The reasons for this and the process of a sibling safety response is discussed in more detail below.

For eight children with open cases, DCJ had only recently become involved; for five children, their report was being considered by the triage team at the CSC and had not been allocated for an assessment when they died; and for the other three children, DCJ received a report about the circumstances that resulted in their death while the child was in hospital.

While a case was then opened for these children, casework focused on the safety of other children in the home and supporting the child and their family. Each of these three children remained in hospital until they died.

2.3.4 Sibling safety response

When a child dies and information known at the time of their death indicates that the death may have been because of abuse, neglect or suspicious circumstances, DCJ has the responsibility to assess the safety and wellbeing of other children living in the same household. This assessment is guided by the **Sibling Safety Child Protection Mandate**. It is not the role of DCJ to investigate the cause of the child's death; however, DCJ can gather information, where relevant, to inform the assessment of safety and risk for other children who live or spend time in the household.

Alongside assessing the safety of other children in a house when a child has died, practitioners are required to work with families to assess their need for support. Good sibling safety assessments occur when practitioners seek to genuinely understand the significant grief and loss that a family is facing. The dual role of assessing safety and risk while supporting a family can feel incompatible and be very challenging for both families and practitioners.

Sibling safety response – cultural considerations

It can be challenging to carry out a safety and risk assessment with a family after a child has died. For DCJ practitioners, the pre-assessment consultation (PAC) can involve the casework specialist or others with specific relevant knowledge and is an opportunity to plan a sensitive and respectful approach.

After the death of an Aboriginal child, cultural consultation should be sought to understand **Sorry Business** and its impact on a child's family, community and the services involved.

Aboriginal consultation and **multicultural consultation** should be sought to understand a family's rituals, lore and practices around death and to inform the approach with a family.

A joint home visit with staff from another service or agency might be helpful and supportive if the family are already involved with them, particularly if the family are Aboriginal or from a migrant or refugee background.

Sibling safety assessments in 2022

In 2022, sibling safety assessments were completed for the families of 28 children who died and were known to DCJ. Fourteen of these 28 children were Aboriginal.

For the 28 sibling safety assessments completed, children in three families were considered 'unsafe' and removed from their parents' care. For the other 25 families, the children were assessed as 'safe with plan' or 'safe' in their parents' care. These sibling safety assessments typically involved:

- ongoing case management from DCJ provided to families
- referrals made to appropriate services for children and families to receive ongoing support
- DCJ ending its involvement because siblings were assessed as safe and no ongoing needs for support or case management were identified.

For the remaining 83 families of children who died in 2022, the response did not include a formal sibling safety assessment for a number of reasons, including that:

- there were no other children aged under 18 years living in the household
- no risk issues were identified for the remaining siblings
- DCJ already held an open case for the family and was considering the information alongside existing casework
- the information about a child or young person's death had been screened as not meeting the risk of significant harm threshold and the report was closed at the Helpline.

Practice reflections and learning

Reviews completed for the children who died in 2022 have highlighted positive and confident practice by DCJ practitioners when responding to families and completing sibling safety assessments. Reviews have highlighted an ongoing holistic process of assessment that is distinctly child focused while being considerate of the grief that parents and family members are experiencing. Practitioners have been able to form strong relationships with the children's family network, supports and services involved to benefit the children's ongoing safety.

Supporting families after the death of a child

Coping with the death of a child can be difficult, isolating and challenging for any relationship. Practitioners can help families by providing information about services that are available to support families after the death of a child. Some examples of services follow.

Red Nose provides free specialised bereavement support to any person affected by the sudden and unexpected death of a baby or child during pregnancy, birth, infancy or

childhood. For more information or to arrange a referral, call the 24/7 Red Nose Grief and Loss Support Line on 1300 308 307 or visit the Red Nose Grief and Loss website.[13]

The **Australian Parenting Website** by the Raising Children Network provides information about the grief that is experienced after the loss or death of a child and guidance for how to talk about death with children. Visit the Australian Parenting Website for more information.[14]

Aboriginal Counselling provides therapeutic counselling for families, individuals and communities within NSW. Aboriginal Counselling can help Aboriginal people to deal with grief and loss. To access this service, call 0410 539 905.

Bears of Hope is an Australian registered not for profit based in Sydney managed by a dedicated team of bereaved parents. They provide ongoing comfort, support and counselling to parents and families who have experienced the loss of a baby during pregnancy, birth and infancy. Call 1300 11 2327 for general enquiries or 1300 11 4673 for grief support, or visit the Bears of Hope website.[15]

2.4 Aboriginal children who died and were known to DCJ

Despite making up only 6.5 per cent of the population in NSW,[16] Aboriginal children are grossly over-represented in areas of disadvantage. As of 30 June 2022, Aboriginal children made up 35 per cent (18,589 of 53,189) of the children in NSW recorded as receiving child protection services[17] and 44 per cent (6661 of 15,223) of the children in NSW who were living in out of home care.[18]

Aboriginal people in Australia continue to suffer from intergenerational trauma. The injustice inflicted on Aboriginal people through the forced removal of children from their families continues to have a devastating impact on families, communities and cultural continuity. As the agency responsible for keeping children safe in NSW, DCJ is continually looking for ways to understand and address the disproportionate number of Aboriginal children in our system. DCJ practitioners do this by working in partnership with Aboriginal families and communities to keep children safe. Of the 111 children who died in 2022 and were known to DCJ, 38 children (34 per cent) were Aboriginal. This section includes specific information about these 38 children.

Identification of Aboriginal and Torres Strait Islander children

Identifying and recording a child's Aboriginal status is an essential part of good cultural practice. Appropriate identification of Aboriginal children will ensure their cultural rights are upheld and they are provided with culturally safe support and planning in all decisions made about them.

Children included in this section of the report have been determined to be Aboriginal after a careful process of checking information from a range of sources available to the SCR Unit. This includes information from birth, death and marriage certificates, police records, coronial documents and other agencies. This information is considered alongside records from ChildStory about casework practice that has taken place with a family.

The *Family is Culture: Independent review of Aboriginal children and young people in out of home care* was completed and released in 2019. The review discusses the fundamental importance of the identification (and 'de-identification') of Aboriginal children and recognises the complex issues and numerous barriers that exist alongside identification. Examples were used to highlight times when a child's Aboriginality had not been correctly identified and how this had led to cultural disconnection, a lack of cultural planning and/or consultation and the Aboriginal Child Placement Principle not being applied. Overall, the review concludes that there are insufficient rules for DCJ practitioners governing the identification and 'de-identification' of Aboriginal children. The review made five recommendations to improve this. Three of these are listed below and are relevant for DCJ practitioners when working with children and their families:

- The NSW Government should, in partnership with relevant Aboriginal community groups and members, develop regulations about identifying and 'de-identifying' children in contact with the child protection system as Aboriginal for inclusion in the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) (Recommendation 76).
- That DCJ should develop a policy to assist in the implementation of the new regulation about the identification and 'de-identification' of children in contact with child protection as Aboriginal (Recommendation 77).
- That DCJ should ensure that it is mandatory for practitioners to complete the Aboriginal or Torres Strait Islander status field (currently named 'Indigenous Status') on ChildStory (Recommendation 78).

The **DCJ Aboriginal Identification Policy** has been developed in response to the *Family is Culture* recommendations to ensure consistency of practice for casework teams working with Aboriginal children and their families across NSW. Consultation has occurred with internal and external stakeholders to inform development of this policy and ensure

integration of Aboriginal perspectives and voices into our practice with Aboriginal children and their families. This policy has been developed in partnership with the DCJ State Aboriginal Reference Group (ARG) and AbSec.

Chapter 3 includes more information about the *Family is Culture* report and the changes taking place in response to the passing of the Children and Young Persons (Care and Protection) Amendment (Family is Culture) Bill 2022.

2.4.1 Age and gender

Of the 38 Aboriginal children who died, 23 were male and 15 were female.

Eighteen of the 38 Aboriginal children (47 per cent) who died and were known to DCJ were aged younger than 12 months when they died. These children died from SUDI (6 children), extreme prematurity (6 children), illness and/or disease (5 children) and drowning (1 child).

Eleven Aboriginal children (29 per cent) were aged between 1 and 12 years. Six of these children were aged 1 to 4 years, three were aged 5 to 8 years and two were aged 9 to 12 years. These children died from illness and/or disease (7 children), other accidental injuries (2 children), in a transport accident (1 child) and from inflicted or suspicious injuries (1 child).

Nine Aboriginal children (24 per cent) were aged 13 to 17 years when they died. These children died from suicide (3 children), in transport accidents (3 children), from illness and/or disease (2 children) and from a drug overdose (1 child).

2.4.2 Circumstances of death

The five main circumstances of death for Aboriginal children were the same as for the overall cohort of all children who died and were known to DCJ in 2022. As shown in Figure 6, of the 38 Aboriginal children who died and were known to DCJ, the most common circumstance of death was illness and/or disease (14 children). This was followed by SUDI (6 children), extreme prematurity (6 children), transport accidents (4 children) and suicide (3 children). The other circumstances of death for Aboriginal children were other accidental injuries (2 children), drowning (1 child), suspected inflicted injury (1 child) and drug overdose (1 child).

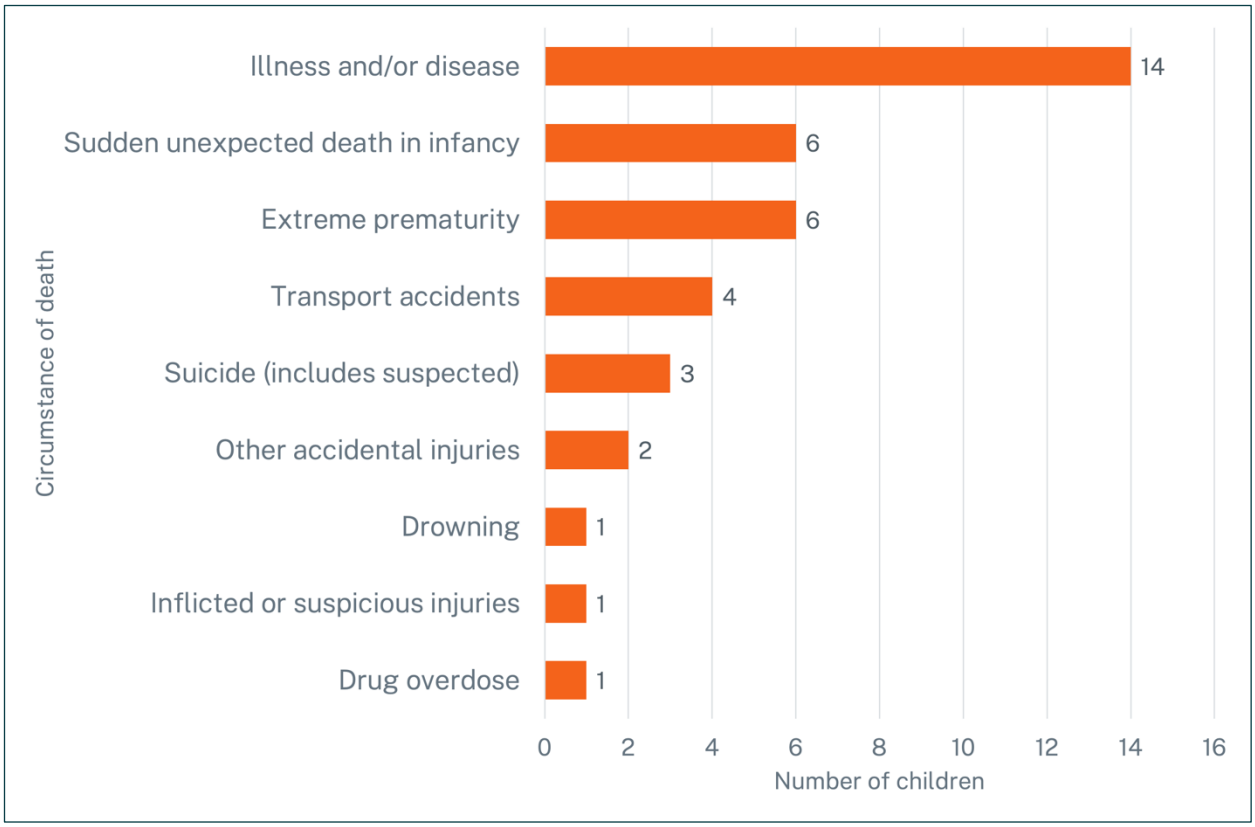

Figure 6: Aboriginal children who died in 2022 and were known to DCJ, by circumstance of death

2.4.3 Aboriginal children in out of home care

Six Aboriginal children were living in out of home care when they died in 2022.

The six Aboriginal children were aged from 1 to 17 years; three were male and three were female. For these six children, the circumstances of death were illness and/or disease (3 children), suicide (2 children) and drug overdose (1 child).

Three of the children were living with authorised carers, one lived in a residential therapeutic care setting and two children died while in hospital. For the two children who died in hospital, interim orders had been made while they were in hospital placing them under the parental responsibility of the Minister. One child was admitted to hospital because of a diagnosed long-term condition and had an end of life plan in place. The second child was born with a serious health condition that required surgery and they remained in hospital until they died.

Improving DCJ practice with Aboriginal children and families

The **Aboriginal Culture in Practice (ACiP) Unit** in the Office of the Senior Practitioner (OSP) is responsible for leading and improving child protection practices for Aboriginal children and their families. The unit focuses on enhancing culturally appropriate approaches to restoration, family preservation, permanency and quality assurance relating to Aboriginal child protection practice. The ACiP Unit supports and empowers Aboriginal practitioners to influence and lead practice with Aboriginal children.

One of the OSP's five strategic priorities for 2023–24 is to **Improve DCJ practice with Aboriginal children and families**. The ACiP Unit is leading the work to achieve this priority and is focused on:

- recruiting Aboriginal practitioners to the OSP unit
- developing functions and systems and communicating its role and purpose to stakeholders
- increasing the number of Aboriginal staff in the OSP, as well as improving cultural competency and enhancing the cultural safety of Aboriginal colleagues
- implementing the *Family is Culture* recommendations related to practice to support new legislation
- supporting the districts to establish panels that safeguard decisions about Aboriginal children.

Chapter 3 has more information about the **ACiP Unit** and the introduction of **Safeguarding Decision Making for Aboriginal Children (SDMAC) Panels**.

2.4.4 Practice reflections and learning

The following practice reflections and learning were identified through the internal serious case reviews of Aboriginal children who died in 2022.

Identification of cultural identity

As discussed earlier in this section, identifying and recording a child's Aboriginal status is an essential part of good cultural practice. During the review process for children who died and were known to DCJ in 2022, the SCR Unit identified that inconsistent information about cultural identity was recorded for some children. This includes children who:

- had not been identified as Aboriginal during DCJ casework with a family but were identified as Aboriginal on their birth and/or death certificate (7 children)

- had been identified as Aboriginal at one or more stages of casework and Aboriginal consultation had occurred, but this had not been recorded on ChildStory and did not match records received by the SCR Unit at the time of death (2 children)
- had been incorrectly identified on ChildStory as Aboriginal because of a sibling's Aboriginality, despite not sharing the parent who was Aboriginal (2 children)
- were confirmed to be Aboriginal through official records such as a birth and/or death certificate and DCJ casework but had not been correctly identified on ChildStory (5 children).

The SCR Unit is using the process of completing internal child death reviews to ensure these errors are corrected. Where relevant, reviews will include details of where and how a child's cultural identity has been inconsistently recorded and a recommendation for practitioners to speak with the family about their culture. The children and families we work with are the experts of their own lives, and their own culture and how they experience it. The family's active and meaningful participation should be the first source of information sought to determine a child's cultural status so that this can be accurately recorded.

DCJ casework requirements for practitioners

DCJ practitioners are required to determine if a child is Aboriginal under section 32 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Section 5 of the Act includes a definition of Aboriginal and Torres Strait Islander.

Aboriginal Case Management Policy

The **Aboriginal Case Management Policy**[19] was introduced in 2019. Implementation of this policy is a cornerstone of the action plan to reduce the rate of Aboriginal children in out of home care. This policy supports practitioners to engage early with Aboriginal families, shape case planning and identify tailored solutions to keep children safe with their family and community.

There are four core enablers of the policy – active efforts, Aboriginal family led decision-making, Aboriginal family led assessment and Aboriginal community controlled mechanisms – across operations, policy and programs and contracted service delivery.

The Aboriginal Case Management Policy makes clear that practitioners need to actively seek to identify the cultural background of all families. The policy encourages practitioners to 'take a curious stance to proactively identify every family's cultural background, engaging them in a robust, iterative process to unpack each family's unique history and heritage'.

The policy also notes that Aboriginal families may be reluctant to self-identify to statutory child protection systems, given justified mistrust of these systems and their treatment of Aboriginal people.

Recognising that **Culture is ever-present** is a principle of the NSW *Practice Framework*. Good cultural practice requires practitioners to bring culture to the forefront, to explore and talk about it, to see it as a source of strength and connection and to understand how its history impacts on individuals and communities.

The 'Indigenous Status' field on ChildStory is mandatory. ChildStory provides prompts to review this status when it has not been completed. As part of the commitment from DCJ to ensure children are not incorrectly de-identified, the ability to de-identify a child or person's status is restricted to Executive Directors or Executive District Directors. DCJ practitioners can find more information about this on Casework Practice.

Collaboration and governance

Internal serious case reviews for Aboriginal children who died and were known to DCJ in 2022 continue to highlight the importance of using Aboriginal consultation to provide guidance, advice and support for decision-making in casework with Aboriginal families. This includes structured internal consultation with Aboriginal practitioners and the Aboriginal Consultation Advisory Panel (ACAP), and external consultation with Aboriginal community and organisations. It also includes partnering with the child, their family and extended family to build a safe network of support around a child. Understanding more about a child's family, kin and Country is important for developing a full understanding of identity and belonging.

Reviews noted the need for casework to be well coordinated and for roles to be clarified and clearly communicated when collaborating with family and other services. For DCJ practitioners, the purposeful use of group supervision with strong leadership and consultation can help to achieve this.

A child's right to participate

Involving children in assessments to understand their perspective is essential to quality child protection practice. Genuinely connecting with children and listening to their experiences helps children to feel seen, heard and supported. Considering a child's perspective allows practitioners to maintain a child focus when assessing issues that impact their safety.

There were positive examples of casework that included strong participation from children. However, several reviews about children who were known to DCJ and died in 2022 identified that casework could have been improved by better engagement with children.

The following case study demonstrates the value of genuine engagement. Readers are advised that the case contains information about an Aboriginal child and their family that may be confronting. Please take care when reading the story.

Case study – Ben's story

Ben was an 8 year old Aboriginal boy who travelled from regional NSW to Sydney to receive medical treatment for cancer. DCJ became involved after concerns were raised about Ben's parents' ability to meet his medical needs due to their struggles with drug use. Ben's family was allocated a caseworker for assessment.

Ben's caseworker organised accommodation for Ben's parents near the hospital so they could visit Ben every day. It was difficult for Ben and his parents to be in Sydney and away from their community and Country. Internal consultation with Aboriginal practitioners reinforced the importance of including Ben's extended family and community in decision-making. The caseworker spoke with Ben's extended family regularly and arranged for his aunts, uncles and grandparents to travel to visit him in hospital.

While family were in Sydney, several meetings and family group conferences were held. These provided an opportunity for everyone who cared about Ben to hear information about his medical condition, hear his family's views about treatment and talk about their own thoughts or worries. The concerns of DCJ about Ben's parents' drug use and the risk this had for Ben's care were discussed. Plans were made for who would care for Ben when he was well enough to return home and how his extended family would be involved.

The caseworker spent time with Ben in hospital. In getting to know Ben, the caseworker learned that he loved animals and watching football with his cousins at home. The caseworker used these conversations to talk with Ben about who had been caring for him at home, who he felt safe with and trusted and how he understood his family, Aboriginal culture and what was important to him.

Sadly, Ben's treatment was not successful in managing his illness, and he died in hospital. DCJ continued to support Ben's family after his death and sought further cultural consultation from Aboriginal practitioners and Ben's local Aboriginal community to understand Sorry Business and how to work with the family in a respectful and culturally sensitive way. The family was supported to travel home to regional NSW, and DCJ helped with the logistical arrangements and financial cost of Ben's funeral, in accordance with the family's wishes.

Learning from Ben's story

Ben's caseworker organised regular Aboriginal consultations. This was done well, as cultural consultation is an ongoing process, not a one-off event. Cultural consultation involves genuine engagement and seeking specific knowledge, skills and help to make sure practice meets the needs of families. The DCJ practitioner organised ethical consultations with purpose and came with an open mind to new suggestions. Thoughtful consultation also took place just before Ben passed away to explore how DCJ could best support Ben and his family through this difficult time.

Ben's caseworker clearly understood the importance of genuinely engaging Ben and his family in decision-making. Self-determination and participation are vital to Aboriginal families and communities and requires opportunities to participate meaningfully in DCJ assessment, planning and review processes. Ben's caseworker consistently listened to Ben and his family about their experiences and supported them to lead the decision-making process about Ben's medical care. DCJ held regular family meetings and helped extended family members to travel to Sydney to participate in meetings and spend time with Ben and his parents. Bringing his family members together meant that despite being away from his community and Country, Ben was still able to spend time with his family. This promoted self-determination and family led decision-making.

2.5 Circumstances of all child deaths

This section of the chapter considers the circumstances of death for all of the 111 children who died in 2022. The five main circumstances of death (illness and/or disease, SUDI, suicide, extreme prematurity and transport accident) are considered in more detail. This includes practice reflections and learnings from reviews completed about the children who died, alongside their statistical information.

The remaining circumstances of death apply to smaller numbers of children who were known to DCJ and died in 2022. A brief overview of information known about these circumstances is provided in section 2.5.6.

2.5.1 Illness and/or disease

Consistent with previous years, child deaths from illness and/or disease accounted for the greatest number of deaths in 2022. As shown in Table 3, 40 children known to DCJ died from illness and/or disease in 2022. While this is the highest number of deaths due to illness and/or disease since 2018, it remains proportionally similar to the previous five years.

Table 3: Children who died from illness and/or disease and were known to DCJ, 2018–22

Illness and/or disease	2018	2019	2020	2021	2022
Number of deaths	39	32	36	31	40
% of total deaths	44%	33%	36%	32%	36%
Age range	0–17 years	0–17 years	0–17 years	0–17 years	0–17 years

Of the 40 children who died from illness and/or disease, 23 were male and 17 were female. As shown in Figure 7, 13 of the children (32 per cent) were under 1 year of age, 11 (28 per cent) were aged 1 to 4 years, six (15 per cent) were aged 5 to 8 years, four (10 per cent) were aged 9 to 12 years and six (15 per cent) were aged 13 to 17 years. Five of the children were living in out of home care when they died.

For most of the children (25) who died from illness and/or disease, their death was due to a chronic health condition. These chronic conditions included cancer, congenital issues or complications from a diagnosed disease and are defined as long lasting with persistent effects. Fifteen children died from an acute illness, which is defined as a medical condition that is sudden and time limited such as asthma or a virus.

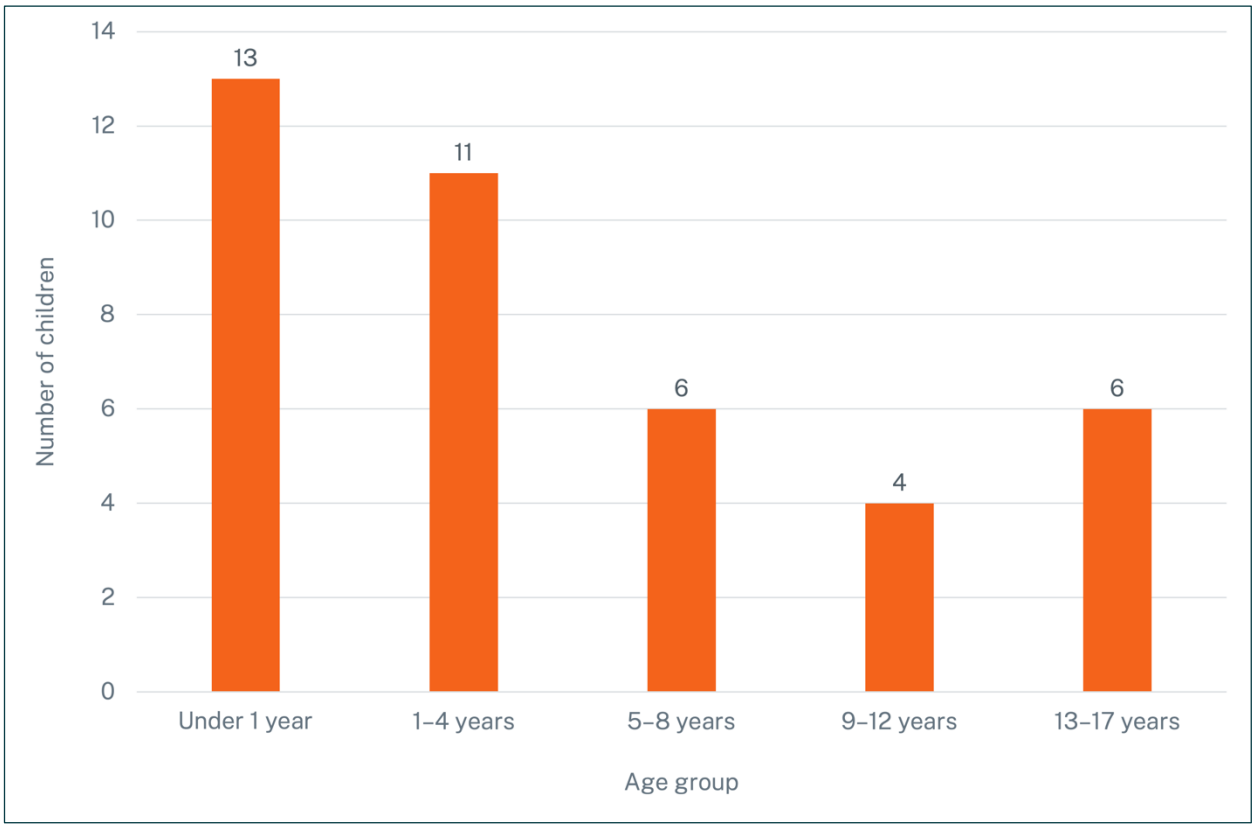

Figure 7: Children who died in 2022 due to illness or disease and were known to DCJ, by age

Children who died due to a chronic health condition

For the 25 children who died from a chronic illness, DCJ holds information that nine children had a disability, and four children were receiving palliative or end of life care.

For three of the 25 children, a cause of death has not yet been determined; however, their deaths have been included in the illness and/or disease category, as they were known to have complex medical conditions and there were no suspicious circumstances related to their death.

For the remaining 22 children the cause of death was:

- a form of cancer (8 children)
- hypoxic ischaemic encephalopathy[20] which was sustained at their birth (4 children)
- complications of prematurity[21] (excluding hypoxic ischaemic encephalopathy) (3 children)
- a congenital illness[22] (3 children)
- complications of a syndrome or degenerative disease (4 children).

Children who died from an acute illness

Four of the 15 children who died from an acute illness had an existing chronic medical condition, and one of these children also had a disability. An additional child was born prematurely and had remained in hospital since their birth.

Twelve of the 15 children (80 per cent) lived in regional NSW.[23]

For two of the 15 children, a cause of death has not been determined, but the children showed signs of being unwell on the day they died such as a temperature and rash. For the remaining 13 children, the cause of death was:

- an infection, including pneumonia, bronchiolitis, meningococcal, urinary tract infection and sepsis (9 children)
- complications of a severe asthma attack (3 children)
- a rare prenatal illness (1 child).

Working with children who have asthma

The three children who died due to complications from a severe asthma attack in 2022 were all diagnosed with asthma before they died.

In Australia, one in four children have asthma. While there is no cure, good asthma control can prevent symptoms which in severe cases can lead to death.

An important part of asthma management is the development and annual review of a written asthma action plan by a child's doctor in conjunction with their primary carer. The plan identifies the signs and symptoms of worsening asthma and provides instructions for how to respond.

The **National Asthma Council Australia** is the national authority for asthma knowledge and provides information on asthma care. Practitioners working with families where a child has asthma can provide support by encouraging parents and carers to:

- develop an action plan and update it every year
- provide the plan to the child's school and other carers
- follow instructions about prescribed medication
- ensure asthma medication is available at each of the child's care settings and is within the expiration dates
- ensure that older children know what to do if they experience asthma symptoms.

Practice reflections and learning

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

Collaboration between DCJ, NSW Health and other services

Several reviews completed for children who died and were known to DCJ in 2022 highlighted the important role of collaboration between DCJ, NSW Health and other involved support services when a child has a chronic health condition with complex care needs. Some aspects of collaboration that reviews noted as supporting casework are:

- using the relationship with the hospital social worker as the main point of contact with NSW Health
- helping families to transport children to medical appointments, organising hospital parking and ensuring families have access to education about the child's illness and needs
- obtaining information from the hospital to assess parents' abilities to meet a child's medical and care needs.

Assessment of families with children who are unwell

The reviews completed identified several casework themes when working with families with a child who has a diagnosed illness or disease. These include:

- the need to clearly identify the role of DCJ when a family has a child who is expected to die
- ensuring home visits adequately address all of the reported concerns
- spending time with family members to understand the extra stressors they face to be able to identify the most beneficial supports
- the need to complete a new safety assessment for children and/or siblings when additional concerns are reported.

The following case study discusses the stressors experienced by families when a child is seriously ill.

Case study – Simon's story

Simon had cerebral palsy, a seizure disorder and developmental delay due to a brain injury sustained at birth. He was susceptible to frequent lung infections and needed to be tube fed to minimise this risk.

Simon was first reported to DCJ when he was 6 years old, because there was a delay in seeking medical attention for him which resulted in hospitalisation. This report also said that he had missed many therapy appointments. DCJ allocated the report to a caseworker for an assessment. During the assessment DCJ learned that there had been delays taking Simon to the doctor because his mother did not drive, and his father was unable to take time off work due to financial pressures. Simon's mother was also experiencing mental illness at the time. Simon's parents showed the caseworker Simon's care equipment and explained the extensive routines that were in place to meet his needs. Before completing the safety assessment, the caseworker spoke with hospital staff, who said they were worried Simon had been fed food orally which caused him to become unwell. The safety assessment outcome was 'safe with plan'. Simon's parents said they would no longer feed Simon orally and agreed to accept help to attend appointments.

The caseworker continued to speak with the parents and the hospital social worker. The social worker provided feedback that Simon's parents had engaged with some training about how to feed Simon and were using the transport assistance. The caseworker referred the family to a service for parenting support, helped them to get in-home care through Simon's National Disability Insurance Scheme (NDIS) package and referred Simon's mother for some counselling. DCJ closed the case because these ample supports were in place.

DCJ did not receive any further reports about Simon until he was 8 years old. His health had deteriorated and there were concerns about him missing hospital appointments. DCJ contacted the hospital social worker, who again applied for help with transport to appointments, and the case was closed due to the CSC not having the capacity to allocate the report for further assessment. Six months later DCJ was informed that Simon had been receiving palliative care and that he had died. A sibling safety assessment was not required as there were no other children in the home.

Learning from Simon's story

Like Simon, many of the children who died from illness and/or disease in 2022 had a chronic illness and a disability. While it is common for children with complex medical conditions to have a shortened life expectancy, it is important to ensure their care needs are being met and they are not experiencing neglect or abuse.

The information known about Simon highlights the stressors experienced by families when a child has an illness and/or disease, including financial pressure and the challenges of attending frequent medical appointments. When DCJ initially completed a safety assessment for Simon, his parents explained how they were meeting his care needs. It was positive that the caseworker contacted the hospital for extra information before completing the safety assessment. The information from the hospital identified that Simon's parents may not have been following his care regime and required extra support to feed him safely.

The hospital social worker was the key contact person for DCJ in the health system. Through collaboration with the social worker many of the family's needs were addressed. This ensured Simon received the care he required and was supported to attend his appointments. The social worker was also able to provide progress information to the caseworker which informed the risk assessment and decisions about case closure.

2.5.2 Sudden unexpected death in infancy

The term 'sudden unexpected death in infancy' (SUDI) is defined as the death of an infant aged from birth to 12 months that is sudden and unexpected and where the cause is not immediately apparent at the time of death. SUDI is a classification, not a cause of death. Excluded from this definition are infants who died unexpectedly as a result of obvious visible injury and deaths that occurred in the course of a known acute illness in a previously healthy infant.[24] Following investigation, SUDI deaths can be further categorised:

- **Explained SUDI** – a cause of death was identified following investigation. These deaths may include those due to disease or morbid conditions not identified as life threatening before death, threats to breathing such as accidental suffocation in an unsafe sleep environment, or other external causes, including deaths that occur in suspicious circumstances.
- **Unexplained SUDI** – the cause of death remains unidentified after all investigations are complete. This includes deaths classified as sudden infant death syndrome (SIDS).

Table 4: Infants who died suddenly and unexpectedly and were known to DCJ, 2018–22

SUDI	2018	2019	2020	2021	2022
Number of deaths	10	19	15	14	17
% of total deaths	11%	20%	15%	14%	15%
Age range	0–11 months	0–12 months	0–8 months	0–9 months	0–9 months

Seventeen of the children who died in 2022 and were known to DCJ died in circumstances of SUDI. Post-mortem reports or coronial certificates were available for five of the children. Once a final post-mortem is received for the other 12 children, the circumstances of death could change and the total number of SUDI deaths that occurred in 2022 may vary. For example, a death classified as SUDI may later be confirmed to have occurred due to illness and/or disease. Numbers and the circumstances of death for previous years are then corrected.

As shown in Figure 8, almost two-thirds (11 children or 65 per cent) of the infants who died suddenly and unexpectedly were aged 3 months or less. Three were younger than 1 month, eight were aged 1 to 3 months, four were aged 4 to 6 months, and two infants were aged 7 to 11 months. Ten of the infants were male and seven were female.

Seven of the infants lived in major cities, six lived in inner regional areas and four infants lived in outer regional and remote areas of NSW.

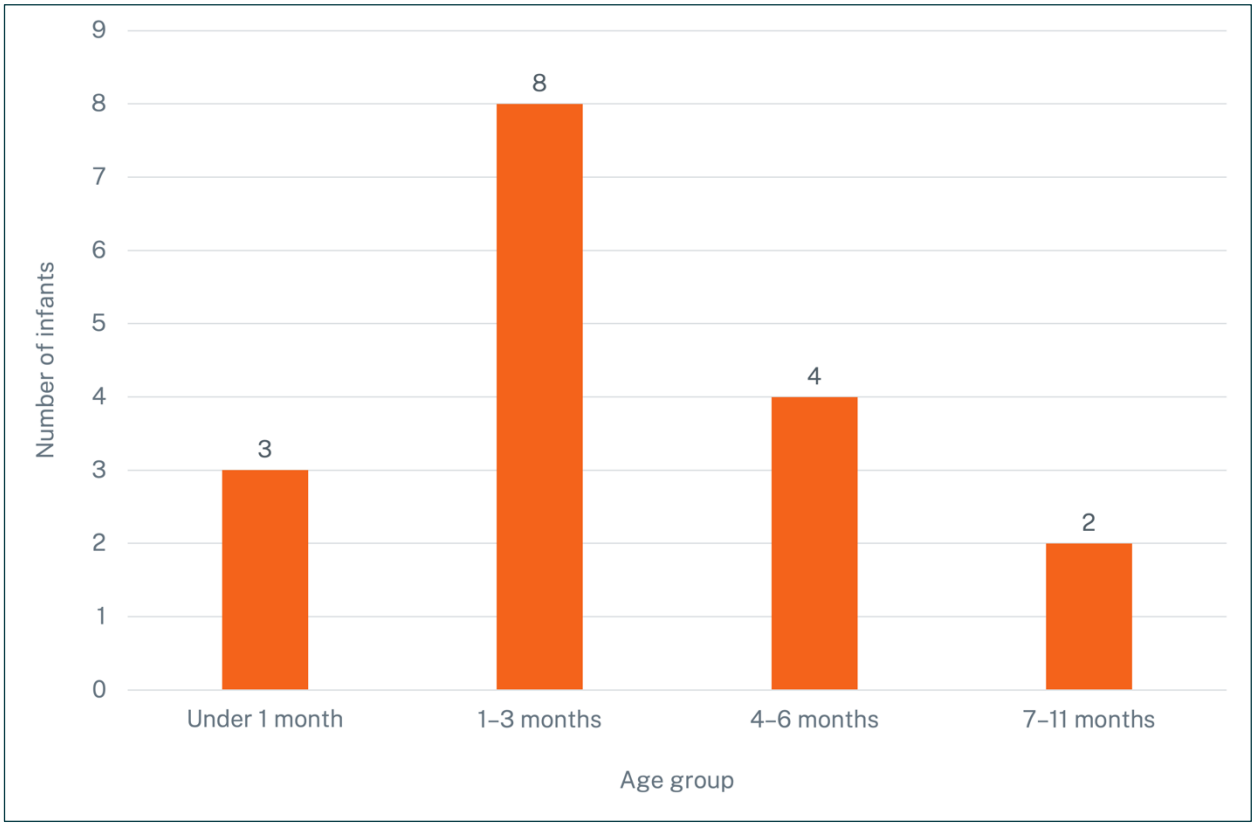

Figure 8: Infants who died in 2022 suddenly and unexpectedly and were known to DCJ, by age

NSW Child Death Review Team work to prevent SUDI deaths

Approximately 14 per cent of all infant deaths in NSW are classified as SUDI.[25] The NSW Child Death Review Team (CDRT) has undertaken considerable work over recent years to prevent sudden and unexpected infant deaths. Their work has focused on:

- gathering information about factors associated with or that may contribute to SUDI through consistent classification and data analysis to inform and support efforts to address modifiable risks
- identifying the demographic characteristics of families most likely to experience SUDI
- raising awareness among the agencies responsible for responding to SUDI.

The NSW CDRT has found that more than half of infants who die in circumstances of SUDI are aged 3 months or less[26] Most infants who die in circumstances of SUDI are exposed to at least one avoidable risk. Children from families known to child protection services, Aboriginal children and those living in the most disadvantaged areas of NSW are over-represented in SUDI deaths.

Risk factors associated with SUDI deaths

All infants are at general risk of SUDI, but research has consistently identified certain factors associated with SUDI. These risk factors are either intrinsic or extrinsic:

- **Intrinsic** factors are individual characteristics and are generally not modifiable. They include factors such as premature birth, low birth weight and a preceding infection (within two weeks of death).
- **Extrinsic** factors can be modified in an infant's sleep environment and can thus be avoided or changed. They include factors such as sharing a sleep surface, sleep position and loose items being present in the sleep environment.

For the 17 children who died in 2022 and were known to DCJ, the review process identified the following modifiable risk factors:

- Being placed to sleep somewhere other than a cot, bassinet or co-sleeper (12 infants)
- Being placed to sleep in bed with a parent or sibling (11 infants)
- Having soft objects such as pillows, clothes or blankets in the sleep environment (4 infants)
- The infant falling asleep with their parent on a lounge (1 infant)
- Exposure to post-birth smoking (4 infants).

DCJ casework practice

Co-sleeping is a particular concern for babies whose parents use drugs and consume alcohol. There is no safe way for a person using substances to sleep with their baby.

The **Alcohol and Other Drugs** practice kit includes a section on safe sleeping and provides clear guidance to practitioners about how to talk with expecting and new parents. For example:

- When having conversations with parents, use language that is strong, clear and consistent.
- Be clear that a parent should never sleep with their baby, whether in a bed, on a lounge or any other surface, when they have consumed alcohol, drugs or prescribed medications.
- Make sure you see where a baby will sleep and talk about safe sleeping practices with parents. Support them to find alternative safe sleeping arrangements.

NSW Health safe sleeping recommendations

The following safe sleeping recommendations are found on the NSW Health website and were adapted from the **Australian Parenting Website** (Raising Children Network). Practitioners can use these recommendations to guide their discussions with expectant or new parents about reducing the risk to babies.

- Place a baby on their back to sleep.
- Babies should have their own cot that meets the Australian safety standard and has a firm, well-fitted mattress.
- Babies should sleep in a parent or caregiver's bedroom at night for the first six to 12 months of life.
- Do not let babies sleep on a couch or an armchair, especially with another person.
- To prevent suffocation or overheating, a baby's head and face should never be able to become covered while sleeping. Tuck in sheets and blankets or use a safe infant sleeping bag. Do not use a doona, cot bumper, mattress padding or sheepskin, or leave soft toys in the cot.
- Babies should be comfortably warm but not hot, to avoid overheating.
- Breastfeed for the first six months where possible.
- Expectant parents should not smoke during pregnancy or after a child is born and should not allow anyone to smoke near a baby.
- Make sure anyone who looks after a baby understands these safe sleeping recommendations.

Practice reflections and learning

In reviewing DCJ practice where reports had been received about children who died in circumstances of SUDI, the following key theme was identified.

Parent education about the risk factors

For some of the children who died in circumstances of SUDI, practitioners had completed safety assessments and had spoken with the parents about how to minimise the risk factors. However, it was identified that the children had still been sleeping in ways which were unsafe, parents were affected by substances, or the children were exposed to cigarette smoke, which are all known risk factors that can increase the risk of SUDI. This highlights the need for clear, intentional and repeated conversations with parents and carers about how to minimise the risks associated with SUDI. The following case study highlights the need for repeated conversations about risk factors.

Case study – Sameh's story

Sameh's older sister, Elena, was first reported to DCJ when she was 2 years old because of her mother, Amira, using cannabis in front of her. The CSC did not have the capacity to allocate this report for an assessment. Six months later a report was made about Elena being left at home alone and Amira being verbally abusive to her. The CSC completed an assessment, finding that Elena was safe but there was a 'high risk' of future harm. The caseworker was worried that Amira did not have many friends or family members providing her with support.

The case was still open when DCJ received a report three months later. Concerns were reported about Amira using cannabis during the pregnancy; a risk of significant harm report was created for Sameh and for Elena. The report for Elena raised concerns about the unhygienic condition of the home and about Amira and her new partner using cannabis. The report was allocated to the caseworker, who completed new safety and risk assessments before and after Sameh's birth. The caseworker saw that Sameh had a cot in her parents' room and safe sleeping was discussed. A packet of cigarettes was observed in the home. The risk of cigarette smoke was discussed, and Sameh's parents said they only ever smoked outside.

The family was transferred to a family preservation service and was waiting for a joint home visit when the caseworker was informed that Sameh had died. Sameh's father had fallen asleep on the lounge while he was feeding Sameh a bottle during the night, and Sameh was found unresponsive in the morning. Sameh's post-mortem determined her death to be classified as SUDI with the extrinsic risk factors of co-sleeping and parents smoking in the home present.

DCJ completed a sibling safety assessment for Elena, and a safety plan was put in place for family members to support Amira and her partner to care for Elena while they were

grieving and making plans for Sameh's funeral. After the funeral Elena's safety was assessed again and she was found to be 'safe'. Two months later DCJ referred the family to a support service and completed a joint home visit before closing the case. There have been no further reports since this time.

Learning from Sameh's story

Sameh died at home after her father fell asleep while feeding her. Like many of the children who died in circumstances of SUDI in 2022, there were modifiable extrinsic factors which may have contributed to her death. The caseworker had discussed the importance of safe sleeping with Sameh's parents before Sameh's death. Sameh's story highlights the importance of providing ongoing clear messages to parents in the lead up to a baby's birth and afterwards. The sibling safety assessment was holistic and considerate of Sameh's parents' grief and the impact that this may have had on their ability to care for Elena. Including family members in the safety plan was a positive way to encourage Amira and her partner to reach out to family members for support. A family group conference may have been a beneficial next step in strengthening these supports.

2.5.3 Suicide

In 2022, 15 children known to DCJ died in circumstances of suicide or suspected suicide. This includes children whose manner of death was determined to be suicide by the NSW State Coroner and deaths that occurred in circumstances that can be considered suicide (e.g. drug overdose or falling from a height) alongside other known information such as clear intent by the child to end their life and/or previous suicide attempts.

Table 5: Children who died in circumstances of suicide or suspected suicide and were known to DCJ, 2018–22

Suicide, including suspected	2018	2019	2020	2021	2022
Number of deaths	8	8	12	12	15
% of total deaths	9%	7%	12%	12%	14%
Age range	14–17 years	13–17 years	14–17 years	14–17 years	13–17 years

Suicide is the leading cause of death among Australians aged 15 to 24 years.[27] Understanding and responding to factors that increase risk for children is critical for preventing suicide. While confronting, it is important to use what information is known about the 15 children who died from suicide in 2022 to inform broader prevention strategies and work with children who are thinking about suicide. The following information includes descriptions about the method of suicide used, what was known about the mental health of

the children who died and any known previous self-harm and suicidal behaviours. Reading this information can be confronting and bring up unexpected emotions, particularly if you have experienced suicide in your personal or professional life. Please be mindful of this when reading the information.

All of the 15 children who died in circumstances of suicide or suspected suicide were aged between 13 and 17 years, with seven aged 13 to 15 years, and eight aged 16 to 17 years. Eight of the children were female, six were male and one was non-binary.

Since public reporting began in 2010, this is the largest number of deaths that DCJ has reported of children known to DCJ who have died in circumstances of suicide or suspected suicide. It is important to note that this number has fluctuated but has remained high in the last three years.

Eleven of the 15 children in this group ended their life by hanging. This is consistent with research about suicide methods for children aged 10 to 19 years worldwide which has found hanging to be the most common method.

Information known to DCJ indicates that nine of the children had a diagnosed disability such as autism spectrum disorder, a conduct disorder, a learning disability, or a diagnosed mental illness such as depression, anxiety or post-traumatic stress disorder. Eight of the children were known to be receiving support from private psychologists, Child Adolescent Mental Health Services (CAMHS), Headspace[28] and school counsellors. Three of the children had spent time in a residential mental health facility or as an inpatient on a mental health ward.

Three of the children who died in circumstances of suicide or suspected suicide in 2022 identified as LGBTQIA+. Research has found that a disproportionate number of gender-diverse children experience poorer mental health and have higher risk of suicidal behaviour than the general population because of the psychological distress that can occur from stigma, discrimination and abuse they may face. The *Child Deaths 2021 Annual Report* includes links to practice advice for DCJ practitioners when working with children who identify as LGBTQIA+ and their families, and information about the NSW LGBTIQ+ Health Strategy 2022–27.

There was evidence of suicidal behaviour, which is the term used to describe talking about or taking action to end one's life, for nine of the 15 children who died. This included self-harm actions such as intentional drug overdose, previous attempts to end their life and telling friends and family that they planned to end their life. A trauma-informed approach recognises that risk-taking behaviour can be directly linked to the experience of trauma and may be a part of a coping mechanism.

Talking about suicide and self-harm

Talking openly with someone who is experiencing suicidal thoughts can let them know that someone cares about them, reduce stigma and help the person to see that they have other options and to re-think their decision.

The **Mental Health** practice kit includes a section on suicide and self-harm and provides information for DCJ practitioners on understanding suicide and self-harm and how to respond to children who are experiencing harmful thoughts and behaviours.

Safeguards: Child and Adolescent Mental Health Response teams

NSW Health is establishing 25 **Safeguards teams** across NSW by 2024–25 to provide innovative and best practice care for children and adolescents aged 0 to 17 years experiencing acute mental distress, and their families. The teams aim to improve access to timely, evidence-based, recovery-focused and trauma-informed assessment, care navigation and brief treatment interventions. Teams have been established in the Central Coast, Hunter New England, Illawarra Shoalhaven, Mid North Coast, Murrumbidgee, Northern NSW, Northern Sydney, South Eastern Sydney, South Western Sydney, Western NSW and Western Sydney local health districts.

In 2022 and 2023, the teams have expanded to include the Justice Health and Forensic Mental Health Network, Sydney Children's Hospitals Network and Nepean Blue Mountains, Sydney and Southern NSW local health districts. Hunter New England and South Western Sydney local health districts received funding for additional half teams that will expand to full teams in 2023 and 2024. From 2024 to 2025, the equivalent of seven additional Safeguards teams will be established across NSW.

Youth Aftercare Pilot

The Youth Aftercare Pilot (known as '**i.am**') is a joint Commonwealth and NSW state funded initiative trialling community-based psychosocial supports for children at significant increased risk of suicide at sites in four local health districts: Western Sydney, Mid North Coast, Hunter New England and South Western Sydney. The program has been expanded from the original two sites to four locations over the three years of funding. Further state funding for the four sites until June 2024 will allow for maximum exploration of the co-designed service delivery and for outcome data to be gathered.

Whole Family Teams

Whole Family Teams (WFTs) have been established in seven locations across NSW. The teams provide intensive and integrated specialist clinical supports to families with significant mental health and/or drug and alcohol problems, where there is a substantiated risk of significant harm for at least one child in the family. The primary referral pathway is from DCJ.

Learning from a cohort review of children who died by suicide

The *Child Deaths 2020 Annual Report* included the findings from a cohort review of 42 children who were known to DCJ and died between 2016 and 2020 by suicide or suspected suicide. While suicide can affect anyone, the cohort review discussed some of the individual, social and environmental factors that make a child with a child protection history more at risk.

Practice reflections and learning

In reviewing DCJ practice where reports had been received about children who died in 2022 in circumstances of suicide or suspected suicide, the following key theme was identified.

Stressful or traumatic events

Many of the children who died had experienced stressful and traumatic events in their personal lives. These included bullying by peers, arguments and relationship breakdowns within either their family or with boyfriends and girlfriends and the death of close family members. The information held by DCJ indicates that seven of the 15 children had experienced sexual harm before they died. Some of the young people did not have strong supports or peer relationships, had disengaged from school and friendships and were also experiencing negative relationships via online gaming. This highlights the need for practitioners to consider the child's experiences alongside any mental health concerns and current behaviours when considering if a danger of self-harm exists and what support may be required. The following case study discusses this difficult area of practice.

Case study – Maggie's story

Maggie was first reported to DCJ when she was 6 years old because of violence she experienced between her older brother and father. During the assessment, DCJ learned that Maggie's father had also been violent towards Maggie's mother for many years. Maggie's mother was provided with supports, and a referral was made to a family support service before DCJ ended its involvement. Maggie's parents subsequently separated.

DCJ did not receive any more reports about Maggie until she was 15 years old. Maggie's school made a report about her lack of attendance, her poor mental health and concerns that she was involved with an older male via social media. Maggie's school told the DCJ Helpline that Maggie had been offered supports to attend school but that her attendance had not improved. The school was aware Maggie had been meeting with the older male in person and had seen photos on social media of her using illicit drugs. The report was screened as meeting the risk of significant harm threshold and transferred to a CSC for assessment.

Triage workers at the CSC spoke with staff at Maggie's school, who said her attendance was 40 per cent and that they were in regular contact with Maggie's mother, who was

cooperative and supportive. The school had offered Maggie supports, including the school counsellor, and she had seen a psychologist at the local mental health service. After this phone call, the report was reviewed by two managers casework and closed, as there was no capacity to allocate it at the CSC.

Sadly, just over 18 months later, it was reported that Maggie had died from suicide. DCJ later learned that Maggie had been seeing a psychologist and was prescribed medications for anxiety.

Learning from Maggie's story

Children with a child protection history are consistently over-represented among suicide deaths. However, like Maggie, many of the children who died from suicide in 2022 did not have a lengthy child protection history but had experienced adverse childhood events.

The information known about Maggie's mother and her response towards Maggie's lack of attendance at school highlights the complexities involved for parents who are trying to keep their teenagers safe. Parents can often be at a loss as to what to do next. The role of a

DCJ practitioner with Maggie's mother could have been to have conversations with the intention of gaining a greater understanding of what supports or services were in place and what efforts were being made to support Maggie. Discussions could have included questions about Maggie's relationship with her parents and brother and her experiences as a child in the family. This information may have helped to inform an appropriate referral or further conversations with the school by a triage worker to ensure the right supports were in place.

It is positive that triage work was undertaken, and the CSC contacted the school, but more could have been done to ensure Maggie was supported when a report was received indicating she was at risk. An interagency case discussion (ICD) that brought together Maggie's school, her parents and any relevant mental health services would have enabled the development of a clear plan of support before DCJ closed the case.

Partnering with NSW Health

Sexual Assault Services

Sexual Assault Services (SAS) provide counselling, advocacy and case coordination, medical treatment and forensic examinations to adults and children who have experienced sexual assault. NSW Health also provides funding to:

- Rape & Domestic Violence Services Australia, who provide 24-hour telephone and online counselling and related services to anyone impacted by sexual assault in NSW and face-to-face trauma processing therapy for women who are survivors of childhood sexual abuse

- Survivors & Mates Support Network (SAMSN),[29] a not-for-profit organisation that works with male survivors of childhood sexual abuse to provide ongoing support services and facilitate support groups and workshops for men and their families.

Child Protection Counselling Services

Located in all local health districts, Child Protection Counselling Services (CPCS) work towards the recovery and ongoing safety and wellbeing of children involved with the care and protection system. The service aims to help children recover from violence, abuse and/or neglect, as well as provide support to achieve safety, security and permanency in living arrangements.

Domestic and family violence and social work services

Social workers play a critical role in providing psychosocial services for people and their families affected by domestic violence, including assessment, crisis counselling, information and other support for people and families in emergency departments and hospital wards. NSW Health has a small number of specific domestic violence services providing supports such as early intervention, safety planning, risk assessment and counselling, as well as local prevention work, capacity building and collaboration with partner agencies. As part of the Violence, Abuse and Neglect (VAN) Redesign Program, NSW Health is also developing a 24-hour Integrated Domestic and Family Violence Crisis Response, which will provide high-quality and consistent medical care, forensic evidence collection, assessment of current and ongoing risk, and safety planning across the state.

2.5.4 Extreme prematurity

In 2022, 12 infants known to DCJ died from complications related to extreme prematurity.

The World Health Organization distinguishes between three categories of premature births: moderately premature (32–36 weeks), very premature (28–32 weeks) and extremely premature (27 weeks or less). As shown in Table 6, the number of infants who died in these circumstances has remained consistent over the past five years, with a slight increase in 2022.

Table 6: Infants who died in circumstances related to extreme prematurity and were known to DCJ, 2018–22

Extreme prematurity	2018	2019	2020	2021	2022
Number of deaths	10	10	9	8	12
% of total deaths	11%	10%	9%	8%	11%
Age range	0–5 months	0–1 month	0–3 months	0–1 month	0–5 months

All 12 of the children who died from complications related to extreme prematurity had been in hospital from the time of their birth until they died. As shown in Figure 9, five infants died within 24 hours of their birth, six infants died within seven days and one infant lived for five months. Eight of the infants were male and four were female.

Learning from a cohort review of children who died in circumstances related to premature birth

The *Child Deaths 2019 Annual Report* included the findings of a cohort review of 59 infants who died between 2015 and 2019 because of their premature birth. Each year, infants who die in circumstances related to their prematurity account for one of the highest circumstances of death among children known to DCJ. Strong intersections exist between child protection concerns and the risk of prematurity. The cohort review discusses these intersections and highlights the importance of prenatal casework and intervention.

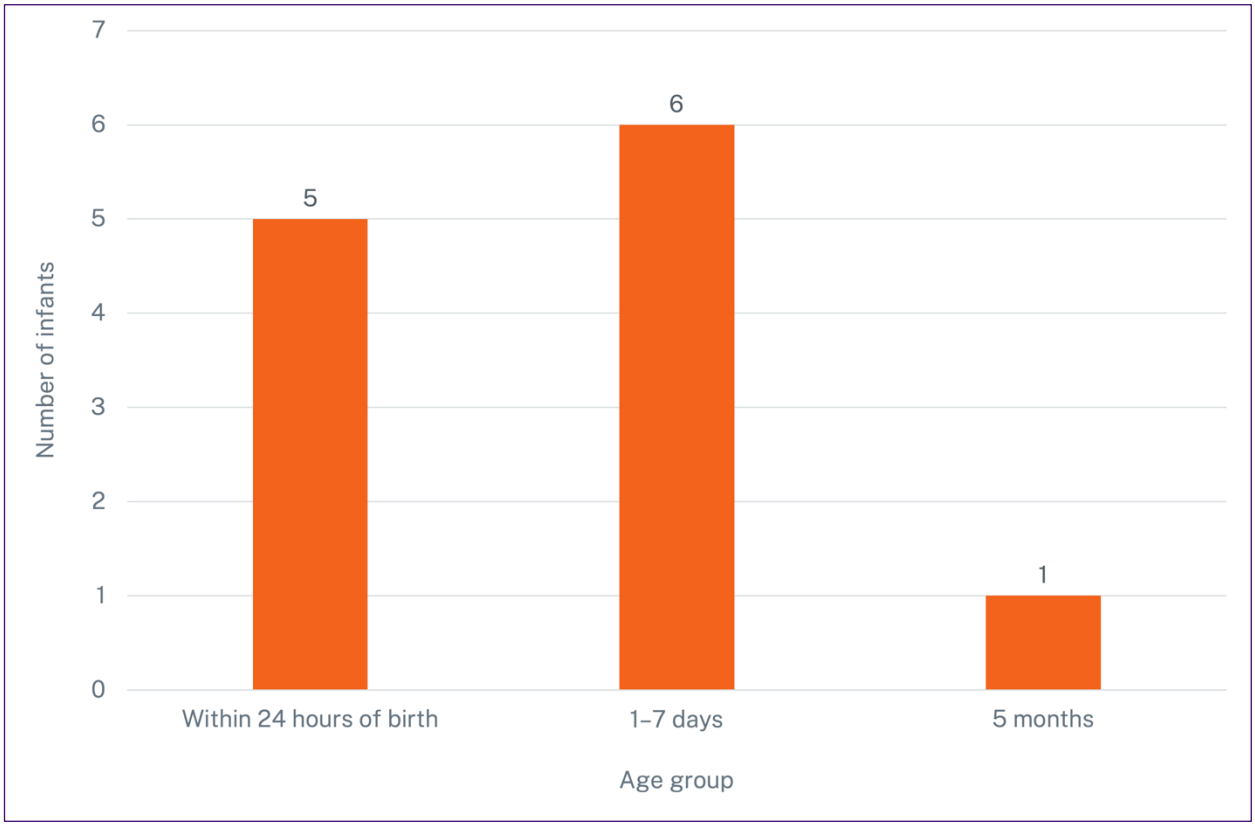

Figure 9: Infants who died in circumstances related to extreme prematurity and were known to DCJ, by age

Practice reflections and learning

In reviewing DCJ practice with the families of children who died in 2022 in circumstances of extreme prematurity and were known to DCJ, the following key theme was identified.

Supporting pregnant mothers

A clear pattern of vulnerability was observed for the mothers of the infants who died in circumstances of extreme prematurity. For the children who died in 2022 and were known to DCJ, the following complexities were present for many of the mothers while they were pregnant:

- Intellectual disability
- Domestic violence during pregnancy
- Significant physical assault while pregnant in circumstances of domestic violence
- Diagnosis of mental health problems.

The following case discusses the challenges faced by mothers who have complex needs.

Case study – Audrey's story

Audrey's siblings were first reported to DCJ when they were aged 7 and 3 years because of their experience of their father, Rod, being physically violent to their mother, Tina. The DCJ assessment found that the parents had separated, and the children were now living with Tina at their maternal grandparents' house. DCJ referred Tina to a program for women who were victims of domestic violence, and the case was closed.

Two years later it was reported that Tina and Rod had resumed their relationship and were expecting a third baby. The reporter had seen bruises on Tina's arm and was concerned about her history as a victim of Rod's use of violence. There was no capacity to allocate the report for an assessment at the CSC. However, triage practitioners spoke with the reporter, who said that the parents had separated since the report was made and Tina had been regularly attending an antenatal group. Triage workers also spoke with staff at the children's school, who did not have any concerns.

Sadly, three months later it was reported that Audrey had been born prematurely at 24 weeks gestation and had died in hospital five days later. There were concerns that Tina may have been physically assaulted, leading to her membranes rupturing, but she had not disclosed this information to DCJ.

DCJ competed a sibling safety assessment, finding that the children were safe and had no contact with their father. Tina shared that she had been verbally abused by Rod in the months leading up to Audrey's birth but did not disclose any physical violence. She was observed to have low mood, was indecisive about her relationship with Rod and found it difficult to maintain her children's routines. DCJ made a referral to Brighter Futures, who completed joint visits with the caseworker before taking case management for the family.

Learning from Audrey's story

The chance of survival for a baby born prematurely depends on their degree of prematurity and birth weight. Like the other children who were known to DCJ and died from extreme prematurity in 2022, Audrey did not leave hospital after her birth.

There were concerns that Tina had experienced domestic violence during her pregnancy. It is possible that the violence as well as the additional stress she experienced placed her at a higher risk for having a preterm birth.[30] Information known about many of the mothers of the infants who died from extreme prematurity in 2022 included indicators of them having complex needs. For women experiencing violence, pregnancy can be an opportunity for intervention and support, as they are likely to have regular contact with health professionals and these opportunities can be used to increase their safety.

While it was positive that the CSC contacted the reporter to check that supports had been put in place, this would have also been a good time for intervention with Tina, Rod and their children. Pregnancy is a time when parents are often more open to change. Any assessment should have included speaking with Tina and Rod. Audrey's case study shows no discussion with Rod or details about his involvement in parenting. Fathers, even when the perpetrators of violence, need to be included in the casework and assessment process. They should be held accountable for their role in violence experienced by their children.

After Audrey's death DCJ completed a sibling safety assessment. This was an opportunity to assess if the children's immediate needs were being met and to understand the experiences of the family from a holistic perspective. The family were referred to a service to support Tina with parenting, her mental health and staying safe from violence. It was hoped this would create long-term change and greater safety for the children.

Partnering with NSW Health

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

- Substance Use in Pregnancy and Parenting Service (SUPPS)
- Domestic Violence Routine Screening (DVRS) in maternity, child and family, mental health, and alcohol and other drugs service streams

- Safe Start program and referral pathways such the Perinatal and Infant Mental Health Service (PIMHS)
- Pregnancy Family Conferencing
- Aboriginal Maternal and Infant Health Service
- Building Strong Foundations for Aboriginal Children Families and Communities.

2.5.5 Transport accidents

In 2022, 12 children known to DCJ died from injuries sustained in transport accidents. This is a lower number of deaths than reported in 2021, when 16 children died in these circumstances.

This year, transport accidents include the deaths of children who were driving or were passengers in motor vehicles, boats or motorcycles and children who were struck by a moving vehicle.

Table 7: Children who died from transport accidents and were known to DCJ, 2018–22

Transport accidents	2018	2019	2020	2021	2022
Number of deaths	10	6	11	16	12
% of total deaths	11%	6%	11%	16%	11%
Age range	13–17 years	0–17 years	1–17 years	2–17 years	1–17 years

Of the 12 children who died in transport accidents and were known to DCJ, five were female and seven were male. As shown in Figure 10, nine of the 12 children who died were teenagers. Five were aged 13 to 15 years and four were aged 16 to 17 years. The other three children who were known to DCJ and died in 2022 in transport accidents were aged 1 to 4 years (1 child), 5 to 8 years (1 child) and 9 to 12 years (1 child).

Information available to DCJ about the accidents at the time of writing this report indicates that speeding was a contributing factor in eight of the children's deaths. Driving too fast is the biggest contributor to death and injury on NSW roads and contributes to 41 per cent of road fatalities and 24 per cent of serious injuries each year.[31] Other contributing factors noted from the information available to DCJ include not being appropriately restrained (both adult seatbelt and age-appropriate child restraint), driving without a licence, and the age and inexperience of the driver.

In 2022, two of the children who died were the driver of the vehicle and five children were a passenger in a vehicle being driven by a person aged under 25 years. In NSW in 2021, crashes involving younger drivers (aged 26 years and under) accounted for almost a quarter of road fatalities.[32]

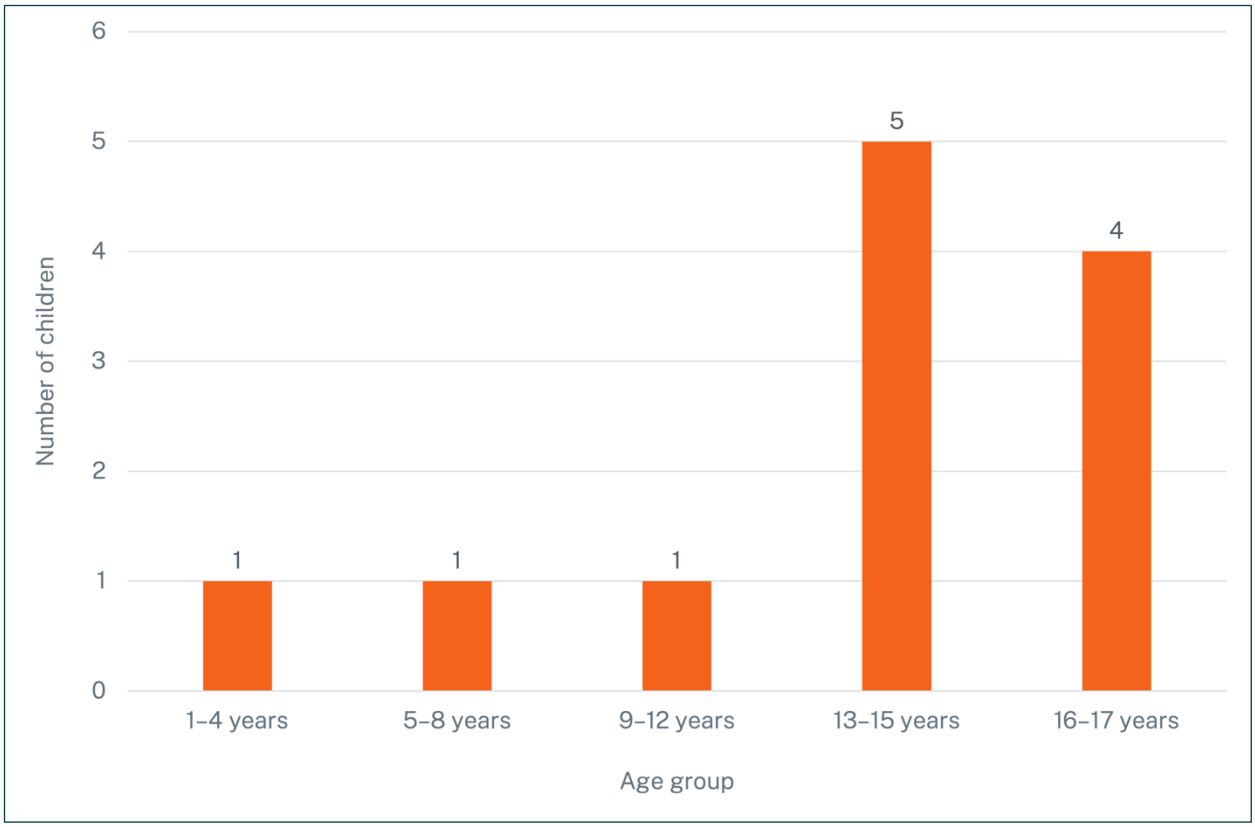

Figure 10: Children who died in 2022 from transport accidents and were known to DCJ, by age

Practice reflections and learning

In reviewing DCJ practice where reports had been received about children who died from injuries sustained in transport accidents, the following key theme was identified.

Risk-taking behaviour

Many of the children who died in 2022 in transport accidents did not have lengthy child protection histories. For seven of the 12 children, DCJ had not received any prior risk of significant harm reports for risk-taking behaviour and had only received a limited number of reports about the children and their family before they died.

However, for many of the children the circumstances of the accident included behaviours which placed them at risk as the driver or passenger of a vehicle, including:

- driving at high speeds or dangerous driving
- driving a stolen car
- failing to stop for a police officer
- not wearing a seatbelt.

This highlights the importance of practitioners speaking with young people, and their parents, about safe driving and decisions about who they travel with in cars.

The following case study discusses some missed opportunities to explore risk-taking behaviours. The case study contains information about an Aboriginal child and their family that may be confronting. Please take care when reading the story.

Case study – Tyler's story

Tyler, an Aboriginal boy, was first reported to DCJ when he was 10 years old because he had sent a sexually explicit photo of himself to a girl in his class. The school had contacted NSW Police and spoken to Tyler's parents. The report was not allocated for further assessment and closed.

By the time Tyler was 13 years old DCJ had received a report that he had self-harmed by punching a wall and that he had been caught shoplifting. A third report was received that Tyler had been punched by his dad, which had left a bruise on his arm. DCJ was unable to allocate these reports for an assessment. The triage caseworker spoke with Tyler's parents and referred Tyler to a local Aboriginal youth adolescent support program. DCJ did not receive any information about whether Tyler attended the service and whether any supports were provided to Tyler and his family.

DCJ did not receive any further reports for Tyler until he was 15 years old and had sadly died in a car accident. Tyler was the passenger in a car driven by a friend who was 19 years old. Other drivers witnessed the car travelling at excessive speeds before it collided with a power pole. The driver and Tyler died at the scene.

Learning from Tyler's story

Teenage males made up the largest group of children who died from transport-related accidents in 2022. It is normal for teenagers to take risks, especially when with their friends. However, it is known that children who have experienced neglect or abuse are more likely to engage in risk-taking behaviour.

Tyler was Aboriginal; limited information was known about his connection to culture, what this meant to him and who he was connected to in his family.

DCJ knew that Tyler had a history of some behaviours which could be classified as risk-taking but was not aware of how his experiences influenced this. It was positive that DCJ referred the family to an adolescent support program, but there were missed opportunities for DCJ to engage with Tyler and his family.

If reports about Tyler had been allocated for further assessment, it would have been beneficial to explore this with him and involve extended family. These discussions could have provided insight about his experiences and behaviour and possible ways to provide support.

2.5.6 Other circumstances of death

Accidental asphyxia

In 2022, one child known to DCJ died due to accidental asphyxia.

Accidental choking

In 2022, one child known to DCJ died from accidental choking.

Drowning

In 2022, two children known to DCJ died in drowning accidents. One child was Aboriginal and aged 1 to 4 years, and one child was aged 15 to 17 years.

Drug overdose

In 2022, two children known to DCJ died from a drug overdose. Both children were aged 13 to 15 years; one of the children was Aboriginal. For both children, the NSW State Coroner has determined the cause of death and determined that an inquest is not required.

Inflicted or suspicious injuries

In 2022, two children known to DCJ died from inflicted or suspicious injuries. One was male and one was female. One of the children was Aboriginal. At the time of publishing this report, charges have been laid against a perpetrator for one child, and the other death remains under police investigation.

Other accidental injuries

The category of other accidental injuries includes children who died from an accident that does not meet the criteria for one of the other circumstances discussed in this report.

In 2022, three children who were known to DCJ died in circumstances of other accidental injuries. One child was aged between 1 and 4 years, one child was aged 5 to 8 years, and one child was aged 9 to 12 years. Two were female and one was male; two of the children were Aboriginal. The circumstances of the accidental injuries in 2022 included a fall, an accidental injury while playing and a dog attack.

2.5.7 Undetermined deaths

At the time of writing this report, the circumstances of death for four children cannot yet be reported. For one of the children, a post-mortem has been received which states that the cause of death is 'unascertained'. For the other three children, a post-mortem has not been completed. The NSW State Coroner's Court is continuing to investigate all four deaths.

Two of the children whose circumstance of death remains undetermined were aged under 1 year, one child was aged 9 to 12 years, and one child was aged 15 to 17 years.

2.6 Children in out of home care

As shown in Table 8, nine children were living in out of home care when they died. Six of the nine children were Aboriginal. Five of the children were female and four were male. This represents 8 per cent of all the children who died and were known to DCJ in 2022.

Five of the children who died while living in out of home care died from illness and/or disease. Two children died from suicide, one from a drug overdose and one in a transport accident.

For the nine children who died, the Children's Court had made an order allocating parental responsibility. For four of the children, the Children's Court had made an interim order allocating parental responsibility to the Minister for Families and Communities, and court proceedings were still continuing when they died. For four children, parental responsibility was allocated solely to the Minister, and for one child parental responsibility was allocated to the Minister with the aspects of culture and religion shared with the parents.

At the time of their deaths, five of the children were living with authorised carers, and one child was placed with a relative carer. One child lived in an intensive therapeutic care placement and two children died in hospital. Of these two, one child did not leave hospital after their birth, and the other was hospitalised for several months before they died.

For four of the children who died while living in out of home care, their case management responsibility had been transferred to a Permanency Support Program (PSP) provider. For two of these children, DCJ and the PSP provider agreed that a joint review would take place. For these two cases, the SCR Unit led the review process, reviewed records from the agencies involved with the children and consulted with staff from within DCJ and from the agencies involved. This joint approach to reviews is in place to ensure the adequacy of casework practice is considered across agencies and to facilitate learning and support practice and systems improvement across the sector.

Table 8: Children who were living in out of home care when they died, 2018–22

Out of home care	2018	2019	2020	2021	2022
Number of deaths	8	7	5	7	9
Age range	0–17 years	3–17 years	0–9 years	0–17 years	0–17 years
Parental responsibility of Minister (any aspect)	7	7	5	6	9
Placed with relative/kin carer	3	4	1	3	1
Placed with authorised carers	5	2	2	1	5
Other (independent living, residential care, hospital)	0	1	2	3	3
% of total deaths	9%	7%	5%	7%	8%

Out of Home Care Mental Health Framework

In 2023, DCJ and the NSW Ministry of Health (Mental Health Branch) progressed a joint initiative to develop a framework to improve coordination, care, access and outcomes for the mental health and wellbeing of children in out of home care. The framework's primary focus is to improve how agencies collaborate to support the mental health and wellbeing of children over the next five years. This framework is informed by broad consultation across both agencies and with key stakeholders. The framework builds on the specialist mental health services already supporting children in out of home care, including the **Elver** consultation program.

3

Improving the way DCJ works with children and families

Chapter 3 outlines the responses from DCJ to the learning that has come from child death reviews completed in 2022.[33] It includes details about the implementation of practice or policy changes made in response to those child deaths and provides an overview of other initiatives aimed at improving DCJ responses to all vulnerable children and families in NSW.

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

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

As noted in Chapter 1, recommendations aimed at improving direct casework with families or about the unique needs of a CSC or district are referred for a localised management response. The implementation of these recommendations is monitored closely through the DCJ Operational Business Review process, providing visibility of recommendations and ensuring accountability.

Section 3.1 of this chapter focuses on the work of the Serious Case Review Panel, which meets regularly to discuss complex case reviews and consider the issues raised for child protection and out of home care practice within DCJ, as well as the broader relationships with other government and non-government services.

Reflecting the Panel's broad focus, not all reviews will have recommendations made in response to the concerns identified. Where the Panel identifies existing reform work underway that will address the issue of concern, that work will be noted and no new recommendation made.

The remaining sections of Chapter 3 provide an overview of some of the practice initiatives and reforms that are aimed at improving DCJ responses to all vulnerable children and families in NSW. This is provided to give a fuller understanding and context to the recommendations that are made in response to the learning from child deaths.

3.1 Practice changes made in 2022 in response to child death reviews

During 2022, the Panel met three times and considered seven complex case reviews that examined DCJ involvement with a child and their family before the child died. One case involved a young person who was over 18 years old at the time of their death. While there was no legislative requirement to review this young person's case, it was felt the complexity of their child protection history would provide an opportunity to identify how DCJ could improve its response to children with disability who have a parent experiencing poor mental health.

The following information presents an overview of the reviews discussed by the Panel in 2022 and is arranged under headings that identify the concern raised. Each concern includes information about the child death that prompted the issue to arise, the ongoing work happening in DCJ to support practice change and any new recommendations that were made.

3.1.1 Improving DCJ response to children assessed at risk of significant harm

Improving referral systems and practices

One review considered by the Panel in 2022 was about an infant who died in 2021. The Panel noted that the practice of making referrals to services without ensuring the service and the family had connected was an issue.

Ongoing work to support practice change

In 2021, the Panel had noted similar issues about referral practices and discussed these in response to reviews it considered (outlined in Chapter 4 of the *Child Deaths 2021 Annual Report*). In considering whether to make recommendations, the Panel noted the following key pieces of work that had happened or were underway since the death of this infant that were contributing to improvements in allocation and referral practices:

- A **Targeted Referrals** fact sheet was published on the DCJ intranet in November 2021.
- During 2022 and 2023, data quality reviews were completed on closed cases to better understand how to strengthen referrals so that families receive the right targeted supports and to improve the guidance given to services about when to report back to DCJ after a case has been closed.[34]
- From 14 July 2022, a **universal referral form** for family preservation services was made available in **ChildStory** (with a supporting knowledge article) for the following programs:

- Family Preservation (formally Brighter Futures and Youth Hope)
- Intensive Family Preservation
- MST-CAN and FFT-CW[35]
- Resilient Families.

The universal referral form will allow ChildStory to track the creation and approval of referrals being sent to providers. The next phase of the ChildStory enhancement work is currently being scoped and will include the ability for family preservation providers to electronically accept or decline referrals, which will also be captured in ChildStory. Effectively, this phase will extend the ChildStory case management workflow into the non-government and Aboriginal organisation sectors.

- As part of the Family Preservation recommissioning program, following external consultation, the **Family Preservation Service Program Specifications** have been updated and now integrate existing family preservation programs into a single continuum of care to help vulnerable families access the right supports at the right time. This is described in more detail in section 3.2.3.
- The **Helpline Advanced Screening Pilot (HASP)** was introduced in 2021 to improve the accuracy and efficiency of the screening and assessment of reports made to the Helpline, by expanding information gathering to inform decision-making at the Helpline to improve the decisions made. HASP has since been expanded to additional districts and CSCs following a review of the pilot.
- DCJ is undertaking a comprehensive policy review of **prioritisation, triage and allocation** processes. The triage assessment is used to prioritise children reported at risk of significant harm for:
  - a face-to-face assessment
  - referral to a local support service
  - no further action.

  This current review aims to ensure that the broader NSW child protection system identifies and responds to the children who are at most risk, within available resources.

  An analysis of current practice and extensive stakeholder consultation, alongside a review of best practice research, is being used to develop improved policy. This will result in a clear policy position and updated casework mandates to strengthen decisions about the responses children receive. The aim is for more effective and consistent decision-making for children and families at critical decision-making points, including in face-to-face assessments, and for when other responses can be considered, such as strengthening case coordination and referrals to funded services.

  The review is expected to be completed in early 2024 and will build on the initial triage review published in 2021 (referred to in the *Child Deaths 2021 Annual Report*).

To further address the practice and making of referrals, the Panel recommended that the DCJ Strategy, Policy and Commissioning division coordinate a workshop aimed at improving referral systems and processes within the broader service system. The progress of this recommendation is linked to current work to co-design and test the recommissioned Family Preservation program with the sector.

Improving data insights

DCJ is undertaking a number of key data projects to improve its understanding of which children reported at risk of significant harm who are 'seen' or 'not seen' by a DCJ practitioner are also supported by other support services. These include:

- **Updates to ChildStory**, including the use of the universal referral form and the expansion of the ChildStory case management workflow (described above) to better capture data on referrals made to family preservation services.
- **infoShare**, an IT solution in development that aims to improve data quality within family preservation programs. In the future, infoShare (and a well-designed minimum dataset and referral form) could be adopted by other key services to collect identified client and service data and provide broader oversight of the government-funded services provided to families reported at risk of significant harm who are 'not seen' by DCJ. infoShare is described in more detail in section 3.2.3 and will be further assessed, following implementation and finalisation of the initial rollout.

Closure of cases assessed as high or very high risk

Three of the reviews considered by the Panel in 2022 identified inconsistent practice about the closure of cases where families had been assessed at high or very high risk after being referred to an Intensive Family Preservation service, including how the closure decisions were endorsed and recorded. The Panel recommended clear policy guidance be developed to remove ambiguity and clarify existing policy.

The reviews are being used to inform work by Strategy, Policy and Commissioning to inform the **Family Preservation recommissioning** program, and by the Office of the Senior Practitioner (OSP) **Better Decisions for Children** project that is working in partnership with the Transforming Aboriginal Outcomes and Strategy, Policy and Commissioning divisions to redesign the approach to safety and risk assessment by DCJ.

Background

The risk assessment was used to help DCJ practitioners understand the level of future risk a child may face without support or other intervention. A risk assessment outcome can be low, moderate, high or very high. The policy position is that families who are assessed as high or very high risk should receive ongoing casework until the risk has been mitigated or assessed to be low or moderate.

Ongoing work to support practice change

DCJ is prioritising referrals to contracted family preservation services for children assessed at high or very high risk. This is not a new practice, but there is an opportunity to improve and strengthen how DCJ makes these referrals to ensure that families are connected to and receiving a service before DCJ stops working with a family. This aims to ensure the best possible outcomes for children and their families.

DCJ has **improved the use of funded family preservation services** for children at high or very high risk following a face-to-face assessment. This has resulted in a 25 per cent increase in children with plans closed with a family preservation service in place.

This improved pathway to keeping families safe and together has been further strengthened by the implementation of an initiative for targeted referrals that was rolled out between August 2021 and July 2022 (by the then Protecting Our Most Vulnerable Children taskforce).

The Strategy and Implementation Unit continued work in 2022 and 2023 to undertake data quality reviews on closed cases. The findings of this work identified common risk assessment errors that led to inaccurate case closure decisions. In response, the taskforce in collaboration with the OSP, developed a series of e-learning sessions that provide concise and accessible guidance for practitioners.

The comprehensive policy review of prioritisation, triage and allocation processes mentioned earlier will also support more effective and consistent decision-making for children and families around all critical decision-making points, including case closure.

3.1.2 Providing a better system response to young people in care who are pregnant

Supporting young women and parents

One review considered by the Panel in 2022 identified the challenge practitioners face in their dual role of supporting young women and parents (including pregnant young women in out of home care) while also assessing safety and risk to their newborn babies. The Panel found that the review highlighted the absence of supported accommodation programs for young parents in non-metropolitan areas of NSW.

Previously, in December 2021, the Panel had discussed a review that identified the need to improve the quality of the service response to young people who are in out of home care and pregnant. The Panel identified reform work underway that would help to address the issues raised in the review and made recommendations to further support this area of practice. These are outlined in Chapter 4 of the *Child Deaths 2021 Annual Report*. Progress on the reforms underway and recommendations made in 2021 are included in the following update.

Ongoing work to support practice change

During discussions in 2022, current work and initiatives were identified that aim to support young people. Further work is continuing in these areas to fill the service system gap:

- The **Premier's Youth Initiative** supports young people aged 16 to 17 years who are leaving statutory out of home care and identified as being vulnerable to homelessness on leaving care. The program aims to build the long-term capacity and resilience of young people to permanently divert them from the homelessness service system.
- **Pregnancy Family Conferencing** allows for the development of support networks during pregnancy as well as additional or supplemented supports; for example, offering doula[36] support at the very early stages of the pregnancy, especially for young parents who have been in care and may experience difficulties with emotional regulation to help them plan and prepare for life once the baby is born and for the months that follow.
- **Review of the DCJ Prenatal Policy:** In 2022, the DCJ Strategy, Policy and Commissioning division began a substantial review and update of the **Prenatal Policy and Practice Mandate** to ensure it aligns with emerging needs and contemporary evidence-based practice. This review is taking place in consultation with the **Better Decisions for Children** project and Transforming Aboriginal Outcomes division, and substantial work has been undertaken with key stakeholders. The outcome of this work will be clear policy, mandate and practice guidance that will support practitioners to understand the different focus of a prenatal child protection response and out of home care casework and work in collaborative ways to support pregnant young people in care.

Following consideration of existing work, the Panel recommended the review be referred to the Strategy, Policy and Commissioning division to inform its recommissioning work, and specifically to consider needs of young people in care who become pregnant, as well as where service gaps exist and whether scope exists to commission new services.

The **Family Preservation recommissioning program** will consolidate disparate services into an integrated service model design which has the flexibility to support clients. The focus is to make sure children and families receive targeted and quality services that meet their needs and help them keep children safe. Section 3.2.3 includes more information about the progress of the Family Preservation recommissioning program.

The **Out of Home Care Health Pathway** also provides key referrals and support for young women who are in care and become pregnant. Out of Home Care Health coordinators (within NSW Health) make a range of referrals for young people in care to provide them with psychological and family support planning and coordinate links to local antenatal services that are experienced in working with young people who are pregnant. The young person's caseworker will support them to attend antenatal appointments and follow up with any recommendations made by relevant health practitioners, including the doctor, obstetrician, midwife or the Out of Home Care Health coordinator during the pregnancy.

Section 10 of the **Health Needs of Children in Out of Home Care Mandate** provides information to DCJ practitioners about working with children and young people in care who are pregnant.

3.1.3 Improving practitioner knowledge of disability service provision

Improving disability knowledge

One review discussed by the Panel in 2022 examined the complexities of working with a parent with longstanding mental health concerns while also trying to build safety and support for their child with disability. The review noted that when compared to other aspects of casework, practitioners were less confident in their disability knowledge or in how to engage with the National Disability Insurance Scheme (NDIS) and broader disability support network. They lacked confidence to include this alongside their broader response and coordination role with the family.

In response, the Panel recommended an online practice forum be developed that focuses on improving child protection practitioner and manager disability services knowledge. A webinar session is due to take place in late 2023 and will be recorded and made available for all DCJ practitioners to access on Casework Practice.

Ongoing work to support practice change

Other initiatives during 2022 to support better practice with families who have children with disability included the following.

Improved data that identifies children with disability: In 2022, DCJ completed a project to make NDIS and Early Childhood Approach (ECA) information easily available for practitioners who are supporting children with disability in out of home care who are NDIS participants. Matched NDIS participant and out of home care data is now regularly uploaded to ChildStory.

Improving NDIS plan use for children in out of home care: In 2022, DCJ undertook significant work with DCJ practitioners and the out of home care sector more broadly to increase NDIS plan use for children in out of home care. This includes:

- a dedicated team (Engagement and Family Support) that provides statewide support for building the capacity of DCJ practitioners to work with NDIS support coordinators, foster carers and out of home care providers to implement NDIS plans and maximise the use of funding to ensure that children get the disability supports they need (and are funded for)
- a whole of sector NDIS plan use capacity-building strategy that implements a range of data and capacity-building activities targeted at key stakeholders, and measures outcomes

- partnering with key NSW stakeholders such as the Association of Child Welfare Agencies (ACWA) and AbSec to increase out of home care service provider sector knowledge of NDIS more broadly, with a particular focus on plan use. Activities include webinars, online presentations and a face-to-face Disability Good Practice Symposium.

Early intervention and prevention: In 2022, DCJ worked closely with the National Disability Insurance Agency (NDIA) to keep children with disability at home with their families under a bilateral memorandum of understanding between DCJ, the NDIA and the Department of Social Services. This collaboration provides an early intervention and prevention approach to support families who are struggling to cope with meeting their child's complex disability support needs in the family home. DCJ also works with other NSW agencies (e.g. education and health) to support access to mainstream services for children and young people with disability and to help with the early identification of families who are struggling to cope.

Out of Home Care Health Pathway: In 2022, DCJ trialled a joint project with NSW Health to enhance the out of home care health pathway for children and young people with a disability or developmental delay who were entering out of home care. Under this enhanced approach, the DCJ Engagement and Family Support team is informed along with the caseworker if a child is identified as having a disability or developmental delay through the out of home care health pathway process. The Engagement and Family Support team provides support to the practitioner to build their capacity to access the appropriate disability supports for the child. The trial was completed in the Murrumbidgee and Illawarra Shoalhaven districts during 2022 and started in Hunter Central Coast in August 2023, with an intended statewide rollout being considered for 2024.

The **Special Out of Home Care Mandate** went live on Casework Practice in May 2023. This mandate outlines the casework expectations and requirements for DCJ practitioners and includes supporting documentation to help practitioners when working with a child who meets the eligibility criteria for special out of home care. Further enhancements are being made to this mandate, one of which includes greater clarity about how DCJ work with NDIS providers to ensure holistic case planning for children who live in this arrangement.

The **Home Visiting Children in Out of Home Care Mandate** was published in July 2023. The new mandate includes special considerations for children with disability in out of home care, such as more regular visits when development or review of a NDIS plan is needed and careful planning for home visits that allow the child to fully participate in the visit with consideration to their specific disability needs.

3.1.4 Working better with adolescents

Improving safety and risk assessments with adolescents

One review considered by the Panel in 2022 identified that practitioners who had worked with an adolescent before his death did not use the safety and risk assessment framework to guide their response to the family, instead preferring a supportive approach to improve their engagement with the young person. This meant the risks to the young person were not well understood.

The Panel noted the actions and work that the district had undertaken following the young person's death[37] to improve its responses to adolescents, including:

- a review of adolescent service provision in the district. The review focused on the role and purpose of existing adolescent teams, their casework practice and the systems in place to support service delivery to young people who require a child protection response, are in out of home care or are being supported by an Intensive Support Service.
- the **Changing the Trajectory** forum in October 2022. The forum included senior representatives from DCJ, the NSW Health Child Wellbeing Unit, the local health district, Justice Health, STARTTS,[38] NSW Education, NSW Police and a number of non-government organisations. The need for the forum had been identified during the COVID-19 pandemic, which saw an increased number of young people requiring DCJ intervention and provided an opportunity to create a cross-agency approach to adverse childhood experiences and impacts to mental health and wellbeing. The forum resulted in a draft collective care approach being developed to improve capability, knowledge and understanding across the sector when responding to the mental health and wellbeing needs of children and young people. This work is ongoing.

To ensure the requirement to use the existing safety and risk assessment framework is well understood by all practitioners and practice leaders, the Panel recommended an online practice forum be developed that focuses on improving the assessment of safety and risk with adolescents. A webinar session is due to take place in late 2023 and will be recorded and made available for all DCJ practitioners to access on Casework Practice.

Ongoing work to support practice change

The work by the **Better Decisions for Children** team is contributing to improving safety and risk for adolescents. Currently, an alternate assessment model is used to assess safety and risk of young people who are in their parents' legal care but have chosen to live away from home. This model does not assess these circumstances well, in particular immediate safety, cumulative harm or trauma responses, or the roles, relationships or circumstances that have contributed to the young person's living arrangements and current experiences of safety and risk. The redesign of this assessment will improve how this group of young

people is assessed. It will focus on understanding the relationships that impact on young people's experiences of safety or risk, including responsibilities of parents (who retain parental responsibility), and support decision-making and case planning for adolescents and their families. The work of **Better Decisions for Children** is discussed in more detail in section 3.2.2.

Young people who are vulnerable to suicide

In 2022, there was an increase in the number of young people who died by suicide who were known to DCJ to 15 (an increase of two over the previous two reporting years), two of whom were in care.

As discussed in Chapter 2, suicide is the leading cause of death for young people aged 15 to 24 years in Australia. The *Child Deaths 2020 Annual Report* included findings from a cohort review of 42 young people who were known to DCJ and who died between 2016 and 2020 by suicide or suspected suicide.

Ongoing work to support practice change

Guidelines for Risk Assessment and Management of Suicide and Self-harm: In 2022, DCJ Psychological and Specialist Services completed a review of these guidelines, which support practitioners in their work with adolescents who are vulnerable to suicide. Since then the guidelines have been adapted and embedded into the **Mental Health** practice kit and an e-learning package called 'Responding to children and young people at risk of suicide and self-harm', which are both available to all DCJ practitioners.

Safety in Care Assessment: DCJ continues to revise and develop its learning content to support the Safety in Care Assessment. This is used when responding to reports about children and young people in out of home care. Children in care often have a history of complex trauma, including cumulative harm. The Safety in Care Assessment focuses on understanding the child's experience and working with them and their networks to improve their immediate safety. The revised assessment will emphasise a young person's responses as 'pain-based behaviour' instead of 'child is a risk to themselves or others', providing a more empathic response and recognising that a young person's behaviour can be their way of communicating.

The **Out of Home Care Health Pathway** is used by DCJ practitioners to support the health needs of adolescents. Under the pathway, all children and young people have their psychosocial and mental health assessed as part of their initial primary health assessment. Adolescents who are preparing to leave out of home care can complete the HEEEADSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression and Safety) Assessment. If issues are identified, the young person can be referred to an appropriate professional for treatment and ongoing support.

In 2023, a Mental Health Reference Group was formed consisting of senior representatives from NSW Health and DCJ to oversee development of an **Out of Home Care Mental Health Framework**. Once implemented, the framework will aim to improve coordination, care, access and outcomes for the mental health and wellbeing for children and young people in out of home care. A collaborative working group has been formed which includes local health district and DCJ representatives. A draft framework is expected by the end of 2023.

A better response to adolescents who contact the Child Protection Helpline

In 2022, the Helpline developed a clear process to support young people who call seeking help and support when they are feeling vulnerable to suicide or self-harm. Calls from children and young people are placed in a priority queue. Callers always have a staff member actively talking to them during their call, and they are not placed on hold.

In consultation with Youth Consult for Change (a young person's reference group with representatives who are or were in out of home care), the Helpline developed a training module to help staff support young people who call the Helpline in distress. The module is called 'Listening and talking to children and young people on the phone with thoughts of suicide', and training was delivered across the Helpline in 2022.

3.1.5 Other recommendations in 2022

Providing a child protection response during the pandemic

Two complex case reviews considered by the Panel in 2022 identified the impact of the COVID-19 pandemic on casework and, more specifically, how the child protection workforce was interpreting messaging about how they could continue to assess safety and risk with families. The Panel recommended a further internal review about these issues.

In December 2022, an internal review of practice directions provided to child protection practitioners during the COVID-19 pandemic was completed. The internal review found that COVID-19 staff updates provided by Deputy Secretaries to all staff by email were clear about key practice requirements, such as directions on the continuation of child protection face-to-face visits and when adjustments were to be implemented.

While the internal review did not identify any communication gaps, some opportunities for improvement were identified. These included the need for practitioners to be advised directly by their manager as well as via general email in situations where practice directions were being distributed in response to important issues. Regular review of recipient lists for all mass communications sent by the Deputy Secretary's office is now routine. Other opportunities for improvement have been logged in case of further waves of COVID-19 or significant disruptions to practice.

Sharing learning to promote child safety

In 2022, the SCR Unit continued, in collaboration with other government and non-government partners, to review the deaths of children who were in out of home care and case managed by non-government out of home care providers. A number of reviews considered by the Panel were referred to other parts of DCJ and to external agencies.

In 2023, the Panel discontinued an earlier recommendation to develop a joint review framework (as noted in the *Child Deaths 2021 Annual Report*). The Panel acknowledged the existing process used by DCJ to undertake joint reviews (supported by the **Permanency Support Program Critical Events Policy**) was now well established. To date the process has been effective and is based on a strong system of partnership with other agencies.

3.2 Improving responses to at risk children and families

During 2022 and continuing in 2023, DCJ continued to implement a range of practice initiatives and reforms that are aimed at improving responses to all vulnerable children and families in NSW. These are described in the next sections.

3.2.1 NSW Practice Framework

The NSW *Practice Framework* has been in operation since 2017 and continues to provide a common set of values, principles, guidance and prompts for practitioners, specialists and managers. The Framework offers a structure which supports practitioner reflection and action. It is vital for good practice in complex cases involving children and families.

The capacity to draw on a consistent framework helps everyone to be conscious of biases, gaps and errors in practice. Familiarity with the *Practice Framework* helps practitioners build their capacity to 'reflect in action' (as they work directly with a child or family). It also helps practitioners 'reflect on action' in structured sessions with colleagues and managers, consider (or reconsider) practice directions and improve future involvement with families. This use of the *Practice Framework* in deliberative professional processes such as consultation and supervision is central to safeguarding practice.

Since the implementation of the *Practice Framework*, the OSP has continued to provide training and consultant support for structured consultations and group supervision sessions. More recently, work has progressed to further refine how group supervision is used.

Group supervision

Group supervision is a key component of the *Practice Framework*. It is used by all casework teams to make collective decisions about practice with children and families while building capability and practice skills through knowledge sharing.

A focus over the last 12 months has been to improve the use of group supervision. Updated guidance and training for staff will ensure group supervision sessions result in clear future directions which address needs and concerns for a child and family in accordance with the principles of the NSW *Practice Framework*.

Core elements of this update include:

- further clarity about the different roles staff and managers play in group supervision sessions, including the roles of facilitator and consultant
- clarification about how staff raise dissenting views so that these can be incorporated in session dialogue and post-session progress
- more links to resources which help practitioners to unearth predictable errors
- a structured group supervision plan for facilitators to use where concerns focus on physical abuse, including denied abuse
- guidance that any sessions focused on structural or systemic issues also include a direct reference to a particular child or family so that sessions are relevant to their direct experiences
- a stronger focus on recognising pitfalls in practice and skill development needs
- the introduction of a new group supervision recording template that ensures cultural and other consultants' advice is recorded and a review component to identify if advice was actioned
- guidance for how facilitators and consultants can better plan and evaluate a group supervision session.

The newly developed resources and improved approach, including an e-learning module, were provided to DCJ managers and practitioners in September 2023.

3.2.2 Better Decisions for Children

In 2021, DCJ began a full review of its approach to assessment in child protection and out of home care to improve the quality, equity and accuracy of decisions made about children and their families. In 2022, this review was renamed the **Better Decisions for Children** project, to reflect its focus.

In June 2023, the DCJ Executive Governance Group overseeing the development and implementation of the revised assessment approaches provided in-principle endorsement for the implementation of the new **Screening Assessment** and **Safety in Care Assessment** in 2024.

- The new **Screening Assessment** will be used by the Helpline to determine if concerns detailed in reports meet the risk of significant harm threshold, if accurate.
- The new **Safety in Care Assessment** captures the unique needs and vulnerabilities experienced by children in out of home care. It is customised to reflect the quality of care that children in out of home care have a right to experience under the Standards of Permanent Care Code of Conduct for authorised carers and the Charter of Rights. It includes assessment of harm relating to disconnection from family, culture, Country and community and harm relating to pain-based behaviours (trauma-related behaviour), with pathways introduced for practitioners to seek psychological consultation if a child or young person in out of home care is at risk of suicide or self-harm.

  One quality assurance focus over the last 12 months has been the development of a new audit and integrity checking process to support departmental responses involving concerns about safety in care. This audit process is now in place and is supported by quality assurance and continuous improvement teams in districts.

  The capacity to systematically check and assure the quality of responses to safety in care concerns will help ensure greater safety for children in care where concerns around risk have been identified.

The revised **Mandatory Reporter Guide** (MRG) helps mandatory reporters to understand whether they should be making a concern report to the Helpline or supporting the family in other ways. The MRG review is being undertaken in partnership with over 40 interagency stakeholders.

The **Better Decisions for Children** project continues to lead the DCJ review of assessment across child protection practice. The following areas have been identified as priorities and are being strengthened across all aspects of assessment and practice:

- **Culture** is at the forefront of thinking. The *Family is Culture* legislative changes and the Aboriginal Case Management Policy are being integrated into all assessments. There will be increased accountability for practitioners to complete Aboriginal and culturally and linguistically diverse consultation throughout assessment and show how the information provided in consultation informed assessment and decisions.
- **Talking to and engaging children** to understand their experience of safety and seeking their views and participation in decision-making. This includes other ways of understanding children's experiences and views when they are not able to verbalise these (e.g. children who are not verbal due to their age or disability).
- Supporting assessment of the **impact on the child** rather than just the existence of parental behaviour or the presenting concern. Talking to children and/or their advocates is at the core of this.
- Assessing the **strengths and protective abilities** of children, families and their networks at each stage of assessment with a child and their family to ensure a holistic

assessment. Practitioners will use this information to leverage existing strengths and protections to build safety for children.
- **Broader engagement** beyond the people who live in the home when assessing safety and risk for children in child protection and out of home care. An emphasis on understanding the child's network and the safety and protection offered by extended family, culture and community will be prioritised across all areas of practice.

3.2.3 Family Preservation recommissioning program

The **Family Preservation recommissioning** program[39] began in 2021 and is working to deliver a new approach for family preservation. The recommissioning of the Family Preservation system will consolidate disparate services into an integrated service model design which has the flexibility to support clients. The focus is to make sure children and families receive targeted and quality services that meet their needs and help them keep children safe. For Aboriginal children and families, this also means investing in culturally safe and community-led services to avoid families reaching crisis and to keep children out of the care system.

The three areas of focus for the recommissioning are:

- **building and using the evidence** to understand need and effectiveness and inform decision-making
- **building collaborative partnerships and practice** to enhance the actions of DCJ and service provider practitioners and improve access pathways for families
- ensuring that services **meet the cultural needs of families**.

Family Preservation contracts came into effect in July 2021 (originally for a three-year term) and will be extended for an additional 12 months to 30 June 2025. The extension will allow time for further research and analysis (including from the **Better Decisions for Children** project) and for additional co-design and testing within the sector of the future recommissioned Family Preservation program. The extension of Family Preservation means the commissioning timeline for Family Preservation, Targeted Early Intervention and Family Connect and Support will align.

DCJ is exploring the opportunities this may present in terms of outcomes for clients, objectives, streamlined processes and communication.

infoShare

The Family and Community Services Insights Analysis and Research (FACSIAR) team and the Family Preservation team have developed a minimum dataset and are building and implementing an IT solution called **infoShare** that aims to improve data quality in family preservation programs. Previously, data captured from Family Preservation providers was not standardised across all programs, and incoming data was manually adjusted.

The infoShare platform has the potential to be applied across multiple program areas and services where DCJ refers children at risk of significant harm. Alongside Family Preservation programs, infoShare is also being scoped for use to collect data for programs such as Men's Behaviour Change and for piloting a Family Preservation Vacancy Management dashboard.

In the future, infoShare (and a well-designed minimum dataset and referral form) could be adopted by other key services to collect identified client and service data and provide broader oversight of government-funded services provided to children reported at risk of significant harm who are 'not seen' by DCJ. This opportunity will be further assessed following implementation and finalisation of the infoShare rollout, which is expected to be completed by late 2023.

3.3 Improving outcomes for Aboriginal children and families

The over-representation of Aboriginal children in child protection and out of home care systems continues to be a primary concern of DCJ. The Transforming Aboriginal Outcomes Division is driving change and working with other parts of DCJ to achieve our Closing the Gap commitments by putting Aboriginal families at the centre of everything we design, centring Aboriginal culture in what we do and sharing authority so all decisions about Aboriginal people are made with them.

3.3.1 DCJ commitment to Closing the Gap

DCJ is committed to the National Agreement on Closing the Gap and is implementing an action plan to drive down rates of over-representation of Aboriginal children in out of home care and meet the NSW Government commitment to Closing the Gap. This action plan aligns with the recommendations of the *Family is Culture* independent review.

Initiatives and projects that aim to address outcome 12 of Closing the Gap with the target 'by 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children and young people in out of home care by 45 per cent' include:

- AbSec has been funded to deliver **Aboriginal-led commissioning** of local programs and services to grow the Aboriginal community controlled sector. Driven by principles of self-determination and accountability, this approach to commissioning ensures that solutions are owned by Aboriginal communities, with Aboriginal children, young people, families and culture at its centre.

- AbSec has been funded to deliver **Strong Families Our Way** to establish and support Aboriginal community controlled mechanisms (ACCM) across NSW. ACCMs will provide for community input into child protection policies and practices.
- advocacy support by the **Aboriginal Child and Family Advocacy Service**. The Aboriginal Legal Service (ALS) received funding under Closing the Gap to offer face-to-face support for families in Moree and Dubbo, and a phone service across NSW, to help prevent Aboriginal children coming into the statutory child protection system. This will include non-legal advocates, disability workers and advisors with lived experience.
- expansion of the **Aboriginal Child and Family Centre** program. This includes six new Aboriginal Child and Family Centres (ACFCs) and expanding the services of the existing nine centres. The ACFCs provide vital early intervention services to Aboriginal children and families to help them grow safely and strong.
- building the **Aboriginal community controlled organisation (ACCO) sector** to support greater access to intervention or diversion services by Aboriginal families and increase the likelihood families will be diverted from contact with the child protection system. In 2022 and 2023, DCJ has increased recurrent funding ACCOs, and there has also been a growth in the total number of ACCOs contracted and the variety of funded programs delivered to Aboriginal people. The growth of service delivery by the ACCO sector is a key pathway to supporting greater Aboriginal self-determination and economic development.
- the **Aboriginal Out of Home Care Transition Project**, which focuses on transferring case management of Aboriginal children from non-government organisations to an ACCO. Transferring case management to ACCOs will provide culturally safe guidance to carers and support to Aboriginal children. Between 1 July 2022 and 31 December 2022, case management of 55 Aboriginal children was transferred to ACCOs.
- increasing the number of **funded Preservation Support Packages** ACCOs are contracted to provide. These packages aim to prevent entries into out of home care.

3.3.2 Family is Culture

In 2016, the NSW Government commissioned the *Family is Culture: Independent review of Aboriginal children and young people in out of home care*. The report was released in November 2019. It made 126 recommendations about how the NSW Government delivers services and over 3000 recommendations that referred to specific children and young people.

Family is Culture legislative changes

Changing casework practice, care and protection legislation and court processes is a key theme to reforming the child protection system for Aboriginal children.

In November 2022, NSW Parliament passed the Children and Young Persons (Care and Protection) Amendment (Family is Culture) Bill 2022 in response to *Family is Culture* recommendations proposing legislative reform. The amendments aim to reduce the over-representation of Aboriginal children in out of home care in NSW by improving practice, oversight and accountability.

The amendments to the *Children and Young Persons (Care and Protection) Act 1998* (NSW) embed the Aboriginal Child Placement Principle, which requires decision-makers to apply each of the five elements of prevention, partnership, placement, participation and connection in making decisions involving an Aboriginal or Torres Strait Islander child or young person. It requires casework practitioners to take 'active efforts' to prevent all children from entering out of home care and to restore children to their families whenever possible. The Care Act also mandates practitioners consider alternative options to out of home care for Aboriginal children and that Aboriginal children, families and communities are involved in decision-making, assessment and case planning processes.

The amendments to the Care Act will require changes to how the child protection system operates. Legislative changes came into effect on 15 November 2023.

DCJ is focusing effort on implementation of the 2022 legislative reforms. This includes work to develop regulations, practice and system-level changes to give effect to amendments and to align policy and mandate changes.

DCJ practitioners and practice leaders have been preparing for the changes via regular communication from senior staff, a mandatory e-learning package and ongoing learning and support in each district.

Winha-nga-nha List

On 7 September 2023, the Winha-nga-nha List was introduced at Dubbo Children's Court.[40] The Winha-nga-nha List is a dedicated court list for Aboriginal families involved in care proceedings at Dubbo Children's Court. It aims to improve the engagement of family and community in the Children's Court process, provide more time to listen, talk and think about what is important for the children and ensure cultural considerations are meaningfully explored in the court process. An Aboriginal Court Liaison Officer is provided to support families who are involved with the Court.

This new culturally responsive approach follows a co-design process that has taken place with Aboriginal community representatives and key stakeholders in response to recommendation 125 of the *Family is Culture* review.

3.3.3 Establishment of the Aboriginal Culture in Practice Unit

In July 2023, the Aboriginal Culture in Practice (ACiP) Unit within the Office of the Senior Practitioner began. This followed a culturally safe recruitment process.

The interview process was centred on cultural and mob ways. It allowed for candidates who progressed to interview and assessment to participate in yarning to share the culture, Country and songlines that bind them and to provide greater insights into what they valued and honoured in their own identity and origins of belonging. A facilitated yarning session also helped candidates to speak to practice, project and cultural focus topics assessed against the capability framework for each of the designated roles.

Having a dedicated team of Aboriginal staff supporting Aboriginal child protection and out of home care practice in DCJ is an incredibly important milestone for DCJ, the Aboriginal people in the organisation and Aboriginal children, young people and families.

The ACiP Unit coordinates Aboriginal Staff Network gatherings in the OSP. These gatherings foster connection between Aboriginal staff and provide an intentional space for cultural care, safety and upkeep. ACiP is also involved in Nguluway Yindyamarra, the DCJ Aboriginal Advisory Network.

The ACiP team is focused on the following key pieces of work to support practice and improve DCJ child protection and out of home care practice:

- A **review of cases for all Aboriginal children in out of home care who have a case plan goal of restoration**. This work aims to identify broad practice themes and examine the casework practice that supports or inhibits Aboriginal children returning to their family. This work is ongoing in consultation with the Family and Community Services Insights Analysis and Research (FACSIAR) team to understand the data and findings and to make recommendations for practice.
- The introduction of Safeguarding Decision Making for Aboriginal Children Panels, as described in the next section.
- Work to **enhance the cultural capability** of DCJ child protection and out of home care practitioners in NSW.

3.3.4 Safeguarding Decision Making for Aboriginal Children Panels

Starting in 2023, Safeguarding Decision Making for Aboriginal Children (SDMAC) Panels are an important new approach to ensure DCJ decisions about Aboriginal children are culturally sound and guided by the Aboriginal Case Management Policy.

The ACiP Unit led the development of the SDMAC Panels operating model, following statewide consultation. This included talking to Aboriginal staff, the Aboriginal Reference Group, practitioners and practice leaders.

The SDMAC Panels reflect the Aboriginal Case Management Policy and its focus on Aboriginal people, families and communities leading decision-making. Panels are consistent with the new legislative requirement for practitioners to make 'active efforts' to prevent children from entering out of home care, community involvement and the Aboriginal and Torres Strait Islander Children and Young Persons Principle. The participation element recognises that Aboriginal community representatives should participate in individual decisions about children and young persons.

SDMAC Panels operate in all districts and aim to improve how DCJ makes decisions about the safety, removal and placement of all Aboriginal children in each Community Services Centre (CSC).

Each SDMAC Panel includes Aboriginal practitioners to ensure consideration of culture remains front and centre of all decisions and representatives from Child Law to provide ongoing legal advice and guidance. Aboriginal staff who sit on SDMAC Panels receive ongoing support around their cultural safety. Decisions are informed by diverse perspectives and independent consultation with senior practice leaders before a Director Community Services makes a decision to remove a child from their family.

Resources, including information sessions and workshops, have been provided to each district and the ACiP Unit provides ongoing support.

Integrity and validation measures are planned to track the outcomes of decisions made by SDMAC Panels to help refine and improve the model over time. Changes to ChildStory and the establishment of a dataset are being developed to support this.

3.4 Supporting the child protection and out of home care workforce in NSW

During 2022, DCJ continued work that focused on supporting the child protection and out of home care workforce in NSW. This includes DCJ practitioners and practitioners in non-government agencies with whom DCJ partners to keep children safe.

3.4.1 Caseworker Development Program

Practice Learning currently delivers the Caseworker Development Program to more than 500 staff per year. This program delivers foundational learning over 17 weeks to new caseworkers via e-learns, workbooks, face-to-face learning and practice-based learning in the CSC. Assessment skills and practice with children are woven throughout the Caseworker Development Program, including material that focuses on:

- ages and stages of development
- assessment basics

- communicating with children and young people
- communicating with children with a disability
- talking to children about abuse and neglect
- a workshop on how to approach adolescents to talk about safety and risk concerns
- using safety-centred practice to elicit an understanding of safety and risk concerns.

Current priorities for practice learning are the design and implementation of learning strategies to support the **Better Decisions for Children** project and the *Family is Culture* legislative changes.

3.4.2 DCJ Practice Conference

The annual DCJ Practice Conference took place on 14 and 15 November 2023. The theme of the conference was 'Better Decisions for Children' and focused on how decisions are made about children, the need to consider multiple perspectives and the importance of critical thinking and analysis. Approximately 500 DCJ practitioners and practice leaders attended in person and many more joined the event online.

3.4.3 Practice Leadership Development Program

In 2021, the Practice Leadership Development Program (PLDP) was created to support the development of practice leaders and Aboriginal and Torres Strait Islander staff who are culturally capable in practice with children, families and communities and who can operate effectively in the five public sector leadership impact areas of people, results, systems, culture and public value.

The program has seven modules and an emphasis on managing and leading staff so that children receive the assessments, supports and services they need and deserve. The PLDP is delivered over 12 months to allow for opportunities to embed and consolidate new skills.

In 2022 and 2023, the PLDP was delivered across all DCJ districts. Managers client services, managers casework and identified emerging leaders participated. Approximately 600 practice leaders completed the program and developed their skills through mandatory e-learns, workshops and focused coaching sessions.

The program is being evaluated by the Research and Evaluation team in the OSP and will continue to be offered to new and emerging leaders.

3.4.4 Change Together

Following a successful pilot, Change Together was redesigned and relaunched in November 2021 as an online resource with eight modules, which consist of a combination of e-learns and an online workshop. The target audience is practitioners from non-government early intervention, family support and family preservation services across NSW.

Feedback has been positive, with the online design of the program making it easily accessible for practitioners across the state. The 'Foundations of Child Protection' module has been the most frequently completed. From its launch in November 2021 to 30 June 2022, 758 of the 1000 available licences had been taken up by early intervention and family preservation services. In the same period, 1493 e-learns were accessed and there were 11 facilitated workshops, attended by 155 practitioners from non-government organisations.

DCJ staff can also access Change Together workshops via Thrive. The e-learns are helpful to those new to child protection practice or DCJ staff who do not work directly with children. As of 30 June 2022, DCJ practitioners had enrolled in these modules 577 times.

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End matter

Glossary

Aboriginal

Refer to the definitions in section 3 of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)* and section 4 of the *NSW Aboriginal Land Rights Act 1983* (NSW). DCJ recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. DCJ also acknowledges that Torres Strait Islander people are among the First Nations of Australia.

Abuse

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

Alcohol and/or drug use

Alcohol and/or drug use in the context of this report refers to significant substance use that interferes with a parent's daily functioning, and negatively impacts on their care and supervision of the child to the extent that there is risk of significant harm.

Assessment

A structured process of information gathering and analysis used at specific points along the continuum of child protection and out of home care practice. This is intended to produce more methodical and thorough assessments.

Authorised carer

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

Case closure

Case closure is a considered casework decision that signals the end of DCJ involvement with a child and their family.

Case planning

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

Casework

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

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. Throughout this report the word 'child' is also used to refer to young people.

Child Protection Helpline

The Helpline provides a centralised system for receiving reports about children who may be at risk of significant harm. It operates 24 hours a day, seven days a week. Phone 132 111.

Children's Court

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

ChildStory

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

Child Wellbeing Unit (CWU)

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

Culturally and linguistically diverse

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

DCJ Community Services Centre (CSC)

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

Domestic and family violence

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

Engagement

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

LGBTQIA+

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

Manager casework

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

Mandatory reporter

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

Mental health concerns

Mental health concerns in the context of this report refer to mental illness that interferes with a parent's daily functioning and negatively impacts on their care and supervision of the child to the extent that there is a risk of significant harm. A mental illness is a health problem that significantly affects how a person thinks, behaves and interacts with other people.

Neglect

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

Non-binary

A 'non-binary' person is one whose gender identity is not exclusively male or female. The term encompasses a variety of gender identities and expressions that fall outside of the traditional binary system of gender, which categorises people as either male or female.

Out of home care

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

Parental responsibility

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

Parental responsibility to the Minister

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

Permanency Support Program (PSP)

The Permanency Support Program (PSP) provides services to vulnerable children so they can grow up in stable, secure and loving homes. A PSP service provider is contracted by the Department to arrange and supervise out of home care placements and/or exercise case responsibility for achieving children's case plan goals of preservation, restoration, guardianship, open adoption and long-term care. For definitions relevant to the PSP, see the PSP Permanency Case Management Policy (PCMP).[41]

Physical abuse or ill-treatment

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

Practitioner

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

Prenatal report

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

Removal

Under section 43 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), this action is taken by an authorised DCJ officer or NSW Police Force officer to remove a child from a situation of immediate risk of serious harm and to place the child in the care responsibility of the Secretary.

Report

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

Reporter

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

Restoration

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

Risk of significant harm

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 if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances:

a. the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met

b. the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care

b1. in the case of a child or young person who is required to attend school in accordance with the *Education Act 1990* (NSW), the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act

c. the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated

d. the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm

e. a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm

f. the child was the subject of a prenatal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.

Risk-taking behaviours

Risk-taking behaviours can include:

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

Sexual abuse or ill-treatment

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

Triage and assessment practice guidelines

The practice guidelines describe the process of triaging risk of significant harm and non-risk of significant harm reports at CSCs.

Young person

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

Youth Justice

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

Notes

[1] NSW Department of Family and Community Services, *Statistical report 2014–2015*, NSW FACS, 2016.

[2] M Davis, *Family is Culture: Independent review of Aboriginal children in out-of-home care in NSW.* NSW Department of Communities and Justice, 2019, accessed 22 September 2023. https://www.dcj.nsw.gov.au/children-and-families/family-is-culture.html

[3] NSW Ombudsman, *Biennial report of the deaths of children in NSW: 2018 and 2019 – Incorporating reviewable deaths of children*, NSW Ombudsman, 2021.

[4] Previous contact with child protection services is often noted as a common factor in child death reviews. Australian Institute of Family Studies, *Child deaths from abuse and neglect* [resource sheet], AIFS, 2017, accessed 22 September 2023. https://aifs.gov.au/resources/resource-sheets/web-resources-child-abuse-and-neglect

[5] S Fish, E Munro & S Bairstow, *Learning to safeguard children: Developing a multi-agency approach for case reviews.* Children and Families Services Report 19, Social Care Institute for Excellence, London, 2008.

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

[7] *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* (Cth).

[8] L Beddoe & V Cree, 'The risk paradigm and media in child protection', in M Connolly (ed.), *Beyond the risk paradigm in child protection: Current debates and new directions*, Palgrave, London, 2017.

[9] B Lonne & N Parton, 'Portrayals of child abuse scandals in the media in Australia and England: Impacts on practice, policy and systems', *Child Abuse & Neglect*, 2014, 38(5):822–836.

[10] Beddoe & Cree, 'The risk paradigm and media in child protection'.

[11] In 2022, DCJ received 224,374 ROSH reports involving 111,291 children (data extracted by the Child Protection Reporting Team, Organisational Performance, FACSIAR, 7 July 2023).

[12] Australian Institute of Health and Welfare, *Deaths in Australia*, AIHW, 2023, accessed 22 September 2023. https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/age-at-death

[13] Red Nose Grief and Loss. http://www.rednosegriefandloss.org.au/

[14] Raising Children Network. https://raisingchildren.net.au/

[15] Bears of Hope. https://www.bearsofhope.org.au/

[16] Australian Institute of Health and Welfare, *Child protection Australia 2021–22*, Table P3, Population of children aged 0–17, by year, age group, Indigenous status and state or territory, as at 30 June 2018 to 2022, AIHW, 2022.

[17] Australian Institute of Health and Welfare, *Child protection Australia 2021–22*, Table S2.3, Children receiving child protection services, by age group, Indigenous status and state or territory, 2021–22 (number, rate and rate ratio), AIHW, 2022.

[18] Australian Institute of Health and Welfare, *Child protection Australia 2021–22*, Table T3, Children in out of home care or on third-party parental responsibility orders, by Indigenous status and state or territory, as at 30 June 2018 to 2022 (number and rate), AIHW, 2022.

[19] DCJ engaged AbSec to write the Aboriginal Case Management Policy. AbSec conducted a statewide consultation process to ensure the policy was informed by the views of Aboriginal people, agencies and communities.

[20] Hypoxic ischaemic encephalopathy (HIE) may happen when not enough oxygen or blood goes to the baby's brain, and this causes the brain to be injured. The brain injury may be mild, moderate or severe. HIE can also affect the lungs, liver, heart and kidneys. Queensland Health, *Queensland clinical guidelines*, Queensland Government, 2022, accessed 22 September 2023. https://www.health.qld.gov.au/__data/assets/pdf_file/0011/140015/c-hie.pdf

[21] While born prematurely, these children were born after 27 weeks of gestation and therefore did not meet the criteria for 'extreme prematurity'.

[22] A congenital disorder is a medical condition that is present at or before birth. These conditions can be acquired during the fetal stage of development or from the genetic make-up of the parents. Congenital disorders may also be caused by infections during pregnancy or injury to the fetus at birth. Spine-heath, *Glossary*, Spine-health, 2023, accessed 22 September 2023. https://www.spine-health.com/glossary/congenital-disorder

[23] The Australian Statistical Geography Standard (ASGS) Edition 3 (2021) Remoteness Structure was released on 21 March 2023. Remoteness areas divide Australia into five classes: major cities, inner regional, outer regional, remote Australia and very remote Australia. These areas are updated every five years to reflect growth in cities and towns and changes in relative service accessibility across Australia.

[24] NSW Ombudsman, *Biennial report of the deaths of children in NSW: 2018 and 2019 – Incorporating reviewable deaths of children*, NSW Ombudsman, 2021.

[25] NSW Ombudsman, *Biennial report*, 2021.

[26] NSW Ombudsman, *Biennial report*, 2021.

[27] Australian Institute of Health and Welfare, *Deaths in Australia*.

[28] Headspace is the National Youth Mental Health Foundation, providing mental health services for 12 to 25 year olds.

[29] SAMSN. http://www.samsn.org.au

[30] Several studies have shown that pregnant women with domestic violence during pregnancy were more likely to deliver low birthweight and preterm neonates and that stress during pregnancy increases the risk of preterm birth. CH Lin, WS Lin, HY Chang & SI Wu, 'Domestic violence against pregnant women is a potential risk factor for low birthweight in full-term neonates: A population-based retrospective cohort study', *PLoS One*, 2022, 17(12):e0279469. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0279469
PD Wadhwa, S Entringer, C Buss & MC Lu, 'The contribution of maternal stress to preterm birth:

Issues and considerations', *Clinics in Perinatology*, 2011, 38(3):351–84. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3179976/

[31] NSW Centre for Road Safety, *Speeding*, Transport for NSW, 2023, accessed 22 September 2023. https://www.transport.nsw.gov.au/roadsafety/topics-tips/speeding

[32] NSW Centre for Road Safety, *Young drivers*, Transport for NSW, 2023, accessed 22 September 2023. https://www.transport.nsw.gov.au/roadsafety/young-drivers

[33] Section 172A(3) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

[34] This work was undertaken by the Strategy and Implementation Unit, which held responsibility for managing and implementing the Premier's Priorities for Permanency and Re-reporting in 2022 and 2023.

[35] Multisystemic Therapy for Child Abuse and Neglect; Functional Family Therapy through Child Welfare.

[36] A doula is a person, often a woman experienced in childbirth, who provides information and physical and emotional support to a new mother before, during and after childbirth.

[37] This young person was 18 years old at the time of their death. Their death was not reportable under section 172A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). The last contact from DCJ with the family occurred two years before the young person's death.

[38] STARTTS: the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors.

[39] NSW Department of Communities and Justice, *Family Preservation recommissioning co-design*, NSW DCJ, 2023, accessed 22 September 2023. https://dcj.nsw.gov.au/service-providers/deliver-services-to-children-and-families/family-preservation/family-preservation-recommissioning.html

[40] 'Winha-nga-nha' (pronounced wi-nun-ga-na), from the Wiradjuri language, means to 'know, think, remember'. NSW Children's Court, *Winha-nga-nha List fact sheet*, NSW Children's Court, 2023.

[41] NSW Department of Communities and Justice, *NSW PSP Permanency Case Management Policy (PCMP)*, NSW DCJ, 2023, accessed 22 September 2023. https://dcj.nsw.gov.au/service-providers/oohc-and-permanency-support-services/permanency-case-management-policy.html

Appendix 1: Counselling and support services

Table A1: Counselling and support services

Service	Description	Contact
Aboriginal Counselling Services	Crisis intervention and counselling for Aboriginal families, individuals and communities in NSW	Call 0410 539 905
Aboriginal Medical Service	Comprehensive health care for the Aboriginal community	Find local contacts at https://www.ahmrc.org.au/
Australian Child and Adolescent Trauma Loss and Grief Network	Resources to help carers understand and respond to the needs of children experiencing trauma, loss and grief	Visit https://tgn.anu.edu.au/
Beyond Blue	Mental health support and 24/7 phone counselling	Call 1300 22 4636 or visit https://www.beyondblue.org.au/
Department of Forensic Medicine	Information, support and counselling for relatives and friends of the deceased person for deaths being investigated by the NSW State Coroner	Call (02) 8584 7800
Gayaa Dhuwi (Proud Spirit) Australia	National Aboriginal and Torres Strait Islander wellbeing and mental health care services	Email info@gayaadhuwi.org.au or visit https://www.gayaadhuwi.org.au/
Healing Foundation	A national Aboriginal and Torres Strait Islander organisation for Stolen Generations survivors and their families	Call (02) 6272 7500 or visit info@healingfoundation.org.au
Kids Helpline	Telephone counselling	Call 1800 55 1800 or visit https://kidshelpline.com.au/
Lifeline	24/7 telephone crisis support and suicide prevention services	Call 13 11 14 or visit https://www.lifeline.org.au/
Link Up (NSW)	Support for Aboriginal people who have been directly affected by past government policies	Call (02) 9421 4700 or email linkup@nsw.link-up.org.au
My Forever Family NSW	A Carer Support Team is available for foster/kinship carers, guardians and adoptive parents	Call 1300 782 975 or email enquiries@myforeverfamily.org.au
NALAG Centre for Grief and Loss	Free face-to-face and telephone loss and grief support	Call (02) 6882 9222 or visit https://www.nalag.org.au/

Service	Description	Contact
National Centre for Childhood Grief	Free counselling for bereaved children; counselling for bereaved adults, parents and carers (fee involved)	Call 1300 654 556 or visit https://childhoodgrief.org.au/
Suicide Call Back Service	Free 24/7 phone, video and online counselling for anyone affected by suicide	Call 1300 659 467
The Compassionate Friends NSW	An organisation offering friendship and understanding to bereaved parents, siblings and grandparents after the death of a child	Call 1800 671 621 or visit http://www.tcfnsw.org.au/
The Gender Centre	Provides a broad range of specialised services that enable the exploration of gender identity and help with gender dysphoria	Call (02) 9519 7599 or visit https://gendercentre.org.au/
Twenty10	Provides a broad range of free, accessible mental health and psychosocial support programs for LGBTIGA+ people in NSW	Call (02) 8594 9555 or visit https://twenty10.org.au/about-us/
13 YARN	24/7 Aboriginal and Torres Strait Islander crisis support line	Call 13 92 76 (13 YARN)

Appendix 2: Tabular representation of graphs

Table A2: Children who died in NSW, by number of total deaths and whether they were known to DCJ

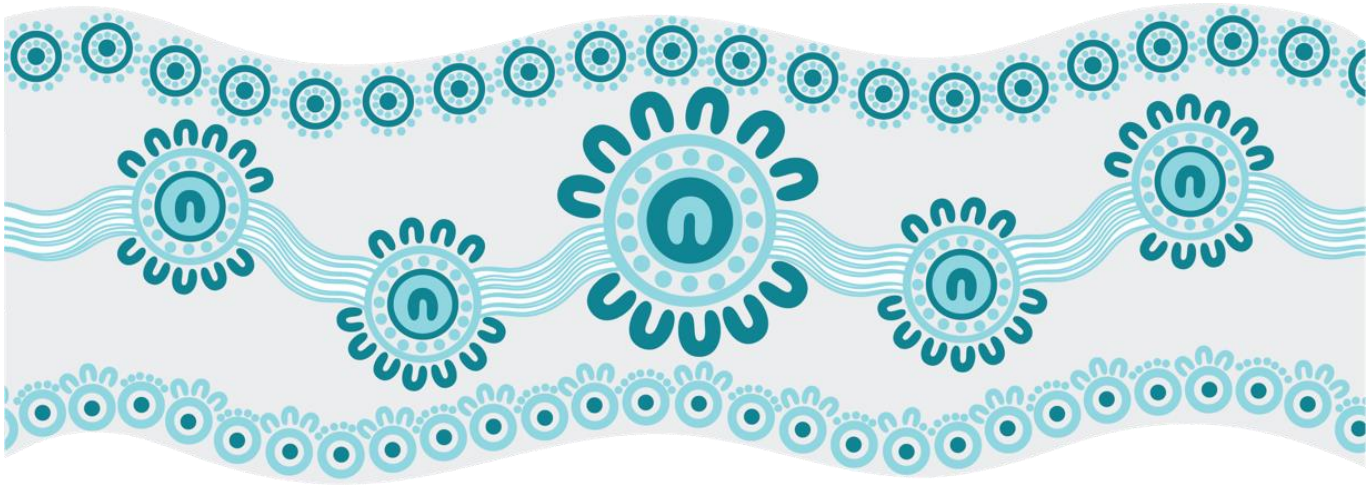
Year	Number of children who died in NSW	Number of children who died and were known to DCJ
2013	558	75
2014	506	79
2015	505	79
2016	465	94
2017	528	91
2018	472	93
2019	517	97
2020	471	100
2021	480	100
2022	463	111

The data in this table is also shown graphically in Figure 2.

Table A3: Children who died in 2022 and were known to DCJ, by age and gender

Age group	Female	Male	Non-binary
Under 1 year	16	29	0
1–4 years	9	7	0
5–8 years	5	3	0
9–12 years	4	4	0
13–15 years	8	10	1
16–17 years	8	7	0

The data in this table is also shown graphically in Figure 4.



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

Leticia Quince

Artwork/design by Leticia Anne Designs & Co.

Department of Communities and Justice
Locked Bag 5000
Parramatta NSW 2124

For an accessible version of this report contact: seriouscasereview@dcj.nsw.gov.au

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