



Family &
Community
Services

Child Deaths

2015 Annual Report

Learning to improve services



A note about this report

A number of stories, based on real cases, are used in this report to draw attention to important learning for practitioners and families about child safety. Names have been changed for privacy reasons. These stories might be confronting for readers. In particular, Aboriginal communities might find some of the report's findings and stories about Aboriginal and/or Torres Strait Islander children distressing. A list of support and counselling services is provided at Appendix 1 of this report.

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Minister's foreword

Every child deserves a safe, secure and healthy life.

When parents and families can't, or won't, provide for their own child's wellbeing, it falls to the individuals who make up the Department of Family and Community Services (FACS) and our non-government partners to try to deliver what families cannot.

Regardless of how hard we try however, there will be circumstances that lead to tragedy. When that occurs the child's family, carers, the community, and our practitioners are devastated but it is imperative we learn from the tragedy. We must ensure all those responsible for other children learn and understand the importance of providing a safe, nurturing environment.

This report analyses the tragic deaths of children in 2015 and is deserving of close scrutiny by all of us who want to achieve better outcomes for children.

This is not a report which seeks to lay blame. Rather, it seeks to build the framework for understanding how we can all give children a positive future.

Chapter 3 of the report focuses specifically on children who have experienced neglect. It reminds us how strong the connection is between neglect and social disadvantage.

To take maximum advantage of the learnings available in this report, we should consider each of the tragic circumstances with an open mind and a preparedness to put ourselves in the place of the child and ask "What could have been done differently?" What could we have done – and what will we do – differently if confronted with a similar situation.

Practitioners and other non-government partners and community members can all learn from this report.

Thank you to each of you who take the time to reflect on how you can play a role in improving the lives of children with whom you come into contact, and who may otherwise be dependent on you to achieve the entitlement of every child – a safe, secure and healthy life.



Brad Hazzard
Minister for Family and Community Services

Secretary's foreword

When a child who was known to Family and Community Services (FACS) dies there is a moral and legal imperative to consider the quality of our practice, the effectiveness of the system and question what may have been done differently. Robust and honest review work matters – it helps build trust in the work of our department and it makes sure we are constantly open to learning. It asks of our workforce what we ask of families – to be open about strengths and areas for improvement.

The Child Deaths 2015 Annual Report provides the opportunity for all of us to consider the experiences of the 79 children who died in 2015 and the role FACS played in their lives. The most useful approach to reading such sad information is one of openness and curiosity, to consider how this learning can be applied to the children and young people who we are working with now, and those we will work with in the future.

Chapter 3 outlines the findings of a major cohort study on neglect – analysing information from a six-year period about 68 children who died and for whom neglect was a contributory factor to their death. It is a particularly confronting read. At the same time it is so important because the stories in the chapter make powerful points about the way neglect affects children, and the power of human relationships to create change, to help, nurture and heal. I am pleased to know that this cohort review will be packaged into reflective learning kits which will be rolled out across all of NSW frontline community services centres, making sure the learning and insights are widespread.

As an organisation, and as people who care, we are still learning how to help children who have been the victim of neglect, and those who have been hurt in other ways. This report goes some way in helping us understand some of the experiences of the children we have worked with, what works well, and what we missed. It is important that all of us together use this information to help improve our child protection system and strive to provide the best care and intervention we can.



Michael Coutts-Trotter
Secretary

Executive Summary

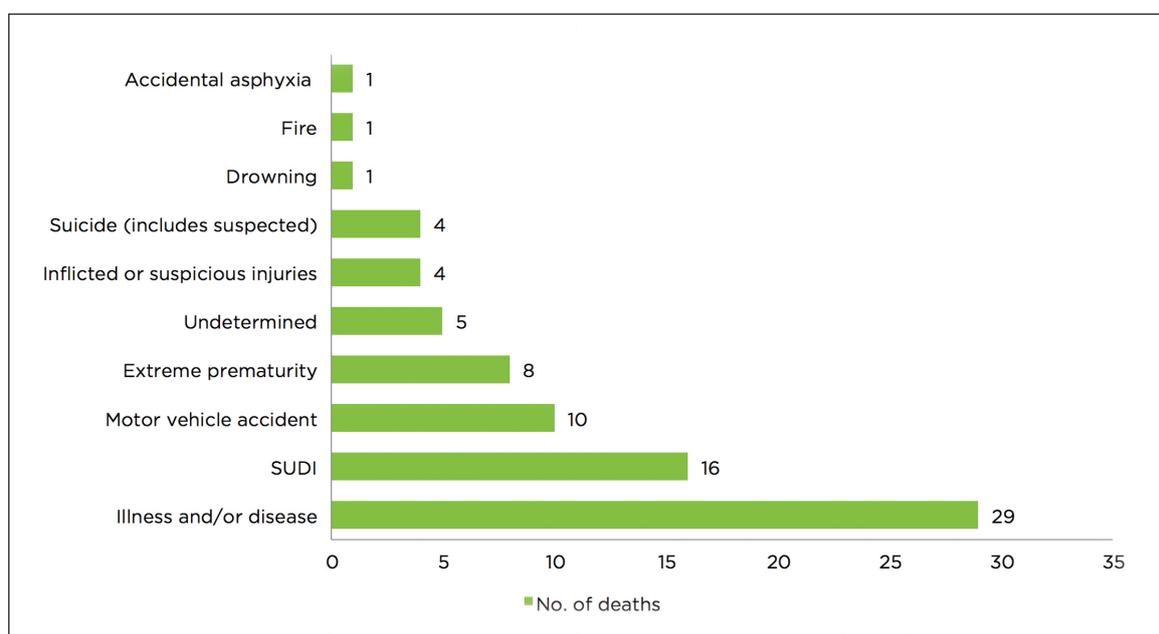
The *Child Deaths 2015 Annual Report* is Family and Community Services (FACS) sixth public report examining FACS involvement with the families of children and young people¹ who died and were known to the department.

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

Child deaths in 2015

Chapter 2 of this report summarises information about the 79 children and young people who died in 2015 who were known to FACS². As outlined in Figure 1, most of these children died in circumstances related to illness or disease, or died suddenly and unexpectedly in infancy (SUDI³).

Figure 1: Children who died in 2015 and were known to FACS, by circumstances of death⁴



- 1 The *Children and Young Persons (Care and Protection) Act 1998* defines a child as aged under 16, and a young person as aged over 16 years and under the age of 18 years. For the purposes of this report, the terms 'child' and 'children' are used to refer to both children and young people
- 2 'Known to FACS' includes children and young people (or their sibling/s) who were the subject of a Risk of Significant Harm (ROSH) report within three years of death. This also includes where a child was in out-of-home care (OOHC) at the time of their death.
- 3 For further information about SUDI, refer to Section 2.2.2 of this report.
- 4 The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

Of the 79 children who died in 2015, 31 (39 per cent) were Aboriginal and/or Torres Strait Islander. This is a slight increase from 2014, when 25 children (32 per cent) were Aboriginal and/or Torres Strait Islander. The over-representation of Aboriginal and/or Torres Strait Islander children in the child protection system and in the number of child deaths has persisted over the years and the factors that contribute to this ongoing over-representation are considered in more detail in Chapter 2.

Nine children were not living with their immediate families at the time of their death, one child was placed with extended family, one was living in a residential care setting and seven children were living with authorised carers. Of the seven children living with authorised carers, three were placed with FACS carers and four were placed with non-government carers.

Most of the children (67 children or 84 per cent) who died in 2015 were the subject of a risk of significant harm (ROSH) report within three years of their death. Eleven of the 79 children who died in 2015 were not the subject of a ROSH report, but their sibling was the subject of a ROSH report prior to the child's death. One child was not the subject of a ROSH report in the three years before their death, but was in care at the time of their death.

Improving our responses to neglect

The need to improve casework practice for children experiencing neglect continues to be highlighted in the child death reviews undertaken by the Serious Case Review (SCR) unit. A cohort review was completed which involved analysis of neglect in child deaths from 2010 to 2015. For the purpose of this chapter, SCR divided the analysis into two groups of children who make up the neglect cohort. Firstly, SCR considered information from all the children who died from 2010 to 2015 who experienced neglect, including where there was a significant history of neglect within the family⁵. Secondly, we examined the circumstances of death, and the characteristics of the children who died from 2010 to 2015, and identified where neglect was a contributing factor to the child's death.

The cohort review found 293 children had experienced neglect or there was a significant history of neglect within their family. Of the 293 children, 68 died in circumstances where neglect was a contributing factor to the child's death.

A number of de-identified stories⁶ have been used throughout the chapter to highlight circumstances of death and themes. There are three practice themes:

- assessing the urgency of neglect
- understanding a child's experience of neglect
- building relationships to address neglect.

The themes acknowledge the strong association between social disadvantage and neglect and emphasise the importance of practitioners assessing neglect with as much urgency as other forms of maltreatment. The importance of knowing children and understanding their experiences to inform an assessment of the cumulative harm they may experience, including from neglect, was a key finding of the review.

5 Where the child (or sibling) had received a ROSH report about neglect, or, prior to the introduction of ROSH, where there was a significant history of neglect, such as children being placed in OOHC because of neglect.

6 These stories are taken from the experiences of children who have died, but have been de-identified to maintain confidentiality. Some of the stories are a composite of several children's experiences.

Improving the way FACS works with children and families

The last chapter of this report outlines the current and future initiatives that seek to strengthen the child protection system. There is a particular focus this year on initiatives that enhance our work with vulnerable teenagers and working with children who experience neglect.

In 2016–2017 financial year FACS is changing how it works with vulnerable families so children have better lives. New evidence-based intensive family preservation and restoration programs will deliver services to 1,000 additional children and their families. Half of these places will be dedicated to Aboriginal and/or Torres Strait Islander children and their families.

FACS will invest \$190 million over four years to help a range of organisations deliver intensive therapeutic programs aiming to prevent out-of-home care (OOHC) entries, increase exits and improve placement stability for children in care. This work builds on the current intensive family preservation program which will see \$11 million invested in 2016–2017 to support approximately 260 families.

Chapter 1: Child deaths in context

This chapter sets out the objectives of the report and outlines the context of the child protection system and processes for child death review and oversight in NSW. This assists the public and other agencies to appreciate the issues underlying child abuse at a societal level.

1.1 Child protection in NSW

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

FACS practitioners work with some of the most vulnerable children and families in the community. Many of these families live with extreme disadvantage because of poverty, lack of access to services, parental unemployment, homelessness, social isolation and reduced access to education. Often families are living with the effects of parental substance misuse, unaddressed mental health concerns and violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect⁷ and lead to many of the Risk of Significant Harm (ROSH) reports made about children in NSW.

FACS is working hard to support good child protection practice that understands how social disadvantage commonly underpins child abuse and neglect. This report shares some of the stories of families whose children have died, reflects on their experiences and considers how FACS could have worked with the families to improve their outcomes.

1.2 Examining child deaths

1.2.1 FACS child death reviews

Children in NSW with a child protection history have a higher mortality rate than those not known to FACS⁸. Other jurisdictions across Australia have similar findings⁹.

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

7 In the reference list, see NSW Family and Community Services 2014b.

8 The NSW Child Death Review Team found that children with a child protection history had 1.4 times the mortality rate than children without a history. That is, of the 6,152 deaths of children aged 0–17 over 2002–2011 in NSW, 1,205 (19.6 per cent) children had a child protection history. See NSW Child Death Review Team 2014.

9 Previous contact with child protection services is often noted as a common factor in child death reviews. See Australian Institute of Family Studies 2014.

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

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

Serious Case Review unit

The Serious Case Review unit (SCR)¹⁰, which sits within the Office of the Senior Practitioner (OSP), reviews FACS involvement with the families of children who have died and were reported (or their sibling was reported) to be at ROSH within three years prior to their death. The unit also completes a review where a child was in care when they died.

These reviews consider how FACS systems at a local and organisational level impacted on practice with the families of children who died. The review process seeks to examine learning opportunities for practitioners who work with families by not only identifying practice issues but also promoting good practice¹¹. This in turn can lead to broader systems improvements.

Making recommendations from serious case reviews

In June 2016, FACS enhanced its approach to making recommendations from complex reviews. This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. On average, the OSP reviews 110 families each year. Approximately 80 of these are child death reviews and 30 are serious cases or casework specialist reviews. Many of the reviews result in recommendations by the OSP aimed at improving direct casework with the family, however a small portion of the reviews are complex and have implications for state-wide practice and systems.

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

Practitioner support and consultation

When a child dies, SCR provides practical support to practitioners straight away so they can get on with the important job of supporting families, assessing the safety of other children in the family and offering support to the family. In many instances SCR works together with casework staff to understand contextual information, and to reflect critically on practice. Despite this being an understandably difficult process for staff, SCR is continually impressed by the courage and openness shown by FACS practitioners and their obvious determination to learn from a child's death.

¹⁰ Formerly known as the Child Deaths and Critical Reports unit.

¹¹ What practice means, in this context, is the way the Department, via casework staff, responds to reports about the safety of children.

Practitioners are often given an opportunity to talk about their thoughts about their work with a family, including any contextual factors or systemic issues they consider relevant, and they are consulted about recommendations aimed at practice and system improvements. SCR provides practitioners with the opportunity to read the review and any critique of their practice.

The staff consultation process is critical because, done well, it reduces the risk of the child's death negatively impacting their future practice with other vulnerable children. It can also reduce staff defensiveness and enhance the quality of information gathered, leading to robust analysis. If review processes are to lead to genuine learning and practice/system improvement, and if they are to support staff to work differently with future children, then a process that allows staff the opportunity to understand what has been said about their work is crucial. If staff feel they have been consulted, they are also more than likely to accept the review findings, even those that are critical of practice. SCR's experience is that consultation can also impact positively on the openness of other staff engaging with the review process in the future.

Turning child death reviews into learning

There is considerable learning from child death reviews, and the OSP looks for opportunities to share the learning proactively with practitioners across FACS. Some examples of the ways FACS learns from child death reviews are highlighted below.

Child deaths annual reports – These reports are published at the end of each calendar year, providing information about the children who died, including their characteristics, the circumstances of their deaths, and how FACS responded to the families before and after their death. The reports aim to engage practitioners and the community in the stories of the children who have died, as well as highlighting the complexities of child protection work in NSW.

Cohort reviews – Each year SCR undertakes a cohort review, which looks at a group of children who died and were known to FACS, who share common statistical characteristics. Previous reviews include an analysis of the deaths of:

- vulnerable teenagers (2014)
- babies who died suddenly and unexpectedly (2013)
- children who were reported to be at ROSH because of domestic violence (2012)
- children who had young parents (2011).

This year SCR completed a cohort review of children who died from 2010 to 2015 and who experienced neglect. Firstly, the review considers information from all the children who died from 2010 to 2015 who experienced neglect or for whom there was a significant history of neglect within the family¹². Secondly, the review examines the lives of the children where neglect was a contributing factor to the child's death¹³. Chapter 3 of this report presents the data, trends and findings from this cohort review. Key themes are discussed to inform future practice with children and families experiencing neglect.

12 Where the child (or sibling) had received a ROSH report about neglect, or, prior to the introduction of ROSH, where there was a significant history of neglect, such as children being placed into OOHHC because of neglect.

13 This means that a parent or carer's action contributed to or resulted in the child's death, such as failure to provide for basic needs such as food, clothing, shelter or medical care; failure to provide adequate supervision; a significantly reckless or careless act; or where information from medical professionals that suggested neglect contributed to the child's death.

Practice review sessions and other forums – The OSP regularly conducts ‘practice review’ sessions with practitioners following a child death review. These sessions support practitioners to reflect on what worked well, what could have been done differently and how learning could be applied to work with other families. The sessions also give staff an opportunity to share their expertise and insights about a family or about the broader issues raised in the review.

The stories of children who have died are also at the heart of many broader OSP learning forums. For example, the stories about children who have died often inform the OSP’s Research to Practice seminars and the OSP’s quarterly report shares news about learning from child death reviews or cohorts.

1.2.2 Public and inter-agency understanding of child deaths

In providing public information about the circumstances surrounding individual child deaths, FACS is committed to protecting the privacy of vulnerable families who are impacted by the death of a child¹⁴. The NSW Parliament has also responded by protecting privacy and confidentiality in a range of legislation that governs the disclosure of information on individual child deaths¹⁵.

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

Child deaths and the media

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

Every year a small number of child deaths are the subject of considerable media attention and scrutiny. These deaths often involve children who have died as a result of abuse by a parent or carer. Understandably, these stories spark strong reactions from the community. The media plays an important role in supporting the community to gain a better understanding of child deaths, however there remains an ever-present risk for the child protection system in the face of media scrutiny and the impact this may have on vulnerable children. The challenge is to ensure that, in the face of public demand for immediate change, the learning from the death of a child results in considered system reform. Professor Eileen Munro¹⁶ identified:

A one-dimensional view, however, can impact on the child protection system in a way that makes it less safe for children. A lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among child protection workers can also be damaged, leading to more workers leaving the profession and making it more difficult for the profession to attract candidates and retain skilled staff.¹⁷

14 Although information about children and young people who have died is given in this report, the identifying details of the families have been removed to protect their privacy.

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

16 Professor Eileen Munro is a Professor of Social Policy at the London School of Economics specialising in child protection research.

17 See Munro 2011, p. 11.

Recent research has indicated that high profile child deaths can weaken the identity of a child protection service and emotionally affect practitioners, causing feelings of distress, poor communication with management, lowered confidence and lowered morale among the workforce^{18,19}.

Review work undertaken by SCR has highlighted the impact the death of a child can have on staff when there has been extensive coverage in the media. Practitioners may adopt a potentially unhelpful defensive response, leading them to become too cautious, and an overly intrusive approach with families and they may not recognise opportunities to build safety for a child within their family. Defensive practice can also paralyse the judgement of a practitioner and reduce their belief that families can achieve positive change²⁰.

At an organisational level, the FACS Care and Protection Practice Framework and Practice Standards help leaders acknowledge the uncertainty of the work and share the risk between workers and management. The Framework and Standards provide a foundation to support work with families and address core areas of work, including relationship-based practice, critical reflection, developing expertise and sharing risk. Within these frameworks, FACS child death review work acknowledges that reviews are one of many ways to create a culture of continual learning, which can encourage the department to reflect critically on practice and how the broader system impacts on the lives of children and families.

1.2.3 Child death oversight in NSW

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

NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which have occurred in a care setting. The aim of this function is to review the causes and patterns of those deaths and identify ways they can be prevented or reduced. The Ombudsman is required to report to Parliament every two years. The last report of Reviewable Child Deaths was tabled in June 2015 and the next report will be tabled in 2017.

NSW Child Death Review Team

The Child Death Review Team (CDRT) reviews the deaths of all children in NSW with the objective of preventing and reducing child deaths. The Ombudsman is the convenor of the CDRT. The team includes the Advocate for Children and Young People, the Community and Disability Services Commissioner, representatives from other government departments (including FACS), and individuals with expertise in relevant fields, including health care, child development, child protection and research methodology. The CDRT reports annually to the NSW Parliament about its work, including research projects.

18 See Cleborun-Jacobs 2013.

19 See Taylor 2008.

20 See Turnell & Edwards 1999.

The CDRT reported that the deaths of 504 children and young people were registered in NSW during 2015²¹. These figures differ from FACS data, highlighting important differences between FACS and CDRT:

- FACS may include NSW children who died in another state in its annual total of child deaths, while CDRT reports on those cases separately and does not include them in the annual total.
- CDRT does not include children who died in care in the 'child protection history' category²².
- CDRT reports on the deaths of children and young people who were reported to FACS but whose reports did not reach the statutory threshold of ROSH.
- In addition to reporting on the deaths of children who were known to FACS, CDRT also includes children who were known to Child Wellbeing Units²³.

NSW Police Force and NSW Coroner

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

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

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

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

Domestic Violence Death Review Team

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

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths²⁴
- establish and maintain a database to identify patterns and trends relating to such deaths
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

21 Information received from NSW CDRT, 2016.

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

23 The Child Wellbeing Units established in NSW Health, the NSW Police Force, and the NSW Department of Education assist mandatory reporters in government agencies to ensure that all concerns that reach the threshold of ROSH are reported to the Child Protection Helpline. In other cases, they identify potential responses by agency or other services to assist the child or family.

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

The death of a child in the context of domestic violence is subject to review by the team. The team's fourth report (2013–2015) was released in 2015. In 2016, the Domestic Violence Death Review Team moved to biennial reporting,²⁵ with the next report due to be tabled in Parliament in October 2017.

Children's Guardian

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

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

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

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

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

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

In response to the significant progress that has been achieved in transitioning the provision of statutory OOHC services from the government to the non-government sector, the SCR unit is working with non-government partners more often as part of the review process. The deaths of children in NGO OOHC settings have led to a broadening of review mechanisms, with some reviews being undertaken jointly and others separately. This flexible and collaborative model of review provides the opportunity for all services to consider their involvement with children and young people and to share reflections and learning in order to improve service provision to benefit all children in care.

²⁵ The Crimes (Domestic and Personal Violence) Amendment (Review) Bill 2016 passed the NSW Parliament on 21 June 2016.

Chapter 2: Child deaths in 2015

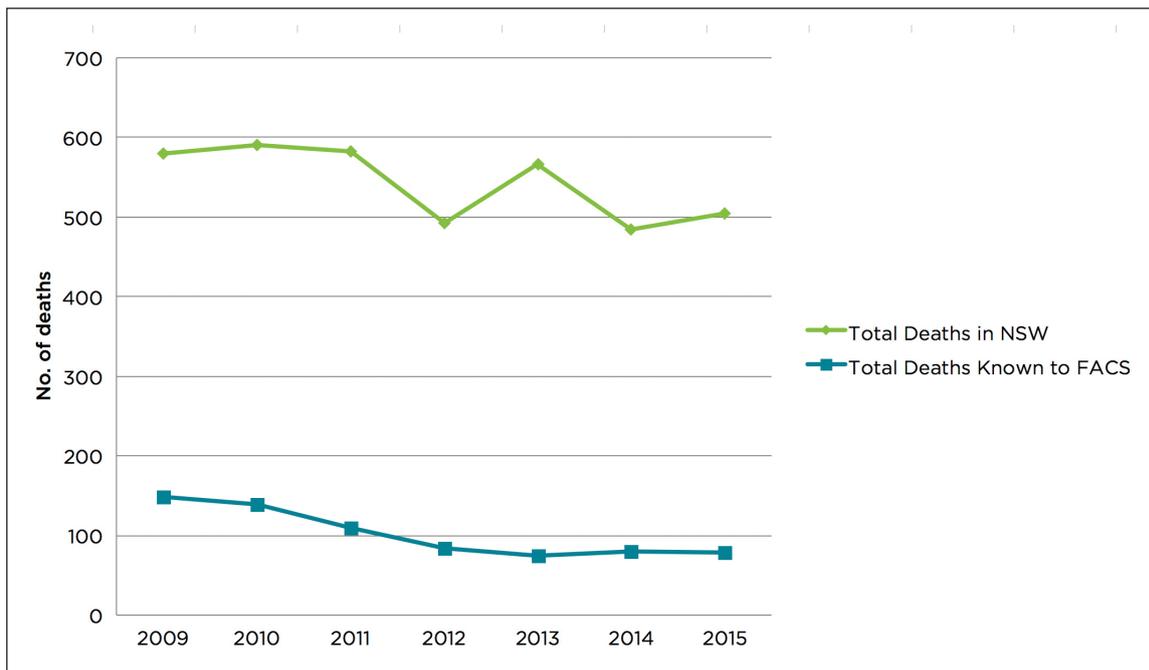
This chapter summarises information about the children and young people who died in 2015 and who were known to FACS prior to their death. It includes the characteristics of the children including their age, gender and Aboriginal and/or Torres Strait Islander status. Analysis also considers their child protection history, the response of FACS prior to and following the child's death, and the circumstances in which the child died.

The chapter provides context to the deaths of the 79 children who died in 2015 and while it cannot tell the full story of each of the children's lives, it aims to build a picture of the circumstances in which these children died and to reflect on any opportunities to improve responses to children, young people and their families.

2.1 Child deaths in NSW in 2015

Between 1 January 2015 and 31 December 2015, the deaths of 504 children were registered in NSW²⁶. In the same period, 79 of these children who had died were known to FACS²⁷.

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to FACS, 2009–2015²⁸



²⁶ Information provided to FACS from the NSW CDRT, 2016.

²⁷ 'Known to FACS' includes children and young people (or their sibling/s) who were the subject of a Risk of Significant Harm (ROSH) report within three years of death. This also includes where a child was in out-of-home-care (OOHC) at the time of their death.

²⁸ FACS and NSW CDRT, 2016.

The number of deaths in 2015 is similar to 2014²⁹. Since 2009 there has been an overall decline in the number of deaths of children who were known to FACS. The overall decline has been previously and consistently attributed to the introduction of the ROSH threshold, which was proclaimed on 24 January 2010³⁰. This legislative change resulted in lower numbers of reports about children meeting the threshold for reporting to FACS.

There was an initial decrease in the numbers of children reported at ROSH but this trend started to reverse in the second half of 2012 when reports about children at ROSH increased. Between 2013–2014 and 2014–2015 ROSH reports have remained relatively stable.

The number of deaths of children who were known to FACS declined initially after the legislative change to ROSH and there has only been a marginal increase since 2013³¹. Given the criteria for FACS reviews of child deaths includes children and young people (or their siblings) who were the subject of a ROSH report within three years of the death, the impact of the overall increase in ROSH reports may not be immediately evident in the child death data^{32 33}.

The number of children who were known to FACS and who died in 2015 (79) represents 0.1 per cent of the total number of children reported to FACS that year. This proportion is consistent with previous years' findings.

2.2 Circumstances of child deaths

FACS receives information about the medical cause and circumstances of a child's death from the NSW State Coroner and the NSW Ombudsman. FACS relies on these sources to report on the circumstances of the child's death. Following the death of a child, FACS completes a review of the department's work with a child and their family, including information from their child protection history and the work completed by practitioners. These reviews, along with the circumstances in which a child died, provide a context for FACS response prior to and following the child's death.

Figure 3 describes the circumstances of death in which all children known to FACS died in 2015. Similar to previous years, most of the deaths in 2015 were associated with illness and/or disease and sudden unexpected death in infancy (SUDI)³⁴. This year, deaths from motor vehicle accidents, followed by extreme prematurity, were the third and fourth most common circumstances of death.

29 There were 80 deaths of children known to FACS in 2014. The published figure was 79 deaths, however FACS was notified of one additional death after publication of the *Child Deaths 2014 Annual Report*.

30 On 24 January 2010 the threshold for reporting to FACS changed from 'risk of harm' (ROH) to 'risk of significant harm' (ROSH).

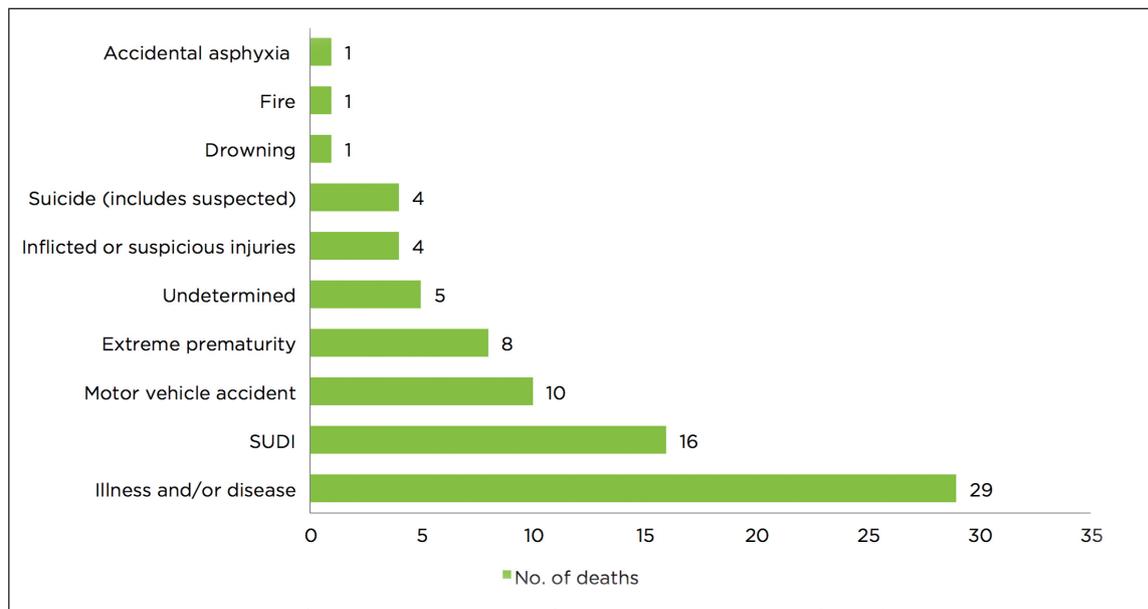
31 Deaths of children known to FACS: 2015 (79), 2014 (80), 2013 (75).

32 In 2015, FACS received 129,701 ROSH reports, involving 75,346 children. This was an increase from the previous year of 2,513 ROSH reports and 1,320 children reported to FACS. In 2014, FACS received 127,188 ROSH reports involving 74,026 children. This was an increase from the previous year of 10,818 ROSH reports and 4,859 children reported to FACS. In 2013, FACS received 116,370 ROSH reports involving 69,167 children.

33 Information provided by FACS Business Reporting Unit.

34 For further information about SUDI, refer to Section 2.2.2 of this report.

Figure 3: Children who died in 2015 and were known to FACS, by circumstances of death³⁵



The categories used to describe the circumstances of death may be different from those for cause of death. For example, the cause of death could be multiple injuries but the circumstances of death could be suicide, motor vehicle accident or an inflicted or suspicious injury.

Table 1 compares the circumstances of death for children who were known to FACS and who died between 2012 and 2015. Despite little change in the overall number of deaths in 2014 and 2015, the percentage of children who died in each category has changed in some areas. It should be noted that figures are subject to fluctuation across years due to the small numbers. Conclusions should not be drawn about these changes. Changes noted include:

- a decrease in the number and proportion of children dying in circumstances of extreme prematurity
- a decrease in the number and proportion of children who drowned
- a slight increase in the number and proportion of children dying in circumstances of illness and/or disease
- an increase in the number and proportion of children dying in a motor vehicle accident.

³⁵ The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

Table 1: Circumstances of death for children who died between 2012 and 2015 and were known to FACS³⁶

Circumstance of death	2012		2013		2014		2015	
	no.	%	no.	%	no.	%	no.	%
Accidental asphyxia	0	0	1	1	0	0	1	1
Accidental choking	0	0	0	0	1	1	0	0
Drowning	5	6	3	4	5	6	1	1
Drug overdose (self-administered)	2	2	0	0	1	1	0	0
Extreme prematurity	13	15	15	20	18	21	8	10
Fire	0	0	2	3	0	0	1	1
Illness and/or disease	25	30	22	29	27	34	29	37
Inflicted or suspicious injuries	2	2	2	3	3	4	4	5
Motor vehicle accident	7	8	6	8	3	4	10	13
Other accidental injury	1	1	1	1	0	0	0	0
SUDI	16	19	16	21	14	18	16	20
Suicide (includes suspected)	12	14	5	7	6	8	4	5
Undetermined	1	1	2	3	2	3	5	6
TOTAL	84	100³⁷	75	100	80	100	79	100³⁸

2.2.1 Deaths from illness and/or disease

Deaths from illness and/or disease account for the greatest proportion of child deaths in 2015. The data provides further information about the circumstances and experiences for these children.

In 2015, 29 children who were known to FACS died from an illness and/or disease. The number and proportion of children who died from an illness and/or disease increased slightly in 2014 and 2015, as shown in Table 2.

Table 2: Children who died from an illness and/or disease between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	25	22	27	29
% of deaths	30	29	34	37
Age range	0–16 yrs	0–17 yrs	0–17 yrs	0–17 yrs
Aboriginal and/or Torres Strait Islander	5	8	6	6

Of the 29 children in 2015 who died from an illness and/or disease, 21 had been diagnosed with a medical condition³⁹ and 14 had a diagnosed disability before their death. Nine of the 29 children had both a medical condition and a diagnosed disability before their death.

³⁶ Note that these data may have changed from previous years' reports due to new information and changes in reporting methods.

³⁷ Percentage does not add to 100 because of rounding.

³⁸ *ibid.*

³⁹ This figure is based on information known to FACS. It is possible that more children had an existing medical condition prior to their death that was not reported to the department.

Age was a feature of the children who died from an illness and/or disease with 12 of the 29 children dying before they were 12 months of age.

Of those babies under the age of 12 months when they died:

- three died at birth
- four died within a month of their birth
- two died within three months of their birth
- two died within six months of their birth
- one died between seven and 11 months of their birth.

Reported risk concerns for children who died from illness and/or disease

Recognising the challenges faced by parents helps FACS to understand and better support families to keep their children safe:

- For 19 of the 29 children (65 per cent), reports about neglect were received about the family prior to the child's death
- For 18 of the 29 children (64 per cent), reports about domestic and family violence were received about the family prior to the child's death
- For 10 of the 29 children (34 per cent), there were reported concerns about parental drug and/or alcohol misuse prior to the child's death.

Of the 12 babies who died within 12 months of their birth from illness and/or disease, the following issues were reported⁴⁰:

- neglect (nine, or 75 per cent of babies)
- domestic and/or family violence (eight, or 66 per cent of babies)
- alcohol and other drug misuse (seven, or 58 per cent of babies).

Most of the reports for children who died before they were 12 months of age were related to concerns identified in the prenatal period and about the unborn child's siblings.

Substance use in pregnancy

There is evidence to suggest that drug exposure in pregnancy can harm the developing foetus and that children exposed to substance use in pregnancy are at a higher risk of:

- premature birth
- low birth weight
- difficulty with sleeping and waking, and 'especially with opioid-exposure withdrawal symptoms'⁴¹.

Pregnancy is a key life stage where an expecting parent may be more inclined to make positive changes for their child. It can present a 'window of opportunity' for the provision of appropriate services⁴². By engaging with 'at risk' pregnant women, practitioners can offer prenatal support or services to improve the health outcomes of newborns and their mothers and lessen the likelihood of future abuse and neglect⁴³. While there are challenges in engaging families with unborn children, Henry's story below demonstrates how it can be an opportunity for change.

40 Note that some babies had more than one issue reported and may be represented in several categories.

41 See Abdel-Latif et al., Burns et al. and Jones & Kaltenbach as cited in Australian National Council on Drugs 2015, p. 11.

42 See Butler as cited in NSW Family and Community Services 2011.

43 See Olds et al. as cited in Watson 2005.

Henry's story

Henry was born extremely ill, with multiple birth defects that were identified while his mother, Theresa, was pregnant. His health needs meant he needed ongoing care in hospital when he was born. Sadly, he died in the hospital when he was only a few months old.

Henry was first reported to FACS while Theresa was still pregnant. Theresa's drug and alcohol misuse was already affecting her care of Henry's siblings, James and Eleanor. Both children were still young and James had significant health needs. There were also concerns that Josh, Theresa's partner, regularly assaulted her in front of James and Eleanor and while she was pregnant with Henry. Josh was incarcerated after he seriously assaulted Theresa.

FACS worked with Theresa about halfway through her pregnancy, after she found out that Henry was going to be born with serious health complications.

Theresa's pregnancy was an opportunity for FACS to help. The relationship between the caseworker and Theresa led to Theresa identifying that she was worried about her children, their future and how her drug misuse and the violence they had witnessed had affected them. She was committed to making change. Caseworkers helped her to link in with support services to care for herself during her pregnancy and develop her parenting skills to care for James and Eleanor. The hospital monitored Theresa's health during her pregnancy and referred her to a substance use in pregnancy service (SUPPS) that was able to provide clinical support to help her understand and address the risks associated with her drug use and to provide help and support to address this. FACS completed an assessment with Theresa that identified both her strengths and the things that needed to change so that she would be able to safely care for all her children.

2.2.2 Sudden unexpected death in infancy

Sudden unexpected death in infancy (SUDI) is the term for the death of seemingly healthy babies aged under 12 months old who die suddenly, without warning, and in circumstances that include:

- unexpected or unexplained circumstances at autopsy (meeting the criteria for sudden infant death syndrome – SIDS)
- an acute illness that was not recognisable by carers and/or health professionals as potentially life threatening
- an existing health condition that was not previously recognised by health professionals
- deaths resulting from accident, trauma or poisoning where the cause was not known at the time of death⁴⁴.

In most circumstances, these babies died after they had been placed to sleep.

44 See NSW Child Death Review Team 2012.

Table 3: Babies who died suddenly and unexpectedly between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	16	16	14	16
% of deaths	19	21	18	20
Age range	0–5 mths	0–10 mths	0–6 mths	0–11 mths
Aboriginal and/or Torres Strait Islander	4	9	3	12

As shown in Table 3, in 2015 the deaths of 16 babies were classified as SUDI⁴⁵, comprising 20 per cent of deaths of all children known to FACS for the year. Post-mortem reports were available for 13 of the 16 babies. The reports provide the following cause of death information:

- undetermined or unascertained (five babies)
- SIDS⁴⁶ (six babies)
- ascending pyelonephritis⁴⁷ (one baby)
- presumed epilepsy⁴⁸ (one baby).

Of the 16 babies who died suddenly and unexpectedly in 2015, one or more modifiable risk factors were found in 10 families. A modifiable risk factor (characteristics in an infant’s sleep environment) increases the risk of SUDI and includes:

- the baby sleeping with their parent
- the position the baby was placed to sleep
- the baby sleeping with loose bedding
- exposure to cigarette smoking
- the baby being prop-fed with a bottle^{49, 50}.

The high number of children who die suddenly and unexpectedly in infancy reiterates the need for practitioners to be sensitively attuned to the modifiable risk factors, be clear in their messages about safe sleeping, and engage in training to keep their knowledge and skills up to date. One of the significant findings in 2015 was that 12 of the 16 babies who died in circumstances of SUDI were Aboriginal and/or Torres Strait Islander. SIDS and Kids provides a range of resources for Aboriginal and/or Torres Strait Islander families and communities to highlight the risk factors and to promote safe sleeping practices⁵¹. FACS has also developed a training package for practitioners about providing culturally appropriate safe sleeping advice to families. The Office of the Senior Practitioner’s Clinical Issues Team is also available for consultations to support practitioners to have conversations with parents about safe sleeping and to assess safety for a child where there are unsafe sleeping practices.

45 Information provided to FACS from the NSW CDRT, 2016.

46 Most SUDI are attributed to sudden infant death syndrome (SIDS), which is a classification of exclusion of cause, or a fatal sleep accident. See NSW Child Death Review Team 2015.

47 Ascending pyelonephritis is pyelonephritis caused by bacterial infection from the lower urinary tract, particularly by reflux of infected urine <<http://medical-dictionary.thefreedictionary.com/ascending+pyelonephritis>>.

48 Epilepsy is a disorder of the nervous system, characterised either by mild, episodic loss of attention or sleepiness (petit mal) or by severe convulsions with loss of consciousness (grand mal).<<http://www.dictionary.com/browse/epilepsy>>.

49 Prop feeding is defined as when you give a baby a bottle by leaning the bottle against a pillow, or other support, rather than holding the baby and the bottle <<http://www.sharecare.com/health/baby-feeding-and-nutrition/why-avoid-bottle-propping-feed>>.

50 See NSW Family and Community Services 2014a.

51 Sids and Kids <http://www.sidsandkids.org/safe_sleeping_parents.html>.

One of the ongoing challenges for practitioners when working with vulnerable families is that messages communicated to parents about safe sleeping and other risk factors are not always put into practice. This may be because parents are reluctant to change their habits, particularly if their child has become used to sleeping with them or if they have older children with whom they co-slept. Where there are risk factors, parents need to be supported to make changes and their capacity to maintain practices that promote safety for their baby needs to be assessed. It also highlights the need to be consistent, persistent and non-judgemental when talking to parents about safe sleeping.

2.2.3 Motor vehicle accidents

In 2015, 10 children died in motor vehicle accidents, as shown in Table 4. This is a substantial increase from previous years, to a trend which had been steadily decreasing since 2011. Six of the 10 children were girls. One child was under the parental responsibility of the Minister for Family and Community Services at the time of their death. Five children (50 per cent) were Aboriginal and/or Torres Strait Islander.

The NSW Aboriginal Road Safety Action Plan 2014–2017 highlights that the key risk factors for Aboriginal and/or Torres Strait Islander people and motor vehicle accidents include:

- speeding
- not wearing appropriate car restraints (seatbelts, child restraints)
- drink driving
- unsafe road conditions in remote communities.

Transport for NSW⁵² has identified strategies⁵³ to improve Aboriginal road safety, including:

- encouraging safer vehicles and child restraints through the Aboriginal Child Restraint Program; this includes education about correct installation and use of child restraints and awareness of restraint fitting stations services
- improving road safety infrastructure around remote Aboriginal communities
- connecting with Aboriginal communities to change attitudes and behaviour about drink driving, restraint use for drivers and passengers and vehicle overcrowding
- encouraging timely access to medical care following a motor vehicle accident.

⁵² See Transport for NSW 2014.

⁵³ *ibid.*

Table 4: Children who died in a motor vehicle accident between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	7	6	3	10
% of deaths	8	8	4	13
Age range	9–17 yrs	5–15 yrs	13–17 yrs	1–17 yrs
Aboriginal and/or Torres Strait Islander	1	4	1	5

Seven of the 10 children in 2015 died in a car accident while the remaining three children died from a motorcycle, motor scooter or quad bike⁵⁴ accident. These three children were boys who were under the legal age to operate a motor vehicle and were not supervised at the time of the accident.

Younger children

With the exception of 2013⁵⁵, children who were known to FACS and died from motor vehicle accidents have been aged between nine and 17 years since 2011. This changed in 2015, when six children aged between one and eight years died from motor vehicle accidents. Of the six younger children, four children were passengers in cars driven by family members.

All six children had been reported to FACS for supervisory neglect. Lack of supervision was a key feature in one of these accidents. For one child, they were unrestrained and the parent was drug affected while driving the vehicle. The remaining four children were mostly in accidents with the driver losing control of the vehicle or the vehicle colliding with another vehicle or object.

54 The Queensland Coroner held an inquest in 2014–15 into nine quad bike deaths (including child deaths). The recommendations included regulatory and legislative changes and improvements to education and training initiatives. See NSW Child Death Review Team 2014.

55 In 2013, four out of six children were between five and six years old.

Older children

Of the four children aged 13 to 16 years, two were driving the vehicle when they died. One child was being driven in a car by a friend and the other was in a car driven by a family member at the time of the accident. All four accidents were linked to risk-taking behaviours by the driver including speeding, driving unlicensed or driving on a suspended license and not wearing a helmet.

Three of the four older children had previously been reported to FACS for risk-taking behaviour, including car racing, substance misuse, self-harm and running away from home.

For practitioners, the growing number of children engaging in transport-related risk-taking behaviour highlights the importance of adequate parental supervision. While research suggests that risk-taking behaviour is a normal part of development and moderate amounts can help young people to develop their social competence, risk-taking behaviours are a major causal factor in adolescent deaths and are considered preventable⁵⁶.

2.2.4 Deaths related to premature births

In 2015, eight babies died from conditions related to their premature birth, as shown in Table 5. Seven babies died at birth or within the first 24 hours after birth, and one died within the first month.

Table 5: Babies who died from conditions related to their premature birth between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	13	15	18	8
% of deaths	15	20	21	10
Age range	0–1 mth	0–2 mths	0–3 mths	0–1 mth
Aboriginal and/or Torres Strait Islander	8	10	12	2

It is important to understand the broader social factors that may have contributed to the premature deaths of these eight babies in 2015. Perinatal mortality often reflects the health status and health care of the general population of women, their access to and quality of preconception, reproductive, antenatal and obstetric services, and health care in the neonatal period⁵⁷.

Domestic violence, maternal education, nutrition, smoking, alcohol and/or drug misuse in pregnancy and poverty are all significant social factors that may have contributed to these premature deaths.

Of the eight babies who died prematurely in 2015, FACS had received reports about all of them during their mother's pregnancy, with concerns about⁵⁸:

- the mother's drug and/or alcohol misuse during pregnancy (seven babies), and/or
- the mother being the victim of violence during pregnancy (six babies).

⁵⁶ See Chapman & Sheehan 2005.

⁵⁷ See Department of Prime Minister and Cabinet 2014.

⁵⁸ Numbers do not add to eight because issues reported to FACS during the mother's pregnancy included concerns about drug and/or alcohol misuse and domestic violence.

Domestic violence in pregnancy

Research indicates that women are at greater risk of domestic violence during pregnancy and, where women are already victims of domestic violence, there is a greater chance that it will worsen during pregnancy⁵⁹. This risk increased for younger women and Aboriginal and/or Torres Strait Islander women⁶⁰. Victims of domestic violence are at greater risk of experiencing health problems during their pregnancy and in the postnatal period⁶¹. An overseas study in 2010 found that domestic violence 'is a significant and independent risk factor for pregnancy trauma and placental abruption after controlling for factors typically associated with these outcomes'⁶².

2.2.5 Inflicted or suspicious injuries

In 2015, four children died of inflicted injuries. Two of those children were under the parental responsibility of the Minister for Family and Community Services at the time of their death and two were living with parents.

Two children were killed by a parent, and for one of those children the parent was charged with murdering their child. For a different child, a family member was charged with the child's murder.

Two of the children who died in suspicious circumstances were girls and two were boys. One child was under three months and two were under two years. One child was under nine years old.

Domestic and family violence were major themes in the child protection histories for three families. Reports were received about physical abuse in three families. Mental health problems were also a significant theme for one family.

FACS had completed a face-to-face assessment for three of the families prior to the child's death. Two families received a face-to-face assessment within 12 months of the child's death. For the third family, a face-to-face assessment was completed in 2011. FACS did not have contact with one family before the injuries that led to the child's death.

The NSW Ombudsman has identified that the 'underlying motives' for child homicides are difficult to identify, however the contexts within which abuse-related deaths occur can help to understand some of the risks prevalent before the child died. For instance, evidence of previous child abuse, murder-suicide where mental health issues were evident, family breakdown, perpetrator psychosis or where harm was not intended, such as use of drugs to pacify a child, have all featured in the deaths of children the Ombudsman's office has reviewed⁶³. It again reinforces the complex nature of child protection work.

59 See Australian Institute of Family Studies 2015a.

60 *ibid.*

61 *ibid.*

62 See Leone et al. 2010.

63 See NSW Child Death Review Team 2014.

2.2.6 Suicide

In 2015, four young people died as a result of suspected suicide, as shown in Table 6. All four had hanged themselves. Two were girls, two were boys.

Table 6: Children who died by suspected suicide between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	12	5	6	4
% of deaths	14	7	8	5
Age range	13–17 yrs	13–16 yrs	< 13 –17 yrs	13–17 yrs
Aboriginal and/or Torres Strait Islander	4	0	0	2

All four children were exposed to trauma in their childhood, including physical abuse and domestic violence, and one child was known to have been a victim of sexual assault. Each child was suffering from mental health problems⁶⁴ prior to their death and ROSH reports were received for all four in the 12 months before their deaths. Reported concerns were about risk-taking behaviour, such as unprotected sex or alcohol and/or drug misuse, and self-harming behaviours. Three young people had made a previous suicide attempt and the fourth young person had made threats to end their life.

A review of children who died by suicide revealed consistently that these children faced multiple risk factors (individual, social and contextual)⁶⁵ that heightened their vulnerability and compromised their safety. For young people known to FACS, it is often the combination of these factors that poses the greatest risk for suicide⁶⁶. Risk factors can relate to recent stressful events or triggers; for example, sexual assault, bullying or factors that are likely to increase vulnerability over time, including chronic neglect⁶⁷.

Supporting vulnerable young people continues to be a priority for FACS and is an area of child protection practice that requires intensive and thoughtful casework. A range of initiatives (discussed in Chapter 4) outline the department's commitment to supporting young people at risk.

⁶⁴ This includes a formal diagnosis of mental health issues and concerns about the young person's mental health.

⁶⁵ Individual risk factors include mental illness, substance misuse, previous suicide attempt and self-harm. Social risk factors include childhood adversity, such as a child protection history; bullying and social exclusion; sexual identity issues; and family factors, such as parental loss, divorce or discord and family depression and suicide history. Contextual risk factors include socioeconomic disadvantage, suicide in family or friends, homelessness and detention or contact with police.

⁶⁶ The suicide of young people was considered in detail in Chapter 3 of the FACS *Child Deaths 2014 Annual Report* and highlighted a number of themes from reviews to assist in understanding the risks associated with suicide.

⁶⁷ See NSW Child Death Review Team 2014.

2.2.7 Drowning-related deaths

In 2015, one child died from drowning in a swimming pool, as shown in Table 7, and this is the lowest reported since 2012.

Table 7: Children who died after drowning between 2012 and 2015 and were known to FACS

	2012	2013	2014	2015
No. of deaths	5	3	5	1
% of deaths	6	4	6	1
Age range	1–13 yrs	0–1 yrs	0–12 yrs	1–4 yrs
Aboriginal and/or Torres Strait Islander	1	2	1	0

The 2015 Royal Life Saving Society *National drowning report* highlights the significant achievements that have been made in reducing child drowning accidents in Australia. FACS now includes compliance checking for children’s access to water in the home inspection checklist, conducted as part of the assessment of FACS foster, relative and kinship care applicants. These requirements have also been extended to NGO’s providing OOHc services. Additionally, a number of information resources and fact sheets have been distributed to practitioners, foster carers and the public to raise awareness about the requirements around water safety. In Australia in 2015, 26 children under five years drowned compared to 68 drowning deaths in 1995⁶⁸. Despite a decrease in the number of deaths of children from drowning in 2015, FACS continues to identify the need to highlight the risks that can lead to children drowning including:

- safe pool fencing and swimming skills
- restricting access to water⁶⁹
- water awareness⁷⁰
- resuscitation⁷¹
- active adult supervision⁷².

68 From 1 July 2014 to 30 June 2015. See Royal Life Saving Society 2015.

69 Restricting a child’s access to water can be done by placing a barrier between the child and the water. This can be done by either placing a barrier around the water (this includes fencing a pool or spa with a self-closing and self-latching gate); closing the door to the bathroom after use; covering pools, spas and tanks; placing mesh on water features and fish ponds; and securely fastening lids on nappy buckets. Inflatable pools with a depth greater than 300mm also need to be fenced by law or by placing a barrier around the child – this takes the form of a child safe play area that can be used inside or outside the home and is especially effective for water you cannot fence like dams on farms. Keep Watch Program <<http://www.royallifesaving.com.au/programs/keep-watch-toddler-drowning-prevention-program>>.

70 Water awareness combines a range of strategies and activities designed to keep children safe when in, on or around water. These include water familiarisation, checking for and removing water hazards, setting rules around water and discussing water safety with your child. Keep Watch Program *ibid*.

71 A family member is the first on the scene in most emergency situations. In fact, many children are alive today because their parents knew how to perform Cardio Pulmonary Resuscitation (CPR) and responded quickly. For this reason alone, Royal Life Saving encourages everyone to learn CPR. Keep Watch Program <<http://www.royallifesaving.com.au/programs/keep-watch-toddler-drowning-prevention-program>>.

72 Active supervision means that a child is being constantly watched by an adult who is within arms’ reach at all times. All of your attention should be on the child and you should never leave a child alone, or in the care of an older child, when they are in, on or around the water. See Royal Life Saving Society 2015.

Practitioners need to be proactive and curious in their engagement with parents and carers to consider the potential dangers of children accessing water, and the adequacy of child safety strategies in place for a household. This includes talking to parents and carers about how problems such as alcohol and drugs, mental health problems and domestic violence may impact on a parent or carer's ability to supervise a child⁷³.

2.2.8 Other circumstances of deaths

Fire

One child died in a house fire in 2015. The child's older siblings were playing with a gas lighter and accidentally set fire to the home. The child's mother was asleep at the time of the accident and the father was not at home. Inadequate supervision was a contributing factor to the child's death. No specific reports about inadequate supervision were received prior to the accident but reports were received about physical and educational neglect, drug misuse, domestic violence and poverty.

Accidental asphyxia

One child in 2015 was strangled accidentally while they were playing at home. The family had been previously reported to FACS, however there was no association between the circumstances of the child's death and the reports.

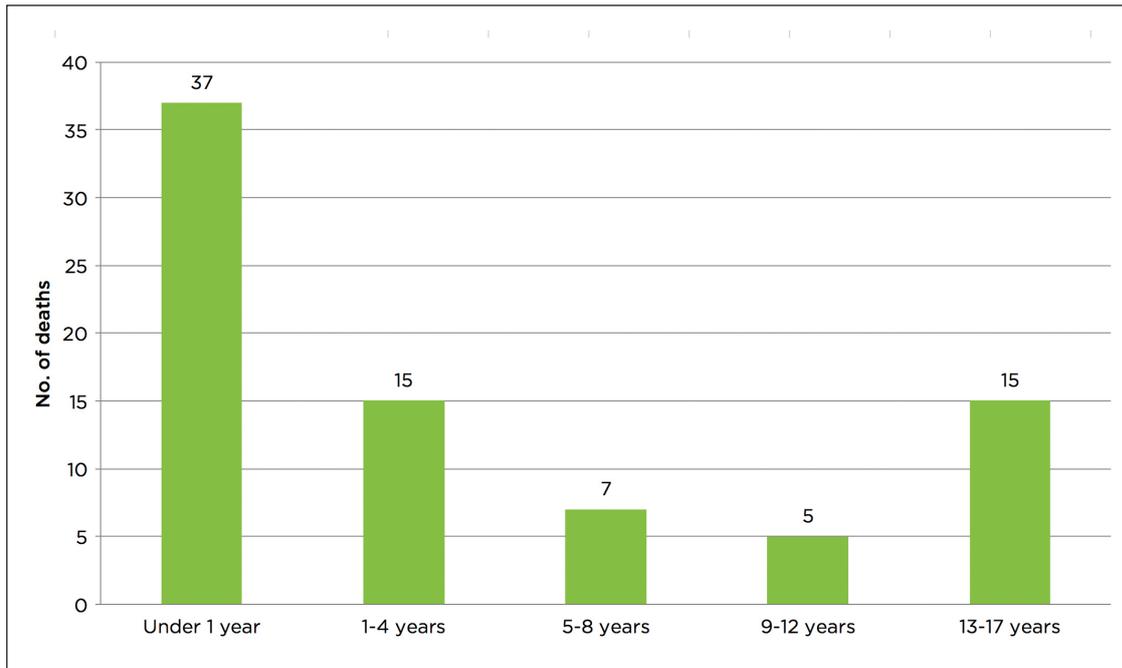
2.3 Characteristics of the children

2.3.1 Age and gender

Consistent with previous years, most children known to FACS who died in 2015 were under 12 months old (37, or 46 per cent). Boys continued to die in higher numbers than girls. In 2015, 43 (54 per cent) of the children who died were male and 36 (46 per cent) were female. Males died in higher numbers in most circumstances of death except in motor vehicle accidents (six girls and four boys), extreme prematurity (five girls and two boys) and suicide, where two males and two females died.

73 See NSW Child Death Review Team 2015b.

Figure 4: Children who died in 2015 and were known to FACS, by age



Of the 37 babies who died, 30 died within their first three months. The circumstances of the 37 deaths included:

- extreme prematurity (eight babies)
- SUDI (16 babies)
- an illness or disease (12 babies)
- inflicted or suspicious injuries (one baby).

For 14 babies who died, domestic violence had been reported to FACS before the baby died. For 13 babies who died, parental drug and/or alcohol misuse had been reported to FACS before the baby died.

Of the 79 children who died and were known to FACS, 15 (18 per cent) were teenagers aged 13 to 17 years. This is relatively consistent with the numbers reported in 2014⁷⁴. The circumstances of these 15 deaths comprised:

- an illness or disease (four teenagers)
- suicide (four teenagers)
- motor vehicle accidents (four teenagers)
- undetermined (three teenagers).

⁷⁴ Chapter 3 of the *Child Deaths 2014 Annual Report* highlighted the vulnerability of adolescents and the behaviours that can enhance their vulnerability.

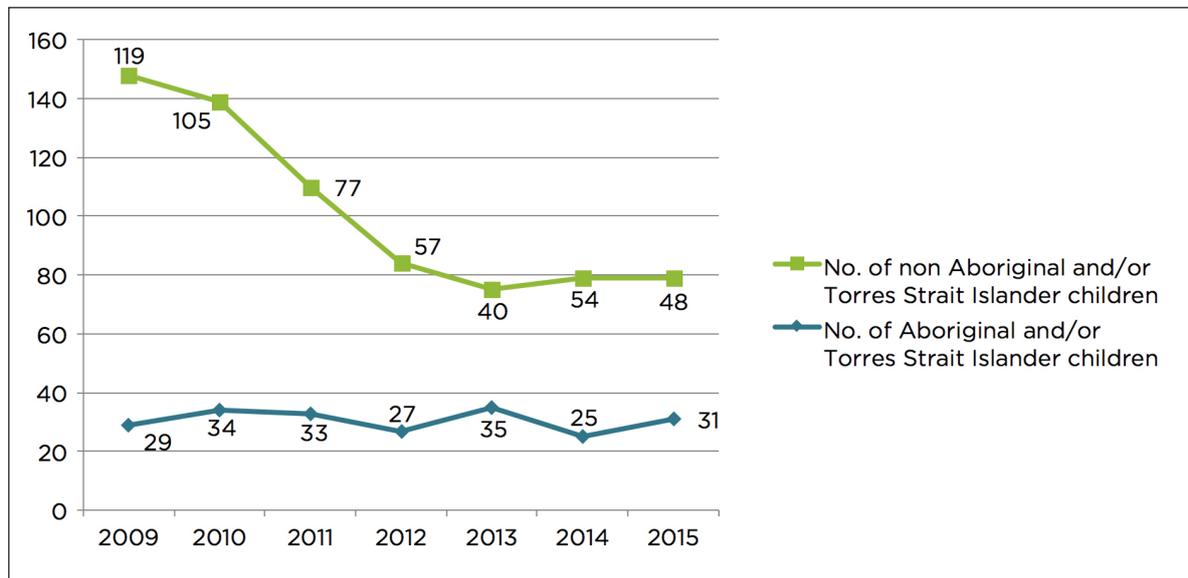
2.3.2 Aboriginal and/or Torres Strait Islander children

Note: the statistics in this section may cause distress for Aboriginal people. A list of contacts for support is provided in Appendix 1 of this report.

The significant over-representation of Aboriginal and/or Torres Strait Islander children and young people in child deaths continues to be an ongoing and consistent trend in NSW and reflects the continuing disadvantage that Aboriginal and/or Torres Strait Islander people face in NSW and around Australia⁷⁵.

In 2015 over one-third (31 children or 39 per cent) of the 79 children who died and who were known to FACS were Aboriginal and/or Torres Strait Islander. This represents a slight increase from 2014 where 32 per cent of children who died and who were known to FACS were Aboriginal and/or Torres Strait Islander. These statistics are not only sobering, but serve as a good reminder to be ethical in our practice with Aboriginal and/or Torres Strait Islander families. Practitioners need to be aware of the impact of inherent social inequalities Aboriginal and/or Torres Strait Islander people continue to face.

Figure 5: Children who died between 2009 and 2015 and were known to FACS, by Aboriginality



Since the introduction of the ROSH threshold in 2010, there has been an overall reduction in the numbers of non Aboriginal and/or Torres Strait Islander children who died and were known to FACS. However, the numbers of Aboriginal and/or Torres Strait Islander children who died and were known to FACS have remained relatively stable. Information in Figure 5 and Table 8 reflects the ongoing vulnerability of Aboriginal and/or Torres Strait Islander children.

⁷⁵ See NSW Family and Community Services 2009.

Table 8: Over-representation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures

	%
Aboriginal and/or Torres Strait Islander children as a percentage of children in NSW ⁷⁶	5
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2015 ⁷⁷	9
Aboriginal and/or Torres Strait Islander children as a percentage of children who were the subject of a ROSH report in 2015 ⁷⁸	21
Aboriginal and/or Torres Strait Islander children as a percentage of children who died in NSW in 2015 who were known to FACS	39

The over-representation of Aboriginal and/or Torres Strait Islander children in child protection and child death figures in NSW is consistent with the national picture. Each year the Australian Institute of Health and Welfare (AIHW) reports on key child protection trends in its report, *Child protection Australia*. Last year's report is consistent with previous years' findings about the characteristics of Aboriginal and/or Torres Strait Islander children within the child protection system. That is, Aboriginal and/or Torres Strait Islander children continue to be significantly over-represented in child protection reports and are more likely to remain in or be placed in OOHC⁷⁹.

Reviewing practice is key to understanding how FACS can do things better and enhance its work with Aboriginal and/or Torres Strait Islander families. One small but significant step in this direction is a commitment FACS has made to review its involvement with Aboriginal and/or Torres Strait Islander children and young people in OOHC. It is proposed the review will consider practice and decisions to ensure that all efforts have been made to achieve the best possible outcome for each Aboriginal and/or Torres Strait Islander child.

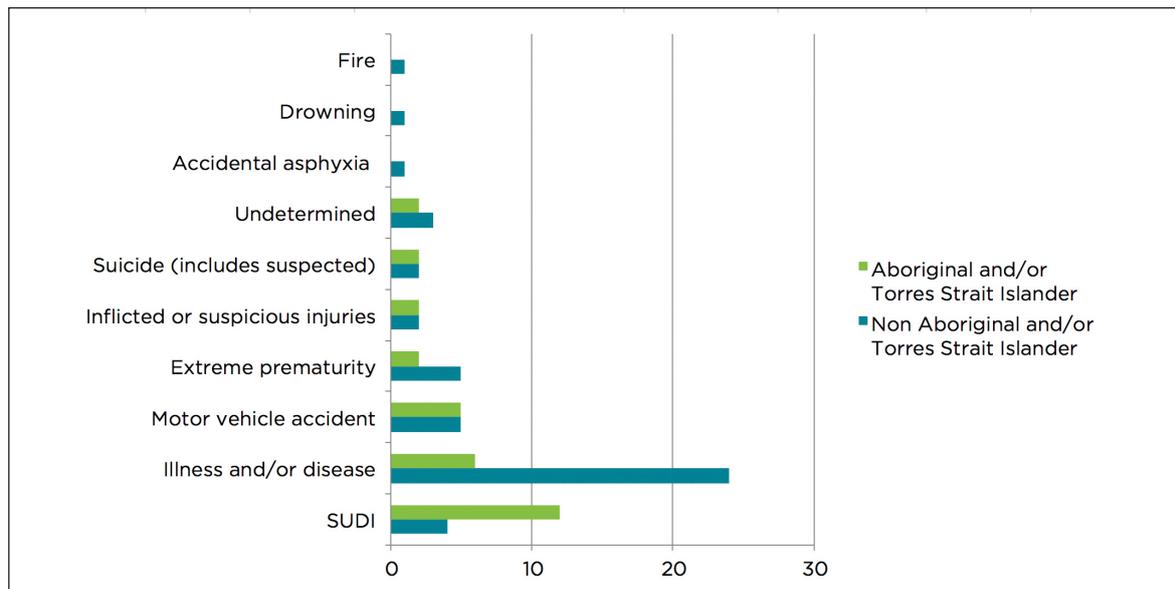
76 At June 2015, there were 92,077 (5 per cent) Aboriginal and/or Torres Strait Islander children and young people and 1,609,970 (95 per cent) non-Aboriginal children and young people in NSW. The total population of children and young people in NSW at June 2015 was 1,702,047; see Australian Institute of Health and Welfare (AIHW) *Child Protection Australia 2014–2015*, Table A47 pp. 113, (April 2016).

77 Information provided to FACS from the NSW CDRT, 2016. There were 504 total child deaths and of those 45 were Aboriginal and/or Torres Strait Islander.

78 Between 1 January 2015 and 31 December 2015, 75,346 children were the subject of a ROSH report. Of these children, 16,043 (21 per cent) were identified as Aboriginal and/or Torres Strait Islander.

79 From 1 July 2014 to 30 June 2015 Aboriginal and/or Torres Strait Islander children continue to be seven times as likely as non Aboriginal and/or Torres Strait Islander children to receive a child protection service. Aboriginal and/or Torres Strait Islander children in OOHC continue to be nine times the rate of non Aboriginal and/or Torres Strait Islander children in OOHC. For the four-year period 30 June 2010 to 30 June 2014, the rate of Aboriginal and/or Torres Strait Islander children subject to care orders has risen steadily, while the rate of non Aboriginal and/or Torres Strait Islander children has remained relatively stable, and the rate of Aboriginal and/or Torres Strait Islander children subject to a care order was higher (almost nine times) than the rate for non Aboriginal and/or Torres Strait Islander children. See Australian Institute of Health and Welfare 2016.

Figure 6: Aboriginal and/or Torres Strait Islander children who died in 2015 and were known to FACS, by circumstances of death compared with non Aboriginal and/or Torres Strait Islander children



Aboriginal and/or Torres Strait Islander children had higher rates of death due to unsafe sleeping environments (in the SUDI category)⁸⁰, illness and/or disease and motor vehicle accidents. Figure 6 highlights the over-representation of Aboriginal and/or Torres Strait Islander children in these categories. Some suggested contributing factors for higher rates of preventable deaths among Aboriginal and/or Torres Strait Islander children are intergenerational cycles of poverty, domestic and family violence, alcohol and/or drug misuse, and inadequate overcrowded housing⁸¹. Understanding some of the contributing factors to the children’s deaths can assist practitioners to focus their work with families and make changes that will enhance safety.

Of the 31 Aboriginal and/or Torres Strait Islander children who died in 2015, intergenerational risk factors were identified in seven families. These factors included the parents of these children experiencing trauma in their own childhood, including alcohol and/or drug misuse, mental health issues, domestic violence, chronic neglect and/or serious physical abuse. The mothers of 17 of the 31 children had their own child protection history (including four who were in care as a child) and 10 of the children’s fathers had a child protection history.

Socioeconomic factors were evident among eight of the 31 Aboriginal and/or Torres Strait Islander children who died in 2015, including⁸²:

- homelessness (seven children)
- family transience (five children)
- geographical isolation (one child).

The underlying systemic factors which continue to contribute to the ongoing over-representation of Aboriginal and/or Torres Strait Islander children in the child protection system include the mistreatment of Aboriginal and/or Torres Strait Islander people and the lasting ramifications of previous welfare policies, including the effects of previous separations

⁸⁰ See Section 2.2.2 for more information on SUDI deaths for Aboriginal and/or Torres Strait Islander children.

⁸¹ See Australian Institute of Family Studies 2013.

⁸² Some children experienced more than one socioeconomic factor, some none.

from family and culture; poverty; and perceptions arising from cultural differences in child-rearing practices⁸³.

Despite the continued impact that these factors have on Aboriginal and/or Torres Strait Islander communities, there is much that can be achieved in child protection practice to limit their impact. Building trust and respect is central to good work with Aboriginal and/or Torres Strait Islander families. The importance of culturally responsive practice with Aboriginal and/or Torres Strait Islander families cannot be overstated. It involves acknowledging the trauma and impact of the Stolen Generations while genuinely valuing Aboriginal and/or Torres Strait Islander culture and connection to community and working collaboratively within that context to address the safety and risk issues identified.

Family Finding

Family Finding⁸⁴ is a set of beliefs and strategies that connects children, young people and parents to family and community supports. It can be used at all stages of the child protection continuum to create a lifetime 'network' of safe family and people for children and young people.

FACS Care and Protection Practice Standards⁸⁵ provide a practical framework to guide and reflect on culturally responsive practice with Aboriginal and/or Torres Strait Islander communities. Building cultural connections for Aboriginal children is more than just exposing them to their culture. It is about helping them to have a lived experience of it.

How to engage with Aboriginal and/or Torres Strait Islander children and families⁸⁶

- Take the time to understand the multiple and entrenched forms of social disadvantage which have come about because of a history of past practices
- Work in a way that is culturally responsive and sensitive to the continued impact of the Stolen Generations
- Use and apply the Aboriginal Consultation Guide and the Aboriginal Child Placement Principles in the *Children and Young Persons (Care and Protection) Act 1998* (NSW)
- Consult often and meaningfully. Practitioners need to genuinely engage in the process and seek specific knowledge, skills and assistance to make sure casework meets the needs of the family
- Critically reflect on your own biases and attitudes to make sure this does not impact on decision-making about a child's safety
- Support self-determination by actively and genuinely engaging Aboriginal and/or Torres Strait Islander families and kin in conversations and important decisions
- Find people who are important to the child, make connections and build a network of safety and love around the child.

83 See Human Rights and Equal Opportunity Commission as cited in Australian Institute of Health and Welfare 2015.

84 See Campbell 2016.

85 See NSW Family and Community Services n.d.

86 *ibid.*

2.4 FACS response to the children who died

This section outlines FACS involvement with the families of the 79 children who died in 2015. Information is provided about the number of reports received, what the reports were about, the decisions made in response to the reports and whether the child was living with their family at the time of their death. This section also considers how FACS responded to families after their child's death.

2.4.1 ROSH reports

Of the 79 children who died in 2015, 67 (84 per cent) were the subject of a ROSH report to FACS in the three years prior to their death⁸⁷. This was slightly more than in 2014 when 62 children were the subject of a ROSH report prior to their death. Eleven of the 79 children who died in 2015 were not the subject of a ROSH report, but their sibling was the subject of a ROSH report prior to the child's death. This was slightly less than in 2014 when 18 siblings were the subject of a ROSH report rather than the child who died. One child was not the subject of a ROSH report but was in care at the time of their death.

Of the 37 babies who died, 13 received a prenatal report prior to their death.

Most of the children who died (52, or 66 per cent) did not have a lengthy child protection history with between zero and two ROSH reports received prior to their death⁸⁸. Fourteen children (18 per cent) were reported at ROSH between three and four times. Thirteen (16 per cent) were reported to FACS on more than five occasions with one child having 17 ROSH reports and another having 13 ROSH reports.

Of the 79 children who died, 23 were allocated to a caseworker at the time the child died, with 21 children receiving a face-to-face assessment prior to the child's death. Of those, seven had received a face-to-face assessment in 2015 and eight in 2014. The remaining five children had an assessment prior to 2014.

Regular quality assessments and case plan reviews enable the changing needs of children and families to be identified and plans adapted to meet those changing needs. The establishment of realistic goals and agreed case plans to address those goals in consultation with families can create change and lead to improved child safety.

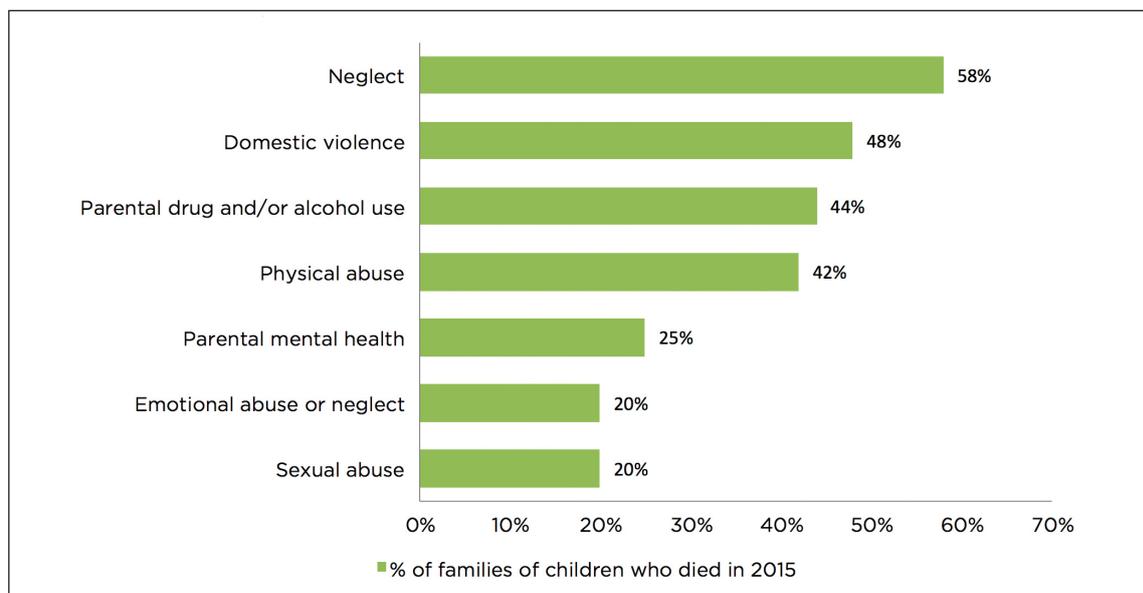
2.4.2 Reported risk concerns

Consistent with the findings from previous years, neglect, domestic violence and parental alcohol and/or drug misuse were the primary reported issues identified from the ROSH reports received for children who died in 2015.

87 Prior to 24 January 2010 'risk of harm' (ROH) was the statutory threshold for reporting concerns about a child to FACS. After 24 January 2010, 'Risk of Significant Harm (ROSH)' was introduced as the new statutory threshold for reports. Reports determined to be non-ROSH are not included in this count.

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

Figure 7: Children who died in 2015, by selected primary reported issues in ROSH reports received about them and their families⁸⁹



A total of 46 children and their families were reported to FACS due to ROSH concerns about neglect. These families were reported for either one or more types of neglect, including⁹⁰:

- physical neglect (24 families)
- supervisory neglect (20 families)
- medical neglect (20 families)
- emotional abuse/neglect (16 families)
- educational neglect (four families).

Chapter 3 of this report provides a cohort review of all the children who were known to FACS who died from 2010 to 2015 and experienced neglect.

While neglect, domestic violence and alcohol and/or drug misuse were the main issues reported for children who died in 2015, these rarely occurred in isolation. Many of the families of the children who died had co-existing risk factors present in the reports FACS received about them. Holistic assessment and family work are essential to understand the child and family’s experiences. Working in partnership with families creates opportunities for change that will enhance a child’s safety.

⁸⁹ Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.

⁹⁰ Numbers do not add to 43 as multiple neglect issues can be present in one family.

2.4.3 Children in out-of-home care (OOHC)

In 2015, there was a slight decrease in the number and percentage of children who were in OOHC when they died as shown in Table 9⁹¹.

Table 9: Children who were living in out-of-home care when they died between 2012 and 2015

	2012	2013	2014	2015
No. of deaths	7	6	10	9
% of deaths	8	8	12	11
Age range	0–17 yrs	0–15 yrs	0–15 yrs	0–17 yrs
Aboriginal and/or Torres Strait Islander	2	1	1	6
Parental responsibility of Minister (any aspect)	4	4	9	9
Placed with a relative	5	3	2	1
Placed with authorised carers	1	3	7	7
Other (e.g. placed in residential care, hospital)	1	0	1	1

Of the nine children in 2015 who died while living in OOHC:

- one was placed with family
- one was living in a residential care setting
- seven were living with authorised carers.

The circumstances of death for these nine children included illness and/or disease, inflicted or suspicious injuries, motor vehicle accident and SUDI. Two of the children's causes of death have not yet been determined. Of the seven children living with authorised carers, three were placed with FACS carers and four were placed with NGO carers.

It is important to consider that authorised carers provide care for some of the most vulnerable children, some of whom have experienced significant trauma and abuse, or who were born in extremely vulnerable circumstances. To support their role in caring for vulnerable children, carers need to be equipped with sufficient knowledge, skills and ongoing support to respond effectively and empathically to children's needs. It is crucial that carers are able to provide children with safe and nurturing environments, provide the opportunity for healthy attachments to occur, and are able to support children's ongoing cultural, health and educational needs in care. Equally important is the need for authorised carers to be able to access appropriate support networks, including practitioners, to work in partnership so that children in OOHC have every opportunity to reach their potential.

As more children are being cared for in NGO placements, NGOs need to have robust arrangements in place to manage critical incidents, mitigate the risk of incidents occurring and to guide responses to critical incidents to ensure the best outcomes for children. There have been a number of resources developed to assist NGO organisations to manage critical incidents in OOHC and FACS continues to provide support to and collaborate with the NGO sector to build capacity in this area⁹².

91 As at 30 June 2015, there were 17,585 children and young people in OOHC. This is a decrease of 7 per cent on the previous year. The reduction is largely due to the implementation of guardianship orders on 29 October 2014 – this change enabled relative and kinship carers who had full parental responsibility for a child or young person in their care to become their guardians. Children on guardianship orders are no longer considered to be in OOHC. See NSW Family and Community Services 2016a.

92 NSW Family and Community Services, *Critical incidents* <<http://www.community.nsw.gov.au/parents,-carers-and-families/out-of-home-care-transition/policies,-procedures-and-tools/critical-incident>>. See also NSW Family and Community Services 2016b.

2.4.4 How FACS responded after the child death

When a child dies due to abuse, neglect or in suspicious circumstances, or the child is in OOHC, FACS has the responsibility to assess the safety of other children living in the same household, including unborn children.

The purpose of the assessment is to identify immediate safety or risk issues for the siblings of the child who died, and to ensure that the family is linked to appropriate supports and counselling. It requires skilful and compassionate practice that is mindful of significant grief and loss being experienced by the family as well as acknowledging any current risks identified, as highlighted through Fetu's story.

case study

Fetu's story

Fetu died when he was five months old; his death was classified as SUDI. Fetu was sleeping on a mattress on the floor in between his mother Lua and father Helu. Lua and Helu were from the Cook Islands and moved to Australia in 2010.

Fetu and his five older siblings had been reported to FACS because of domestic violence, drug misuse and concerns that the family were sharing a two-bedroom house with extended family. Lua was reported to be stressed and 'not coping' with looking after Fetu and his siblings. FACS referred the family to an early intervention service which provided the family with support for three months.

After Fetu died, FACS visited the family and completed a sibling safety assessment. The caseworker spoke with Lua and Helu and gathered information from all of the services previously involved with the family. FACS became aware that Helu was under the supervision of Probation and Parole for assault and had completed courses to address his issues with perpetrating violence and emotional regulation.

The caseworker also discussed the family's circumstances during group supervision, where a range of professionals including a multicultural caseworker, representatives from the early intervention service, Probation and Parole and Housing were invited to attend. During this meeting, information about Lua, Helu and the extended family was shared and discussed. A pattern of violence by Helu toward Lua was identified by FACS through disclosures made by Lua which were not known by Probation and Parole. Cultural considerations were also discussed with guidance provided by the multicultural caseworker about the grieving processes for Cook Islander families.

FACS organised a family meeting with 15 different family members attending, including the parents, children, extended family and the family's pastor from the local church. At this meeting (held in the family home), the family acknowledged that they had concerns for the children and proposed that an aunt and uncle's home would be a safe place for the children to stay while FACS continued their assessment and supported Lua and Helu to work on their drug misuse and Helu's violence. The caseworker completed relevant background checks for the relative carers and arranged for the carers to attend carer training.

Of the 79 families of children who died in 2015 and were known to FACS, 28 (35 per cent) received an assessment by FACS following the child's death which involved:

- FACS providing ongoing case management to the family (11 children)
- the families being referred to other services and FACS ceasing their involvement (four children)
- the siblings being separated from their family and assumed into care (seven children)
- other responses such as FACS ceasing their involvement because no risks were identified.

The remaining 51 families (65 per cent) did not receive an assessment by FACS following the child's death. Of these families, a decision was made that no response was required due to:

- no risk issues identified for the surviving siblings (30 children)⁹³
- no children living in the same household who were under 18 years (14 children)⁹⁴.

The remaining seven families were not allocated due to the priority of other families. The number and proportion of families who received a sibling safety assessment by FACS following the child's death was similar to 2014. This suggests that decisions about whether to undertake a sibling safety assessment are being made appropriately and consistently.

93 The CSC is not required to complete an assessment if the death is clearly attributable to natural causes or an accident where there is an absence of suspicious circumstances involving the parents, carers or any person in whose care the parent left the child who died (Human Services Sibling Safety Policy 2010).

94 This includes where the child who died did not have any siblings or the child had siblings who were in OOHC at the time of the child's death.

Chapter 3: Improving our responses to neglect

The focus of this year's cohort review is neglect. Neglect refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted in a society as being essential for their physical and emotional development and wellbeing⁹⁵. Neglectful behaviours can be divided into different sub-categories:

- **supervisory neglect:** characterised by absence or inattention and can lead to physical harm or injury, sexual abuse or, in an older child, permitting criminal behaviour
- **physical neglect:** characterised by the caregiver's failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care
- **medical neglect:** characterised by a caregiver's failure to provide appropriate medical care; this could occur through a failure to acknowledge the seriousness of an illness or condition, or the deliberate withholding of appropriate care
- **emotional neglect:** characterised by a lack of caregiver warmth, nurturance, encouragement and support (note that emotional neglect is sometimes considered a form of emotional maltreatment)
- **educational neglect:** characterised by a caregiver's failure to provide an education and the tools required to participate in the education system⁹⁶.

Understanding that neglect is not only harmful but can be fatal should be considered by practitioners as it would be with other kinds of maltreatment⁹⁷. Practitioners must be aware of how easily the harm that can come from neglect can be minimised or downplayed, or the ways in which casework may 'drift'⁹⁸. The purpose of this chapter is to reflect on the work FACS does with children who have experienced neglect and provide learning that will support practitioners to develop their skills to be able to respond to neglect in a confident, purposeful and compassionate way.

95 See Broadbent & Bentley 1997; Bromfield 2005; Scott 2014; World Health Organization 2006.

96 See Australian Institute of Family Studies 2015b.

97 See Brandon et al. 2013.

98 *ibid.* Casework 'drift' refers to the situation where casework intervention with a child and their family over a long period has little impact. Practitioners may become accustomed to what the child is experiencing and see this as 'normal'. The case may drift without the practitioner noticing a worsening situation for the child. Brandon et al. 2013 discuss other risks of case drift including when cases are left open and unallocated for periods of time, serious concerns are not responded to effectively or there is confusion and delay in responding and decision-making is delayed.

A cohort review was completed which involved analysis of neglect in child deaths from 2010 to 2015. For the purpose of this chapter, SCR divided the analysis into two groups of children who make up the neglect cohort. Firstly, SCR considered information from 293 children who died from 2010 to 2015 who experienced neglect, including where there was a significant history of neglect within the family⁹⁹. Secondly, SCR examined the circumstances of death, and the characteristics of 68 children who died from 2010 to 2015, and identified where neglect was a contributing factor to the child's death. This meant that a parent or caregiver's action (or inaction) contributed to the child's death, such as:

- failure to provide for basic needs such as food, clothing, shelter or medical care
- failure to provide adequate supervision
- a significantly reckless or careless act
- information from medical professionals that suggested neglect contributed to the child's death.

This chapter presents the cohort review in three sections. Section 3.1 describes the circumstances of death and characteristics of the 293 children who died, and had experienced neglect at some point in their lives. Section 3.2 describes the circumstances of death and characteristics of the 68 children who died where neglect was considered a contributing factor to the child's death. Section 3.3 discusses practice themes and considers how findings from the review can inform current practice.

SCR used a number of de-identified stories throughout the chapter to highlight circumstances of death and themes. Some of these stories are based on child death reviews, and others are examples of recent casework with families who have been experiencing neglect. It is important to be mindful that reading these stories can be emotionally challenging, particularly if you have experienced the death of a child in your professional or personal life.

3.1 Children who died and experienced neglect 2010–2015

This section of the cohort review shows how prevalent experiences of neglect are among the families FACS works with. It also reveals the ways neglect harms children and can have a devastating impact on their potential. The outcome for children who experience neglect depends on the age of the child when neglect occurs, the nature and duration of the neglect, and its severity. Research is consistently finding that neglect is more serious than other forms of child maltreatment, both in terms of the numbers of children who are at risk or harmed and the severity of harm incurred, including loss of life¹⁰⁰. It has been proposed that neglect may be the core issue underlying all child maltreatment, as most children involved with child protection services have been found to contain an element of neglect¹⁰¹.

⁹⁹ Where the child (or sibling) had received a ROSH report about neglect, or, prior to the introduction of ROSH, where there was a significant history of neglect, such as children being placed into OOHC because of neglect.

¹⁰⁰ See Smith & Fong 2004.

¹⁰¹ *ibid.*

Neglect in Australia

The Australian Institute of Health and Welfare (AIHW) reiterates the prevalence of children who have experienced neglect across child protection services throughout Australian jurisdictions. In their 2014–2015 report, the AIHW showed that nationally, neglect was the second most common assessed issue for children, representing 26 per cent of all assessed issues.

The number of neglected children reported to FACS appears consistent with the national findings. From 2010 to 2015, FACS received 555,085 reports that met the ROSH threshold for 334,110 children¹⁰². Of these, 119,360 (22 per cent) ROSH reports featured neglect as the primary reported issue for 65,269 (20 per cent) children. However, neglect is likely to be underestimated, particularly if there are other reported issues that may appear to jeopardise a child's immediate safety, such as physical or sexual abuse. The co-occurrence of neglect with other forms of maltreatment is considered further in Section 3.1.2 of this chapter.

3.1.1 Circumstance of death

Table 10: Circumstances of death for children who died between 2010 and 2015, who were known to FACS and had a history of neglect

Circumstance of death	2010	2011	2012	2013	2014	2015	Total deaths	%
Accidental asphyxia	0	0	0	0	0	1	1	<1
Accidental choking	0	0	0	0	1	0	1	<1
Drowning	3	6	4	3	5	1	22	8
Drug overdose (self-administered)	1	3	2	0	1	0	7	2
Extreme prematurity	8	6	4	8	12	3	41	14
Fire	3	0	0	2	0	1	6	2
Illness and/or disease	9	16	12	13	23	17	90	31
Inflicted or suspicious injuries	3	3	2	1	2	3	14	5
Motor vehicle accident	2	2	2	6	1	8	21	7
Other accidental injury	1	1	0	1	0	0	3	1
SUDI	14	13	6	14	8	10	65	22
Suicide (includes suspected)	1	1	5	3	3	1	14	5
Undetermined	1	0	1	1	1	4	8	3
No. of deaths	46	51	38	52	57	49	293	100

Between 2010 and 2015, 567 children known to FACS died. Since 2010, neglect has consistently featured as a child protection concern for over half (293, or 52 per cent) of the children who died and were known to FACS.

Deaths from illness and/or disease (90, or 31 per cent) and sudden unexpected deaths in infancy (SUDI) (65, or 22 per cent) were the leading circumstances of death for the 293 children. Section 3.2.1 of this chapter considers these circumstances of death in more detail.

¹⁰² Information prepared by FACS Corporate Governance and Performance. This data is based on the financial year, not the calendar year.

3.1.2 Characteristics of the families

It is impossible to consider neglect without acknowledging the context of poverty¹⁰³. While poverty may not directly cause neglect, there are many families known to FACS who experience poverty. Families who experience poverty are likely to be associated with higher levels of parent stress, inadequate housing, homelessness, lack of basic needs, inadequate supervision, substance misuse and domestic violence¹⁰⁴, all of which have strong associations with neglect.

Across Australian child protection jurisdictions, 33 per cent of children were from the lowest socioeconomic areas¹⁰⁵. Aboriginal and/or Torres Strait Islander children were also far more likely to be from the lowest socioeconomic areas, comprising 49 per cent¹⁰⁶. The high number of children known to FACS who died and had a history of neglect reflects research about the strong association neglect has to social disadvantage. Many of the families reported to FACS experience social isolation, racism, limited education, poverty, transience, homelessness and intergenerational disadvantage. It is important for practitioners to understand how disadvantage may compound a child's experience of neglect, exacerbate other problems, or create barriers to a parent's ability to meet their child's needs.

The influence of housing

Insecure and/or inappropriate housing can cause additional stress to families and may have an adverse impact on the health and wellbeing of a child. Families who do not have stable housing also have fewer social connections and support, which can increase a child's vulnerability. Socioeconomic factors were evident among almost half of the families of the children in the cohort (145, or 49 per cent)¹⁰⁷:

- transience (78 children)
- homelessness (87 children)
- poverty (58 children)
- geographical isolation (18 children).

Intergenerational factors were also evident across many of the 293 children and their families, with 136 mothers and 68 fathers having either previously been reported to FACS or placed in OOHC as children. The intergenerational cycles of social disadvantage, coupled with domestic and family violence, alcohol and drug misuse and mental health problems make meeting even the most basic needs of a child all the more difficult. Understanding the underlying reasons behind neglect and the influence of social factors is an important part of the casework role to build ongoing safety and improve the lives of vulnerable and disadvantaged families¹⁰⁸.

103 See Scott 2014.

104 See Dubowitz et al. 2000.

105 See Australian Institute of Health and Welfare 2016. This was based on the postcode of the child's residence at the time of the first substantiated notification. Socioeconomic data did not include NSW because location data was not available.

106 *ibid.*

107 Numbers do not add to 145 because some children experienced more than one socioeconomic factor.

108 See Scott 2014.

Age and gender of the children

From 2010 to 2015, 176 (60 per cent) of the 293 children who died were male and 117 (40 per cent) were female. Neglect of babies can affect all areas of cognitive, social and emotional functioning¹⁰⁹. Half of the children who died were younger than 12 months (147, or 50 per cent). Bruce Perry¹¹⁰ has indicated that the impact of child neglect is often similar to that of physical trauma. Permanent changes may occur in the brain that may limit a child's ability to develop normally. Children who have been the subject of chronic neglect have problems with attachment, cognitive development, social self-confidence, social competence, perseverance in problem-solving and empathy¹¹¹.

Forty-nine (17 per cent) of the 293 children were teenagers aged 13 to 17 years. Research links early experiences of maltreatment and poor experiences of parenting during childhood and adolescence to increased vulnerability and risk taking for teenagers¹¹². The behaviour of teenagers who have been neglected may lead to poorer outcomes, particularly if they become increasingly involved in offending behaviour or drug misuse as they move into their teenage years¹¹³. As well as increased alcohol and drug misuse and risk-taking behaviour, the effects of neglect on their development may also present as a conduct disorder or recurrent victimisation¹¹⁴. These behaviours have consequences as teenagers transition into adulthood, and they may require additional support¹¹⁵.

A long-term history of neglect can have a tragic effect on a child's mental wellbeing¹¹⁶. Fourteen of the 293 children with a history of neglect died from suicide. Deaths from suicide are largely thought to be preventable and are often linked with risk-taking behaviour. Many of the teenagers who died from suicide had experienced a long history of neglect that included inadequate supervision, and exposure to parental alcohol and drug misuse. Several teenagers had been experiencing conflict with a parent or caregiver, moved away from their family home or were abandoned by a parent. Previous child death reviews showed that abandonment by a parent was often due to their inability to deal with the behaviour of their teenager that resulted from the neglect they had experienced as a child. A number of teenagers had also experienced the recent loss of a friend or family member by suicide.

Family size

A study which looked at neglect in serious case reviews¹¹⁷ in England between 2003 and 2011 identified that families with four or more siblings were more likely to be involved with statutory agencies because of concerns about neglect¹¹⁸. This research highlighted the additional stress, not least financial, that can come with a large family, and that children can become 'lost' in such consuming circumstances.

These findings appear consistent with SCR's cohort review. Of the 293 children who had a history of neglect and died from 2010 to 2015, 139 (47 per cent) had four or more siblings. Thirteen children had nine or more siblings.

109 See Perry 2000.

110 See Perry 2003.

111 See Child Welfare Information Gateway 2013.

112 See Gorin & Jobe 2013.

113 See Farmer & Lutman 2014.

114 See Brandon et al. 2013.

115 Chapter 3 of the *Child Deaths 2014 Annual Report* (see NSW Family and Community Services 2015) considers the deaths of 111 teenagers who died between 2009 and 2014 and provides further details.

116 See Brandon et al. 2013.

117 Local multi-agency reviews of child deaths or serious injury where abuse or neglect is known or suspected.

118 See Brandon et al. 2013.

Reported issues

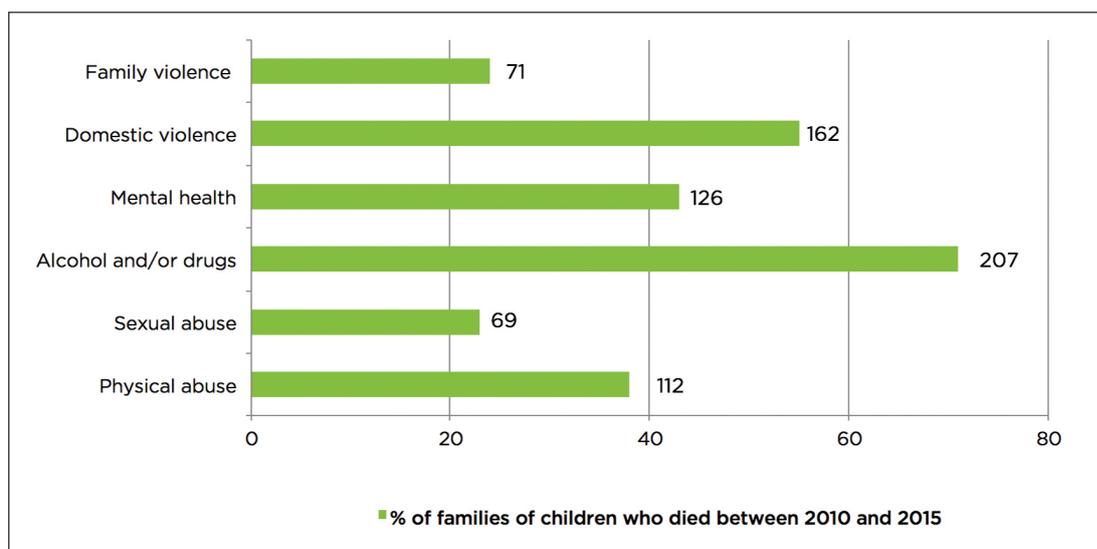
As mentioned at the beginning of this chapter, the 293 children in this cohort review had experienced neglect, or there was a significant history of neglect within the family. These families were reported for either one or more types of neglect, including¹¹⁹:

- medical neglect (105 children or 36 per cent)
- educational neglect (40 children or 14 per cent)
- supervisory neglect (129 children or 44 per cent)
- physical neglect (137 children or 47 per cent)
- emotional abuse/neglect (68 children or 23 per cent).

Physical neglect tends to be the most obvious form of neglect, and typically receives the most superficial response, such as arranging a skip bin to clean up a hazardous home environment. Supervisory neglect can mean a child is in physical danger, depending on their age and surrounding environment, when appropriate adult supervision is not being provided. While it may seem obvious, being aware of the potential for life-threatening consequences of medical neglect needs to be at the forefront of practitioners' minds when reports are received for children experiencing health issues. Understanding the link between this and parental neglect is critical when assessing a child's safety.

While fewer children were reported for emotional abuse/neglect and educational neglect, these concerns have the potential to pose a high level of risk to children. Reports about educational neglect can often provide insight into other parts of a child's life including what else a child may be experiencing at home. The consequences of educational neglect can lead to a child failing to acquire basic life skills, and poor patterns of attendance can place children at risk of not achieving their academic, personal and social potential. Similarly practitioners can miss life-threatening risks that arise when relationships are so poor that care, nurture and supervision are almost non-existent. The importance of understanding parental bonding and empathy for a child is explored in more detail in Section 3.3.2 of this chapter.

Figure 8: Children who died between 2010 and 2015, by reported issues and who were known to FACS and had a history of neglect¹²⁰



¹¹⁹ Numbers do not add to 293 as multiple neglect issues can be present in one family. These include ROH reports and ROSH reports.

¹²⁰ Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors. These include ROH reports and ROSH reports received for the child who died and/or their sibling/s.

Not only is neglect one of the most prevalent issues reported to FACS, the co-occurrence of neglect with other types of maltreatment is common. From 2014 to 2015, 28 per cent of the children reported to an Australian statutory agency for neglect were also reported to experience more than one type of harm¹²¹.

Understanding the reasons behind neglect

The importance of practitioners understanding the underlying reasons behind a child experiencing neglect is a key finding of the cohort review.

Figure 8 shows that for many of the children who experienced neglect, their families were experiencing other problems which likely contributed to the stress and dysfunction within the home. Neglect is associated with substance misuse¹²² and a significant number of children were reported to FACS because of concerns about their parents' alcohol or drug misuse. This can impact on a parent's ability to provide adequate supervision for their child, not providing their child with regular meals, not meeting a child's hygiene needs or maintaining a safe home and safe sleep environment. For children who experience this type of neglect over a period of time, they may stop attending school, and for some children, they may even take on a parenting role and care for younger siblings. Similarly, mental health problems can have a big impact on a parent's ability to comprehend their child's physical and emotional needs appropriate for their age.

Over half of the children experienced domestic violence in their home environment. This is consistent with research about the rate of domestic violence and neglect¹²³. One US study found that domestic violence preceded child maltreatment in 78 per cent of families where domestic violence and neglect co-occurred¹²⁴. The consequences of a home environment characterised by violence can jeopardise a parent's ability to bond with and care for their child. Victims are often consumed by fear of the perpetrator's behaviour and their focus is to survive and resist the violence by maintaining their own and their child's physical safety. This may mean the developmental and emotional needs of their child are, often unintentionally, neglected. Neglect stems from reduced parenting capacity and mental health problems, such as depression, or substance misuse or through the perpetrator's neglectful parenting¹²⁵. The violent partner's omission in caregiving, or their refusal to allow the other parent to respond to the needs of the child, is an active tactic used by perpetrators who use violence.

Physical abuse or sexual abuse of children may take priority of action over neglect, during decisions about allocation of families at a local office, and during the assessment of a child's safety. This is because there may be more obvious immediate and physical consequences of this abuse. While this is appropriate in some instances, practitioners must remain open in their assessment of neglect and for some of these children, they may be at a high level of risk that requires an urgent response ahead of other forms of maltreatment. This is explored further in Section 3.2.

121 See Australian Institute of Health and Welfare 2016.

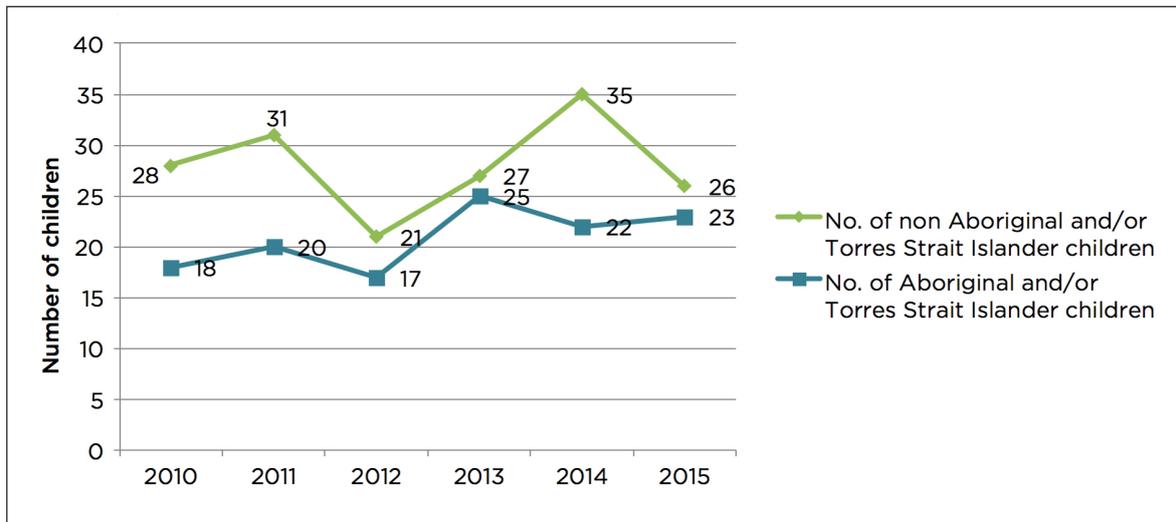
122 See Brandon et al. 2013.

123 See Antle et al. 2007.

124 See McGuigan & Pratt 2001.

125 See Coohy & Zhang 2006; Hartley 2004; and Antle et al. 2007.

Figure 9: Children who died between 2010 and 2015, were known to FACS and had a history of neglect, by Aboriginality



The numbers of Aboriginal and/or Torres Strait Islander children who experienced neglect is confronting. Between 2010 and 2015, FACS received 68,815 ROSH reports about Aboriginal and/or Torres Strait Islander children, of which 17,210 (25 per cent) had neglect as a primary reported issue¹²⁶. Between 2010 and 2015, 185 children who were known to FACS and died were Aboriginal and/or Torres Strait Islander. Of these Aboriginal and/or Torres Strait Islander children, over half (125, or 68 per cent) experienced neglect and were included in this cohort review¹²⁷.

¹²⁶ Information prepared by FACS Corporate Governance and Performance. This data is based on the financial year, not the calendar year.

¹²⁷ In the same timeframe, 383 non Aboriginal and/or Torres Strait Islander children who were known to FACS died. Of these, 168 (44 per cent) had a history of neglect.

3.2 Children who died where neglect contributed to their death 2010–2015

Although the long-term impacts of neglect are known to be detrimental, neglect is seldom perceived to be associated with fatality¹²⁸. This section of the cohort review provides an analysis of 68 (23 per cent) of the 293 children who died in circumstances where neglect contributed to their death. This included where a parent or caregiver's action (or inaction) contributed to the child's death, such as:

- failure to provide for basic needs such as food, clothing, shelter or medical care
- failure to provide adequate supervision
- a significantly reckless or careless act
- information from medical professionals that suggested neglect contributed to the child's death.

This section explores the types of neglectful behaviours that resulted in the needs of children not being met. It shares stories of the children who died and highlights the learning that can be taken from some of these tragedies to help future work with other families.

3.2.1 Circumstance of death

Table 11: Circumstances of death for children who died between 2010 and 2015, were known to FACS, and neglect contributed to their deaths

Circumstance of death	2010	2011	2012	2013	2014	2015	Total deaths	%
Drowning	3	6	4	3	4	1	21	31
Fire	2	0	0	2	0	1	5	7
Illness and/or disease	1	2	1	0	3	1	8	12
Inflicted or suspicious injuries	0	1	1	1	0	0	3	4
Motor vehicle accident	2	0	1	2	0	3	8	12
SUDI	6	3	3	4	2	3	21	31
Undetermined	0	0	0	1	0	1	2	3
No. of deaths	14	12	10	13	9	10	68	100%

Table 11 shows the various ways that neglect can manifest itself through a number of pathways to harm, and even death:

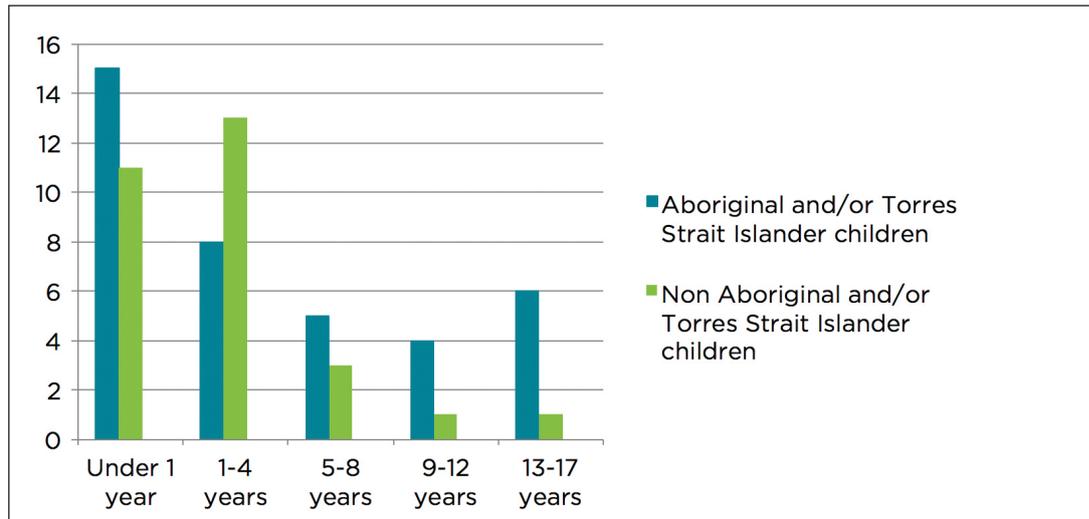
- inadequate supervision leading to tragic accidents such as drowning or a house fire
- unexplained infant deaths within a context of neglectful care or a hazardous home environment
- accidents which occur in a context of chronic neglect
- neglect of medical conditions, including injuries from physical abuse, occurring in a context of neglectful care.

¹²⁸ See Brandon et al. 2013.

The leading circumstances of death for this group were SUDI and drowning, with 21 children (31 per cent) in each category. These two circumstances of death comprised over half of the children in this group (42, or 62 per cent). Motor vehicle accidents (8, or 12 per cent) and illness and/or disease (8, or 12 per cent) were the next two highest circumstances of death. While the final causes of two deaths were undetermined¹²⁹ information available indicated neglect contributed to the child's death.

3.2.2 Characteristics of the children

Figure 10: Children who died between 2010 and 2015, were known to FACS and neglect contributed to their death, by age and Aboriginality



This section looks at some of the key demographics of the 68 children who died in circumstances where neglect contributed to their death.

Aboriginality

Of the 68 children who were known to FACS and died between 2010 and 2015, in circumstances where neglect contributed to their death, 29 (43 per cent) were Aboriginal and/or Torres Strait Islander.

Age and gender

Of the children who died 40 (59 per cent) were male and 28 (41 per cent) were female. Males died at higher rates than females across all circumstances of death, except for illness and/or disease, where males and females were the same.

There were a higher number of deaths for young children with 26 children (38 per cent) being younger than 12 months when they died. Of the 26 babies, 17 died within their first three months. With the exception of one child who died from an illness, 16 deaths were classified as SUDI¹³⁰.

¹²⁹ The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

¹³⁰ For further information about SUDI, refer to Section 2.2.2 of this report.

However, consistent with the finding of neglect and serious case reviews in England from 2003 to 2011, neglect, with the most serious outcomes, is not confined to the youngest child¹³¹. The experiences of young children create a legacy which they carry with them through their lives and as a consequence, threats to their own life can come from their own high-risk behaviour, and tragically, even suicide¹³². Of the 68 children who died, seven (10 per cent) were teenagers aged 13 to 17 years. The circumstances of these adolescents' deaths were:

- illness and/or disease (three teenagers)
- motor vehicle accidents (two teenagers)
- fire (one teenager)
- undetermined (one teenager)¹³³.

3.2.3 Accidental deaths with features of neglect

While the vast majority of the deaths in this category were accidents, a closer examination of the children who died in these circumstances revealed features of neglect that contributed to these deaths. These children also had a history of neglect reported to FACS prior to their deaths.

A key finding of the cohort review highlighted that unsafe accommodation and lapses in parental supervision can be life threatening and have devastating consequences. Twenty-one children (31 per cent) died from 2010 to 2015 as a result of drowning, and five children (seven per cent) died in house fires. While most of these were the result of a tragic accident, the cohort review showed a lack of adequate supervision was a contributing factor for almost all the children in this category. This was characterised by the absence or inattention of a parent or caregiver toward a child, appropriate for their age, development, maturity and needs¹³⁴. The deaths of children from fires and drowning highlight that practitioners need to be aware of the real and lethal risk that supervisory neglect can present. Practitioners need to engage with parents about potential hazards and respectfully challenge inappropriate strategies that may not ensure a child's safety. A common strategy that was seen across reviews was parents relying on older siblings to supervise younger siblings near water. In this context, practitioners needed to respectfully challenge parents about the use of older children and their ability and capacity to supervise their brothers and sisters. Practitioners need to be aware that talking with children can act as a measure of safety in considering their experiences of both adequate and inadequate supervision and interactions with potential hazards.

For most of these children, FACS received reports about inadequate supervision and physical neglect prior to the child's death. Similar to the findings of Brandon, Bailey, Belderson and Larsson¹³⁵, these reports conveyed the sense that the risk of accidental harm for these children was high, due to the hazardous living conditions and inadequate level of supervision.

131 See Brandon et al. 2013.

132 *ibid.*

133 This child experienced medical neglect.

134 See Scott 2014.

135 See Brandon, Bailey, Belderson & Larsson 2013.

The 21 children who drowned varied in age:

- under one year (three children)
- aged between one and four years (14 children)
- aged between five and eight years (three children)
- aged between nine and 12 years (one child).

This finding is consistent with research that children aged between one and four years have the highest risk of drowning¹³⁶. For half of the children who drowned, barriers such as fencing and gates were inadequate. Three of the children who drowned had diagnosed disabilities that meant they required a higher level of supervision than their peers.

The SCR cohort review found that FACS responses to reports about these children often involved referrals to early intervention services because practitioners considered the neglect 'low level' or 'generalised'. On some occasions FACS was aware of inadequate barriers surrounding water, however there was no urgency about the dangers associated with this hazard and there was no follow-up to ensure this hazard had been addressed.

A 2008 longitudinal study into childhood injury concluded that in order to prevent accidents, interventions need to focus on behaviour risks in the child, parental factors and household circumstances rather than on environmental or community-based risks¹³⁷.

136 See World Health Organization 2016.

137 See Reading et al. 2008.

Dasha's story

Dasha was eight years old when she drowned in an above-ground pool at the back of her family's rural property. There was no fencing around the pool, making it easily accessible. Dasha had autism and her parents often relied on her older brother Mark (12) and sister Terri (14) to keep an eye on her. On the day Dasha died, her father was at work and her mother asked Terri to watch Dasha while she went to pick up the younger children from preschool. When Terri left the house, Dasha was watching a movie in her bedroom. Shortly after her mother left, Terri told Mark she was going to make lunch and told him to watch Dasha.

Dasha was one of six children and her family were known to FACS, with numerous reports about inadequate supervision. Dasha was regularly found wandering the streets alone or with her brothers and sisters. FACS had received reports about the living conditions of the home, there was limited food in the house and the amenities did not work. Most of these reports were streamed to early intervention for a response because the concerns were about 'generalised neglect'.

When FACS visited, practitioners saw the children were in 'clean appropriate clothing' and there was food in the home. Practitioners spoke with Dasha's mother and father about the reported issues and noted that there was no fencing in the backyard or around the pool. Dasha's parents told practitioners that the children were not to go near the pool without adults, and that the older children were repeatedly told to watch out for their younger siblings.

FACS received more reports that the children were 'smelly' at school. Practitioners did not respond to the information in the reports because of 'ongoing intervention with the family'. Five months after the initial home visit, FACS developed a case plan, but the concerns about the children having access to the pool and reliance on older children to supervise a younger child with autism were not included in the case plan.

- Be aware of the risk inadequate supervision presents and the urgency in responding, particularly if poor supervision has previously been identified.
- Consider the child's capacity to address dangerous conditions.
- Practice regular critical reflection with colleagues to consider cumulative harm and avoid casework 'drift'.
- Remain curious when reported information may not appear to match what you see during a home visit.
- Be aware that children with disabilities or special needs may need more supervision than other children their age. It is important that the individual needs of each child in a family are considered and addressed in case planning.

3.2.4 Sudden unexpected death in infancy

Of the 68 children who died in circumstances of neglect between 2010 and 2015, 21 children died suddenly and unexpectedly. While the overall number of deaths classified as SUDI during this period is much higher, the deaths of these 21 children occurred in circumstances where there was a significantly reckless act by a parent or carer, or where the child was exposed to known and dangerous modifiable risks (such as characteristics in an infant's sleep environment). The number of male and female children who died was similar (10 female and 11 male) and just over half (12) were aged between one and three months. Eight of the children (38 per cent) identified as Aboriginal and/or Torres Strait Islander. Chapter 2 discusses the significant over-representation of Aboriginal and/or Torres Strait Islander children who died suddenly and unexpectedly in 2015.

Unsafe risk factors for the 21 children whose deaths were categorised as SUDI where neglect was considered to have contributed to their death included:

- co-sleeping¹³⁸ (16 babies)
- alcohol or drug misuse (15 babies)
- parent taking prescription medication combined with alcohol (one baby)
- injuries were found to the child after death (seven babies)
- parents left the child unchecked for an unreasonable length of time and/or delayed seeking medical attention after discovering the child was not breathing¹³⁹ (three babies)
- parent later charged with failing to care for the child (one baby).

While these 21 deaths were not necessarily predictable, analysis of the circumstances of the deaths highlights opportunities to work with families where modifiable risk factors are identified. In 2013, SCR completed a cohort review about safe sleeping. This review highlighted that modifiable risk factors were present in 103 of 108 babies who died between 2008 and 2012. FACS promotes a very clear message that under no circumstances should a parent sleep with their baby when they have consumed alcohol or drugs. For this cohort, FACS had received previous reports about parental alcohol and drug misuse for 18 of the 21 children (86 per cent). While practitioners may have spoken to parents about their drug and alcohol misuse, the risk of co-sleeping was not always discussed. These messages need to be continually discussed, checked and reinforced when working with a family where there is suspected or known alcohol and drug use. In response to the 2013 cohort review about safe sleeping, FACS has worked hard to improve responses in supporting parents to make safe choices when putting their babies to sleep¹⁴⁰.

138 In order to be included in the cohort review, co-sleeping needed to occur alongside other modifiable risk factors, such as alcohol or drug misuse.

139 Two children were left for close to 12 hours unchecked and one child was undressed, showered and the parent took almost an hour to seek medical attention.

140 See NSW Family and Community Services 2015. FACS developed a briefing package about safe sleeping and child deaths; a one-day training package for practitioners about the risks of SUDI; and an e-learning package in collaboration with other government agencies and non-government organisations.

While SUDI deaths can occur in any family that has a baby, they occur at a significantly higher rate for families who are known to the child protection system. In 2014, the NSW CDRT study found that SUDI mortality rates were almost 10 times as high among children with a child protection history as those children who were not known to the child protection system¹⁴¹. Families known to the child protection system are often disadvantaged, poorly resourced and present with a range of vulnerabilities such as unemployment, transience, domestic violence and parental alcohol or drug misuse. The risk factors that were evident in the histories of the 21 children and their families in this cohort included that:

- eleven of the families had been reported for physical neglect
- nine of the families had experienced transience
- six had been homeless before the child died
- ten of the children had a parent with a child protection history
- two of the families had experienced a previous child death¹⁴².

case study

Lucy's story

Lucy was six weeks old when she died. Her mother had put her to sleep in her bassinet. In the early hours of the morning, Lucy woke, was fed and had her nappy changed by her mother. Her mother took her back into bed with her and they both fell asleep. A few hours later, Lucy's father was getting ready for work and could not find Lucy. He woke Lucy's mother and found that she had rolled onto Lucy in bed. Lucy was pale and not breathing.

Police went to the home the day Lucy died and reported their concerns to FACS. They said there was clear evidence of cannabis use in the home and open alcohol bottles, both were accessible to children and the home was unhygienic. FACS went to see Lucy's parents, assessed the safety of her two older siblings, and found more hazards. They saw broken glass on the floor, poisonous chemicals next to the children's toys, water half filled in the bathtub and rotting food in the kitchen. Lucy's siblings were taken and they stayed with relatives who were assessed as able to provide care for them.

Applying the learning to practice

- Avoid judgement about the physical conditions of the home. Instead be curious about what is taking place in the home that results in it reaching an unsafe state.
- Recognise the particular vulnerability of infants in dangerous living and sleeping conditions.
- Be aware that a good relationship between a child and their parents cannot keep them safe if their living conditions are not safe.
- Talk with parents about the dangers of co-sleeping and what parents can do to change their behaviour, and check that change occurs.

141 See NSW Child Death Review Team 2014.

142 One child was stillborn and one was smothered when the mother fell asleep breastfeeding.

3.2.5 Deaths from illness and/or disease

Eight children died between 2010 and 2015 from an illness and/or disease. All of these children experienced medical neglect, in the form of a parent not providing appropriate medical care. This occurred through a parent's failure to acknowledge the seriousness of an illness or condition when a reasonable response would be to seek help.

The intersection of a child's medical needs with reported parental neglect was poorly understood across all of these children's deaths. For some of the children in this group, neglect was not considered a medical emergency, despite the life-threatening nature of the child's condition being clearly conveyed to FACS by health professionals. For others, the issue was that the risks were not always clearly conveyed to FACS. A number of practice issues were apparent across several of these reviews:

- practitioners did not understand the risks for the child and the consequences of the child's health needs not being met
- poor assessment of the care and support families' required to meet their child's health needs
- unrealistic expectations placed on teenagers to manage their own complex and often multiple health needs
- a lack of engagement with the family to understand the underlying reasons behind the lack of compliance with medical treatment
- parents were not respectfully challenged about their behaviour when medication or treatment plans were not being followed
- lack of consultation with NSW Health and clarity about the role FACS had in supporting NSW Health.

A key finding of the cohort review was the need for practitioners to understand that when safety concerns exist for a child because of their health, it is a child protection issue. The risks for these children required joint child protection and health service intervention to manage them effectively.

In management of chronic health conditions, maintaining a family's emotional health and resilience is as vital as directly following up on a child's physical progress, since one directly affects the other¹⁴³. Most parents lacked an understanding of their child's condition, but made attempts to respond to their child's medical needs, attend appointments and engage with services. For others, attempts to attend appointments were inconsistent. Factors such as a large number of medical appointments, the need to care for siblings, chaotic home environments, unpredictable care arrangements, alcohol and drug misuse, mental health problems and domestic violence meant a child's medical needs were not always prioritised.

143 See Brandon et al. 2013.

A key finding of SCR's cohort review reveals a child's experience of medical neglect reflects powerfully how the label of 'low level neglect', combined with a lack of urgency, can influence an assessment of safety and risk in a child protection response. For all eight children, FACS had received reports about medical neglect prior to their deaths. These children had complex health and medical needs and not having these needs met had a cascading affect on their social and emotional wellbeing. For example, the bullying and isolation from school peers experienced by one child because she was morbidly obese, whose clothes did not fit, and whose hygiene was described as offensive, was obviously not low level and would likely have impacted negatively on her self-esteem and social development.

Another form of medical neglect can occur where a parent deliberately withholds appropriate care. Physical abuse in the context of neglect presents a high level of risk for any child. High profile stories have shown that where children are known to be experiencing neglect, they can die in situations of horrific abuse. Between 2010 and 2015 two children died as a result of inflicted injuries. What makes these stories even more tragic is that there was a delay in getting help and obtaining medical attention.

For these two children, FACS had received reports about parental alcohol and drug misuse, domestic and family violence and mental health issues, along with reports about medical, physical, supervisory and educational neglect. The neglect issues were underestimated and therefore not managed well. The impact of issues such as transience, unstable housing, loss of support networks and reduced visibility in the community meant there was not a clear picture of risk, including risk of other forms of maltreatment.

Abdul's story

Abdul was 15 years old when he died from health-related issues associated with his multiple health diagnosis, including diabetes. He was required to take medication multiple times a day and attend regular medical appointments. However, Abdul's parents did not take him to appointments, he had no other way of getting there himself and therefore he could not renew his prescriptions and took his medication inconsistently. FACS and NSW Health records showed that Abdul had been unwell because of his condition for a number of years prior to his death.

Abdul was the sixth child and he and his siblings were reported to FACS on 28 occasions spanning 19 years. The majority of the reports were about Abdul's parents' methylamphetamine and heroin use and their neglect of the children's basic care.

Abdul's health issues were unique and presented a challenge for casework. Abdul was regularly cared for by other family members who had different levels of understanding about his health needs and there was a heavy reliance on Abdul to medicate himself. Information available to FACS suggested that medical professionals, Abdul and his parents had different views of what Abdul's health needs were. When his health deteriorated, a medical professional identified potentially fatal consequences for Abdul if he and his parents did not comply with his treatment program. The medical professional noted that Abdul's poor compliance with medication was partly due to his chaotic home environment.

FACS responded to the reports about Abdul's health, assessing them at intake, but they were not allocated for a secondary assessment or intervention. The intake assessment involved contacting the medical professional and asking them to report to the Helpline if Abdul did not attend his next appointment. The caseworker did not ask about Abdul's diagnosis, treatment plan or his parents' ability to meet his health needs and because of this, the risks for Abdul, and the intersection of his medical needs with reported parental neglect were not adequately considered and therefore not understood. The family history suggested the likelihood that Abdul's parents would comply was low and Abdul needed a joint response from child protection and health working collaboratively together.

- Understand the risks associated with non-compliance of medication.
- Engage with the child to understand their day-to-day experience of neglect.
- Assess a parent's understanding of their child's health and wellbeing needs, and their willingness and capacity to follow through with treatment plans.
- Respectfully challenge parents' behaviour when medication is given inconsistently and understand the reasons why they are not complying with medical advice.
- Be clear about the role of FACS in the intersection of medical needs and reported neglect so that a child's medical needs can be met.
- Practice strong collaboration with NSW Health, including consistency in messaging to families.

3.2.6 Transport accidents

Eight children died in transport accidents between 2010 and 2015 that were identified as occurring in circumstances of neglect. Five were male and three were female. These children were aged between two and 17 years, with half of them aged between five and eight years.

SCR reviews of these eight children found there was a significantly careless act by a parent or caregiver that resulted in direct injury to the child or a lack of age appropriate supervision that resulted in injury to the child. The eight deaths occurred in the context of:

- one child not wearing a seatbelt and two children not correctly restrained in car seats appropriate for their age
- three children being driven by a parent/caregiver who tested positive for illicit drugs and illicit drugs being found in one vehicle
- three children riding motorbikes without helmets or appropriate supervision for their age. One of the motorbikes had mechanical issues affecting the accelerator and brakes.

Five of the children who died in motor vehicle accidents were Aboriginal and/or Torres Strait Islander. This is consistent with the NSW CDRT's findings that Aboriginal and/or Torres Strait Islander children are consistently over-represented in transport deaths¹⁴⁴. Chapter 2 of this report considers the risk factors and identified strategies to improve Aboriginal road safety outlined in the NSW Aboriginal Road Safety Action Plan 2014–2017.

Similar to the group of children who died from accidents with features of neglect, these transport accidents were not predictable. Closer analysis revealed that there were features of neglect evident prior to the child's death or evidence of the parents' behaviour that contributed to the death had been reported previously:

- six of the eight children had been reported to FACS because of parental alcohol and drug misuse
- seven had been reported due to exposure to domestic violence at home
- reports about supervisory neglect had been received for five of the eight children
- for one of the children who died, FACS had received a report about the parent driving with the child unrestrained in the car prior to their death.

144 See NSW Child Death Review Team 2015a.

3.3 Practice themes

Practitioners play a critical role in assessing safety and risk for children who experience neglect. The interplay between social disadvantage and child protection concerns makes this work challenging. Child neglect is complex, with a range of possible interconnecting causes, and will often require a variety of targeted intervention responses¹⁴⁵. Early intervention responses that attempt to engage families as soon as neglect is identified are needed, as well as later intervention responses for families where early identification was not possible and neglect has become entrenched¹⁴⁶.

This section discusses three practice themes:

- assessing the urgency of neglect
- understanding children's experiences of neglect
- building relationships to address neglect.

3.3.1 Assessing the urgency of neglect

Neglect is more likely to be overlooked than other forms of maltreatment (such as physical abuse) as each episode in isolation may not appear to reflect high risk when compared with other forms of maltreatment¹⁴⁷. SCR's review found that responses to neglect were generally given a low priority and for families without or with a short FACS history, the response of FACS tended to involve a referral to early intervention services. Consequently, neglect often reached a chronic level before a family received a statutory response. This is supported by research in the UK that considered 138 children who had experienced neglect. It found for many of these children a 'trigger' event was needed to prompt a statutory intervention, despite the child having experienced severe and chronic neglect over a long period of time¹⁴⁸.

Neglect occurs on a continuum and the level or type of neglect experienced by a child may fluctuate at different times depending on other factors. Crisis or situational neglect may be found in families where FACS has been involved during times of unusual stress or crisis, and parents may revert to patterns of behaviour that result in a child's needs being unmet for a period of time. It is important to be able to recognise when this occurs and support parenting practices that enhance safety during times of stress and crisis. Where parents are unable to meet their child's needs for a period of time, for example, because of alcohol and drug misuse or mental health concerns, this may be considered episodic neglect.

At the other end of the spectrum, research demonstrates that children who experience chronic neglect are often living in families whose parents provide continuous low level care, and have pervasive, entrenched patterns of inaction and a sense of hopelessness¹⁴⁹. When a child is experiencing chronic neglect, it is important to explore all areas of family functioning.

145 See Turney & Taylor 2014.

146 *ibid.*

147 See NSW Department of Community Services 2006.

148 See Farmer & Lutman 2014.

149 See Watson 2005.

Remembering history

Several reviews identified that the history for the child raised serious risks for the child's current situation. Previous reports of neglect were not always given the weight that they needed because practitioners held the view that neglect does not have a sense of immediacy. Another dangerous reaction for practitioners in statutory child protection practice is 'start again syndrome'¹⁵⁰, where practitioners are at risk of putting aside knowledge of the family's past and focusing on the present as a way of dealing with the overwhelming information and feelings of helplessness. The research warns of the dangers that accompany 'start again syndrome' including the tendency to refer on or cease working with a family, failure to engage with the parents' fundamental problems in parenting, trying the same interventions that have been unsuccessful in the past, failure to recognise the child's experience of harm and the likelihood of referral to short-term programs (which are unlikely to produce the long-term changes that are needed)¹⁵¹. Practitioners may have an increased sense of helplessness because they are unable to provide sufficient and broad-ranging support needed to ameliorate the impact of poverty on neglect.

Such practice becomes increasingly problematic where practitioners have been aware of episodes of neglect reported for a family over a period of years, where there has been no or little assessment and no intervention. SCR's cohort review found that without considering a family's history, the absence of this knowledge contributed to the way subsequent reports and the family's circumstances were responded to.

When considering children who have a long child protection history, practitioners need to assess each report as bringing new information, to carefully integrate this into the history and consider a holistic assessment of the cumulative experience for the child, rather than focus solely on the immediate safety posed by the most recent reported incident. What was evident across reviews was that incident-based responses to reports about a family distracted practitioners from understanding children's cumulative experiences of neglect. For example, a new report about a child who was morbidly obese, had other medical conditions and was experiencing significant medical neglect involved FACS contacting the school, which confirmed the child always presented as clean and tidy and always had lunch with them. While this response is understandable as an initial assessment of the child's immediate safety, the long-term and cumulative effect of the parents' failure to access medical care was overlooked.

Victoria's Human Services Cumulative Harm practice resource sets out a number of indicators of cumulative harm in child protection history reports, which may include:

- multiple reports
- previous substantiations
- multiple sources alleging similar problems
- evidence of children not meeting developmental milestones
- allegations of inappropriate parenting in public¹⁵².

150 See Brandon et al. 2008.

151 *ibid.*

152 See Bromfield, Gillingham & Higgins as cited in Human Services Victoria 2012.

It is also important to consider a parent's history and experiences and how these contribute to their parenting. Neglect has been associated with young maternal age, low socioeconomic status and low levels of educational achievement. One study found that 40 per cent of mothers of neglected children had experienced ongoing domestic violence and that fathers were more likely to have been charged with violent crimes and crimes against property¹⁵³. Parents' own experiences and issues may make them less available to focus on and attend to the needs of their children, and should be considered when completing an assessment of the family.

Best practice means constantly retesting practitioners initial views and remaining open and curious about what is known and not known or understood yet.

Preventing 'casework drift'

Neglect is particularly difficult to work with because there are so many interconnected issues that it may become overwhelming for practitioners to target risk. Statutory involvement may lose its meaning, and in some instances, become purposeless. This can increase a practitioner's sense of uncertainty about how and when to respond. The importance of practitioners remaining curious and vigilant about the risks associated with neglect cannot be understated. The cohort review revealed casework drifted, in part because of the lack of a sense of urgency, and professionals becoming apparently tolerant of dangerous conditions and poor care. Good casework practice involves an awareness that neglect can be life threatening and needs to be treated with as much urgency as other types of child abuse¹⁵⁴.

Practitioners need to remain clear about the reasons for their involvement when working with families who experience neglect, particularly when this stretches over an extended period. Research suggests that long-term casework needs to focus on expected outcomes for children and involve parallel processes of intervention with the child and the parents¹⁵⁵. Research has shown that statutory intervention is often ceased while there is still evidence of difficulties or the underlying problems remain¹⁵⁶. The length of time a practitioner is involved with a family should not be an excuse for casework drift. This requires managers to take on the position of practice leaders, remain open and curious about progress and changes, respectfully challenge where appropriate, and support practitioners to critically reflect about their work with a family and ongoing safety for a child.

153 See Scott 2014.

154 See Brandon et al. 2013.

155 See Tanner & Turney 2003.

156 See Farmer & Lutman 2014.

Regular case planning and review

A case plan needs to be underpinned by and involve:

- building a trusting relationship with the family and a network of safety for the child through maximising the involvement of family members and informal networks
- completing a holistic assessment that takes into account the child protection history, including understanding the child's experience of cumulative harm, considering the outcome of previous interventions and an assessment of the current situation for the family
- meeting concrete (survival) needs first – build life skills around time, money and family planning goals that are specific, achievable and measurable and related to the overall outcome of enhancing safety for the child
- making frequent purposeful visits
- referrals that are targeted to the needs of the parent/s and where they are at in the stages of change, that create safety and do not create a false sense of security
- building on skills to include problem-solving, parenting and interpersonal relationships¹⁵⁷.

The following story about BJ highlights best practice and demonstrates how powerful a curious and skilful practitioner's response can be.

¹⁵⁷ See Child Welfare Information Gateway 2013.

BJ's story

BJ (five months) was the youngest of Michelle's three children. He had a brother, Casper (nine) and a sister, Grace (six). BJ's family was known to FACS since 2006, when Michelle was pregnant with Casper. The reported concerns were about Michelle's drug misuse and minimal antenatal care. FACS work with the family had included:

- When Casper was born, practitioners explained the dangers of co-sleeping while drug affected and helped Michelle set up a cot for Casper to sleep in. Michelle was engaged with a methadone program, and alcohol and drug services, and she worked with a family support service to develop her parenting skills. Practitioners stopped working with the family because they had good family support, were engaged with early childhood and were attending medical appointments with Casper.
- The family was again reported in 2010 and 2011 when Grace was born. Michelle said she was not managing the care of her children and relied heavily on hospital staff and her family for support. Michelle admitted to using drugs because she was not coping. FACS worked with the family for one month, liaised with NSW Health, supported Michelle to attend medical appointments with Grace and Michelle provided drug screens which on occasion returned positive results for methylamphetamine. Other reports were closed because of competing priorities.
- When Michelle was pregnant with BJ in 2015, the methadone clinic reported she was injecting methylamphetamine and smoking cannabis throughout pregnancy. Her drug screens tested positive. Casper and Grace were attending school irregularly and on occasions did not have lunch with them.

During the weekly allocation meeting, the family history was discussed; FACS had information that Michelle had been using drugs for almost 10 years and despite engaging with services there had been little change. At times, she struggled to care for her children, however there were also occasions where she was able to meet their needs. Practitioners agreed that a proactive and intensive response was needed if meaningful change was to be achieved.

Practitioners contacted the Clinical Issues team to help prepare them to visit the family and assess the impact of Michelle's drug misuse on her care of her three children. Rather than drug screens, practitioners engaged Michelle in an open discussion about her drug misuse to understand her triggers, the times when she did not use and the children's experiences of her drug misuse. Practitioners spoke with Casper and Grace, who described feeling scared when their mum used drugs.

Practitioners were clear about their concerns for the children based on the history of drug misuse and supported Michelle to attend a rehabilitation program with BJ. FACS held a meeting with the family, the children's school, the early childhood worker and the family network to develop a case plan to care for Casper and Grace. Practitioners visited the family weekly, and received weekly updates from services. As the family progressed the visits moved to fortnightly, and then monthly. When FACS ceased working with the family Michelle had stabilised on the methadone program, Casper and Grace were well engaged with school and BJ was meeting his developmental milestones.

3.3.2 Understanding children's experiences of neglect

Because neglect is often about the inaction of a parent, children who experience this form of maltreatment may become invisible, unheard, unseen, uninvolved and unloved. When practitioners seek to understand a child's experience of neglect, they make a child visible. The experience of neglect for a child can provide insight into a parent's level of functioning, capacity and ability to change. In order for practitioners to feel confident about a child's safety, 'children need to be seen, and importantly, to be known'¹⁵⁸. Research by Kari Killen highlights what a difficult and emotionally challenging task this can be¹⁵⁹. To have true empathy for a child and understand their experiences can be painful; it requires a practitioner to face the anxiety, emptiness, grief and aggression about the child's experiences and to accept the losses of the parent. Killen warns practitioners about the risks that are inherent in facing these situations; the possibility of over-identifying with the parent, and believing they can achieve more than is realistic¹⁶⁰. These reactions can often result in minimising the neglect a child is experiencing and can hinder good work. Killen's research also notes how a practitioner can withdraw from a child and their family – by postponing home visits, feeling relief when parents cancel an appointment and making referrals for ongoing services despite having knowledge of the limited potential for development.

Managers play a key role in supporting their staff to work through these emotional responses to the work. Practitioners need to be supported through supervision and provided a forum to talk about their responses to working with a family. This involves critically reflecting on how their responses may be impacting on their assessment of a family's progress and the ongoing safety for a child.

Empathising with a child's experience of neglect

- Put yourself in the child's shoes. Try to understand who they are, what it must be like to live their day-to-day life, and what their behaviour is telling you about their experience in the family
- Practice critical reflection to test that interventions with a family are considering all information and not being skewed by over-identification
- Recognise and accept the feelings that working with a family can evoke
- Be curious about the child's relationship with their parents and seek opportunities to observe it in different scenarios and in different environments. Consider how the child experiences this relationship
- Use compassion and sensitivity to be attuned to the relationship between a parent and their child
- Ask the child to tell you, in whatever communication method they choose, about their life. Ask them what they think needs to change and what would be different for them.

158 See Brandon et al. 2013.

159 See Killen 1996.

160 *ibid.*

Being attuned to the parent–child relationship

Attachment is characterised by an enduring emotional relationship with a person that brings safety, comfort, soothing and pleasure¹⁶¹. Attachment helps a child recognise, regulate and soothe their emotions particularly during times of distress and anxiety. A positive attachment has a cascading effect for how children navigate the wider world as they grow up. Secure attachments to adults who love them provides the strongest protection for children; it also sustains carers through tough times and should never be compromised.

For child protection work, unpredictable patterns of care from a parent can be harmful as children struggle to know who they can turn to for safety, what cues result in positive or negative interactions and who they should model their emotional states from. Neglect can impact negatively upon the attachment process between a parent and their child. The risk for a child is greater when there is a lack of connection with their parent. Considering attachment when completing an assessment of a child and their family can be a powerful way to see life from a child's perspective.

Parent–child relationships are often complex and practitioners need to be attuned to this relationship, even when parents may show genuine affection for a child but are struggling to cope; for example, where a child has a disability and requires a high level of care. Where a parent–child relationship has deteriorated, urgent action needs to be taken and there are no quick or easy fixes. Strong management support is needed to help practitioners to understand complex relationships and consider neglect in these contexts.

Tips for practitioners when assessing attachment

- The absence of a positive connection between a parent and their child can help to determine where casework attention should be focused and in assessing risk
- Be curious and ask a parent questions about their relationship with their child: 'Tell me about your role in your child's life?', 'What does your child do when they want your attention?'
- Ask the child about their relationship with their parent/s: 'What does mum/dad do when you're feeling sad?', 'What does mum/dad do when you want them to help you with something?', 'What does mum/dad do to make you feel happy?'
- Consider attachment when developing a case plan. If the attachment between a parent and child is not strong, a case plan can include repetitive tasks that help parents and children develop better relationships and increase a child's sense of predictability and routine. For example, developing a weekly schedule dividing up time to complete household chores, schoolwork and quality time spent together doing activities the child enjoys
- Attachment, genuine love and affection for a child are crucial however not always enough to ensure that the child's needs are met.

¹⁶¹ See Perry 2013.

A safe and healthy environment

It is important for children who are neglected to be physically and emotionally healthy and to have safe and healthy living conditions¹⁶². It is also important that those caring for a child accept responsibility to maintain a child-friendly environment¹⁶³. This reinforces the need for sufficient living conditions for all children and families, irrespective of their age¹⁶⁴.

While assisting a family to achieve a safe living environment is important, practitioners should not let this become the sole focus of casework. Within this cohort review, there were several examples of casework becoming overly focused on the visible issues and state of a family's home, rather than on the underlying issues that were causing it, such as a parent's mental health or alcohol misuse.

Maintaining a healthy environment for children also involves a parent having the ability to protect and supervise a child and teach their children safety. Thirty-four of the 68 deaths in this cohort review were accidents (drowning, fires and transport) that occurred in the context of neglect. For similar children studied between 2003 and 2011, Brandon et al.¹⁶⁵ described a 'lack of boundaries; both in the physical sense of inadequate fences and gates, but also about what the children were allowed to do, and the times they were allowed to stay out until'. A parent's attachment to their child can help them to provide safety and be attuned to the environmental and physical risks that their child faces, in line with their age and development. It is important for practitioners to assess a parent's ability to teach their child safety and understand the risks they face. Practitioners should discuss how to have conversations about safety with children and model this when working with parents and their children. For example, they can initiate discussions about matches and fire not being safe, staying away from water, and road safety.

Do not allow issues such as the condition of the home to distract you from the chronic underlying causes and long-term problems faced by a family.

3.3.3 Building relationships to address neglect

Addressing neglect is notoriously difficult and the histories of families with neglect are usually complex, confusing and overwhelming. Research suggests that real investment in these families is needed to avoid the human and economic cost of developmental difficulties in children who, as a result of neglect, are unable to achieve their potential in terms of happiness, health, education and social functioning¹⁶⁶. This requires long-term and intensive work that is purposeful and focused. Successful work to address neglect will require practitioners to build relationships with both the immediate and extended family and develop supportive social, cultural and community connections to improve negative outcomes for children.

SCR is conscious that good practice thrives where practitioners are supported by a system that allows them to make good relationships with children and parents, while addressing risks that stem from neglect as well as other risks.

¹⁶² See Brandon et al. 2013.

¹⁶³ *ibid.*

¹⁶⁴ *ibid.*

¹⁶⁵ *ibid.*, p. 57.

¹⁶⁶ See Gardner 2008.

Being partners with parents

The work of child protection is more than assessment; it includes encouraging and supporting change. Research has shown that a partnership model to addressing neglect is more likely to break the cycle between poverty and neglect than a response based on investigation and substantiation of harm¹⁶⁷. However, research also acknowledges that in order for the cycle to be broken, concrete services and practical support must be available in the form of financial assistance for food, rent, transportation, childcare and health needs.

Social marginalisation that is experienced by many families where children experience neglect is a critical factor that may lead to mistrust of a system designed to deliver the support a family may need. The ongoing marginalisation may lead a family to feel a sense of hopelessness, particularly when the means of providing support is delivered via a system that starts with an investigative rather than a cooperative approach¹⁶⁸. Good casework by its nature is complex and integrated, combining intuitive and rational thought, with an ability to connect with people to create change. Skilful practice means practitioners understand how a family's previous experience with the child protection system may result in reluctance and fear. Engaging families who may have minimal energy and motivation requires exceptional skills, patience and staying power¹⁶⁹. Remaining compassionate to the complexity of families' lives is integral to responding effectively to neglect.

The literature shares a consensus that the quality of the relationship between professionals and family members is essential to achieving successful change¹⁷⁰. Practitioners who engage families in a partnership promote the aim of a statutory response to being one of 'how we can work with the realities you face and ensure the safety and wellbeing of your children'¹⁷¹. Relationship-based practice relies on practitioners investing themselves in the relationship, and this investment being the key driver for change. The FACS Care and Protection Practice Framework provides a clear mandate to the workforce about their role and gives explicit permission to build relationships with children and their families.

When working with the families of children who experience neglect, there is often a strong focus on mothers without equivalent attention being given to the role and contribution of fathers¹⁷². Neglect is often seen as the fault of mothers, and the role and responsibility of fathers is often not taken into account. However it is critical to consider a father's physical or emotional absence as neglect¹⁷³, and it is essential that they are involved in assessment and family work throughout FACS intervention.

167 See Straus & Kantor 2005.

168 See Scott 2014.

169 See Child Welfare Information Gateway 2013.

170 See Ashley & Nixon 2007; De Boer & Coady 2007; and Turnell & Edwards 1999.

171 See Council of Australian Governments 2009, p. 22.

172 See Tanner & Turney 2003.

173 See Howarth 2002.

How to engage a family to increase safety

Engaging with a family increases a practitioner's ability to influence factors affecting safety. In order to successfully engage a family, practitioners must demonstrate what they, as professionals, are able and willing to do to help them create change, by showing the family that they:

- trust the family and can be trusted by the family
- believe the family is more than the problem that led to statutory intervention
- acknowledge and understand the family's social context that may be causing risk including experiences of poverty, disadvantage, violence and oppression
- understand the family's needs from their point of view
- understand the effort it takes for a family to change
- have a genuine interest in supporting change¹⁷⁴

A statutory service responding to neglect is authoritative in that it couples empathic support for parents with an unwavering focus on improving children's lives¹⁷⁵.

Working with our inter-agency partners

There is no quick fix for services working with children who experience neglect. The response must be based on careful assessment of needs that takes into account the diverse nature of neglect and the compounding impact of multiple and complex needs¹⁷⁶. Where child protection intervention is necessary in order to respond to neglect, an effective response is likely to be long term, resource intensive and complex. Responses to neglect require multiple levels of support and resourcing, and are often beyond the responsibility or capacity of any one agency.

No single method of intervention or response to neglect is sufficient to achieve change for a family. The interconnecting causes of neglect require an approach that is carefully coordinated and based on a detailed and comprehensive assessment of a family.

The cohort review consistently identified unclear lines of responsibility where multiple agencies were working with a family where children experienced neglect. Information was not pieced together and considered, and case plans were not developed with the involvement of key services or followed through. The involvement of extended family in addressing neglect also needs to be managed delicately, and it is important not to make assumptions about their presence or how supportive they may or may not be.

The following story about Jack highlights the positive outcomes that can be achieved for children and their families when practitioners use the skills and resources available to build relationships with parents and coordinate a support network around them.

174 See Child Welfare Information Gateway 2013.

175 See Daniel et al. 2014.

176 See Scott 2014.

Jack's story

FACS received a report when Sam was pregnant with Jack. Sam was living in a refuge, a victim of domestic violence and suffering from depression. Her three older children had been removed because Sam had not been able to meet their basic needs. Because of this, FACS and other services were worried about whether Sam would be able to care for her new baby.

Jack's caseworker, Jane, knew that developing a relationship with Sam was the key to creating change. After completing a holistic assessment to understand all of the child protection concerns, she drew on her knowledge of domestic violence and recognised that Sam's experiences of domestic violence contributed to the neglect of her other children.

Jane saw the report as an opportunity to work with Sam and recognised the importance of showing her that she believed things could change. Understanding the fear Sam may be experiencing because she had her three older children taken away, Jane explained to Sam that she wanted to explore all the issues and give her and Jack the best opportunity to stay together. Jane was always open, honest and respectful. Although she knew Sam may be upset by what she had to say, she did not shy away from important conversations, which provided Sam the opportunity to make changes.

Sam had just moved to the area, she was isolated and she did not have connections with family or community. Working in a rural community, Jane had close relationships with family services and supports and went on regular joint home visits. She was able to work collaboratively with the women's refuge, hospital, early childhood nurse, housing worker and family support service.

Jane developed a case plan to address the domestic violence as the underlying issue that caused the neglect. Through ongoing counselling, Sam recognised the impact domestic violence had on her ability to meet her children's needs. When Jack was born, Jane focused on small, concrete and practical support and worked with the refuge and the housing worker and Sam got her own home. Centacare provided parenting courses and helped Sam budget. The early childhood nurse supported Sam so that Jack met his developmental milestones.

A measure of Jane's skills in building a relationship with Sam was when Sam asked her to look after Jack while she attended her psychologist appointment. Jane knew that Sam trusted her. She found this uplifting. Sam described feeling like everyone was on the journey together with her to make sure that Jack stayed in her care.

Sam and Jack have frequent contact with Jack's older brother and sisters and Sam has lodged an application to have all her children restored to her care. Sam keeps in contact with Jane and she told her that her frank and honest approach was what made her change. Sam continues to live in her own place, close to her older children. She is very proud to have her own home to look after.

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

This last chapter outlines the current and future initiatives that seek to strengthen the child protection system. There is a particular focus this (financial) year on initiatives that enhance our work with vulnerable teenagers and working with children who experience neglect.

4.1 Empowering children and families to live fulfilling lives and achieve their potential

In 2016–2017, FACS is going to significantly change the way the department works with vulnerable families so children have better lives. New evidence-based intensive family preservation and restoration programs will deliver services to 1,000 additional children and their families. Half of these places will be dedicated to Aboriginal and/or Torres Strait Islander children and their families.

FACS will invest \$190 million over four years to help a range of organisations deliver intensive therapeutic programs to prevent OOHC entries, increase exits and improve placement stability for children in care. This work builds on the current intensive family preservation program which will see \$11 million invested in 2016–2017 to support approximately 260 families.

4.2 Working better with teenagers

Last year, SCR completed a cohort review of 111 teenagers known to FACS who died between 2009 and 2014. These teenagers were considered to be vulnerable, with their deaths occurring in the context of suicide, alcohol/drug misuse, risk-taking behaviour or other vulnerabilities such as medical neglect. The themes acknowledged the challenges faced when working with teenagers, as well as the importance of practitioners being curious and understanding the underlying reason behind a teenager's behaviour. The importance of strong and effective working relationships was a dominant theme across many of the reviews.

A number of initiatives are underway to support teenagers and their families to improve their outcomes and support them in achieving safety and stability to help them reach their potential.

Initiatives to support teenagers and their families

Youth Hope

Youth Hope is a pilot program targeting nine to 15 year olds who are at high to very high risk of entering the child protection system. The trial commenced in March 2014 and will run for three years, until June 2017. Youth Hope aims to increase the number of children and young people:

- who are engaged in education
- living in a safe and protective home environment
- connected to family, culture and community
- whose parents possess skills in positive parenting, and who experience improved family functioning
- who can assess and recognise family needs, seek appropriate support and access resources.

What young people and coordinators participating in Youth Hope say

“One of the best services I’ve been involved with in terms of supporting our family ... I think they went above and beyond what I’ve seen other services do.”

“They were wonderful for my family in a time of need ... people need to know these services are there.”

“Always had these goals but had never achieved them. Good to have someone help achieve your goals.”

“I’m not getting into trouble as much as I did and not fighting with my mum and dad, and doing the right thing.”

“They’ve done a lot of work to get Anne back into school, to actually go, and to want to educate herself ... she’s actually talking about going to TAFE now.”

Homelessness

Of the 28,190 people who were homeless in NSW according to Australian Bureau of Statistics data for 2011, 6,274 (22 per cent) were children aged under 18 years¹⁷⁷. In 2014–2015, 30 per cent of unaccompanied homeless young people aged 15–24 successfully moved from specialist homelessness services to long-term accommodation.

FACS is investing additional funding for youth homelessness initiatives that prioritise young people leaving OOHC. These children are at increased risk of homelessness. Over \$10 million is being provided for support and accommodation under the Homeless Youth Assistance Program for unaccompanied children and young people. These measures are aimed at continuing to increase the proportion of young people who leave specialist homelessness services into stable housing.

¹⁷⁷ See NSW Family and Community Services 2016a.

Celebrating the contribution of young people

FACS will invest \$3.9 million in youth participation programs. This includes:

- small grants to local councils for Youth Week activities
- funding to support Youth Frontiers, a mentoring program for students in years 8 and 9 that focuses on leadership, skill development and involvement in community activities
- financial support for the Youth Opportunities Program, which provides grants for projects that engage young people to lead and participate in a range of community development activities.

4.3 Responding to neglect

Chapter 3 of this report highlighted that the causes of neglect are complex and interconnected; neglect may be as a result of poor parenting practices and is also strongly associated with poverty. Therefore, a variety of intervention responses should be considered, including early intervention as soon as neglect is identified, through to more intensive intervention where early identification has not been possible and/or neglect has become entrenched.

The Council of Australian Governments National Framework for Protecting Australia's Children 2009–2020 has adopted a public health approach to keeping children safe. The Framework encourages involvement of services beyond the child protection system to consider the wellbeing of all children, thereby minimising the likelihood that neglected children will require a child protection response. The public health model is particularly suited to identifying neglect. It also has the capacity to address underlying issues associated with neglect, such as poverty, and promotes a government-wide approach to dealing with child protection rather than relying solely on a statutory child protection response to families where children are neglected.

Initiatives to support families where children experience neglect

Brighter Futures

Brighter Futures targets families with at least one child aged under nine years who have been reported as being at ROSH. The program identifies families early in the risk trajectory and provides targeted services to enhance child wellbeing and reduce parental vulnerability. The goal of the program is to prevent entry to or escalation within the statutory child protection system.

The program offers long-term intensive case management, case coordination and specialised services, such as pre-purchased high-quality childcare places and parenting programs. Families can remain in the program for up to 24 months and receive regular assessment, case planning and review. A caseworker visits regularly and coordinates services, including needs-based universal, secondary and tertiary services.

The Brighter Futures program

Brighter Futures may make a difference to children experiencing neglect by:

- enrolling children under school age in high-quality childcare, with a high level of staff to child ratios
- coordinating early intervention services for children showing early signs of developmental delay
- coordinating therapeutic interventions and assessments for children
- supporting parents to enhance their parenting skills, including prioritising parent–child relationships and quality parent–child interactions
- providing practical resources, such as school uniforms, which may enhance a child’s self esteem
- coordinating additional support for school age children who may be experiencing difficulties at school due to their experience of neglect.

A total of 3,062 families and 7,174 children received this service in 2014–2015, and eight in 10 children that completed the program were not re-reported at ROSH within 12 months.

Mandatory Reporter Guide 2016 review

The Mandatory Reporter Guide (MRG) helps mandated reporters make sound decisions on whether or not to report to FACS children and young people they suspect may be at risk of being neglected or physically, sexually or emotionally abused.

The MRG is reviewed regularly, in consultation with stakeholders, to reflect legislative, policy and practice changes. The MRG review will better support mandatory reporters by:

- improving definitions across decision trees, including neglect, and providing better supports to make a report
- improving links to alternative service and referral pathways, and having a stronger focus on responding to risk
- introducing additional sections outlining information required of mandatory reporters by the Helpline and the process followed by FACS once a report is made.

An important focus of the updated MRG will be to strengthen the provision of additional guidance and links to improve the capacity of mandatory reporters to respond to the needs of children and young people rather than just reporting to the Helpline.

Community-based referral service pilot – Out-posted Caseworker Program

The Out-posted Caseworker Program involves FACS practitioners based at local services (overseen by NSW Health and NGOs) to assist host agencies to provide a more effective service to children and young people. The program targets children and young people who have met the ROSH threshold and require a response within 10 days. FACS refers families to one of 15 out-posted practitioners based at Family Referral Services (FRS) across most districts. The goals of the program include:

- establishing an alternative referral pathway
- building capacity of agencies to engage and assess the needs of families and assisting them to provide a more coordinated response
- strengthening relationships between host agencies and FACS to encourage enhanced collaborative responses
- improving the wraparound response to the target group.

case study

Asha's story – Out-posted Caseworker Program

A referral from a FACS Community Services Centre was made to a FRS that had an out-posted caseworker for Asha, a mother who was the victim of domestic violence and had problems with her mental health. Asha's two young children were responsible for getting themselves to and from school, cleaning and maintaining the home, and provided daily emotional support to Asha.

The out-posted caseworker met with Asha and talked through their concerns, highlighting the effects the neglect was having on the children, physically and emotionally. They assisted Asha with transport to her appointments so she could begin to address some of her mental health problems. The FRS realised the value of discussing daily routines with Asha, including who was doing what in the home. As a result, the out-posted caseworker identified that the family needed ongoing support. They referred Asha to a local service that was able to assist with daily routines and remained involved until Asha's mental health stabilised. She was also linked to a local support service and was seeing a counsellor regularly.

Vulnerable Families Program – Western Sydney District

The Vulnerable Families Program is a partnership between FACS Western Sydney District and Western Sydney Local Health District delivering health-related services to targeted FACS clients in Western Sydney. The program provides for the timely delivery of health services where the existing health system is unable to either meet the need or provide the service in a timely manner.

The program targets children and young people at ROSH who require assessment and provision of health services to either prevent them entering care and/or to improve their life outcomes. Children and young people in OOHC are also eligible for services where they fall outside of the existing health care pathways.

Tien's story

Tien has six children under 12 years of age, five of whom live in the family home. The two youngest children are aged 20 months and six months. Since the beginning of 2016, Tien has had a recurrent golden staph infection.

Between February 2016 and May 2016 the infection returned on four separate occasions. In early May 2016, the second youngest child was also diagnosed with a golden staph infection, suggesting it had spread within the home. Tien said she felt quite ill during the bouts of infection, leaving her unable to provide the children with adequate supervision.

FACS asked Uniting Care Burnside and NSW In-Home Care Services to work with the family. Due to the infectious environment both services advised that they were unable to enter the home.

A referral was made to the Vulnerable Families coordinator for funding to clean and disinfect the home. The coordinator referred the matter to the Infectious Diseases Control Team, which said that cleaning and disinfecting the home would not control the infection. Instead a treatment plan for ongoing medication with review by the Infectious Diseases Clinic was developed.

Tien's experience demonstrates how the Vulnerable Families Program provided prompt access to specialist knowledge within Western Sydney Local Health District that might otherwise have only been able to be obtained through a GP referral with possible delay in service provision.

Making a Safe Home Program – Western Sydney District

The Making a Safe Home (MaSH) program is a co-designed program in the FACS Western Sydney District which seeks to intervene with at risk families in a different way, so that more children and families get the supports and services they need to keep children safe in their homes.

It balances the provision of intensive practical supports in the family's home with parental acceptance of accountability for their need to improve and develop their parenting capacity. It does this by engaging with the family and collectively reviewing the information available to determine what support is required and aims to bring together a model of care which is tailored to the specific needs of the family. Eligibility extends to:

- children aged 0–5 years (including prenatal) who are at imminent risk of entering care and
- where there is anticipated willingness and readiness for parent/s to improve their parenting capacity.

The referral pathway is via a panel involving the Director Community Services and the Coordinator of the Western Sydney Integrated Violence Prevention & Response Service (NSW Health).

Ruth's story

Ruth is a 28-year-old Aboriginal woman who entered the MaSH program following the birth of her child in April 2016. Ruth has three older children aged seven, nine and 11 years. Her three children were removed from her care because of her mental health, drug and alcohol misuse and neglect (unhygienic living conditions, inadequate supervision and medical neglect). Previous attempts to assist Ruth were unsuccessful because she was unwilling to leave her home to engage with services she had been referred to.

In 2010 Ruth suffered a spinal injury and is now confined to a wheelchair. Based on her history and current circumstances, there were concerns that Ruth may not be able to meet the needs of her new baby and that the baby may need to be taken from her mother.

FACS engaged Ruth during her pregnancy and identified that she had addressed her drug dependency and was committed to working with FACS and other services to keep her child. In planning with Ruth, a number of services were put in place:

- a physiotherapist to assist her with wheelchair and home modifications
- the ongoing use of a Doula¹⁷⁸ who Ruth identified as a key support
- a psychologist to visit her in her home to support her mental health
- Aboriginal Home Care to assist her with housekeeping and transport for shopping, assistance for budgeting and financial management.

Ruth has continued caring for her child, continues to make progress and has engaged with the services in place, and the future appears positive.

Better outcomes for Aboriginal children, families and communities

The FACS Aboriginal Cultural Inclusion Framework 2015–2018 aims to improve engagement with Aboriginal communities and staff, increase Aboriginal staff within FACS and invest in viable Aboriginal NGOs. Through cultural inclusion, accountability and monitoring processes the Framework measures success via reportable headline indicators across all areas of FACS service delivery. At the local level, districts report outcomes to their local community and Aboriginal Cultural Inclusion Committee.

The NSW Government is investing in the continued funding of Aboriginal Child and Family Centres, which provide integrated and culturally appropriate services, tailored to the needs of the local communities of Ballina, Lightning Ridge, Brewarrina, Gunnedah, Toronto, Doonside, Mt Druitt, Minto and Nowra.

Early childhood education and care services are central, with most centres operating a licensed childcare service. This model has helped Aboriginal families access a range of integrated services. It has reached families who would not previously have accessed services because they were unaware of them, not confident using them or could not afford them. Most centres are operated by Aboriginal organisations and staffed predominantly by Aboriginal people.

178 A woman who gives support, help and advice to another woman during pregnancy and during and after the birth.

Reducing domestic and family violence

The personal, social and economic implications of domestic violence are profound. Transience, homelessness, unstable housing, parental substance misuse and mental health concerns can have significant consequences for children's experiences of neglect, from immediate and episodic experiences, to longer term and cumulative harm to their health and wellbeing. A number of initiatives were progressed in 2015:

- **Men's Behaviour Change** – FACS piloted four new community-based programs.
- **Domestic and Family Violence Skills Development Strategy** – training to support frontline non-government workers.
- **NSW Government Domestic Violence and Family Violence Framework** – It Stops Here: Standing Together to End Domestic and Family Violence.
- **Safer Pathway Trial** – a new approach to assessment, referral and service coordination launched in Orange and Waverley.
- **Staying Home Leaving Violence** – prevents homelessness by supporting women and children to remain in the home of their choice. The service operates in 23 locations and will expand in 2016.

The NSW Government is investing \$20 million in 2015–2016 in a Domestic Violence Response Enhancement program, enabling 24-hour support and after-hours access to crisis accommodation.

Office of the Senior Practitioner – focus on neglect

The Office of the Senior Practitioner (OSP) has taken a coordinated approach to supporting frontline staff to enhance their work with children and families who experience neglect. The combined efforts of the units¹⁷⁹ that make up the OSP have provided the opportunity to draw on the work of each unit, from independent reviews of practice, to a comprehensive and contemporary literature review, to the development of practice resources and learning forums to support and improve FACS response to neglect. In 2016–2017, the OSP will strive to achieve the following initiatives.

Literature review on neglect

A comprehensive and contemporary literature review exploring the causes of neglect, its impact on children, and strategies and interventions that have been found to be effective in minimising this type of harm.

Neglect practice resource

A practice resource that includes pertinent findings from the literature review alongside practical ideas and practice tools that can be used when working with a family where neglect is a feature.

Research to Practice

The OSP is facilitating a Research to Practice day focused on neglect that will bring experts in the field of neglect together to share their knowledge and help practitioners transfer theory into practical strategies that work for families. A series of Research to Practice notes will be published following this seminar. The findings from the cohort review outlined in Chapter 3 of this report were used to plan this day and target learning for practitioners.

¹⁷⁹ The OSP is made up of Practice Quality and Clinical Support, Serious Case Review, Reportable Conduct, and Practice Support (Southern, Northern, Western Clusters).

FACS Child Protection Practice Conference

The FACS Child Protection Practice Conference provides learning that can be applied to any risk type. In 2016, the conference will provide specific learning on the area of neglect. Professor Marion Brandon¹⁸⁰, whose work underpins and is referred to strongly throughout Chapter 3 of this report, will deliver a keynote address and masterclass. For over a decade Professor Brandon has directed national analyses of serious case reviews for the English and Welsh governments. In 2013, she led an analysis of neglect in serious case reviews for the National Society for the Prevention of Cruelty to Children (NSPCC) and has recently been a part of a Department of Education Expert Advisory Group constructing guidance for practitioners about indicators of neglect.

The findings from Chapter 3 of this report will also feature as a workshop at the conference and be presented by staff from SCR.

***Child Deaths 2015 Annual Report* briefing session**

Each year, SCR develops a learning package to share the findings from the *Child Deaths Annual Report* with practitioners. Learning packages are presented by local staff at each CSC and include real examples to support and develop learning for practice based on the number of children who have died, the circumstances of their death and the response of FACS to their family before and after their death. There is a particular focus on the findings of Chapter 3 of this report, and how practitioners can improve their practice when working with children who experience neglect.

For the first time SCR will make this package available to external agencies with the aim of building capacity across the child protection sector, with the hope of strengthening child protection practice throughout human services in NSW.

Practice review learning package on neglect

Internal child death reviews often reveal practice issues and highlight how the broader child protection system could have better supported a child and their family before the death. The OSP regularly delivers practice review sessions at local offices to support practitioners to reflect on FACS work with the family of a child who has died. Practitioners consider what could have been done differently and how the learning from a child's experience can be applied to work with other families.

Sometimes these reviews are also shared across all local offices. For example, a practice review learning package is being prepared to strengthen the identification and response to neglect.

¹⁸⁰ Marion Brandon is a Professor of Social Work and Director of the Centre for Research on Children and Families at the University of East Anglia. Her research focuses on child protection, children's views of child protection, family support and inter-agency working.

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Appendix 1: Counselling and support services

Name	Description	Contact
Child Protection Helpline	Report suspected child abuse or neglect to FACS	132 111
Aboriginal Counselling Services (ACS)	Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW	0410 539 905
Aboriginal Medical Service	Provides comprehensive health care to the Aboriginal community	Local contacts can be found at < www.ahmrc.org.au >
SIDS and Kids NSW and Victoria	Provides 24/7 bereavement support to families who have suffered the loss of a baby	1300 308 307
NALAG Centre for Loss & Grief	Provides free face-to-face and telephone loss and grief support	02 6882 9222
Lifeline	Provides 24/7 telephone crisis support and suicide prevention services	13 11 14

Glossary

Aboriginal and/or Torres Strait Islander

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

Abuse

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

Alcohol and/or drug misuse

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

Authorised carer

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

Case closure

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

Case plan

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

Casework

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

Caseworker

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

Child

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

Child Protection Helpline

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

Child Wellbeing Unit (CWU)

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

Children's Court

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

FACS Community Services Centre (CSC)

Locally based community services offices. There are 82 CSCs across NSW.

Domestic violence

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

Engagement

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

Key Information and Directory System (KIDS)

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

Manager Casework

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

Mandatory reporter

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

Medical examination

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

Mental health concerns

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

Neglect

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

Order

An order of a court or an administrative order.

Out-of-home care (OOHC)

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

Parental responsibility

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

Parental responsibility to the Minister

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

Physical abuse or ill-treatment

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

Prenatal report

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

Removal

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

Report

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

Reporter

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

Restoration

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

Risk of harm assessment

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

Risk of significant harm (ROSH)

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

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

Risk-taking behaviours

Risk-taking behaviours includes but is not limited to:

- suicide attempts or ideation
- self-harm
- engaging in criminal activities
- gang association and/or membership
- dealing drugs
- drug alcohol and/or solvent use
- engaging in unsafe sex
- prostitution.

Safety and risk assessment (SARA)

SARA is a SDM® system for assessing risk. The goals of the system are to determine risk to children and young people through a structured process of information gathering and analysis. This is intended to produce more methodical and thorough assessments. SARA includes three distinct tools: Safety Assessment, Risk Assessment and Risk Reassessment.

Sexual abuse or ill-treatment

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

Structured Decision Making (SDM®)

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

Supervision

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

Supported care allowance

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

Triage and assessment practice guidelines

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

Weekly allocation meeting (WAM)

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

Young person

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

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

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