NSW GOVERNMENT

Child Deaths
2020 Annual Report

Learning to improve services

A note about this report

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

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Minister's foreword

This report contains details about the 100 children who were known to the Department of Communities and Justice (DCJ) and died in 2020.

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

The *Child Deaths 2020 Annual Report* is DCJ's eleventh annual report about the deaths of children who were known to the department's child protection service. This report shares information openly about the details and circumstances of death for these children who were known to be at significant risk of harm or in out-of-home care.

The challenges for NSW have continued in 2021. No-one could have predicted that our state would be involved in a second round of restrictions because of the COVID-19 pandemic. Having laid the groundwork in 2020 to ensure continuity of service provision, DCJ practitioners quickly adapted their practice once again, in response to the challenging circumstances.

The reviews that sit behind the report were contributed to by child protection practitioners who reflected on their work with families and as a consequence provides a deeper understanding of how we can improve.

Since stepping into my role as Minister for Families, Communities and Disability Services, I have seen the commitment, skill and dedication of staff from DCJ and our interagency partners who have continued to focus on putting children first during this challenging time. Their work to protect children and keep them safe from harm has not stopped. I am grateful for the work that you do.

Alister Henskens
Minister for Families, Communities and Disability Services

Acting Secretary's foreword

This is the first year I have read this report as Acting Secretary for the Department of Communities and Justice (DCJ). It is a humbling experience, and a report that forces me to stop and think about the children whose lives are reflected in it.

Firstly, to those who knew and loved these children, I am deeply sorry for your loss. The death of a child under any circumstances is always a tragedy.

It is important that we devote the time to consider the work undertaken for those children who have died, and the opportunities we had to make a difference.

For each of the 100 children who were known to DCJ and died in 2020, DCJ reviewed its involvement with them and their families. The reviews provide an opportunity to look closely at our work, and to consider what could have been done better and to make changes where needed.

Chapter 3 of this year's report focuses on the 42 children who died in circumstances of suicide or suspected suicide over the last five years. To the families and carers of these children, I extend my deepest sympathies. While suicide can affect anyone, there are factors that may make a child who has experienced abuse or neglect more vulnerable. The chapter provides practice advice around urgent, intentional support that can be provided across the government and non-government sector.

Despite the challenges of the pandemic, the NSW Government continued to implement vital reforms to the child protection and out of home care system. The work of DCJ continues to be informed by the NSW Practice Framework, the Permanency Support Program and other important reforms. You can read more about these, alongside information about how recommendations made following child death reviews have been implemented, in Chapter 4 of the report.

Working to keep children safe from abuse or neglect is an incredibly challenging job. When a child dies the impact is far reaching and those practitioners who worked with the child and their family are also deeply affected. For every practitioner who has been a part of a child death review process, I thank you for your courage in openly discussing your practice, and your continued commitment to improving our response to vulnerable families.

Staff in DCJ have continued to navigate massive changes at work due to COVID-19 restrictions but have sustained face-to-face visits and worked with hundreds of at risk children and families each week.

I am inspired and encouraged by the creativity and persistence of our staff.

Catherine D'Elia
Acting Secretary

Summary

The *Child Deaths 2020 Annual Report* is the eleventh public report from the NSW Department of Communities and Justice (DCJ)[1]. It examines DCJ involvement with the families of children[2] who died and were known to DCJ.

The report provides context about the deaths of children who were known to DCJ, with the intention of strengthening the child protection system, improving child protection practice and supporting other services working with vulnerable children and families. It is the aim of the DCJ Child Death Annual Report to strengthen community understanding of the complexities of the work, including the widespread social disadvantage among the families whose children are reported to the child protection system.

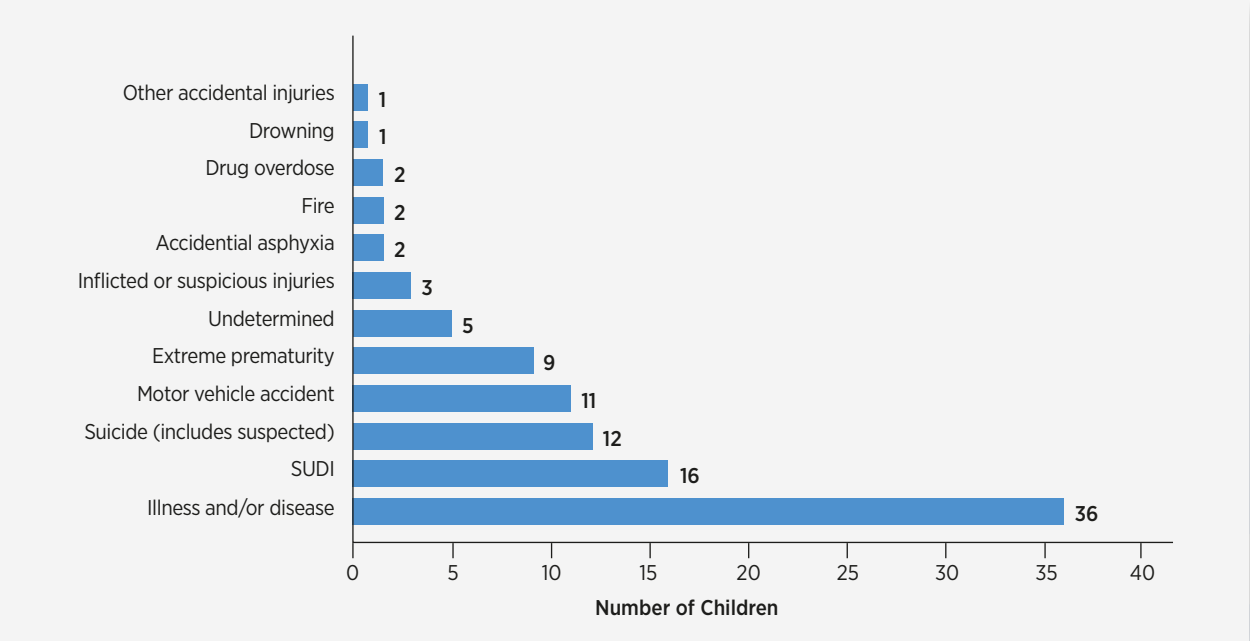
Child deaths in 2020

Chapter 2 summarises information about the 100 children who died in 2020 and were known to DCJ.[3] As shown in Figure 1, and consistent with previous years, the most common circumstance of death was illness and/or disease. Just under half (45) of the children who died were under the age of 12 months.

Aboriginal children continue to be disproportionately represented in deaths of children known to DCJ. In 2020, 23 of the children who died were Aboriginal. This report considers these 23 deaths both within the larger cohort of the 100 children who died and separately, providing specific detail about their circumstances, age and gender.

Five of the children who died in 2020 were not living with their parents and the Children's Court had made an order allocating parental responsibility to another person.[4] For one child their care was shared between a relative and the Minister for Families, Communities and Disability Services (the Minister) and for the other four children their care was allocated solely to the Minister.

Figure 1: Children who died in 2020 and were known to DCJ, by circumstance of death[5]



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

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

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

4 See Chapter 2 for information about the circumstances of the children's deaths.

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

Children who died by suicide

The focus of Chapter 3 is the findings from a cohort review of 42 children who were known to DCJ and died between 2016 and 2020 by suicide or suspected suicide.

Suicide can affect anyone but there are individual, social and environmental factors that may make a child who has experienced abuse or neglect more vulnerable.

The insights about the systems and practice in the reviews of these suicide deaths is used to increase practitioner and sector understanding when working with all families where children may be at risk of suicide. The chapter provides clear practice advice around urgent, intentional support that can be utilised to make a difference.

Improving the way DCJ works with children and families

Across 2020 and 2021, the NSW Government continued to implement reforms to the child protection and out of home care system in the state.

Chapter 4 includes a summary of how the child protection system has been strengthened as a result of recommendations made in DCJ child death reviews. The work of the Serious Case Review Panel is discussed alongside key practice reform and changes that have taken place following recommendations made in 2020.

Chapter 1: Child deaths in context

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

1.1 Child protection in NSW

The NSW Department of Communities and Justice (DCJ) was formed on 1 July 2019. It brought together the former departments of Family and Community Services (FACS) and Justice. DCJ is the statutory child protection agency in NSW and works with other government departments, non-government organisations (NGOs) and the community to support families to keep children safe from abuse and neglect. DCJ enables services to better work together to support individuals' rights to access justice and help for families, and promote early intervention and inclusion, with benefits for the whole community. DCJ is the lead agency in the Stronger Communities Cluster and brings together under one roof all government services targeted at achieving safe, just, inclusive and resilient communities.[6] [7]

DCJ child protection practitioners work with some of the most vulnerable children and families in NSW. Many of them live with extreme disadvantage because of poverty, lack of access to services, unemployment, homelessness and social isolation. Often, families live with the impacts of problematic parental substance use, unaddressed mental health issues and domestic violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect and lead to many of the risk of significant harm (ROSH) reports made about children in NSW.[8]

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

1.2 Examining child deaths

1.2.1 DCJ child death reviews

Reviewing child deaths is a requirement in the *Children and Young Persons (Care and Protection) Act 1998*. Each year, DCJ is required to report on the number and circumstances of death of children who have died and were known to DCJ. This includes children and/or their siblings who were reported to be at risk of significant harm within three years before the death of the child, or a child who was in out of home care when they died.[9]

Children in NSW with a child protection history have a higher mortality rate than those not known to DCJ, and account for a greater relative proportion of the children and young people who die from certain causes in NSW.[10] Other jurisdictions across Australia report similar findings.[11]

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

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

8 NSW FACS (2016).

9 Section 172A.

10 NSW Ombudsman (2021).

11 Previous contact with child protection services is often noted as a common factor in child death reviews. See Australian Institute of Family Studies (AIFS) (2017).

Each year the Child Deaths Annual Report has four objectives:

1. To promote transparency and accountability about child deaths by publicly reporting on DCJ involvement with the families of children who have died
2. To increase public trust and confidence in DCJ by reporting on what has been learned from child death reviews, and the improvements to practice and systems made as a result of this learning
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 interagency partners in other government and NGOs.

Serious Case Review Unit

The Serious Case Review Unit (SCR) is part of the Office of the Senior Practitioner (OSP) within DCJ. SCR reviews DCJ involvement with all children who have died and 'were known to DCJ'. These practice reviews consider how DCJ systems at a local and organisational level may have impacted on practice with the families of children who died. The reviews create learning opportunities for practitioners who work with families by not only identifying areas for practice improvement, but also promoting good practice.[12] This in turn leads to broader system improvements.

Practitioner support and consultation

When a child dies, SCR works to help practitioners so that they can focus on the important job of offering and providing support to families and assessing the safety of any other siblings or children in the home.[13] The measures provided by SCR include practical support such as debriefing practitioners who may have been working with a family recently, and preparing briefings for senior officers about the circumstances of the child's death. In many instances, SCR consults with casework staff to understand contextual information and to reflect critically on practice. Participating in an internal serious case review process when a child dies can be an understandably difficult process for staff. SCR is continually impressed by the courage and openness shown by DCJ practitioners in their willingness to reflect on their practice and learn from a child's death.

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

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

Learning from child death reviews

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

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

13 Chapter 3 of the *Child Deaths 2016 Annual Report* contained a cohort review of DCJ responses to families of children who died. The review outlines the key role child protection agencies play after the death of a child including supporting families in their grief and loss, and in completing sibling safety assessments with vulnerable families.

Child Deaths Annual Report

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

Cohort and other reviews

Each year, SCR undertakes a cohort review that looks at a group of children who died and were known to DCJ who share some common characteristics. Previous child deaths cohort reviews have considered:

- Children who died in circumstances related to premature birth (2019)
- Children who died and whose parents had a child protection history (2018)
- Children who died from illness and/or disease (2017)
- Responses to families of children who died (2016)
- Children who experienced neglect (2015)
- Vulnerable teenagers (2014)
- Babies who died suddenly and unexpectedly (2013)
- Children who were reported to be at risk of significant harm because of domestic violence (2012)
- Children who had young parents (2011).

This year's cohort review (Chapter 3 of this report) presents findings about 42 children who died in circumstances of suicide or suspected suicide.

Practice review sessions and other forums

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

The stories of children who have died are also at the heart of many broader OSP learning forums and are used to inform the OSP's Practice Conference and Research to Practice seminars.[14]

1.2.2 Public and inter-agency understanding of child deaths

In providing public information about the circumstances surrounding children's deaths, DCJ is committed to protecting the privacy of vulnerable families who are impacted by the death.[15] The NSW Parliament has also responded by protecting privacy and confidentiality through a range of legislation that governs the disclosure of information on individual child deaths.[16]

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

Child deaths and the media

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

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

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

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

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

While there are important and positive aspects to media coverage of child abuse such as raised public awareness and increased reporting of concerns, there are negative consequences of media coverage that is sensationalist and distracts from solutions and a prevention approach. An approach that draws child protection risk to the public's attention and then focuses on what should be done about it is advocated for in recent literature.[18]

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

At an organisational level, the NSW Practice Framework[20] (see also Chapter 4) helps departmental and practice leaders acknowledge the uncertainty of work and share the risk between frontline workers and management. The Framework integrates the approach, values, standards, tools and principles that guide the NSW statutory child protection system. It clearly articulates mandates for how DCJ works and brings these together in one framework that is used by the whole Department. Within it, information about DCJ child death review work acknowledges that reviews are one of many ways to inform current child protection practice. Internal child death reviews show DCJ willingness to reflect and maintain an open culture, where critique leads to improved outcomes and supports meaningful change for families.

PRACTICE FRAMEWORK STANDARDS FOR CHILD PROTECTION AND OUT OF HOME CARE

The **Practice Framework Standards** for child protection and out of home care practitioners (Practice Standards) help children achieve better outcomes – sustained safety with family, emotional and legal permanency, safety in care and lifelong belonging in community.

In 2014, the department released its first ever set of Practice Standards. They provide evidence-informed role clarity and professionalism, and give a shared and clear message about what children and families should experience when they are supported by DCJ.

In addition, in the six years since their release, the department has continuously improved the way we work with children and families.

In recognition of significant reforms such as the DCJ Aboriginal Cultural Capability Framework, NSW Practice Framework, the Permanency Support Program, and reaching the NSW Child Safe Standards for Permanent Care, in 2020 it was time to revise the Practice Standards to reflect contemporary evidence and practice.

The OSP also consulted with young people with experience of the care system and their voices can be heard loud and clear through the revised Standards. They bring together the components of the NSW Practice Framework and explain how each of them looks in daily practice with children.

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

1.2.3 Child death oversight in NSW

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

NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is the systemic review of deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths that have occurred in a care setting. The purpose of this function is to prevent the deaths of children in circumstances of abuse or neglect, and the deaths of children in care or detention. The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in August 2021 and considered reviewable deaths of children in 2018 and 2019 in the context of longer term trends and issues.[21]

NSW Child Death Review Team

Convened by the NSW Ombudsman, the NSW CDRT registers, examines, analyses and classifies the deaths of all children in NSW with the objective of preventing and reducing child deaths. The CDRT includes the Advocate for Children and Young People, the Community and Disability Services Commissioner, representatives from other government agencies,[22] and individuals with expertise in relevant fields including health care, child development, child protection and research methodology. The CDRT reports biennially to the NSW Parliament about the causes and trends of deaths of all children in NSW, as well as annually in relation to its operations and activities, including research projects and progress on the implementation of the CDRT's recommendations.

In 2021, the CDRT advised DCJ that 471 children aged from birth to 17 years died in NSW in 2020. One hundred of these children were known to DCJ. These figures can differ slightly from DCJ data, highlighting important differences between the CDRT and DCJ:

- The deaths of children from NSW who died outside the state are reported in the CDRT biennial report
- CDRT reports include the 'child protection history' of children who die in NSW. Unlike DCJ:
  - CDRT does not include children in care who died as having a child protection history unless the child and/or a sibling was the subject of a report to DCJ within the three years before their death
  - CDRT child protection history includes children and/or their siblings who were the subject of a report (ROSH or non-ROSH) about their safety, welfare or wellbeing made to DCJ or a Child Wellbeing Unit.[23]

NSW Police Force and the NSW State Coroner

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

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

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

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

21 NSW Ombudsman (2021).

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

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

Domestic Violence Death Review Team

The Domestic Violence Death Review Team is convened by the NSW State Coroner. The team includes representatives from government agencies, including DCJ, Police and Health, and representatives from non-government sectors and academia.

The core functions of the team are to review and analyse individual closed cases of domestic violence deaths;[24] to establish and maintain a database to identify patterns and trends relating to such deaths; and to develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

The death of a child in the context of domestic violence is subject to review by the team. In 2016, the team moved to reporting every two years. The team's fifth report (2017–2019) was published in 2020.[25]

Joint Child Protection Response Program (JCPRP)

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

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

Office of the Children's Guardian

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

- accredit and monitor designated agencies that arrange statutory out of home care in NSW
- maintain and monitor the NSW Carers Register, a database of people who are authorised, or who apply for authorisation, to provide statutory or supported out of home care
- register and monitor agencies that provide, arrange or supervise voluntary out of home care
- accredit non-government adoption services providers
- authorise the employment of children under the age of 15, and child models under the age of 16, in the entertainment sector
- administer the Working With Children Check and encourage organisations to be safe for children
- administer the Child Sex Offender Counsellor Accreditation Scheme – a voluntary accreditation scheme for counsellors working with people who have committed sexual offences against children
- administer the reportable conduct scheme.[26]

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

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

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

26 From 1 March 2020, the Office of the Children's Guardian became responsible for administering the Reportable Conduct Scheme under the Children's Guardian Act 2019 (NSW).

1.2.4 Reviewing the deaths of children in out of home care

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

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2020, this included children placed with carers authorised by DCJ or Permanency Support Program (PSP) providers, and children who died in a facility funded, operated or licensed by DCJ. These reviews consider the adequacy of the involvement of all agencies with the child and family up to the child's death.

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

1.2.5 Making and monitoring recommendations following child deaths

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

Making and monitoring recommendations in DCJ

Approximately 90 serious case reviews are undertaken each year. Many of the reviews result in recommendations aimed at improving direct casework with families or about the unique needs of a Community Service Centre (CSC) or district. All reviews with recommendations are referred to the Executive District Director, Director Community Services and Director Practice and Permanency to consider the casework practice issues highlighted in the review and any need for a localised management response to those issues.

The implementation of these recommendations is monitored closely through the DCJ Quarterly Business review process, providing visibility of recommendations and ensuring accountability.

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

Serious Case Review Panel

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

This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. Chapter 4 of this report includes details of recommendations made from child death reviews considered by the Panel in 2020 and how these recommendations are progressing. The OSP maintains a secretariat role for the Serious Case Review

Panel and monitors the progress of recommendations. The Panel reports to the DCJ Executive Board on its work and the progress of systemic recommendations. When requested, the NSW Ombudsman and NSW Coroner are provided with a copy of the recommendations and DCJ response to implementing them. This informs the NSW Ombudsman's and Coroner's broader role in overseeing the whole service system's response to the learning from child death reviews.

Making and monitoring recommendations about the broader service system

NSW Child Death Review Team

The CDRT makes recommendations about legislation, policies, practices and services for implementation by government and non-government agencies and the community.[27] These aim to prevent and reduce the likelihood of child deaths. The CDRT discusses the recommendations in its biennial reports and formally monitors these recommendations in its annual report to Parliament. In its 2019–2020 annual report, the CDRT was monitoring 19 open recommendations.

NSW Ombudsman

The NSW Ombudsman also makes recommendations about legislation, policies, practices and services for implementation by government and non-government agencies and the community. The NSW Ombudsman recommendations are monitored and discussed in biennial reports.

NSW State Coroner

Following an inquest, a Coroner may make recommendations to government and other agencies. These recommendations aim to improve public health and safety and prevent similar deaths. Agencies are required to report to the Attorney-General about their responses to coronial recommendations, which are published on the DCJ website. Since July 2009, a consistent process for responding to and monitoring NSW State Coroner recommendations has been in place and a report is made public in June and December each year as provided in Premier's Memorandum M2009-12 Responding to Coronial Recommendations.

DCJ received five recommendations from three coronial inquests held in 2020.[28] DCJ has acknowledged receipt of the Coroner's findings in each of these three cases. These are being considered by the relevant area of DCJ and a progress update will be provided to the Attorney-General before the end of 2021.

Domestic Violence Death Review Team

The Domestic Violence Death Review Team (DVDRT) reports to the NSW Parliament biennially, setting out findings from qualitative case analysis and recommendations from this analysis. This report also profiles the team's quantitative data and any recommendations arising. The DVDRT undertakes public monitoring of its recommendations and responses to these in its tabled reports and on its website.

27 This function is outlined in section 34D (1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).
28 The Coroner's findings in these cases were handed down on 10 March 2021, 17 March 2021 and 1 June 2021.

Chapter 2: Child deaths in 2020

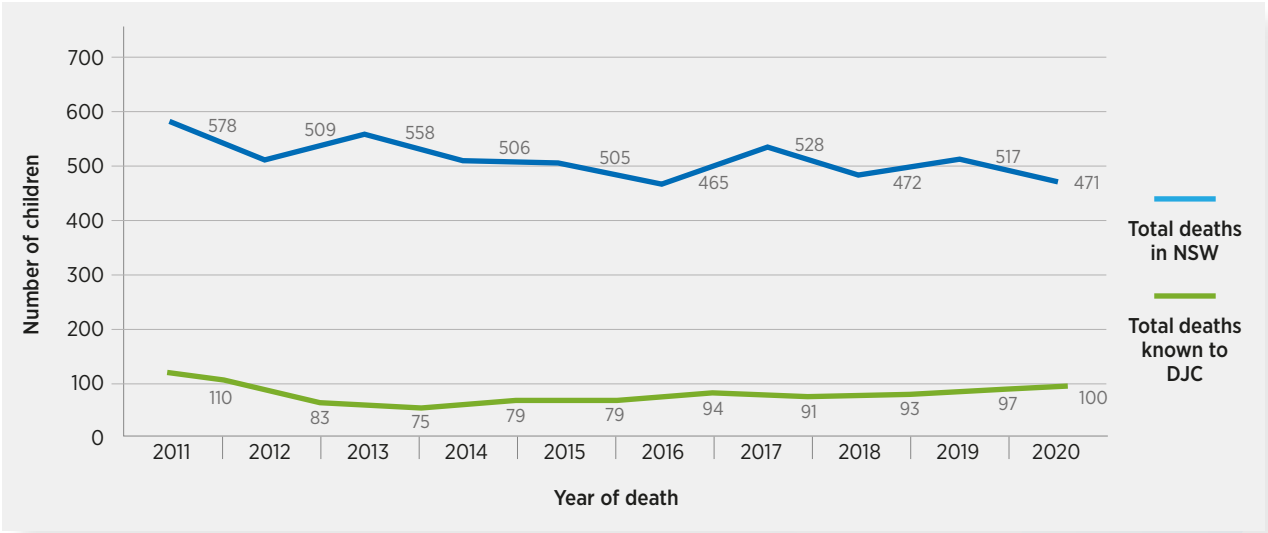
In 2020, 100 children died who were known to DCJ before their death. Chapter 2 provides a summary of those children and their families, including information about the characteristics of these children such as their age and gender. Analysis also considers the circumstances of the children's deaths, their child protection history and how DCJ responded to the families before and after the children died.

The purpose of the chapter is to reflect on DCJ responses, alongside other government and non-government services, to the children who died and their families. To maintain confidentiality for the families whose children have died, this chapter can only provide broad information that assists in describing the key themes for practice, good work and areas for practice improvement.

2.1 Child deaths in NSW in 2020

Between 1 January 2020 and 31 December 2020, the deaths of 471 children were registered in NSW.[29] Of the 471 children who died in NSW, 100 children were known to DCJ because they and/or their siblings had been reported at risk of significant harm in the three years prior to their death, or the child was in out of home care when they died.

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ, 2011–2020 [30]



In 2020, there was a slight increase in the number of children known to DCJ who died, compared to 2019,[31] but the numbers have remained proportionally stable over the previous five years. The number of children who were known to DCJ and who died represented 0.1 per cent[32] of the total number of children reported to DCJ in that year. This is consistent with previous years' findings.

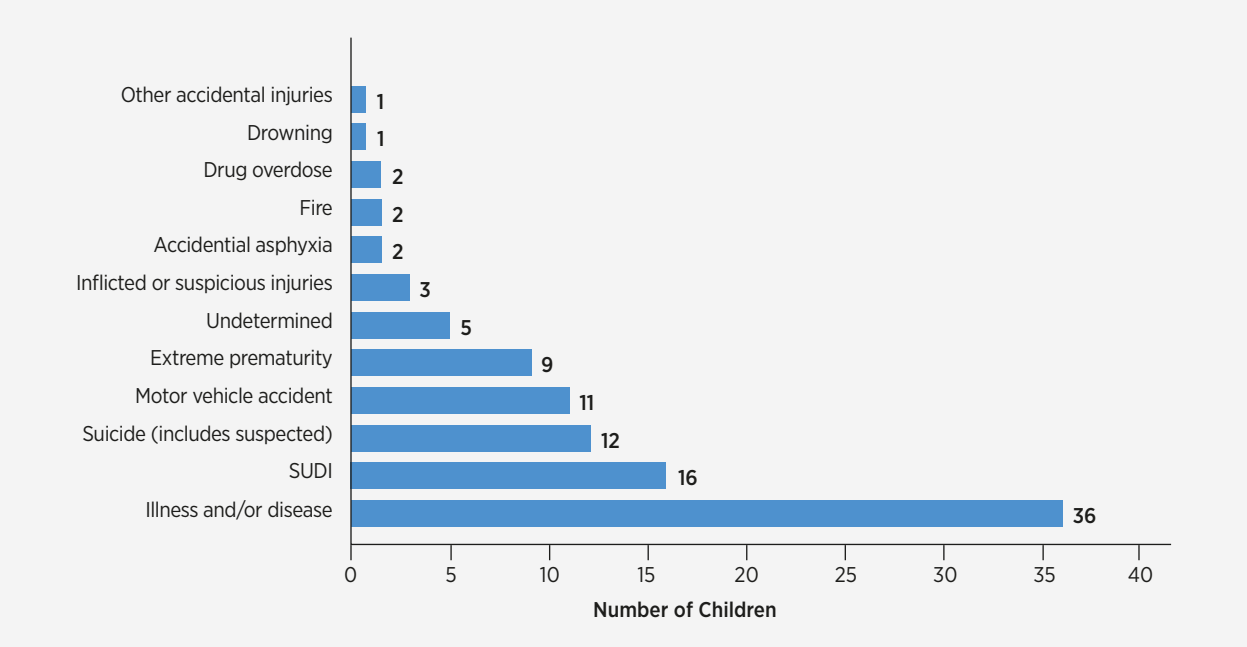
Of the 100 children who died, 84 deaths were attributed to five main circumstances. The most common circumstance of death was illness and/or disease (36 children). This was followed by sudden unexpected death in infancy (SUDI) (16 children), suicide (12 children), motor vehicle accident (11 children) and extreme prematurity (9 children).

Figure 3 (a repeat of Figure 1 in this report) shows the circumstances of death for the children who were known to DCJ in 2020. The categories used to describe the circumstances of death can be different to the cause of the child's death. For example, the cause of a child's death might be 'multiple injuries', while the circumstance of death may be a motor vehicle accident.

29 Information provided by the NSW Ombudsman's Office on 13 July 2021. The information is subject to change due to subsequent reporting of deaths to the CDRT.
30 The number of children who died in NSW was provided by the NSW Ombudsman's Office.
31 The slight increase was by three children. In 2019, there were 97 children who died.
32 In 2020, DCJ received 257,640 ROSH reports, involving 118,837 children (data were extracted by the Child Reporting Team, FACSIAR, on 8 July 2021).

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

Figure 3: Children who died in 2020 and were known to DCJ, by circumstance of death [33]



Over the five-year period 2016 to 2020, the number of deaths across each of the circumstances has remained relatively stable. Death from illness and/or disease has remained the most prevalent circumstance for all children who died and who were known to DCJ. This is consistent with the deaths of children in the general population.[34]

Table 1: Children who died and were known to DCJ, by circumstance of death, 2016–2020

	2016		2017		2018		2019		2020	
CIRCUMSTANCE OF DEATH	No.	%	No.	%	No.	%	No.	%	No.	%
Accidental asphyxia	0	0%	1	1%	1	1%	1	1%	2	2%
Accidental choking	0	0%	0	0%	1	1%	1	1%	0	0%
Drowning	5	5%	1	1%	2	2%	3	3%	1	1%
Drug overdose	1	0%	1	1%	2	2%	3	3%	2	2%
Extreme prematurity	11	12%	13	14%	10	11%	10	10%	9	9%
Fire	2	2%	0	0%	1	1%	3	3%	2	2%
Illness and/or disease	34	36%	46	50%	39	44%	32	33%	36	36%
Inflicted or suspicious injuries	4	4%	5	5%	8	9%	7	7%	3	3%
Motor vehicle accident	9	10%	2	2%	10	11%	6	6%	11	11%
Other accidental injuries	2	2%	1	1%	1	1%	3	3%	1	1%
SUDI	15	16%	15	16%	10	11%	19	20%	16	16%
Suicide (includes suspected)	11	12%	4	4%	8	9%	7	7%	12	12%
Undetermined	0	0%	2	2%	0	0%	2	2%	5	5%
Total	**94**	**100**	**91**	**100**	**93**	**100**	**97**	**100**	**100**	**100**

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

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

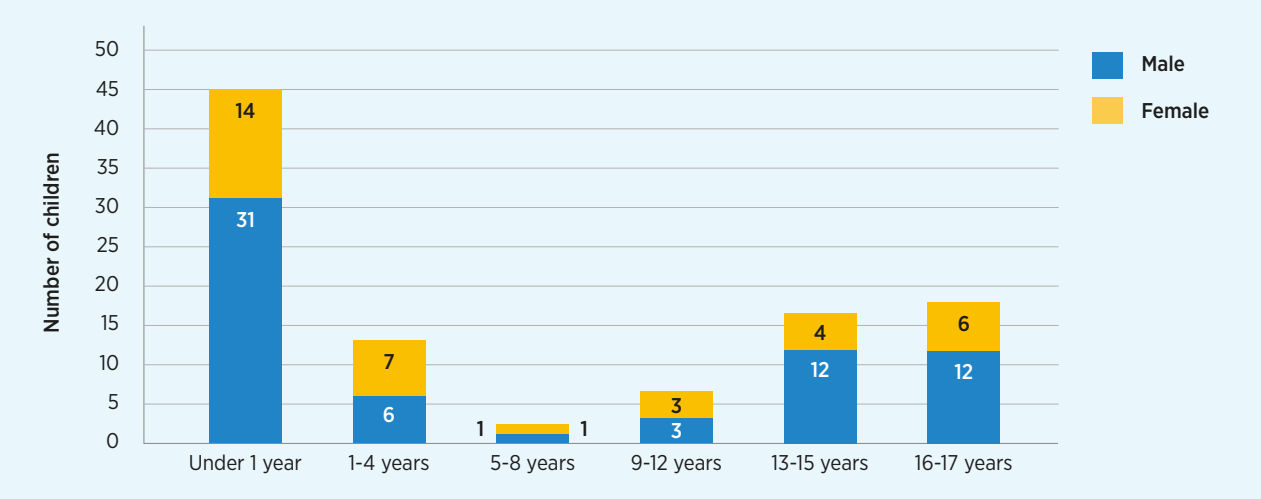
2.2 Characteristics of the children

2.2.1 Age and gender

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

In 2020, 65 children who died were male, and 35 were female. This aligns with the CDRT *Biennial report of the deaths of children in NSW: 2018 and 2019* which found that males had mortality rates 1.4 times higher than females (in 2018 and 2019).[36] Although a consistent trend, the male to female difference seen in 2020 is the highest comparative rate seen for the children known to DCJ who have died in the past five years.

Figure 4: Children who died in 2020 and were known to DCJ, by age and gender



Infants aged under 12 months

Of the 45 infants who died under the age of 12 months, 31 (69 per cent) were male and 14 (31 per cent) were female.

Thirty-seven of the infants (82 per cent) died within three months of their birth.

The main circumstances of death for infants under the age of 12 months were:

- SUDI (16 infants; 12 male and 4 female)
- Illness and/or disease (15 infants; 9 male and 6 female)
- Extreme prematurity (9 infants; 7 male and 2 female)
- Suspicious or inflicted injury (3 infants; 2 male and 1 female)
- Fire (1 female infant)
- Accidental asphyxia (1 male infant).

Children aged one to 12 years

Of the 21 children who died aged from one to 12 years there was little difference by gender; 47 per cent of the children were male and 53 per cent were female.

The main circumstances of death for children in this age group were:

- Illness and/or disease (13 children; 7 male and 6 female)
- Undetermined causes (4 children; 1 male and 3 female)
- Motor vehicle accident (2 children; 1 male and 1 female)
- Accidental asphyxia (1 male child)
- Other accidental injuries (1 female child).

35 In 2019, 47 of the children who died were under the age of 12 months; in 2018, 36 of the children who died were under the age of 12 months.

36 NSW Ombudsman (2021).

Children aged 13 to 15 years

Of the 16 children aged from 13 to 15 years when they died, 12 were male and four were female.

The main circumstances of death for this age group were:

- Illness and/or disease (6 children; 5 male and 1 female)
- Suicide or suspected suicide (6 children; 4 male and 2 female)
- Motor vehicle accidents (2 male children)
- House fire (1 female child)
- Accidental drug overdose (self-administered) (1 male child).

Young people aged 16 to 17 years

Of the 18 young people aged 16 to 17 years, 12 (67 per cent) were male and six (33 per cent) were female. The greater proportion of males than females is attributed to the higher number of males represented in motor vehicle accidents and suicide deaths.

The main circumstances of death for this age group were:

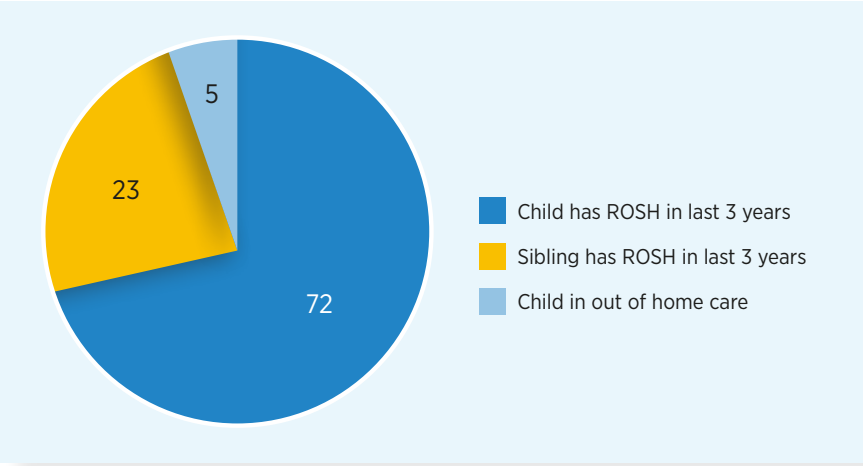
- Suicide or suspected suicide (6 young persons; 4 male and 2 female)
- Motor vehicle accidents (7 young persons; 5 male and 2 female)
- Illness and/or disease (2 young persons; 1 male and 1 female)
- Drowning accidents (1 male young person)
- Accidental drug overdose (self-administered) (1 male young person)
- Underdetermined (1 female young person).

Deaths from suicide and motor vehicle accidents were also the most common circumstances of death for the general population of children aged 16 and 17 years who died in NSW in 2018 and 2019.[37]

2.2.2 Reported child protection history

As seen in Figure 5, 72 of the 100 children who died in 2020 were known to DCJ because a ROSH report had been made about them in the previous three years. Twenty-three children were known to DCJ because a ROSH report had been made about their sibling/s in the previous three years. Five children were living in out of home care.[38]

Figure 5: Number of children who died in 2020, by how they were known to DCJ



37 The *Biennial report of the deaths of children in NSW: 2018 and 2019* found that for all children aged 15 to 17 years who died in NSW, the main circumstances of death were suicide and transport accidents.

38 For four of the five children in out of home care, ROSH reports were made about them within the past three years. One child had been in out of home care for more than five years and no ROSH reports were made during this time.

Of the 72 children who were the subject of a ROSH report before their death, most did not have a lengthy child protection history. Twenty-nine (40 per cent) of the children had two or fewer ROSH reports and 19 (27 per cent) children had between three and five ROSH reports made about them before they died. Nineteen (27 per cent) children were reported at risk of significant harm more than five times, and five (7 per cent) had more than 25 ROSH reports raising concerns about them before their death.

PREMIER'S PRIORITY – PROTECTING OUR MOST VULNERABLE CHILDREN

Decreasing the proportion of children and young people re-reported at risk of significant harm by 20 per cent by 2023.

Why is this important?

Children and young people deserve to have the best possible start in life and to live free from abuse and neglect. Once a child has been reported at 'risk of significant harm', child protection practitioners support families to create change and provide safer homes for their children. Reducing re-reporting is important because it demonstrates the effectiveness of the support provided to vulnerable families, either by DCJ to make children safer, or through its partnerships with the broader service system.

Tracking progress

Achieving this Premier's Priority will result in 20 per cent fewer children and young people re-reported to the child protection system by 2023.

Performance against this indicator is challenging. The rate of re-reporting continues to hover around the 40% mark in 2020–2021, and the trajectory is not approaching the target. Over the past decade there has been a consistent year on year trend of increasing ROSH reports, with many of these reports being re-reports. This increased level of community reporting places upward pressure on the re-report rate.

The government is closely monitoring the available data for this priority due to concerns that the COVID-19 pandemic and recession could lead to heightened risk for the children in this cohort.

What is being done?

Reducing re-reporting has been a Premier's Priority since the last term of government. Much was done to improve practice and lower re-reports during that time, leading to better outcomes for many children in NSW.

In March 2021, DCJ established a re-reporting taskforce to build on this work by developing and implementing a number of interconnected strategies that will result in a significant system shift. Three strategies were developed to ensure better outcomes for our most vulnerable children. These are:

- Improving assessments of ROSH reports
- Focusing casework interventions on key areas of evidence-based practice
- Enhancing future safety through improved closure decisions and support for mandatory reporters.

See www.nsw.gov.au for more information about this Premier's Priority.

2.3 Aboriginal children who died in 2020 and were known to DCJ

In 2020, Aboriginal children in NSW continued to represent a significant proportion of the deaths of children known to DCJ, although there was a decrease in the number of Aboriginal children who died compared with previous years.[39]

Of the 100 children who died in 2020, 23 were Aboriginal.

Aboriginal children and families continue to be significantly over-represented in the NSW child protection system. Aboriginal children are reported at a disproportionally higher rate and are three times more likely to be taken into care. The proportion of Aboriginal children in out of home of care in NSW has continued to increase. As at June 2019, 39 per cent of the children in out of home care were Aboriginal.

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

In addition to the broader reforms in place, DCJ practitioners have a responsibility to work in partnership with Aboriginal families and communities to keep children safe.

Culturally responsive practice involves acknowledging that Aboriginal children and families are the experts on their experiences, fostering self-determination and ensuring a child's culture is considered in every decision made about their care. Connection to Aboriginal culture protects children, and provides a sense of belonging and understanding of identity. Practitioners can draw on the strength and support of communities, wisdom and leadership from Elders, and learn about the cultural practices, protocols and spirituality that supports healing and parenting. Guidance on how to do so should come from cultural consultation with Aboriginal staff and community members.[40]

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

2.3.1 Circumstance of death

Unlike previous years, the deaths of children from illness and/or disease did not represent the highest circumstance of death for Aboriginal children. In contrast, there was an equal number of children who died in circumstances of illness and/or disease, SUDI and from suicide or suspected suicide.

Of the 23 Aboriginal children who died, their circumstances of death were:

- Illness or disease (5 male children)
- Suicide or suspected suicide (5 male children)
- SUDI (5 children; 3 male and 2 female)
- Motor vehicle accident (2 male children)
- Extreme prematurity (2 male children)
- Drug overdose – child accidently self-administered (1 male child)
- Accidental asphyxia (1 male child)
- Inflicted or suspicious injury (1 female child)
- Undetermined (1 male child).[41]

39 In 2019, of the 97 children who died and were known to DCJ, 33 (32 per cent) were Aboriginal children.
40 See Casework Practice > Cultural practice with Aboriginal families for more information about ensuring culturally responsive practice in casework.
41 One child's cause of death was unable to be determined by the NSW State Coroner before publishing this report.

2.3.2 Age and gender

Of the 23 Aboriginal children who died, 20 were male and three were female. This represents a change in the gender make-up of Aboriginal children who died in previous years. Fourteen (60 per cent) of the 23 Aboriginal children who died were under the age of five years, which is a decrease from 2019.[42]

ABORIGINAL CHILD AND FAMILY CENTRES

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

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

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

An evaluation of the ACFC program in 2014 found that the proportion of Aboriginal children receiving all relevant health checks had increased from 81 per cent to 95 per cent. An outcomes evaluation has been completed and DCJ districts are working with local service providers and communities to determine how the centres can best meet the needs of the local population in the future.

2.3.3 Aboriginal children in out of home care

There were no Aboriginal children living in out of home care known to DCJ who died in 2020. This represents a significant decrease from previous years.[43]

DCJ response to the Aboriginal children who died and their families

Of the 23 Aboriginal children who died and were known to DCJ, 18 children had a ROSH report made about them in the three years before their death. For the remaining five children, their sibling had been reported at risk of significant harm in the three years before the child's death.

Of the 18 Aboriginal children who were reported at risk of significant harm in the three years before their death:

- 14 children had a ROSH report in the previous 12 months[44]
- Four children had a ROSH report in the previous three years.[45]

42 In 2019, 23 (70 per cent) of the Aboriginal children who died were under the age of five years.

43 In 2019, five (15 per cent) of the 33 Aboriginal children who died were living in out of home care. In 2018, five (13 per cent) of the 36 Aboriginal children who died were living in out of home care.

44 The number of ROSH reports received for each child varied. Ten of the 14 children had five reports or less. For the other five children, between five and 60 ROSH reports had been received.

45 This means that the concerns reported about the children were received more than 12 months but less than three years before their death.

Reported issues of concern

The issues of concern reported for the 23 Aboriginal children who died and their siblings were:

- Parental alcohol and drug use (17 families)
- Domestic violence (16 families)
- Physical abuse (14 families)
- Sexual abuse (12 families)
- Neglect (11 families)
- Parental mental health (8 families).

Of the 18 children who were the subject of a ROSH report in the three years before their death, DCJ undertook an assessment for 16 children (89 per cent) before they died. For two children DCJ did not undertake an assessment. For one child the only ROSH report about them was the report that led to their death,[46] and a susequent sibling safety assessment found no risk issues for the child's siblings. For the other child where an assessment was not undertaken, there was a related Joint Child Protecton Response assessment undertaken which determined that further enquiries could not proceed.

DCJ sibling safety response

Sibling safety assessements were undertaken for 10 of the Aboriginal children known to DCJ. All of the children's siblings were assessed as safe. For two of the children's siblings a safety plan was put in place to ensure their continued safety. Of the remaining 13 Aboriginal children who died, sibling safety assessements were not undertaken because no risk issues were identified (10 children),[47] the children's case was allocated and they were the subject of ongoing work (2 children) or there were no siblings whose safety needed to be assessed (1 child).

Practice themes

Culturally responsive practice was a key theme in the reviews of DCJ practice with Aboriginal children. Some of the reviews identifed very good cultural practice. After a child had died, practitioners needed to work with the child's family and community to balance the need for a compassionate and supportive response with assessing safety for surviving siblings. Consulting with Aboriginal staff was a key theme in these examples of good practice.

However, many cases still demonstrated a lack of cultural consultation and serious case reviews provided feedback on how improved cultural consultation could have occurred. Engaging family in discussions about culture, keeping appropriate records of children's Aboriginality and making referrals to culturally appropriate services were some of the suggestions provided in serious case reviews.

Feedback from serious case reviews about culturally responsive practice

'Consultation is a key tool for culturally responsive practice. Consulting with family, local Aboriginal Elders and organisations provides information about local customs, parenting practices, family and community dynamics and referral pathways.'

'Caring about, respecting and understanding culture requires practitioners to acknowledge past injustices that took away Aboriginal families' basic human rights, their families and connection to Country and ensures that current day practices do not repeat them. Aboriginal consultation is essential in providing practitioners with insight into a family and/or community's context and to identify culturally safe supports for Aboriginal families who are experiencing the impact of abuse across generations.'

'Aboriginal consultation is an important way of empowering Aboriginal families and communities to help make decisions on matters that affect the care and protection of their children and young people. It involves casework staff engaging genuinely in the process and seeking specific knowledge, skills and assistance to ensure practice meets the needs of children and their families.'

46 The child died suddenly and unexpectedly.

47 The 10 children's deaths were illness/disease (three children), extreme prematurity (two children) suicide (one child), SUDI (one child), drug overdose (one child), motor vehicle accident (one child).

The reviews also found a number of other practice themes not specifically related to culture:

- The use of safety and risk assesment tools to guide decision-making
- Appropriate securing of records when DCJ staff were named in ROSH reports
- Developing measurable family action plans to support change
- Engaging young parents, who had experienced abuse and neglect themselves as children, to understand how their experiences affected their parenting capacity
- Involving fathers in practice.

Recommendations to improve practice

Several reviews identified the need for further action to improve practice. These actions include:

- Updating children's records to appropriately identify children's Aboriginality
- Seeking an Aboriginal consultation to inform future work with a child and their family
- That if future ROSH reports are received for other children in the family, those reports should be prioritised for assessment to allow consideration of the risks not adequately addressed by previous assessments.

ABORIGINAL CULTURAL CAPABILITY FRAMEWORK

The **Aboriginal Cultural Capability Framework** (ACCF) provides a roadmap to support staff and DCJ as an organisation to build cultural capability to deliver better outcomes for Aboriginal families.

It addresses the need for improved cultural capability and cultural safety in DCJ, where up to 40 per cent of clients are Aboriginal people. The work covered by the framework should result in DCJ becoming a more culturally capable and safe place for Aboriginal people including Aboriginal staff in DCJ.

Aboriginal staff, experts, Elders, families, carers, community organisations, peak bodies and government and non-government agencies worked with DCJ over a six-month stakeholder engagement process to develop the framework.

More than 2,000 staff also said, in a staff survey in 2017, that they wanted support to improve their cultural capability to work better with Aboriginal families and deliver better outcomes for them.

Learn more about the framework at DCJ initiatives > **Aboriginal Cultural Capability Framework**.

2.4 Circumstances of child deaths

This section of the chapter considers the circumstances of death for all the 100 children who died in 2020.

2.4.1 Deaths from illness and/or disease

Consistent with previous years, child deaths from illness and/or disease accounted for the greatest number deaths in 2020. Thirty-six children died from illness and/or disease in 2020, which is proportionally consistent with previous years. Table 2 provides further detail.

The high number of children known to DCJ who died from illness and/or disease is consistent with findings from the NSW CDRT, which undertakes analysis about all children who die in NSW. In 2018 and 2019, 989 children died in NSW, with natural causes the leading underlying cause of death for all infants and children aged from birth to 17 years.[48]

Of the 36 children known to DCJ who died from illness and/or disease, information provided to DCJ indicates that 28 were diagnosed with a medical condition before their death and 15 had a diagnosed disability before their death.[49]

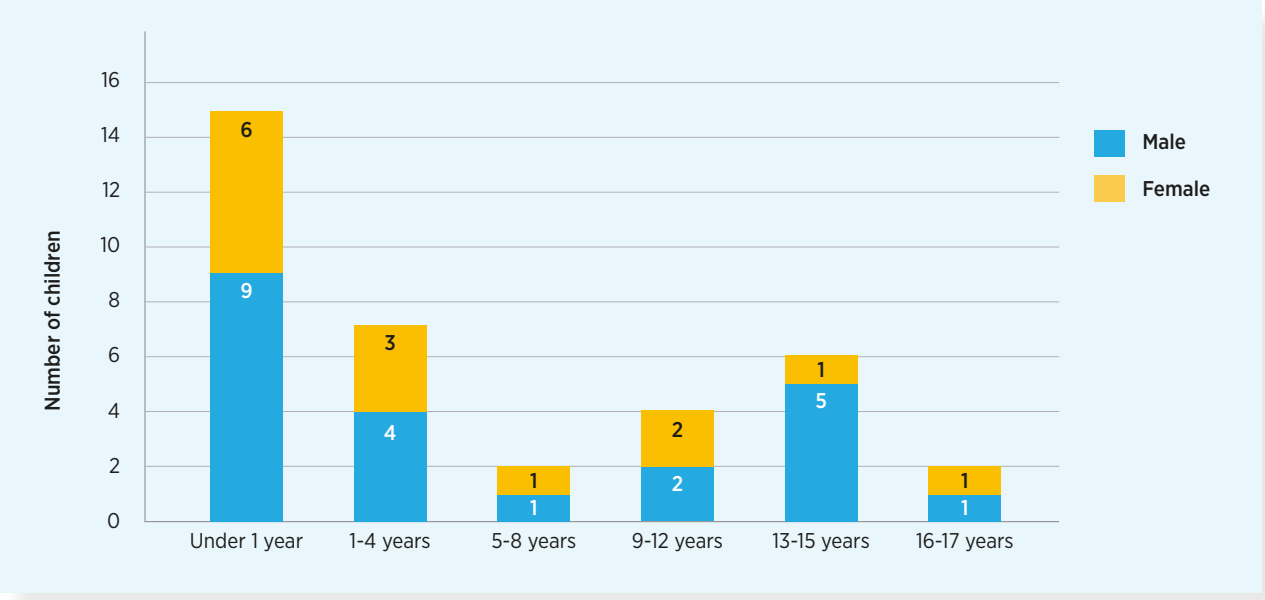
One of the children who died from illness and/or disease was under the parental responsibility of the Minister, and living with authorised carers.

As shown in Figure 6, infants under the age of 12 months (15 children) made up the largest group of children who died from illness and/or disease. This was followed by children aged one to four years (7 children) and children aged 13 to 15 years (6 children).

Table 2: Children who died from illness and/or disease and were known to DCJ, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	34	46	39	32	36
% of total deaths	36%	50%	44%	33%	36%
Age range	0–17 years	0–17 years	0–17 years	0–17 years	0–17 years

Figure 6: Children who died in 2020 from illness and/or disease, by age and gender



48 NSW Ombudsman (2021).

49 These figures are based on information known to DCJ. It is possible that more children had an existing medical condition and/or disability before their death that was not reported to the Department.

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

For 27 of the 36 children who died from illness and/or disease DCJ received a ROSH report raising concerns about them before their death.[50] The remaining eight children were not reported at risk of significant harm and were known to DCJ due to concerns that had been reported about their sibling/s in the three years before the child's death; one child was living in out of home care.

Twenty-four of the 36 families had been seen by DCJ caseworkers and an assessment completed with the family before the child's death. Holistic assessment is important when working with families who have a child who has been diagnosed with an illness and/or disease. The safety needs of the child can be overlooked, particularly when the child has complex health needs. When working with a family where a child has been diagnosed with an illness and/or disease caseworkers must manage the challenging task of assessing the child protection concerns at the same time as considering the child's medical needs.

Reported issues of concern

The issues reported to DCJ included:

- Physical abuse (15 families)
- Parental alcohol and/or drug use (15 families)
- Sexual abuse (13 families)
- Neglect (12 families)[51]
- Domestic violence (9 families)
- Parental mental health (8 families)
- Child or young person's risk-taking behaviour (2 families)
- Family violence (2 families).

DCJ sibling safety response

Sibling safety assessments were completed for five of the 36 families in which children had died in circumstances of illness and/or disease. All five assessments indicated the sibling/s were safe in their parents' care.

For the 31 families who did not receive a sibling safety assessment the reasons were:

- The report was not allocated at the CSC after enquiries were made with other services and it was confirmed that the family was being supported (5 families)
- No siblings or other children under 18 years were living in the household (9 families)
- No risk issues were identified for the siblings (17 families).

It is common for the Helpline to assess information about a child's death from circumstances of illness and/or disease as not meeting the ROSH threshold and this not proceeding to a sibling safety assessment. This is usually due to information that the child's death is expected and there are no reported issues of abuse, neglect or suspicious circumstances related to the child's death. There is also often a delay between when the child died and when information about the child's death is reported to DCJ. On review, many of these families received support from medical and community services for the child and their family throughout the course of the child's illness and/or disease.

Practice themes

The key themes arising from a review of DCJ work with children who died from illness/and or disease and their families indicated that, in some cases, the stressors for parents and carers of a child with an illness or disease can lead to and exacerbate other child protection concerns, such as parental mental health issues, domestic violence, problematic drug and alcohol use, and the neglect of the child or young person's medical, physical and emotional needs. Recognising the challenges faced by parents and

50 Sixteen of the 27 children with a ROSH report raising concerns about them before their death, had those concerns raised within 12 months of their death.

51 Reported issues of neglect included supervisory neglect (10 families), medical neglect (9 families), emotional neglect (9 families), physical neglect (8 families) and educational neglect (5 families).

carers of a child with an illness or disease is critical to understanding and better supporting families, and assessing safety and risk for children.

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

Recommendations to improve practice

Five of the reviews for children who died in circumstances of illness and/or disease made recommendations for practice improvement in general, and in ongoing casework with the children's families. These recommendations include:

- Clarifying a family's Aboriginality and consulting with Aboriginal practitioners to ensure culturally appropriate practice with the family
- To review the CSC application of the Triage Assessment mandate specifically around responding to prenatal reports
- To consider refresher training in engaging fathers and working with men who use violence.

Several reviews made recommendations that if further ROSH reports were received about siblings in the family, that DCJ considers prioritising the family for an assessment.

WORKING WITH FAMILIES OF CHILDREN WHO HAVE AN ILLNESS AND/OR DISEASE

The *Child Deaths 2017 Annual Report* included a cohort review on children and young people who died from illness and/or disease and provides practice advice about working with families.

2.4.2 Sudden unexpected death in infancy

The NSW CDRT[52] defines sudden unexpected death in infancy (SUDI) as the death of an infant younger than 12 months that is sudden and unexpected, where the cause is not immediately apparent at the time of death. Excluded from this definition are infants who died unexpectedly as a result of injury, and deaths that occurred in the course of a known acute illness in a previously healthy infant. Further classifications for SUDI are:

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

Table 3: Infants who died suddenly and unexpectedly and were known to DCJ, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	15	15	10	19	16
% of total deaths	16%	16%	11%	20%	16%
Age range[53]	0–11 months	0–9 months	0–11 months	0–12 months	0–8 months

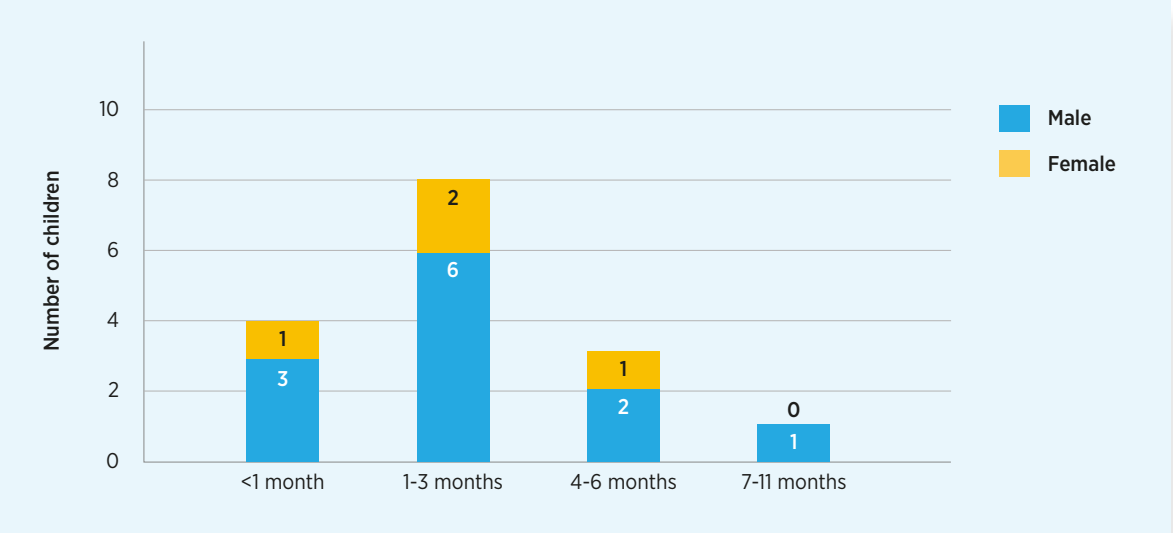
52 The NSW CDRT examines and analyses the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths. The NSW Ombudsman is the CDRT Convenor.

53 The age range shown reflects the actual age in months of the infants who died each year.

Sixteen of the 100 children who died and were known to DCJ in 2020 died suddenly and unexpectedly. Post-mortem reports or a final coronial certificate of death were available for nine of the 16 children. Once a final post-mortem is received for the other seven children, the circumstances of death could change and the total number of SUDI deaths that occurred in 2020 may vary.[54]

As shown in Figure 7, 12 of the babies who died suddenly and unexpectedly were aged three months or less. In 2020, 12 of the babies were male and four were female.

Figure 7: Infants who died in 2020, suddenly and unexpectedly and were known to DCJ, by age and gender



Risk factors associated with SUDI deaths

Risk factors associated with SUDI can be intrinsic and extrinsic. Intrinsic risks are individual factors that 'affect an infant's susceptiblity'[55] and include things such as premature birth, low birth weight and prenatal exposure to smoking, drugs and alcohol. In its latest report,[56] the CDRT states that 'intrinsic factors are generally not modifiable, except for exposure to maternal cigarette smoking (or other drug and alcohol consumption) during pregnancy'.

Extrinsic factors are environmental and modifiable and can be avoided or changed. They include factors such as sleep position, sharing a sleep surface and overheating.

Practitioners must understand and be aware of modifiable intrinsic and extrinsic risk factors. When working with families who are known to DCJ, practitioners must be clear in their advice about safe sleeping and should use language that is strong, clear and consistent.

DCJ response to the children who died suddenly and unexpectedly

Of the 16 babies who died suddenly and unexpectedlyin 2020, 10 had a report made about them before they died. Six babies were known to DCJ because reports had been received about their older siblings in the three years before they died.

Three of the 10 babies who were reported became known to DCJ because a ROSH report was made about the circumstances that led to their death, and there was a short time period between the report being made to DCJ and the baby's death.[57] One baby was only known to DCJ due to requests for assistance that were made by the family to which DCJ had responded.

54 Once a post-mortem is received, the circumstances of death are updated and numbers are corrected for previous years. For example, a death classified as SUDI may be later confirmed to have occurred due to illness and/or disease.
55 NSW Ombudsman (2021).
56 ibid.
57 In these circumstances the baby was often taken to hospital in a critical condition, a ROSH report was made by a mandatory reporter and the baby subsequently died after the ROSH report was made.

In July 2019, NSW Health published a revised policy directive called **Management of Sudden Unexpected Death in Infancy (SUDI)**. This policy is the most comprehensive resource available in relation to cross-agency responses to SUDI. The revised policy outlines the mandatory requirements for management of SUDI in NSW health facilities as well as the role of other agencies that respond to SUDI including NSW Ambulance, the NSW Coroner and NSW Police.

Of the other six babies who had a ROSH report made about them before they died, DCJ undertook a safety and risk assessment for one of the babies and casework was ongoing with the family when the baby died. DCJ had not completed assessments for the other five babies. Their reports were awaiting allocation at a CSC (1 baby), had been referred to an external service for support (2 babies) or had been closed without assessment due to the family not being located (1 baby) or capacity issues at the CSC that prevented a child protection response (1 baby).

For the six babies who were known because of ROSH reports received for their older siblings, DCJ had completed safety and risk assessments for three families. The other three families had not received an assessment due to capacity issues that existed at the CSC when reports were received.

Reported issues of concern

The issues reported to DCJ for the families who were known because of a history of ROSH concerns included:[58]

- Parental alcohol and/or drug use (11 families)
- Father's use of violence towards the mother (11 families)
- Supervisory neglect (10 families)
- Physical abuse (6 families)
- Physical neglect (6 families).

DCJ sibling safety response

Sibling safety assessments were completed for 11 of the families (69 per cent) whose children died in circumstances that were sudden and unexpected. For one family, a sibling was found to be unsafe and arrangements were made for their safe care. For the five families who did not receive a sibling safety assessment the reasons were:

- No siblings or other children living in the household (1 family)
- The family was living in supported accomodation and being closely supported by services (1 family)
- No risk issues were identified for the siblings (3 families).[59]

Practice themes

The majority of babies (12 out of 16) who died suddenly and unexpectedly were found to have modifiable risk factors present in their sleeping environment. For these 12 babies this included:[60]

- Being placed to sleep somewhere other than a cot or bassinet (11 babies)
- Being placed to sleep in bed with a parent or sibling (8 babies)
- Having soft objects or their head covered in the sleep environment (4 babies)
- The child being either breast or bottle-fed by a parent who fell asleep (2 babies).

An ongoing challenge for practitioners working with families who experience a range of vulnerabilities is that advice to parents about safe sleeping practices for their infants are not always received,

58 Numbers do not add up to 16 due to multiple issues being reported for some families.
59 Two of these families were only known to DCJ because of the circumstances that led to the child's death and the other family was known because of one report only for an older sibling.
60 Numbers do not add up to 12 as some babies had more than one modifiable risk factor present when they died.

understood or adopted. In some instances, safe sleeping arrangements may need to be assessed over time as part of the safety and risk assessment process. Practitioners need to build relationships with families and communities, and support families to find ways to keep their infants safe. It is important that practitioners are consistent, persistent and non-judgemental when talking to families about safe sleeping arrangements. Where appropriate, referrals to other family support services, such as Tresillian or Karitane, may be needed. When working with Aboriginal families, it is important to use cultural consultation and engage expertise from Aboriginal practitioners or services. The Red Nose Foundation has resources that have been developed by and provide Aboriginal families with advice about how to sleep their baby safely.

Recommendations to improve practice

Of the reviews about children who died suddenly and unexpectedly, four made recommendations about ongoing casework with the families of the children who died. These recommendations included that the CSC review its practice around:

- using group supervision to make decisions about families
- the need for refresher training in the safety and risk assessment framework
- training on safety planning in the context of domestic violence
- better use of Aboriginal consultation to ensure culturally appropriate practice.[61]

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

SAFE SLEEPING

Ask to see the infant's cot

- Does it meet the Australian safety standard?[62]
- Is the mattress in good condition? Is it firm, flat and the right size for the cot?
- Make sure there is nothing in the cot – remove all loose/soft objects, including toys, pillows, bumpers and loose bedding, and talk to parents about the dangers of these items.
- Ask the parents to show you how they put their infant to sleep and where appropriate demonstrate safe sleeping positions.
- Reinforce to parents that the safest place for their infant to sleep is in a cot next to their bed.
- Explain to parents that covering an infant's head increases the risk of sudden infant death.
- Is the bedroom free of other risks, including cigarette smoke?

Assess the risk of substance use

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

61 See section 2.3.3 for practice insights about using Aboriginal consultation to ensure culturally appropriate practice.
62 All infant's cots must meet Australian and New Zealand Standard AS/NZS 2172:2003 Cots for household use – safety requirements.

Discuss sleep routines

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

Parents who smoke

- Explain the increased risk of SUDI for infants exposed to smoke, particularly if they share a sleep surface with a parent who smokes.
- Look for indicators such as ashtrays and a smell of smoke in the home.
- Remind parents to ask others in the home or visitors not to smoke in the home or car.
- Explain that even second-hand smoke or smoke on clothes is a risk.
- Talk to parents about wearing a 'smoking shirt' and hair covering, and removing them before coming inside, and washing their hands after smoking.

Talk to breastfeeding mothers

- Educate mothers so they are aware of the potential dangers of fatigue and sedation.
- Encourage mothers to breastfeed their infant out of bed to avoid the risk of falling asleep.
- If the mother is using substances, practitioners should refer to the breastfeeding advice in the **NSW Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period**.[63]

Did you know?

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

DCJ CASEWORK PRACTICE

The **Alcohol and Other Drugs Practice Kit** contains useful advice for working with parents to address concerns about unsafe sleeping practices.

See Casework Practice > Support > Practice kits > Alcohol and other drugs > Working with expecting and new parents.

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

SUPPORTING PARENTS IN THEIR GRIEF AND LOSS

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

See rednosegriefandloss.org.au

Appendix 1 also provides a list of counselling and support services.

2.4.3 Deaths related to premature births

Each year, infants who die in circumstances related to their extreme prematurity[64] account for one of the highest circumstances of death among children known to DCJ.

In 2020, nine babies known to DCJ died from conditions related to their extreme prematurity. The number and proportion of children who have died in cirumstances of extreme prematurity since 2016 has remained consisten.

Table 4: Infants who died from conditions related to their premature birth and were known to DCJ, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	11	13	10	10	9
% of total deaths	12%	14%	11%	10%	9%
Age range	0–1 months	0–3 months	0–6 months	0–4 days	0–8 months

Premature birth occurs for a range of reasons and at various times during the gestational period. For the nine babies known to DCJ, six were born premature spontaneously, and three births were medically induced.

A DCJ cohort review of children who died in circumstances related to premature birth in 2019 reinforced the importance of prioritising allocation of prenatal reports. This acknowledges the risks for unborn babies and the importance of work with parents at a time when they are often motivated to make changes.[65]

DCJ response to the babies who died in circumstances related to premature birth

Of the nine children who died in circumstances related to their premature birth, only three of the children had a ROSH report made about them prior to their death. For two of these children a prenatal ROSH report was received. For the other child the report was received after the child's birth. The remaining seven children were known to DCJ prior to their death because their sibling was the subject of a ROSH report.

For the two children where ROSH concerns were raised prior to birth, DCJ intervention included safety and risk assessments and a plan with the family to address the risks. For the remaining families, interventions included safety and risk assessments (4 families) and referral to early intervention services such as Brighter Futures (3 families). For two of the families, DCJ had made the decision not to see the families after making enquiries with other services and ensuring supports were in place. For one family the CSC was satisfied that the issues were being addressed by decisions made in the Family Court of Australia.

64 The World Health Organization distinguishes between three categories of premature births: moderately premature (32–36 weeks gestational age), very premature (28–32 weeks) and extremely premature (27 weeks or less). See www.who.int/news-room/fact-sheets/detail/preterm-birth

65 NSW DCJ (2020).

Reported issues of concern

Understanding the broader factors impacting on the nine families provides greater insight into some of the issues which may have contibuted to the premature births of the babies and the support needs of the families. The concerns raised with DCJ included:[66]

- Parental alcohol and drug use (7 families)
- Physical abuse (5 families)
- Domestic violence (5 families)
- Physical neglect (5 families)
- Supervisory neglect (5 families)
- Medical neglect (4 families)
- Parental mental health (4 families).

DCJ sibling safety response

A sibling safety assessment was completed for one of the families. Eight families did not receive a sibling safety assessment because:

- There were no identified risk factors identified in the report about the baby's death (5 families)
- The siblings were not living in the current household (3 families).

Practice themes

One of the key themes from reviews of DCJ practice was the opportunity for DCJ to better understand the experiences of the parents, and to empathise and show compassion at a time when they were most vulnerable and had to make difficult medical decisions about their pregnancies.

DCJ CASEWORK POLICY AND PRACTICE

The Prenatal Policy: **Responding to Prenatal Reports** and corresponding practice mandate have been updated following review. The main changes and updates to the policy include:

- For the purpose of the policy, imminent birth is now defined as 32 weeks gestation (reduced from 37 weeks)
- A major emphasis on early intervention, as working with families during the gestation period can result in major and lasting change
- Articulating the need for effective and regular communication with NSW Health
- De-gendering language from 'pregnant women' to 'expectant parent'; encouraging the inclusion of fathers/co-parents where appropriate
- Changes in line with DCJ domestic violence policy, including introducing coercion and control as a high risk factor (previously only related to physical abuse resulting in serious injury)
- Documents brought in line with the Practice Framework, including dignity driven practice and holistic practice
- Additional practice advice, including when and how to make appropriate referrals to NSW Health, obtaining early legal advice and working with incarcerated expectant parents
- Updated information on working with Aboriginal families, shaped by advice from stakeholders
- Updated terminology for Structured Decision Making assessments and ChildStory
- Updates to reflect the PSP and permanent placement principles, case planning for permanency and permanency coordinator consultations
- The requirement to access Family Group Conferencing or Pregnancy Group Conferencing where available; caseworkers must record reasons why this is not completed.

66 Numbers do not add up to nine because children can be reported across multiple categories of risk.

2.4.4 Suicide

In 2020, 12 children known to DCJ died in circumstances of suicide or suspected suicide, as shown in Table 5. Eight of the children who died in 2020 were male and four were female.

Deaths from suicide are explored further in Chapter 3 of this report, which includes a five-year cohort review of children and young people who died in circumstances of suicide or suspected suicide between 2016 and 2020.

Table 5: Children who died by suspected suicide and were known to DCJ, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	11	4	8	7	12
% of total deaths	12%	4%	9%	7%	12%
Age range	13–17 years	< 10–17 years	13–17 years	13–17 years	12–17 years

2.4.5 Motor vehicle accidents

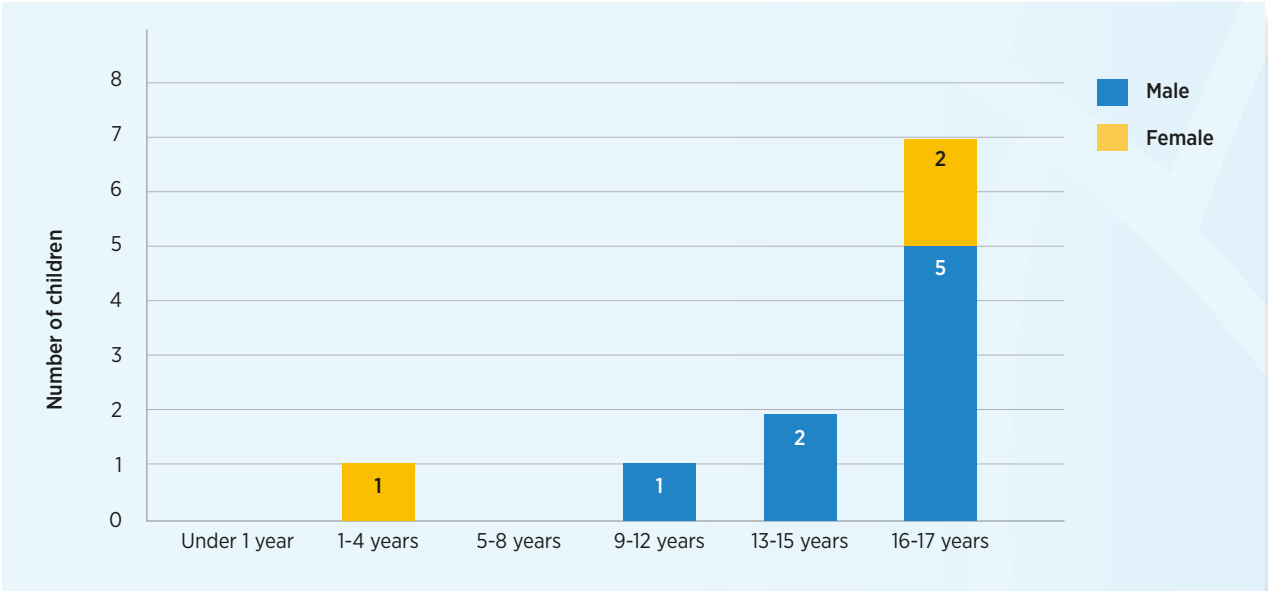
In 2020, 11 children known to DCJ died from injuries sustained during a motor vehicle accident. This includes children who were driving a vehicle, were a passenger in a vehicle, were on a motorcyle, or were struck by a vehicle. As shown in Table 6, the number of deaths due to motor vehicle accidents has been variable over the past five years, with no trend apparent.

Table 6: Children who died in motor vehicle accidents and were known to DCJ, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	9	2	10	6	11
% of total deaths	10%	2%	11%	6%	11%
Age range	9–17 years	8–17 years	3–17 years	0–17 years	1–17 years

As shown in Figure 8, three females and eight males died in motor vehicle accidents. The children ranged in age from one to 17 years. Nine of the children were aged over 14 years. Male and older children were over-represented in transport-related fatalities, which is consistent with the trend in motor vehicle accident child deaths across NSW in 2018 and 2019.[67]

Figure 8: Children who died in 2020, from injuries sustained in motor vehicle accidents



67 NSW Ombudsman (2021).

Risk factors associated with motor vehicle accidents

Four children died after being struck by a vehicle and four children died while driving a car (all were aged 15 to 17 years). Three children (aged 14 to 17 years) died when they were the passenger of a car or motorcycle.

In five of the children's deaths, the driver lost control and the car rolled or collided with a tree or pole. In two of the deaths, the car or motorcycle collided with an oncoming car.

For the nine children who were 13 years or older at the time of their death, there was risk-taking behaviour by them or the driver of their vehicle evident at the time of the accident. The risks included speeding, alcohol consumption, drug use, an unlicenced driver, driving while sleep deprived and not wearing a helmet or seatbelt.

DCJ response to the children who died in motor vehicle accidents

For the children who died from injuries sustained in motor vehicle accidents, five had a ROSH report made about them in the last 12 months, five had a ROSH report about them more than 12 months prior to their death but within the last three years, and one was not known to DCJ but their siblings was known.

Reported issues of concern

The main concerns raised in reports for the children were:[68]

- Risk-taking behaviour (9 children)
- Physical abuse (9 children)
- Sexual abuse (8 children)
- Emotional abuse or neglect (7 children)
- Parental alcohol or drug use (6 children).

DCJ intervention had included safety and risk assessments and early intervention services such as Brighter Futures for eight of the families. Three of the families did not proceed to assessment after further assessment at triage.

DCJ sibling safety response

A sibling safety assessment was completed for five of the families where a child died from a motor vehicle accident. Six families did not receive a sibling assessment because there were no identified risk factors for siblings in the report about the child's death.

Practice themes

Insights about risk factors and support needs of families were obtained through DCJ reviews of the child protection history for the children in this group. Several themes specific to motor vehicle accidents emerged.

The children and young people in this category died from tragic accidents. However, it is important to consider some of their deaths from a child protection lens. Some of the children lived in families where there were concerns raised about neglect of the children's care over many years, prompting doubt about whether the children had received the necessary skills and knowledge and/or were mature enough to travel independently. These issues can be explored during safety assessments and casework in relation to a child's age and road safety skills.

On review, in some of the cases where a young person died while driving a car or motorcycle there was a known history of the young person showing risk-taking behaviour, as well as prior reports about other child protection risk factors. The reviews of these cases highlighted the importance of providing support to families of young people, particularly when there are reports of risk-taking behaviour. Where DCJ is unable to allocate a family for assessment and casework, referrals to services which are able to provide support is recommended.

68 Numbers do not add up to 11 because children can be reported across multiple concerns.

2.4.6 Inflicted or suspicious injuries

In 2020, three children who were all aged under 12 months died from inflicted or suspicious injuries. This is a reduction from previous years and is the lowest number of deaths recorded due to these circumstances in the past five years.[69]

One of the children was reported at risk of significant harm at the time of their injury, however were not known to DCJ before this. The child subsequently died. As DCJ did not receive any reports about the family before this time there was no opportunity to intervene before the child's death.

DCJ received three or fewer ROSH reports for the other two children before their death. The common reported concerns for these two families was about parental substance use and domestic violence. DCJ had completed an assessment for one of these families in 2019 in relation to a sibling.

All three of the families received support from DCJ after the child died. For one family, DCJ assessed the siblings as safe and continued working with the family for 12 months before referring them to a family support service. For the second family, the sibling was taken into care. No sibling safety assessment was completed for the third family as the sibling had been taken into out of home care when their sibling was injured and work was ongoing with the family.

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

2.4.7 Other circumstances of death

Fire

In 2020, two children died in house fires. One child was aged less than 12 months and the other was aged between 13 and 15 years. Both were female. One of the children's deaths is still being investigated by the NSW Coroner.

The number of children known to DCJ who have died in house fires has remained consistently low over the past five years.[70] If a child dies in a house fire and the house is owned by DCJ Housing, consultation occurs and DCJ Housing are invited to participate in the review process and share information about support they were providing to the family.

DCJ had completed an assessment and worked with one of the families in 2020. DCJ referred the family to Brighter Futures, who were working with the family at the time of the child's death. DCJ completed a sibling safety assessment and both DCJ and Brighter Futures continued to work with the family until the family were referred to an Intensive Family Support Service.

For the second child, DCJ had been working with the child's family at the time of the child's death. Other services were also working with the family. DCJ remains involved with the family.

Fire and RESCUE NSW

Fire prevention information

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

Fire safety awareness

Fire and Rescue NSW also provides a range of resources for households about fire safety awareness at www.fire.nsw.gov.au under Fire safety > Home fire safety.

Home fire safety checks

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

69 In 2019, seven children died from suspicious or inflicted injuries, in 2018 eight children died, in 2017 five children died, and in 2016 four children died.

70 In 2019, three children died in fire-related circumstances, in 2018 one child died, in 2017 no children died, and in 2016 two children died.

Drowning

In 2020, one young person died from drowning in a well-known swimming area. This is the lowest number under this circumstance of death in the last three years.[71] The young person was aged between 16 and 17 years, and was male.

DCJ had previously worked with the family and undertaken an assessment.

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

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

Swimming lessons are no substitute for adult supervision. Parents and carers should always be expected to keep watch of children and weak swimmers when they are in and around water.[72]

BE WATER SAFE, NOT SORRY

The NSW Government, in partnership with Surf Life Saving NSW, Royal Life Saving Society Australia and Marine Rescue NSW has launched the **Be Water Safe, Not Sorry**[73] water safety campaign in response to the number of drownings that occur in NSW throughout summer.

Always supervise children in or near water

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

Don't drink or take drugs and swim

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

No flags means no lifesavers

Nearly 36 per cent of people who drowned in the summer of 2017–2018 drowned at the beach, frequently at unpatrolled locations or outside of patrol hours

- Swim at patrolled beaches, where possible
- Don't swim outside of lifesaver hours at patrolled beaches
- Don't swim beyond your abilities, particularly in unfamiliar waters.

Practitioners can enhance children's safety by undertaking holistic assessments that consider how issues such as substance use, domestic violence and mental health problems impact a parent or carer's ability

71 In 2019, three children died in drowning accidents, in 2018 two children died, and in 2017 one child died.
72 See 'Swimming safety' at www.watersafety.nsw.gov.au/Pages/swimming-safety/swimming-safety.aspx
73 Water Safety NSW (NSW Government, 2019).

to supervise a child around water, and having conversations with parents and carers about the need for ongoing and attentive supervision around water.

Swimming pool safety compliance continues to be monitored by the Office of the Children's Guardian as part of the out of home care standards for children in out of home care. DCJ and PSP providers undertake compliance checking for children's access to water during foster or relative carer assessments, as part of the home safety inspection checklist. There are a number of resources and fact sheets available to practitioners to provide to families, carers and the public to raise awareness about the importance of water safety.

Drug overdose

In 2020, two children died from accidental drug overdose. One of the families had received an assessment by DCJ before the child died. Both children were reported at risk of significant harm within three months of their deaths. One of the reports had been closed at triage after assessment of a related matter, and the other report was allocated for an assessment and remained allocated to a caseworker at the time of the child's death. The common reported concerns were about mental health and risk-taking behaviour.

No sibling safety assessments were completed by DCJ after the children's deaths. For one of the families there were no siblings in the home and for the other family there were no risk issues identified in the home for the surviving siblings.

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

NSW SUBSTANCE USE AND YOUNG PEOPLE FRAMEWORK

The *NSW Substance Use and Young People Framework* is a NSW Health initiative which provides principles for services working with young people who have substance use concerns. The key message from the framework is that while there are inherent barriers to adolescents seeking help for substance use, additional effort to make services accessible and working collaboratively across agencies to ensure appropriate referrals, is the best way to ensure young people get the support they need.

Accidental asphyxia

In 2020, two children died from accidental asphyxia. Deaths from accidental asphyxia remain low.[74]

One of the children had not been reported to DCJ before their death, but were known due to reports being received for their sibling. DCJ did not complete a sibling safety assessment as the report about the child's death did not identify any risk issues for surviving siblings.

The other child had been reported at risk of significant harm before their death, with concerns about parental substance use and neglect. In 2019, DCJ completed an assessment. A sibling safety assessment was completed following the child's death. DCJ continued to work with the family for a short time before the child's surviving sibling was taken into out of home care.

Other accidental circumstances

In 2020, one child died from a fall. The number of children who have died in accidental circumstances has remained consistently low over the past five years.[75]

74 In 2019, one child died from accidental asphyxia, in 2018 no children died, in 2017 one child died, and in 2016 no children died.
75 In 2019, three children died in accidental circumstances, in 2018 and 2017 one child died, and in 2016 two children died.

2.4.8 Undetermined deaths

At the time of writing this report, the cause of death for five children has not been determined by the NSW State Coroner and circumstances of death are unable to be reported.

Three of these children were aged between one and four years; one was aged between nine and 12 years; and one young person was aged between 16 and 17 years. Four children were female, and one was male.

2.5 Children in out of home care

As shown in Table 7, five children were living in out of home care when they died. This number is lower than in 2019 and represents the lowest number of children who have died while living in out of home care in the last five years.

At the time of their death, these five children had been in out of home care for varying lengths of time. Two of the children had been in care for less than two months and their entry into out of home care occurred while they were in hospital. Both children died while still admitted to hospital. The other three children had been in out of home care for one, two and six years.

Table 7: Children who were living in out of home care when they died, 2016–2020

	2016	2017	2018	2019	2020
No. of deaths	10	9	8	7	5
Placed with a relative	4	4	3	4	1
Placed with authorised carers	4	3	5	2	2
Other (e.g. independent living, residential care, hospital)	2	2	0	1	2
% of total deaths	11%	10%	9%	7%	5%
Age range	0–17 years	0–17 years	0–17 years	3–17 years	0–14 years
Parental responsibility of Minister (any aspect)	8	8	7	7	5

Of the children who died and were living in out of home care:

- One child died from accidental injuries
- One child died from illness and/or disease
- One child died in circumstances of extreme prematurity
- One child died from inflicted/suspicious injuries
- One child's death remains undetermined

When children cannot live safely at home the Children's Court makes an order allocating parental responsibility. The Minister for Families, Communities and Disability Services had parental responsibility for four of the five children who died in out of home care.[76] The other child remained in the care of their parent and the Minister had parental responsibility for the aspect of parent/child visiting arrangements only. Two of the five children were in the primary case responsibility of a PSP provider. They were living with carers authorised by those providers.

76 For one child parental responsibility was delegated to a PSP provider.

OOHC EDUCATION PATHWAY

The OOHC Education Pathway is an agreement between DCJ and the three major education sectors in NSW (Government, Catholic and Independent) on how children and young people in statutory out of home care will be supported at school. The pathway is in place to provide collaborative and consistent educational support to pre-school and school-aged children and young people in out of home care to support them to be engaged in suitable quality education and help them to reach their full learning potential.

Children in out of home care have a right to access quality education. One of our key responsibilities is to support their access and engagement in education and training. Education is a contributing factor in a person's quality of life and the level of education they achieve has been found to have an impact across generations. People who receive a sound education are likely to live longer and to experience better health outcomes.

The OOHC Education Pathway is triggered by notifying an educational facility that a child or young person has entered out of home care.

OOHC HEALTH PATHWAY

The OOHC Health Pathway is a joint initiative of DCJ and NSW Health aimed to ensure that every child or young person entering statutory out of home care receives timely and appropriate health assessment, intervention, monitoring and review of their health needs.

Children and young people in out of home care are more likely to experience physical, developmental, emotional and mental health problems compared with their peers. It is our duty to not only respond to a child's health issues, but also create opportunities to promote good physical and mental health and wellbeing so they can reach their individual life potential. Doing so will create opportunities for children to have stronger and longer life prospects and a sense of wellbeing into adulthood.

A referral form is used to place a child or young person on the OOHC Health Pathway when they enter out of home care. All children that participate receive a primary health assessment and, as a result, all children receive a Health Management Plan. The plan should be reviewed annually for children aged over five years and every six months for younger children.

Four of the five children who died while in out of home care in 2020 were not eligible for an OOHC Education Pathway due to their young age and not attending a childcare or educational setting. The child who was eligible was not attending any educational facility due to their illness.

Four of the five children had been referred to the OOHC Health Pathway. Three of these children had health plans developed, while one child died before the plan could be developed. The fifth child had an end of life health plan in place and was receiving palliative care when they died.

Practice themes

For two of the children who died, it was agreed that joint serious case reviews between DCJ and the PSP providers that held primary case responsibility for the children at the time of their death would be undertaken.[77] Joint reviews ensure that both single and cross-agency learning can be identified and, where required, systems improvements made.[78]

Of the three reviews finalised at the time of publishing this report, a number highlighted positive casework by DCJ practitioners in assessments, decision-making and case planning. Practitioners relied on resources available to them to support their practice, including consultations with DCJ psychologists, permanency support coordinators, and multicultural caseworkers. The reviews also recognised a strong collaboration between DCJ districts and PSP providers.

77 The agencies were Barnardos, Anglicare and Creating Links.

78 At the time of writing this report, only one of the joint reviews has been finalised. The findings and recommendations from the remaining review will be reported in the *Child Deaths 2021 Annual Report*.

2.6 DCJ practice changes in response to or resulting from child deaths

As noted in Chapter 2, a number of common practice themes raised in serious case reviews result in practice recommendations and improvement.

Child Protection Assessment Review Project

In early 2021, the responsibility for DCJ assessment tools transferred to the OSP. During 2021, the OSP is collaborating with key directorates in DCJ and community partners to review the tools, systems and processes used to assess, and make decisions about, children and young people. The Child Protection Assessment Review Project will take place over the next two years and aims to improve the quality, equity and accuracy of decisions made about children and their families. This review will prioritise the tools most in need of update and involve staged improvements to assessment processes and practices:

- Stage 1 (mid 2021): short-term improvements to Helpline screening processes
- Stage 2 (mid 2022): Screening and Response Priority Tool (SCRPT) and Safety Assessment ready for ChildStory build
- Stage 3 (late 2022): Risk Assessment, Family Strengths and Needs Assessment (FSNA) and Risk Reassessment ready for ChildStory build.

Casework Journey Guide

The **Casework Journey Guide** was launched by the OSP in March 2021, to help practitioners navigate the key activities children and families need along the casework journey to identify and mitigate dangers, reduce risk and support meaningful change.

The guide brings together current practice mandates, policies, approaches and standards to visually represent where they fit along the practice continuum and in case management.

The guide includes an interactive map of key casework activities with links to explore topics further, including relevant mandates, policies, practice tips and quality indicators. It can help practitioners and managers to clarify the next steps when responding to a report when a child is assessed as safe or safe with plan, including talking to families and understanding the what, how and why of mandated practice.

Triage mandate and practice guidance

The **Triage Assessment** practice mandate is used to prioritise and make decisions about reports that come to CSCs for allocation. Children and young people at risk of significant harm have a right to responsive assessment and casework to keep them safe. The triaging process helps to make sure that children and young people at the highest risk are given priority to be allocated for a field response. It is also an opportunity, where possible, for those children and young people who are unable to be allocated a field response to be referred to an agency for support, aimed at improving their safety and wellbeing. The mandate was updated in August 2021 and is informed by the learning from serious case reviews.

New interagency guidelines

The **Collaborative Practice in Child Wellbeing and Protection: NSW Interagency Guidelines for Practitioners 2021** highlight the importance of collaboration between providers to coordinate services for vulnerable children, young people and their families. Importantly, the guidelines also provide key information for interagency partners to work collaboratively to help meet the safety, welfare and wellbeing needs of children and young people. Some of the changes to the guidelines were informed by a practice working group formed from a recommendation arising from a serious case review.

Domestic and Family Violence Practice Kit

To support the important but challenging role of working with men who use violence, there are new updates to the **Domestic and Family Violence Practice Kit** to better reflect our partnership with Justice colleagues. The changes were informed through a practice working group with Community Corrections alongside the Serious Case Review team, formed in response to a recommendation arising from a serious case review.

New material was also drawn from this year's *Safe and Together* conference, as well as valuable feedback provided earlier this year from the NSW Aboriginal Reference Group about how we speak about privilege.

LGBTQIA+ consultation model

In August 2021, the LGBTQIA+ consultation model went live. It provides an online practice resource co-designed with staff and young people who identify as LGBTQIA+, and focuses on working with children and young people who identify as LGBTQIA. Supporting the model is a register of practice consultants made up of staff across DCJ who identify as LGBTQIA+ with child protection and out of home care practice experience. These staff are available for practice consultation for staff working with children and young people who identify.

Chapter 3: Children who died in circumstances of suicide or suspected suicide

Introduction

When a child takes their own life, the impact is devastating and far reaching. Such tragedies have profound effects on families, friends and communities. Despite the overwhelming impact, suicide often remains clouded in secrecy, guilt and shame. It is a topic many people find difficult to talk about, both with those who are at risk and with others who are affected by it. The stigma surrounding mental health and suicide also means many people considering ending their life or who have attempted suicide do not seek help.[79]

In NSW, the rate of suicide among children increased over the 15-year period 2005 to 2019, from 2.5 deaths per 100,000 children in 2005 to 3.7 deaths per 100,000 children in 2019. The majority of these children were aged from 15 to 17 years.[80]

Each year, suicide is one of the highest circumstances of death for children aged 10 or more years and who are known to DCJ. Between 2016 and 2020, 475 children known to DCJ died. Of those, 42 (9 per cent), died in circumstances of suicide or suspected suicide. Significantly, between 2016 and 2020, suicide accounted for the highest number of deaths for children known to DCJ aged from 15 to 17 years. This is consistent with the findings from the CDRT *Biennial report of the deaths of children in NSW: 2018 and 2019*, which found 80 per cent of child deaths by suicide were children aged 15 to 17 years.[81]

Suicide can affect anyone but there are individual, social and environmental factors that may make a child who has experienced abuse or neglect more vulnerable. While it is important to note that these risk factors are not unique to suicide and the majority of people who experience risk factors for suicide will not kill themselves, understanding and responding to factors that increase risk for children is critical for preventing suicide.

It is easy to feel a sense of despair when considering how to support children who are thinking about suicide. It is challenging work, but suicide is preventable. This chapter includes the voices of practitioners who have worked with children who have considered suicide, and young people with their own experiences of suicidal behaviour. It provides clear practice advice that urgent, intentional support can and does make a difference.

> *'I've been around long enough to have children and young people come back as adults and say "thank you for riding it out with me". What a huge reward. They've gone on to live happy and fruitful lives. These are amazing human beings that go on to contribute to society, you just have to help them through it.'*
>
> ***DCJ caseworker***

A NOTE ABOUT SELF-CARE

Reading about suicide can be confronting or distressing. Take care when reading, look after yourself and if needed talk to someone about how you are feeling. Some support services are listed below.

NSW Mental Health Line: 1800 011 511
Lifeline: 13 11 14
Suicide Call Back Service: 1300 659 467
Beyond Blue: 1300 22 4636
Kids Helpline: 1800 55 1800

79 World Health Organization (2014).
80 NSW Ombudsman (2021).
81 ibid.

Language matters

The words practitioners use to describe children and families shape interactions and relationships, set the tone for what is believed about a child or family, and frame intervention and decision-making. When talking about suicide, safe, inclusive language helps to reduce stigma and lets a person know that they will be supported and that others care about them. Choosing the right words can also help to avoid judgemental or sensationalist language about suicide.

Instead of	Say	Why it matters
'unsuccessful suicide'	'non-fatal' 'made an attempt to end their life'	To avoid glamorising or normalising a suicide attempt
'successful suicide'	'took their own life' 'ended their own life'	So that suicide is not presented as the desired outcome
'committed suicide'	'died by suicide' 'deaths by suicide'	To avoid the association between suicide and crime or sin

3.1: The cohort: Children who died in circumstances of suicide or suspected suicide

3.1.1 Defining the cohort

Joiner's theory of suicide

Thomas Joiner[82] proposed three factors that enable a person to complete suicide: the feeling of being a burden to others (perceived burdensomeness); a sense of isolation (thwarted belongingness); and, alarmingly, the learned ability to hurt oneself and not fear death. These three factors, as well as knowledge of ways to die, enable a person to complete suicide.

As stated in Chapter 2, DCJ receives information about the medical cause and circumstances of a child's death from the NSW State Coroner and NSW Ombudsman. This information is used to report on the circumstances of a child's death. This review includes children whose circumstance of death was determined to be suicide or suspected suicide. Deaths that occurred in circumstances that are sometimes considered suicide (e.g. drug overdoses or single vehicle accidents), or where there had been a previously reported suicide attempt, were also considered to determine whether the circumstance of death was suicide.

3.1.2 The cohort

In the five years from 2016 to 2020, 2408 children died in NSW.[83] Of these, 475 were known to DCJ. Forty-two of the 475 children (9 per cent) died in circumstances of suicide or suspected suicide. By comparison, in NSW, 136 children died by suicide during the same period.[84]

The number of suicide deaths for children known to DCJ each year ranged from four deaths (2017) to 12 deaths (2020). The proportion of children who died in circumstances of suicide or suspected suicide each year ranged from 4 per cent (2017) to 12 per cent (2016 and 2020) over the five years of this cohort review.

82 Joiner (2005).

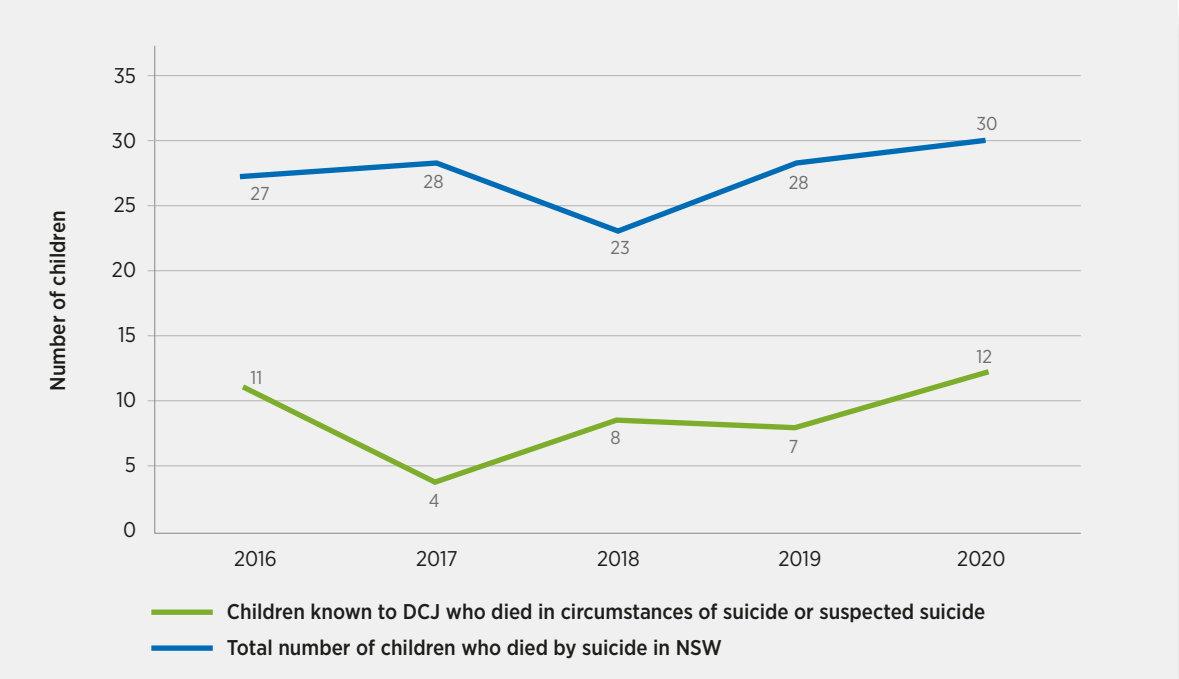
83 Information provided each year from the NSW Ombudsman's Office.

84 Figures from 2016 to 2019 were provided to DCJ from the NSW Ombudsman's Office. The total number of children who died by suicide in NSW in 2020 is taken from the NSW Suicide Monitoring System, Report 8, dated 29 June 2021. This information is subject to change as final causes of death are determined by the Coroner. www.health.nsw.gov.au/mentalhealth/resources/Pages/sums-report-apr-2021.aspx

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

	2016	2017	2018	2019	2020
No. of deaths	11	4	8	7[85]	12
% of total deaths	12%	4%	9%	7%	12%

Figure 9: Children who died by suicide in NSW, by number of total deaths and whether they were known to DCJ



3.1.3 Age

To many, it is incomprehensible that young children understand the concept of suicide and are able to end their own lives. However, research has identified that children as young as eight are developmentally capable of understanding the finality of death.[86] It is now commonly accepted that intent to cause self-harm or death is most important when assessing risk of suicide, regardless of a child's cognitive understanding of the lethality or finality of their actions.[87] Recognising that young children are capable of contemplating and attempting suicide is important for suicide prevention.

The youngest child in this cohort was 10 years old. The ages of the children ranged from 10 to 17 years. Almost three-quarters (30, 71 per cent) of children included in this cohort review were aged 15 to 17 years at the time of their death. This is consistent with NSW data, which identified that in 2018 and 2019, 80 per cent of child suicides occurred in the 15 to 17 year age group. Over the 15 years to 2019, the number of children aged 15 to 17 years who died by suicide increased from 4.8 deaths per 100,000 in 2005–2009 to 7.8 deaths per 100,000 in 2015–2019.[88]

Research has theorised that the greater risk of suicide in older adolescents (15 years and over) may be at least partly due to developmental changes that occur during this period. As children become adolescents, it is hypothesised that they become more capable of suicidal behaviour; they take more risks; they are more vulnerable to depression, substance use disorders, or certain anxiety disorders that increase suicide

85 This figure has been updated since the Child Deaths 2019 Annual Report as new information about the circumstances and cause of death has become known.
86 Mishara (1999).
87 Soole, Kõlves and De Leo (2014).
88 NSW Ombudsman (2021).

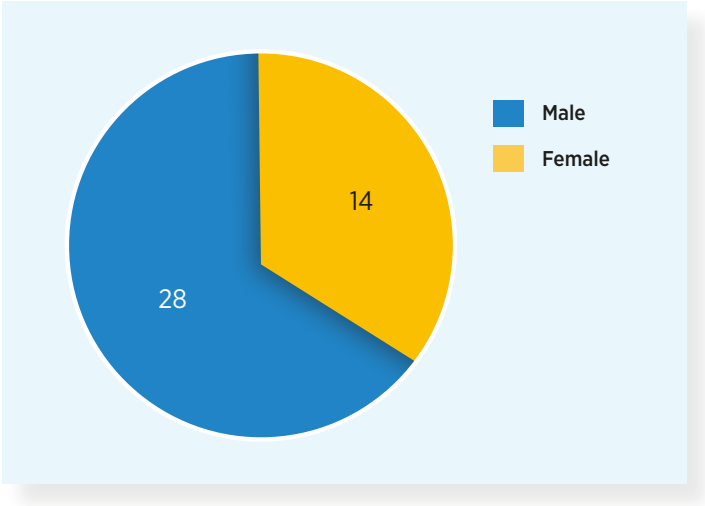
risk;[89] and they are more vulnerable to maladaptive thinking that may facilitate feelings of hopelessness.[90] Older adolescents may also be at increased risk of suicide death due to increased experience engaging in suicidal behaviour.[91]

3.1.4 Gender

Worldwide, suicide rates have been found to be higher in males aged 10 to 19 years than females of the same age.[92] In Australia in 2019, the Australian Bureau of Statistics reported the gender ratio from child suicides to be 1.9 male deaths for every female death.[93] In NSW, more young males die by suicide, and this gender gap increased in the last five years.[94]

As shown in Figure 10 and consistent with these findings, 28 males (67 per cent) and 14 females (33 per cent) were known to DCJ and died in circumstances of suicide or suspected suicide between 2016 and 2020.

Figure 10: Gender of children who died in circumstances of suicide or suspected suicide and who were known to DCJ, 2016–2020



3.1.5 Geographical distribution

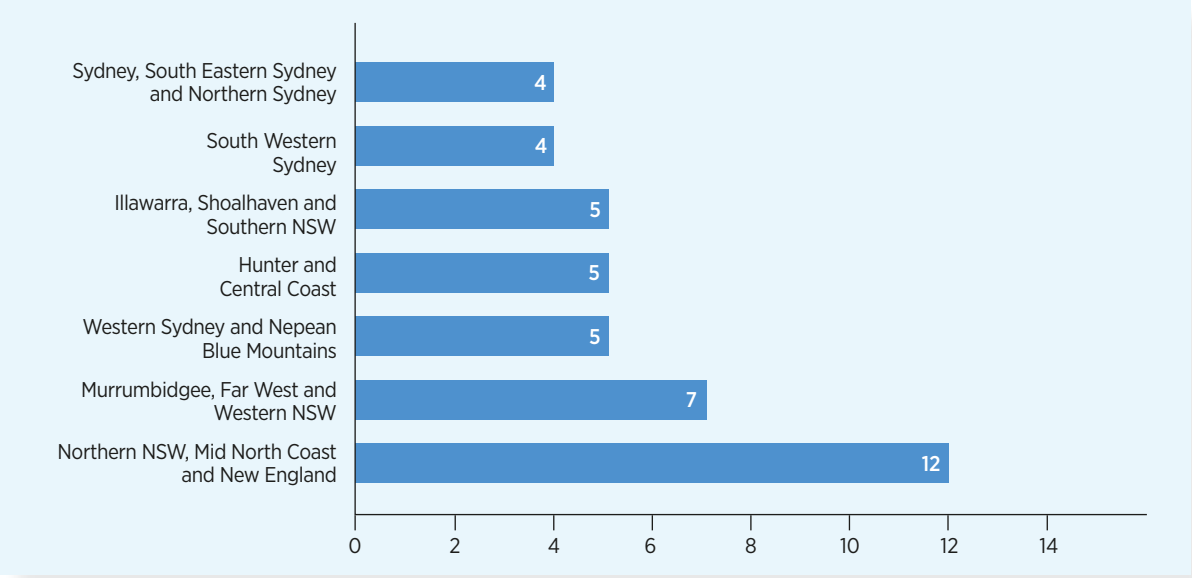
As shown in Figure 11, the largest proportion of children in the cohort (12, 29 per cent) lived in the Northern NSW, Mid North Coast and New England District. This was followed by the Murrumbidgee, Far West and Western NSW District (7, 17 per cent). Three districts each had five children who died in circumstances of suicide or suspected suicide: Western Sydney and Nepean Blue Mountains; Hunter and Central Coast; and Illawarra Shoalhaven and Southern NSW (5, 12 per cent). South Western Sydney District, and then Sydney, South Eastern and Northern Sydney District, had the lowest number, with four children each in the cohort.

The Centre for Rural and Remote Mental Health found that people living in rural and remote Australia are up to twice as likely to die by suicide as people living in major cities. The more remote the community, the higher the suicide rate.[95]

The CDRT *Biennial report of the deaths of children in NSW: 2018 and 2019* found that children living in regional and remote areas and those living in the most disadvantaged areas of NSW were over-represented in suicide deaths.[96]

89 Costello, Copeland and Angold (2011).
90 Kosnes et al. (2013).
91 Glenn et al. (2020).
92 ibid.
93 Australian Bureau of Statistics (ABS) (2019).
94 NSW Ombudsman (2021).
95 Hazell et al. (2017).
96 NSW Ombudsman (2021).

Figure 11: Children who died in circumstances of suicide or suspected suicide and who were known to DCJ, by DCJ District, 2016–2020



Studies have highlighted unique suicide risk factors for people living in rural and remote communities, including poor employment opportunities, lower levels of education, social isolation and reduced access to medical and allied health services.[97] Families living outside large regional centres often wait many weeks and travel long distances to attend medical appointments or therapeutic support services. For small populations in rural communities, maintaining privacy while seeking support is more difficult. The lack of access to services and perceived risks to personal privacy can mean that children who need support may delay seeking help.[98] Consultations with young people living in rural communities have highlighted that positive interpersonal relationships and a sense of belonging are crucial for suicide prevention.[99]

3.1.6 Method of suicide

The information presented here is intended to provide an understanding of the methods of suicide used by the children in this cohort. This information may be confronting or distressing.

To prevent children from dying by suicide, it is important to understand the methods which lead to suicide deaths. While restricting access to means of suicide is not always possible, doing so can be effective when part of broader prevention strategies.[100] Recent studies of suicide methods in children and young people aged 10 to 19 years worldwide found hanging to be the most common method.[101] [102] In Australia, being struck by a moving object or jumping from a height were the next most common methods of suicide in children.[103]

Consistent with this research, the majority of children in this cohort review used hanging as the method to complete suicide. Thirty-five (83 per cent) of the children died by hanging (11 females and 24 males). The remaining seven children died from suffocation, falling from a height, poisoning, and lying in front of or being struck by a moving object.

97 Bishop et al. (2017).
98 Hazell et al. (2017).
99 Bourke (2003).
100 Sarchiapone et al. (2011).
101 Kõlves and de Leo (2017).
102 Glenn et al. (2020).
103 ibid.

3.1.7 Aboriginal children

The stories of the Aboriginal children in this cohort review expose the continued and devastating impact of colonisation on Aboriginal families and communities. The statistics here are confronting. They highlight the ongoing trauma and oppression Aboriginal children face, and the need for improved child protection and system responses to Aboriginal children experiencing suicidal behaviour.

Tragically, Aboriginal children are grossly over-represented in this cohort. Of the 42 children who died, 17 (40 per cent) were Aboriginal. They were aged from 13 to 17 years at the time of their death. Thirteen of the Aboriginal children were male; four were female.

These numbers are consistent with Australian data which show that from 2015 to 2019, one-third of all deaths of Aboriginal children aged from five to 17 years were due to suicide. The majority of Aboriginal children who died by suicide were aged 15 to 17 years.[104] Rates of suicide are higher among Aboriginal males than Aboriginal females,[105] and Aboriginal people aged 15 to 19 years are over five times more likely to end their own life than their non-Aboriginal peers.[106]

It is important to note that within all Aboriginal languages and dialects, Aboriginal people do not have a word for suicide. There is no single word, collection of words or phrase to describe it.

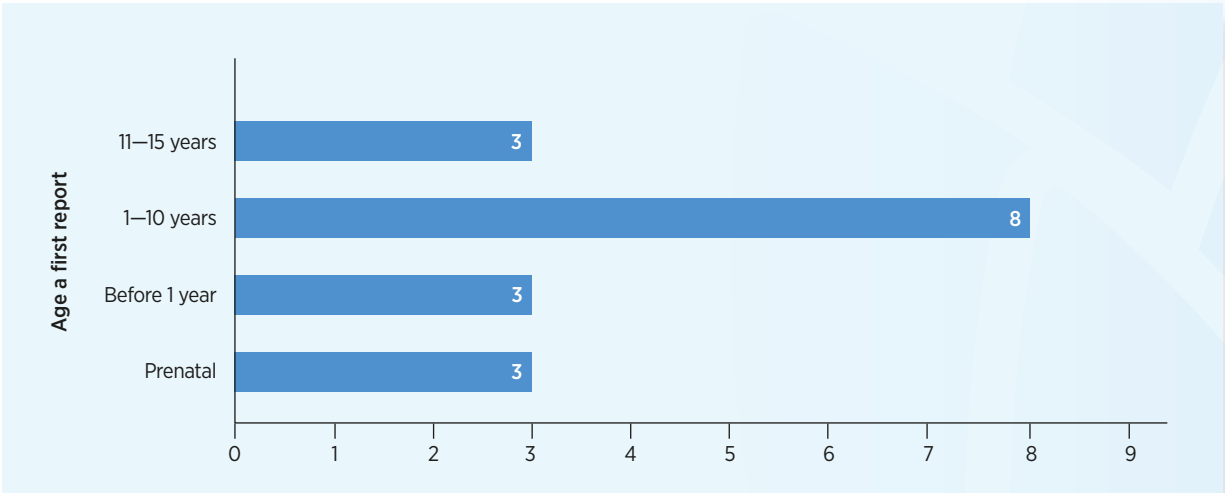
The impact of trauma and oppression on Aboriginal children

Each of the Aboriginal children in this cohort was reported to be at risk of significant harm at least once in the three-year period before their death. Eight were reported within the 12 months before they died. At the time of their death, three of the 17 Aboriginal children in the cohort were under the parental responsibility of the Minister.

As shown in Figure 12, three of the children three of the children were first reported to DCJ before they were born; three had been reported before they turned one; eight were first reported between the age of one and 10 years; three were first reported between the age of 11 and 15 years. An assessment had been completed for 12 of the 17 children.

This data illustrates the over-representation of Aboriginal children reported to be experiencing trauma. Experiences of abuse and neglect are known to be a risk factor for suicide[107] and these children's stories point to the need for practitioners to understand the intergenerational effects of colonisation and its aftermath, and provide intervention that is conducive to healing.

Figure 12: Aboriginal children in cohort, by age at first report



104 ABS (2019).
105 AIHW (2015).
106 Australian Indigenous HealthInfoNet (2019).
107 Katz et al. (2006).

The importance of connection to culture for Aboriginal children

In an Australian study, Aboriginal children described culture as 'who you are', 'what helps get you through' and 'what holds you together and keeps you going'.[108]

Getting the right support is important for any child having thoughts of harming or killing themselves. For Aboriginal children, this means culturally safe, trauma-informed support that reaches them when and where they need it. However, many Aboriginal children experience barriers in receiving such support including racism or discrimination, the fear of stigma or of breaking accepted cultural norms and a lack of culturally competent services.[109]

Additionally, Aboriginal people often report that mainstream concepts of mental health focus too much on problems and do not encompass the many factors that contribute to and influence wellbeing. Significantly, mainstream services regularly overlook the undeniable link between connection to traditional land or Country and mental wellness.[110] Understanding this link is critical when working with Aboriginal children at risk of suicide, as studies have found that moving off traditional land, whether by choice or circumstance, has an adverse effect on mental health.[111] [112]

By contrast, connection to culture has been confirmed as a protective factor against the risk of suicide, as it underpins the safety and wellbeing of Aboriginal children.[113] Factors such as connection to spirituality, ancestry and kinship networks, as well as strong community governance and cultural continuity, have led to enhanced wellbeing among Aboriginal individuals and communities.[114]

Alarmingly, of the 17 Aboriginal children in this cohort, 10 were living in circumstances that did not afford them physical permanency and, for many, belonging. Of these 10 children, six had experienced homelessness. The internal serious case reviews completed following the deaths of Aboriginal children in this cohort highlight the need for practitioners to engage in regular and meaningful cultural consultation in order to understand the importance of connection to culture and apply this in practice.

Consider the following case example to support practice with Aboriginal children at risk of suicide.

Jerome's story

When Jerome was six years old, he and his brother, Ty, were taken from their parents, Nathan and Isla, because of Nathan's use of violence towards Isla, and Nathan and Isla's drug and alcohol use. Jerome and Ty moved to live with authorised carers, Tammy and Wes.

Nathan and Isla, and Tammy and Wes, lived in the same remote community in Western NSW. They worked together to make sure the children maintained connected to their culture. The children spent time with their parents multiple times a week, and saw their relatives regularly.

When Jerome was 11 years old, he began struggling to regulate his emotions, was often very distressed, and had started to physically harm other children. Tammy and Wes decided they needed more support to look after Jerome and Ty, so they moved to Sydney to be closer to Tammy's family.

Not long after they arrived in Sydney, Jerome's mental health began to deteriorate. Tammy told the caseworker that Jerome had become withdrawn, and seemed angry and upset. Caseworkers referred Jerome to participate in

108 Moore, Bennett and McArthur (2007).
109 ibid.
110 Westerman (2021).
111 Symptoms can present in the form of spiritual ill health, cognitive disorientation, dissociative fugue, cultural ill health, identity confusion, disorientation and acculturative stress.
112 Westerman (2021).
113 SNAICC (2017).
114 Australian Indigenous HealthInfoNet (n.d.).

a mental health assessment and he was subsequently diagnosed with post-traumatic stress disorder and depression.

At this time, DCJ was supporting Nathan and Isla to visit the children in Sydney each month. While the children enjoyed spending time with their parents, they told the caseworker they missed their cousins, aunts, uncles and grandparents.

When Jerome was 12, he became increasingly distressed after spending time with Nathan and Isla during their monthly visits. He had also begun physically harming Ty. Tammy and Wes told the caseworker they did not feel equipped to keep both children safe, and asked the caseworker to find somewhere else for Jerome to live.

Caseworkers arranged for Jerome to move to live with an authorised carer, Dean, a proud Aboriginal man who grew up in Sydney. Jerome told Dean that he felt alone, and as though no one in Sydney understood him. He said the pain of missing his parents and relatives made him want to hurt himself and other people. On one occasion, Dean found a poem Jerome had written called 'unwanted'. The poem described feelings of loneliness, disconnection and despair.

Jerome's caseworker worked hard to connect with him. She visited him regularly, told him she cared about him, and asked him directly if he was having thoughts of suicide. With Jerome's input, the caseworker developed a plan for Jerome to engage with a mentor from a local youth program, and to see a counsellor for his mental health. Tragically, Jerome ended his life before he was able to attend the appointments that had been scheduled for him.

LEARNING FROM JEROME'S STORY

Jerome and Ty needed caseworkers to understand the importance of their connection to family and culture, and to act to maintain and strengthen this connection. When Jerome and Ty were unable to remain safely at home, they needed caseworkers to build relationships with their relatives and kinship network, in order to explore whether they were able to remain living within their family and community.

Similarly, when their carers Tammy and Wes decided to move to Sydney to get more familial support, this was an opportunity for caseworkers to arrange a Family Group Conference. Doing so would have invited the children's family to participate in the decisions about their care, and how their identity, cultural connections and relationships were going to be preserved.

When Jerome began to show signs of distress, his caseworker visited and spoke with him regularly, and showed great skill and compassion in asking him directly about his suicidal ideation. Engaging in regular and meaningful cultural consultation with Jerome's family, kinship group and with Aboriginal casework colleagues would have enhanced this practice.

Cultural consultation would have supported the caseworker to look beyond western notions of mental health, and properly consider the impact that living off Country, far away from his community and relatives, may have been having on Jerome's mental health. Had his distress been understood from a cultural perspective, intervention could have been aimed at reconnecting Jerome with his family and culture and helped to increase his sense of connection and belonging.

DCJ CASEWORK PRACTICE

To ensure culturally safe practice with Aboriginal children and families, critically reflect on the following questions. Have I / have we:

- Engaged in regular purposeful consultation with Aboriginal colleagues and community members to increase cultural capability? Have I acted on the recommendations made?
- Sought to learn deeply about Aboriginal concepts of mental health and brought this into my analysis, decision-making and planning?
- Involved relatives, community members and Aboriginal organisations in decision-making and interventions? Have I valued their input and encouraged Aboriginal family-led decision-making?
- Listened to this child's story, and asked questions to understand how they experience their culture?
- Asked about and understood the significance of this child's culture, clans, totems, languages, and family and kinship networks? Have I recorded this information accurately?
- Referred to the **Aboriginal Case Management Policy** to inform my practice?
- Applied the principles of the Act that relate directly to Aboriginal children and their families? Including:
  - Aboriginal and Torres Strait Islander self-determination
  - Aboriginal and Torres Strait Islander participation in decision-making
  - Aboriginal and Torres Strait Islander child and young person placement principles.

See the **Cultural Practice with Aboriginal Communities** practice advice topic for further advice about working with Aboriginal families.

3.1.8 Culturally and linguistically diverse children

Eight children (19 per cent) who were known to DCJ and died in circumstances of suicide or suspected suicide between 2016 and 2020 were identified as culturally and linguistically diverse (CALD). Cultural consultations were not completed for any of the reports received about these children.

The way suicide and suicidal thinking is viewed can be diverse, even within the same culture. Consequently, it is important to consider the way in which suicide is discussed. In some cultures, spiritual and religious beliefs may mean there is stigma attached to suicide and to the individual experiencing suicidal behaviour. This stigma may extend to family, friends and the community. Social understanding and attitudes towards mental health and suicide may also impact a family or community's view of suicide.[115] Practitioners may find that beliefs, fear and stigma make it difficult for people from CALD communities to discuss suicide and self-harm openly.

Seeking to understand a family's culture, values and beliefs – and observing cultural appropriateness and sensitivity when working with families from diverse cultures – is likely to reduce distress and feelings of guilt or shame when discussing issues of suicide and self-harm.

For many families from CALD communities, family and social networks are key to both prevention and recovery from poor mental health. Children need a sense of connectedness and belonging, within their own family, and within the service system. Accessing support from mental health professionals may not be a common practice for people in CALD communities. Some communities prefer to seek out alternative medicine or religious leaders for support. Practice should explore these networks in order to build a culturally supportive network around the child and their family.

115 Life in Mind Australia (2021).

Consider the following case example to support practice with children from CALD backgrounds at risk of suicide.

Aas

Aas, a 13 year old Indian Sikh girl, had been cutting her arms since she was 11. When she told a friend she wanted to kill herself, the friend told the school counsellor, who made a report to DCJ. The report was allocated to caseworker Maddison, who arranged a multicultural consultation before visiting Aas and her family. During the consultation, Maddison asked the following questions:

- *How can I talk about mental health, parenting and suicide in a way that is sensitive to the family's culture?*
- *What beliefs might the family hold about asking for and receiving help?*

Maddison reported that the consultation helped her to understand common beliefs and perceptions held by Indian and Sikh communities about mental health, suicide and help-seeking behaviour. This allowed Maddison to talk to Aas and her parents about these topics in a way that was respectful. The consultation also helped Maddison to better understand why Aas' parents were worried about getting help for Aas, and allowed Maddison to offer culturally appropriate support options to the family.

DCJ CASEWORK PRACTICE

For further advice about supporting families from CALD backgrounds, practitioners can refer to the **Culturally Responsive Practice with Diverse Communities** practice advice topic.

3.1.9 LGBTQIA+ children

Up to 12 per cent of children identify as gender and/or sexually diverse.[116] Research has found that a disproportionate number of gender and/or sexually diverse people experience poorer mental health and have higher risk of suicidal behaviour than the general population. These health outcomes are not related to sexuality or gender identity but rather the psychological distress that can occur from the stigma, prejudice, discrimination and abuse they face from others.[117]

An Australian survey, Writing Themselves in 4, found gender and/or sexually diverse young people (aged 16 to 17 years) had thoughts of suicide at more than five times the proportion observed in same-aged peers in the general population; they were also three times more likely to have attempted suicide.[118] Gender and/or sexually diverse young people who experience abuse and harassment are even more likely to self-harm, have thoughts of suicide or attempt suicide.[119]

116 Lucassen et al. (2017).
117 National LGBTI Health Alliance (2020).
118 Hill et al. (2021).
119 National LGBTI Health Alliance (2020).

DCJ CASEWORK PRACTICE

For further advice about supporting children and young people who identify as LGBTQIA+, and their Families, practitioners can refer to the **Working with LGBTQIA+ children and young people** practice advice topic.

When working with children in out of home care, refer to the **Identity and Culture for Children in Out of Home Care** mandate to ensure a child's need for positive identity is upheld in case planning.

LGBTQIA+ RESOURCES

Stigma, prejudice and discrimination are often barriers for gender and/or sexually diverse children seeking help. Access to safe affirmative care is important. When working with gender and/or sexually diverse children, consider the following resources:

- **AusPATH** is Australia's peak body for professionals involved in the health, rights and wellbeing of transgender, gender diverse and non-binary people.
- **Twenty10** works with gender and/or sexually diverse children and young people aged 12 to 25 years across NSW providing services including housing, mental health, counselling and social support.
- **ACON** is a community health service for people of diverse sexualities and/or genders.
- **The Gender Centre** is the peak statewide multidisciplinary centre of excellence providing a broad range of specialised services that enables the exploration of gender identity and help with the alleviation of gender dysphoria.
- **qheadspace** provides an online community forum for people who identify as, are questioning or are interesting in learning about gender diversity and/or sexuality. The Headspace website also includes resources about gender and sexual diversity.
- **Beyond Blue** provides resources about anxiety and depression for gender and/or sexually diverse people.

LGBTQIA+ PRACTICE CONSULTATION REGISTER

In June 2021, the OSP established the LGBTQIA+ Practice Consultation Register. The register is made up of LGBTQIA+ practice consultants from across NSW. LGBTQIA+ consultations provide practitioners with the opportunity to benefit from the collective experience and expertise of LGBTQIA+ staff members.

For more information about how to consult about practice with LGBTQIA+ children and their families, practitioners can refer to the **LGBTQIA+ practice consultation** page.

3.2 Vulnerabilities that increase a child's suicide risk

3.2.1 Self-harm, suicidal behaviour and mental health

Adolescence is a critical period for brain development, with rapid changes in physical, cognitive, emotional and social development. This is a time when teenagers explore their emerging identity, learn new skills, and develop a sense of self-worth and independence. This period can also be characterised by risk-taking, impulsivity and suggestibility. While this is an important part of growing up, research showed that it also means teenagers are particularly vulnerable to the emergence of mental health disorders,[120] self-harm[121] and suicidal behaviour.[122]

'Suicidal behaviour' is the term used to describe talking about or taking action to end one's life. It is confronting to thinking about the ways in which people may harm themselves, a person's thoughts of suicide and the means a person might use to kill themselves. However, it is critical that all suicidal behaviour is taken seriously and responded to with urgency and compassion. With the right support, children can learn to cope with difficult situations without hurting themselves.

A large majority of children in this cohort review (37, 88 per cent) experienced mental health issues, self-harm or suicidal behaviour, or a combination of these issues. It is important to note that information about a child's self-harm or suicidal behaviour is not always known to DCJ. Some of the information reported below was not known to DCJ until after the child's death.

LEARNING FROM CHILD DEATH REVIEWS

In March 2021, the OSP developed the **Evan's Story** learning package. The package aims to build practitioner knowledge and skill in responding to children who are self-harming or at risk of suicide.

Self-harm

Self-harm, also referred to as non-suicidal self-injury, is any behaviour that involves deliberately causing pain or injury to oneself, without suicidal intent. It is usually done in secret and on areas of the body that can be easily covered. Self-harm might include cutting, burning or hitting oneself, binge eating or starvation, or repeatedly putting oneself in dangerous situations. It may also include intentional drug overdose.

The reasons for self-harm are different for each person. Self-harm is not normally triggered by one event, but is usually a response to distress or overwhelming negative thoughts, feelings or memories. Some people report that the physical pain of self-harm provides a temporary relief from emotional pain, but it does not address the underlying cause of the distress that drives the behaviour.

Self-harm often goes unreported, unless medical treatment is required, making it difficult to understand the true extent of the problem.

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing (the Young Minds Matter survey), conducted in 2013 and 2014, captured information about self-harm and suicidal behaviour for young people aged 12 to 17 years. It estimated that in any 12-month period, some 8 per cent of all 12 to 17 year olds (about 137,000 children) engage in self-harming behaviour, without suicidal intent. When considering 16 and 17 year olds, the prevalence increased to around 12 per cent.[123]

120 McGorry et al. (2014).
121 Shepherd et al. (2018).
122 Miller and Prinstein (2019).
123 Zubrick et al. (2016a).

In many instances, self-harm does not lead to suicide. Often people who self-harm report that they have no intention to die, but harm themselves as a way to cope with challenges in their life. Despite this, research has identified that self-harm is a strong predictor of later suicide.[124] It is important to notice and respond to self-harming behaviour and support children to develop safe alternatives to coping with distress, or negative thoughts or feelings.

For the children in this cohort, 23 (55 per cent) self-harmed. Of these 23 children, nine were aged from 10 to 14 years, and 14 were aged from 15 to 17 years.

Although males are more likely to die by suicide, in Australia, females are hospitalised for intentional self-harm (with and without suicidal intent) almost twice as frequently as males.[125] Some 10 of the 14 females in this cohort (71 per cent) and 13 of the 28 males (46 per cent) had harmed themselves.

Suicidal ideation

MYTH Talking to someone about their thoughts of suicide is a bad idea and can be interpreted as encouragement.

FACT Rather than encouraging suicidal behaviour, talking openly with someone who is experiencing suicidal thoughts can let them know that someone cares about them, reduce stigma, help the person see that they have other options and may prompt them to rethink their decision.[126]

'Suicidal ideation' is the term used to describe thoughts about suicide or wanting to take one's own life. Thoughts can differ in intensity from fleeting to specific plans for killing oneself. Some people experience suicidal ideation when they see no hope for the future and want to end their emotional pain. Most people who have suicidal thoughts do not want to die, they just cannot see another end to their distress. Even though the majority of people who experience thoughts of suicide do not take their own life, suicidal ideation must be taken seriously, as it indicates a person is in need of help.

The Young Minds Matter survey estimated that in any 12-month period, some 8 per cent of children aged 12 to 17 years (about 128,000 children) will report having suicidal ideation.[127]

Three-quarters of the children in this cohort review (32, 76 per cent) were known to have expressed suicidal ideation at some stage prior to their death, highlighting the need to take all suicidal expression and behaviour seriously.

Three of the 32 children who were known to have expressed suicidal ideation before their death began expressing such thoughts when they were eight years old. Fourteen were aged between nine and 14 years when they first expressed suicidal ideation, and 15 of the 33 children were aged from 15 to 17 years.

It can be confronting to consider that young children may be thinking about killing themselves and see death as a way to end their distress. As already stated, research suggests that by around eight years old, children have the capacity to think about and understand the finality of death and understand the concept of suicide. This understanding develops from talking with peers (but rarely with adults), seeing suicide in the media, or experiencing the suicide death of a family member or friend.[128] Online discussion forums have also been identified as associated with increased suicidal ideation.[129]

> *'Everyone will talk to you about self-care, but no one wants to sit down and ask "Are you feeling suicidal? Are you having thoughts of killing yourself? Are you feeling beyond the feeling of being sad?" No one wants to have that conversation; but if you're a caseworker, you need to.'*
>
> ***Young person***

124 Duate et al. (2019).
125 AIHW (2021).
126 World Health Organization (2014).
127 Zubrick et al. (2016a).
128 Mishara (1999).
129 Dunlop, More and Romer (2011).

DCJ CASEWORK PRACTICE

In order to understand a child's risk of suicide, the best approach is to ask directly if they are thinking about suicide.

Tips for having the conversation:[130]

- If possible, do some preparation. Sometimes conversations will be unexpected and you will not have time to prepare, but getting prepared can make you feel more comfortable.
- Start the conversation. For example, 'I've been worried about you lately' or 'I've noticed some differences in you lately and I'm just wondering how you are?'
- Listen without judgement.
- Use open-ended questions. For example, 'How long has this been going on?'
- Ask directly about suicide. For example, 'Are you having thoughts of suicide?' or 'Are you thinking about killing yourself?'
- Ask about plans. If the person confirms they are thinking about suicide, it is important to determine if they are in immediate danger.
- Keep the person safe. Consider access to lethal means. If you are concerned about imminent risk, contact emergency services immediately.
- Encourage and support the child to seek help. This may be with a professional or people who have supported them in the past (e.g. family friends, Elders, clergy or teachers).

ADVICE FROM A YOUNG PERSON

- Do not rely on us to tell you how we are feeling. Ask us, regularly.
- Get to know us, so that you can notice when our behaviour changes.

Suicide attempts

MYTH Once someone is suicidal, they will always be suicidal.

FACT Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and a person with previous suicidal thoughts and attempts can go on to live a long life.[131]

In Australia, in any 12-month period, it is estimated that around 2 per cent of children (about 41,400) will attempt suicide.[132] A previous suicide attempt has been identified as the single biggest risk factor for further suicide attempts and death by suicide.[133] This is consistent with Joiner's theory of suicide, which proposes that the learned ability to hurt oneself enables a person to die by suicide.[134] The process of attempting suicide familiarises a person to suicidal behaviour, making later suicide more likely.[135]

Alarmingly, for the children in this cohort review, 22 (52 per cent) had previously attempted suicide. Twenty children attempted suicide within three years of their death.

While data consistently demonstrate that boys die by suicide at much higher rates than girls, adolescent females attempt suicide more often.[136] [137] For the children in this cohort review, there was little gender difference. Eight of the 14 females (57 per cent) and 14 of the 28 males (50 per cent) had attempted suicide before their death. One explanation for the lack of gender difference identified here is that this cohort review does not capture those children whose attempt to end their life did not result in their death.

130 Adapted from Conversations Matter (2013).
131 World Health Organization (2014).
132 Zubrick et al. (2016b).
133 McKean et al. (2018).
134 Joiner (2005).
135 Spirito and Esposito-Smythers (2006).
136 Shain and Committee on Adolescence (2016).
137 Miranda-Mendizabal et al. (2019).

BEYOND NOW – SUICIDE SAFETY PLANNING

Having a safety plan can be useful for reducing the intensity of suicidal thoughts and increasing a person's ability to cope with them.

Beyond Now is a suicide safety planning app developed by Beyond Blue.[138]

DCJ CASEWORK PRACTICE

For further advice about responding to self-harm or suicidal behaviour, practitioners can also refer to the Psychological and Specialist Services **Guidelines for Risk Assessment and Management of Suicide and Self-Harm**.

Mental health

MYTH Only people with mental health conditions are suicidal.

FACT Suicidal behaviour indicates deep unhappiness but not necessarily that the person is experiencing a mental health issue. Many people living with mental health issues are not affected by suicidal behaviour, and not all people who take their own lives have a mental health issue.[139]

It is widely accepted that mental health conditions are associated with an increased vulnerability to self-harm and suicidal behaviour. The presence of a mental health condition is considered a key risk factor for suicide. This includes depression, anxiety disorders, substance use disorders, personality disorders, eating disorders and schizophrenia.[140]

The Young Minds Matter survey found higher rates of self-harm among those who met the criteria for a mental health condition. This was especially true of those with major depressive disorders.[141] The survey also found that the presence of a mental health condition showed the largest significant association with lifetime and 12-month suicidal behaviour.[142]

While the presence of a mental health condition may increase a person's vulnerability to suicide, many people with mental health conditions never experience suicidal behaviour. Equally, people without a mental health disorder may have thoughts of suicide, attempt suicide or die by suicide.

For about two-thirds of the children in this cohort (27, 64 per cent), concerns had been identified about their mental health. Fourteen of these 27 children had a diagnosed mental health condition. The most commonly diagnosed conditions were depression (10 children), anxiety (6 children) and post-traumatic stress disorder (3 children).[143] For the remaining 13 of the 28 children, significant people in their lives had raised concerns about emerging signs of mental illness but there had not been a formal diagnosis.

Twenty-three (55 per cent) of the children in this cohort received support for their mental health or suicidal behaviour within three years before their death. The type of support varied and included hospital inpatient mental health support, school counsellor, GP, psychologist, psychiatrist, Headspace and the Child and Adolescent Mental Health Service. Some children were also receiving sexual assault counselling or drug and alcohol counselling.

138 Beyond Blue (2021).
139 World Health Organization (2014).
140 Bilsen (2018).
141 Zubrick et al. (2016a).
142 Zubrick et al. 2016b).
143 Numbers reported here do not add to 15 because some children were diagnosed with more than one mental health condition.

Eleven children in the cohort were prescribed medication for their mental health condition,[144] although only four children were known to be taking their prescribed medication.

Neurodevelopmental disorders

Disorders of early brain development are often called neurodevelopmental disorders. These are conditions that begin in infancy or early childhood, disrupt brain development, and do not show episodes of worsening or improving. Neurodevelopmental disorders impair motor, learning, language, non-verbal communication and sensory functions. Definitions vary, but neurodevelopmental disorders can include autism spectrum disorder, intellectual disabilities, motor disabilities (e.g. cerebral palsy), seizures, learning disabilities and attention deficit hyperactivity disorder.[145]

Of the 42 children in the cohort, six had a diagnosed neurodevelopmental disorder. This included attention deficit hyperactivity disorder, autism spectrum disorder, foetal alcohol spectrum disorder and intellectual impairment. Five of these six children had also been diagnosed with a mental health condition. This data is consistent with research that indicates children with neurodevelopmental disorders are at an increased risk of experiencing mental health issues[146] and may also experience suicidal behaviour.

Children with these disorders often experience similar symptoms to those with mental health conditions, including increased impulsiveness and emotional instability. However, children with neurodevelopmental disorders face additional barriers to accessing mental health support, such as increased social isolation and difficulties in communicating.[147] For this reason, it is important for practitioners to collaborate with health services to ensure assessments are holistic, screening includes an understanding a child's suicide risk, and intervention upholds a child's sense of choice and control and is tailored to their individual needs.

PARTNERING WITH MENTAL HEALTH SERVICES

Working as a team with community partners will lead to a shared understanding of risk and better decisions.

Headspace provides early intervention for 12 to 25 year olds (including mental health, physical health, sexual health, alcohol and other drug services, and work and study support) and information, support and resources for young people and professionals about mental health, self-harm and suicide.

Headspace also provides one on one online and telephone support counselling for 12 to 25 year olds and their families and friends.

Child and Adolescent Mental Health Service (CAMHS) is a specialist mental health service for children and young people. CAMHS offers short- to medium-term support to infants, children, adolescents and their families and carers who are experiencing emotional, behavioural and social difficulties. Support is provided through individual, family or group therapy; referrals to other community health care providers; links to school-based supports; and in some circumstances, home visiting. CAMHS also provides a pathway to specialist mental health programs such as the Perinatal Infant Mental Health Service (PIMHS)[148] and Getting on Track (Got it!).[149]

144 For the remaining children in this cohort, they were either not prescribed medication or information about prescribed medication was not known to DCJ.

145 Orygen, The National Centre of Excellence in Youth Mental Health (2019).

146 Hansen et al. (2018).

147 Orygen, The National Centre of Excellence in Youth Mental Health (2019).

148 PIMHS offers support and intervention to women and families affected by severe and complex mental illness. www.health.nsw.gov.au/mentalhealth/services/parents/Pages/perinatal-infant-mental-health-services.aspx

149 Got it! delivers specialist mental health early intervention services for children in kindergarten to Year 2 and five to eight years of age who display emerging conduct problems. Got It! is delivered in schools by CAMHS in partnership with the Department of Education. www.health.nsw.gov.au/mentalhealth/resources/Publications/got-it-guidelines.pdf

3.2.2 Living in out of home care

Four children (10 per cent) who were known to DCJ and died in circumstances of suicide or suspected suicide between 2016 and 2020 were in out of home care at the time of their death. All four children were under the parental responsibility of the Minister until they turned 18 years old. Two of the children were case managed by DCJ and two children case managed by a PSP provider. All of the four children were aged from 15 to 17 years at the time of their death.

Research suggests that children in care are at an elevated risk of suicide as they are more likely to be exposed to established risk factors for suicide and they may lack access to protective factors that might prevent them from taking their own life. Research has found that children in care are up to three times more likely to attempt suicide when compared to children not in care.[150]

More placements and longer time in care have also been identified as factors that may increase suicide risk.[151] The four children in this cohort who were in out of home care at the time of their death had been in care for between three and 14 years. In the three years before death, three of the four children experienced unstable living arrangements and multiple placements.

Three of the four children who were in out of home care at the time of their death had a diagnosed mental health condition. One of the four children did not have a mental health diagnosis, although concerns had been raised about this child's mental health and suicidal behaviour. In the three years before their death, all four children received support aimed at improving their mental health. This support varied and included help through connection with a mentor, CAMHS, Headspace, psychologists and psychiatrists.

In 2010, DCJ and NSW Health jointly developed the Out of Home Care (OOHC) Health Pathway program to ensure that every child or young person entering statutory out of home care receives timely and appropriate health screening, assessment, intervention, monitoring and review of their health needs. Two of the four children in this cohort were referred to the program. One of these children had a health management plan developed.

OOHC HEALTH PATHWAY

All children should be referred to the OOHC Health Pathway when they enter care. Children currently in statutory out of home care who are not on the pathway should be referred when they turn 15 and their planning for leaving care starts.

HEALTH MANAGEMENT PLANS

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

Casework practice: for more information on meeting the health needs of children in care see the **Health Needs of Children in Out of Home Care** mandate.

ELVER PROGRAM

The Elver Program was established in 2018, in partnership between DCJ and NSW Health. The program is a statewide multidisciplinary trauma-informed mental health assessment and intervention service for children and young people in out of home care with complex developmental and mental health needs. The program is based in Parramatta and co-located with Metro Intensive Support Services (ISS).

150 Evans et al. (2017).
151 Taussig, Harpin and Maguire (2014).

LINKS TRAUMA HEALING SERVICE (LINKS)

LINKS delivers trauma-focused, evidence-based support to children in out of home care. There are two teams, in Penrith and Newcastle. Each team includes mental health clinicians, Aboriginal mental health clinician, occupational therapist, speech pathologist and psychiatrist. LINKS teams partner with children and families to improve a child's psychological wellbeing and responses to trauma.

Consider the following case example to uphold the rights of children at risk of suicide.

Oliver

Oliver, a 17 year old young person living in out of home care, had made many attempts to end his own life. Oliver's DCJ caseworker, Greg, was helping him develop a leaving care plan aimed at reaching his goal of living independently.

Because Oliver had so many professionals supporting him with different things, Greg recognised that it was important for everyone supporting Oliver to meet regularly to share important information, coordinate the support being provided, and help Oliver to reach his goals and overcome his suicidal ideation.

Rather than leading the meetings himself, Greg invited Oliver to plan and chair them. Oliver reported that this gave him a sense of control over his life, and made it easy for him to participate in making decisions about his life. Oliver said that being tasked with deciding which professionals to invite, setting the agenda, and chairing each meeting acknowledged him as the expert in his own life, gave him a sense of purpose and control, and provided him with an achievable task that he was able to complete each week.

DCJ CASEWORK PRACTICE

The NSW Practice Framework Standards provide reflective prompts to think critically when working with children at risk of suicide. For example, have I / have we:

- Regularly considered the power I hold as an adult, and if I ever use this power in a way that disempowers or silences children?
- Reflected on any assumptions or biases I hold about this child?
- Considered if the child may be behaving in ways that resist pain, violence or oppression?
- Adapted how I involve each child, in ways that best suits their needs, rather than what I am most comfortable with?
- Referred to the rights of the child to guide my casework, to advocate for children or as a tool in group supervision?

ADVICE FROM A YOUNG PERSON

- Get to know the people in my network, learn who I trust and respect, and include these people when you make decisions
- Communicate with me in a way that makes me feel heard and seen
- Be brave and speak directly to me about your worries, even if you feel more comfortable speaking with the adults in my life.

For further advice about meaningfully engaging children in practice see the **Talking to Children and Participation** practice advice topic.

3.2.3 Children involved in the criminal justice system

Children involved in the criminal justice system have been identified as at increased risk of self-harm and suicide. This is thought to be because children involved in criminal activity have often experienced cumulative negative life experiences, making them more vulnerable to self-harm and suicide risk factors such as childhood trauma, running away from home and homelessness, mental health issues, and drug and alcohol use.[152 153 154]

Of the 42 children in this cohort, 19 (45 per cent) had involvement with the criminal justice system. Thirteen of these children were male and six were female.

Fourteen of the 19 children were known to Youth Justice (9 male, 5 female).[155] Levels of involvement with Youth Justice varied and included periods of incarceration, community supervision orders, participation in Youth Justice conferences and being subject to bail conditions.

Six of the young people in contact with Youth Justice were still in contact at the time of their death (5 under community supervision; 1 completing their Youth Justice conference outcome plan). Three of the five young people under community supervision had received mental health support from Youth Justice psychologists and Youth Justice alcohol and other drug counsellors. None of the five had a mental health diagnosis recorded with Youth Justice.

The remaining five of the 19 children involved in the criminal justice system had contact with police only. This related to issues such as vandalism, violence towards others or being the defendant in an apprehended violence order. For two of these children, there had been allegations of sexually harmful behaviour towards others, although these allegations had not been formally investigated at the time of the child's death.

DCJ YOUTH JUSTICE PRACTICE

A child's vulnerability to suicide may be compounded by involvement in the criminal justice system. The creation of the DCJ in 2019 provided an opportunity to work more collaboratively to support shared clients in child protection, out of home care and youth justice, to improve their individual circumstances and life trajectory through a whole of system approach to the provision of care, intervention and case management. When a child is known to both the child protection system and the criminal justice system, assessment and support provided by Youth Justice plays a key role in supporting wellbeing.

Youth Justice practice to support children at risk of suicide is guided by the **Youth Justice Self-harm and Suicide Prevention Policy** and the **Youth Justice Practice Guide 2020**. All children are assessed for risk of self-harm or suicidal behaviour at the point of entry and throughout their time in Youth Justice. The Youth Justice Psychological and Allied Health Services continually assess risk of self-harm and suicidal behaviour and respond accordingly and in line with the **Youth Justice Psychologists' Manual**.

3.2.4 Exposure to suicide

'Suicide contagion' is the term used to describe the increased risk of suicide when a person is exposed to suicide or suicidal behaviour within a family or peer group, or through media reports of suicide. Several studies have explored the association between exposure to suicidal behaviour of others and risk of suicide, suicide attempt and suicidal ideation. Experiencing the death of a relative or friend by suicide is

152 Bhatta et al. (2014).
153 Borschmann et al. (2014).
154 Justice Health and Forensic Mental Health Network, and Juvenile Justice (2017).
155 For one child, although known to Youth Justice, there had been no action before the child's death.

known to increase a person's risk of suicide.[156] The experience may suggest to a child that suicide is also an option for them. Therefore, it is critical that an understanding about a child or young person's risk of suicide includes screening for a history of suicide or suicidal behaviour in relatives and friends.

The suicidal behaviour of a peer or family member is not always known to DCJ, meaning it is possible that the information captured here is an under-representation of the true exposure to suicidal behaviour for children in this cohort. In particular, the influence of suicidal behaviour in peers and media reports of suicide is not completely captured here. Regardless, the information that is known for this cohort reinforces that asking a child or young person about their exposure to suicidal behaviour is critical for understanding a child or young person's risk of suicide. This cohort review identified that:

- Twenty-one children (50 per cent) had relatives who expressed suicidal ideation. This included parents, siblings, extended family members and friends. Of these 21 children, six children had more than one relative or friend who had thoughts of suicide.
- Eleven children (26 per cent) had a parent, sibling or extended family member who had attempted suicide. Two of the 11 children had more than one relative attempt suicide.
- Six children (14 per cent) experienced the suicide death of a parent, extended family member or friend. Three of these children had more than one relative or friend die by suicide.

DCJ CASEWORK PRACTICE

Understanding a family's history is important. It provides practitioners with information about a family's context, patterns of behaviour, and the ways in which families have harnessed their strengths to overcome adversity. When working to understand a child's risk of suicide, it is critical to know about their exposure to suicidal behaviour.

In order to feel comfortable talking with a child about their exposure to suicide, practitioners need to be prepared. **Pre-assessment consultations** are one forum in which practitioners can practise difficult conversations, and plan approaches that may be the most useful. Pre-assessment consultations also provide an opportunity for practitioners to review the information already known about a family's exposure to suicide, and reflect on:

- What do we already know about this child's exposure to suicidal ideation? What do we still need to know, and how might we find out?
- What emotional responses do we each have to this family's experiences? How can we attend to our emotions so that they do not get in the way?
- Who else do we need to consult with or talk to? Could we use group supervision to do this?

3.2.5 Warning signs and tipping points

MYTH Most suicides happen suddenly and without warning.

FACT The majority of suicides are preceded by warning signs, whether verbal or behavioural. On rare occasions, some suicides occur without warning, but it is important to understand the warning signs and look out for them.[157]

Research has identified that children who die by suicide commonly experience stressful or traumatic events just prior to their death such as arguments with parents and family; arguments or the end of a relationship with a girlfriend or boyfriend; problems at school (discipline, bullying or other problems);

156 Hill et al. (2020).
157 World Health Organization (2014).

adverse contact with the criminal justice system; being the victim of violence or sexual abuse; and the death of a family member or friend.[158 159]

Information obtained by DCJ after the deaths of the children in this cohort indicated that 25 (60 per cent) experienced a stressful or traumatic event in the days before their death. The most commonly reported events were arguments with parents, family members or girlfriend/boyfriend; relationship break-up; contact with police about criminal matters; recent experience of sexual abuse; death of family member or friend (including the recent loss of a loved one to suicide); and issues at school.

DCJ CASEWORK PRACTICE

It is common for children to go through the ups and downs of growing up and to feel strong emotions. But for some, the downs can be so intense that they think about taking their own life. There are behavioural changes and thoughts or feelings that can provide 'clues' or 'red flags' about a child's risk of suicide.

Behavioural indicators[160]

- Increased use of drugs or alcohol
- Saying goodbye or giving away important or sentimental belongings
- Engaging in risky behaviour
- Anger, aggression or irritability
- Changes in mood
- Withdrawing from social contact
- Changes to routine, including eating or sleeping patterns, or losing interest in things previously enjoyed
- Seeking access to something lethal.

Verbal expressions

- Sense of hopelessness
- Feeling like a burden to others: 'No one would care if I was gone' or 'If I was gone, people wouldn't have to worry about me'
- Negative view of self
- Frequently talking about death or suicide: 'I don't want to be here anymore' or 'I wish I could go to sleep and never wake up'
- Isolation or feeling alone.

Risk factors, warning signs and tipping points should not be viewed in isolation. It is important to talk with children and hear their perspective to understand what life is like and assess their risk of suicide.

ADVICE FROM A YOUNG PERSON

Get to know me. Learn about my personality, my experiences, what I like and do not like. If you get to know me, you will be able to notice if my behaviour changes. You will be able to recognise when I am struggling and when I am doing well. You will be able to pick up on behaviour that might indicate that I am feeling suicidal. Getting to know me will also help me to trust you. It will show me that you care about me, and that is all we really want - we want our caseworkers to care about us.

I also need to have people in my life that I can talk to about difficult things. I need you to find the people that I already trust and respect. Build a relationship with them, connect them to each other, build a strong network of support around me and invite them into your work with me.

158 Karch et al. (2013).
159 Holland et al. (2017).
160 Adapted from Conversations Matter (2013).

3.3 Child protection responses

As already stated, for 37 of the children (88 per cent) in this cohort, concerns about their mental health, self-harm or suicidal behaviour had been identified at some point before their death. However, this was not always reported to DCJ, which had received reports or held information about the mental health, self-harm or suicidal behaviour for 27 (64 per cent) of the children. For 10 children, after their death, DCJ learned that their family or other important people in their lives had been worried about the child's mental health, self-harm or suicidal behaviour. For the other five of the 42 children in the cohort, no concerns were raised about their mental health and no one knew that the child was thinking about suicide.

3.3.1 Reported risk of harm concerns

Forty-one (98 per cent) of the 42 children in this cohort were reported to DCJ at risk of significant harm within three years of their death. One child's death was reviewable because a sibling had been reported in the three years before the child died.

As shown in Figure 13, for a large majority of children known to DCJ and who died in circumstances of suicide or suspected suicide between 2016 and 2020, DCJ had received reports raising concerns that the needs of at least one child in the family were not being met (35 children and families, 83 per cent). The reports about neglect included:[161]

- Supervisory neglect (23 families, 55 per cent)
- Emotional abuse/neglect (22 families, 52 per cent)
- Physical neglect (20 families, 48 per cent)
- Medical neglect (13 families, 31 per cent)
- Educational neglect (10 families, 24 per cent).

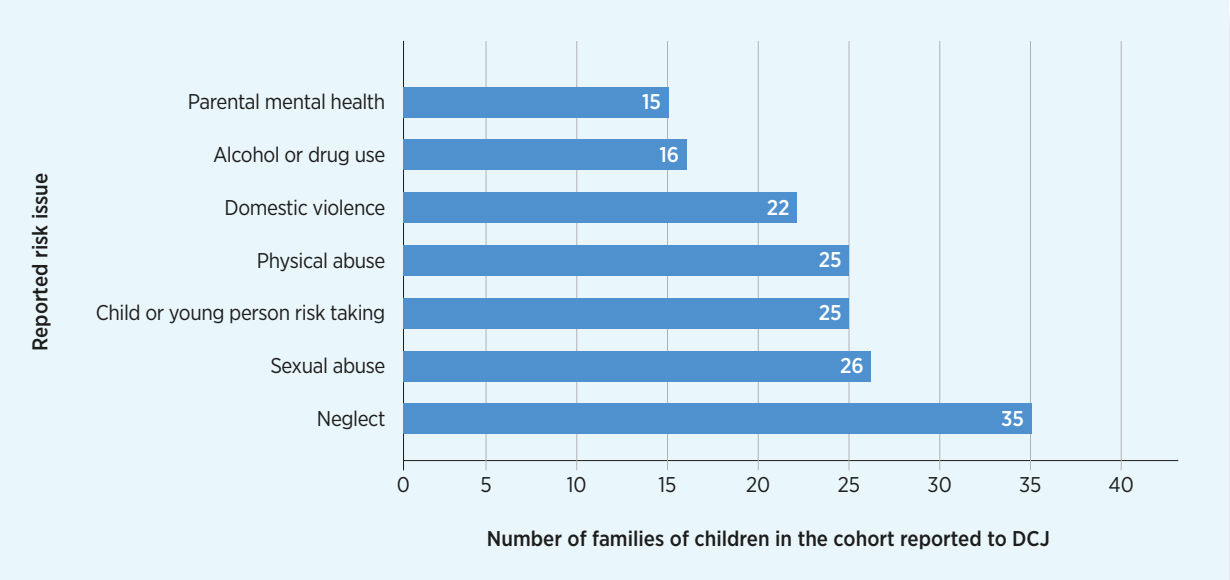
Neglect is often the most commonly reported risk factor for all children who died and were known to DCJ. This is also consistent with national trends of children who are reported to child protection services across Australia.[162]

As also shown in Figure 13, the families of children in this cohort were also reported to DCJ at risk of significant harm for the following concerns:[163]

- Sexual abuse (26 families, 62 per cent)
- Child or young person risk-taking (25 families, 60 per cent)
- Physical abuse (25 families, 60 per cent)
- Domestic violence (22 families, 52 per cent)
- Parent alcohol or drug use (16 families, 38 per cent)
- Parent mental health (15 families, 36 per cent).

161 Numbers do not add to 100 per cent because families can be reported multiple times for multiple neglect concerns.
162 Scott (2014).
163 Numbers do not add to 100 per cent because families can be reported multiple times for multiple concerns.

Figure 13: Reported ROSH concerns, by number of families



Research has consistently identified an association between experiences of abuse and neglect and suicide risk. A systemic review of the literature identified that childhood sexual abuse, physical abuse, emotional abuse and neglect were associated with adolescent suicidal ideation and attempts.[164] Between 2016 and 2020, children known to DCJ accounted for 31 per cent of suicide deaths in NSW.[165]

A higher number of reports to child protection services has also been found to be associated with higher risk of suicide, suggesting that chronic experiences of abuse or neglect increase suicide risk.[166] Five children in this cohort had been reported to DCJ once, and 15 had been reported from two to nine times. Half of the children in the cohort (21, 50 per cent) were reported to DCJ more than 10 times.

Furthermore, research has identified that abuse and neglect experienced early in development increases lifetime suicide risk. It is theorised that disruptions to early attachments may create a unique risk for suicide.[167] Four children were first reported to DCJ during pregnancy; 17 were known to DCJ by the time they were five years old.

DCJ CASEWORK PRACTICE

Children need practitioners to consider reported information in the context of their daily lived experiences, not just their experience of one event. A child's risk of suicide should be considered in all triage actions.

For further advice practitioners can refer to the **Triage Assessment** mandate.

164 Miller et al. (2013).

165 Figures for child suicide deaths in NSW from 2016 to 2019 were provided to DCJ from the NSW Ombudsman's Office. The total number of children who died by suicide in NSW in 2020 is taken from the NSW Suicide Monitoring System, Report 8, 29 June 2021. This information is subject to change as final causes of death are determined by the Coroner. www.health.nsw.gov.au/mentalhealth/resources/Pages/sums-report-apr-2021.aspx

166 Taussig, Harpin and Maguire (2014).

167 Handley et al. (2019).

3.3.2 Case allocation

For children in his cohort, at the time of their death DCJ had allocated cases for seven families:

- Two children in out of home care had DCJ allocated caseworkers.
- Two children in out of home care were in the primary case management responsibility of a PSP provider, with secondary case responsibility exercised by a Child and Family District Unit.
- Three children had their families allocated to DCJ caseworkers. For the family of one child, an assessment had occurred. The remaining two families were awaiting an assessment at the time of the child's death.

A further seven families had open reports but these were not allocated to a caseworker. A decision about allocation had not been made when the child died.

In the three years before death, DCJ completed assessments for the families of 13 children in this cohort. When reviewing children's deaths, it was identified that DCJ did not seek to understand the children's full experience by approaching assessments with curiosity and including children in assessments and decision-making. Often information about a child's mental health or risk of suicide was either not identified during the assessment, or identified but not responded to with enough urgency.

BUILDING PARTNERSHIPS TO STRENGTHEN RESPONSES TO CHILDREN AT RISK OF SUICIDE

In two districts, practitioners from DCJ and local mental health services facilitate regular interagency meetings to support relationships between services and sharing information and expertise about children at risk of suicide.[168] This allows for considered, tailored and coordinated responses to children and young people at risk of suicide and their families.

Additionally, the **Central Coast Multi-agency Response Centre** (CCMARC), supports a collaborative approach to triaging reports about children and young people at risk of suicide. CCMARC is represented by DCJ, NSW Health[169] and Education Child Wellbeing Units, enabling information about children and young people with complex support needs to be discussed in twice-weekly local planning response meetings, or referred for an interagency complex case discussion. The opportunity for interagency discussion builds understanding of other agency resources and strengthens partnerships.

3.3.3 Intervention after a child has died

'Postvention' is the term used to define support provided after the death of a loved one to suicide. It might include counselling, support groups or support from family and friends. As has already been highlighted, when a person experiences the suicide death of a family member or friend, it increases their vulnerability to suicide. Therefore, the support provided to a family after a child dies by suicide is critical.

For families known to DCJ, this support begins with the sibling safety assessment. DCJ undertook an assessment for the families of 15 children in this cohort after the death of their child. For another three families, while no assessment was completed, DCJ practitioners made contact with the family to confirm they were appropriately supported.

For the remaining 24 families, the reasons a sibling safety assessment was not completed included that there were no other children in the household, no risk issues were identified for the surviving siblings, the child's death was reported to DCJ retrospectively, or competing demands.

168 Northern NSW, Mid North Coast and New England District; and Sydney, South Eastern and Northern Sydney District.
169 The NSW Health representative on CCMARC is the Central Coast Local Health District Child Wellbeing Coordinator.

DCJ CASEWORK PRACTICE

Casework and assessments after a child death is difficult work. The dual roles of assessment and support can often feel incompatible. Keeping children's safety at the centre of practice while managing the overwhelming grief of family members takes great skill and care. This is especially true for assessments and support provided after a child dies by suicide.

Practitioners can refer to the **Sibling Safety** mandate for further advice on casework and assessments after a child death.

3.3.4 Working with Aboriginal families after a child or young person has died by suicide

The term 'Sorry Business' refers to a period of cultural practices and protocols associated with the death of an Aboriginal person. When completing assessments with Aboriginal families following the death of a child, it is critical for practitioners to engage in cultural consultation, and to adapt their practice to ensure they are able to provide adequate support as they assess safety and risk for surviving siblings, while being respectful of the obligations and responsibilities Aboriginal people have in the period following a death.

For many Aboriginal families, Sorry Business may mean returning home to Country immediately following a death, as a way to pay respect to and grieve the person who has died. Other common responsibilities and obligations include not using the person's name or broadcasting the voice of a person who has died. It is also common during Sorry Business for Aboriginal people not to participate in non-bereavement-related activities or events.[170] This may mean that relatives, rather than parents, become the main point of contact for practitioners working with a family following the death of a child.

Because cultural protocols relating to Sorry Business vary across Aboriginal communities and Nation groups, it is important for practitioners to seek advice and guidance through cultural consultation about the most appropriate and effective ways to provide support to a family following the death of a child. Similarly, cultural consultation should occur to determine the most appropriate support to provide to a family once Sorry Business has ended.

REFLECTIONS FROM ABORIGINAL PRACTITIONERS

Practitioners must respond with empathy and compassion when engaging with any family following the death of a child. When working with Aboriginal families, it is particularly important to acknowledge that grief and loss can bring about a multitude of emotions. For some, grief may present as frustration or anger. In other circumstances, people may turn inwards, masking grief with silence. Navigating this space when working with Aboriginal families can be difficult and confronting for practitioners.

In these situations, it is important that practitioners seek out purposeful and regular cultural consultation, and use forums such as individual and group supervision. Doing so creates opportunities for practitioners to seek cultural consultation about alternative ways to approach, speak and connect with children and families; engage in critical reflection; apply professional judgement in assessments; acknowledge and challenge their own cultural biases; and consider parents' and relatives' behaviour in the context of their experiences of grief and loss.

170 SNAICC. www.supportingcarers.snaicc.org.au/

3.4 Learning from child death reviews

Kayla's story

Kayla was first reported to DCJ when she was six months old. Throughout her childhood, reports raised concerns that her parents, Stephanie and Luke, were using drugs, and Luke was using violence towards Stephanie. The family did not have a place to live, so they spent time living with a number of relatives in different places across NSW.

When Kayla turned 13, she started running away from home. She sometimes stayed with relatives, or at youth refuges, but other times her parents did not know where she was. Reports made to DCJ around this time described Kayla as sad and withdrawn. She had started truanting from school, was cutting herself in class, and was finding it difficult to talk to adults about her experiences.

When a community member reported that she had found Kayla sleeping at a local park, DCJ allocated the report for an assessment. Kayla told caseworkers she did not feel safe at home. She said she ran away to escape the violence she was experiencing. Kayla said she had studied self-defence, and always had a bag packed ready to leave. She told caseworkers that she smoked cannabis to numb the emotional pain she was feeling, and that sometimes she thought about killing herself.

When caseworkers spoke with Stephanie and Luke, they said Kayla had 'made everything up to cause trouble and get attention'. Luke said Kayla was being a 'typical teenager' and that she used cannabis to fit in with her peers. It was at this time that Kayla's family decided that she would move to live with her uncle, Alan.

Not long after moving to live with Alan, Kayla took an overdose of his prescription medication. She was taken to hospital, where she told a social worker that she hated Alan, and felt that no one cared about her.

Caseworkers worked collaboratively to make a plan for Kayla to stay with a school friend for two nights, before moving to stay at a youth refuge. DCJ referred Kayla to a youth homelessness service and closed the case.

When Kayla was 14, a relative reported that she had returned to live with her parents, Stephanie and Luke. The report noted that the family was living in a caravan park, and had no food, running water or electricity. The report was closed without assessment, noting it was Kayla's choice to live with her parents.

Further reports raised concerns that Kayla was selling drugs at school, often talked about suicide and that Stephanie often had injuries to her face and body. These reports were also closed without an assessment.

Two months after returning to live with her parents, Kayla ended her life. After her death, DCJ learned that in the months before she died, Kayla had made a number of posts on social media about being lonely, unloved, and that she could not see how her life could get better.

LEARNING FROM KAYLA'S STORY

Kayla was just 13 years old when she started running away from home in an attempt to maintain her dignity and resist the violence she was experiencing. Around the same time, she also started self-harming and using drugs. Practitioners could have recognised that the actions Kayla was taking, in an attempt to protect herself, actually made her more vulnerable to harm. She needed an urgent response and a plan to increase her safety.

Kayla needed the adults in her life to build strong, trusting and caring relationships with her. Caseworkers began to role-model this kind of relationship when they met with Kayla to talk about and understand her experiences. Asking Kayla directly about her suicidal ideation and self-harming during this conversation would have helped to find ways to increase her safety and sense of hope, and demonstrate to Kayla that people cared about her.

In the 12 months before she died, Kayla had moved more than five times. Each time, she moved alone. It was clear that Kayla craved connection, and physical and emotional stability. While caseworkers rightly worked to ensure Kayla had a place to live, they needed to respond with equal urgency to her need for security, connection and belonging.

Recognising the vulnerability of teenagers

> *'As a caseworker, you can't just look at someone and say "You're this age, so that's okay for you to be doing this" without looking at what is going on at the very core.'*
>
> ***Young person***

Twenty-five of the children (60 per cent) who were known to DCJ and died in circumstances of suicide or suspected suicide were reported to be at risk of significant harm because of their risk-taking behaviour. For 16 of these 25 children, reports about their risk-taking included concerns about self-harm or suicidal behaviour. Reports also raised concerns about running away, being involved in criminal activity, violent or aggressive behaviour, and causing sexual harm to others. Nineteen of the 25 children who had been reported to DCJ because of their risk-taking behaviour were aged from 15 to 17 years.

The reviews for children aged 15 to 17 years in this cohort found that as children become teenagers, they are often no longer seen as a victim of their circumstances but as young people who are less vulnerable, more resilient and contributing to their own difficulties. A teenager's mobility was often viewed as a protective factor. However, the factors that increase a teenager's safety also mean they become more vulnerable to a broader range of risks, come into contact with wider social networks, become more vulnerable to harm outside the home, and are more likely to be involved in risk-taking behaviour that actually increases their vulnerability.[171]

Reviews identified that practitioners often overemphasise the resilience and capacity of a teenager to take care of themselves and manage difficult situations, including when responding to thoughts of suicide.

171 Gorin and Jobe (2013).

DCJ CASEWORK PRACTICE

To safeguard practice when working with teenagers at risk of suicide, critically reflect on the following questions. Have I / have we:

- Connected with this teenager to understand how to make them feel safe?
- Built a relationship that has allowed me to understand or ask about the feelings underpinning this teenager's behaviour?
- Overemphasised this teenager's resilience, or capacity to manage difficult situations, make adult decisions, and take care of themselves?
- Acknowledged the impact of trauma on this teenager's development?
- Considered whether this teenager requires additional support to face the usual challenges of adolescence?
- Sought to understand whether this teenager's 'risk-taking behaviour' could be an act of resistance?
- Asked this teenager if they are having thoughts of suicide or self-harm and responded with care and urgency during these conversations?
- Used individual or group supervision to think critically about this teenager's experiences, to notice patterns in behaviour and develop hypotheses that can be tested in my assessments?

Building strong relationships with children

> *'It's all going to fall back onto your relationship with the young person, because if you don't have that, you're not going to be able to see those changes of behaviour.'*
>
> ***Young person***

Children have a basic right to participate in decisions about their lives. Their participation is driven through the relationship with their caseworker. Relationships that demonstrate commitment, connection and continuity are imperative for working with vulnerable children. It is through such relationships that the practitioner is able to convey respect, develop trust, influence change, let the child know they have been heard and, ultimately, help them to reach their potential.[172]

Children need their caseworker to be their advocate and develop a relationship that ensures they are supported to thrive. Meaningful, positive relationships with children set the foundation for casework that is purposeful and effective. When a child is supported to tell their story, including when they may be thinking about suicide, a positive social response reduces isolation and improves a child's sense of self-worth. This helps children to feel valued and develops trust.[173]

Many of the reviews for children in this cohort identified that children were not included in assessments and decisions about their lives. This meant that practitioners did not spend time getting to know the child, understand their perspective and experiences, and talk to them about their suicidal behaviour.

172 Richardson and Bonnah (2015).
173 Graham and Fitzgerald (2011).

DCJ CASEWORK PRACTICE

Practitioners can build positive relationships with children who may be thinking about suicide by being consistent, transparent and patient; including children in decision-making; and building on their strengths. To safeguard practice, consider, have I / have we:

- Challenged any assumptions I might hold about this child's capacity to participate?
- Built a meaningful partnership with this child?
- Been flexible and creative in my approach to seeking this child's views?
- Checked in with the child regularly and involved them in conversations where decisions are made about their life?
- Shown this child, in my words and actions, that I want to hear and understand their experiences?
- Recorded the child's views and experiences accurately?

Buffering loneliness and isolation

> *'Our purpose in Family Finding is to restore the opportunity to be unconditionally loved; to be accepted and to be safe in a community and a family.'*
>
> ***Kevin Campbell, Family Finding model author***

The key to suicide prevention is building and maintaining protective factors for children. As already stated, Joiner[174] proposed that perceived feelings of burden and isolation, or a lack of belonging, enable a person to complete suicide. Conversely, a strong sense of social belonging with family, peers and community is at odds with loneliness and feelings of burdensomeness. It is for this reason that connectedness and a sense of belonging are so important for children, and have been identified as one way to buffer the risk of suicide.[175]

Safe, enduring relationships build emotional permanence and long-term resilience for children. Permanent relationships reduce isolation and loneliness and help children to feel safety and love. To help prevent suicide, children need long-lasting, positive relationships within their family, school and community.

Several reviews for the children in this cohort highlighted that children need positive relationships that provide them with connection and emotional permanence. Reviews commented that children need practitioners to see them and hear them, recognise their resistance, and support their need for belonging and positive lifelong relationships.

174 Joiner (2005).
175 Frederick et al. (2017).

DCJ CASEWORK PRACTICE

To reduce feelings of isolation and loneliness in children at risk of suicide, critically reflect on the following questions. Have I / have we:

- Asked this child about people or things in their life that they feel connected to, and used these connections in my practice?
- Invited the people in this child's support network to participate in case planning?
- Sought to use, develop and strengthen existing connections?
- Harnessed the expertise of others by consulting with DCJ colleagues such as casework specialists, permanency coordinators and psychologists?
- Harnessed the expertise of cultural consultants to understand how best to link this child to their culture?
- Harnessed the expertise of LGBTQIA+ consultants to ensure this child is linked to a community of support?
- Considered what experiences of discrimination, racism, ableism, homophobia or transphobia the child may be experiencing and considered what I can to address this while advocating and supporting this child?

'We always have to hold hope that change is possible. If they're in a dark hole, children can't climb out on their own, they need us to reach down and pull them out... We need to stop and listen, because when we do, we can be part of changing a family's world for the better.'

DCJ caseworker

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

The NSW Government provides vital services and additional frontline workers to support the most vulnerable members of our communities. Across 2020 and 2021, the NSW Government continued to implement vital reforms to the child protection and out of home care system in NSW. The work of DCJ in this sector continues to be informed and strengthened by the Stronger Communities Cluster, recommendations from serious case reviews, NSW Practice Framework,[176] the Stronger Communities Investment Unit[177] and the Permanency Support Program.[178] These reforms are essential in guiding the Department's approach and practice with vulnerable children and families. Together, they promote a smart, connected system that provides evidence-based and needs-based supports to create meaningful relationships that sustain change and improve life outcomes. Chapter 4 provides an overview of these key reforms and initiatives, and a separate section on current and future initiatives that focus on improving practice and outcomes for children who are reported to DCJ of being at risk of suicide.

NSW State Budget

The Stronger Communities Cluster delivers community services that support a safe and just NSW. It supports safer, stronger communities through operating an effective legal system; the protection of children and families; building resilience to natural disasters and emergencies; promoting public safety; reducing reoffending; supporting community harmony and social cohesion; and promoting physical activity and participation in organised sport, active recreation and sporting events.

One of the seven NSW State Outcomes is that **children and families thrive**. This is achieved by ensuring the safety and wellbeing of vulnerable children, young people and families, and protecting them from the risk of harm, abuse and neglect. The key programs to support the delivery of this outcome include Out of Home Care and Permanency Support, Child Protection, Targeted Early Intervention, and Domestic and Family Violence.

In 2021–2022, the Stronger Communities Cluster will invest $2.9 billion in the **children and families thrive** outcome[179] including:

- $1.4 billion to support the safety, welfare and wellbeing of vulnerable children in out of home care and supporting permanency outcomes. This includes $5.7 million ($12.0 million over four years) to increase guardianship and adoptions for children in out of home care. Funding will support a targeted promotion and awareness campaign, establish a dedicated guardianship and adoption taskforce, and improve support for prospective guardians and adoptive parents.
- $756.5 million to support a robust child protection system to assess reports of child abuse and neglect, and provide support to keep children safely at home and prevent entries to care.
- $204.9 million to prevent family, domestic and sexual violence, reduce reoffending and support victim safety through the continuation of evidence-based early intervention, victim support and perpetrator interventions. This includes:
    - approximately $70.0 million ($140.0 million over two years) to invest in frontline family, domestic and sexual violence services across NSW, jointly funded with the Commonwealth Government under the new National Partnership on family, domestic and sexual violence.
    - $7.2 million ($33.9 million over four years) to support the safety of domestic and family violence victim survivors with specialist case management through the expansion of the Staying Home Leaving Violence program, and continuation of the Domestic Violence Pro-Active Support Service.

176 NSW FACS (2017). Launched September 2017.
177 NSW Government (2016). Previously called *Their Futures Matter*, launched November 2016.
178 Launched October 2017.
179 NSW Treasury (2021). See sections 7.1 and 7.4.

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

As noted in Chapter 1, the Serious Case Review Panel meets quarterly to discuss complex practice reviews and consider the issues raised for child protection and out of home care practice within DCJ, as well as the broader relationships with other government and non-government services. Details of recommendations made from child death reviews considered by the Panel in 2020 and how these recommendations are progressing is provided below.

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

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

4.1.1 Recommendations by the Serious Case Review Panel

The information below summarises the key practice reforms and changes arising from the SCR Panel in 2020.

Objectives and membership

In July 2020, the Panel considered a review about a child who died after being assaulted by their mother's new partner. The discussion that followed prompted the Panel to identify the value that a person with specific expertise in family and domestic violence would bring to the Panel. In December 2020, an Executive Director from Women NSW joined the Panel as a new permanent member.

Review of policy

The learning from reviews often shows where gaps lie in existing DCJ policy and procedure. The following have been updated in response to recommendations made by the SCR Panel in 2020:

- The **Permanency Support: Critical Events in Statutory OOHC** policy was updated in October 2020 to mandate that the OSP liaises with external providers to arrange joint child death reviews where necessary.
- The **Away from Placement** policy is being updated in 2021 to strengthen and clarify the arrangements for supporting a child or young person who is away from their usual placement.
- The **Service Provision Guidelines for the Recommissioned Family Preservation and Intensive Family Preservation Programs** were published in July 2021 and include guidance for managers and caseworkers when making referrals to funded service providers, and in understanding their ongoing role when case management remains with DCJ.
- The new **Supervising a placement when a service provider is no longer able to fulfil its duties** policy was implemented in November 2020 to ensure caseworkers have clear guidelines setting out what is required when DCJ becomes responsible for supervising a placement under section 141 of the Care Act.

Sharing learning to promote child safety

A number of reviews considered by the SCR Panel were referred to internal DCJ units and external agencies to share learning and inform program design. When appropriate, reviews are also shared with non-government partners that provide case management to children in out of home care. As a result of work in 2020, reviews were shared with the following external organisations:

- Mental Health Commission
- Office of the Children's Guardian

In 2020, the Panel considered a review about a young person who died and had significant involvement with funded service providers. The review highlighted the need for the development of a joint review framework. A scoping paper has been written; consultation with the Ombudsman, Children's Guardian and relevant organisations is planned later in 2021 to inform this work.

Improving the effectiveness of high needs kids panels

In April 2020, the Panel considered a review about a young person who died while in out of home care and was case-managed by a non-government agency. The review and subsequent discussion by the Panel identified limitations in the current systems in place to manage children with complex care needs in out of home care, particularly for children who are transient and not living in a stable placement. As a result of this review, a working group was established and consultation took place across all DCJ districts. A paper was presented to the DCJ Secretary that considers the strengths and limitations of the existing statewide arrangements for high needs kids panels and proposes options for a preferred system to be applied consistently across NSW.

Responding to young people with mental health issues

In July 2020, the Panel considered a review about a young Aboriginal person who died from a drug overdose. The review highlighted particular learnings for practitioners about responding to the mental health needs of young people and ensuring each child and young person has connection and stability. In response to this, a learning package was developed to improve practitioner knowledge and confidence to talk with children and young people about self-harming and suicide and to work with young people who experience placement instability.

Interstate liaison

A review discussed by the Panel in April 2020 identified limitations in DCJ policies and procedures when supporting children and young people who are moving between Australian jurisdictions. Since these were identified, the OSP has partnered with the Interstate Liaison Team and used group supervision to identify practice opportunities and develop new resources to support practitioners working with children moving interstate. For example, work took place with the Child Protection Helpline to ensure the Interstate Liaison Team receives a notification each time a ROSH or non-ROSH report is made about a child who is living interstate.

The Interstate Liaison Team has completed a roadshow to all DCJ districts and funded service providers. This roadshow provided practitioners with an understanding of the role of the Interstate Liaison Team and how they can support practitioners who are working with children that live interstate.

Work with Child Protection and Community Corrections

A joint review between Child Protection and Community Corrections was considered by the Panel in September 2020. The review identified a number of gaps in collaborative working between the two agencies. In response, the Panel recommended a working group to examine:

- improving information exchange and each agency's role and functions
- case coordination where there are shared clients.

The working group, formed in January 2021, met on seven occasions up to the end of March 2021. Representatives from Community Corrections, the OSP (Serious Case Review, and Practice Quality),

Helpline and Strategy Policy & Commissioning participated. The first five meetings were devoted to sharing information about the work of each agency and identifying where policies, practice guidance, training and mandates could be updated to enhance information sharing and collaboration between the two agencies. The final two meetings were devoted to two extended workshops where the working group mapped the journey of the child's family, from both Community Services and Community Corrections perspectives, to ensure that working group members from both agencies who were responsible for leading the updates to relevant guidance had a clear understanding of where information sharing and collaboration could be enhanced.

Proposed system improvements: The working group identified relevant work already underway that could be enhanced to promote information exchange and collaborative practices between the two agencies. An update on these activities, some of which have been completed and some which are still ongoing, follows.

Completed work

Child Protection

- In 2021, the OSP reviewed and published revised content in the **Domestic and Family Violence Practice Kit** to identify areas where more information is required about partnering with Community Corrections when supporting families experiencing domestic and family violence.
- On 5 May 2021, DCJ released the **Collaborative Practice in Child Wellbeing and Protection: NSW Interagency Guidelines for Practitioners 2021**, which now include information about the role of Community Corrections in Child Protection.

Community Corrections

- Revised Chapter 16A information exchange processes to explicitly promote communication between Community Services and Community Corrections when Community Services submits a Chapter 16A request for information and the client is under active supervision.
- Reviewed and amended the training provided to new Community Corrections Officers (CCOs) in relation to child protection, to improve Community Corrections understanding of Community Services. Training has been updated and provided to new CCOs. The Child Protection Coordination and Support Unit continues to work with Brush Farm Corrective Services Academy to refine the training.
- Created an intranet page about child protection for Community Corrections staff. The intranet page provides a central point for Community Corrections to locate information about child protection, including information about the role of Community Services.

Work in progress

Child Protection

- The **OSP** is reviewing content across a number of practice advice topics (e.g. Relationship-Based Practice, and Collaboration and Respectful Partnerships with Families, which will be merged; Sharing Risk, Working with Fathers, Responding to Domestic Violence During COVID) to identify areas where information about partnerships with Community Corrections can be strengthened.
- **Child & Family Strategy** (Commissioning) is reviewing a number of mandates (e.g. Assessing Safety and Risk, Case Planning with Expectant Parents, and Responding to Prenatal Reports) to identify where information about partnerships with Community Corrections can be strengthened.

Community Corrections

- The child protection policy is under review to enhance the current pathway for linking Community Corrections and Community Services staff who are actively engaged with offenders and their families. This will include redesigning the form for Community Corrections Officers to request information from Community Services under 16A.
- A review of the Community Corrections Handbook is underway. The updated handbook will include information about managing risk to children, information sharing and collaboration with Community Services, where appropriate. The updated handbook is expected to be released in early 2022.

4.2 NSW Practice Framework: Implementation and progress

4.2.1 Overview of the Framework

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

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

The Framework is overtly and deliberately intentional in its child focus. It encourages DCJ staff to see that all of their work with a family needs to align with a constant responsibility to improve safety and outcomes for children. Staff are helped to understand that all relationships they form – with parents, carers and community partners – must be built on common goals about improving safety to children.

Figure 14: NSW Practice Framework (launched September 2017)

4.2.2 Implementing the Framework

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

Training modules

The initial Practice Framework program involved nine days of face to face training. In mid-2020 this program was redeveloped in response to COVID-19, and a virtual program was piloted in one district. With the extended restrictions, remaining districts started a virtual program in 2021.

The virtual program covers the same modules and learning goals, but is now delivered through a series of e-learn modules, structured group supervision sessions and five remote learning modules:

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

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

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

Practice Framework Working Group

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

The Working Group has an established terms of reference. It meets quarterly and reports into the Operations Executive Group. The Executive Group provided guidance on what and when new initiatives will be introduced, ensuring increased support and knowledge at the district level of implementation plans and clarifying what is needed to support the implementation of new pilots, programs and policy in local CSCs.

Group supervision: Statewide implementation and ongoing support

The OSP has adapted the DCJ group supervision model to incorporate the Framework's principles, approaches and capabilities. In 2018, the OSP delivered more than 100 one-day group supervision introduction sessions to 2,400 caseworkers across the state, and three days of facilitation training to leaders. The OSP continues to deliver training to leaders, ensuring that staff facilitating group supervision have been adequately trained and supported to do so. Post-training surveys suggest that the group supervision training packages were well targeted, engaging and enhanced learning.

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

The Practice Framework Standards for child protection and out of home care practitioners

The **Practice Framework Standards** (Practice Standards) were first launched by DCJ in September 2014. Developed by practitioners, this resource was the first of its kind – providing one set of expectations to unite and guide consistent practice across NSW. In the six years since the release of the first set of standards, DCJ has continuously improved the way it works with children and families. The renewed Practice Standards now outline a comprehensive set of quality indicators that cover all areas of casework – the first in place in DCJ for the full spectrum of child protection and out of home care practice. These will help all areas of DCJ to have a consistent benchmark of what quality looks like and where to find evidence of this.

The revitalised Practice Standards provide a refreshed set of expectations for practitioners, drawing on contemporary evidence and giving greater clarity. They bring together how practitioners work within the systems, principles, approaches and capabilities of the Framework, while considering other related reforms such as the PSP and the DCJ Aboriginal Cultural Capability Framework. The Practice Standards make it clear how each standard comes to life as expectations in daily practice with children. They also outline practice behaviours that, when brought together alongside a strong service system, are pivotal to achieving better outcomes for children such as:

- sustained safety with family
- relational, cultural, physical and legal permanency
- safety and potential in care.

The standards also offer practical tools to help practitioners and their leaders to engage in critical reflection and meaningful Performance and Development Program (PDP) discussions.

Consultation

The Practice Standards have been developed in partnership with the Practitioner Advisory Group, which comprises representatives of caseworkers, managers and directors from across the districts. The following groups participate in consultation and implementation:

- Youth Consult for Change
- Young people from Settlement Services International
- Multicultural Services Team
- Cross Divisional Aboriginal Outcomes Unit
- Child and Family Aboriginal Outcomes Unit
- Aboriginal Care Review Team
- State Aboriginal Reference Group
- AbSec
- Practice and Permanency
- Performance and Continuous Improvement
- Public Service Association.

Assessment Capability Refresher Program

The Assessment Capability Refresher Program aims to improve the assessment capability of child protection practitioners. This includes the application of assessment skills at key decision-making points and the use of Structured Decision Making (SDM) tools in assessing safety and risk with families.

The program develops capability in three critical areas:

1. Development and refinement of core assessment skills and capabilities
2. Understanding how these skills and knowledge are validated and evidenced in the SDM assessment model
3. Applying these skills and knowledge to assessments with families.

The program takes a blended learning approach that spans a four-week period for each CSC. This includes pre-program preparation, an e-learning course, a workshop, coaching and reflective discussions through group supervision.

COVID-19 restrictions have created delays in the delivery of the program, however by the end of 2021, the program will be delivered to CSCs in all districts (except Western Sydney Nepean Blue Mountains, which was participating in the Practice Framework implementation program at the time of delivery) and Mid North Coast, which put the program on hold due to COVID restrictions. The program will also be delivered to the Helpline After Hours Response Team and JCPRP teams.

NGO program

In 2020, the DCJ NGO Training Program was moved to the OSP. The program has now been redesigned to better align learning to the recently redeveloped Caseworker Development Program. Renamed **Change Together**, the program aims to provide more contemporary learning opportunities for DCJ funded NGOs providing Targeted Earlier Intervention, Family Connect and Support or Family Preservation services, and reach more practitioners around NSW.

The Change Together program is made up of nine different modules:

- An introduction to child protection services (available October 2021)
- Culturally responsive practice (available October 2021)
- Trauma-informed practice (available October 2021)
- Foundations of child protection (available October 2021)
- Understanding and responding to commonly co-existing issues in child protection (available October 2021)
- Mandatory reporting and family preservation practice (available October/November 2021)
- Working with children (available April 2021)
- Talking with families (available April 2021)
- Working with families for change (available April 2021).

The new program was launched in October 2021, with a 'soft launch' starting with 50 NGO practitioners on 13 September 2021.

Practice Leadership Development Program

The **Practice Leadership Development Program** project is working to design, develop and implement a learning and development program for managers casework and managers client services. This program design has been informed by collaboration with managers, their staff, supervisors and district leaders.

The program draws on the NSW Practice Framework, the DCJ Aboriginal Cultural Capability Framework and the NSW Public Sector Leadership Framework to support the development of child and family focused practice leaders who are culturally capable in their practice with children, families and communities, and Aboriginal staff, and who can all operate effectively in the five public sector leadership impact areas of people, results, systems, culture and public value. Consultation and feedback about the design of the program is currently being sought by the DCJ Executive. The project will aim to be ready for implementation by April/May 2022.

Child Protection Assessment Review Project

During 2021-22, DCJ is undertaking a project to review its approach to child protection safety and risk assessment practice. This project will include review of the tools, systems and processes used to make decisions about children and young people.

The project aims to improve the quality, equity and accuracy of decisions being made about children and their families. The review will prioritise the review of the SDM tools most in need of update and will involve staged improvements to assessment processes and practices. It will review the following tools:

a. SDM Screening and Response Priority tool – used by the Child Protection Helpline to determine if a concern report meets the ROSH threshold and if so, a recommended timeframe for response;
b. SDM Safety assessment – used to determine whether a child is safe to remain living with their parents in the immediate period, or if protective measures need to be put in place;
c. SDM Risk assessment – used to estimate the likelihood that the child will be reported to DCJ over the next 18 months if purposeful interventions are not put in place;
d. SDM Family Strengths and Needs Assessment **(FSNA)** – used to identify the child and parent's strengths that provide resilience and protection to maltreatment and prioritise their needs in order for a holistic and purposeful Family Action Plan to be put in place (FSNA is not currently implemented in child protection practice in NSW but will be implemented as part of this project); and
e. SDM Risk reassessment – used to monitor the progress towards case plan goals and reassess the family's risk level over time.

The SDM Quality Service Review will be managed by an organisation called Evident Change; the owners of SDM and a well-established United States-based not for profit organisation providing expert child protection research, evaluation and design services internationally. In close partnership with DCJ, led by the OSP and the Family and Community Services Insights Analysis and Research **(FACSIAR)**, the project's work will include consultation with Aboriginal people, community members and sector partners alongside DCJ Operations and Strategy, Policy and Commissioning directorates.

The goals of the Child Protection Assessment Review project are to:

a. increase the validity and cultural safety of the tools, processes and practices;
b. improve the quality and accuracy of decisions made about safety of, and risk to, children;
c. increase identification of child and family needs and strengths in order to inform interventions;
d. improve the appropriateness of casework interventions arranged with and for families to reduce risk; and
e. streamline assessments to create more clarity, consistency and efficiency.

The following are some of the benefits that may result from the updates to assessment tools and processes:

a. re-reporting may reduce as a result of more holistic assessment and purposeful intervention;
b. improved focus on family's strengths and needs so that case planning and referrals are based on evidence; and
c. strengthened benchmarks to assess change over time.

Given that the purpose of SDM is to make decisions about individual children while also supporting the system to prioritise its resources, the review of the SDM process may provide valuable insights in relation to broader service system design.

4.2.3 Evaluation and future implementation of the Framework

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

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

The OSP Research Team's evaluation contained many positive findings. On average, practitioners reported an increase in skills and knowledge, an increased connection to their work, greater role clarity and more purposeful assessments and use of group supervision. The evaluation also found a positive difference between non-implementation and implementation districts. Overall, a clear majority of caseworkers and practice leaders reported that they have changed or are changing how they work with children and families because of the Framework. Specifically, the majority of practice leaders and caseworkers who responded to a workforce survey for the evaluation strongly agreed, agreed or somewhat agreed that:

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

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

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

4.2.4 Youth Justice Practice Framework

The Youth Justice NSW Practice Framework provides a synthesis of the key theories and skills, underpinned by 'what works' literature, in addressing youth offending. This Framework, outlined in the Youth Justice NSW Practice Guide, directs Youth Justice practice across the spectrum of engagement, assessment, case planning and intervention programs that are aimed at changing behaviour and improving life circumstances.

One of the underpinning principles of the Framework is that childhood trauma can have profound and long-lasting psychological, physical and social impacts on an individual. These range from experiences of sexual abuse, to neglect, to living in a household where a parent or sibling is treated violently or where there is a parent with a mental illness. The Young People in Custody Health Survey (YPiCHS) has consistently found significantly higher levels of childhood trauma for young people in custody compared with the general population (and figures are likely to be under-reported). The growing awareness of the effect of trauma requires Youth Justice NSW to work in a trauma-informed way, using interventions that are responsive to the impact of trauma on young people. Trauma-informed practice emphasises physical, psychological and emotional safety and creates opportunities for those that have experienced trauma to rebuild a sense of control and empowerment. This concept is a challenge when working with involuntary clients in restrictive environments. However, Youth Justice caseworkers use many tools to ensure their practice is trauma informed. Currently, Youth Justice draws on the attachment, regulation and competency (ARC) framework as a baseline for how to understand and work with children and young people.

Being responsive to trauma in practice means promoting an understanding that some behaviour is an adaptation that stems from trauma. Practitioners and young people can learn about possible triggers in order to avoid these or to help deescalate when triggered.

4.3 Investment approach for human services in NSW [180]

4.3.1 Implementing an investment approach for human services in NSW

In February 2021, the Attorney General and Ministers responsible for portfolios relating to families and communities, health, mental health, education and early childhood endorsed a post-Their Futures Matter (TFM) authorising environment for the continued cross-agency implementation of an investment approach to the joint design, commissioning and delivery of human services.

The post-TFM investment approach has shifted towards localised, place-based commissioning and joined-up service delivery. Regular and ongoing analysis of the Human Services Dataset helps to identify vulnerable cohorts; service gaps will be central to this. DCJ has developed a draft Investment Plan for Human Services in NSW, which sets out how the NSW Government will implement the full cycle of an investment approach for human services design, delivery and evaluation. At the time of writing, consultation with agency and non-government partners on the draft plan is underway. The final plan is expected to be released publicly in November 2021.

The investment approach involves four main components:

- Drawing on the Human Services Dataset and local-level service mapping/gap analysis to identify community needs and priority cohorts for intervention
- Collaborative work by local stakeholders across government and the non-government sector to define the problem to be solved and identify opportunities for new or tailored service models
- Collaborative work by local stakeholders, service providers and service recipients to design and implement evidence-based interventions to address identified local need
- Determining the methodology, data sources and indicators to measure outcomes and quantify benefits.

As part of moving towards an investment approach to the prioritisation and funding of human services in NSW, DCJ and agency partners have committed to trialling a place-based, three-year phased implementation of the investment approach in a selection of demonstration sites. The intent is to test and refine arrangements in these sites to inform a progressive statewide rollout.

Western Sydney has been selected as the first demonstration site, given its strong pre-existing interagency governance mechanisms and successful delivery of a range of interagency programs. A second demonstration site in South West Sydney is currently in the exploratory phase.

4.3.2 Programs and outcomes

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

Programs and, where already reported, their outcomes and achievements are described below.

Aboriginal children and their families

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

Aboriginal Child and Family Centres

The Department funds nine Aboriginal Child and Family Centres (ACFCs) in NSW to provide quality wraparound services for Aboriginal children, families and communities including early childhood education

180 For background information about *Their Futures Matter* (TFM) and the move to the investment approach to human services in NSW, go to www.theirfuturesmatter.nsw.gov.au.

and care, school readiness programs, coordinated child and family health services, and integrated family supports such as parenting groups, counselling and men's/women's groups.

Two ACFCs received funding for the Thriving Aboriginal Families program, to improve the experience of wraparound service provision for Aboriginal children and families, increase support and advocacy for families including children with disabilities, and increase service access for families. **Thriving Aboriginal Families** is a place-based service co-led with Aboriginal communities to enhance local service systems and improve access to services for families displaying early signs of health, educational and social vulnerability.

ID. Know Yourself

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

Nabu Demonstration Project

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

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

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

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

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

An independent formative evaluation of Nabu, commissioned by the Stronger Communities Investment Unit, is still underway and a report is due by the end of 2021.

Aboriginal Evidence Building in Partnership

The Stronger Communities Investment Unit is also partnering with Aboriginal communities to develop a strong evidence base of what works for Aboriginal children, young people, families and communities. The Aboriginal Evidence Building Partnership Project (AEBP) has been established to ensure that the broader NSW child protection service system is culturally appropriate and supports the needs of Aboriginal children, families and communities. The AEBP does this by linking Aboriginal organisations with partnered consultants, to work together to build data collection and evaluation capabilities. The data helps organisations to understand their outcomes, make improvements to service delivery, and build the evidence base about 'what works' for improving outcomes for Aboriginal communities. AEBP has been largely successful in showing how validated assessment tools are improving service performance and improving outcomes for Aboriginal people accessing those services.

Family preservation and restoration programs

Two evidence-based family preservation and restoration programs are underway, called Functional Family Therapy through Child Welfare[181] (FFT-CW®) and Multisystemic Therapy for Child Abuse and Neglect[182] (MST-CAN®). Both have been shown internationally to be successful with families. Where it is suitable to restore a child or young person to their family, intensive support will be provided through FFT-CW and MST-CAN or other services to ensure the pathway home for children is successful. Step-down support will also be provided at the completion of the programs following the return of a child or young person to their family. By reducing the number of children in out of home care – that is, by preserving and restoring families – funds can be invested into services that strengthen the capacity of families to care for their children. This creates a stronger long-term service system.

Functional Family Therapy through Child Welfare

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

Multisystemic Therapy for Child Abuse and Neglect

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

Achievements

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

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

As at 30 June 2021, more than 3,950 families (322 in MST-CAN and 3,635 in FFT-CW) have been accepted into the programs. This translates to at least 12,900 siblings and other family members receiving benefits from the services.

Cumulative to the end of June 2021, some 1,762 families have completed the programs, including 442 Aboriginal families.

The National Drug and Alcohol Research Centre (NDARC) delivered its final evaluation of MST-CAN and FFT-CW in June 2020.[183] The evaluation is a significant contribution to the growing NSW and international evidence base for preservation and restoration therapeutic home-based programs.

The NDARC report includes a process, outcomes and economic evaluation of the FFT-CW and MST-CAN programs. The key findings of the evaluation were:

- Although the programs are in the early stages of their life cycle, completion rates across both are positive
- Entries to out of home care are substantially lower than control groups for families who have successfully completed other programs
- ROSH re-report rates for FFT-CW and MST-CAN are lower than control groups for families who successfully completed other programs
- Referrals of Aboriginal families were lower than expected and the number of Aboriginal families accessing services could be improved

181 Functional Family Therapy (2017).
182 Developed at the Medical University of South Carolina. See Global Family Solutions (2017).
183 Shakeshaft et al. (2020).

- Families and district directors are enthusiastic about the therapeutic and practical value of both programs
- It is too early to quantify the economic benefits of the programs but the evaluation methodology will be re-run regularly
- The acceptance rate for families offered a program placement is relatively high (76 per cent of Aboriginal families and 77 per cent of all families).

NDARC's report is available on the DCJ website: www.theirfuturesmatter.nsw.gov.au

Family Connect and Support (FCS) is a statewide, whole of family early intervention and prevention, case coordination and referral service that targets families experiencing vulnerability and provides comprehensive needs assessment, active outreach, short-term case planning, and Family Group Conferencing. The FCS model targets priority groups (families with children aged zero to five years, and families with children and young people affected by mental illness) and ensures that priority is given to Aboriginal children, young people and families. The aim of FCS is to provide support to families early and prevent the escalation of current challenges and contact with the statutory child protection system.

FCS started service delivery across NSW on 1 January 2021 and is being delivered in every DCJ district by seven NGOs and four sub-contracted partner agencies.[184] The service also builds on the strengths of the previous Family Referral Service model, including service features like outreach into universal services, warm referrals and follow-up, and the use of active holding to prevent vulnerable families from falling through gaps. A program-wide Common Assessment Framework (CAF) has been co-designed with FCS services and will be implemented in the second half of 2021. The CAF provides a consistent approach across FCS services when assessing children, young people and families' strengths and needs.

Futures Planning and Support

The Futures Planning and Support initiative is a pilot project that offers four levels of tailored mentoring-based support, above the universal support already provided, to young people aged 17 and 24 with high and complex needs who have been in out of home care:

- **Connections:** working with out of home care and Aftercare services to link young people to services like health care and entitlements
- **Futures coaching:** mentoring and advocacy to help young people achieve their goals
- **Intensive case work:** to address complex issues like mental health and substance addiction
- **Brokerage:** pooled brokerage funds to help care leavers achieve their goals.

The pilot started in April 2020 on the NSW Mid North Coast and provides culturally safe services delivered by Burrun Dalai Aboriginal Corporation as the lead agency, and its partner, Uniting. The Mid North Coast District is managing the project, which will operate until November 2022.

Achievements

As at 19 July 2021:

- 93 young people have accessed the program, of which 69 identify as Aboriginal and/or Torres Strait Islander
- 87 children and young people are currently being supported.

Ladder Step Up Sydney

The Ladder Step Up Sydney program provides support to young people (aged 15 to 20 years) who are or were in out of home care. It involves an intensive eight-week program to identify and build independent living skills, clarify vocational pathways, build self-efficacy and confidence, and develop employability skills such as teamwork and the technical skills required to find and keep a satisfying job.

184 FCS is the redesign of the Family Referral Service which ceased operation on 31 December 2020.

The program also offers follow-up support over 26 weeks to help participants undertake community-based activities, internships and other work experience opportunities, as well as an opportunity to participate in an alumni program to become youth leaders. The program is funded by DCJ and supported by the Australian Football League (AFL) industry.

Achievements

In 2020–2021 (to 31 March 2021), 43 young people completed the eight-week Ladder Step Up Sydney program and 27 of them received further support over 26 weeks.

All of the 36 young people who completed an exit survey reported improvements in social functioning, daily living skills, self-efficacy and the ability to navigate vocational pathways. More than 30 young people continued engagement with Ladder Step Up in the alumni program to become youth leaders and participate in ongoing health and wellbeing activities.

LINKS Trauma Healing Service

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

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

The evidence-based support includes Trauma-Focused Cognitive Behaviour Therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), Parent–Child Interaction Therapy (PCIT)[185] and Tuning into Kids/Teens.[186]

Achievements

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

Evaluation

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

OurSPACE

Implemented in December 2018, OurSPACE is a tailored trauma therapeutic intervention for children and young people aged 15 years and under who are in statutory foster and kinship care and experiencing placement instability. The goal of the initiative is to stabilise placements for children and carers through evidence-based trauma therapies like Bringing Up Great Kids, Dyadic Developmental Psychotherapy, Sensorimotor Psychotherapy, Theraplay, the TrACK (Treatment and Care for Kids) Program, Trauma-Focused Cognitive Behaviour Therapy (TF-CBT) and Wraparound (Care Team Approach).

In May 2021, OurSPACE was recommissioned, maintaining the core components and therapies of the model but resulting in minor modifications to the program logic and program model to align with evaluation outcomes and lessons from its initial implementation.

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

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

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

OurSPACE provides two service options following an initial screening process:

- Comprehensive assessment and therapeutic support **(CA&TS)**: active outreach and in-home therapeutic specialist planning and direct counselling using evidenced-based treatments for six to nine months.
- Advice, consultation and support (AC&S): short-term telephone, video call or face to face advice and support to stabilise placements and provide education about impacts of trauma. Referrals come from multiple pathways including NGOs, out of home kinship care providers, DCJ caseworkers, kinship and foster carers, school teachers, juvenile courts and other professionals. Referrals can be made through a centralised intake number: 1300 381 581.

Achievements

From July 2020 to June 2021, OurSPACE provided:

- comprehensive assessment and therapeutic support for 531 children and young people
- advice, support and consultation to 625 children and young people.

For children receiving a service, there was a 78 per cent reduction in ROSH reports, 69 per cent reduction in Youth Justice involvement, 84 per cent decrease in behavioural presentation indicated on referral, and 51 per cent increase in school attendance.

The program has also accepted 51 children and young people who live in alternative care arrangements.

OurSPACE has employed six full-time Aboriginal staff, including a team leader, who were funded by the Australian Childhood Foundation to complete a Graduate Certificate in Developmental Trauma. The Australian Childhood Foundation has also offered a number of scholarships to NGO out of home care Aboriginal staff to complete the Graduate Certificate in Developmental Trauma.

The active outreach service has been well received in rural, remote and regional areas of NSW. The service has a strong relationship with Aboriginal communities and services, and 57 per cent of referrals are for Aboriginal children and young people.

Evaluation

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

A preliminary economic evaluation from NDARC was not able to be completed due to the very early implementation of the program.

SafeCare

SafeCare is a highly structured, evidence-based behavioural skills parenting program that has been shown to reduce neglect and abuse among families with a history of, or risk factors for, abuse and neglect.

The goals of SafeCare are to:

- increase positive parent–child interactions
- improve how parents care for their children's health
- enhance home safety and parent supervision, thereby reducing future incidents of child maltreatment.

In NSW, a trial of SafeCare began in 2017 and has been implemented as a component of an existing program called Brighter Futures. Brighter Futures is a longer established program that delivers voluntary targeted intervention services to families with at least one child under the age of nine years living at home, where concerns of risk of significant harm have been raised for those families. There are eight SafeCare trial sites across NSW.

SafeCare involves one 1.5-hour home visit per week for 15–20 weeks that targets risk factors for child neglect and physical abuse. Parents are taught skills in three module areas:

1. Interacting in a positive manner with their children, to plan activities, and to respond appropriately to challenging child behaviours
2. Recognising hazards in the home in order to improve the home environment
3. Recognising and responding to symptoms of illness and injury, in addition to keeping good health records

An independent evaluation has been conducted, with promising results. A final report is due for public release in September 2021.

Thriving Families NSW

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

Achievements

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

A formative review of Thriving Families NSW in 2019 found that the initiative is well designed to meet the needs of the young parents with young children who have been engaged in the program. An outcomes evaluation is underway to identify lessons from implementation and early client outcomes to inform future decisions. Findings are due in the second half of 2021.

Treatment Foster Care Oregon

Treatment Foster Care Oregon (TFCO) is a strengths-based, relational model developed to create opportunities for children and young people to successfully live in a family setting as an alternative to institutional, residential and group care placements. TFCO aims to change the negative trajectory of behaviour that gets in the way of experiencing positive relationships, stability of placement and engagement with education, peers and the community. TFCO also coaches parents (or other long-term family relationships) to provide effective parenting in order to support sustainable placement stability over time.

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

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

TFCO is an intensive program, and carers must be able to participate in rigorous contact, such as daily phone calls, and be willing to receive and implement instructions in working with complex children and

young people. Carer recruitment carefully ensures that participants can support children and young people in the program effectively. Carers are supported and trained by OzChild.

In May 2021, OzChild was recommissioned to continue to provide the TFCO program across the Sydney metropolitan area until June 2024. Challenges which continue to impact on the delivery of this program include the successful recruitment of appropriate carers and the identification of an appropriate destination placement for the child or young person to move to once they have graduated from the TFCO program.

Achievements

Since becoming operational in 2019:

- 23 children and young people, including 13 Aboriginal children, and 16 children from alternative care arrangements, have entered the program
- 15 children and young people have graduated from the program (3 to parents, 2 to family, 8 to foster care, and 2 to semi-independent living); of these 15 graduating children and young people, nine are Aboriginal.

Youth justice system programs

A Place to Go

A Place to Go (APTG) aims to improve supports and deliver a better response for children and young people aged 10 to 17 years entering and exiting the youth justice system, with a focus on young people in remand. It draws on NSW Government and non-government providers to deliver a coordinated and multi-agency service solution that can support a young person to change their life trajectory. APTG focuses on using a young person's contact with police and/or the Children's Court as an opportunity to intervene and provide the supports they need to reach their potential.

APTG is being implemented in the Nepean Police Area Command and the Parramatta Children's Court, with a trial that will run until 31 December 2021. The initiative is funded by Youth Justice NSW.

Achievements

An independent evaluation of APTG in 2020 found that the initiative successfully supported positive outcomes for young people. Young people were supported in finding stable and appropriate accommodation, accessing health services, removing barriers to education, and connecting with their communities.

Key to this success was:

- the multi-agency nature of APTG, which supports a holistic approach that benefits young people with complex and overlapping needs
- the key worker function, which provides personalised support and a single point of contact for young people to navigate the service system
- flexible brokerage (using designated funds to purchase timely goods or services to meet the individual needs of young people)
- the availability of therapeutic, trauma-informed short-term accommodation (APTG House).

APTG House successfully supported young people in the initiative through the residential support model with high staff to resident ratios; use of a therapeutic, trauma-informed framework; a therapeutic specialist to support ongoing application of the framework; the approachability of the APTG House workers; and a physical environment that facilitated positive outcomes.

Broadmeadow Children's Court Pilot

The Broadmeadow Children's Court Pilot (BCCP) aims to prevent young people from having repeated contact with the justice system and support them to reach their potential. BCCP brings together a team

of government agencies and NGOs to provide alternative service pathways and wraparound supports to young people entering r exiting the justice system.

By working in a multidisciplinary team, services are better able to provide targeted and holistic support to young people with the aim of supporting wellbeing and reducing reoffending. This collaborative way of working has increased referral pathways, prevented duplication of services, and coordinated resources and actions between government and non-government service partners.

BCCP has been subject to an external evaluation, alongside A Place to Go. The evaluation found that young people were supported to find accommodation, access mental health supports, engage in an appropriate educational pathway or employment, and access victim services.

Youth Action Meetings

Youth Action Meetings are facilitated by NSW Police and provide opportunities for local-level service collaboration on interventions targeting children and young people (aged 10 to 17 years) at risk of harm, reoffending or re-victimisation.

Youth on Track

Youth on Track is the NSW Government's flagship youth justice early intervention scheme. It provides case management and behaviour and family interventions to young people aged 10 to 17 years who are at risk of long-term involvement in the criminal justice system. The voluntary scheme has the benefit of multi-agency support and addresses underlying causes of offending through targeted evidence-based behaviour and family strategies.

Youth on Track is based on strong evidence of 'what works' with reducing youth offending: early intervention and targeting underlying causes for involvement in crime. Research shows that early intervention can create significant savings in the criminal justice system and other human service sectors.

Achievements

In 2020–2021, Youth Justice funded three NGOs with $5.6 million to deliver Youth on Track in seven sites across NSW to approximately 360 young people.

Seventy-five percent of young people in Youth on Track reduced or stabilised their formal contact with police in the 12 months after consenting to participate. Young people also improved their engagement with education, employment and positive peers.

The Bureau of Crime Statistics and Research (BOCSAR) has started a robust reoffending evaluation, using a randomised controlled trial to measure the effectiveness of Youth on Track in reducing reoffending compared to a brief intervention. BOCSAR will provide their final reoffending evaluation report by late-2021.

Projects incorporated into other service areas

With the conclusion of *Their Futures Matter*, a number of existing projects have been incorporated into other service areas.

- The **Collaborative Support Pathways Pilot**, initially funded under the TFM Access System Redesign, aims to provide a service or supports to as many children reported at risk of significant harm as possible, through mapping current service provision and trialling new processes to test the capacity of the broader child protection service system to respond to children at risk of significant harm. The project is about to enter Phase 3, which will the consolidation of triage functions into one centralised allocation hub, linking in other key services within the South Western Sydney District (including health services, police and family violence support services), and developing a district-wide strategy for collaborative work with shared clients across housing, child protection and youth justice services.
- Similarly, the **Helpline Advanced Screening Program** (HASP) provides for improved assessment of Helpline reports and more targeted access to supports and services for children and young people. The HASP team undertakes advanced screening of reports that fall within the catchment of Ballina, Tweed Heads, Clarence Valley, Blacktown, Nowra, Shellharbour and Wollongong CSCs as well as the suburb

of Casino under Lismore CSC. The HASP team makes enquiries with other sources to obtain additional information and verify or validate reported concerns to gain a better understanding of a child's lived experience. This allows for holistic assessment as the team works with key stakeholders to identify concerns, and also to consider strengths, what may be going well for the family and what actions or next steps are required. The benefit is that these CSCs are able to divert triaging resources into seeing more children and families that require statutory intervention, in a time frame that meets their needs. HASP has also provided opportunities for the Helpline to work with key stakeholders such as Child Wellbeing Units and some services within Family Preservation to enhance a culture of collective responsibility for child protection through the referral of non-ROSH reports for a non-statutory response. This prevents matters from entering the child protection system where possible, as opposed to closing reports at the Helpline, which may result in no further contact or support being provided to vulnerable children and families.

- **Child Wellbeing Units** will also be reviewed and redesigned to enable outcomes measurement through effective governance, identification of target outcomes, high quality data collection and formal evaluation.

4.4 Permanency Support Program

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

The PSP has three goals:

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

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

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

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

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

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

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

DCJ POLICY

The PSP **Permanency Case Management Policy** (PCMP) was released in 2018 and updated in November 2019. The policy explains the way we achieve safety, permanency and wellbeing for vulnerable children. It clarifies how DCJ and PSP service providers collaborate in assessing safety and case planning. The PCMP embeds into practice culture a focus on:

- Responding earlier to the impact of trauma
- Collaborative and evidence-based approach to casework practice
- Partnering with children and their families, kin and carers to achieve meaningful change
- Engaging family strengths, nurturing resilience and giving dignity.

4.4.1 Implementing the PSP

In 2020–2021, PSP implementation continued, with a budget of $828 million. More than 8,000 children and young people were supported by NGOs with case management responsibility. Forty-eight service providers including 14 Aboriginal providers partnered with DCJ to deliver the program, and 10 service providers contracted to deliver Intensive Therapeutic Care.

Family Preservation Program

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

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

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

As at 30 June 2021:

- 271 families had received a service through a preservation package; 202 of these packages (75 per cent) were being delivered to Aboriginal children and families
- 132 families had achieved their case plan goal; 88 of these families (67 per cent) are Aboriginal.

PSP Learning Hub

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

My Forever Family NSW

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

Intensive Therapeutic Care

DCJ is continuing to implement Intensive Therapeutic Care (ITC), the component of the PSP replacing residential care. Some of the outcomes of ITC support as at February 2021 were:

- 471 ITC and ITC Significant Disability placements
- 95 children and young people in less intensive placements with ITC providers, such as carer-based placements and Therapeutic Supported Independent Living, which helps young people to successfully transition to adulthood
- 10 Intensive Therapeutic Transitional Care Units providing upfront intensive support for children and young people as they enter the ITC service system.

Permanency coordinators

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

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

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

4.5 Other relevant reforms in DCJ

4.5.1 Redesigned Caseworker Development Program

In July 2020, DCJ launched the new Caseworker Development Program. This redesigned foundational program is a new approach to training child protection caseworkers in DCJ. The course runs over 17 weeks and is mandatory for all new caseworkers. The redevelopment of the Caseworker Development Program is underpinned by the NSW Practice Framework. The new program includes a substantial orientation in DCJ, and training in:

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

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

As at 30 June 2021, more than 300 caseworkers have been enrolled in the program. It is expected that more than 500 caseworkers will participate in the program in 2021.

4.6 Improving our responses to children at risk of suicide

The cohort review (Chapter 3) in this year's report focused on 42 children who died between 2016 and 2020 in circumstance of suicide or suspected suicide. This section describes current and future initiatives that focus on increasing casework knowledge and improving practice and outcomes for children who are reported to DCJ of being at risk of suicide.

4.6.1 NSW initiatives

In June 2020, the Department of Premier and Cabinet advised it was considering how best to support the Premier's Priority Towards Zero Suicides. The advice contained details about a range of initiatives and strategies relevant to children and young people and noted that NSW Health would be taking the lead. The Premier's Priority aims to help improve the support provided, particularly access to aftercare services, for young people who have attempted suicide; alternative services for young people presenting to emergency departments; services in rural and remote areas; and access to community mental health teams. The initiatives include preventative mental health programs for high school students, a local suicide alert system to allow for rapid sharing of information about people at risk of suicide, and a Youth Aftercare Pilot for new models of aftercare for young people who have attempted suicide.

Launched in November 2020, the NSW Suicide Monitoring and Data Management System is a new collaboration between the NSW Ministry of Health, DCJ, the State Coroner and NSW Police to enable the collection and reporting of information on recent suspected and confirmed suicides in NSW. The monitoring system uses data collected by NSW Police and the State Coroner to provide information to support communities, local organisations and government agencies to respond to suicide in a more timely and effective way.

The first NSW Suicide Monitoring System Report was published on 9 November 2020 and provides the first estimates of suspected suicides in NSW in 2019 and 2020 from the newly established system. It includes suspected suicides of young people aged under 18 years. The information can be used in the evaluation and improvement of services to vulnerable people and has the potential to save lives.[187]

4.6.2 Departmental initiatives

Youth Justice

Young people coming into contact with the criminal justice system have complex needs, often as a result of developmental trauma, and are among the most vulnerable young people in NSW. There is no single approach that will eliminate self-harm or attempted suicide. Any intervention or support provided to young people must be individualised and responsive.

Initiatives to reduce self-harm across Youth Justice

- Youth Justice has 42 psychologist roles, 23 in Youth Justice centres and 19 in Youth Justice community offices, supported by a central Psychological Services Unit consisting of two professional development psychologists, three clinical managers and a principal psychologist.
- All Youth Justice psychologists were trained and accredited to administer the Westerman Aboriginal Symptom Checklists (WASC-Y and WASC-A) in April 2021. The WASC-Y and WASC-A are the only mental health screening tools validated for use with Aboriginal and Torres Strait Islander peoples.
- Youth Justice have trained all Youth Justice psychologists and relevant Justice Health staff across NSW in Dialectical Behaviour Therapy (DBT). DBT is an evidenced-based and trauma-informed response to self-harm behaviours, aggression and domestic and family violence. It aims to teach skills to improve emotional regulation, including interpersonal skills, mindfulness and distress tolerance. These are all elements that can help young people reduce their self-harming behaviours.
- Trauma-informed practice training: Youth Justice operational training packages have been updated to ensure trauma-informed care principles are incorporated into all operational functions.

187 NSW Health (2021).

- Justice Health has increased its collaboration with Youth Justice around mental health, and Youth Justice has also started working with Redbank House in Western Sydney Local Health District to identify opportunities for practice improvement.

Initiatives in Youth Justice Centres

- The establishment of an Enhanced Support Unit (ESU) in late 2019 at Frank Baxter Youth Justice Centre: the ESU implements a trauma-informed care model and seeks to provide increased clinical support for the physical, psychological and emotional wellbeing of young people experiencing difficulties in the mainstream custodial population. The unit includes a clinical manager, speech pathologist and occupational therapist. Justice Health works alongside Youth Justice staff in supporting young people accommodated on the ESU. While an evaluation of this unit is underway, initial results indicate a reduction in self-harm and other incidents for the high-needs individuals accommodated on the ESU.
- Programming at Reiby Youth Justice Centre, which accommodates females and younger males who present with unique challenges and comparatively high rates of self-harm. This centre is developing a strong culture of innovation in relation to mental health response, in addition to standard systems and individualised responses including:
  - The establishment of a Dialectical Behavioural Therapy (DBT) pilot in collaboration with Justice Health and Forensic Mental Health Network (Justice Health). A working group is now establishing a program manual. It is anticipated that this therapy, co-delivered in small groups by Youth Justice and Justice Health staff, will help to further reduce the prevalence of self-harming incidents across the detainee population at Reiby.
  - Justice Health is also working with Reiby Youth Justice Centre staff to improve detainee risk management plans and other individual risk assessments, with a strong focus on mental health responses, and equipping youth officers with supervision and other tools.
- Touch, Feel & De-Stress is a project co-designed with Justice Health to prevent self-harm at Acmena Youth Justice Centre. The steps of the project are to:
  - purchase a range of sensory tools to help implement the use of sensory modulation
  - provide a detailed training session to mental health and primary care nurses and psychologists in creating sensory modulation profiles for adolescents in Acmena
  - convert two camera cells into sensory rooms
  - provide a brief training session to all youth officers in recognising early signs of distress in a young person and how to use the sensory room and sensory modulation tools
  - evaluate success using surveys and reviews of self-harm and aggression incidents.
- Where risk is identified, an individual My Safety Plan is developed with the young person, and progress is monitored.
- Each Youth Justice centre works to develop immediate individualised strategies to address and manage instances of self-harm, when such behaviour is demonstrated by a young person. Each young person is monitored and continually risk assessed by staff.
- Every centre has a local plan, and continuous improvement to custodial practices is embedded in operational systems, resulting in a range of initiatives aimed at increasing care and wellbeing outcomes of young people in custody. Young people at risk of self-harming can be placed on intensive supervision and monitoring to help in managing distress – this includes the use of a room with a camera to constantly monitor young people at risk.
- Screening on admission and relevant referrals to the centre-based Youth Justice psychologist, Justice Health clinical nurse, or Justice Health psychiatrist for young people who display mental health concerns.
- When young people are at risk of self-harm and/or suicidal ideation a case conference occurs at each Youth Justice centre with expertise from Justice Health, and Youth Justice psychologists, caseworkers, operational managers and frontline staff, who work together and plan to reduce the self-harm behaviour.

- Other strategies include development of rapport between staff and young people, ensuring a safe and secure physical environment, and providing a structured day with purposeful activities.

Elver Trauma Treatment Service

DCJ Intensive Support Services (Statewide Services) in partnership with South Western Sydney Local Health District Infant, Child and Adolescent Mental Health Services (iCAMHS) established the Elver Program in September 2018. Elver is a statewide multidisciplinary trauma-informed mental health assessment and intervention service for children and young people in out of home care with complex developmental and mental health needs. The program is based in Parramatta and co-located with Metro Intensive Support Services (ISS).

The Elver program is funded by DCJ to target the following cohorts of children and young people who are in out of home care across NSW:

- Children with complex needs in individualised placements
- Children in ITC, particularly those who need specialist intervention to avoid escalating to a more intensive placement or care model
- Children under the age of 12 with a Child Assessment Tool (CAT) score of 'high' and unable to enter ITC.

DCJ and non-government agencies can refer children to the Elver program. The team includes practitioners from disciplines such as psychiatry, occupational therapy, speech pathology, social work, nursing and psychology. The multidisciplinary nature of the team allows the program to consider trauma, development and attachment through the lens of mental health expertise, supporting holistic treatment that is based on the individual needs of each child.

The model of service delivery is flexible and dependent on the child's needs, and includes assertive treatment, outreach video or telelink and office-based face to face reviews. Clinical work is closely integrated with the child's caseworker and care team through regular feedback sessions, care team meetings and training and ongoing consultation. Elver clinicians also actively support and work alongside DCJ, out of home care services and local mental health services for children with complex needs, building networks across government and non-government services.

All children referred to Elver have mental health concerns; many are referred with acute or chronic suicide risk including self-harming behaviour. While Elver is not an acute mental health service, the team provides support to children and young people and their care teams to:

- build pathways to mental health treatment
- assess, monitor and manage suicide risk for children and young people in the program
- strengthen, support and educate a child's care system
- actively link and work with NSW Health services on management of acute risk including acute mental health community teams and hospital inpatient services
- coordinate services (including emergency services) to ensure all involved are working from a shared clinical formulation and risk management plan.

This leads to greater stability and wellbeing, increased carer and service engagement, and ideally reduced risk and diversion away from ongoing use of emergency services.

Evaluation

The program is currently being formally evaluated against its intended outcomes.

For the children, young people and their supports, these outcomes are:

- improved psychological wellbeing
- improved behavioural and emotional functioning

- improved physical wellbeing
- improved placement stability, or a move to less intensive care
- increased engagement in education, training or employment
- decreased contact with the justice system (or stability where already low).

For government and service providers, these outcomes are:

- strengthened capacity in the skills, knowledge and confidence to understand and meet the complex needs of these children and young people
- improved services access for children and young people
- improved partnerships with DCJ, Health, Education and Funded Service Providers (FSP)
- a contribution to the evidence base for trauma treatment.

Elver runs a weekly seminar delivered by Professor Ken Nunn, with guest presenters for a broad cross-sector audience on the psychopathology of developmental trauma. This seminar is in its second year. Each session is recorded and can be accessed across DCJ for group supervision sessions and professional development. Some seminars explore self-harm and assessing and responding to the risk of suicide.

4.6.3 District initiatives

The **Inverell and Surrounding Region Community Collaborative Meeting (ISRCCM)** (New England District) is coordinated by Headspace, and attended by representatives from DCJ, NSW Health, NSW Police, Community and Allied Health, the Department of Education and Training (including school principals and counsellors), Pathfinders, Biripi, Armajun, Centacare and TAFE.

The ISRCCM has developed a Rapid Response Action Plan, currently in draft. The plan targets suicide postvention. Information sessions facilitated by Headspace are available to parents, carers and community members. The sessions focus on strengthening the understanding of mental health and the warning signs for suicide and self-harm; skills in responding to suicidal behaviour; building awareness of local services; and strengthening relationships between local mental health services, schools and other organisations.

Evan's Story (Hunter/Central Coast, Western NSW and Nepean/Blue Mountains districts) is an OSP-developed training package that shares lessons, resources and guidance on conversations to have with young people or parents who may be at risk of suicide. The package was delivered to the Directors Community Services in February 2021 and will be delivered to all practitioners via group supervision. It has been incorporated into the Caseworker Development Program for new staff joining DCJ.

Some CSCs will roll out Evan's Story in conjunction with the OSP and local CAMHS. Additionally, some districts, in partnership with the OSP and Psychological & Specialist Services, have used this package with DCJ caseworkers and funded service provider youth workers to support the needs of a young person in an ITC placement who had significant suicidal ideation.

The **Central Coast Multi Agency Response Centre (CCMARC)** (Hunter/Central Coast districts) is a collaborative approach to triaging and planning for children and young people at risk of suicide. CCMARC is co-located with NSW Health and the Education Child Wellbeing Unit, meaning information about children and young people with complex support needs is discussed in twice-weekly local planning response meetings or referred for an interagency complex case discussion. The opportunity for interagency discussion builds understanding of other agency resources and strengthens partnerships.

Psychological and Specialist Services (P&SS) is finalising updated guidelines to replace the 2015 Suicide and Self-Harm: Risk Management for DCJ Staff guidelines. The new **Guidelines for Risk Assessment and Management of Suicide and Self-Harm** will sit alongside resources like Evan's Story, and help casework staff respond to and prevent youth suicide.

The **Northern Sydney Suicide Response Interagency** (Sydney / South East Sydney / Northern Sydney districts) is convened by the Northern Sydney Primary Health Network to detect and mitigate emerging risk, and coordinate postvention responses to incidents of youth suicide. The interagency also addresses prevention through programs to engage young people, and education about community perceptions of the incidence of youth suicide. DCJ attends and is considered a 'Tier 2' participant (i.e. unlikely to be directly involved unless the young person concerned is a DCJ client).

Prevention and capacity building includes presentations and training opportunities:

- SafeTALK is a half-day workshop that prepares anyone over the age of 15, regardless of experience or training, to become a suicide-alert helper
- ASIST is a two-day workshop on an applied suicide intervention model to help carers recognise and respond to suicide risk, in order to increase immediate safety and link people to further help

Postvention responses include:

- Child and youth mental health services contact bereaved immediate family members
- Local schools activate processes to map and support people connected with their school communities
- The Be You team (Headspace Schools) supports schools and education sector representatives
- Lifeline supports bereaved community members
- Northern Sydney Primary Health Network and Headspace Schools deliver geo-targeted messaging about mental health support services
- Flyers with local service information distributed to schools and other key services.

Caseworkers Sitting at Schools (South Western Sydney District) involves a designated caseworker sitting at school one day a fortnight to provide support to and link the school in with services and their Child Wellbeing Unit. Caseworkers also engage mental health services in conversations around supports and other services working with the family. This initiative encourages sector engagement, and links families with supports and services when DCJ allocation is not possible, or when other avenues of support have not yet been considered.

Nepean Blue Mountains District and the **local CAMHS** are exploring how the two agencies can build a closer relationship and gain a shared understanding of each other's roles. This will help to break down barriers and help support relationships that effect change for families.

A three-year **Clinical Healthcare Manager Pilot** (Hunter New England and South Western Sydney districts) started in June 2019 and will run to July 2022. The pilot provides short-term intensive intervention for children with complex needs, including mental health services, targeted responses and service coordination. The pilot also aims to build the capacity of young people, families, carers and caseworkers to navigate the health care system.

Project CRAFT was developed by South Eastern Sydney and Northern Sydney districts in partnership with Burwood and Sydney Youth Justice Community Offices to improve outcomes for young people in contact with Youth Justice and community services. CRAFT provides combined service expertise through integrated case management, case planning and targeted interventions to increase the potential for improved outcomes.

4.6.4 Children in out of home care

Support for carers

A number of training initiatives support out of home carers to identify and respond to children and young people's trauma, depression and anxiety:

- Trauma training is delivered by My Forever Family and LINKS.

  My Forever Family also offers:

  - pre-recorded online training on emotional regulation and understanding risk-taking in adolescents
  - parenting information about mental health issues for children and young people
  - referral to online coaching for carers to identify behaviours and strategies and seek help
  - a carer support team that refers carers and provides information on the Mental Health Access line, Headspace, Kids Helpline and Parentline. The team works with carers to ensure they can deal with extra supports already in place for children and young people, such as psychologists and paediatricians.

- Many providers deliver Mental Health First Aid.
- Resources such as Caring For Kids and Leading The Way (for carers) include content on emotional and mental health. They cover topics such as anxiety and depression and link to support services such as Headspace, Beyond Blue and Reach Out.
- The PSP Learning Hub is a DCJ initiative to develop practice skills for all out of home care caseworkers. The Hub includes guidance on talking with children and young people about mental health and a practice area devoted to trauma-informed care.

DCJ RESOURCES

The DCJ website has a page devoted to mental health and wellbeing information for young people.

www.facs.nsw.gov.au/families/children/mental-health

PSP LEARNING HUB

Preventing self-harm among young people in out of home care is a brief but useful resource on the PSP Learning Hub.

https://psplearninghub.com.au/document/preventing-self-harm-among-young-people-in-out-of-home-care/

Children and young people's mental health and wellbeing

A number of resources, guidelines and programs focus on mental health and wellbeing for young people in care.

- Resources like the **Your Next Step** guide and the **YOU** website include sections about mental health and wellbeing, with information and links about help and support.
- The DCJ **Guidelines for the Provision of Assistance after Leaving Out of Home Care** were amended in October 2020 to give greater prominence to providing counselling and to improve access to counselling services at every stage of the leaving care process including at the initial planning stage and any subsequent reviews of the plan. Counselling can include support to address past trauma from abuse or neglect or acquire independent living and social skills.

DCJ RESOURCES

Find the **Your Next Step** guide at www.facs.nsw.gov.au by searching for 'leaving care' or 'aftercare'.

Explore the **YOU** website at https://you.childstory.nsw.gov.au/home

OOHC Health Pathway

The OOHC Health Pathway was established in 2010 to improve health outcomes for children and young people entering statutory out of home care in NSW. The Pathway is a joint initiative of the Ministry of Health and DCJ and is underpinned by a memorandum of understanding establishing roles and responsibilities across the two sectors.

The OOHC Health Pathway provides children and young people with health assessment, planning, implementation, monitoring and review. An OOHC Health Coordinator in each local health district is responsible for managing the Pathway process. A child or young person's psychosocial and mental health is considered in the initial assessment process and concerns are referred to an appropriate professional (e.g. psychologist, psychiatrist) for further treatment or support. The need for mental health treatment or support is documented in the child or young person's health management plan and reviewed in line with the current schedule.

The OOHC Health Pathway also includes a focus on young people aged 15 to 18 years by ensuring that they undertake an age-appropriate health assessment and have the opportunity to build health literacy. This includes knowing how to access appropriate mental health services and support if required in the lead up to leaving care.

The Ministry of Health has been provided with approximately $3 million in funding from 2019–2020 to 2021–2022 to enhance the operation of the Pathway. The funding has been used to ensure a 50 per cent increase in review of children's health management plans. Funding has also been allocated to ensure consistent implementation of activities of the Pathway focused on young people aged 15 to 18 years.

Psychological and Specialist Services

Psychological and Specialist Services (P&SS) provides direct therapeutic support to children and young people in out of home care, as well as training for carers, families and staff. P&SS recently started a review of its suicide risk management policy.

P&SS provides individual clinical interventions including Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Parent–Child Interaction Therapy (PCIT) and eye movement desensitisation and reprocessing (EMDR).

P&SS also delivers Healing from Trauma training, which is based on the evidence-based Trauma Systems Therapy for Foster Care (TST-FC) program. It has been adapted by the LINKS Training and Support team to meet the needs of the NSW out of home care system. In this model, carers and professionals receive equivalent training and develop a shared language around trauma.

Healing from Trauma participants:

- learn how to identify and respond to trauma-based behaviours
- discover how to reduce trauma triggers
- explore collaborative ways to support children in out of home care
- practise using simple assessment tools
- develop ways to create environments of safety while building strength and resilience.

The program also focuses on skill building, positive parenting and self-care.

Statewide Out of Home Care (OOHC) Mental Health Working Group

In July 2021 the NSW Health Mental Health Branch and DCJ established a Statewide Out of Home Care (OOHC) working group to improve systemic supports for integrated care with vulnerable children in OOHC.

The OOHC Mental Health Working Group aims to improve collaboration between Local Health Districts (LHDs) and other key stakeholders to improve outcomes for children and young people in OOHC with complex needs whose needs are not being adequately met by the current service systems.

The OOHC working group will provide advice and recommendations to the NSW Child & Youth Mental Health Advisory Group to improve systemic coordination and access to health & mental health services across NSW.

Glossary

Aboriginal

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

Abuse

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

Alcohol and/or drug use

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

Alternative Care Arrangement

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

Authorised carer

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

Case closure

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

Case planning

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

Casework

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

Caseworker

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

Child

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

Child Protection Helpline

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

Children's Court

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

ChildStory

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

Child Wellbeing Unit (CWU)

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

DCJ Community Services Centre (CSC)

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

Domestic and family violence

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

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

Engagement

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

Manager casework

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

Mandatory reporter

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

Medical examination

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

Mental health concerns

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

Neglect

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

Order

An order of a court or an administrative order.

Out of home care

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

Parental responsibility

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

Parental responsibility to the Minister

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

Permanency Support Program (PSP)

For definitions relevant to the PSP see the Permanency Case Management Policy (PCMP) Rules and Practice Guidance.

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, carer or other person responsible for the child or young person.

Practitioner

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

Prenatal report

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

Removal

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

Report

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

Reporter

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

Restoration

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

Risk of harm assessment

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

Risk of significant harm (ROSH)

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

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

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

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

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

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

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

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

Risk-taking behaviours

Risk-taking behaviours include:

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

Safety and risk assessment (SARA)

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

Sexual abuse or ill-treatment

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

Structured Decision Making (SDM®)

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

Supervision

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

Supported care allowance

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

Triage and assessment practice guidelines

The practice guidelines describe the process of triaging risk of significant harm (ROSH) events and non-ROSH information at CSCs and outline the minimum practice required by CSCs when a ROSH event and non-ROSH information is received. DCJ is currently reviewing the triage mandate. This work will strengthen the triage process, particularly with families experiencing high levels of risk, by clarifying the management of reports.

Weekly allocation meeting (WAM)

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

Young person

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

Youth Justice

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

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Appendix 1: Counselling and support services

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

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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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