



Family &
Community
Services

Child Deaths 2012 Annual Report

Learning to improve services



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Minister's Foreword



It is my great privilege to introduce this report, the third Annual Child Death report since I took on the role of Minister for Family and Community Services. Each report has been hard reading, each speaks to the sad reality of disadvantage and vulnerability of many families in our community and the experiences of their children who are reported to Community Services. Each report has examined Community Services' work with those families and explores how we can do better to keep more children safe. As always, my heart goes out to the families and communities that have lost children and my deepest sympathies are with them.

Despite the sadness behind the stories, I present the report to you with pride in the work Community Services has undertaken to critique its own practice openly and honestly. I am proud of the courage of our practitioners to examine their own practice in the face of such tragedies and I am grateful for the difficult conversations that have been held, all over NSW, to inform this report. Children need us to be brave and to reflect honestly on our practice and what can be done to improve it. The community needs to be able to trust a system that is prepared to learn from its mistakes, and our staff are prepared to honour that trust, and to make changes to prevent similar tragedies happening to other children.

The practitioners who are the backbone of the statutory child protection system value and respect Community Services' internal child death review team. Even when practitioners have to accept findings that are hard to live with the review process is very rarely met with

defensiveness. The review team works hard to deliver a rigorous and transparent process. The Family and Community Services Executive and the Government are strongly committed to these reviews – every word of them is read, every recommendation is taken seriously and we share responsibility across all levels of the agency.

Sadly there are some themes in this report that are consistent with the themes identified in the previous two years. Aboriginal children continue to be grossly over represented amongst the children who have died. We know we need to do more for Aboriginal children and we are committed to long-term efforts to achieve positive change in collaboration with our partners across government and the non-government sector.

This year's report focuses on domestic violence. Many of the cases examined have not attracted media attention. The stories are about children who have died from a range of causes but their families had been reported with concerns about domestic violence at some stage. Domestic violence cuts across culture and class. It has devastating consequences for the victims – most often women and children who live in constant terror. From the outside it is not always easy to understand the psychological and economic dependence that entraps them or the psychological and entrenched abusive behaviours of the perpetrators. The widespread social and economic impacts of domestic violence have been well documented and responding to reports of domestic violence presents particular challenges. The

Minister's Foreword

work is usually complex and our staff need support to make informed professional judgements about the best way to work with families to stop the violence and reduce the risks. In this report Community Services has reflected honestly on its practice with families where there is domestic violence and I hope that in sharing what we have learned to reduce risks and provide support to people impacted by domestic violence.

NSW is showing strong leadership in its reform of the child protection system, and is dedicated to better protect the most vulnerable members of our community and break the cycle of disadvantage. However, it is important to emphasise that governments alone cannot make a difference for vulnerable children and their families. Government agencies, non-government organisations, the community and of course parents need to work together to create strong communities that can respond to the needs of children and keep them safe.

The NSW Government remains committed to an ambitious program of legislative, policy and practice reforms to improve services which can make a difference in the lives of children every day. At the heart of these reforms are the ideals of putting children first; supporting families to provide safe home environments, and ensuring that children who cannot live safely at home are provided with permanency and a home for life. Reform is continuous and I appreciate the unwavering dedication and commitment of our staff, particularly our caseworkers, in carrying out the important work they

do everyday to improve the lives of children and families and for their ongoing openness to learn from child deaths.



Pru Goward MP

Minister for Family and
Community Services
Minister for Women

Executive Summary

The *Child Deaths 2012 Annual Report* is Family and Community Services' third public report examining the involvement of the agency with the families of children and young people who died and were known to Community Services.

Families are defined as known to Community Services if a report was received about the child who died, and/or their siblings, in the three years prior to death. This definition also includes children and young people who were in statutory care at the time of their death. There were 83 children and young people known to Community Services who died between 1 January 2012 and 31 December 2012.

This report is written by the Child Deaths and Critical Reports Unit, an internal team within Community Services. It is based on internal child death reviews. The report's purpose is to enhance accountability, transparency and, most importantly, learn from child death review.

Objectives of this report

The *Child Deaths 2012 Annual Report* has four key objectives:

1. To boost transparency and accountability about child deaths by publicly reporting on Community Services' involvement with the families of the children who have died.
2. To increase public trust and confidence in Family and Community Services by reporting on lessons learned from child death reviews, the improvements to practice and systems made as a result of this learning, and how these are integrated into the government's reform agenda.
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage impacting on outcomes for families.
4. To share learning from child death reviews with Family and Community Services' staff and with our interagency partners in other government departments and non-government organisations (NGOs).

Chapter 1: Child deaths in context

Community Services has reviewed its involvement with the families of children who have died since 2006 and, with the NSW Ombudsman, NSW State Coroner, NSW Police Force and the NSW Children's Guardian, plays a core part in a strong system of child death review and oversight.

Community Services' child death reviews are conducted using a considered, robust and balanced methodology. They demonstrate a thoughtful and transparent response to child deaths and, more broadly, to child wellbeing and child protection issues.

Public reporting on the deaths of children and young people shows the community how caseworkers are learning from the review of child deaths and when lessons learned have resulted in real improvements. It also creates opportunities to share this learning with a wider audience: the public, media and, critically, interagency partners in other government departments and NGOs who have a role to play in improving services and improving the lives of children and young people.

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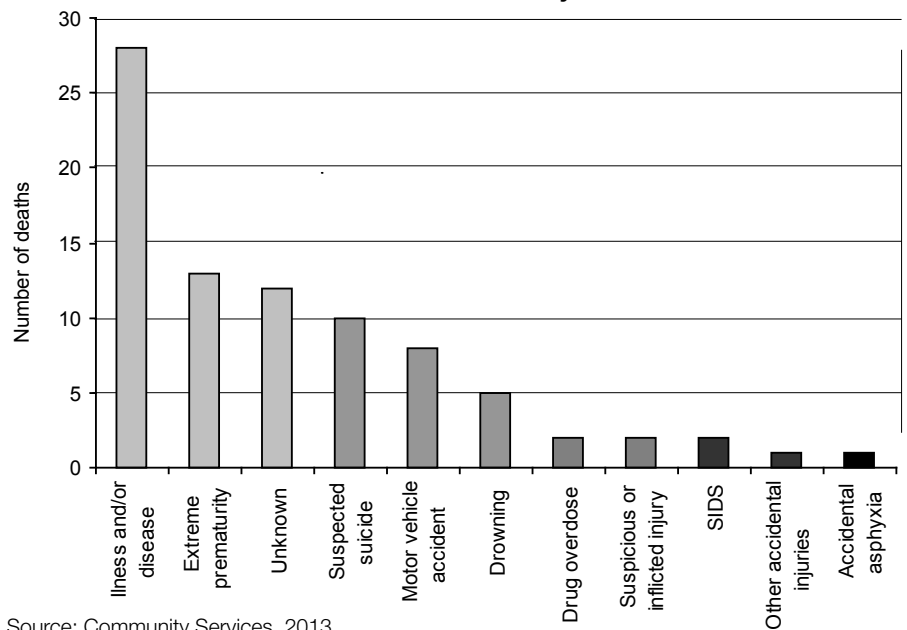
Chapter 2: Child deaths in 2012

The NSW Child Death Review Team (CDRT), convened by the NSW Ombudsman, reported in October 2013 that 493 deaths of children and young people were registered in NSW between 1 January 2012 and 31 December 2012. Of these, 83¹ were known to Community Services. A total of 61,715 children and young people were reported to Community Services in 2012².

In line with previous years, most deaths in 2012 were associated with illness, disease or extreme prematurity. Ten children and young people died from suspected suicide. This is the highest number of suicide deaths of children known to Community Services in the last five years and is examined in the report.

The data is discussed in detail in Chapter 2.

Figure 1: Circumstances of death of children and young people who died in 2012 and were known to Community Services.



Source: Community Services, 2013.

Characteristics of the children and young people

In 2012, 50 (60 percent) of the children and young people who died were male, and 33 (40 percent) were female. This finding is consistent with the trends in previous years³.

Children aged less than one year accounted for 46 percent (38) of all children who died. The over-representation of infants in child deaths reflects their vulnerability and has been a consistent pattern over the past 15 years in NSW⁴. A further third (24) of the children and young people who died were teenagers.

The continued over-representation of Aboriginal and/or Torres Strait

Islander children in the child protection system is also reflected in their continued over-representation in child deaths. Thirty-one percent (26) of children and young people who died in 2012 were Aboriginal and/or Torres Strait Islander. This figure is consistent with Community Services' 2011 data⁵.

Seventy-six (92 percent) children and young people who died in 2012 were living with their immediate families at the time of their death. Seven (8 percent) children and young people were not living with their immediate families at the time of death. Four of these seven children were under the parental responsibility of the Minister. The

1. The NSW Child Death Review Team (2013) *Annual Report 2012* identified the deaths of 88 children who had a child protection history. This figure differs slightly from Community Services data, due to a number of differences between the CDRT and Community Services categories. These differences are outlined on page 14.

2. Source: Corporate Information Warehouse dynamic production environment (Community Services' data).

3. NSW Department of Family and Community Services, Community Services 2012, *Child Deaths 2011 Annual Report: Learning to improve services*, Sydney, Community Services.

4. NSW Child Death Review Team 2012, *Annual Report 2011*, NSW Ombudsman, Sydney. Available at www.ombo.nsw.gov.au

5. In 2011, 30 percent of the children who died were Aboriginal and/or Torres Strait Islander.

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remaining three were not subject to legal orders but were in the care of extended family.

Community Services' involvement with the children and families

Sixty-one (73 percent) of the 83 children and young people who died had been reported to Community Services on at least one occasion within three years of their death. The remaining 22 (27 percent) children and young people were not the subject of a report, however, their sibling/s had been reported in the three-year period before their death.

Parental alcohol and/or drug misuse was the most commonly reported concern about the families of the children who died. Thirty-two (39 percent) families were the subject of a risk of significant harm (ROSH) report about this risk factor. Exposure to parental domestic and family violence and neglect were the next most reported concerns reaching the ROSH threshold.

Socioeconomic disadvantage was also a key theme in the reported issues for the families of children who died. Issues relating to transience, geographic isolation and/or poverty⁶ were reported in 24 (29 percent) cases. The presence of intergenerational concerns in a third of the families highlights the complexity of the issues facing the multiple agencies that support families to help keep children safe.

Chapter 3: Lessons for improvement – domestic violence

In 2012, Community Services finalised a review of practice with the families of 466 children who died between 2007 and 2012 where domestic violence was a reported risk. These cases were compared with the cases of 302 children who died within the same period where concerns about domestic violence had not been reported.

Very few of the deaths were directly linked to the violence, however, the cases illustrate the many risks violence poses to children and other victims in the household, usually their mothers, and the importance of child protection intervention in effectively addressing risks.

The review highlights how risk for children who experience domestic violence is often accompanied by higher levels of emotional abuse, physical abuse, sexual abuse and physical neglect than children whose families are not reported for domestic violence.

The cases involving domestic violence also reflect notably higher levels of reported parental mental health problems, parental alcohol and/or drug misuse, poverty, transience and homelessness than the cases where domestic violence had not been reported.

The standout message from the review of practice is the need for an in depth understanding of the dynamics associated with domestic violence, including coercive and/or controlling behaviour, and how this impacts on parenting and the safety and wellbeing of children. Risks for children are clearly linked to the risks for victims of domestic violence, usually mothers. Positive practice examples highlight that the best results can be achieved through a balanced response where equal focus is placed on both parents and where periods of heightened risk, windows of opportunity and the potential overtime for there to be multiple violent partners in a child's household are recognised. Finally, the review of practice reinforces that we can improve our work with families where domestic violence is a concern if we adequately understand the impact of the violence on adult and child victims, and on the capacity of both parents to nurture, care for and protect their children.

6. For the purposes of this report, poverty refers to children in the family who are significantly disadvantaged by the family's financial circumstances. Transience is defined as families who move continuously and do not have a stable accommodation base. Geographical isolation refers to families who are living in a remote/isolated area, or families who are geographically isolated due to a lack of resources, such as a combination of poor transport, communication technology and poverty.

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Chapter 4: Progress in child protection reform

The NSW Government, through the State Plan *NSW 2021*, is committed to improving the protection of vulnerable children and young people, through much needed organisational reform in Community Services.

Chapter 4 outlines the NSW Government's reform agenda for Community Services, which aims to achieve better outcomes for children, young people and families in NSW. The chapter reports on initiatives that intend to increase caseworker capacity, improve the way we work with families and strengthen our commitment to providing quality child protection services. In addition, it outlines the 'road ahead', a bold legislative reform agenda which is dedicated to delivering a more localised and responsive system.

Chapter 4 provides an update on the initiatives and reforms listed in the *Child Death 2011 Annual Report*, particularly the reforms that target the themes identified from Community Services' child death reviews in 2011: assessing risk in young parent families, engaging young parents to build parenting capacity, and keeping a focus on the child in a young parent family.

The chapter also reports on a number of new, important initiatives that will support children and young people experiencing domestic violence. Directly relevant to the practice themes discussed in Chapter 3, these initiatives demonstrate the strong commitment from the government to reducing risk and improving the safety of women and children experiencing violence while lowering community tolerance to domestic and family violence.

Chapter 1: Child deaths in context

Chapter overview

This chapter outlines the objectives of the *Child Deaths 2012 Annual Report* and details the government's commitment to accountability, transparency and, most importantly, learning from child death review. It highlights how this commitment aligns with the significant program of reform that is underway to improve the NSW child protection system. This reform program is guided by the *Community Services Plan 2012–2014*. The plan builds on the work already undertaken under the *Keep Them Safe* reforms arising from the 2008 Wood Special Commission of Inquiry into Child Protection Services in New South Wales.

The *Child Deaths 2012 Annual Report* balances the intensive focus on individual child deaths with contextual information to enhance understanding among the service network and the public about the complexities of child protection and the levels of disadvantage faced by

many families in NSW. It is intended to increase knowledge about the common themes arising from child death reviews and the challenges of child protection, and encourage greater involvement of individuals, communities and agencies in keeping children safe.

Child death reviews are an important window to Community Services' child protection practice but must be viewed in the broader context of the NSW system. Current reforms build on the *Keep Them Safe* vision of a shared approach to child wellbeing, where child protection is understood as the collective responsibility of the whole of government and the community.

This chapter provides an overview of the rigorous system of child death review and oversight in NSW. It explains how Community Services' review functions align with the roles of other agencies such as the NSW Ombudsman, NSW State Coroner, NSW Police Force and the NSW Children's Guardian.

Chapter 1: Child deaths in context

As well as high levels of disadvantage, the reality for many of the families Community Services works with is that they are also living with the effects of intergenerational abuse, drug and alcohol addictions, mental health problems and chronic domestic violence.

1.1 Child Deaths 2012 Annual Report: objectives

The Child Deaths 2012 Annual Report is Family and Community Services' third publicly available report, examining the deaths of children who were known to Community Services. This report is a key element of the government's reform agenda. Its purpose is to:

- boost transparency and accountability about child deaths by publicly reporting on Community Services' involvement with the families of the children who have died
- increase public trust and confidence in Family and Community Services by reporting on lessons learned from child death reviews, the improvements to practice and systems made as a result of this learning, and how these are integrated into the government's reform agenda
- inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage impacting on outcomes for families
- share learning from child death reviews with Family and Community Services' staff and with our interagency partners in other government departments and NGOs.

The NSW Government is currently considering a proposal to amend the *Children and Young Persons (Care and Protection) Act 1998* to require the Director-General of the Department of Family and Community Services to present this report to Parliament annually. If this amendment is made, it will formalise the government's commitment to transparency and accountability about child deaths.

1.2 Child protection in NSW

Community Services

Community Services is the statutory child protection agency in NSW. Community Services works closely with other government departments, NGOs and the community, which all play a key role to support families to keep children and young people safe from abuse and neglect.

The realities of modern child protection work

Community Services, along with other agencies providing child protection services and support, works with some of the most vulnerable families in our community – those living with the effects of structural disadvantage such as low socioeconomic status, lack of access to services, unemployment, homelessness, social isolation and reduced access to education⁷. For Aboriginal and/or Torres Strait

Islander people, a history of trauma and dispossession underpins and compounds these inequities, which are also experienced with greater frequency.

The Child Deaths 2011 Annual Report highlighted clear links between child deaths and disadvantage. Homelessness, poverty and intergenerational involvement with statutory services are common findings in Community Services' child death reviews. Similarly, the NSW Child Death Review Team (CDRT) has noted growing inequities in health outcomes for children who are Aboriginal, geographically isolated or living with socioeconomic disadvantage⁸.

As well as high levels of disadvantage, the reality for many of the families Community Services works with is that they are also living with the effects of intergenerational abuse, drug and alcohol addictions, mental health problems and chronic domestic violence. Research confirms that families with multiple and complex problems of this nature have become the primary client group of modern child protection systems. Further, these problems often occur within a wider context of exclusion and, for many parents, their own experiences of trauma and victimisation⁹.

The NSW Government continues to implement practice, policy and law reforms to support children to reach their full potential, ensure

7. Nivison-Smith, I & Chilvers, M 2007, *Child Protection Reports in Context, Statistical Report*, NSW Department of Community Services, Sydney. Available at www.community.nsw.gov.au

8. NSW Child Death Review Team 2008, *Trends in Child Deaths in New South Wales 1996 – 2005*, NSW Commission for Children and Young People, Sydney.

9. Bromfield, L, Lamont, A, Parker, R & Horsfall, B 2010, *Issues for the safety and wellbeing of children in families with multiple and complex problems*, Australian Institute of Family Studies, <http://www.aifs.gov.au/nch/pubs/issues/issues33/>

Chapter 1: Child deaths in context

safer home environments, and give children who are unable to live with their families a home for life. Already, the NSW Government has made significant improvements, but more needs to be done to increase support for families.

Child protection reform in NSW

Since the Child Deaths 2011 Annual Report was published, Community Services has implemented a number of reforms and strategies including:

- reduce the number of children in care – seeing more families earlier, better targeting early intervention and helping families take responsibility and change
- achieve permanency for children in care – making decisions quickly about a home for life and focusing on education and health needs
- improve services for vulnerable adolescents – getting our policies and programs right and encouraging innovative new approaches
- localise the service system – harnessing the capacity of community and government partners to deliver services to the most vulnerable.

These reforms and strategies are outlined in Chapter 4.

To increase the capacity of caseworkers, one of Community Services' main priorities is to reduce red tape. Work is underway to identify ways to simplify the computer system, introduce new ways of making standard and better decisions about risk, and working with key stakeholders to make the court system simpler so that caseworkers spend less time at their desks and court, and more time with families.

Chapter 3 examines Community Services' response to the families of children who died where concerns were reported about the impact of domestic violence on children. Significant reforms currently underway to improve cross-sector service provision to victims of domestic violence are detailed in Chapter 4.

Public and interagency understanding of child deaths

When a child dies at the hands of someone close to them, the community understandably finds the circumstances difficult to comprehend. Such a death attracts considerable media attention and demands explanations. In this regard the media plays an important role in holding services to account.

What is often missing in media coverage is an understanding of the complex nature of child protection work with some of the most disadvantaged and troubled families in NSW. With the focus on

cases where police are involved or where agency or system failure is suspected, assumptions can be made that all children who died and were known to child protection services died as a result of abuse or neglect¹⁰. *The Children (Criminal Proceedings) Act 1987* prohibits, except in certain circumstances, the publication or broadcast of the name of any child mentioned in criminal proceedings – even if that child is deceased and the proceedings relate to that child's death. This legislation is intended to protect the integrity of criminal investigations and the privacy of children impacted by crime.

The legislative framework, including the *Children and Young Persons (Care and Protection) Act 1998*, as well as the privacy and the interests of vulnerable families impacted by the death of a child or young person, restricts the information that Family and Community Services can provide to the public about the circumstances surrounding the death of a child or young person who was known to Community Services. This does not mean that Family and Community Services cannot be transparent about the findings from Community Services' child death reviews and the lessons learned. By including these in this report, we can provide information to the community without compromising either the justice process or the privacy of families.

It is hoped that the findings from Community Services' child death reviews provide learning

10. See Chapter 2. Suspicious or inflicted injuries were identified in the cases of two of the 83 children and young people who died in 2012. These numbers may change due to the ongoing work of police, the State Coroner and Ombudsman to determine or characterise children who died from abuse, neglect or in suspicious circumstances. It is further acknowledged that some of the other deaths may have involved a combination of physical illness, other vulnerabilities in the child, and poor parenting capacity in the carers.

Chapter 1: Child deaths in context

While no child protection system can prevent all tragedies, Community Services is working hard to reform casework practice, service delivery and legislation. Major reform takes time, considerable courage and commitment.

opportunities for practitioners, both within the organisation and externally. It is also hoped that sharing the learning will build on Justice Wood's vision expressed in the recommendations of the 2008 Special Commission of Inquiry into Child Protection Services in New South Wales of a shared responsibility for child wellbeing where agencies and the community have a greater understanding of the role they can play in protecting children and young people. It may also assist non-government and other government agencies, such as the NSW Ministry of Health, NSW Police Force, NSW Department of Attorney General and Justice, and the NSW Department of Education and Communities, to appreciate the increased risks for children in these families.

The intention is that the report is a useful addition to the suite of existing public child death reports in NSW. While no child protection system can prevent all tragedies, Community Services is working hard to reform casework practice, service delivery and legislation. Major reform takes time, considerable courage and commitment.

1.3 Child death review in NSW

Community Services' Child Deaths and Critical Reports Unit

Community Services' Child Deaths and Critical Reports Unit reviews the deaths of all children who were 'known to Community Services' prior to their death. This means children who were reported in the three years prior to their deaths, or whose siblings were reported in that same period. It also includes children who were in out-of-home care at the time of their death. These reviews focus on the involvement of Community Services with the child and family, including how staff worked with partner agencies and non-government organisations. Reviews make recommendations to improve practice both at internal and systemic levels.

Community Services has a systems approach to child death review¹¹, which emphasises the need to understand not just what happened in a case, but why it happened. Reviews consider how work at a local and organisational level impacted on practice with the families of children who died, identifying both good and problematic practice.

In addition, Community Services undertakes cohort reviews to consider patterns, themes or trends in the work. For example, the

Child Deaths 2011 Annual Report presented the findings of the review of 105 cases of children known to Community Services who died between 2006 and 2011. This review focused on challenges and opportunities when working with young parents. This year over 400 cases spanning a six-year period have been reviewed to consider the response to reports about domestic violence.

The findings from these reviews provide rich learning opportunities for practitioners, both within the organisation and externally, and help identify ways to support caseworkers and their managers to deliver best practice.

Community Services works closely with a number of agencies in NSW to support a strong system of oversight, review and investigation of child deaths. The 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.

The NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children which may be due to abuse or neglect or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which have occurred in a care setting.

11. This has been adapted from a case review model in England sourced from: Fish, S, Munro, E & Bairstow, E 2008, *Learning together to safeguard children: Developing a multi-agency systems approach for case reviews*, Children and Families Services Report 19, Social Care Institute for Excellence, London.

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The Ombudsman is required to report to Parliament on a biennial basis. The most recent report was tabled in March 2013.

The NSW Child Death Review Team

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

In 2013, the CDRT reported that the deaths of 493 children and young people were registered in NSW in 2012. Of these cases, the team identified the deaths of 88 children who had a child protection history¹². These figures differ slightly from Community Services' data, which highlights important differences between the CDRT and Community Services' categories:

- the CDRT reports on the deaths of children and young people that were registered in

a calendar year with the NSW Registry of Births, Deaths and Marriages while Community Services reports on deaths that occurred in a calendar year¹³

- Community Services may include cases where NSW children died in another state in its annual total of child deaths, while the CDRT reports on these cases separately but does not include these cases in their annual total
- the CDRT does not include cases where children died in care in the 'child protection history' category¹⁴
- in addition to reporting on the deaths of children who were known to Community Services, the CDRT also includes children who were known to a Child Wellbeing Unit (CWU).

The NSW Police Force and NSW Coroner

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

Under Section 24 of the *Coroners Act 2009*, a senior coroner has the power to hold an inquest into a child's death where it appears to the coroner that there is 'reasonable cause to suspect' that the child:

- was in care
- was reported to Community Services within a period of three years immediately preceding the child's death, or a child who is a sibling of a child reported to Community Services within three years preceding the child's death
- died in suspicious circumstances, or circumstances that may have been due to abuse or neglect
- died while living in, or was temporarily absent from, residential care provided by a service provider authorised or funded under the *Disability Services Act 1993* or a residential centre for people with disabilities
- was a person in a target group within the meaning of the *Disability Services Act 1993* who received assistance from a service provider to enable them to live independently in the community.

Community Services is responsible for reporting the deaths of children known to the division to the State Coroner. Community Services and the State Coroner's Office also regularly share information about child deaths.

12. NSW Child Death Review Team 2013, *Annual Report 2012*, NSW Ombudsman, Sydney.

13. For example, a child who died in December 2012, but whose death was registered in January 2013, would be included in Community Services' 2012 figures and the CDRT's 2013 figures.

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

Chapter 1: Child deaths in context

The Domestic Violence Death Review Team

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

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths¹⁵
- establish and maintain a database to identify patterns and trends relating to such deaths
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

The death of a child in the context of domestic violence is subject to review by the team. The team's second report was released in October 2012¹⁶.

The Children's Guardian

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

- promote the best interests of all children and young people in out-of-home care
- ensure that the rights of all children and young people

in out-of-home care are safeguarded and promoted

- exercise functions relating to persons engaged in child-related work, including the working with children check clearance under the *Child Protection (Working with Children) Act 2012*
- accredit designated agencies and monitor their responsibilities under the *Children and Young Persons (Care and Protection) Act 1998* and the *Children and Young Persons (Care and Protection) Regulation 2012*
- register organisations that provide or arrange voluntary out-of-home care and to monitor their responsibilities under this Act and the regulations
- develop and administer a voluntary accreditation scheme for persons and programs working with persons who have committed sexual offences against children
- to encourage organisations to develop their capacity to be safe for children as referred to in Section 38 of the *Child Protection (Working with Children) Act 2012*.

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

Reviewing the deaths of children in out-of-home care

NSW has a particularly strong system of oversight into the deaths of children in out-of-home care. Where a child dies in out-of-home care, their case may be examined by the CDRT, reported to the State Coroner and the Children's Guardian, investigated by police and the State Coroner and reviewed by Community Services and the Ombudsman.

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

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

16. Available at www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m40160115/dvdr Annual_report_oct2011x.pdf

Chapter 2: Child deaths in 2012

Chapter overview

This chapter details the 83 children and young people known to Community Services who died in 2012. The circumstances of the deaths are examined, as well as the characteristics of the children and young people, including their age, gender and Aboriginal and/or Torres Strait Islander status. The extent of Community Services' involvement with the families of the children is outlined, including reported risk factors, whether reports met the ROSH threshold introduced in January 2010, and how Community Services responded to information about those risk issues.

Of the 83 deaths, 61 (73 percent) children and young people had been the subject of a report to Community Services. In the remaining 22 (27 percent) cases, the child or young person's sibling was the subject of a report to Community Services in the three years prior to the child or young person's death.

In line with previous years, most deaths in 2012 were associated with illness, disease or extreme prematurity. Children under 12

months accounted for 38 (46 percent) of all deaths. Teenagers represented the next highest proportion of deaths with 24 (29 percent), aged between 13 and 17 years.

Ten (12 percent) children and young people died from suspected suicide in 2012. This is the highest number of suicide deaths of children known to Community Services in the last five years.

Seven (8 percent) children and young people who died were not living with their immediate families at the time of their death. Four of the seven were under the parental responsibility of the Minister for Family and Community Services. The remaining three were not subject to legal orders but were in the care of extended family. Community Services had assessed and approved their eligibility for the Supported Care Allowance¹⁷, which their carers were receiving at the time of their death.

The over-representation of Aboriginal and/or Torres Strait Islander children and young people within the child protection system is strongly reflected in the numbers

of Aboriginal and/or Torres Strait Islander children and young people who died¹⁸. While the same group represents approximately five percent of NSW's population of children and young people¹⁹, they represented 31 percent of all child deaths in 2012. These figures reflect the continued disadvantage, poorer health outcomes and increased vulnerability experienced by this group of children and young people in NSW and around Australia .

The Children and Young Persons (Care and Protection) Act 1998 contains provisions which protect the privacy of children and families and prevent the publication of certain information. The names and identifying details of individual cases have not been used. This has restricted the capacity for informed discussion, even of high profile cases such as those where there are charges of murder or manslaughter.

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

18. In 2012, 26 (31 percent) Aboriginal and/or Torres Strait Islander children died. Twenty-one percent of the children and young people involved in ROSH reports were Aboriginal and/or Torres Strait Islander.

19. Australian Bureau of Statistics 2012, New South Wales, Aboriginal and Torres Strait Islander Peoples (Indigenous) profile, cat.no. 2002.0, ABS, Canberra.

20. NSW Department of Community Services 2009, Deaths of Aboriginal Children and Young People 2005-2007, Community Services, Sydney.

Chapter 2: Child deaths in 2012

2.1 Child deaths in NSW in 2012

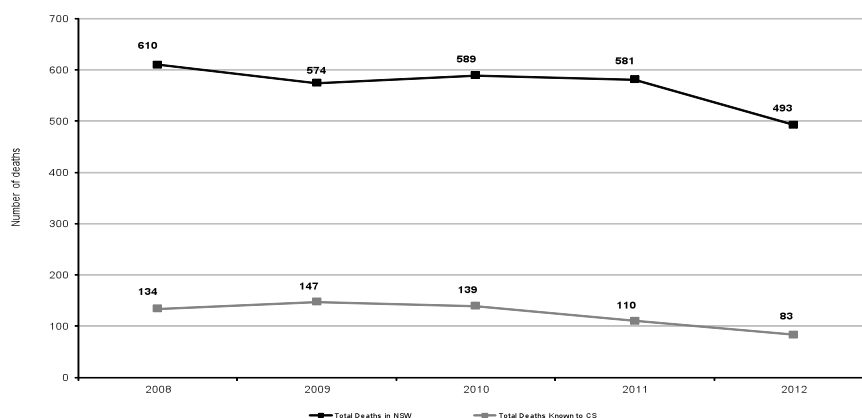
Between 1 January 2012 and 31 December 2012, the deaths of 493 children and young people were registered in NSW²¹.

In the same period, a total of 83 children and young people died who were known to Community Services. This figure is a decrease from 2011, where the number of such deaths was 110.

In 2010, the threshold for reporting to Community Services changed from 'risk of harm' (ROH) to 'risk of significant harm' (ROSH). The change has resulted in a lower rate of reporting²², and it is highly likely that this has led to the decrease in the number of deaths of children and young people known to Community Services. Figure 3 highlights a decrease in the number of deaths of children and young people who are 'known to Community Services' since 2010.

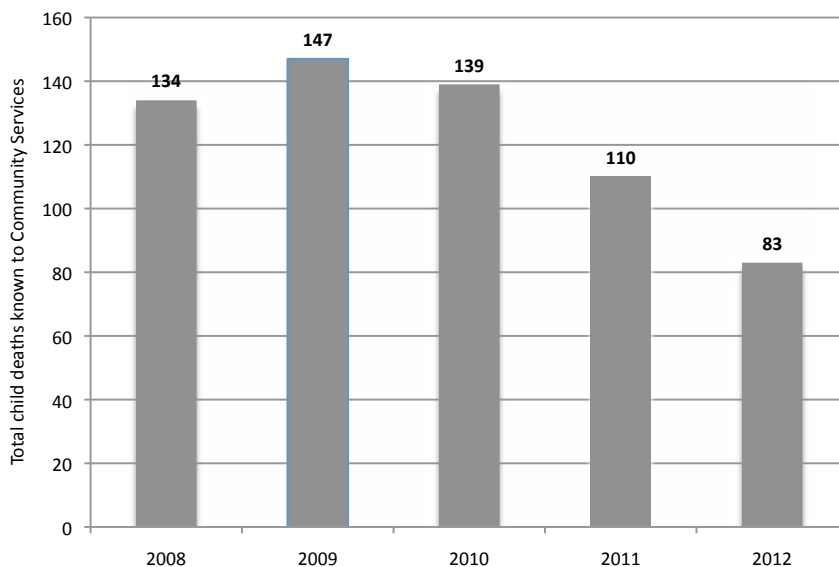
There is extensive research that confirms that it is not possible to predict which children and young people known to child protection services will die^{23,24,25}. Despite this, media reporting of child deaths frequently focuses on the most serious cases where there was a high level of risk. This has created a

Figure 2: Children and young people who died in NSW, compared to children who died and were known to Community Services, 2008 to 2012.



Source: Community Services and CDRT, 2013.

Figure 3: Impact of increased threshold for reporting to Community Services introduced in 2010.



Source: Community Services, 2013.

21. NSW Child Death Review Team, 2013.

22. NSW Department of Family and Community Services, Community Services, 2013, Annual Statistical Report 2011/12, Information Management Branch, Organisational Performance Directorate, Community Services, Sydney.

23. Munro, E 2011, The Munro review of child protection: final report – a child-centred system, Department for Education, The Stationery Office, http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

24. Brandon, M, Bailey, S & Belderson, P 2013, Neglect and Serious Case Reviews; A report from the University of East Anglia commissioned by NSPCC, Centre for Research on the Child and Family, School of Social Work and Psychology, University of East Anglia, Norwich, http://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrrs-pdf_wdf94689.pdf

25. Brandon, M, Bailey, S, Belderson, P, Gardner, R, Sidebotham, P, Dodsworth, J, Warren, C & Black, J 2009, Understanding serious case reviews and their impact: a biennial analysis of serious case reviews 2005-2007, University of East Anglia, Norwich.

Chapter 2: Child deaths in 2012

view that all child death cases are high risk and stand out from other cases. In contrast, it is not always the children and young people considered to be at the highest risk who will be the ones to die.

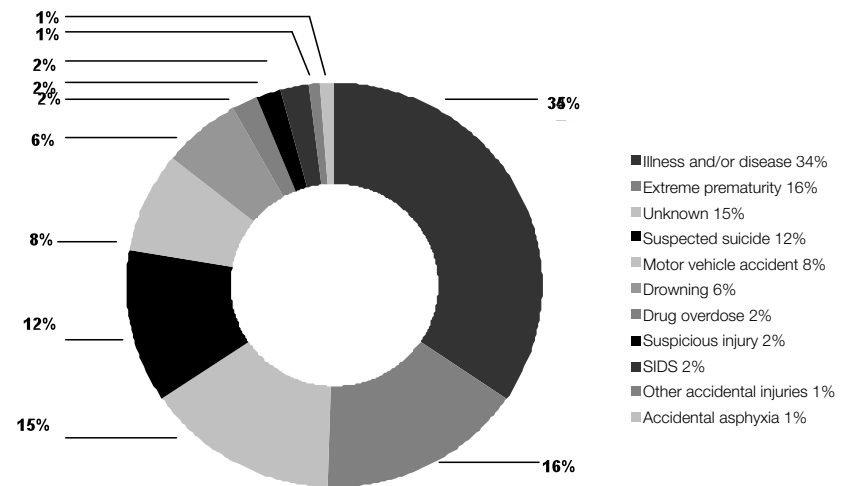
2.2 Circumstances of child deaths

In NSW, medical practitioners or the State Coroner determine the cause of a child's death. The NSW Registry of Births, Deaths and Marriages provides the NSW Ombudsman with a list of all child deaths, including causes of death, if that information is known. Community Services uses this data as well as information obtained from the State Coroner to identify how the children and young people died.

Community Services focuses on the circumstances of a child's death, rather than the medical cause. This is because the circumstances are more relevant to an understanding of the child protection history and the opportunities to intervene with a family prior to the death.

The categories used by Community Services to describe a child's circumstances of death are outlined in Figure 4. These categories may be different from the medical cause of death listed on the death certificate or autopsy report. For example, the cause of death could be multiple injuries, but the circumstance of the death could be a motor vehicle accident, suspicious injury, or another type of accidental injury.

Figure 4: Circumstances of death of children and young people in 2012 who were known to Community Services²⁶



Source: Community Services, 2013.

Most deaths in 2012 were associated with illness, disease and extreme prematurity²⁷. As reported in previous years, socioeconomic disadvantage or child protection concerns, such as neglect or the capacity of parents to nurture and care for their children, can impact on child health outcomes. Parental capacity may also impact on deaths in a number of categories where modifiable risk factors are evident.

Very few child deaths each year are determined to be suspicious by police. In 2012, two children died in circumstances involving suspicious and/or inflicted injuries. In both cases, the child was in the care of a biological parent when the injuries were sustained.

Each year a number of infants die in sudden and unexpected circumstances. Section 2.2.10 provides additional information about the 16 infants who died suddenly in 2012. The circumstances of death for the infants include illness and/or disease, Sudden Infant Death Syndrome, accidental asphyxia, and cases where the cause of death could not be determined at autopsy.

The actual numbers of deaths are relatively small in many of the categories presented in Figure 4, and caution should be exercised when analysing and drawing conclusions about fluctuations from year to year.

26. This data may change over time as new information is received by Community Services.

27. Community Services does not always have access to information about the circumstances of death when reviews are being completed. At the time of this report, the circumstances of 12 deaths were not known.

Chapter 2: Child deaths in 2012

2.2.1 Death from illness and/or disease

2012		2011	
28 Deaths	34% Of all deaths	35 Deaths	32% Of all deaths
14 Males	14 Females	16 Males	19 Females
0–17 years age range	6 Aboriginal and/or Torres Strait Islander	0–17 years age range	6 Aboriginal and/or Torres Strait Islander

Illness and/or disease were the most common circumstances of death for children and young people. It has been the most common circumstance of death consistently for children known to Community Services since 2006.

Twenty-eight deaths resulted from illness and/or disease. This accounted for 34 percent of all deaths. Of the 28 deaths, all but four children had been diagnosed with an illness, disease or disability before their death.

In almost a third of cases²⁸, the family of the child or young person who died had previously been reported for medical neglect. ROSH reports about medical neglect had been made in nearly half the nine cases²⁹.

2.2.2 Prematurity related deaths

2012		2011	
13 Deaths	16% Of all deaths	13 Deaths	12% Of all deaths
7 Males	6 Females	7 Males	6 Females
0–4 weeks age range	8 Aboriginal and/or Torres Strait Islander	< 1 month age range	0 Aboriginal and/or Torres Strait Islander

Thirteen (16 percent) infants died from conditions related to their premature birth³⁰, ten within 24 hours of their birth, one within 48 hours and two infants lived for less than a month.

Three (23 percent) of the 13 infants had been reported before their birth. For one, reports alleged the unborn

child had been exposed to maternal drug use and domestic violence³¹.

In 10 (77 percent) of the 13 cases, the infants had not been reported before their death but information had been received about the deceased infants' sibling/s. In nine of the 10 cases, reports were received about both domestic

violence and substance misuse. In three of those cases, information had been received about domestic violence and substance abuse during the mother's previous pregnancies.

Many causes of premature birth are unexplained and unknown, however, there are some risk factors that increase the chances of babies being born early³². Research

28. 32 percent – nine of 28 cases.

29. The ROSH reports were made following changes to the reporting threshold in January 2010.

30. Cases were included in this category when prematurity was recorded as either the underlying or associated cause of death or a contributing factor in the death.

31. Risk factors for the other two infants included concerns about the mother's history and mental health.

32. National Premmie Foundation 2013, Risk factors and causes of premature birth, <http://www.prembaby.org.au/risk-factors-causes-of-premature-birth/>

Chapter 2: Child deaths in 2012

indicates that alcohol and illicit drug use³³, cigarette smoking and domestic violence³⁴ are risk factors for premature birth³⁵. As pregnant women may experience more than one of these issues, it is often difficult to determine which health

problems are caused by which issue³⁶. There is consistent support in some research about the adverse effect of heavy alcohol consumption on the developing foetus and its link to an increased risk of preterm birth³⁷.

2.2.3 Unknown

2012		2011	
12 Deaths	15% Of all deaths	9 Deaths	8% Of all deaths
8 Males	4 Females	7 Males	2 Females
0–17 years age range	2 Aboriginal and/or Torres Strait Islander	0–17 years age range	2 Aboriginal and/or Torres Strait Islander

Community Services does not always have access to information about the circumstances of death when reviews are being completed. At the time this report was written,

the circumstances of 12 deaths in 2012 were not known.

The 'unknown' category also includes cases where the autopsy report did not make a finding on the

cause of death and a coroner has determined the cause of death to be 'unascertained' or 'undetermined'. The causes of death for three cases in 2012 were classified as 'unascertained'.

33. Reference to the impact of drug and alcohol use retrieved from http://www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html

34. McMahon, S, Huang, C, Boxer, P & Postmus, JL 2011, 'The impact of emotional and physical violence during pregnancy on maternal and child death at one year post-partum', *Child and Youth Services Review*, vol.33, pp. 2103-2111.

35. Centers for Disease Control and Prevention, <http://www.cdc.gov/features/prematurebirth>

36. Reference to the impact of drug and alcohol use retrieved from http://www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html

37. Behrman, RE & Butler, A 2007, *Preterm birth: causes, consequences, and prevention*, Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes, National Academies Press (US), Washington DC.

Chapter 2: Child deaths in 2012

2.2.4 Suspected suicide deaths

2012		2011	
10 Deaths	12% Of all deaths	4 Deaths	4% Of all deaths
7 Males	3 Females	2 Males	2 Females
13–17 years age range	3 Aboriginal and/ or Torres Strait Islander	14–17 years age range	0 Aboriginal and/ or Torres Strait Islander

As mentioned previously, 10 children and young people died from suspected suicide in 2012, accounting for 12 percent of all deaths. This is the highest number of deaths in this category in the last five years. In 2011, four (4 percent) children and young people died in circumstances of suspected suicide.

All were teenagers at the time of their death. Seven were male and three were female. Consistent with general suicide data, large gender disparities occur in youth suicide, with females more than twice as likely to attempt suicide and males more than five times as likely to die as a result of suicide³⁸.

In 2012, the majority (7) of children and young people died from injuries related to hanging. A report by Suicide Prevention Australia found that youth suicides are typically a result of hanging, a

readily accessible means of suicide that is difficult to restrict³⁹. Some studies have also suggested that hanging may be seen as 'socially acceptable' among young people and intervention and prevention strategies should focus on how to challenge that view⁴⁰.

Adolescent vulnerabilities, risk factors and suicide

Substance abuse may increase suicide risk for young people⁴¹. Of the 10 suspected suicide deaths, alcohol and/or marijuana were detected at autopsy in seven cases, suggesting recent use. The same number of children and young people had also previously been reported to Community Services for alcohol and substance misuse.

A past history of attempted suicide has been shown to be a strong predictor of death by suicide⁴². Two young people had previously

attempted suicide. These and a further four young people had also previously been reported for depression, self-harm and/or suicidal thoughts. Self-harm is defined as deliberate self-injury without intent of death, and is therefore different from a suicide attempt⁴³. Although self-harming behaviours generally do not involve suicidal intent, evidence strongly suggests that people who engage in self-harming behaviours are at greater risk of suicide than those who do not⁴⁴.

In their annual report for 2010, the CDRT found that young people known to Community Services were 4.9 times more likely to suicide than young people not known to the agency⁴⁵. This is not unique to NSW and reflects the vulnerability of children and young people known to statutory child protection services. The CDRT outlined risk

38. Suicide Prevention Australia 2010, *Youth suicide prevention position statement*, <http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-Youth-Suicide-Prevention-Position-Statement.pdf>

39. *Ibid.*, p 12.

40. Beautrais, A 2000, 'Methods of youth suicide in New Zealand: trends and implications for prevention', *The Australian and New Zealand Journal of Psychiatry*, vol.34, no.3, pp. 413-419.

41. Suicide Prevention Australia, 2010, *op. cit.*

42. Hawton, K & James, A 2005, 'Suicide and Deliberate Self Harm in Young People', *British Medical Journal*, vol.330, pp. 891-894.

43. Suicide Prevention Australia, 2010, *op. cit.*

44. *Ibid.*, p 5.

45. NSW Child Death Review Team 2011, *Annual Report 2010*, NSW Ombudsman, Sydney.

Chapter 2: Child deaths in 2012

factors that were linked to suicidal behaviour, including mental illness, previous suicidal behaviour, substance misuse, personal crises, family circumstances, a history of abuse or neglect and social exclusion or isolation⁴⁶. One or more of these risk factors was included in the histories of all of the young people who died from suspected suicide in 2012.

As part of its adolescent service delivery reform, Community Services has completed the *review Better Lives for Vulnerable Teens* to consider reforms that can be implemented to assist vulnerable teenagers to better engage with education and employment, support their connection to family, peers and community and to live in stable accommodation. Family and Community Services will

be working to improve service integration and provide support that is responsive to the individual needs of teenagers. In August 2013, Family and Community Services began liaising with stakeholders to commence implementation of the review recommendations and to look at opportunities to work closely with other human services and justice agencies and non-government agencies to better support vulnerable teenagers.

2.2.5 Motor vehicle accidents

2012		2011	
7	8%	8	7%
Deaths	Of all deaths	Deaths	Of all deaths
4	3	2	6
Males	Females	Males	Females
9–17 years age range	1	0–17 years age range	0
	Aboriginal and/or Torres Strait Islander		Aboriginal and/or Torres Strait Islander

Seven (8 percent) children and young people died as a result of motor vehicle accidents. Three children were aged between nine and 10 years and four young people were aged 16 to 17 years.

Two children were passengers in cars being driven by family members and three young people

were driving alone when they had single vehicle accidents. Alcohol was reported to be a factor in one accident. One young person was killed as the driver in a motorcycle accident. Another child died when the motorcycle he was a passenger on crashed.

Chapter 2: Child deaths in 2012

2.2.6 Drowning related deaths

2012		2011	
5 Deaths	6% Of all deaths	7 Deaths	6% Of all deaths
3 Males	2 Females	6 Males	1 Females
1–13 years age range	1 Aboriginal and/or Torres Strait Islander	1–15 years age range	6 Aboriginal and/or Torres Strait Islander

Five (6 percent) children aged between 12 months and 13 years died as a result of drowning. Of these:

- three children drowned in a fenced backyard swimming pool at their home, all without adequate adult supervision
- one child drowned in an unfenced swimming pool at a family friend's home
- one child drowned when a dinghy capsized and a lifejacket was not worn.

2.2.7 Drug overdose

2012		2011	
2 Deaths	2% Of all deaths	3 Deaths	3% Of all deaths
1 Males	1 Females	2 Males	1 Females
15–17 years age range	1 Aboriginal and/ or Torres Strait Islander	15–17 years age range	0 Aboriginal and/or Torres Strait Islander

Two (2 percent) young people died from self-administered drug overdoses. Both autopsies found mixed drug toxicity, and both young people had reported histories of alcohol and/or drug use.

Chapter 2: Child deaths in 2012

2.2.8 Suspicious and/or inflicted injuries

2012		2011	
2 Deaths	2% Of all deaths	7 Deaths	6% Of all deaths
2 Males	0 Females	2 Males	5 Females
6 months–2 years age range	2 Aboriginal and/or Torres Strait Islander	4 months–11 years age range	3 Aboriginal and/or Torres Strait Islander

Two children died from suspicious and/or inflicted injuries⁴⁷. Both children were in the care of a biological parent when the injuries that caused their death were

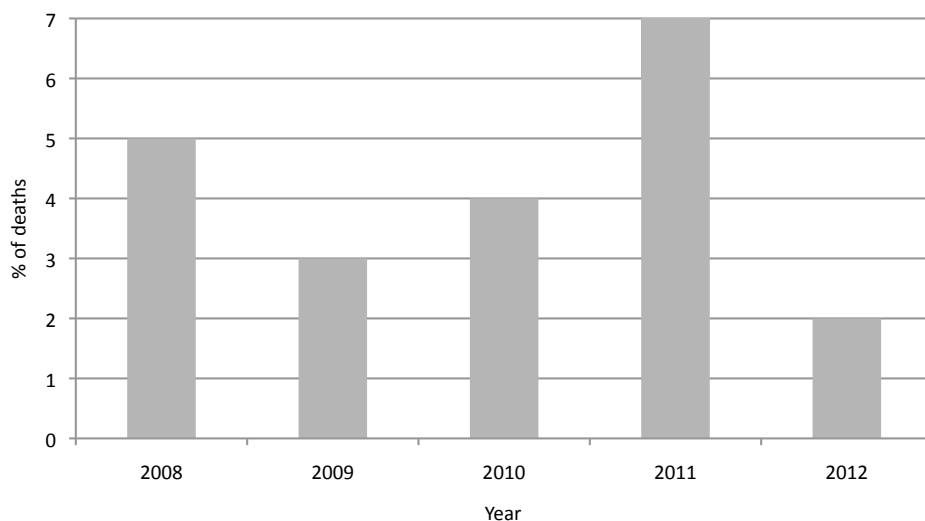
sustained. The mother of one child and the father of another child have been charged with inflicting the injuries. For both children, ROSH reports about abuse and/

or neglect had been made within 12 months of their death. Reports about alleged physical harm had been received about one child. One case was closed at the time of the child's death. The other case was unallocated at the time of death.

Suspicious or inflicted injury cases since 2008

This is the lowest number of deaths in this category in the last five years. Figure 5 shows the percentage of suspicious or inflicted injury deaths for each year in that period.

Figure 5: Percentage of children and young people known to Community Services who died from suspicious or inflicted injuries, 2008 to 2012.



Source:
Community Services, 2013.

47. This category includes children who died from alleged assault, abuse or other types of injuries that were investigated by the NSW Police Force and determined to be inflicted by another person.

Chapter 2: Child deaths in 2012

2.2.9 Sudden Infant Death Syndrome (SIDS)

2012		2011	
2 Deaths	2% Of all deaths	2 Deaths	2% Of all deaths
2 Males	0 Females	2 Males	0 Females
1–4 months age range	0 Aboriginal and/or Torres Strait Islander	1–4 months age range	1 Aboriginal and/or Torres Strait Islander

Two (2 percent) infants died from SIDS. Both infants were sharing an adult bed with at least one of their parents at the time of their death.

2.2.10 Sudden and Unexpected Deaths in Infancy (SUDI)

2012		2011	
16 Deaths	19% Of all deaths	20 Deaths	18% Of all deaths
10 Males	6 Females	13 Males	7 Females
0–5 months age range	5 Aboriginal and/or Torres Strait Islander	0–7 months age range	7 Aboriginal and/or Torres Strait Islander

When infants aged less than 12 months die suddenly, and where the cause of death is not immediately obvious after the completion of an investigation and autopsy, it is described as Sudden Unexpected Death in Infancy (SUDI). These deaths usually occur after the infant was placed to sleep or during sleep.

Infants aged less than four months, infants born prematurely and with low birth weight, infant boys, infants sleeping on their stomachs, and infants born to mothers who smoked during pregnancy are particularly vulnerable to sudden infant death^{48,49}.

SUDI is not a cause of death but rather a broad category of sudden and unexpected infant deaths that includes SIDS, fatal sleep accidents, illnesses that were not recognised as life threatening prior to the infant's death, and other types of undetermined deaths. The most frequent cause of SUDI is likely to be SIDS or a fatal sleep accident^{50,51}.

48. Blair, P, Sidebotham, P, Berry, JP, Evans, M, & Fleming, P 2006, 'Major epidemiological changes in sudden infant death syndrome: A 20-year population-based study in the UK', *Lancet*, vol.367, pp. 314-319.

49. Trachtenberg, FL, Haas, EA, Kinney, HC, Stanley, C & Krous, HF 2012, 'Risk factor changes for sudden infant death syndrome after initiation of back-to-sleep campaign', *American Academy of Pediatrics*, vol.129, no.12, pp. 630-638.

50. Queensland Health 2008, *Safe infant care to reduce the risk of sudden unexpected death in infancy: Policy statement and guidelines*, Queensland Health, Brisbane.

51. Wilson, L, Quine, S & Lewis, M 2010, 'Sleeping infants safely – considerations for GPs', *Australian Family Physician*, vol.39, no. 1/2, pp. 66-68.

Chapter 2: Child deaths in 2012

Of the 41 infants known to Community Services who died in 2012, 16 died in sudden and unexpected circumstances. This represents more than a third of the infant deaths. All 16 infants were less than five months old when they died. Of these infants, nine were aged between two and four months. Five of the 16 infants were identified as Aboriginal and/or Torres Strait Islander.

Details about the cause of death for the 16 infants are:

- two infants' deaths were attributed to SIDS
- one died from positional asphyxia
- four died from an illness not previously identified
- two infants died from causes that could not be determined after post-mortem investigations were completed

- seven infants died from causes unknown before finalisation of post-mortem investigations (however, the deaths occurred in a sleeping context).

Modifiable risk factors

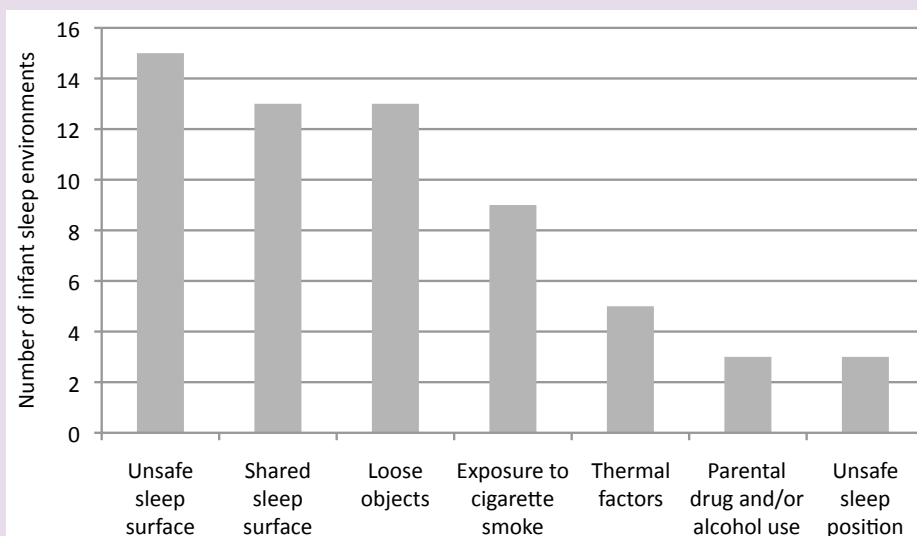
Fifteen infants were sleeping on an unsafe surface. This was mostly on an adult bed or a mattress on the floor. In 13 of these cases, the infant was sharing the sleep surface (sometimes described as co-sleeping) with either one or both parents and/or a sibling. The risk of a parent rolling on top of the infant, and the infant being smothered, is increased in these circumstances. The risk of this occurring is significantly heightened when the parent is under the influence of alcohol and/or drugs, including prescribed medication. Given that alcohol and/or drug use can cause a much heavier state of sleep, there is a high risk of the parent being

unable to rouse or be aware of the position of their infant⁵².

Research on sudden infant death consistently shows that most risk factors for SUDI are modifiable, and that the risk of sudden infant death can be significantly reduced by ensuring that infants are placed to sleep in a safe environment—day and night.

Figure 6 provides a breakdown of individual risk factors which could be identified from available information about the sleep environment for each of the 16 SUDI related deaths in 2012. Three or more of the risk factors were present in 13 of the 16 cases. Caution should be used when drawing conclusions about these findings. The accuracy of the information is dependent on carers providing a clear account of the circumstances of the baby's death at a time when they are grieving their loss.

Figure 6: Individual risk factors in the sleep environments of the infants known to Community Services who died suddenly and unexpectedly in 2012.



Source: Community Services, 2013.

52. Dodd, J 2012, *Evaluation of the Department of Health Western Australia Operational Directive Statewide co-sleeping/bed-sharing policy for WA hospitals and health services*, Collaboration for Applied Research and Evaluation, Telethon Institute for Child Health Research under contract with the Department of Health Western Australia.

Chapter 2: Child deaths in 2012

2.3 Characteristics of the children and young people

This section outlines the characteristics of the children and young people known to Community Services who died in 2012 by age, gender, and Aboriginal and/or Torres Strait Islander status.

2.3.1 Age and gender

In 2012, 50 (60 percent) of the children and young people who died were male, and 33 (40 percent) were female. This finding is consistent with the trends in previous years⁵³.

Infants aged less than one year accounted for 46 percent (38) of all children who died. Thirty-three (87 percent) infants died in the first three months of life, and 18 (47

percent) in the neonatal period⁵⁴. The over-representation of infants in child deaths in NSW has been a consistent pattern over the past 15 years⁵⁵.

The circumstances of death for the infants aged less than one year in 2012 included⁵⁶:

- extreme prematurity (13)
- illness and/or disease (12)
- SIDS (2)
- accidental asphyxia (1)
- suspicious and/or inflicted injuries (1).

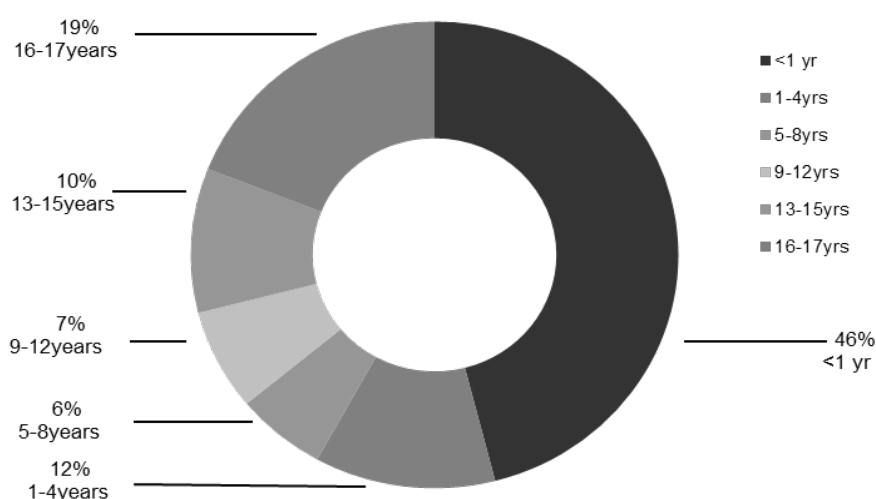
Twenty-four (29 percent) of the children and young people who died were teenagers. Consistent with previous years, they represented a higher proportion of the deaths that were linked to risk-taking behaviour.

The circumstances of death for teenagers in 2012 included:

- suicide (10)
- illness and/or disease (5)
- motor vehicle accident (4)
- drug overdose (2)
- drowning (1)
- transport accident (1).

International research suggests that adolescents may face a range of particular risk factors that can make them more vulnerable to certain types of death, including family and societal alienation, developmental pressures, physical changes associated with puberty and challenges inherent to adolescence, accommodation and school problems, violence, drug and alcohol use, and mental health issues⁵⁷.

Figure 7: Age of the children and young people known to Community Services who died in 2012.



Source: Community Services, 2013.

53. NSW Department of Family and Community Services, Community Services, 2012.

54. The neonatal period refers to the first 28 days after an infant's birth.

55. NSW Child Death Review Team, 2012.

56. The circumstances of death for nine children were not known at the time of the report.

57. Office for Standards in Education, Children's Services and Skills (Ofsted) 2011, *Ages of concern: learning lessons from serious case reviews: a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*, Manchester, United Kingdom.

Chapter 2: Child deaths in 2012

2.3.2 Aboriginal and/or Torres Strait Islander status

Approximately 5 percent of children and young people in NSW are Aboriginal and/or Torres Strait Islander⁵⁸, however, they continue to be grossly over-represented in the child protection system. In 2012, Aboriginal and/or Torres Strait Islander children and young people accounted for 21 percent of the children and young people

involved in ROSH reports⁵⁹. The reasons for their over-representation in the child protection system are complex yet there is general consensus that factors such as intergenerational poverty, disadvantaged socioeconomic status, violence, drug and alcohol abuse, and inadequate housing are associated^{60,61}.

Child death figures paint a similar picture. In 2012, 31 percent (26) of the children and young people

known to Community Services who died were Aboriginal and/or Torres Strait Islander. This figure is consistent with 2011⁶². Aboriginal and/or Torres Strait Islander children and young people are consistently over-represented in child death figures each year. Between 2008 and 2012, 614 children and young people known to Community Services died. Twenty-five percent were Aboriginal and/or Torres Strait Islander.

Table 1: Aboriginal and/or Torres Strait Islander children and young people who died and were known to Community Services, 2008 to 2012.

	2008	2009	2010	2011	2012
Number of children who died and were known to Community Services	134	148	139	110	83
Number of Aboriginal and/or Torres Strait Islander children who died and were known to Community Services	33	29	33	33	26
% of Aboriginal and/or Torres Strait Islander children who died and were known to Community Services	25%	20%	24%	30%	31%

Source: Community Services, 2013.

The circumstances of death for the 26 Aboriginal and/or Torres Strait Islander children who died in 2012 include⁶³:

- extreme prematurity (8)
- illness and/or disease (6)
- suicide (3)
- suspicious or inflicted injury (2)
- drowning (1)
- drug overdose (1)
- motor vehicle accident (1)
- accidental asphyxia (1)
- other accidental injury (1).

Figure 8 provides a comparison of the circumstances of death for Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or Torres Strait Islander children and young people in 2012.

58. Australian Bureau of Statistics, 2012.

59. Information & Reporting Unit, Community Services, 2013.

60. Australian Institute of Health and Welfare 2011, Aboriginal and Torres Strait Islander Child Safety, AIHW, Canberra.

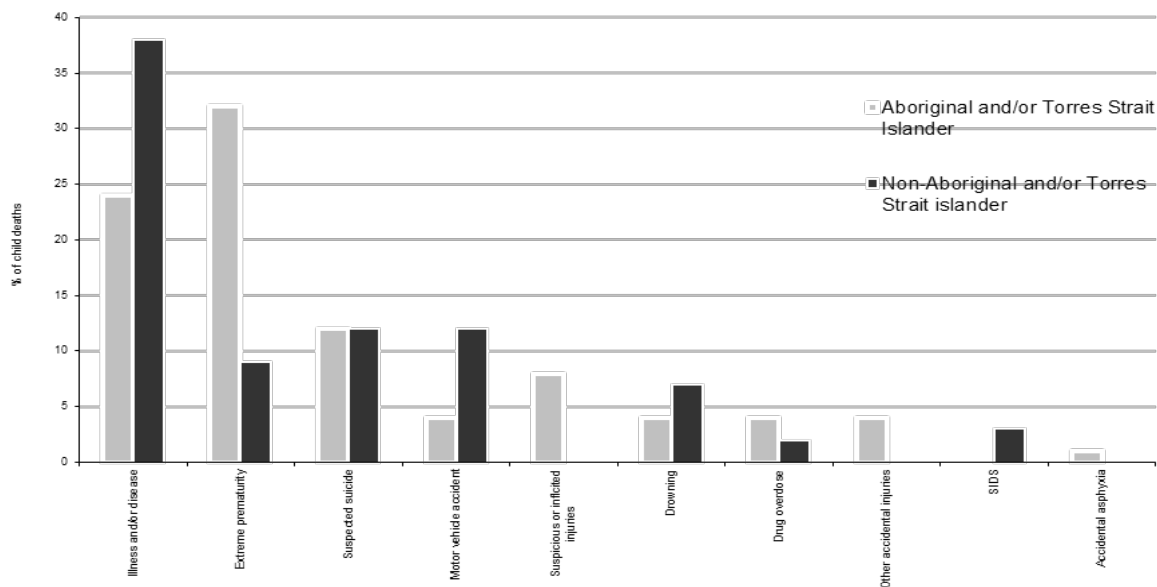
61. Libesman, T 2004, Child welfare approaches for Indigenous communities: international perspectives, Child Abuse Prevention Issues No. 20. National Child Protection Clearinghouse, Australian Institute of Family Studies, <http://www.aifs.gov.au/nch/pubs/issues/issues20/issues20.pdf>

62. In 2011, 30 percent of the children who died were Aboriginal and/or Torres Strait Islander.

63. The circumstances of death for two children were not known at the time of the report.

Chapter 2: Child deaths in 2012

Figure 8: Comparison of circumstances of death for Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or Torres Strait Islander children and young people in 2012⁶⁴.



Source: Community Services, 2013.

A higher percentage of Aboriginal and/or Torres Strait Islander children and young people died in circumstances involving extreme prematurity, suspicious injury, drug overdose and other accidental injury. The higher incidence of extreme prematurity deaths is particularly associated with poor health status, under use of antenatal services, a high adolescent birth rate and the social, economic and political factors affecting many women in Aboriginal and/or Torres Strait Islander communities⁶⁵. While caution must be exercised in analysing such small figures, the higher numbers of suspicious injury, drug overdose and other accidental injury may be reflective of broader issues of

intergenerational trauma, poverty and disadvantage, which increase the vulnerability of Aboriginal and/or Torres Strait Islander communities, their families and children and young people.

SIDS was not identified as a cause of death for Aboriginal and/or Torres Strait Islander children, however five deaths were categorised as SUDI. Research findings consistently show that Aboriginal and/or Torres Strait Islander children are over-represented in sudden infant deaths. According to the Australian Bureau of Statistics (2011), the death rate of Aboriginal and/or Torres Strait Islander infants is

more than four times the rate of non-Aboriginal and/or Torres Strait Islander infants.

The number of Aboriginal and/or Torres Strait Islander children who died while sharing a sleep surface with another person decreased from previous years. In 2012, Aboriginal and/or Torres Strait Islander children represented 31 percent (4) of the children who died while sharing a sleep surface compared to 38 percent (5) in 2011 and 40 percent (6) in 2010. Between 2008 and 2012, 35 percent of the children who died while sharing a sleep surface were Aboriginal and/or Torres Strait Islander⁶⁶. While there has been a decrease in the

64. Figure 8 displays the number of Indigenous child deaths by circumstances of death as a percentage of the total number of Indigenous child deaths and the number of non-Indigenous child deaths by circumstances of death as a percentage of the total number of non-Indigenous child deaths.

65. Murphy, E & Best, E 2012, The Aboriginal maternal and infant health service: a decade of achievement in the health of women and babies in NSW, vol.23 (3-4), NSW Public Health Bulletin, http://www.publish.csiro.au/?act=view_file&file_id=NB11051.pdf

66. Department of Family and Community Services, Community Services, 2013.

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number of Aboriginal and/or Torres Strait Islander children known to Community Services who died in these circumstances, it is too early and the number of children too small to draw conclusions about this. Community Services will continue to work with families to provide information about the dangers of co-sleeping and monitor the incidence of future deaths where a child was co-sleeping.

The NSW Ombudsman reports that over one-half of the Aboriginal and/or Torres Strait Islander children whose deaths were reviewable in 2010 and 2011 were aged less than five years⁶⁷. Community Services' data for 2012 is consistent. Of the 26 Aboriginal and/or Torres Strait Islander children and young people who died, 18 (69 percent) were aged less than five years. Fourteen (54 percent) were less than a year old.

The NSW Government is committed to closing the gap in health outcomes between Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or Torres Strait Islander children. The health of Aboriginal people of NSW report states that, in order to reduce infant and child mortality rates, it is necessary to address access to antenatal and obstetric services and the quality of population health strategies, as well as broader issues

such as social and community cohesion, socioeconomic and environmental factors and behavioural risk and protective factors⁶⁸. As part of the National Indigenous Reform Agreement 2008 and the State Plan, NSW 2021, the target is to halve the gap in mortality rates for Aboriginal and/or Torres Strait Islander children aged less than five years by 2018⁶⁹.

2.4 Community Services' response to child deaths

2.4.1 Context

This section describes Community Services' response to reports received about the families of children who died. It explains how decisions were made about what constitutes a report and how the agency responds when a child dies.

Reports to the Child Protection Helpline can be made if a person suspects that a child is at risk of significant harm. Not every report about a child who is reported reaches the ROSH threshold. In some cases, Community Services, using Structured Decision Making (SDM®) tools and professional judgement, concludes that the reporter's concerns do not reflect risks that reach the ROSH threshold and therefore do not warrant assessment. In other cases, while the reporter's concerns do reach the threshold, Community Services

is already aware of the reported concerns and is working with the family to address risks. In some cases, Community Services may hold other information confirming that, while the reporter's concerns reach the threshold, the child is not in fact at risk of significant harm. These cases can be closed without further assessment, referred for early intervention or referred to other agencies for ongoing support. Competing priorities prevent Community Services from responding to all reports that reach the ROSH threshold.

Child death reviews show that, in many cases, children die in circumstances unrelated to the parenting that they received. A child may die for reasons unrelated to the nature of the child protection report and child protection intervention may have had no influencing impact on their deaths (for example, in deaths due to illness or disease). That being said, the disadvantage that this population of children experiences may also make them more vulnerable to health concerns. Some children do die in circumstances related to parental actions or family risk factors and a small number of children die directly as a result of suspicious or inflicted injuries (2 percent of cases in 2012). International research confirms that it is simply not possible to predict which children will die based on the

67. NSW Ombudsman 2013, Report of Reviewable Deaths in 2010 and 2011, NSW Ombudsman, Sydney.

68. Centre for Epidemiology and Evidence 2012, The health of Aboriginal people of NSW: Report of the Chief Health Officer, Sydney, NSW Ministry of Health.

69. Centre for Aboriginal Health 2012, Aboriginal Health Report Card, NSW Ministry of Health, http://www0.health.nsw.gov.au/resources/publichealth/hsnsw/pdf/aboriginal_health_health_.pdf

Chapter 2: Child deaths in 2012

reports received about their families ^{70,71,72}.

Community Services' child death reviews illuminate what the research refers to as 'hindsight bias'⁷³. When looking back at a case where there has been a tragic outcome, hindsight can lead us to identify actions and decisions which could potentially have altered the outcome. Child death review work needs to carefully distinguish which information was available at the time, and avoid making unrealistic comments about practice and raising unrealistic expectations about intervention.

While it is crucial to understand this context, it is central to the

review process to identify where intervention could have been better.

2.4.2 Reports

When reviewing deaths, Community Services' Child Deaths and Critical Reports Unit (CDCR) considers all reports received for children and their families that meet the statutory child protection threshold. This is necessary because the history of reports is critical to gaining a detailed understanding of the experience of the child⁷⁴.

Sixty-one (73 percent) of the 83 children and young people who died had been reported on at least one occasion before their death. Of these children, 51 (84 percent) had been the subject of a ROSH report and 36 (59 percent) had been the

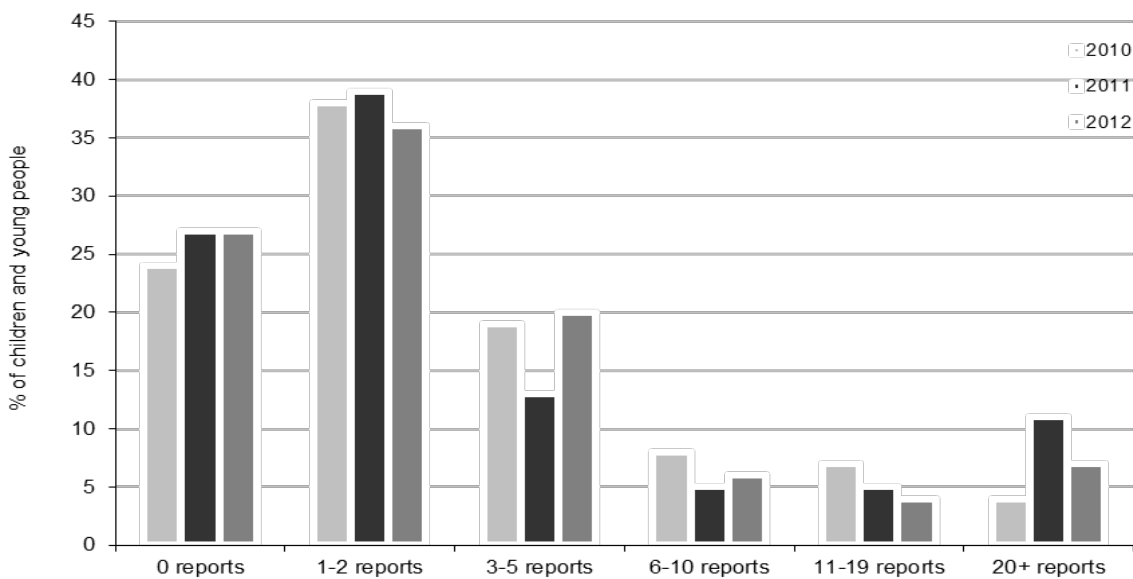
subject of a ROSH report in the 12 months before their death.

Twenty-two (27 percent) children and young people were not the subject of a report, yet their sibling/s had been reported. A ROSH report had been received about 15 (68 percent) of these families. Seven families had not been reported since the introduction of the ROSH threshold in January 2010.

Just over a third (36 percent) of the deaths were cases that had received one or two reports. Twenty percent (17) had been the subject of three to five reports. Six children and young people (7 percent) had been reported over 20 times.

Figure 9 shows a comparison of the number of reports received for

Figure 9: Number of reports received for the children and young people known to Community Services who died between 2010 and 2012.



Source: Community Services, 2013.

70. Munro, 2011.

71. Brandon *et al.*, 2013.

72. Brandon *et al.*, 2009.

73. Munro, 2011.

74. This is different from other public reporting by Community Services that focuses on reports received within 12 months.

Chapter 2: Child deaths in 2012

children and young people who died between 2010 and 2012. This period corresponds with changes to the reporting threshold. Consistently over the three years, children and young people who died were either reported once or twice or not at all⁷⁵, indicating that the majority of them did not have lengthy child protection histories and were therefore not well known to Community Services. This signifies that it is not always the children who have the greatest contact with child protection authorities who die.

2.4.3 Community Services' response

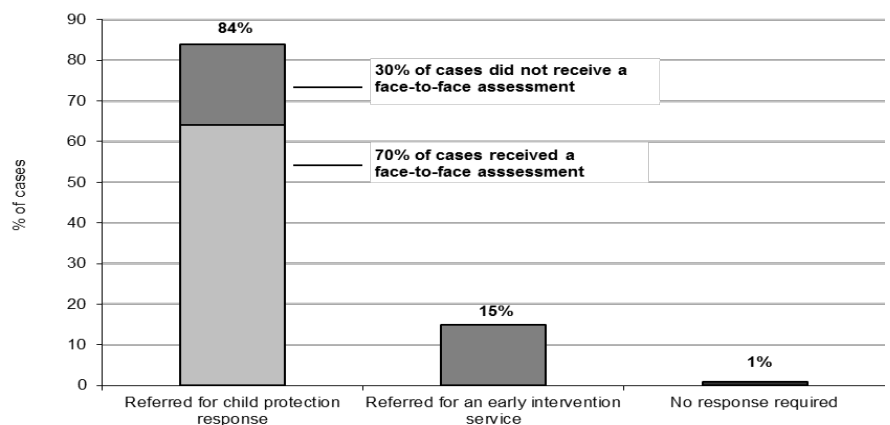
When reviewing child deaths, the CDCR considers how the agency has responded to the child and their family by looking at all reports that meet the statutory child protection threshold.

The response provided by Community Services to these children and families varied depending on circumstances. Some may have received more than one type of response, for example a family could have received both an early intervention service and a face-to-face child protection assessment⁷⁶. In order to consider Community Services' involvement with these families, they are classified by the highest level of response they received.

Of the 83 families where a child or young person died:

- 70 (84 percent) were assessed as requiring a child protection response
- 49 (70 percent) of the 70 received a face-to-face child protection assessment from Community Services at some point prior to the death of the child or young person
- 21 (30 percent) of the 70 did not receive a face-to-face child protection assessment due to other cases being assessed as higher priority. This is a decrease from 2011 where 41 percent of cases that were assessed as requiring a face-to-face response did not receive one.
- of those that received a face-to-face child protection assessment, in 13 (27 percent) cases the assessment occurred in either 2011 or 2012
- 12 (15 percent) of families met eligibility for an early intervention service⁷⁷. Of these, four (33 percent) received an early intervention service from either Community Services or a non-government lead agency and eight (67 percent) did not receive a service⁷⁸
- One (1 percent) case did not require a response from Community Services as preliminary casework determined that statutory intervention was not required.

Figure 10: Response to reports received about the families of children known to Community Services who died in 2012.



Source: Community Services, 2013.

75. The children who were not the subject of any reports were 'known to Community Services' due to their sibling/s being reported to Community Services within three years prior to their death.

76. A face-to-face child protection assessment is considered to have occurred when a risk assessment was completed, or when work occurred with the family (such as interviews, meetings and/or removal of a child).

77. The criteria for referral of families to early intervention services are designed to identify families who would not otherwise receive a child protection response, with the goal of preventing future child protection reports.

78. Of the eight cases where there was no service supplied, four were closed due to competing priorities in the early intervention teams; two families chose not to engage with the service; one family was on the waiting list of a non-government service when the child died; and one family was considered not suitable for the program.

Chapter 2: Child deaths in 2012

A quarter of 2012 cases did not receive any child protection response. The agency is working to improve systems and practice with the aim of increasing the number of reports that receive a response. A range of strategies have been developed to improve capacity to respond to and assess children at risk of significant harm. Supporting caseworkers to see and help more children and young people is one of Community Services' key objectives. Chapter 4 outlines current initiatives.

2.4.4 Children in out-of-home care

Seven (8 percent) children and young people who died in 2012 were not living with their parents at the time of their death.

Four of the seven children and young people were under the parental responsibility of the Minister. Two were placed with extended family, one was placed with Community Services authorised carers and one child remained hospitalised following birth. The circumstances of death for the children in the parental responsibility of the Minister included illness, disease and extreme prematurity. The cause of death could not be ascertained at autopsy for one child. One child was Aboriginal and/or Torres Strait Islander.

The remaining three children and young people were not living with their parents and were in the care of extended family. They

were not subject to legal orders, however, their carers were receiving the Supported Care Allowance at the time of their death. The circumstances of death for these children and young people included suicide, a motor vehicle accident and a transport accident. One young person was Aboriginal and/or Torres Strait Islander.

2.5 Reported risk concerns

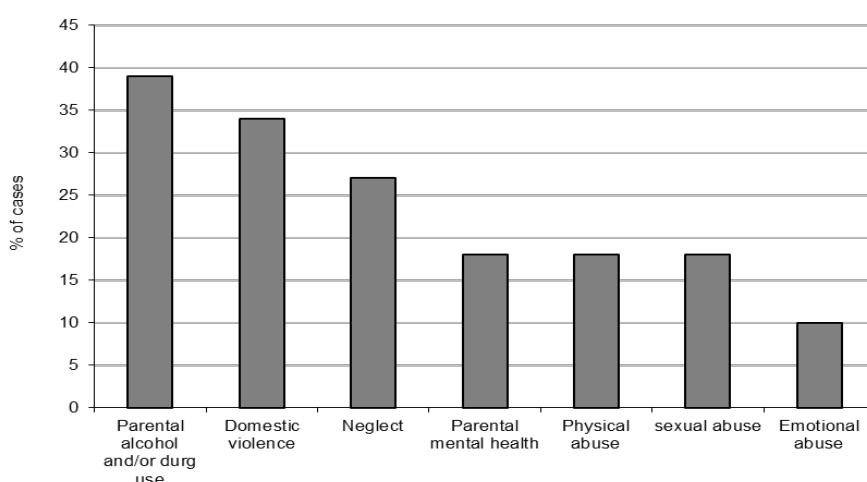
This section outlines the concerns that were reported about the families of the children who died in 2012⁷⁹. The information is collected from the child protection histories of the children and their sibling/s and can span many years.

2.5.1 Risk factors

Parental alcohol and/or drug misuse was the most commonly reported concern – 32 (39 percent) families were the subject of a ROSH report about this risk factor. Exposure to parental domestic and family violence and neglect were the next most reported concerns.

Socioeconomic disadvantage was also a key theme in the reported issues for the families of children who died. Issues relating to transience, geographic isolation and/or poverty⁸⁰ were reported in 24 (29 percent) cases.

Figure 11: Reported ROSH risk factors for the families of the children and young people known to Community Services who died in 2012⁸¹.



Source: Community Services, 2013.

79. Reports received prior to the increase of the ROSH threshold in January 2010 are not included in this analysis.

80. For the purposes of this report, poverty refers to children in the family who are significantly disadvantaged by the family's financial circumstances. Transience is defined as families who move continuously and do not have a stable accommodation base. Geographical isolation refers to families who are living in a remote/isolated area, or families who are geographically isolated due to a lack of resources, such as a combination of poor transport, communication technology and poverty.

81. Multiple risk factors may have been reported in one case.

Chapter 2: Child deaths in 2012

Intergenerational factors

A number of intergenerational concerns were identified for the families of the children who died in 2012. It can be difficult for parents to care for their children when they themselves experienced abuse and neglect during their childhood – more so if they were unable to experience positive examples of parenting. The issues in these families are complex and frequently require the services of multiple agencies to help keep children safe. Child protection agencies alone cannot address longstanding and intractable issues of alcohol and/or drug misuse, domestic violence, disadvantage and poverty.

Research is clear that abuse and neglect during infancy and early childhood can have enduring repercussions into adolescence and adulthood. When early childhood experiences are primarily negative, children can develop emotional, behavioural, and learning problems that persist throughout their lifetime. There is evidence of the link between childhood abuse and neglect and later adverse experiences, such as physical and mental illness and high risk behaviours⁸². Dr Bruce Perry argues that maltreated children are, essentially, rejected. Children who are rejected by their

parents may experience a host of developmental challenges, including difficulty developing emotional intimacy and secure attachment. In abusive families, it is common for this rejection and abuse to be transgenerational, where those neglected themselves as children in turn parent in the only way they know⁸³.

Intergenerational risk factors were identified in 25 (30 percent) of the child death reviews. The most commonly reported concerns identified across generations were domestic violence, alcohol and/or substance misuse and neglect.

About a third (26 or 31 percent) of the cases had at least one parent who had been reported to child protection services when they themselves were children. In 13 (16 percent) cases, both parents had child protection histories. Of the 26 parents who had been reported to child protection services, seven had experienced state care.

Young parents

In 2012, five (6 percent) children had a young parent aged less than 22 years⁸⁴. There were five young fathers and two young mothers aged between 16 and 21 years. Of the seven parents, six had been reported for child protection concerns when they were children.

The circumstances of death for the children of the young parents included illness and/or disease, extreme prematurity and accidental asphyxia. All of the children were Aboriginal and/or Torres Strait Islander. Issues of transience, homelessness and poverty were identified in the histories of the families.

In 2011, CDCR examined the agency's practice with a cohort of children who died between 2006 and 2011 who were born to parents aged less than 22 years⁸⁵. The review identified those children living in young parent families as a particularly vulnerable group in the community. This was found to be particularly so when:

- the family is living with disadvantage
- there are intergenerational risks, including a parent with a child protection history
- there are poor family support networks
- there is poor access to and engagement with professional support services.

82. Child Welfare Information Gateway 2009, Understanding the Effects of Maltreatment on Brain Development, Washington, D.C., U.S. Department of Health and Human Services, www.childwelfare.gov/pubs/issue_briefs/brain_development/

83. Perry, BD 2001, Bonding and attachment in maltreated children: consequences of emotional neglect in childhood, The Child Trauma Academy, www.ChildTraumaAcademy.org

84. Community Services does not, at the time of publishing, have information about the age of 38 parents.

85. NSW Department of Family and Community Services, Community Services (2012) Child Deaths 2011 Annual Report: Learning to improve services.

Chapter 3: Lessons for improvement – domestic violence

Chapter overview

Each year Community Services selects one main theme to highlight in its annual report. Last year included a focus on working with young parents. This year, the overwhelming number of cases reviewed where domestic violence featured made it an obvious choice. To this end, this chapter outlines the learning from a review of Community Services' practice with the families of 466 children who died between 2007 and 2012

where domestic violence was a reported risk. While the deaths of these children were not directly linked to domestic violence, the review highlights areas for improved practice in engagement, assessment and intervention. The review identifies the clear link between violent, coercive and controlling behaviour towards an adult member of the household (usually the mother) and risks to the children. The cases examined illustrate the multiple risks associated with domestic violence.

Chapter 3: Lessons for improvement – domestic violence

Domestic violence is a widespread and chronic social problem. It exposes children to adverse experiences which often lead to poor outcomes. Children of all ages living with domestic violence have higher rates of depression and anxiety, trauma symptoms and social, behavioural and cognitive problems than children who are not living with domestic violence^{86,87,88}.

As the focus of this review was on domestic violence⁸⁹, cases where family violence that was not accompanied by intimate partner violence were excluded⁹⁰. The methodology for this review involved:

- analysis of electronic records, child death reviews, child death data and available police reports to the coroner in the 466 cases
- comparison with the 302 cases of children known to Community Services who died in the same period and who had not been reported with concerns about domestic violence
- in depth analysis of 30 cases involving 34 children where the review included information from electronic records, child protection files and interviews with field staff

- a review of national and international research and literature about domestic violence and child protection
- action learning focus groups from three locations (Metro West, Metro South West and Western regions) with child protection practitioners in a range of positions (Caseworkers, Managers Casework, Child Protection Casework Specialists and Managers Client Services).

Section 3.1 presents findings of the comparison between 466 children who died who were reported for domestic violence and 302 children who died who were not reported for domestic violence. This section highlights that, in more than half of the families of children who died during the review period, violence and its effects led to significant risks while not directly causing most deaths.

In those cases involving domestic violence, there was a considerably higher incidence of other associated issues compared to cases where domestic violence was not involved. In particular, there was a greater likelihood that emotional and physical abuse and physical neglect

were reported where there was domestic violence than in other cases.

Similarly, there was a stronger association of certain parental behaviours and attributes in cases where there was domestic violence compared to other cases, specifically parent alcohol and/or drug misuse and mental health problems. Substance misuse was a feature of two-thirds of the cases where domestic violence was reported.

One in three children who died and had been reported for domestic violence was Aboriginal and/or Torres Strait Islander. In situations where domestic violence was not reported, one in six children known to Community Services who died was Aboriginal and/or Torres Strait Islander.

Section 3.2 reviews Community Services' work identifying positive and problematic practice with families where there was domestic violence. The review underlines the importance of:

- placing an equal focus on the impact of domestic violence on children and on assessing the capacity of both parents to keep their children safe

86. McCloskey, LA & Walker, M 2000, 'Posttraumatic stress in children exposed to family violence and single-event trauma', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol.39, pp. 108-115.

87. Graham-Bermann, SA & Levendosky, AA 1998, 'Traumatic stress symptoms in children of battered victims', *Journal of Interpersonal Violence*, vol.13, no.1, pp. 111-128.

88. Holt, S, Buckley, H & Whelan, S 2008, 'The impact of exposure to domestic violence on children and young people: a review of the literature', *Child Abuse & Neglect*, vol. 32, no.8, pp. 797-810.

89. The definition of domestic violence used in this review and provided below has been taken from: NSW Department of Premier and Cabinet 2010, Stop the Violence End the Silence, NSW Domestic and Family Violence Action Plan, <http://www.women.nsw.gov.au/>

"Domestic Violence, also referred to as Intimate Partner Violence, is gender-based violence and a violation of human rights. It involves 'Violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control or dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman."

90. A very small number of cases involved female violence toward males. There were no cases of violence within same sex relationships in the review sample

Chapter 3: Lessons for improvement – domestic violence

- recognising periods of heightened risk and working with windows of opportunity
- incorporating knowledge about domestic violence dynamics and effects in risk assessment and intervention
- recognising risk where multiple violent partners are a recurring dynamic
- understanding the importance of language.

The review identifies patterns and trends in systems and practice and lessons for improved practice. Throughout the chapter case examples are used to illuminate the experience of children. These stories provide a compelling argument that child protection intervention needs to be informed by the best possible understanding of the dynamics and risks associated with domestic violence.

3.1 Domestic violence and child deaths

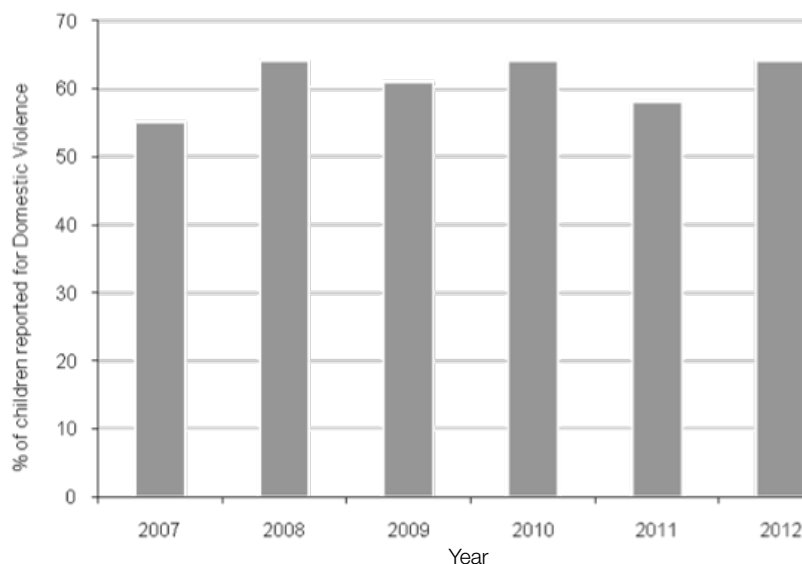
Between 2007 and 2012, 768 children known to Community Services died. Domestic violence was previously reported in 466 (61 percent) of these children's families. This section reports the findings of the comparison between the 466 children who died who were reported for domestic violence and the 302 children who died who were not reported for domestic violence.

3.1.1 Reports

The *Children and Young Persons (Care and Protection) Act 1998* was amended in 2000 to include domestic violence as a new risk of harm category. Since that time, domestic violence has been the most frequently reported risk in reports to Community Services. Between 2007 and 2012, the percentage of deceased children who had been reported with concerns about domestic violence has remained steady with an average of 61 percent (see Figure 12).

In January 2010, following a recommendation of the Wood Special Commission of Inquiry into Child Protection Services in New South Wales, the threshold for mandatory reporting was raised from 'risk of harm' to 'risk of significant harm' (ROSH)⁹². Domestic violence continued to be the primary reported risk for the families of children who died between 2010 and 2012. In 2010, domestic violence was reported in 64 percent of cases, in 2011 in 58 percent of cases, and in 2012, 64 percent of cases. Thus, raising the risk level did not impact on reports of domestic violence.

Figure 12: Children who died whose families had been reported for domestic violence, 2007 to 2012.



Source: Community Services, 2013

92. Wood, J 2008, *Report of Special Commission of Inquiry into Child Protection Services in NSW*, State of NSW.

Chapter 3: Lessons for improvement – domestic violence

Reported abuse types

Case analysis identified other reported abuse types in the 466 cases:

- 36 percent physical abuse
- 34 percent emotional abuse
- 30 percent supervisory neglect
- 29 percent physical neglect
- 23 percent medical neglect
- 19 percent sexual abuse

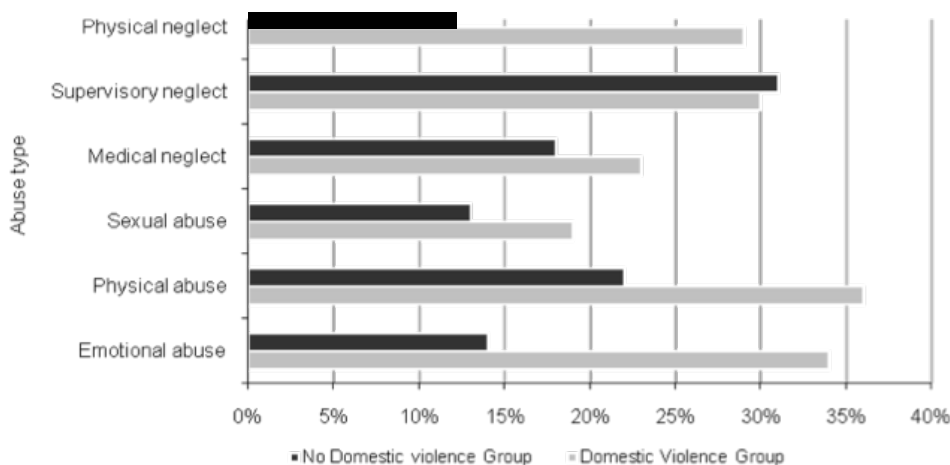
In comparison, the 302 children who died but who did not have a reported history of domestic violence had lower reported abuse types:

- 22 percent physical abuse
- 18 percent medical neglect
- 14 percent emotional abuse
- 13 percent sexual abuse
- 12 percent physical neglect.

These findings highlight how risk for children who experienced domestic violence was often compounded by higher levels of other co-existing abuse types. In particular, concern about emotional abuse, physical abuse, sexual abuse and physical neglect was reflected in the histories of the children whose families were reported for domestic violence. The Margolin *et al.* research is consistent with a growing body of international writing, which confirms

the overlap between domestic and family violence and other forms of child abuse^{93,94,95}. The authors found children living with domestic violence are not only more likely to experience coercive and controlling forms of discipline, they are also less likely to experience parenting that is sensitive, consistent and structured⁹⁶. Edleson suggests that perpetrators may be violent, intimidating or controlling toward children as a way of harming the victim, usually the mother⁹⁷. The research also suggests that victims of domestic violence can be violent to their children, sometimes as a reaction to the violence from their partners^{98,99}.

Figure 13: Comparison of co-existing abuse types for families reported/not reported for domestic violence.



Source: Community Services, 2013

93. Banks, D, Landsverk, J & Wang K 2008, 'Changing policy and practice in the child welfare system through collaborative efforts to identify and respond effectively to family violence', *Journal of Interpersonal Violence*, vol.23, no.7, pp. 903-937.

94. Stanley, J & Goddard, C 2002, *In the firing line: violence and power in child protection work*, Wiley and Sons, New York.

95. Laing, L 2004, Risk assessment in domestic violence, Australian Domestic Violence Clearinghouse Topic Paper, http://www.adfvc.unsw.edu.au/PDF%20files/risk_assessment.pdf

96. Margolin, G, Gordis, E, Medina, A & Oliver, P 2003, 'The co-occurrence of husband to wife aggression, family of origin aggression and child abuse potential in a community sample', *Journal of Interpersonal Violence*, vol.18, pp. 413-440.

97. Edleson, JL 2001, 'Studying the co-occurrence of child maltreatment and domestic violence in families', in SA Graham-Bermann & JL Edleson (ed.), *Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy*, American Psychological Association, Washington, DC.

98. Coohy, C (2004), 'Battered mothers who physically abuse their children', *Journal of Interpersonal Violence*, vol.19 no.4, pp. 943-952.

99. Knickerbocker, L, Heyman, R, Slep, A, Jouriles, E & McDonald, R (2007), *Co-occurrence of child and partner maltreatment: Definitions, prevalence, theory, and implications for assessment*, State University of New York, New York.

Chapter 3: Lessons for improvement – domestic violence

Reported parental risk factors

Domestic violence, parental substance misuse and mental health problems frequently go hand in hand, as is commonly reported in Australian and international research. Bromfield *et al.* (2010) found that families with multiple and complex problems, including violence, parental substance misuse and mental health problems, have become the primary client group of modern child protection systems. They assert that these problems often occur within a wider context of exclusion and disadvantage and, for many parents, their own experiences of trauma and victimisation¹⁰⁰.

The research points to an increased likelihood of people who experience domestic violence misusing substances as a form of self-medication, to relieve the effects of the violence, for example, pain, anxiety, isolation, guilt and shame.^{101,102}

Humphreys and Thiara examined the research evidence on the co-occurrence of domestic violence and parental mental health problems, concluding that there was a direct link between victims'

experience of domestic violence and heightened rates of depression, trauma symptoms, self-harm and/or attempted suicide. Humphreys and Thiara contend that these arise as "symptoms of abuse" for many victims¹⁰³.

The cases involving domestic violence reflect higher levels of reported parental mental health problems, substance misuse, poverty, transience and homelessness than the cases where domestic violence had not been reported:

- in 66 percent of cases parental substance abuse was reported
- in 40 percent of cases at least one parent was reported to experience mental health problems
- in 23 percent of cases families were reported to be in poverty
- in 22 percent of cases families were reported to be homeless
- in 21 percent of cases families were reported to be transient.

The families who had not been reported with concerns about domestic violence reflected lower levels of substance misuse, mental health problems, poverty, transience and homelessness:

- in 29 percent of cases parental substance abuse was reported
- in 19 percent of cases at least one parent was reported to experience mental health problems
- in 9 percent of cases families were reported to be in poverty
- in 9 percent of cases families were reported to be homeless.
- in 8 percent of cases families were reported to be transient.

These findings confirm the complexity of cases where domestic violence has been reported and the need for skilled and confident child protection intervention to address multiple risk issues. They also confirm the need to consider the risk of homelessness and transience for adult and child victims.

100. Bromfield, L, Lamont, A, Parker, R & Horsfall, B 2010, *Issues for the safety and wellbeing of children in families with multiple and complex problems*, Australian Institute of Family Studies, <http://www.aifs.gov.au/nch/pubs/issues/issues33/>

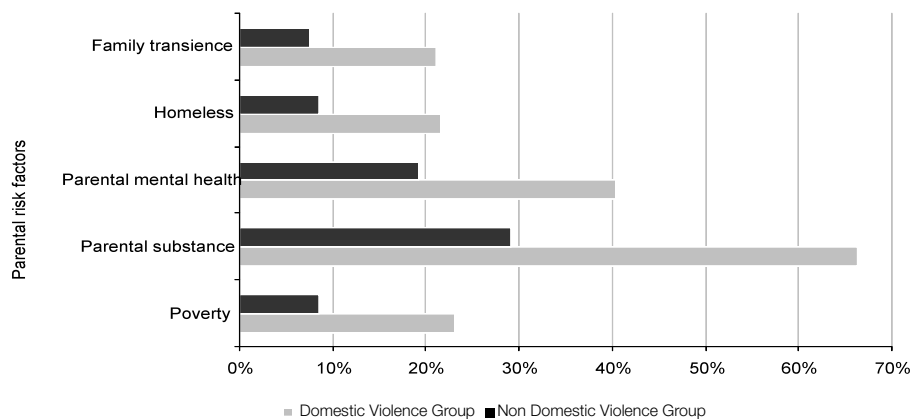
101. Chan, C 2005, *Alcohol issues in domestic violence*, Australian Domestic and Family Violence Clearinghouse Topic Paper 17, http://www.adfvc.unsw.edu.au/PDF%20files/Alcohol_Issues.pdf

102. Zubretsky, T 2002, 'Promising directions for helping chemically involved battered victims get safe and sober' in AR Roberts (ed.), *Handbook of Domestic Violence Intervention Strategies: Policies, Programs and Legal Remedies*, Oxford University Press, New York.

103. Humphreys, C & Thiara, R 2011, 'Mental health and domestic violence: I call it symptoms of abuse', *The British Journal of Social Work*, vol.34, pp. 209-226.

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Figure 14: Comparison of reported parental risk factors for families reported/not reported for domestic violence.



Source: Community Services, 2013

3.1.2 Characteristics of the children

When comparing the age, gender and Aboriginal and/or Torres Strait Islander status of the children¹⁰⁴ who had been reported with concerns about domestic violence with those who had not, differences in age and gender were minimal.

Of concern, is the considerable over-representation of Aboriginal and/or Torres Strait Islander children. One hundred and forty seven (32 percent) of the 466 children who had been reported with concerns about domestic violence were Aboriginal and/or Torres Strait Islander. In comparison, 44 (15 percent) of the 302 children who had not been reported with concerns about domestic violence

were Aboriginal and/or Torres Strait Islander. This reflects the extreme rate of violence against Aboriginal women who have been reported as victims of domestic violence, which is nearly six times that against all NSW women¹⁰⁵.

3.1.3 Circumstances of death

The circumstances of death of the children¹⁰⁶ were largely consistent in most categories regardless of whether the children had been reported with concerns about domestic violence.

Of note is that domestic violence was reported in the families of 21 percent of all infants who died of extreme prematurity between 2007 and 2012. This compares to 12 percent of families where concerns

about domestic violence had not been reported. This is notable in light of the link between premature birth and domestic violence and is further discussed in section 3.2.

The majority of children who were the victims of injuries suspected to be perpetrated by a parent or parent figure had a history of domestic violence. These cases are examined closely in the following section to determine the impact and relevance of a reported history of domestic violence.

Domestic violence and suspicious or inflicted injuries

Community Services' overall child deaths data highlights the comparatively small number of children who die from suspicious and/or inflicted injuries. These findings are consistent with research literature. The tragic circumstances in which these children die often attract significant media attention.

Twenty-five children¹⁰⁷ died between 2007 and 2012 as a result of suspicious injuries or injuries that were believed to be inflicted by a parent or parent figure. Eighteen of these children (72 percent) had been reported with concerns about domestic violence. The children who died as a result of suspicious or inflicted injuries in the CDCR sample had a higher rate of reported domestic violence than has been noted in other reviews about the fatal abuse of children. The *Trends in the Fatal Assault of Children in New South Wales 1996-2005* (NSW

104. Known to Community Services who died.

105. Ridley, John R & NSW Department of Aboriginal Affairs 2008, *Two Ways Together report on indicators 2007*, NSW Department of Aboriginal Affairs, Surry Hills, NSW.

106. Known to Community Services who died.

107. Known to Community Services who died.

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Child Death Review Team, 2008) report states that the presence of domestic violence could be definitively determined in the families of 50 percent of the children who died from non-accidental injuries inflicted by a parent or parent figure. This included cases of all children in NSW, not just those who were known to Community Services¹⁰⁸. It is possible that this group included cases where unreported domestic violence had occurred.

The link between domestic violence and child homicide is supported by research which shows that a history of domestic violence may be the single major precursor to child abuse and neglect fatalities¹⁰⁹. However, while a link can be established, the presence of domestic violence in the home is not a predictor that a child death will occur. Domestic violence features in many families that Community Services works with and, in the vast majority of cases, does not lead to child deaths.

The cases

Case analysis of the 18 children¹¹⁰ who died from suspicious injuries and/or injuries believed to be inflicted by a parent or carer indicates that, in eight (44 percent) of these cases, one or both parents had an intergenerational child protection history.

In six cases the child's stepfather¹¹¹ was charged with or convicted of the offences which resulted in the death. In one of these cases the mother was charged with

manslaughter. In a seventh case legal proceedings are ongoing but, on the basis of available evidence, it is considered likely that the stepfather was the perpetrator.

In a further two of the 18 cases the mother has been convicted of murder. In one of these two cases the father was also convicted of manslaughter. In the remaining cases, one mother has been charged with murder, one mother has been convicted for murder and the stepfather convicted of manslaughter, one mother has been charged with manslaughter and one mother took her own life after killing her two children.

Of the 18 cases, one father killed his three children in a homicide/suicide and in another case a father killed his child in the context of an assault on his wife.

Directly attributable

The death of a child would be considered directly attributable to domestic violence where the fatal assault of the child occurred in the context of the father's immediate or ongoing violence toward the mother. In two families domestic violence was considered to be a directly attributable factor associated with the deaths of four children. In one of the families, three children were killed by their father, who then committed suicide. The father had a history of serious physical violence towards the children's mother and had made previous threats to kill her. He was facing an imminent court date and possible

incarceration for a violent assault against the mother when he killed his children. Following the children's murder, the mother was quoted in the media as suggesting that she felt their father had killed them to punish her. This was a final act of violence.

In the other case a three-year-old child was killed in the context of an attempted murder of the mother.

The three-year-old child witnessed her father repeatedly punch her mother in the face. The child's mother ran from the family unit screaming for help from her neighbours. The father followed and stabbed her thirteen times before neighbours intervened. The father entered the family unit where the child was waiting and locked the doors. The father stabbed the child and himself repeatedly. The child died from her injuries; her father was charged with the murder of his child, and attempted murder of the mother.

One report about the child had been received more than two years before her death. The report stated that the child's father punched her mother in the face and the arm. The father had previously stabbed himself in the stomach a year earlier and possibly had an undiagnosed mental illness.

The review found that:

... although the child had a limited history, the father's possible mental health issues should have been a consideration when the report was received.

108. CDCR data captures 'reported' domestic violence which differs from the domestic violence being 'definitively determined'.

109. White, A & Jochelson, T 2005, *Fatal child maltreatment: key messages from the research*, NSW Community Services' Centre for Parenting and Research, Sydney.

110. Reported with concerns about domestic violence.

111. The term stepfather is used in this chapter to describe any male partner in the child's household.

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Strongly associated

In two families involving three children who died as a result of suspicious or inflicted injuries, domestic violence was identified as an entrenched issue in the family. These cases, such as the one below, involved the children being killed by their mothers. The case below demonstrates the often difficult scenario of assessing allegations by one parent about the other parent's care in the context of family law proceedings. This is discussed further on page 49.

Two children were killed by their mother who then committed suicide. The mother had written letters prior to the killing indicating that the father had threatened to kill her and blaming the father for her actions.

Community Services had received eleven reports in the two years leading up to the homicide/suicide. The frequency of reports escalated as proceedings in the Family Law Court progressed. Both parents made allegations about the other abusing the children, particularly the mother who alleged that her partner had threatened to kill her and her eldest child. It was also reported that the mother was physically and verbally assaulted by her partner.

The review found that:

... the children for many years had been exposed to domestic violence that had never been adequately assessed.

In the other case the mother fatally physically assaulted her child, who she said reminded her of the child's father, the perpetrator of frequent and severe sexual and physical violence toward her. The children in this family had experienced domestic violence that was severe, chronic, entrenched and perpetrated by at least three men who had over time been partners with their mother.

Associated

Domestic violence was an associated factor in seven cases where children died as a result of suspicious or inflicted injuries and the child's stepfather was charged, convicted or suspected to be the perpetrator. In these seven cases, domestic violence was considered an associated factor as a child in the family had been the subject of a report about domestic violence, or the child's mother later informed authorities that she had been subjected to abuse in the relationship or the mother had been subjected to domestic violence either in childhood or in previous relationships.

Common elements in the seven cases included:

- In all cases, the children's mother had recently begun a relationship with the stepfather. The average length of the relationship was five months.

- In five cases the family's accommodation was unstable. Four of the families had moved three or more times in the six months leading to the death.
- Children in six of the seven families had lived with violence toward their mother perpetrated by multiple violent partners. In all of these cases there was a pattern of serious and sustained domestic violence.
- Five of the seven mothers themselves had a known child protection history which included reports of domestic violence and physical abuse. Records reflect that none of the mothers experienced sexual assault and transience.
- In six cases the children had been reported with concerns about their mother's mental health and in five about their mother's substance misuse.

A picture emerges of young mothers parenting young children in often stressful, isolated and unstable circumstances while living with the effects of their own childhood trauma and sometimes with a series of violent partners. Research suggests that the psychological effects of domestic violence – such as the loss of self-confidence, emotional and physical exhaustion, depression, anxiety or substance misuse,¹¹² can undermine the capacity of victims to make good choices for their children.

112. Carter, LS, Weithorn, LA & Behrman, RE 1999, 'Domestic violence and Children: Analysis and recommendations', *Domestic Violence and Children*, vol.9, no.3, pp. 4-20.

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3.2 Practice themes

When mandatory reporting of domestic violence was introduced in NSW¹¹³, there was an overwhelming increase in reports, placing pressure on Community Services' capacity to respond. Unmet demand was considered during the 2008 Special Commission of Inquiry into Child Protection Services in New South Wales and the Keep Them Safe reforms which were subsequently introduced. These included strategies to offer earlier support to families from a range of agencies, including police. The cases considered as part of this review capture the period before and after the inquiry.

Key practice themes were identified in child death reviews undertaken in 466 cases¹¹⁴. Within this sample, 34 children from 30 families were the subject of intensive review¹¹⁵. These reviews provide rich and detailed information about the trends in systems and practice emerging from the wider sample. Five broad themes for learning emerged from the review:

- placing an equal focus on the impact of domestic violence on children and on assessing

the capacity of both parents to keep their children safe

- recognising periods of heightened risk and working with windows of opportunity
- incorporating knowledge about domestic violence dynamics and effects in risk assessment and intervention
- recognising risk where multiple violent partners are a recurring dynamic
- understanding the importance of language.

3.2.1 Getting the balance right – placing an equal focus on the impact of domestic violence on children and on assessing the capacity of both parents to keep their children safe

The common practice of focusing child protection intervention on the non-violent partner and failing to include the violent partner or ex-partner in assessment and intervention is widely discussed in the literature^{116,117,118}. Burke (1999) wrote about the tendency for statutory interventions to be gender biased, focusing on the mother as the primary carer and person responsible for providing

protection to the children¹¹⁹. She described this tendency as 'the invisible man syndrome'. Humphries (2007) considered the literature on child protection intervention in the context of domestic violence and used the phrase 'culpable women and invisible men' to describe the widely reported issue of 'mother blaming'¹²⁰.

Community Services' review of cases revealed that intervention with the families of the deceased children frequently involved focusing most attention on the non-violent partner. Intervention and assessment tended to focus less often on engaging with perpetrators and with children, or those who could provide information about the experiences of children.

Parents

In the 30 families where intensive review was conducted, it was observed that the casework response frequently involved engaging with the non-violent partner and included minimal or no contact with the perpetrator of the violence. There was often a focus on the non-violent parent's 'failure to protect' children and minimal exploration of the efforts made to keep them safe. Case plans

113. To date, NSW is one of only three (NSW, Western Australia and Tasmania) of the eight states and territories in Australia that incorporates exposure to domestic and family violence as reportable within child protection legislation (Special Commission of Inquiry into Child Protection Services in New South Wales, 2008).

114. Where available information about the circumstances of death and electronic records held by Community Services was considered.

115. Where information was taken from the electronic records, interviews with field staff, the child protection files and, where applicable, the out-of-home care files.

116. Burke, C 1999, 'Redressing the balance: child protection intervention in the context of domestic violence', in J Breckenridge and L Laing (ed.), *Challenging silence-innovative responses to sexual and domestic violence* (Studies in society, Sydney, NSW) Allen and Unwin, NSW.

117. Nixon KL, Tutty, LM, Weaver-Dunlop, G & Walsh CA 2007, 'Do good intentions beget good policy? A review of child protection policies to address intimate partner violence', *Children and Youth Services Review*, vol. 29, pp. 1469-1486.

118. Irwin, J, Waugh, F & Wilkinson, M 2002, *Domestic violence and child protection: a research report*, The Department of Social Work, Social Policy and Sociology, University of Sydney, Sydney.

119. Burke, 1999, op. cit.

120. Humphries, C 2007, *Domestic Violence and Child Protection: challenging directions for practice*, Issues Paper 13, Australian Domestic and Family Violence Clearinghouse, http://www.adfvc.unsw.edu.au/documents/IssuesPaper_13.pdf

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required the non-violent partner to take measures such as ‘stopping’ the violence in front of children, seeking or acting upon breaches of apprehended violence orders (AVOs) or excluding their partner from the home. These expectations are likely to have been intended to improve safety for children. It was the absence of supportive casework and corresponding work with the perpetrator to redress imbalances of power that was problematic.

In one family there were reports about substance misuse for both parents and severe violence perpetrated toward the mother by her partner, including information about his attempts to strangle her while repeatedly hitting her. On one occasion the mother was holding her daughter who was eight weeks old. Police reported that the mother had extensive bruising to her face and body and that the daughter also had facial bruising. A temporary AVO was in place.

Caseworkers spoke to the mother through her front screen door because she did not allow them inside her home. They persisted and discussed the seriousness of drug and alcohol misuse and domestic violence. The mother did not intend to pursue an AVO and did not want her partner to be charged. She was referred to a family support service and it was documented that the child was safe as the mother had undertaken not to allow the father

near her or the child when he had been drinking.

The review found that:

... it appeared that this mother had inherited the sole responsibility of stopping further violence and that the father’s violence remained unchallenged. Given the pattern and extreme level of violence it was unlikely that the mother had sufficient power or influence to ‘not allow the father to be present/or around the child when he has been drinking’.

Research backs up the reality that victims are often anxious and reluctant to engage with police and child protection services as they are concerned that they will not receive support and will have their children removed^{121,122,123}. This increases the importance of a respectful and non-judgemental approach to working with the non-violent parent and one that really understands what it is like to live in fear.

Intervention only occasionally included strategies aimed at engaging men to take responsibility for their violent, coercive and controlling behaviour and consider its impact on their partner or ex-partner and children. This is a practice challenge that has been recognised by Community Services, leading to significant strategies aimed at enhancing skills in working with men who use violence¹²⁴ and assisting them to take responsibility.

Reports detailed severe domestic violence and death threats made toward one mother. Police records confirm that the father was abusive, aggressive, violent and controlling toward both the mother and the children. He was charged, convicted and incarcerated on several occasions.

The review found:

... practice strengths were that the case was allocated for a nine-month period during which the caseworker was able to identify the domestic violence as posing a serious risk to the children and to work with the mother to support her in addressing her own mental health needs. However, during the period of allocation the father was never interviewed and held to account or asked to address his violence.

Positively, in the following case as with many others noted in the wider sample of 466 cases, the response of Community Services’ staff encouraged and required the perpetrator to take responsibility for his violent, coercive and controlling behaviour at the same time as allowing the children in the family to remain in their own home.

In one family where a child died from complications associated with a chest infection numerous reports were received describing violence towards the mother by the father. One report described the father threatening to physically assault the

121. Davies, L & Krane, J 2006, ‘Collaborate with caution: Protecting children, helping Mothers’, *Critical Social Policy*, vol.26, no.2, pp. 412-425.

122. Radford, L & Hester, M 2006, *Mothering Through Domestic Violence*, Jessica Kingsley Publishers, London.

123. Burke, 1999, op. cit.

124. In 2012, the Community Services Clinical Issues Unit finalised a training package entitled *Working with men who use violence in the home*. This followed an independent study in 2010 that benchmarked caseworker skills, knowledge and development needs in casework with clients where there are clinical issues. The package was delivered throughout the state by casework specialists.

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mother with a baseball bat that he had placed nails into. Another report described the children screaming and crying in distress as their mother was being assaulted.

The review found that:

... the caseworker addressed the core issues of domestic violence and the lack of family supports. The approach was holistic in that it included the perpetrator of the violence who was assisted with accommodation to remain away from the family and minimise the risk to the children while interventions were being put in place. The caseworker had up-front conversations with him about the impact of his violence on his partner and children and as well as taking out an AVO and referring him to a program for men who use violence.

Barriers to including the perpetrator in assessment

Lack of inclusion of the perpetrator in assessment and intervention can be linked to locating and engaging them, fear for worker safety, and availability of resources for referral. Stanley and Goddard say that child protection workers can become gripped with the same fear that immobilises victims and children, resulting in them either avoiding or colluding with the perpetrator¹²⁵. Sustained support is required to develop the skills and confidence required for such intervention. In a largely female workforce this is particularly pertinent. It may be necessary for staff to request the support of police in cases where there are concerns about worker safety.

Relevant reforms and practice developments

The Community Services' Clinical Issues Unit in the Office of the Senior Practitioner has developed extensive training and a comprehensive website for staff with information on strategies to work with men to get them to acknowledge responsibility for their violent and controlling behaviour and the effect it has on their partner and children.

In 2012, the NSW Government introduced minimum standards for men's domestic violence behaviour change programs. The objective of the minimum standards is to ensure that all programs in NSW reflect good practice and are safe and effective in changing the behaviour of perpetrators of domestic violence. While there is room for variation in the methods and approaches adopted by program providers, the minimum standards set benchmarks that apply to all programs. Both government and non-government providers of domestic violence behaviour change programs have been assessed against the standards, and compliant programs have been registered for a period of two years from January 2013.

In August 2013, the Men's Behaviour Change Network was established to advise on effective ways of working with men to reduce domestic violence. This body will help by supporting the programs that support men who use violence to change their attitudes and behaviour.

Practice guidance

Working with perpetrators

Men who use violence and control are often adept at placing responsibility for their actions on others, particularly their partners. It is important that workers hold men accountable for their behaviour and its impacts on the children. This requires skilful casework and support.

Work undertaken with perpetrators must be informed by the outcome of worker safety assessments to identify risks and provide guidance on safety strategies.

Use statutory leverage to develop a case plan designed to keep the perpetrator's role in focus and 'under the spotlight'. Highlighting the experience of children can be used as one strategy to assist perpetrators to consider the impact of their violent and controlling behaviour.

Working with non-violent partners

Protective intervention to increase safety for children requires caseworkers to plan interventions to support and protect the non-violent partner. There is a delicate balance here, as women need trusting relationships but are often fearful that if they admit the violence and intimidation they are living with they will lose their children.

Casework needs to balance respectful use of authority with compassion. A quality intervention will acknowledge the dilemma women face in being honest, but will keep a focus on immediate, medium and long-term safety for

125. Stanley & Goddard, 2002, op. cit.

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her and her children. Practical considerations such as finances and accommodation as well as counselling and other support needs for the mother and her children should be discussed. It will also involve regular re-assessment to consider any changes needed.

Understanding the frequency, pattern and severity of domestic violence and considering the effects of the violence on mothering and on the mother-child relationship is essential. Acknowledging, valuing and supporting attempts to parent in the face of adversity convey respect and compassion and will assist in strengthening and rebuilding the mother's relationship with her children.

Children and young people

The infrequent inclusion of children or of those who may be able to give some insight into their experience was evident in the cases reviewed. While the capacity to allocate cases remains an issue, many of the cases where casework was undertaken did not involve contact or interviews with children. The review found it was evident that intervention in most of these cases did not involve children and assessments did not articulate the experience of children with any depth. Interviews with children were usually motivated by the occurrence of actual physical harm to the children rather than consideration of their emotional wellbeing. Talking to children or those outside of their immediate family who can provide an account about their experiences helps to form a much more accurate picture of risk and safety.

One child was first reported as being at risk from domestic violence perpetrated toward her mother by her father when she was four months old. Her parents separated when she was approximately one year old and her mother began a new relationship and had three more children.

The stepfather was violent toward her mother including serious physical and verbal abuse, threats of harm and intimidation. Many AVOs were granted and the stepfather was incarcerated several times for breaching AVOs and associated bail conditions.

The review found that:

... the casework response did not include an assessment of the ongoing pattern of violence and its impact on parenting or on the children. Only two of the five children in the family were spoken with (on two occasions) despite an increase in the frequency and severity of the violence.

The stepfather was interviewed once despite being the perpetrator of violence for more than 13 years. The mother was interviewed nine times. The case also illustrated the over reliance on police intervention, AVOs and incarcerations as a protective measure in the absence of other actions taken to assess and support parenting capacity and reduce risk.

In the review of another case it was found that:

... after the death of a sibling, this child was interviewed. The child described the violence with which the family had been living. There had been many field visits and at no time had the children been spoken

with. It is impossible to hypothesise about whether interviewing the children in this family earlier may have had an influence on the outcome of the case. It provides a valuable reminder to make every effort to speak to children.

Reviews also highlight the critical importance of speaking to extended family members and others who may be able to give some insight into the experience of children.

One young child died as a result of inflicted injuries. There had been reports about suspicious and unexplained injuries for all children in the family. A complicating factor was that medical experts assessed that the children's injuries were not the result of abuse and that plausible explanations could be provided.

The review found that:

... contact with extended family after the death provided critical information about risk. Greater engagement with extended family would have provided opportunities to understand the experiences of the children through the eyes of the family. The value of medical evidence may then have been analysed and evaluated alongside the broader picture of risk, including information known by extended family members.

Relevant reforms and practice developments

The adequacy of focus on children in assessments is a practice issue that has been given attention across Community Services. Strategies to redress this include initiatives aimed to promote caseworkers spending more time in direct work with families by reduction in the administrative burden, inclusion

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in learning initiatives and use of enhanced assessment tools. With the introduction of the SARA tool¹²⁶, caseworkers are now required to indicate whether the child/children were observed or interviewed.

Practice guidance

Finding ways of speaking (and listening) to children about domestic violence is essential. This is particularly important if children are displaying any of the symptoms associated with living with violence and abuse. These symptoms may include physical, emotional, learning, behavioural or developmental problems which can often be misdiagnosed as illness, permanent learning or attention difficulties or naughtiness.

Children living with domestic violence are often quite keen to discuss these experiences. They can also be reluctant to talk about their experiences because they are fearful about further violence to their mother, themselves, their siblings or other family members. Children may worry about being 'taken away', which will be particularly relevant in the many cases where threats of this type are made by the perpetrator. In cases where the perpetrator is their natural parent, children may also be protective of

the perpetrator or fearful that they will be incarcerated.

Talking to children about their experiences helps to form a picture of risk. Understanding the violence through the child's eyes can also be an important motivator for the parent to change. Children need safety as the first priority. Children also need opportunities to make sense of what has happened through individual safety planning, counselling, group work, play therapy and life story work. Talking about their experiences will help them make sense of what has happened and not blame themselves.

3.2.2 Recognising and working with periods of heightened risk and windows of opportunity

There are times when risk to children in families where there is domestic violence is heightened, such as during the prenatal period or when parents or carers separate. At other times there will be a greater window of opportunity to work with families, such as when a perpetrator is incarcerated or an AVO is in place. The following provide critical periods for achieving change.

Prenatal period

The frequency and severity of violence is higher when women

are pregnant^{127,128}. A study conducted by the Australian Bureau of Statistics (ABS, 2006) found that, amongst women who had experienced violence by a previous partner, 46 percent reported that this occurred when they were pregnant and 20 percent experienced violence for the first time when they were pregnant. Similar findings emerged from a 2008 Australian survey of 400 pregnant women, in which 27 percent reported that they had experienced domestic violence during pregnancy¹²⁹. Pregnant women may be less independent, less able to focus exclusively on the needs of their partner and more physically vulnerable than other women. A violent and controlling partner may be in an even greater position of physical and psychological power when a woman is carrying his baby.

The links between domestic violence during pregnancy and negative outcomes for infants, including miscarriage, prematurity and low birth weight, have been widely discussed in the research^{130,131}. Domestic violence can also pose other risks for infants such as impacting on prenatal care and exacerbating parental substance abuse and mental health issues, which are also related to significant

126. The SDM process structures decisions at several key points in case processing through use of assessment tools and decision guidelines. SDM tools include: the mandatory reporter guide for use by all mandatory reporters across NSW, SDM screening and response priority tools, and safety and risk assessment (SARA) tools.

127. Burch, RL & Gallup, GG 2004, 'Pregnancy as a stimulus for domestic violence', *Journal of Family Violence*, vol.19, no.4, pp. 243-47.

128. Martin, SL, Harris-Britt, A, Li, Y 2004, 'Changes in intimate partner violence during pregnancy', *Journal of Family Violence*, vol.19, no.4, pp. 201-210.

129. Walsh, D 2008, 'The hidden experience of violence during pregnancy: A study of 400 pregnant Australian women', *Australian Journal of Primary Health*, vol.14, no.1, pp. 97-105.

130. Taft, A, Watson, L & Lee, C 2004, 'Violence against young Australian women and association with reproductive events: a cross-sectional analysis of a national population sample', *Australian and New Zealand Journal of Public Health*, vol.28, pp. 324-329.

131. Humphreys, C, Houghton, C & Ellis, J 2008, *Literature review: Better outcomes for children and young people experiencing domestic abuse – Directions for good practice*, The Scottish Government, Edinburgh.

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risks for babies in the ante- and post-natal period.

The CDCR review found that domestic violence was present in the families of nearly a quarter (21 percent) of the infants who died of extreme prematurity between 2007 and 2012. The research literature suggests a possible link between domestic violence and premature births. For example, a study conducted in 2002¹³² found that domestic violence during pregnancy was associated with numerous health problems, including a higher likelihood of premature birth.

An infant was born at five months gestation and died shortly after her birth. Although the cause of the premature birth was unclear, a prenatal report received the day before her death stated that the father had punched the mother in the head. The mother had fallen and begun leaking amniotic fluid. The report also stated that the mother had disclosed chronic physical violence from the father. Shortly after the infant's death, the mother became pregnant again. She miscarried at nine weeks gestation following another reported assault by her partner.

Practice guidance

Prenatal support for at-risk pregnant women through referrals to health services, early intervention and domestic violence support services can improve outcomes for women and for their newborn babies.

Relevant reforms and practice developments

Community Services' *Responding to Pre-Natal Reports* policy¹³³ was implemented state-wide from 2010. It aims to increase the likelihood that adequate supports are in place for the expectant mother, such as health and police services.

The Clinical Issues Unit provides expert advice to staff, helping them to develop their knowledge about working with domestic violence. *Practice First*, a service delivery model being trialled by Community Services, is described in further detail in Chapter 4. The group supervision operating in Practice First includes Community Services' psychologists and child protection casework specialists who participate to share their expertise.

Separation

Many Australian and international studies highlight that mothers and children experience domestic violence during and after separation^{134,135,136,137}. A recent Australian report cites the 2011 study by Humphreys and Thiara of 161 Australian women who had experienced domestic violence and ended their relationships. Seventy-six percent of these women experienced post-separation violence and reported that child contact arrangements '*... provided the most consistent vulnerability to post-separation violence and undermined relocation as a safety strategy*'¹³⁸.

The CDCR review revealed a degree of uncertainty among caseworkers about the best approach to working with separated families. The following themes were observed.

Seeing separation only as a protective factor

Where there was reference to separation (and in many cases, incarceration) there was a strong tendency to record the separation

132. A study of 202 women who were pregnant or in the post-partum period (Huth, BA, Levendosky, A & Bogat, A 2002, 'The effects of domestic violence during pregnancy on maternal and infant health', *Violence and Victims*, vol. 17, no.2, pp. 169-185).

133. Endorsed by Community Services and NSW Health.

134. Humphreys, C & Thiara, RK 2011, 'Neither justice nor protection: women's experiences of post-separation violence', *Journal of Social Welfare and Family Law*, vol.25, issue 3, pp. 195-214.

135. Bagshaw, D, Brown, T, Wendt, S, Campbell, A, McInnes, E, Tinning, B, Batagol, B, Sifris, A, Tyson, D, Baker, J & Fernandez Arias, P 2011, 'The effect of family violence on post-separation parenting arrangements: the experiences and views of children and adults from families who separated post-1995 and post-2006', *Family Matters*, vol.86, pp. 49-61.

136. Laing, L 2010, *No way to live, women's experiences of negotiating the family law system in the context of domestic violence*, Faculty of Education and Social Work, University of Sydney, <http://ses.library.usyd.edu.au/bitstream/2123/6255/1/No%20way%20to%20live%20final%20report.pdf>

137. Lodge, J & Alexander, M 2010, *Views of adolescents in separated families - A study of adolescents' experiences after the 2006 reforms to the family law system*, Australian Institute of Family Studies, Melbourne.

138. Benevolent Society and the Australian and Domestic Violence Clearinghouse 2011, *The impact of domestic violence on children: a literature review*, <http://www.adfvc.unsw.edu.au/documents/ImpactofDVonChildren.pdf>

Chapter 3: Lessons for improvement – domestic violence

(or incarceration) as a protective factor without further analysis of the circumstances, particularly if an AVO was in place. This practice did not reflect an understanding of the potential for: post- separation violence (including when an AVO is in place), reconciliation, or of the ongoing harmful consequences of domestic violence and other reported risk issues.

Missing opportunities to work with families beyond separation

Assessments were not often expanded to consider other reported risk factors and the ability of each parent to provide safe and adequate care after separation. This was the case even when the reported risk factors extended well beyond concern about domestic violence and, in some cases, where there was a clear picture of violent behaviour directed toward children. It was sometimes also the case when the perpetrator was the biological parent of at least one child in the family and the ongoing risk posed to children was not considered in the context of shared care arrangements. This was highlighted in the review of the following case.

The children lived with neglect and serious physical abuse in the context of parental substance abuse, the chronic mental health condition of their father and his ongoing violent, coercive and controlling behaviour toward their mother.

The review found that:

... intervention frequently focussed on the 'violent event' yet when it

was established that the father was not residing in the home there was no further assessment. There was evidence on file of contact with the mother, but no records suggest that formal interviews assessing all presenting risk factors including the reported domestic violence perpetrated by the father and the parents' drug and alcohol misuse, occurred. In addition, there was no assessment of the ongoing pattern of violence and its effect on the family or its impact on the mother's wellbeing and capacity to parent.

Practice guidance

Separation, or incarceration of the perpetrator, can be good windows of opportunity to work with families to build support and safety. The non-violent partner may be more able to further explore the impact of domestic violence and other identified risk issues, their children's well-being and to accept support. It is also a good time to explore the ongoing effects of domestic violence on the mother, the children and their relationship.

Be aware that even after separation the effects of domestic violence and associated risks can continue to impact on the mother, her parenting and her children long after the relationship has ended.

Understanding the interface with the Family Law Courts¹³⁹

Only a small number of Community Services' cases included information about the Family Law Courts (FLC). Practice in those cases indicated that there was an uncertainty about how or when to become involved in cases with FLC proceedings

and a misunderstanding about the different roles of the FLC and the Children's Court. Practitioners in the focus groups reported that, with the pressure to allocate cases, the fact that a case was in the FLC could build a rationale for closure because a greater degree of protection is likely as 'somebody is looking at it'. Practitioners suggested that this sometimes extended to advising families to involve the FLC in the hope that children would receive a level of associated protection owing to the requirement for courts to make reports if concerns are held.

Nearly 100 reports on one family of four children detailed concerns about chronic and serious parental mental health issues, drug and alcohol abuse, serious domestic violence and poor parenting skills. Chronic neglect was a significant feature of this case and allegations of physical and sexual abuse had been made for one child.

Over a two-year period following separation during which the violence toward the mother continued, numerous reports were received with concerns that the older children were at risk during contact with their father because of his drug misuse and violence. There were reports of physical assaults of the children. Community Services understood that contact was as a result of interim orders made in the FLC.

Of concern, the review found that:

... in response to this information, the mother was regularly advised by casework staff to pursue her concerns with the FLC and to apply

139. In April 2013, the Federal Magistrates Court of Australia, which includes the Family Law Court, was re-named the Federal Circuit Court of Australia.

Chapter 3: Lessons for improvement – domestic violence

for an AVO, to which she often replied that she was too fearful to take any legal action because the father was 'very violent and unpredictable'. The mother also told caseworkers that she was concerned about applying for an order that the child live with her due to concerns that the father would get an order that the rest of the children live with him. There was no further follow up with the mother about whether she did approach the FLC. The records do not reflect that there was any referral to Domestic or Family Violence Services for follow up. This would have provided support and guidance to the mother and children during separation, a recognised period of heightened risk.

In their 2010 study of the experience of women in the NSW family law system, Laing identified the reluctance of statutory child protection services to become or remain involved when the context of parental separation became known¹⁴⁰. She contends that a consequence of statutory child protection services referring parents experiencing serious violence to the Family Court is the risk that child safety moves to the realm of private law, which depends on the financial and emotional resources of the non-violent partner¹⁴¹.

Practice guidance

Community Services has clear policies and practice procedures on the appropriate use of the Children's Court and Family Law Courts. The primary message is that where there are child protection concerns and proceedings have not begun in the Family Court or Federal Circuit Court, it is advisable to suggest matters are heard in the Children's Court. Where proceedings are underway in the Family Court or Federal Magistrates Court, it is important that Community Services' respond to requests for information and notify those jurisdictions about risk issues and where considered appropriate, intervene in those proceedings.

3.2.3 Incorporating knowledge about domestic violence dynamics and effects to enhance risk assessment and intervention

There is a risk that assessment and intervention can focus on a single issue or problem and exclude important information. The challenge is to keep in mind the impact of all of the risk issues on children and on the way domestic violence interacts with other risk factors.

The review revealed that the strong focus on gathering information about 'incidents' from agencies, such as police and health, to

confirm reported details frequently led the focus away from considering other very significant concerns and from an appreciation of the difficulties of parenting while living with domestic violence. This tendency to focus on incidents obscured historical information and appeared to undermine the capacity of staff to think more holistically. It also meant that the picture of cumulative harm to children got lost.

In the 30 cases¹⁴² it was observed that the focus of assessment (and subsequent intervention) was often placed on parental substance misuse, mental health problems or other variables such as home hygiene or the behaviour of children. In these cases, assessment failed to target the domestic violence and the possibility that it may be linked to or exacerbate the other risk factors. In two of the three focus groups practitioners thought that the tendency to focus on substance misuse or mental health happens because these are seen to be 'more treatable' than domestic violence.

The importance of a case plan including strategies to address the other risks is illustrated in the following case of suicide.

Reports about and accounts from the children painted a concerning picture of neglect and serious physical abuse in the context of parental substance misuse.

140. Laing, L (2010), op. cit.

141. Ibid.

142. Where an intensive child death review was undertaken.

Chapter 3: Lessons for improvement – domestic violence

Domestic violence was reported to be an almost daily occurrence. The perpetrator of the abuse had been arrested, charged and incarcerated for the offences. He had also been scheduled to a mental health facility for treatment a number of times. The case plan identified many tasks including: assisting with housing, financial assistance, arranging bus passes for the children to travel to school, supporting the mother to link up with a medical service for the children's health and psychological needs and supporting her to maintain contact with services.

The review found that:

... the case plan treated the symptoms, rather than considering the underlying risk issues associated with the violence and parental mental health concerns. The review also found that there was no reference to the father, the perpetrator of domestic violence over many years.

Alternately, there were examples where the focus was placed on domestic violence and other risk factors and consideration of parenting capacity were missed.

Reports included information about risk associated with the mother's multiple violent partners, substance misuse, poor mental health, inadequate supervision and pattern of leaving the young child to be cared for by acquaintances.

The review found that:

... the strong focus on following up to gather information about reports of domestic violence was positive.

However, it was not accompanied by talking to the mother to understand her experiences of physical, psychological and emotional abuse and to assess how this impacted on her parenting and on the other risk factors. There was a reliance on implementing a static case plan to address domestic violence despite the other risk factors.

There were many cases where Community Services' staff clearly examined the impact of domestic violence amidst information about physical and sexual abuse and parental mental health concerns to achieve a comprehensive assessment for all of the children in the family. This is demonstrated in the following case about a sibling group of five children.

Reported concerns about the five children included parental mental health issues, domestic violence toward the mother by multiple partners, sexual assault of the oldest sibling by the mother's current and previous partners and physical abuse of another sibling by one of the mother's previous partners.

The review found that:

... extensive information was gathered from numerous sources and the response was thorough in its examination of the recent concerns and the entire child protection history for the children. The assessment carefully considered the impact of the identified issues on all of the children and clearly defined the concerns into a case plan.

Practice guidance

A holistic assessment will consider the domestic violence among the other concerns, the impact of the violence on the health and wellbeing of the non-violent partner and on parenting.

The consultants in the Clinical Issues Unit are available to assist with risk assessment and case planning. They can provide expert advice on the interaction of domestic violence with other parental risk factors and the impact on children and parenting. They can help explore ways to encourage women to talk about what is happening.

3.2.4 Recognising risk when multiple violent partners are a recurring dynamic

Many studies have revealed that significant numbers of women living with violence in their current relationship have also done so previously. A 2009 comparative study in America indicates that rates ranging between 40 percent and 56 percent of women experiencing domestic abuse have experienced at least one previous violent relationship¹⁴³. Relevant also is that the literature highlights that much of the harm associated with domestic violence is due to multiple victimisations¹⁴⁴.

Multiple violent partners were observed as a feature in many of the cases. Practitioners in focus groups noted that this is frequently observed in their everyday work. Practitioners commented on the challenges of 'keeping up' with who

143. Alexander, PC 2009, 'Childhood trauma, attachment, and abuse by multiple partners', *Psychological Trauma*, vol.1, pp. 78-88.

144. Coolidge, FL & Anderson, LW 2002, 'Personality profiles of women in multiple abusive relationships', *Journal of Family Violence*, vol.17, no.2, pp. 117-131.

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is residing in the household given how swiftly new partners can move in and also because of violent men 'moving family to family'.

The intensive review of 30 cases found that:

- in 18 cases there was evidence that children had experienced domestic violence toward their mothers by two or more partners
- seven of these cases involved three or more violent partners.

Understanding that victims may be subject to domestic violence and abuse by more than one partner was not often recognised in the assessment. This is important in understanding the experience of women and children. There was a tendency to 'start again' when a new partner entered a household without recognising the pattern whereby victims may be subject to domestic violence perpetrated by a new partner, and without conducting background checks and taking steps to understand the role the new partner may play in caring for children.

A one-year-old child died as a result of non-accidental injuries in circumstances which gave rise to the suspicion that the injuries were caused by the mother's defacto partner. Reports consistently raised concerns that the child was being exposed to domestic violence perpetrated by different partners toward her mother. The person likely

to have fatally injured the child was the fifth partner who was known to be violent toward the mother.

The review found that:

... at points throughout the case assessment identified many of the risk issues and involved a strong response in which casework staff tackled some very difficult issues. What was not reflected in the records was an understanding of the pattern of domestic violence and discussion about this child's experience of living with violence toward her mother by multiple people. Consideration of this pattern would have provided a much clearer picture of risk and of the potential that the mother's new partner would also be a perpetrator of domestic violence and abuse. The assessment would also have benefitted from an exploration of the impact of domestic violence on the mother, her parenting capacity and the support she may need to nurture and protect her child.

3.2.5 Understanding the importance of language

The capacity of child protection systems nationally and internationally to adequately capture and record the experience of children affected by domestic violence is widely discussed in the literature^{145,146,147}. Language in common use in society frequently either minimises the severity and/or impact of domestic violence, or suggests that domestic violence

that does not involve physical violence is less serious or has less impact. Such language is dominant not only in the child protection sector, but is also used by a range of other professionals and the broader community.

Lamb (1991) analysed articles in 11 professional journals across five disciplines to consider descriptions of domestic violence. She concluded that frequently the terms used to describe domestic violence did not make clear who was violent and who was the victim. Lamb described this as "acts without agents" where there is no reference to who is perpetrating the behaviour and who is thereby responsible for the abuse¹⁴⁸. The relevance of this in terms of assessing the impact of domestic violence on children is that it can minimise the violence, obscure who is doing what to whom and subsequently what the risks are for the children.

Frequent use of inaccurate or inadequate language was noted in Community Services' review and was observed in three main areas.

Describing the experience for children

Common use of the terms 'witnessed' or 'exposed to' domestic violence was found. In the absence of further detail, these descriptors did not capture the child's experience or consideration of a range of potential risks. It did not demonstrate an understanding

145. Bedi, G & Goddard, C 2007, 'Intimate partner violence: what are the impacts on children?', *Australian Psychologist*, vol.42, no.1, pp. 66-77.

146. Laing, L 2000, *Children, young people and domestic violence*, Australian Domestic and Family Violence Clearinghouse, Issues Paper 2, The University of New South Wales, Sydney.

147. Humphries, C 2007, *Domestic Violence and Child Protection: challenging directions for practice*, Issues Paper 13, Australian Domestic and Family Violence Clearinghouse, http://www.adfvc.unsw.edu.au/documents/IssuesPaper_13.pdf

148. Lamb, S 1991, 'Acts without agents: an analysis of linguistic avoidance in journal articles and men who batter victims', *American Journal of Orthopsychiatry*, vol.61, pp. 250-257.

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of the multiple impacts of domestic violence on children, and that they will experience the effects of domestic violence even when they do not directly observe it.

Capturing an accurate picture of the violence

Assessment records in many of the cases included terms such as 'argument', 'a domestic', 'a bit of pushing and shoving' and 'a verbal' to describe violence, when there were clear indicators that serious assaults had occurred. Inaccurate language was used to describe cases where assault occurred in the context of a pattern of abusive behaviours and attitudes that escalated over time. This is likely to have contributed to an underestimation of the severity of the domestic violence and lack of understanding about the pattern and impact.

Naming the responsible party

Violence was often articulated as being in the context of 'violent relationships', 'domestic disputes' or described as 'violence between the parents'. This is despite many instances where the evidence (often police and health records) confirmed that criminal charges had been laid against the perpetrator and victims had received medical treatment. These descriptors were inappropriately used in cases where there was a clear pattern of domestic violence and control toward victims by their partners or ex-partners, and a lack of information about violence directed at the perpetrator which would support a description of mutual violence. The review below was perhaps the most striking case in

which language was misleading and unhelpful in depicting an accurate picture.

The three children lived with chronic and severe domestic violence perpetrated by the father toward the mother. The mother suffered significant injuries on many occasions. The children and their mother were regularly reported to flee their home to escape violence. The perpetrator was also extremely violent and terribly cruel to the children.

The review found that:

... the reports about domestic violence throughout the history refer to 'violence between the parents' and to the mother as being in a 'violent relationship'. Language in corresponding assessment records suggested a judgement that the mother was responsible for her children becoming homeless, rather than allocating responsibility to the father and acknowledging the mother's attempts to increase safety for her children by leaving the violent situation – and her home.

Practice guidance

Spell out the frequency, severity and nature of the violence, including information about who did what to whom, the consequences for the child and on the capacity of both parents to nurture, care for and protect their children. This will support informed assessments and sounder decision-making.

Relevant reforms and practice developments

Practitioners in focus groups highlighted the usefulness of the SARA tool, noting improvements in considering and recording the experience of children since its implementation.

The *New Partners and New Household Members* casework practice tool, introduced in August 2012, provides practitioners with different strategies which they can employ when assessing the safety of children when it is suspected/ reported that the composition of their household has changed.

One of the principles of practice underpinning the *Practice First* model is about recognising the powerful impact of language. Language influences the way practitioners think about, talk about, understand and work with families. Language is also critically important when describing domestic violence. The way violence is described directly influences the thinking about the seriousness of the situation and the way assessment of risk is approached. Language is also important in establishing a precise understanding of who is doing what to whom and therefore how to address this.

Chapter 3: Lessons for improvement – domestic violence

3.3 Conclusion

As highlighted earlier, while most of the deaths were not a direct result of domestic violence, the violent, coercive and controlling behaviour and its effects were highly significant and in some cases critical factors. The standout message from the review is the importance of practice being informed by an in depth understanding of the dynamics associated with domestic violence, and how this impacts on parenting and the safety and wellbeing of children.

The review highlights that practitioners need to ensure a balanced response that holds the perpetrators of violence accountable for their actions, assesses the capacity of both parents to keep their children safe, and achieves the safety of children and mothers. This approach requires knowledge, skill, time, curiosity, patience and

understanding and can only be developed by building honest, trusting and compassionate relationships.

This chapter also highlights that working with families experiencing domestic violence, often with accompanying trauma-related substance misuse and mental health issues, can be challenging and complex.

Chapter 4 of this report details initiatives to support children and young people experiencing domestic violence. These include specific domestic and family violence programs, the 24-hour *NSW Domestic Violence Line*, and enhanced clinical support, training and resources for frontline staff managing cases where domestic violence is a risk to the safety and/or wellbeing of children and young people.

Chapter 4: Progress in child protection reform

Chapter overview

The NSW Government is continuing to reform the child protection system to better support vulnerable children, young people and families. At the centre of these changes is a greater focus on increasing caseworker capacity, early intervention and the importance of working more closely with the non-government sector than ever before.

Key actions of the reform program include:

- seeing more families earlier, better targeting early intervention, and working with families and communities to change so that where possible children can stay safely at home
- seeking permanency for children in care – making decisions quickly about a home for life and focusing on open adoption for children who cannot live safely at home or with extended family
- doing better for vulnerable adolescents – getting policies and programs right and encouraging innovative new approaches for this age group
- localising the service system – harnessing the capacity of community and government partners to deliver local services to the most vulnerable.
- Transition out-of-home care to the non-government sector as recommended by Justice Wood.

This chapter considers progress of major changes and new initiatives in Community Services since the 2011 Child Deaths Annual Report.

Also outlined here is the important work being done to support children and young people experiencing domestic violence – a particularly vulnerable group identified in chapter three.

Chapter 4: Progress in child protection reform

4.1 The reform agenda

The NSW Government is committed to improving services and lives for vulnerable children, young people and their families through an effective, integrated and contemporary child protection system. More simply, the system is being shaken up to put children and families, instead of systems and programs, at the centre of all decisions.

Changes have been made to reduce reliance on the statutory system and “better protect the most vulnerable members of our community and break the cycle of disadvantage.” (Goal 13, *NSW 2021 State Plan*)

4.2 Community Services’ reforms in progress

Improvements for children, young people and families can already be demonstrated in the following three areas:

Community Services now co-delivers (with our partner government and non-government agencies) integrated child protection services from early intervention to leaving out of home care. Government support is enabling the non-government sector to grow their capacity to deliver services and their capabilities and expertise.

Community Services’ reforms are guided by four overarching goals:

- fewer children and young people are vulnerable to abuse and neglect
- children and young people at risk of significant harm are safer

- children and young people in out of home care have a better future
- a capable organisation and service system.

4.2.1 Fewer children and young people are vulnerable to abuse and neglect

Early intervention

The NSW Government continues to invest in early intervention programs such as *Brighter Futures* and *Families NSW* to provide families with services earlier. To help realise Community Services’ priority of allowing caseworkers to focus on the most serious cases, other government agencies and NGOs receive support to work with vulnerable children, young people and their families. This includes arranging suitable referrals where risk falls below the ‘risk of significant harm’ threshold.

Early intervention programs aim to support children to develop normally without ongoing involvement in the child protection system. Community Services invests more than \$270 million a year in early intervention and community programs, close to 20% of its total budget.

Brighter Futures is an early assistance program to build the resilience of families and children considered at high risk of entering the child protection system. *Brighter Futures* can support about 3,000 vulnerable families with complex needs each year. This program is now delivered exclusively by 16 community organisations. The streamlining of referrals and eligibility

for the program has given families earlier access to the program.

The *Aboriginal Child, Youth and Family Strategy* is a state-wide prevention and early assistance program for Aboriginal families who are expecting a child or have children up to five years old. During 2011–12, the program funded 62 projects to a total of \$3.9 million, including playgroups, family workers, parenting programs and school transition programs.

The first *Protecting Aboriginal Children Together* (PACT) service, which is run by the Illawarra Aboriginal Corporation at Shellharbour, began in April 2012. PACT services advise Community Services’ caseworkers and work with Aboriginal communities and organisations on practical ways to keep Aboriginal children safe. A second service is located in Moree.

Promoting good parenting

The reforms are also about promoting good parenting and parental accountability. For these families increasing parenting ability needs a sustained effort over time. Partnerships between Community Services, the non-government sector and other government agencies are central to helping disadvantaged families improve their parenting skills.

Community Services is examining greater use of alternative models of dispute resolution, such as Family Group Conferencing, as a means of better engaging families to resolve child protection concerns.

Chapter 4: Progress in child protection reform

4.2.2 Children and young people at risk of significant harm are safer

Child protection legislative reform

To reduce the number of children and young people at risk of harm, Community Services is leading bold legislative changes to:

- provide a safe and stable home for children and young people in care
- create a child-focused system
- promote good parenting.

Getting things right in these areas will provide a solid foundation to reduce the number of children and young people at risk of harm and also in statutory care. It will also enable the system to be about truly what is most important – providing children, young people and their families with the support they need when they need it.

In November 2012 the NSW Government released the *Child Protection Legislative Reform Discussion Paper*. After a four-month public consultation period Community Services received 231 submissions from child protection and adoption organisations, carers, parents, Community Services staff, government and non-government agencies, the legal fraternity, children and young people and the general public.

80% of the proposals in the Discussion Paper were generally supported. The Government is currently further developing the legislative changes following feedback from non-government partners, the community and Community Services staff.

Programs addressing intergenerational risk

Child Death Annual Reports have consistently identified the challenges faced by caseworkers when working with families where there are multiple, often intergenerational, risk factors present. Community Services has introduced a number of programs designed to work intensively with vulnerable families where risk of significant harm has been identified.

Strengthening Families

Strengthening Families is a placement prevention program delivered by Community Services' caseworkers. The target group is families with children under nine years of age (or unborn) where there is a risk of significant harm involving specific issues relating to parenting capacity. If these issues are successfully addressed, the child would be able to remain safely in the home.

Strengthening Families aims to:

- reduce risk of significant harm associated with parental issues such as drug or alcohol misuse, domestic violence or lack of parenting skills
- provide a comprehensive assessment and response where children are reported at risk of significant harm
- reduce entry to, or length of stays in, out of home care.

The program builds on existing family strengths through structured home visiting, parenting programs and casework focused on parent vulnerabilities. This is combined with practical support such as quality childcare to improve the long-term

safety of the child and avoid the need for them to be placed in out of home care.

Strengthening Families began in January 2012 and is delivered by 240 Community Services' caseworkers.

Intensive Family Support and Intensive Family Preservation

The *Intensive Family Support* and *Intensive Family Preservation* programs target families in crisis whose children and young people (aged 0 to 15 years) are at risk/imminent risk of removal and placement in out of home care. Following referral from Community Services, NGOs provide case management and service delivery. Families receive an average of 12 weeks of intensive support, including 24-hour on call assistance, followed by up to 40 weeks of continuous and individually-tailored casework.

These programs were introduced in late 2011 when NGOs were contracted to provide 257 places in total.

Intensive Family Based Services

Intensive Family Based Services are provided for Aboriginal families in crisis within the child protection system. The services provide 12 to 16 weeks of intensive case management. Caseworkers work with two to three families at any time due to service intensity.

The program is offered both by Community Services caseworkers and by Aboriginal NGOs. Community Services now manages seven *Intensive Family Based Services* in Dapto, Redfern, Campbelltown, Mt Druitt, Newcastle, Casino and Bourke.

Chapter 4: Progress in child protection reform

In 2011, a pilot project of four Intensive Family Based Services in Aboriginal NGOs began in Wagga, Clarence Valley, Kempsey and Wyong/Lakes). This pilot is currently being evaluated.

4.2.3 Children and young people in out of home care have a better future

Too many children in care are experiencing revolving door placements. This impacts on their development, education, health and general wellbeing. Aboriginal and Torres Strait Islander children and young people continue to be significantly over-represented in the care system.

Working more closely with non-government organisations

Significant progress has been achieved in transitioning the provision of statutory out of home care services from government to the non-government sector. Between March 2012 and June 2013, 2,335 children and young people were successfully transitioned to the non-government sector.

The transition recognises non-government organisations are well placed to provide the support services that children, young people and carers need. It also allows Community Services' caseworkers to focus on preventing more children from entering care in the first place.

The transition began in March 2012 and will continue for a number of years.

Manager, Metro West and member of the Practitioner Advisory Group

"I believe we can achieve a truly whole-of-government and non-government approach to child protection which is where the best outcomes occur for the families and children that we work with. In developing a culture of trust and sharing best practice ideas, we can dare to become more innovative and caseworkers and managers are able to develop confidence and use their professional judgement to help families achieve change."

Safe and stable out of home care

The reforms are about providing more children and young people in care with safe and stable homes to improve their social, emotional, health and education outcomes. By providing stable and permanent placements, the reforms also seek to break intergenerational cycles of abuse and neglect.

Community Services is committed to improving permanent placement options such as open adoption for children and young people in care. Wherever possible, short-term orders will be used so that children can be returned to their family as soon as it is safe to do so. For some families, ongoing problems of substance abuse, mental illness, neglect, physical and sexual abuse, and domestic violence mean that their children have no realistic possibility of restoration. Children entering care with no possibility of being able to live with their birth parent/s need a permanent family who give them love, nurturing and a home for life.

Open adoption offers the best chance of long-term security and an opportunity to belong to a family. For other children and young people, particularly Aboriginal children, adoption is not culturally appropriate, and guardianship by a relative or kin is the preferred option.

The proposed reforms will create a more child-focused regulatory system that promotes better lives for vulnerable children and young people. These include changes in contact arrangements between children and young people in care and their birth families, the administration of special medical treatment to children and young people, improvements to information sharing, and new court orders that better meet the needs of children.

4.2.4 A capable organisation and service system

Increasing caseworker capacity

Community Services is developing robust evidence-based practice and increasing organisational capacity through initiatives designed to improve casework efficiency.

Chapter 4: Progress in child protection reform

Initiatives already being implemented to increase the number of face-to-face assessments for children or young people include:

- changing the way we engage and work with our clients - further roll out of the *Practice First* model and through the development of the *Care and Protection Practice Framework*
- examining ways to reduce the administrative work of caseworkers by streamlining the recording of casework and redirecting some tasks to administrative staff
- streamlining Children's Court processes¹⁵¹.

Early intervention services are now delivered by non-government organisations and, with the progressive transition of out of home care services to the non-government sector, Community Services is more able to focus on children who are at risk of significant harm.

Improving practice

Office of the Senior Practitioner

In late 2011, Community Services established the Office of the Senior Practitioner (the Office). This is the first time the agency had appointed a 'practice expert' to its executive, leading a team focused on evidence-based practice and skill development. The Office is made up of the Clinical Issues Unit, Practice Quality Team, a Critical

Case Response Team, and the Child Deaths and Critical Reports Unit. Together, staff in the Office are leading on innovations to improve practice, increase consistency and ultimately improve outcomes for children and families.

Practice First

Until quite recently, the level of analytical thinking, innovative practice, compassionate and empathic understanding of family disadvantage was not consistent across all Community Services Centres.

Practice First aims to change this. It is a new model for child protection and out of home care service delivery. The model has been developed specifically to fit with the current resourcing, legislative and policy framework in NSW. *Practice First* re-orientates the current child protection system by putting children and families at the centre of Community Services' work.

The model is guided by principles of practice that emphasise the importance of relationship-based practice, a strong appreciation of context and a culture that supports family work. The principles are evidence-based, reflect contemporary research about what works in child protection, and provides a basis for improved outcomes.

The *Practice First* model strengthens caseworker's skills to work with and support families. The

model seeks to ensure that only the children who really need to come into care are being brought into care and only after intensive family work has revealed that parental change is not possible in the timeframe needed and safety cannot be achieved. Our practitioners tell us that when matters are taken to Children's Court, matters are progressing more efficiently. There is confidence that comprehensive and quality work has been done with children and families before a case arrives at Court.

Developed in late 2011¹⁵², *Practice First* was trialled in Bathurst/ Mudgee Community Service Centre. Following positive early results, the trial was extended to 15 additional Community Services Centres and one regional Adolescent Team in December 2012.

Professor Eileen Munro from the London School of Economics and Political Science reviewed the *Practice First* model, its implementation and the initial qualitative and quantitative information on outcomes for families and staff satisfaction.

Professor Munro provided a report about how the model can be improved, ongoing implementation to additional sites and, where known, likely resourcing needs to sustain *Practice First*.

A further rollout of *Practice First* to additional Community Service Centres is underway.

151. In consultation with key stakeholders.

152. Alexander, K 2010, *Child protection systems in England, Norway and the USA with a focus on supporting and inspiring frontline practice*, Winston Churchill Memorial Trust of Australia

Chapter 4: Progress in child protection reform

Practice First under the microscope

Professor Eileen Munro

“Child protection services around the world face similar challenges in providing effective help to children who are suffering, or at risk of suffering maltreatment by their parents or carers. Child abuse and neglect are both welfare and criminal problems so services have to balance playing a policing/investigative role with a helping/supportive one.

“NSW has become predominantly investigative with continual increases in the number of children removed from their families in recent years.

“Practice First contains well evidenced strategies for improving child protection work; it is leading to rapid and enthusiastically welcomed change in frontline practice. Initial evidence suggests that this is having some beneficial effects on children, young people and their families.

“In terms of caseworkers’ engagement with families, there is clear evidence that they are changing the way they relate to families, spending more time with them, and developing their skills and confidence in working with them so that they are beginning to see themselves more as agents of change rather than primarily investigation officers.”

Practitioner Advisory Group

Community Services formed its first Practitioner Advisory Group (the Group) in July 2012, made up of Community Services’ staff from across NSW with broad experience as child protection experts. This group promotes quality and innovation in practice and is responsible for:

- gathering information about topical practice, culture and systems issues and strengths
- advice and consultation about a specific subject, project, program or training
- development or review of key work, for example, review and reframing the Practice Standards
- communicating and influencing areas of best practice in the field.

Care and Protection Practice Framework

Developed by members of the Practitioner Advisory Group, the *Care and Protection Practice Framework* was introduced in December 2012.

Put simply, the framework helps staff to get the basics right. It clearly outlines to staff in government and non-government agencies the values and principles that underpin the approach to working with children and families. The framework also describes the specific skills and knowledge that are fundamental to improving children’s lives.

Manager, Northern

“My vision for the future is to build a strong workforce which values and continually strengthens the expertise of its practitioners. A workforce that can easily identify and articulate a practice framework that they work from.”

Bringing services closer to communities

In February 2013, Family and Community Services announced changes to the department to better place individuals, families and local communities at the centre of all our work. Fifteen new service delivery districts were created to enable more localised planning and decision-making and to improve links between senior management and frontline staff.

These changes brought together local Ageing, Disability and Home Care, Community Services and Housing NSW operations, and aligned the department with one of its key service partners – NSW Health.

Exploring different geographic boundaries for service delivery networks is driven by the need to focus better on people, not on service streams or programs.

4.3 Addressing practice themes identified in the Child Deaths 2011 Annual Report

The *Child Deaths 2011 Annual Report* focused on challenges and opportunities when working with young parents. Three themes

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identified where practice and systemic improvements were needed when dealing with young parents and their children:

- assessing risk in young parent families
- engaging young parents to build parenting capacity
- keeping a focus on the child in a young parent family.

A number of reforms already implemented or currently underway are contributing to practice improvement in this area.

4.3.1 Assessing risk in young parent families

Young parents' history in risk assessment

The majority of young parents of deceased children in the 2011 Report were known to Community Services as a child. Assessing risk in young parent families has its own complexities and will often require a unique approach, especially when intergenerational risk factors are present.

For these young mothers and fathers, early parenthood can represent the continuation of an intergenerational pattern of disadvantage, abuse and neglect and other associated factors. The 2011 Report highlighted the importance of considering the impact of the young parent's own child protection history on their parenting capacity. The report also highlighted the importance of assessing the complex interplay of multiple risk factors in young parent families, such as a history of parental substance abuse and mental health issues.

The Structured Decision Making (SDM®) risk assessment system has been used by caseworkers promotes consistency in decision-making when reporting, screening or assessing child protection concerns. SDM® guides caseworkers to consider the impact of a parent's own history of abuse and neglect as a child or young person and the impact this may have on parenting capacity and risks to the child.

Safe sleeping practices

The 2011 Report also identified that the primary circumstance of death for children in the young parents group was SUDI/SIDS, including in circumstances where infants died while co-sleeping. The majority of co-sleeping deaths in the young parents group featured a history of reports about parental substance abuse.

Community Services has delivered organisational learning and community education initiatives aimed at reducing the number of babies who die in these circumstances.

In 2012, updated information about the risks of co-sleeping was provided to all Community Services' child and family staff throughout NSW.

Community Services is currently analysing cases between 2008 and 2012 where infants died in unsafe sleeping circumstances. This piece of work aims to identify opportunities for Community Services' staff to intervene more effectively with vulnerable parents, including young parents, to promote safe sleeping practices for their infants. The review will identify the learning needs of Community

Services' staff and opportunities to work with other agencies, including NSW Health and SIDS and Kids, to reduce SUDI deaths.

Community Services' Clinical Issues Unit is currently working with SIDS and Kids to deliver a one-day training package for Aboriginal caseworkers. The purpose is to enhance the knowledge, skills and confidence of Aboriginal staff to deliver strong and consistent messages to Aboriginal families and non-Aboriginal staff who need cultural advice about the risks for infants whose parents sleep with them when affected by drugs and alcohol.

Child protection adolescent response teams

As part of the work to improve the lives of vulnerable adolescents, including young parents, Community Services is establishing Child Protection Adolescent Response Teams across NSW to respond to adolescents at risk of significant harm. It involves caseworkers providing child protection case management to adolescents aged 12 to 17 years, including young parents and their families. This initiative aims to:

- increase the effectiveness of Community Services' response to risk of significant harm reports for adolescents
- enhance caseworker knowledge and skills in working effectively with adolescents and their families
- strengthen interagency partnerships by improving collaborative and coordinated service intervention in adolescent casework.

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4.3.2 Engaging young parents to build support networks and parenting capacity

There was a very clear need for Community Services to improve engagement with young parents to help them build supportive networks and improve parenting capacity. In response, a number of initiatives have already been implemented.

The provision of early intervention services, particularly to young parents leaving the out of home care system, is important. Young parents and pregnant young women in care or leaving care have priority access to the *Brighter Futures* and *Strengthening Families* programs, which focus on building parenting capacity. This includes access to the full range of services, as well as quality children's services and parenting programs.

Families in crisis are now able to access intensive support provided by the *Strengthening Families Intensive Family Support* and *Intensive Family Preservation* programs.

Adolescent service delivery reform

Community Services has completed the *Better Lives for Vulnerable Teens* review, which identifies changes that the department can implement to - assist vulnerable teenagers (including young parents) to better engage with education and employment, help them connect to

their family, peers and community and live in stable accommodation.

Community Services is now putting in place the review's recommendations, working closely with other human services and justice agencies to improve support for vulnerable teenagers, including young parents.

A new \$40 million service has been introduced called *Youth Hope* to support nine to 15 year olds who are reported to Community Services as being at risk of significant harm to remain safely at home. The service is being trialled for four years in Hunter/Central Coast, Greater Western Sydney, Northern area, South West Sydney and Western NSW.

Educational neglect

Evidence showed that many disadvantaged young parents had disengaged from education, contributing to isolation from professional support networks. Community Services is leading the *Schoolzin* action research project to identify factors in both individual and interagency work that can improve school attendance outcomes and address child protection issues for children and young people.

4.3.3 Maintaining the focus on the child in a young parent family

It is clear that there are many challenges faced by caseworkers when managing dual clients within

the same family – the child and the young parent. It is critical that caseworkers build effective relationships with young parents to effect change and increase safety for the child. The young parent and their child require very different supports and services and a nuanced approach to case planning.

The *Care and Protection Practice Framework* provides a mandate to ensure work with families is child-centred and family-focused. This mandate is essential because in order to create effective child-centred outcomes, the child or young person cannot be viewed in isolation. Excellent practice means working alongside families to keep the child or young person and their experiences at the forefront of discussions, actions and decisions. The framework reminds caseworkers that, regardless of their circumstances, a child or young person (whether at home or in out of home care) is part of a family and should always be valued and recognised.

The introduction of group supervision as mandatory in *Practice First* sites also helps to keep all family members in mind while assessing and working to reduce the risk to children.

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It Stops Here – ending domestic and family violence in NSW

The NSW Government announced new reforms in 2013 to improve the response to domestic and family violence. It Stops Here: Standing together to end domestic and family violence reforms is a whole of government response to domestic and family violence.

Domestic and family violence affects far too many people in our community. Police recorded more than 30,000 domestic and family violence assaults in NSW between September 2011 and September 2012.

More than 300 domestic and family violence experts from more than 50 non-government and government agencies worked together to design the new reforms, including the following on-the-ground initiatives:

- A common risk identification tool to help identify people at high risk of further violence.
- Central referral points to ensure support services relevant to the victims needs

are quickly engaged in a coordinated manner.

- A state-wide network of Local Coordination Point that will concentrate on victim safety.
- The referral of those at serious threat to Safety Action Meetings.
- Safety Action Meetings to bring together local agencies and service providers to share information about high-risk cases so service providers can respond more collaboratively.
- Investment in early intervention programs that support men, women, young people and children in NSW to understand and develop healthy, respectful relationships to break the inter-generational cycle of violence.
- Minimum practice standards for all agencies, which will enable a consistent and appropriate level of response from mainstream and specialist domestic and

family violence services for victims.

The NSW Government supported the reforms further by committing \$9.8 million for preventative domestic and family violence work. An additional \$620,000 was invested in three major violence prevention studies to inform future funding allocation.

Cleo*, who was in an abusive relationship and was nearly killed in her own home, said the reforms to the service system would have supported her to take action sooner.

“The proposed reforms recommend a central referral point so that people who need help can navigate services, and a coordinated team approach with police and agencies to identify the level of danger the victim is in. This would have been so effective for me as under extreme duress and threats to my loved ones, I retracted my statements and was too afraid to face my abuser in court.”

*Name has been changed

4.4 Initiatives to support children and young people experiencing domestic and family violence

Chapter three of this report presented findings from a review of cases where families had been reported due to risks associated with domestic and family violence. The chapter identified positive and problematic practice with

families where there is domestic and family violence and highlighted the importance of focusing on the experience of children in these situations.

Community Services collaborates with the NSW Police Force, NSW Health, the departments of Attorney General and Justice and Education and Communities and Legal Aid NSW, and local partners to deliver programs for families and children experiencing and escaping domestic and family violence.

Housing NSW manages the Staying Home Leaving Violence Service and offers a number of services to support those experiencing domestic and family violence.

NSW Police Force and Community Services continue to explore ways to share critical information to promote the safety of children and young people. In 2012, the NSW Police Force launched a system that enables Community Services staff to request and receive information held by police that is relevant to

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child protection investigations. This has created a streamlined, faster process that allows caseworkers to obtain criminal histories and identify adults who may pose a significant risk to children in that household.

Staying Home Leaving Violence (SHLV) is an important program that aims to reduce the risk to women and children experiencing domestic and family violence by supporting them to stay safely in their own home while the offender is removed. With this program, children are less likely to experience displacement and disruption to their education, personal and social development when escaping violence.

In 2012, this program trialed an innovative SOS duress response system that quickly connects victims with police when needed.

SHLV has been expanded with the addition of three new locations in Parramatta/Holroyd, Tamworth and Cessnock. These additional locations mean SHLV now operates across 23 locations including: Bega, Eastern Sydney, Blacktown/Mt Druitt, Redfern, Penrith, Liverpool, Fairfield, Campbelltown, Wollongong, Nowra, Dubbo, Moree, Kempsey, Gosford, Wyong, Maitland, Lake Macquarie, Newcastle and Walgett. More than 2,500 adults and children have received support from this program¹⁵³.

The Integrated Domestic and Family Violence Services Program is a multi-agency, coordinated response to improve the safety of women and children and lower community tolerance to domestic and family

violence. The program has helped more than 2,700 people from six locations and provides flexible, needs-based case work to people experiencing domestic and family violence¹⁵⁴.

4.4.1 NSW Domestic Violence Line

Community Services provides support for people experiencing domestic and family violence through the 24-hour *NSW Domestic Violence Line*, which received 22,015 calls in 2011–12. The majority of clients accessing the line were affected by verbal, physical and psychological violence. More than 6,762 calls involved 13,898 children.

The line provides information on approximately 2,500 different support services available state-wide and acts as a single referral point for women and children seeking emergency accommodation due to domestic and family violence.

4.4.2 The Clinical Issues Unit

Community Services' Clinical Issues Unit delivers services, training and resources to improve the capacity of frontline workers to assess and manage cases where drug and alcohol misuse, mental illness, or domestic and family violence is a risk to the safety or wellbeing of children and young people. Services include advice and support to caseworkers provided through face-to-face, email and telephone consultations by the Clinical Consultancy Team. Consultants also provide group activities such as tailored short courses, seminars and workshops and they participate

in reviews of complex cases and practice discussions.

In 2011–12, the Unit developed the training package *working with men who use violence in the home*. This followed an independent study in 2010 that benchmarked caseworker skills, knowledge and development needs in casework with clients with clinical issues. The package was delivered throughout NSW by casework specialists.

The *Safety Planning Resource* was released in 2012 and is available on the Community Services Casework Practice site for all staff who may want additional support with safety planning as part of the SDM® Safety and Risk Assessment Framework. The resource explores some of the specific issues to consider when safety planning with families where there are domestic and family violence concerns and provides specific intervention ideas. Clinical consultants also deliver training on how to use the resource.

The *Domestic Violence Safety Planning* training package will be distributed to frontline workers across Community Services in 2013. The package aims to improve caseworker skills and confidence to engage in holistic safety planning and risk assessment in families where there is domestic and family violence.

The Unit was independently evaluated in 2013 and it was found to be an effective, highly valued service to casework staff. Casework staff believe that the expertise the Unit provides has increased their knowledge and skills in working

153. The number of people who receive support is an estimate based on 2011–12 figures.

154. Also based on 2011–12 figures.

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with domestic and family violence, mental health and drug and alcohol issues.

A caseworker's response to the consultancy work of the Clinical Issues

"She could put together something that we could read and go, 'yes, I understand that, the parents will understand that, and the court will understand that.' It wasn't jargon and it wasn't above everybody's head. It was just an assessment...she had grasped the reality of what it was and managed to put it into context."

As part of the NSW Government's domestic and family violence reforms, Family and Community Services have partnered with TAFE NSW to provide \$1.5 million for education, training and professional development for frontline workers who deal with victims of domestic and family violence in NSW.

4.5 Conclusion

Community Services recognises that the quality of work with families is the most valuable asset the system has to offer. Much has been done to reposition practice, and its importance, as central to work and agency efforts. A sustained effort is needed to build on this and to free-up caseworkers from their desks and get them into the field. Organisational and system reforms will build the landscape needed for improved work with families that meaningfully addresses risk.

The government acknowledges there is no quick fix to the problems which underpin child abuse, in particular longstanding intergenerational, social and economic disadvantage. The international literature acknowledges it is not possible to prevent all child deaths – it never will be. What can be achieved, through the Government's reform agenda, is an improved NSW child protection system and better outcomes for vulnerable children and young people. At the heart of all of these changes is placing children back at the centre of the child protection system.

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Glossary

Glossary

ABORIGINAL AND/OR TORRES STRAIT ISLANDER

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

ABUSE

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

ALCOHOL AND/OR DRUG MISUSE

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

ALLOCATED CASE

A case that has been allocated to a caseworker for case management.

AUTHORISED CARER

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

BRIGHTER FUTURES

Community Services' *Brighter Futures* early intervention program provides families with the necessary services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing. The transfer of the *Brighter Futures* program has been finalised, with Early Intervention and Prevention Services now delivered across NSW by non-government organisations.

CASE CLOSURE

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

CASE PLAN

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

CASEWORK

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

CASEWORKER

A Community Services' 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 the Manager Casework.

CASEWORK SPECIALIST (CWS)

The CWS is a member of a regional team that fosters the implementation of quality casework practice that is consistent with the centrally developed Community Services' professional development program. CWS are based in Community Service Centres (CSCs). They maintain a strong operational focus in assisting Caseworkers and Managers Casework to meet corporate operational standards around casework practice and quality improvement.

CHILD

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

CHILD PROTECTION HELPLINE

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

CHILD WELLBEING UNIT (CWU)

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

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CHILDREN'S COURT

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

COMMUNITY SERVICES CENTRE (CSC)

The locally based Community Services offices. There are 82 CSCs across NSW.

DOMESTIC VIOLENCE

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

ENGAGEMENT

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

KEY INFORMATION AND DIRECTORY SYSTEM (KIDS)

Community Services' electronic system for keeping records and plans about children, young people and their families.

MANAGER CASEWORK

Managers Casework provide direct supervision and support to a team of Community Services 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 and those grounds arise during the course of or from the person's work, it is the duty of the person to report to Community Services, as soon as practicable, the name or a description of the child and the grounds for suspecting that the child is at risk of significant harm. This is outlined in section 27 of the *Children and Young Persons (Care and Protection) Act 1998*.

MEDICAL EXAMINATION

Pursuant with Section 173 of the *Children and Young Persons (Care and Protection) Act 1998*, if the Director-General or a police officer believes on reasonable grounds that a child is in need of care and protection, the Director-General 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 Director-General of 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 significant risk of significant harm.

NEGLECT

Neglect means that the child or young person's basic needs (for example 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.

Supervisory neglect means that the child or young person's need for supervision is unmet as a result of being left unattended (parent/carer is absent, or is present but not attending to the child or young person) in circumstances that

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represent a significant risk to his/her safety; or the parent/carer has failed to protect the child from other people who have abused or neglected the child.

Medical neglect means that the child has an acute and/or chronic medical or mental health condition that requires immediate or ongoing treatment by a medical or mental health professional, but the parent/carer is not obtaining or maintaining essential medical services for the child or young person or is not following a prescribed plan of treatment for the child/young person (includes over-medicating).

Educational neglect can occur when a parent or other carer is unable or unwilling to arrange for a child or young person to receive an education. Refer to the *Children and Young Persons (Care and Protection) Act 1998*, Section 23 (1) (b1).

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* 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 parental responsibility of the Minister under Section 79(1)(b) of the *Children and Young Persons (Care and Protection) Act 1998*.

PHYSICAL ABUSE OR ILL-TREATMENT

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

PRENATAL REPORT

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

REMOVAL

The action by an authorised Community Services 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 Director-General.

REPORT

A report made to Community Services, usually via the Helpline, to convey a concern about a child or young person who may be at risk of significant harm.

REPORTER

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

RESTORATION

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

RISK OF HARM ASSESSMENT

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

RISK OF SIGNIFICANT HARM (ROSH)

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

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(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*—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

Includes but is not limited to:

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

SAFETY AND RISK ASSESSMENT (SARA)

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

SEXUAL ABUSE OR ILL-TREATMENT

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

STRENGTHENING FAMILIES

Community Services' established *Strengthening Families* program provides a differential child protection response to families where there are both high levels of long-term risk and the children are currently assessed as being at risk of significant harm. Strengthening Families is aimed at keeping these children living safely at home through effective interventions with the family. Where families seek to withdraw from the program, caseworkers will conduct an assessment to determine the appropriate follow up action required.

STRUCTURED DECISION MAKING (SDM®)

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

SUPERVISION

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

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SUPPORTED CARE ALLOWANCE

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

TASKS

Individual actions required to achieve objectives in a plan. Tasks document the actual activities undertaken by persons identified in the plan to achieve the current objective.

TRIAGE AND ASSESSMENT PRACTICE GUIDELINES

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

WEEKLY ALLOCATION MEETING (WAM)

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

YOUNG PERSON

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

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

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