



# Child Deaths 2018 Annual Report

Learning to improve services



## **A note about this report**

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

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

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## Minister's foreword

There are few things more devastating than the death of a child. For children known to the Department of Communities and Justice we have a responsibility to make sense of the loss through the examination of the role of the child protection system in the lives of the children and their families.

This report, the *Child Deaths 2018 Annual Report*, is the Department of Community and Justice's ninth annual report about the deaths of children who were known to the department's child protection service. It is also my first report tabled as Minister for Families, Communities and Disability Services, and while I acknowledge the report is incredibly sad and at times hard to read, it is essential in helping us to think about our work with families and how we can continue to strive to do things better. I extend my deepest sympathies to all of the families who have lost children.

In 2018, 93 children who were known to the department died. This report provides the details about the circumstances of these children's deaths and DCJ involvement with the children and their families. Chapter 3 looks specifically at the children who died and whose own parents were reported to be at risk of harm when they were a child. The chapter identifies opportunities for us to improve our practice and target our work to create safety for children, through holistic assessment and successful partnerships.

The NSW Government's commitment to improving services that can make a real difference to the lives of children and families remains strong. Over 2018 and 2019, the NSW Government continued to implement vital reforms to the child protection and out of home care system in NSW including *Their Futures Matter*, the Permanency Support Program and the NSW Practice Framework. These systems together promote a connected system that strives to create sustained change for families and to improve life outcomes.

I am proud to present this year's report. Many of the reviews that sit behind the report were enhanced by child protection practitioners who reflected on their work with families and it provides a richer understanding of how we can improve. Since commencing as Minister for Families, Communities and Disability Services, I have met with many practitioners who every day work with vulnerable families, with children's best interests at the forefront of their practice. I am grateful for the work that you do.

### **Gareth Ward**

Minister for Families, Communities and Disability Services

# Secretary's foreword

Making sense of the death of any child, no matter the circumstances, is difficult. The sadness and loss that families experience is profound and ever-present. To those families who loved and cherished the children whose deaths are reflected in the pages of this report, I am deeply sorry for your loss.

For practitioners who worked with the child and their family, the death of a child also causes feelings of deep loss and sadness, but alongside this there is also a commitment to thinking about their work with the family, and what they and others can learn from it. To those practitioners I commend your commitment to this difficult process.

Each year I read the *Child Deaths Annual Report* it causes me to stop, slow down and think about what we have learned and what we can do better. This year's report is about the 93 children and young people who died in 2018 and who were known to the NSW child protection system. It describes information about how these children and young people died and shines a light on practice challenges and opportunities for improvement.

Chapter 3 of this year's report focuses specifically on the findings from a cohort review of 167 children who died between 2015 and 2018 and whose own parents were the subject of reports to child protection services as being at risk of harm, when they were a child. Focusing on this group of children and their parents provides a useful and important insight into how practitioners engaged with parents to understand their experiences as children, and how these experiences impacted on them in adulthood and in their role as parents. The review highlights a key principle from the NSW Practice Framework, that the relationships that our practitioners form with families are the best chance of keeping children safe, as they provide opportunities for families to feel safe to share intimate aspects of their lives, enabling holistic assessment to occur.

This year's report also provides an opportunity to consider the progress of reforms to the child protection and out of home care system under *Their Futures Matter*, including key DCJ projects such as the Permanency Support Program and related legislative reforms and the continued implementation of the NSW Practice Framework. You can read more about the progress of this work in Chapter 4.

I continue to be inspired by the passion, skill and dedication of our staff. None of this work would be possible without them and I hope that the insights and learning from this report will help practitioners to continue to make a difference to the children and families we work with.

**Michael Coutts-Trotter**  
Secretary

# Summary

The *Child Deaths 2018 Annual Report* is the ninth public report from the NSW Department of Communities and Justice (DCJ)<sup>1</sup> examining DCJ involvement with the families of children<sup>2</sup> who died and were known to DCJ.

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

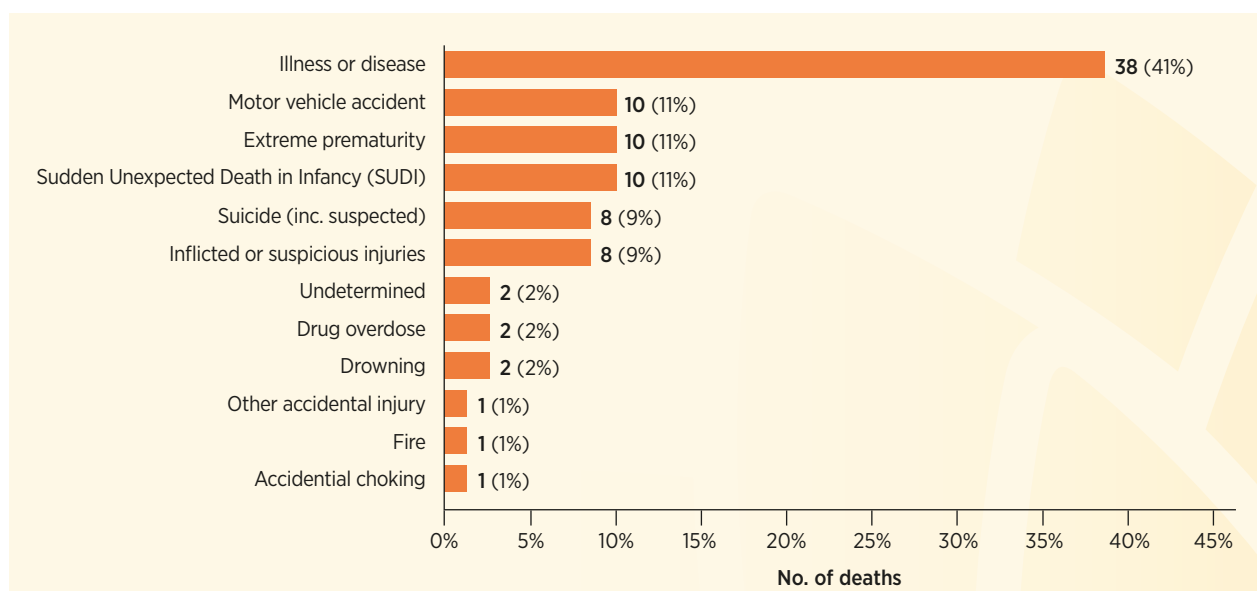
## Child deaths in 2018

Chapter 2 of this report summarises information about the 93 children who died in 2018 who were known to DCJ.<sup>3</sup> As shown in Figure 1, most of the children died in circumstances related to illness and/or disease, from extreme prematurity or in motor vehicle accidents.

Each year, deaths from illness and/or disease consistently account for the greatest proportion of children who die and were known to DCJ. In 2018, deaths of children known to DCJ from illness and/or disease remained proportionally higher than in previous years.<sup>4</sup>

Eight of the children who died in 2018 had their parental responsibility reallocated through the Children's Court. The parental responsibility for one child was allocated to a relative, one child had parental responsibility shared between a relative and the Minister for Family, Communities and Disability Services (the Minister) and six children had their parental responsibility allocated to the Minister. Of these six children, one child had been living with relatives, and five children were living with authorised foster carers at the time of their death.

**Figure 1: Children who died in 2018 and were known to DCJ, by circumstance of death<sup>5</sup>**



1 The Department of Communities and Justice (DCJ) commenced on 1 July 2019. The new department brought together the former departments of Family and Community Services and Justice.

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

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

4 In 2017, 48% of children known to DCJ died from illness and/or disease compared with 32% in 2016, and 37% in 2015.

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

## Children who died and whose parents experienced abuse or neglect as a child

The focus of Chapter 3 in this year's report is on the findings from a cohort review of 167 children who died between 2015 and 2018 and whose own parents were the subject of reports to child protection services as being at risk of harm, when they were a child. Focusing on this group of children and their parents provides a useful and important insight into how practitioners engaged with parents to understand their experiences as children, and how these experiences impacted on them in adulthood and in their role as parents.

Chapter 3 considers the children's experiences, why they were known to DCJ and what we can learn from the reviews of our work with them and their families.

Analysis and findings have been written to inform future practice. It is hoped that learning from these deaths can improve DCJ work with all children whose own parents had a child protection history and those who are working to support them.

## Improving the way DCJ works with children and families

Across 2018 and 2019, the NSW Government continued to implement reforms to the child protection and out of home care system in NSW. More information about these reforms is outlined in Chapter 4.

The NSW Practice Framework, launched in 2017, continues to bring together practice approaches, reforms and priorities to guide DCJ child protection work across systems, policies and practice.<sup>6</sup> The Framework unites DCJ through shared principles, language and standards, and keeps children and families at the forefront of our thinking and action. More information about the implementation and rollout of the Framework is included in Chapter 4.

*Their Futures Matter*,<sup>7</sup> launched in 2016, is the NSW Government's long-term strategy for improving outcomes for vulnerable children and families. It brings all areas of government together to deliver a more cohesive and accountable system. Chapter 4 provides an update about the implementation of the *Their Futures Matter* reforms, including key DCJ projects such as the Permanency Support Program, and details achievements that have occurred since implementation began. It also provides an update on amendments to the *Children and Young Persons (Care and Protection) Act 1998* and *Adoption Act 2000*, under the *Children and Young Persons (Care and Protection) Amendment Act 2018*, which came into effect on 4 February 2019, to support current child protection reforms. Together, the NSW Practice Framework and *Their Futures Matter* have been essential in guiding our approach and practice with vulnerable children and families.

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

<sup>7</sup> NSW Government (2016).



# Chapter 1: Child deaths in context

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

## 1.1 Child protection in NSW

The NSW Department of Communities and Justice (DCJ) commenced on 1 July 2019. The new department brought together the former departments of Family and Community Services and Justice. DCJ is the statutory child protection agency in NSW and works with other government departments, non-government organisations and the community to support families to keep children safe from abuse and neglect.

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

DCJ is committed to achieving child protection practice that understands how social disadvantage, and stressors associated with it, are related to child abuse and neglect. As an agency, DCJ has a significant role in protecting children and young people and is committed to doing its best to influence and improve the long-term outcomes for all children. This report shares some of the stories of families whose children have died, reflects on their experiences and considers how DCJ could have worked with the families to reduce risk and create safety.

## 1.2 Examining child deaths

### 1.2.1 DCJ child death reviews

Children in NSW with a child protection history have a higher mortality rate than those not known to DCJ.<sup>9</sup> Other jurisdictions across Australia have similar findings.<sup>10</sup>

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

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

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

8 NSW FACS (2016b).

9 NSW FACS (2017a).

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

## Serious Case Review unit

The Serious Case Review Unit (SCR)<sup>11</sup> is part of the Office of the Senior Practitioner (OSP) within DCJ. SCR reviews DCJ involvement with all children who have died and 'were known to DCJ'. This includes children and/or their siblings who were reported to be at ROSH within three years before the death of the child, or a child who was in out of home care when they died.

These often difficult reviews consider how DCJ systems at a local and organisational level impacted on practice with the families of children who died. The reviews create learning opportunities for practitioners who work with families by not only identifying areas for practice improvement, but also promoting good practice.<sup>12</sup> This in turn can lead to broader system improvements.

## Making and monitoring recommendations from serious case reviews

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

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

## Practitioner support and consultation

When a child dies, SCR provides practical support to practitioners straight away including debriefing practitioners who may have been working with a family recently, and preparing briefings for senior officers about the circumstances of the child's death. This enables practitioners to focus on the important job of offering and providing support to families, and assessing the safety of other children in the home. In many instances, SCR consults with casework staff to understand contextual information and to reflect critically on practice. Despite this being an understandably difficult process for staff, SCR is continually impressed by the courage and openness shown by DCJ practitioners in their obvious willingness to learn from a child's death.

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

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

## Learning from child death reviews

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

<sup>11</sup> Formerly known as the Child Deaths and Critical Reports Unit.

<sup>12</sup> 'While child protection is what we do, practice is how we do it. Practice is the relationships, the conversations, the thinking and the care. When it works, practice is the magic that keeps children with family, connected to culture and cherished by those who love them best.' See NSW FACS (2017b).

## **Child Deaths Annual Report**

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

### **Cohort and other reviews**

Each year, SCR undertakes a cohort review that looks at a group of children who died and were known to DCJ who share some common characteristics. In 2017, SCR completed a review of children known to DCJ who died from illness and/or disease. That review focused on the children's experiences, why the children were known to DCJ and what was learned from the reviews of our work with them and their families.

Previous child deaths cohort reviews have considered:

- responses to families of children who died (2016)
- children who experienced neglect (2015)
- vulnerable teenagers (2014)
- babies who died suddenly and unexpectedly (2013)
- children who were reported to be at ROSH because of domestic violence (2012)
- children who had young parents (2011).

This year's cohort review (Chapter 3 of this report) presents findings about 167 children who died between 2015 and 2018 and whose own parents had a child protection history.

### **Practice review sessions and other forums**

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

The stories of children who have died are also at the heart of many broader OSP learning forums and often inform the OSP's Research to Practice seminars.<sup>13</sup>

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

In providing public information about the circumstances surrounding children's deaths, DCJ is committed to protecting the privacy of vulnerable families who are impacted by the death of a child.<sup>14</sup> The NSW Parliament has also responded by protecting privacy and confidentiality through a range of legislation that governs the disclosure of information on individual child deaths.<sup>15</sup>

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

<sup>13</sup> Each year the OSP offers a program of Research to Practice seminars to frontline workers and other professionals, to provide them with up to date research and the best of current practice on a range of child protection areas.

<sup>14</sup> Although information about children who have died is given in this report, identifying details of families have been removed to protect their privacy.

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

## Child deaths and the media

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

Every year a small number of child deaths are the subject of considerable media attention. These deaths often involve children who died as a result of abuse by a parent or carer. Understandably, these stories spark strong reactions from the community. The media plays an important role in supporting the community to gain a better understanding of child deaths. The media can increase awareness in the general population about child protection issues, increase the level of vigilance and sensitivity to signs of abuse, and affect the likelihood that professionals suspecting abuse will report it.<sup>16</sup>

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

At an organisational level, the NSW Practice Framework<sup>17</sup> (see also Chapter 4) helps departmental and practice leaders acknowledge the uncertainty of our work and share the risk between frontline workers and management. The Framework integrates the approach, values, standards, tools and principles that guide the NSW statutory child protection system. It clearly articulates mandates for how DCJ works and brings these together in one framework that is used by the whole department. The Framework is available to all child protection employees with whom DCJ works. Within it, information about DCJ child death review work acknowledges that reviews are one of many ways to guide practice. Internal child death reviews show DCJ willingness to reflect and maintain an open culture, where critique improves outcomes and supports meaningful change for families.

### LIVING THE PRACTICE FRAMEWORK

To be the best we can be for families, we must invite and provide critique. We need to be open to hear and accept critique and willing to change our practice when required. Critique supports practice improvement, which ultimately leads to child safety.

**NSW Practice Framework Principle – Critique leads to improved practice**

### 1.2.3 Child death oversight in NSW

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

#### NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths that have occurred in a care setting. The aim of this function is to prevent the deaths of children through the systemic review of deaths of children in circumstances of abuse or neglect, and the deaths of children in care or detention.

<sup>16</sup> Ayre (2013).

<sup>17</sup> NSW FACS (2017b).

The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in June 2019 and considered reviewable deaths of children in 2016 and 2017.<sup>18</sup>

## NSW Child Death Review Team

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

In 2019, the CDRT advised DCJ that 464 children aged from birth to 17 years died in NSW in 2018. These figures differ from DCJ data, highlighting important differences between the CDRT and DCJ:

- The deaths of children outside NSW are not included in CDRT data analysis or reporting.
- CDRT reports include the 'child protection history' of children who die in NSW. Unlike DCJ, however:
  - CDRT does not include children who died in care as having a child protection history unless the child and/or a sibling was the subject of a report to DCJ within the three years prior to their death.
  - CDRT child protection history includes children who were reported to DCJ but whose reports did not reach the ROSH statutory threshold, and also children who were known to Child Wellbeing Units.<sup>19</sup>

## NSW Police Force and the NSW State Coroner

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

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

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

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

## Domestic Violence Death Review Team

The Domestic Violence Death Review Team is convened by the NSW State Coroner. The team includes representatives from 11 government agencies, including DCJ, Police and Health, and representatives from non-government sectors and academia.

The core functions of the team are to review and analyse individual closed cases of domestic violence deaths;<sup>20</sup> to establish and maintain a database to identify patterns and trends relating to such deaths; and to develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

<sup>18</sup> NSW Ombudsman (2019).

<sup>19</sup> The Child Wellbeing Units established in NSW Health, the NSW Police Force and the NSW Department of Education help mandatory reporters in government agencies ensure that all concerns that reach the ROSH threshold are reported to the Child Protection Helpline. In other cases, they identify potential responses by NSW DCJ and other services to help the child or family.

<sup>20</sup> Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as a death that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person. The Act also provides that a domestic violence death is 'closed' if the Coroner has dispensed with or completed an inquest concerning the death, and any criminal proceedings (including appeals) concerning the death have been finally determined.

The death of a child in the context of domestic violence is subject to review by the team. In 2016, the Domestic Violence Death Review Team moved to reporting every two years. The team's fifth report (2015–2017) was published in 2017.<sup>21</sup>

## Office of the Children's Guardian

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

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

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

### 1.2.4 Reviewing the deaths of children in out of home care

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

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2018, this included children placed with DCJ or non-government organisation (NGO) carers, and children who died in a facility funded, operated or licensed by the Ageing, Disability and Home Care division of DCJ. These reviews consider the adequacy of the involvement of all agencies with the child and family up to the child's death.

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

<sup>21</sup> NSW Domestic Violence Death Review Team (2017).

## Chapter 2: Child deaths in 2018

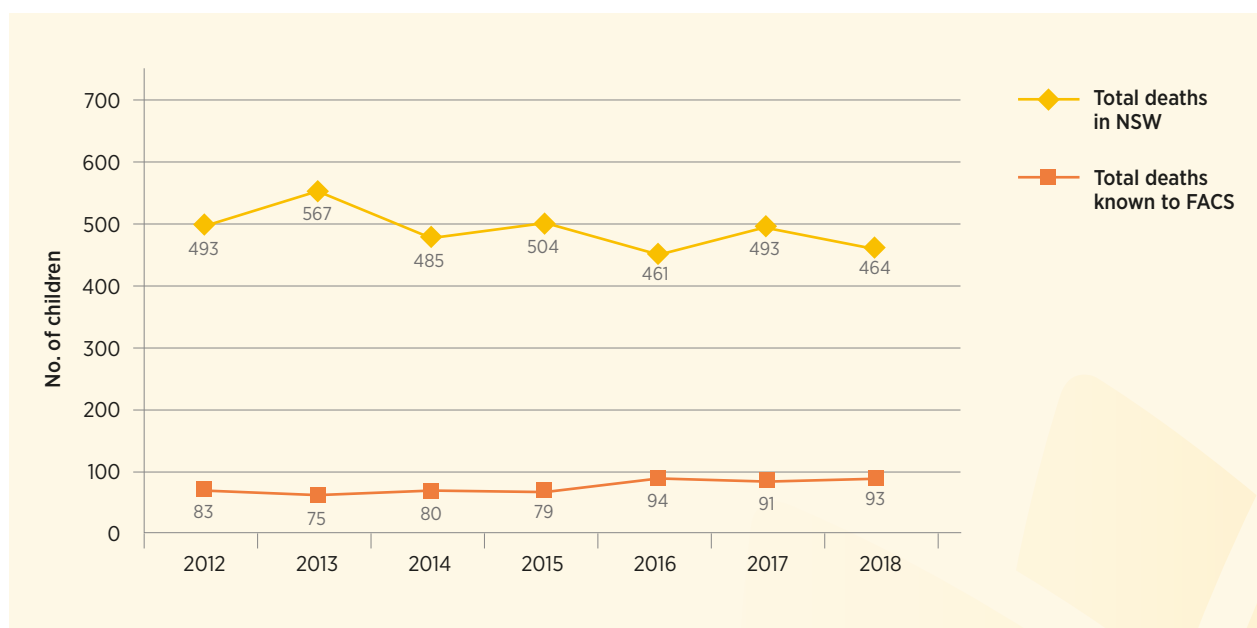
Chapter 2 provides a summary of information about the children who died in 2018 and who were known to DCJ prior to their death. It includes characteristics of the children such as their age, gender and socioeconomic background. Analysis considers the children's child protection history, DCJ responses before and after the child's death, as well as the circumstances in which the children died.

This chapter can only provide a broad background to the 93 children who died in 2018 who were known to DCJ. The information provides a picture of the circumstances in which the children died and, where appropriate, an opportunity to reflect on and improve DCJ responses to these children, young people and their families.

### 2.1 Child deaths in NSW in 2018

Between 1 January and 31 December 2018, the deaths of 464 children occurred in NSW.<sup>22</sup> Ninety-three of the 464 children who died in NSW were known to DCJ because they and/or their siblings had been reported at risk of significant harm (ROSH) in the three years prior to their death, or the child was in out of home care.

**Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ, 2012–2018<sup>23</sup>**



In 2018, the number of deaths of children known to DCJ remained relatively stable statistically compared to 2017, up from 91 to 93. The 93 children who were known to DCJ and who died in 2018 represented 0.1 per cent of the total number of children reported to DCJ in that year.<sup>24</sup> This is consistent with previous years' findings.

<sup>22</sup> Information provided to DCJ in 2019 from the NSW Child Death Review Team.

<sup>23</sup> *ibid.*

<sup>24</sup> In 2018, DCJ received 185,815 ROSH reports, involving 98,732 children (data correct as at 8 October 2019).

## 2.2 Characteristics of the children

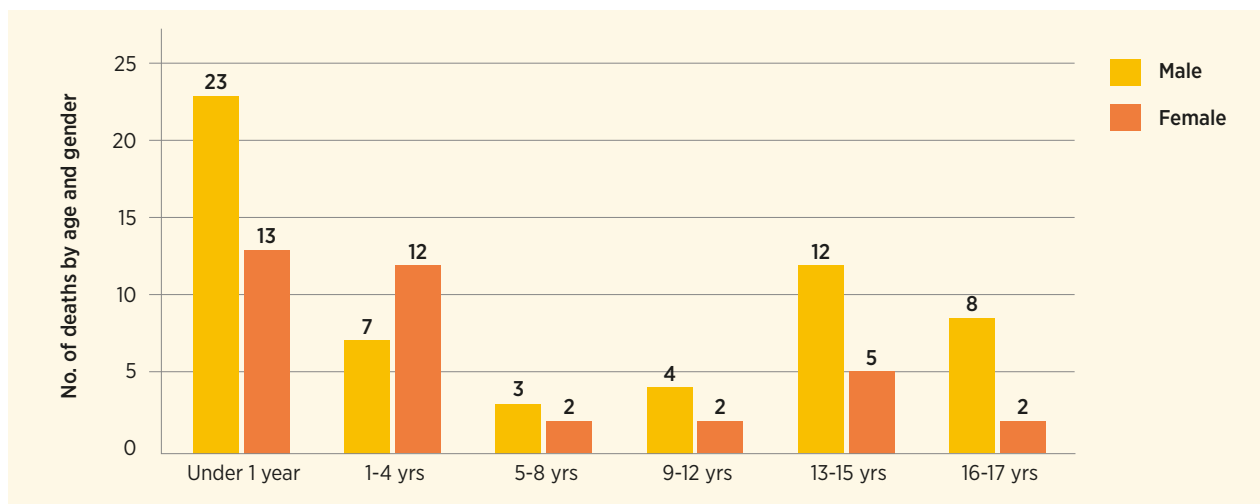
### 2.2.1 Age and gender

Consistent with previous years, a significant proportion of the children known to DCJ who died in 2018 were under the age of 12 months (36 children; 39 per cent). This number decreased from 51 children in 2017. There was an increase in the deaths of children aged between one and four years, from nine children in 2017 to 19 children in 2018. This was due to an increase in the number of children who died across a range of circumstances outlined in more detail below.

There was also an increase in the number of children who died between the ages of 13 and 15 years (17 children; 18 per cent) in 2018, compared with 2017 (7 children). The increase in deaths across the 13–15 year age group is largely attributable to an increase in the number of children in this age group who died in motor vehicle accidents (5 children) and from suicide (6 children).

In 2018, 57 (61 per cent) of the children who died were boys and 36 (39 per cent) were girls. This is consistent with previous years where male children known to DCJ died more frequently than females.<sup>25</sup> As seen in Figure 3, the male to female difference is most pronounced in the under one, 13–15 and 16–17 age categories.

**Figure 3: Children who died in 2018 and were known to DCJ, by age and gender**



#### Children younger than 12 months

Of the 36 babies who died and were aged less than 12 months, 24 of the babies died within three months of their birth. The circumstances of these children's deaths were predominantly from illness and/or disease (14 babies), extreme prematurity (10 babies) and sudden unexpected death in infancy (SUDI;<sup>26</sup> 10 babies).

Of the 36 babies who died, the history of DCJ involvement revealed that previous reports had been made to DCJ for 24 of the babies before they died, either before or after their birth. For 12 of the babies a report had been made to DCJ about the child's sibling in the three years before their death. For all of the 36 babies the concerns raised with DCJ were:<sup>27</sup>

- parental drug and/or alcohol misuse (21 reports)
- domestic violence (16 reports)
- neglect (22 reports)
- parental mental health (10 reports).

#### Children aged 1–4 years

Nineteen (20 per cent) of the 93 children who died were between one and four years of age. Illness and/or disease and suspicious injuries were the most frequent circumstances of death for this age group.

<sup>25</sup> In previous years the male to female ratio of deaths of children known to DCJ was 60:40 (2017), 58:42 (2016) and 54:46 (2015).

<sup>26</sup> For further information about SUDI, see Section 2.3.4.

<sup>27</sup> Numbers do not add up to 36 because of multiple reported issues.



## Teenagers

Twenty-seven (29 per cent) of the 93 children who died and were known to DCJ were teenagers aged between 13 and 17 years. This is higher than reported in 2017.<sup>28</sup> The circumstances of these 27 deaths were primarily from suicide (8 young people), motor vehicle accident (8 young people) and illness and/or disease (7 young people).

**Table 1: Children who died in 2018, by age and circumstance of death**

|   | < 12 months | 1-4 years | 5-8 years | 9-12 years | 13-15 years | 16-17 years |
|---|-------------|-----------|-----------|------------|-------------|-------------|
| Accidental choking                        | 0           | 1         | 0         | 0          | 0           | 0           |
| Drowning                                  | 0           | 2         | 0         | 0          | 0           | 0           |
| Drug overdose                             | 0           | 0         | 1         | 0          | 0           | 1           |
| Extreme prematurity                       | 10          | 0         | 0         | 0          | 0           | 0           |
| Fire                                      | 0           | 1         | 0         | 0          | 0           | 0           |
| Illness and/or disease                    | 14          | 8         | 4         | 5          | 4           | 3           |
| Inflicted or suspicious injuries          | 2           | 4         | 0         | 0          | 2           | 0           |
| Motor vehicle accident                    | 0           | 1         | 0         | 1          | 5           | 3           |
| Other accidental injury                   | 0           | 0         | 0         | 0          | 0           | 1           |
| Sudden unexpected death in infancy (SUDI) | 10          | 0         | 0         | 0          | 0           | 0           |
| Suicide (including suspected)             | 0           | 0         | 0         | 0          | 6           | 2           |
| Undetermined                              | 0           | 2         | 0         | 0          | 0           | 0           |
| <b>Total</b>                              | <b>36</b>   | <b>19</b> | <b>5</b>  | <b>6</b>   | <b>17</b>   | <b>10</b>   |

### 2.2.2 Aboriginal children

The deaths of Aboriginal children continue to represent a significant proportion of children who died and were known to DCJ.

Of the 93 children who died in 2018, 36 children (39 per cent) were Aboriginal. This represents an increase from previous years.<sup>29</sup>

The circumstances of death for Aboriginal children were:

- illness or disease (13 deaths)
- extreme prematurity (5 deaths)
- motor vehicle accident (4 deaths)
- inflicted or suspicious injuries (3 deaths)
- SUDI (3 deaths)
- suicide (including suspected) (3 deaths)
- undetermined (2 deaths)
- drowning (1 death)
- drug overdose (1 death)
- fire (1 death).

In 2018, 21 of the Aboriginal children known to DCJ were female and 15 were male. Twenty-three of the 36 Aboriginal children who died in 2018 were aged five years or under, which is consistent with 2017. The increase of Aboriginal children known to DCJ is largely attributable to an increase in the deaths of Aboriginal children aged five years and older (13 children). The circumstances of these deaths were:

- illness or disease (5 deaths)
- motor vehicle accident (4 deaths)
- suicide (including suspected) (3 deaths)
- drug overdose (1 death).

<sup>28</sup> In 2017, 19 children who died and were known to DCJ were teenagers aged 13–17 years. Chapter 3 of the *Child Deaths 2014 Annual Report* highlighted the vulnerability of adolescents and the behaviours that can enhance their vulnerability.

<sup>29</sup> In 2017, 32% of children who died and were known to DCJ were Aboriginal. In 2016, 27% of children who died and were known to DCJ were Aboriginal.

The over-representation of Aboriginal children in the child protection and out of home care systems is well documented.<sup>30</sup> Practitioners have a responsibility to work to keep children safe, and look for ways to understand and address the disproportionate number of Aboriginal children in the child protection and out of home care systems, through culturally responsive practice. Working in partnership with Aboriginal families and communities to foster self-determination is the best way to ensure that Aboriginal children are safe and have a connection to their culture.

Last year, DCJ admitted 35 per cent fewer Aboriginal children into care than in 2015–2016. Additionally, for the second year in a row, the number of Aboriginal children in care has fallen, which indicates positive progress in addressing the over-representation of Aboriginal children in the out of home care system in NSW.<sup>31</sup>

However, it is important to remember that the underlying systemic factors which continue to contribute to the ongoing over-representation of Aboriginal children in the child protection system must not be forgotten and include the mistreatment of Aboriginal people and the lasting ramifications of previous welfare policies, including poverty, the effects of the Stolen Generations which took Aboriginal children away from their families and culture and the long-lasting impact of this, and perceptions arising from cultural differences in child-rearing practices.<sup>32</sup>

## CULTURALLY RESPONSIVE PRACTICE

We respect all cultures. We are deeply sorry about the impact of the Stolen Generations. Being sorry means we are committed to making sure we do not repeat past injustices.

Culturally responsive practice can be achieved by practitioners taking the time to understand the stories and cultural context of the Aboriginal families they work with, while maintaining a focus on the safety and wellbeing of children.

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

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

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

For further information refer to the Casework Practice topic **Cultural practice with Aboriginal communities**.<sup>33</sup>

The Aboriginal Case Management Policy, introduced in 2018, is a landmark policy written by AbSec<sup>34</sup> in consultation with Aboriginal communities, children and families. The policy supports practitioners to engage early with families to shape case planning and identify tailored solutions to keep children safe with their family and community.

30 In September 2016, the former Minister for Family and Community Services in NSW announced an Independent Review of Aboriginal Children and Young People in Out of Home Care (OOHC). This followed concerns raised in the Our Kids, Our Way: Hearing the Voice of Aboriginal People forum about the high numbers of Aboriginal children and young people in out of home care. The Review is examining the reasons for the disproportionate and increasing number of Aboriginal children and young people in out of home care in NSW. Learn more at [familyisiculture.nsw.gov.au/home](http://familyisiculture.nsw.gov.au/home)

31 KiDS and ChildStory – CIW annual data.

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

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

34 AbSec, the NSW Child, Family and Community Peak Aboriginal Corporation, works to empower Aboriginal children, young people, families and communities impacted by the child protection system. See [absec.org.au](http://absec.org.au)

## LIVING THE PRACTICE FRAMEWORK

Caring about, respecting and understanding Aboriginal culture means we acknowledge past injustices that stripped Aboriginal families of basic human rights, their families and connection to country, and we ensure that current day practice does not repeat them.

### NSW Practice Framework Principle – Culture is ever-present

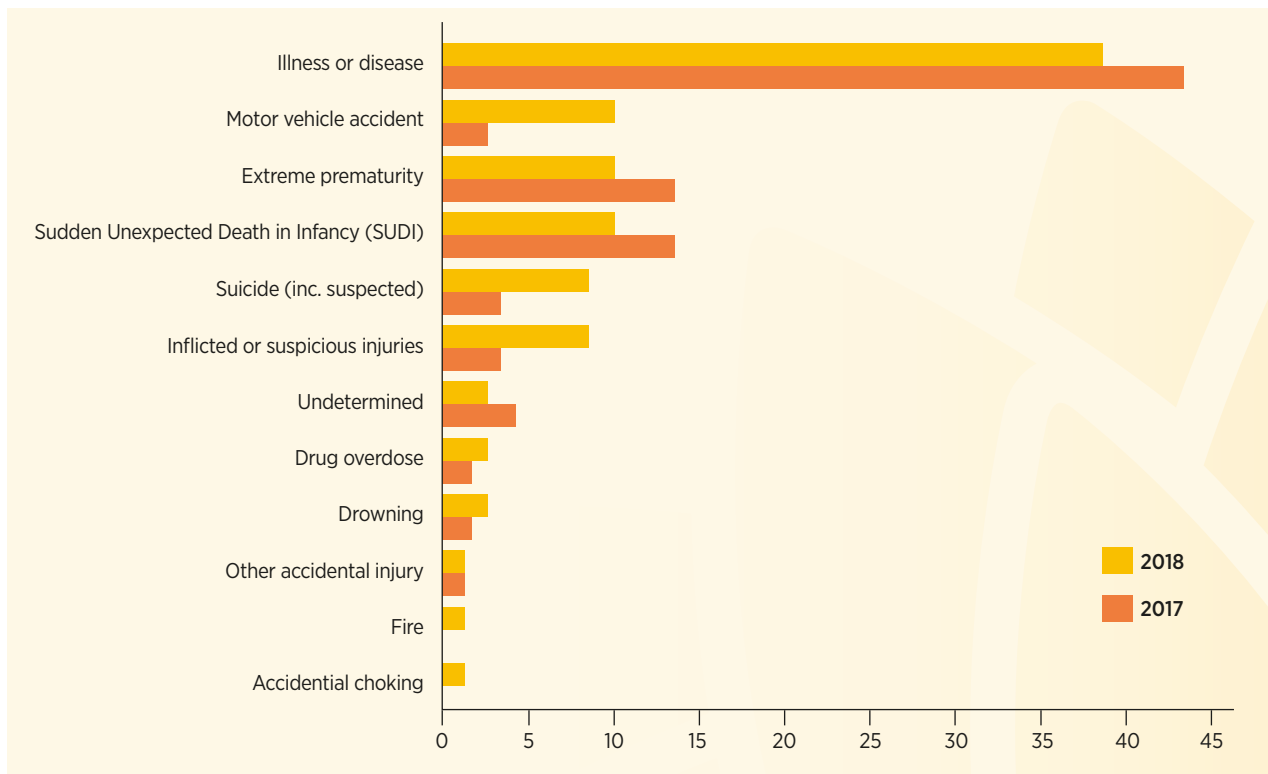
## 2.3 Circumstances of child deaths

The Department of Communities and Justice (DCJ) receives information about the medical cause and circumstances of children’s deaths from the NSW State Coroner and NSW Ombudsman. DCJ relies on these sources to report on the circumstances of the child’s death. Following the death of a child, DCJ completes a review of the department’s work with the child or young person and their family, including information from their child protection history and the work completed by practitioners. These reviews, along with the circumstances in which the child died, provide a context for DCJ responses to the family.

Figure 4 shows the circumstances of death for the children known to DCJ in 2017 and 2018. Similar to previous years, most deaths in 2018 were from illness and/or disease. However, deaths from motor vehicle accidents and extreme prematurity were the second highest circumstances of death, differing to previous years.

The number of children whose circumstance of death was sudden unexpected death in infancy (SUDI) reduced in 2018. There were two deaths where the circumstance is listed as ‘undetermined’. The Coroner has not yet determined the cause of death for these children.

**Figure 4: Children who died in 2017 and 2018 and were known to DCJ, by circumstance of death**



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

Table 2 compares the circumstances of death for children who were known to DCJ and who died between 2015 and 2018. Despite little change in the overall number of deaths in 2017 and 2018, the numbers of children who died in each category has changed in some areas.<sup>35</sup> These changes include:

- a decrease in the number of child deaths classified as SUDI
- an increase in the number of child deaths from suicide
- an increase in the number of child deaths from motor vehicle accident
- an increase in the number of child deaths from drowning.

**Table 2: Children who died and were known to DCJ, by circumstance of death, 2015–2018<sup>36</sup>**

| Circumstance of death            | 2015      |            | 2016      |            | 2017      |            | 2018      |            |
|----------------------------------|-----------|------------|-----------|------------|-----------|------------|-----------|------------|
|                                  | No.       | %          | No.       | %          | No.       | %          | No.       | %          |
| Accidental asphyxia              | 1         | 1          | 0         | 0          | 1         | 1          | 0         | 0          |
| Accidental choking               | 0         | 0          | 0         | 0          | 0         | 0          | 1         | 1          |
| Drug overdose                    | 0         | 0          | 1         | 1          | 1         | 1          | 2         | 2          |
| Drowning                         | 1         | 1          | 5         | 5          | 1         | 1          | 2         | 2          |
| Extreme prematurity              | 8         | 10         | 11        | 12         | 13        | 14         | 10        | 11         |
| Fire                             | 1         | 1          | 2         | 2          | 0         | 0          | 1         | 1          |
| Illness or disease               | 33        | 42         | 34        | 36         | 44        | 48         | 38        | 41         |
| Inflicted or suspicious injuries | 4         | 5          | 4         | 4          | 4         | 4          | 8         | 9          |
| SUDI                             | 13        | 16         | 15        | 16         | 13        | 14         | 10        | 11         |
| Suicide (including suspected)    | 4         | 5          | 11        | 12         | 4         | 4          | 8         | 9          |
| Motor vehicle accident           | 10        | 13         | 9         | 10         | 2         | 2          | 10        | 11         |
| Undetermined                     | 4         | 6          | 0         | 0          | 7         | 8          | 2         | 2          |
| Other accidental injury          | 0         | 0          | 2         | 2          | 1         | 1          | 1         | 1          |
| <b>Total</b>                     | <b>79</b> | <b>100</b> | <b>94</b> | <b>100</b> | <b>91</b> | <b>100</b> | <b>93</b> | <b>100</b> |

### 2.3.1 Deaths from illness and/or disease

Deaths from illness and/or disease account for the greatest proportion of child deaths in 2018. This is consistent with previous years. The information below provides further information about the circumstances and experiences of these children.

In 2018, 38 children (41 per cent) died from illness and/or disease. This figure represents a decrease from 2017, however is more consistent with previous years. Table 3 highlights this in more detail.

**Table 3: Children who died from illness and/or disease and were known to DCJ, 2015–2018**

|                   | 2015       | 2016       | 2017       | 2018       |
|-------------------|------------|------------|------------|------------|
| No. of deaths     | 33         | 34         | 44         | 38         |
| % of total deaths | 42         | 36         | 48         | 41         |
| Age range         | 0–17 years | 0–17 years | 0–17 years | 0–17 years |

<sup>35</sup> Figures are subject to fluctuation across years due to the small numbers. Conclusions should not be drawn about the changes.

<sup>36</sup> The numbers for some circumstances of death in this table have varied from reports in previous years. This is due to updated information from the Coroner or NSW Ombudsman about causes and circumstances of death. In particular, deaths that were once classified as 'undetermined' or 'SUDI' have been confirmed to be from illness and/or disease. Percentages may not add up to 100% due to rounding.

Of the 38 children who died from illness and/or disease, information provided to DCJ indicates that 25 of the children had been diagnosed with a medical condition<sup>37</sup> before their death and 15 of the children had a diagnosed disability before their death.

### Babies who died from illness and/or disease

Of the 38 children who died from illness and/or disease, 14 (37 per cent) were less than 12 months of age when they died, and 11 (79 per cent) of those children died at birth or in the first month after their birth.

While it is unlikely that DCJ could have prevented the deaths of these children, it is important to view these deaths through a child protection lens, to identify the opportunities that DCJ had to work with the parents and carers of these children to create safety.

Of the 14 babies under the age of 12 months who died from illness and/or disease, nine babies had a ROSH or prenatal report made about them before their death raising concerns about:

- the child's siblings having current child protection concerns and the child's mother's impending pregnancy (5 babies)
- the child's mother having a child protection history that may cause a risk of harm to the child once born (1 baby)
- the child's mother using drugs and/or alcohol during pregnancy (3 babies)
- the child's father using violence against the child's mother placing the child at risk of harm (1 baby)
- the child's mother not accessing antenatal care (4 babies)
- the child's father's use of drugs and/or alcohol, use of violence and mental health impacting on the child's mother and causing risk of significant harm to the child (1 baby).

Of the nine babies who had a ROSH or prenatal report raising concerns about them before their death, the parents of seven babies had a child protection history. Chapter 3 of this year's annual report includes a cohort review of children who died between 2015 and 2018 and whose parents had been reported at risk during their own childhood. Overall, the cohort review seeks to highlight the complexities of child protection practice, explore what DCJ has learned from its review of children who died in such tragic circumstances, and understand how a parent's own childhood experiences may impact on their experience as a parent.

### WORKING WITH PARENTS DURING PREGNANCY

Where available, the preferred DCJ model for working with parents when concerns are raised during pregnancy is the Pregnancy Family Conferencing program. The Pregnancy Family Conferencing program provides early engagement and inter-agency care planning for pregnant women and families, where there are serious child protection concerns and risk of taking the newborn into out of home care at birth. The program aims to improve the health and wellbeing of pregnant women and families who require intervention from child protection services.

Go to [aci.health.nsw.gov.au/innovation-exchange/projects/pregnancy-family-conferencing](https://aci.health.nsw.gov.au/innovation-exchange/projects/pregnancy-family-conferencing) for more information.

Stressors for parents and carers of a child with an illness or disease can lead to and exacerbate other child protection concerns, such as parental mental health issues, domestic violence, problematic drug and alcohol use, and the neglect of the child or young person's medical, physical and emotional needs. Recognising the challenges faced by parents and carers of a child with an illness or disease is critical to understanding and better supporting families, and assessing safety and risk for children.

<sup>37</sup> This figure is based on information known to DCJ. It is possible that more children had an existing medical condition prior to their death that was not reported to the department.

Serious case reviews have found that even experienced parents and carers face challenges in meeting the emotional and physical needs of children with complex health issues. Ongoing case management and support to parents and carers is important to ensure that a child’s medical needs do not prevent them from receiving the love, nurture and stimulation they require for quality of life. Careful case management and support for parents and carers allows for work with families and other agencies to be organised and undertaken, and helps to case plan for children with complex medical needs. Chapter 3 of the *Child Deaths 2017 Annual Report* includes a cohort review of children who died between 2013 and 2017 from illness and/or disease and considers these issues and others in more detail.

### 2.3.2 Deaths related to premature births

In 2018, 10 babies died from conditions related to their premature birth (11 per cent of all deaths of children known to DCJ) as shown in Table 4. Six babies died at birth or within the first 24 hours after birth. Two babies died within one month of their birth and one baby died in the first three months after their birth.

**Table 4: Babies who died from conditions related to their premature birth and were known to DCJ, 2015–2018**

|                   | 2015       | 2016       | 2017       | 2018       |
|-------------------|------------|------------|------------|------------|
| No. of deaths     | 8          | 11         | 13         | 10         |
| % of total deaths | 10         | 12         | 14         | 11         |
| Age range         | 0–1 months | 0–1 months | 0–3 months | 0–6 months |

Understanding the factors that may have contributed to these premature births and the subsequent deaths of these 10 babies can lead to greater insights about the support needs of the families DCJ works with. The health status and health care of the general population of women, their access to and the quality of preconception, reproductive, antenatal and obstetric services, and health care in the neonatal period are often reflective of perinatal mortality.<sup>38</sup> Broader social factors such as social disadvantage, maternal education, nutrition, smoking and substance use in pregnancy are also significant risk factors that have an association with preterm birth.<sup>39</sup>

Of the 10 babies known to DCJ who died from conditions related to their premature birth, DCJ received prenatal reports for four of the babies raising concerns about:

- the child’s mother using drugs and/or alcohol during the pregnancy (1 baby)
- the father’s violence towards the child’s mother during the pregnancy (2 babies)
- the child’s mother leaving hospital against medical advice (1 baby).

#### Pregnancy and substance use

The use of alcohol or other drugs during pregnancy is linked to many potential risks for a baby. While pregnancy increases many women’s motivation to change their substance use, it is important to remember that dependency is an illness, not just a behaviour. Some women may not be ready to change. If the pregnancy has been unplanned, creating new patterns of behaviour or finding new ways to manage emotional and physical needs can be even more challenging.

Substance use during pregnancy can harm a growing foetus and can result in low birth weight and premature birth. However, when responding to reports that raise concerns that a woman is using drugs and/or alcohol during pregnancy, it is important to recognise that a dependency on drugs and/or alcohol can be linked to social stressors and physical and mental health.

While not all women who use substances and/or alcohol during pregnancy experience problems with their physical and mental health, many women experience poverty, encounter social disadvantage, face unemployment, are young parents, have poor health and miss out on antenatal care. Mental health

<sup>38</sup> Department of Prime Minister and Cabinet (2014).

<sup>39</sup> Department of Health (2019).

issues are common when there is an alcohol or drug dependency, with depression and anxiety the most common diagnoses.<sup>40</sup>

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

## WORKING WITH PARENTS TO REDUCE RISKS FOR THEIR BABY

Babies are safer when their parents are getting both antenatal care and treatment for their alcohol or other drug use. It is the practitioner's role to make sure expectant parents are connected to the best available service to them. The NSW Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period (NSW Clinical Guidelines)<sup>41</sup> provides in-depth advice about appropriate treatments.

Additionally, Substance Use in Pregnancy and Parenting Services (SUPPS) provide multidisciplinary support for pregnant women who use alcohol and other drugs during pregnancy, their families and the service system. These services were expanded in 2016 across NSW. This has resulted in most local health districts having some coverage of support for pregnant women who may be using substances and their families. SUPPS offers intensive clinical and case management to pregnant women who use substances, from the antenatal period up to five years post-delivery. Through these services, key partnerships are formed between maternity, child and family health, child protection and alcohol and other drug services

## DCJ CASEWORK PRACTICE

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

## Domestic violence in pregnancy

Research suggests that domestic and family violence often begins during pregnancy or, if violence already existed, can get worse during pregnancy and into the first month of motherhood.<sup>42</sup>

Women who experience violence during pregnancy are at an increased risk of postnatal depression, which can impact on the bond and attachment between a mother and her baby. Violence during pregnancy can lead to babies having a low birth weight or being born prematurely.<sup>43</sup>

Pregnancy and early parenthood are good opportunities to engage women and men, if violence is suspected, as families are likely to come into contact with health and other social services during the antenatal period.<sup>44</sup> Expecting and new mothers may also be in a good place to be motivated towards change. Engaging men at this stage can also help to create safety for women and children. It is important to recognise a man's role as a father and carer first while engaging him in conversations about how his violent behaviour may impact those close to him. A father who is expecting a new baby may also be motivated to change his behaviour.

40 National Drug and Alcohol Research Centre (NDARC) (2018).

41 NSW Health (2014).

42 Australian Institute of Family Studies (AIFS) (2016b).

43 *ibid.*

44 *ibid.*

## LIVING THE PRACTICE FRAMEWORK

Social responses to violence have the power to further reinforce violence and oppression, or validate positive experiences and support recovery. It is important for caseworkers to learn about and recognise adults' and children's acts of resistance, because it allows them to understand how a person exercises caution, creativity, deliberation or awareness to enable them to handle a difficult situation.

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

## DCJ CASEWORK PRACTICE

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

### 2.3.3 Motor vehicle accidents

In 2018, 10 children died from motor vehicle accidents (11 per cent of all deaths of children known to DCJ). This represents an increase from 2017 where only two children died from motor vehicle accidents. A review of the deaths of children known to DCJ from motor vehicle accidents since 2015 indicates that this circumstance of death is changeable from year to year, as shown in Table 5.

Eight of the children who died in motor vehicle accidents were male and two were female. Of the 10 children who died, seven died as a passenger in the car, two died in motorcycle accidents and one child died after being hit by a car.

**Table 5: Children who died by motor vehicle accident and were known to DCJ, 2015–2018**

|                   | 2015       | 2016       | 2017       | 2018       |
|-------------------|------------|------------|------------|------------|
| No. of deaths     | 10         | 9          | 2          | 10         |
| % of total deaths | 13         | 10         | 2          | 11         |
| Age range         | 1–17 years | 9–17 years | 8–17 years | 3–17 years |

### 2.3.4 Sudden unexpected death in infancy

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

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

**Table 6: Babies who died suddenly and unexpectedly and were known to DCJ, 2015–2018**

|                   | 2015        | 2016        | 2017       | 2018        |
|-------------------|-------------|-------------|------------|-------------|
| No. of deaths     | 13          | 15          | 13         | 10          |
| % of total deaths | 16          | 16          | 14         | 11          |
| Age range         | 0–11 months | 0–11 months | 0–9 months | 0–11 months |



As shown in Table 6, 10 babies died suddenly and unexpectedly in 2018, accounting for 11 per cent of the deaths of children known to DCJ in 2018. Post-mortem reports were available for three of the babies and provided the cause of death as 'SUDI unexplained'.

In 2019, the CDRT published a review of 83 infants whose deaths were sudden and unexpected in 2016 and 2017. The review<sup>45</sup> found that:

- although SUDI has declined over the past 15 years, this decline has plateaued and the rate has not changed significantly over the past decade
- most infants who die suddenly and unexpectedly are very young; over two-thirds of the infants whose death was classified as SUDI over the past 15 years were aged less than three months
- most infants who died suddenly and unexpectedly were exposed to at least one avoidable risk, including smoking and objects that pose a risk of suffocation
- over the last 15 years, almost half of the infants whose death was classified as SUDI were from families with a child protection history
- agencies need to continue to focus on targeting interventions to parents of infants in disadvantaged and vulnerable families
- comparing the number of explained deaths over the period 2014–2015 with 2016–2017, the proportion of sudden and unexpected infant deaths where a cause was identified through post-death investigation increased from 27 per cent to 45 per cent.

Families known to DCJ are more likely to experience a child dying in sudden and unexpected circumstances. The SUDI mortality rate is higher for children with a child protection history.<sup>46</sup>

Three of the 10 babies who died in circumstances of SUDI were from Aboriginal families. Over the past few years, the number of children from Aboriginal families who have died in circumstances of SUDI has fluctuated. The number of children from Aboriginal families who died from SUDI-related circumstances in 2017 was five, a decrease from 2016.

Of the 10 babies who died suddenly and unexpectedly in 2018, eight of the babies had a report made about them before their deaths (6 prenatal, 2 ROSH). One of the babies was known to DCJ because their sibling had been reported at ROSH in the three years before the child's death. The issues reported to DCJ were:<sup>47</sup>

- parental drug and/or alcohol use (6 babies)
- father's violence toward the child's mother (4 babies)
- cumulative harm due to chronic neglect (2 babies)
- lack of antenatal care (3 babies).

Of the 10 babies who died suddenly and unexpectedly in 2018, one or more modifiable risk factors (characteristics in an infant's sleep environment) were found in seven of the families. A modifiable risk factor increases the risk of SUDI and includes:

- the baby being placed to sleep in bed with a parent (5 babies)
- soft objects or other objects in the sleep environment (1 baby)
- the baby being breastfed and their parent falling asleep (1 baby).

The number of children who die suddenly and unexpectedly in infancy highlights the need for practitioners to understand and be aware of modifiable risk factors.

When working with families that are known to DCJ, practitioners should promote that the safest place for a baby to sleep is in their own safe sleeping place in the same room as an adult carer.

Practitioners must be clear in their messages about safe sleeping when they are speaking to families. Practitioners should also participate in ongoing training to keep their skills and knowledge up to date.

45 NSW Child Death Review Team (2019).

46 *ibid.*

47 Numbers do not add up to 10 because of multiple reported issues.

An ongoing challenge for practitioners working with families who experience a range of vulnerabilities is that messages about safe sleeping are not always received, understood or adopted. In some instances, safe sleeping arrangements may need to be assessed over time. Practitioners need to build relationships with families and communities, and support families to find ways to keep their babies safe. It is important that practitioners are consistent, persistent and non-judgemental when talking to families about safe sleeping arrangements.

## SAFE SLEEPING AND COT-TO-BED SAFETY

NSW Health has several resources for families that provide clear messages around safe sleeping. These include a Safe Sleep Cot Card and a safe sleeping brochure for Aboriginal families. NSW Health also provides information for professionals on its website.<sup>48</sup>

The Red Nose Foundation has developed two mobile phone apps – called Red Nose Safe Sleeping and Red Nose Cot-to-Bed Safety – for expectant mothers, carers and professionals, aimed at providing vital educational information on topics such as safe sleeping, tummy time, safe wrapping, when to move a child from their cot into a bed, what type of bed to use and how to provide a safe environment for a child.<sup>49</sup>

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

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

The *Child Deaths 2013 Annual Report* included a cohort review of 108 babies who died suddenly and unexpectedly between 2008 and 2013. In 2015, the findings from this review were used to develop a training package that was delivered across DCJ. Helpful practice tips for talking with parents about safe sleeping are included below.

## SAFE SLEEPING

### Ask to see the baby's cot

- Does it meet the Australian safety standard?<sup>50</sup>
- Is the mattress in good condition? Is it firm, flat and the right size for the cot?
- Make sure there is nothing in the cot – remove all loose/soft objects, including toys, pillows, bumpers and loose bedding, and talk to parents about the dangers of these items.
- Ask the parents to show you how they put their baby to sleep.
- Reinforce to parents that the safest place for their baby to sleep is in a cot next to their bed.
- Explain to parents that covering a baby's head increases the risk of sudden infant death.
- Is the bedroom free of other risks, including cigarette smoke?

### Assess the risk of substance use

- Ask parents about their alcohol and drug use. Do they use drugs and alcohol? If so, what alcohol and drugs (including prescribed medication) and how much? When do they use and what impact does it have on them? When did they last use? What types of drugs or alcohol did they take and did they feel sleepy or sedated?

*continued next page...*

<sup>48</sup> NSW Health (2017).

<sup>49</sup> See also Red Nose Foundation (2018).

<sup>50</sup> All baby cots must meet Australian and New Zealand Standard AS/NZS 2172:2003 *Cots for household use – safety requirements*.

- Ask parents about their baby's sleep routine. Does this routine coincide with their substance use? Is there another adult in the home who can care for or supervise the baby when they use?
- Explain to parents the risks associated with sleeping with their baby while under the influence of substances.

#### **Discuss sleep routines**

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

#### **Parents who smoke**

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

#### **Talk to breastfeeding mothers**

- Educate mothers so they are aware of the potential dangers of fatigue and sedation.
- Encourage mothers to breastfeed their baby out of bed to avoid the risk of falling asleep.
- If a mother is using substances, refer to the NSW Clinical Guidelines mentioned earlier in this report.

#### **Did you know**

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

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

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

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

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

### 2.3.5 Suicide

In 2018, eight young people died as a result of suicide or suspected suicide (9 per cent of all deaths of children known to DCJ). Of the eight young people who died, six were male and two were female. The young people ranged in age from 13 to 17 years.

**Table 7: Children who died by suspected suicide and were known to DCJ, 2015–2018**

|                   | 2015        | 2016        | 2017          | 2018        |
|-------------------|-------------|-------------|---------------|-------------|
| No. of deaths     | 4           | 12          | 4             | 8           |
| % of total deaths | 5           | 13          | 4             | 9           |
| Age range         | 13–17 years | 13–17 years | < 10–17 years | 13–17 years |

Of the eight young people who died from suicide, all experienced trauma in their childhood. This trauma included neglect, physical abuse, witnessing domestic violence, parental mental health concerns and parental drug and/or alcohol use. Five of the eight young people were reported to be at risk of sexual harm.

DCJ received ROSH reports for seven of the eight young people who died by suicide in the 12 months prior to their death. Reported concerns were about the young person’s risk-taking behaviour, alcohol or drug misuse and problematic sexual behaviour, physical abuse and self-harming behaviour.<sup>51</sup>

Four of the young people had concerns raised about their mental health prior to their death, including three of the young people having self-harmed.

In 2014, a cohort review undertaken by the Serious Case Review Team of vulnerable teenagers who died revealed that those who died from suicide faced multiple individual, social and contextual risk factors<sup>52</sup> that heightened their vulnerability and compromised their safety. For children known to DCJ, it is often the combination of these factors that poses the greatest risk for suicide.<sup>53</sup> Risk factors can relate to events or triggers; for example, sexual assault or bullying. The cumulative effect of neglect is likely to increase a child or young person’s vulnerability over time.<sup>54</sup>

In 2019, the NSW Child Death Review Team Report identified that in 2016 and 2017, the suicide rate for school-aged young people aged 10–17 had increased and males continued to be more highly represented than females, as were young people from an Aboriginal background.<sup>55</sup>

The NSW Premier’s Priority Towards zero suicides aims to reduce the rates of suicide in NSW by 20 per cent by 2023, as part of an ambitious journey towards zero suicides. The NSW Government is investing in a number of initiatives to address priorities under the *Strategic framework for suicide prevention in NSW 2018–2023*, which is outlined in more detail below.<sup>56</sup>

51 Other reported ROSH concerns related to parental risk factors such as mental health, domestic violence, neglect, inadequate shelter or homelessness.

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

53 The suicide of young people was considered in detail in Chapter 3 of the NSW FACS *Child Deaths 2014 Annual Report*. The report highlighted a number of themes from reviews to help in understanding the risks associated with suicide. See NSW FACS (2015).

54 NSW Child Death Review Team (2014).

55 NSW Child Death Review Team (2019).

56 See NSW Health (2019).

## A STRATEGIC FRAMEWORK FOR SUICIDE PREVENTION

In October 2018, in conjunction with the release of the *Strategic framework for suicide prevention in NSW 2018–2023*, the NSW Government announced additional funding of \$87 million over three years for eight *Towards zero suicides* initiatives.<sup>57</sup>

- After-care services for people who have made a suicide attempt.
- Alternate services for people presenting to emergency departments in distress.
- Support services for people bereaved by suicide.
- More counsellors for regional and rural communities.
- Expanded community mental health outreach teams.
- Strengthening practices in the mental health system to eliminate suicides and suicide attempts among people in care.
- Resilience building in local communities.
- Improvements to the collection and distribution of suicide data in NSW.

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

## PREMIER'S YOUTH INITIATIVE

The Premier's Youth Initiative is a pilot program that provides services to young people leaving statutory out of home care, who are identified as being vulnerable to experiencing homelessness or are at risk of homelessness when leaving care. The program aims to build the long-term capacity and resilience of young people in order to permanently divert them from the homelessness service system.

The Premier's Youth Initiative is available in the DCJ districts of Hunter, Central Coast, Illawarra Shoalhaven, Southern NSW, Mid North Coast, Northern NSW, Nepean Blue Mountains, New England, South Western Sydney and Western NSW.

Go to [nsw.gov.au/improving-nsw/premiers-priorities-2015-2019/reducing-youth-homelessness](https://nsw.gov.au/improving-nsw/premiers-priorities-2015-2019/reducing-youth-homelessness) for more information.

## LIFE SPAN FOR SUICIDE PREVENTION

Funded by the Paul Ramsay Foundation and with the support of the NSW Government, the Black Dog Institute is trialling **LifeSpan**, a systems approach to suicide prevention, incorporating health, education, frontline services, business and the community. LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis.

LifeSpan is currently being trialled in four sites in Newcastle, Illawarra Shoalhaven, Central Coast and Murrumbidgee.

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

### 2.3.6 Inflicted or suspicious injuries

In 2018, eight children died from suspicious or inflicted injuries (9 per cent of all deaths of children known to DCJ). This was double the number from previous years.<sup>58</sup> While it is difficult to identify the cause of the increase, it appears to be largely attributable to the deaths of a number of children from one family occurring at the same time. Additionally, the death of one child interstate was reviewable because the child had been resident in NSW in the three years prior to their death even though the child was spending a significant amount of time in Victoria; and the death of one child in NSW was reviewable because even though the child and their family were normally living in Queensland, the child was visiting NSW at the time of their death.

At the time of publishing this report, five of these eight deaths are before the criminal court or police investigations are still underway.

### 2.3.7 Other circumstances of death

#### Drowning

In 2018, two children died from drowning (2 per cent of all deaths of children known to DCJ). The deaths of children from drowning has fluctuated over the last several years. In 2017, there was one death from drowning compared to five deaths in 2016.<sup>59</sup>

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

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

- Don't get distracted.
- Designate a supervisor so an adult is always watching.
- Ensure pool fences meet safety standards.
- Ensure the pool gate is securely closed.<sup>60</sup>

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

#### SAFETY AROUND WATER

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

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

The Office of the Children's Guardian now specifically mentions swimming pool safety compliance as part of the out of home care standards. DCJ and NGOs now include compliance checking for children's access to water during foster or relative carer assessments as part of the home safety inspection checklist. Additionally, there are a number of resources and fact sheets available to practitioners to provide to families, carers and the public, to raise awareness about the importance of water safety.

<sup>58</sup> There were four child deaths in each of 2015, 2016 and 2017 from an inflicted or suspicious injury.

<sup>59</sup> Further, of children known to DCJ, there were five deaths as a result of drowning in 2014 and one death in 2015.

<sup>60</sup> NSW Government (2017).

## SWIMMING POOL FAQs

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

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

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

## Drug overdose

Two children (2 per cent of all deaths of children known to DCJ) died accidentally from drug overdoses in 2018. One child died from ingesting their parent's methadone and one young person died from 'hydrocarbon toxicity'.<sup>61</sup>

## METHADONE STORAGE

There is no safe dosage of methadone for a child and methadone should always be stored in a locked space and out of reach from any children.

## Other accidental circumstances

In 2018, one child died after being hit by a train, one child died after accidentally choking on an object and one child died in a house fire.

### 2.3.8 Undetermined deaths of children

At the time of writing this report, two of the children's causes of death have not been determined by the NSW Coroner and their circumstances of death are unable to be reported.

## 2.4 DCJ response to the children who died in 2018

This section outlines DCJ involvement with the families of the 93 children who died in 2018. It discusses information about the number of reports received, what the reports were about, what decisions were made in response to reports, and whether the children were living with family at the time of their death. This section also considers how DCJ responded to families after their child's death to ensure that any siblings were safe.

### 2.4.1 ROSH reports

Of the 93 children who died in 2018, 70 (75 per cent) were reported at ROSH in the three years before their death. This is more than in 2017, when 58 children (63 per cent) were the subject of a ROSH report in the three years prior to their death, but consistent with previous years. Of these 70 children, 28 (30 per

<sup>61</sup> 'Hydrocarbon poisoning can occur from accidental exposure (often young children) or deliberate exposure (often from inhalation e.g. from "sniffing" or "chroming"). Sources include petrol, kerosene, lighter fluid, paraffin oil, two stroke fuel, diesel fuel, solvents, white spirit, lubricating oil, furniture polishes, essential oils and mineral turpentine.' (Royal Children's Hospital Melbourne, 2017).

cent) were the subject of a ROSH report in the 12 months before their death. The remaining 42 children (45 per cent) were the subject of a ROSH report to DCJ in the three years prior to their death.

Fifteen (16 per cent) of the 93 children who died in 2018 were not reported to DCJ at ROSH, but a sibling was reported prior to the child or young person's death.

Fifty-seven (61 per cent) of the children who died did not have a lengthy child protection history, with between zero and two ROSH reports received prior to their death.<sup>62</sup> Twenty (22 per cent) of the children were reported at ROSH three to five times. Fourteen (15 per cent) of the children were reported at ROSH more than five times, with two children having more than 30 ROSH reports.

Sixty-two (67 per cent) of the children who died, or their siblings, had previously had a face to face assessment with DCJ before the child's death. Thirty-six of the children or their siblings received the assessment in the 12–18 months before their death.

Many of the children who died and who were known to DCJ received a practitioner response to assess the child's safety and risk, and were required develop a plan with the child's family to address the identified concerns. Regular quality assessments and case plan reviews help to identify the changing needs of children and families, and to adapt plans to meet those changing needs. Establishing realistic goals and agreed case plans to address those goals in consultation with families can create change and lead to improved child safety.

The NSW Practice Framework is designed to enable practitioners to partner with families, understand the worries and risks for children and to be agents of change.

## LIVING THE PRACTICE FRAMEWORK

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

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

## DCJ CASEWORK PRACTICE

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

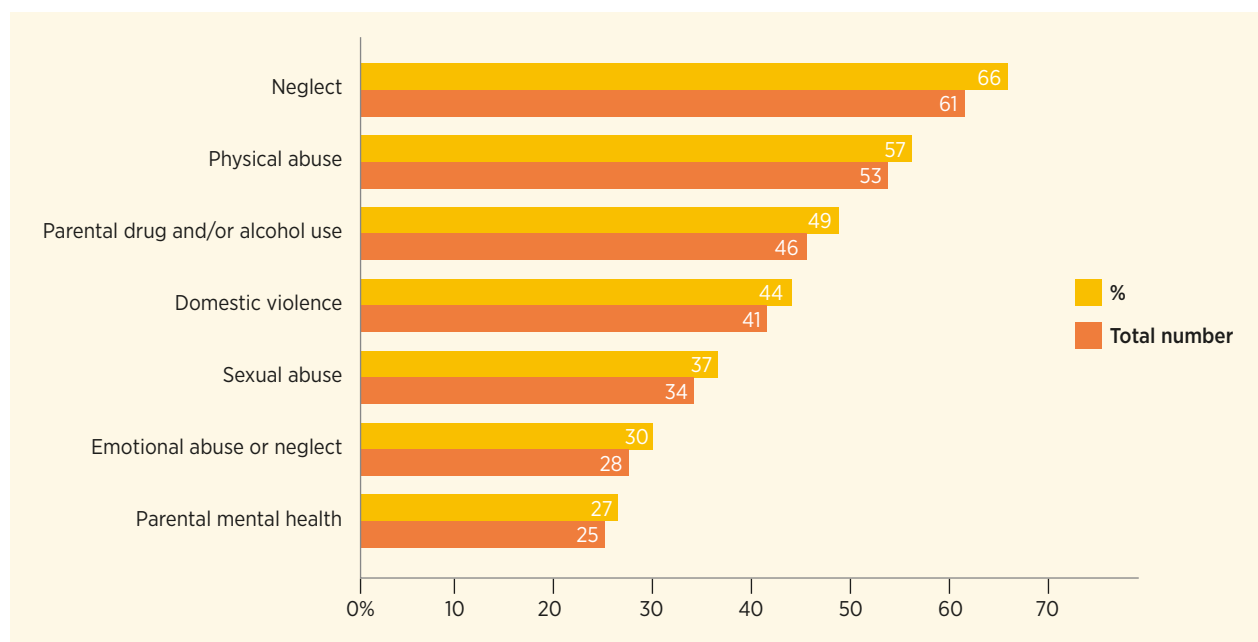
<sup>62</sup> This figure only includes children who died and who were reported to DCJ.



## 2.4.2 Reported risk concerns

Neglect, physical abuse, parental drug and/or alcohol use and domestic violence were the highest reported issues identified from the ROSH reports received for children who died in 2018 and their siblings.

**Figure 5: Children who died in 2018 and were known to DCJ, by selected reported issues in ROSH reports received about them and their families<sup>63</sup>**



A total of 61 children (66 per cent) and their families were reported to DCJ due to ROSH concerns about neglect. These families were reported for one or more types of neglect:<sup>64</sup>

- supervisory neglect (33 families)
- physical neglect (33 families)
- emotional abuse/neglect (28 families)
- medical neglect (28 families)
- educational neglect (9 families).

The main issues reported for children who died in 2018 rarely occurred in isolation. Practitioners often work with families where co-existing conditions<sup>65</sup> are present. A practitioner's role is to assess how the issues reported may impact on parenting and, in turn, the child's safety. A parent who is experiencing multiple challenges will often have a number of vulnerabilities and factors that influence this, including:

- current or past experience of trauma or childhood abuse (see Chapter 3 of this report)
- social disadvantage, living in poverty, family breakdown, intergenerational abuse or trauma
- early school failure, social isolation, peers involved with alcohol and/or drug use
- a community with disadvantages and a lack of social resources, or a neighbourhood characterised by high crimes or low employment rates
- unemployment, trauma (physical, emotional or sexual abuse), isolation, disconnection and family breakdown.<sup>66</sup>

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

<sup>63</sup> Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.

<sup>64</sup> Numbers do not add to 61 as multiple neglect issues can be present in one family.

<sup>65</sup> Previously known as dual diagnosis or comorbidity.

<sup>66</sup> NSW DCJ Casework Practice topic *Alcohol and other drugs: Risk assessment*. See also a list of DCJ Casework Practice intranet URLs in the reference section of this report.

## LIVING THE PRACTICE FRAMEWORK

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

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

## DCJ CASEWORK PRACTICE

The Casework Practice topic **Social justice and human rights** can help practitioners to consider multiple challenges, vulnerabilities and factors when completing safety and risk assessments.

## GROUP SUPERVISION AT DCJ

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

Current evidence highlights that group supervision in child protection work benefits practitioners, children and families because it:

- allows practitioners to share the risk in decision-making
- provides practitioners with multiple perspectives to support decision-making
- promotes ethical, transparent and dignity driven practice
- supports workers collectively to manage uncertainty
- supports practitioners to identify feelings arising from the work and draw on each other for structured emotional support
- develops important group work skills
- is a forum for learning and professional development

There is a strong and emerging evidence base<sup>67</sup> about the value of group supervision in child protection. Well delivered, it supports strength-based, family-focused child protection practice.

Group supervision helps practitioners, practice leaders and DCJ to fulfil our mandate to embed principles, approaches and capabilities into practice with children and families.

<sup>67</sup> DeWane (2013); Hawkins & Shohet (2000); Lohrback (2008).

### 2.4.3 Children in out of home care

As shown in Table 8, eight children in 2018 were in out of home care when they died. This represents nine per cent of all the children who died and were known to DCJ in 2018, the lowest in five years.

**Table 8: Children who were living in out of home care when they died, 2014–2018**

|   | 2014       | 2015       | 2016       | 2017       | 2018       |
|---|------------|------------|------------|------------|------------|
| Number of deaths  | 10         | 9          | 10         | 9          | 8          |
| Placed with a relative                                      | 2          | 1          | 4          | 4          | 3          |
| Placed with authorised carers                               | 7          | 7          | 4          | 3          | 5          |
| Other (e.g. independent living, residential care, hospital) | 1          | 1          | 2          | 2          | 0          |
| % of total deaths   | 12         | 11         | 11         | 10         | 9          |
| Age range   | 0–15 years | 0–17 years | 0–17 years | 0–17 years | 0–17 years |
| Parental responsibility of Minister (any aspect)            | 9          | 9          | 8          | 8          | 7          |

Seven of these eight children died from illness and/or disease. The other young person's death was from an accidental drug overdose.

Seven of the children who died in 2018 had their parental responsibility reallocated through the Children's Court. The parental responsibility for one child was allocated to a relative, one child had parental responsibility shared between a relative and the Minister for Family, Communities and Disability Services and six children had their parental responsibility allocated to the Minister. Of these six children, one child had been living with relatives, and five children were living with authorised NGO foster carers at the time of their death.

Five of the eight children who died were Aboriginal. Six of the children were male and two of the children were female.

### 2.4.4 How DCJ responded after the child's death

When a child dies due to abuse, neglect or in suspicious circumstances, or the child is in out of home care, DCJ has a responsibility to assess the safety of other children living in the household, including unborn children. DCJ has a sibling safety mandate<sup>68</sup> to guide practitioners when responding to a report about sibling safety after the death of a child.

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

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

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

- working alongside families to assess the safety and wellbeing of children in the household
- assessing a family's support needs, while making a decision about future DCJ involvement
- learning about and considering the family's history
- talking with services that may already be involved with the family

<sup>68</sup> The sibling safety policy states that a response to assess the safety of siblings should happen when the death is due, or may be due to abuse, neglect or suspicious circumstances and there are siblings, unborn children or other children and young people living in the household.

- talking with practice leaders about the impact the child's death has had on the family
- raising any concerns or worries they may have with the family
- working with the family to identify supports that can help in their time of grief
- being conscious of not looking for culpability or blame when responding to a child death where there are suspicious or unknown circumstances
- remembering that the focus is on the children's safety and wellbeing.<sup>69</sup>

Of the 93 children who died and were known to DCJ in 2018, 28 (30 per cent) received an assessment from DCJ following the child's death. This is consistent with previous years. Typically, these assessments involve:

- DCJ providing ongoing case management to families
- families being referred to other appropriate support services
- siblings being taken into care
- DCJ ending its involvement because siblings were assessed as safe in their circumstances.<sup>70</sup>

The remaining 65 (70 per cent) of the 93 families did not receive an assessment by DCJ after the child's death. The decision not to complete a sibling safety assessment is usually made due to:

- no risk issues being identified for the siblings
- no children or young people living in the household who are aged under 18 years<sup>71</sup>
- DCJ already being involved, working with the family and considering the information alongside existing casework
- a child or young person's death being screened as non-ROSH at the Helpline.

<sup>69</sup> NSW FACS (2017a).

<sup>70</sup> *ibid.*

<sup>71</sup> This includes where the child who died did not have any siblings, or the child had siblings who were in out of home care at the time of the child's death.

## Chapter 3: Children who died and whose parents had a child protection history

The child protection history of parents and specifically its later impact on their children is an important and recurring theme in child protection research.<sup>72</sup> Some research suggests that children whose parents experience child abuse are more likely to experience child abuse themselves.<sup>73</sup> It is important to note that from the research considered for this review, it was clear that a parent's experience of abuse as a child does not mean that a parent will go on to abuse their own child. Indeed there is consensus that more research is needed to fully understand why child abuse may occur across generations and to identify those most vulnerable to it.<sup>74</sup>

Understanding the extent to which child abuse in one generation increases risk of child abuse to the next, alongside consideration of the factors that assist children and parents to build resilience and heal from it, will assist practitioners to develop and target their work with families with children who are reported to be at risk of significant harm (ROSH). This cohort review seeks to add to this growing body of research and to inform current child protection practice.

In the four years from 2015 to 2018, 357 children known to DCJ died. For 167 of these children (47 per cent) at least one parent had a child protection history.<sup>75</sup> This chapter contains the findings from a cohort review of these 167 children and their parents.

Section 3.1 introduces the cohort, provides details about the characteristics of the children who died and their parents, and compares some of the child protection issues experienced across the two generations. This information is compared with all children who were known to DCJ and died in the same four-year period.

Section 3.2 has been informed by a qualitative analysis of current research about child abuse occurring from one generation to the next alongside several case studies that highlight issues relevant to practice. It considers the intersection of childhood experiences of abuse and its impact on parenting. The data is also used to highlight those child protection issues most prevalent for children in the study and reveals the importance of relationship-based practice and holistic assessment.

Section 3.3 considers how practitioners can work better with children and families where child abuse has occurred across generations to assess children's safety and work together with parents to build resilience and keep children safe. This part of the report outlines a number of key approaches to enable holistic work and partnership with families and provides suggestions for improving practice through the NSW Practice Framework.

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

### 3.1 The cohort: Children who died 2015–2018 and whose parents had a child protection history

One hundred and sixty-seven children who died and were known to DCJ from 2015 to 2018 had at least one parent with a child protection history. Overall, this represents 47 per cent of children who died during this period.

72 Menger Leeman (2018).

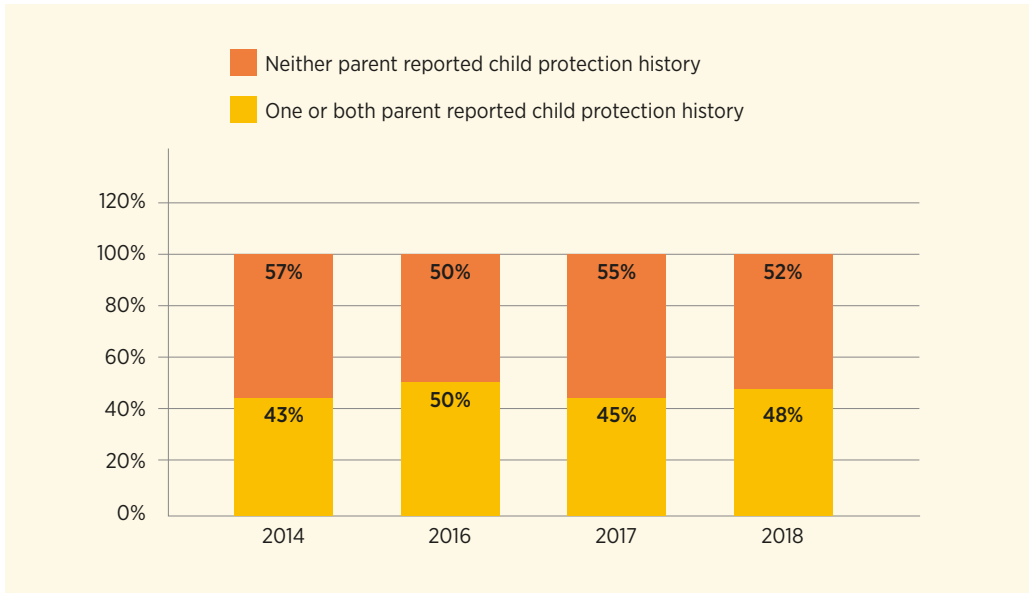
73 Madigan et al. (2019).

74 Butler & Cockburn (2017).

75 History includes reported to a statutory child protection authority or living in out of home care.

The proportion of children who died and whose parents had a child protection history is relatively consistent over each of the years considered in this cohort review. For instance in 2015, 34 (43 per cent) of children had a parent with a child protection history while 45 (57 per cent) did not. This compared with 47 (50 per cent) with a child protection history in 2016 and 47 (50 per cent) who did not. In 2017, 41 (45 per cent) of children’s parents had a child protection history while 50 (55 per cent) did not. In 2018, 45 (48 per cent) had a child protection history, while 48 (52 per cent) did not.

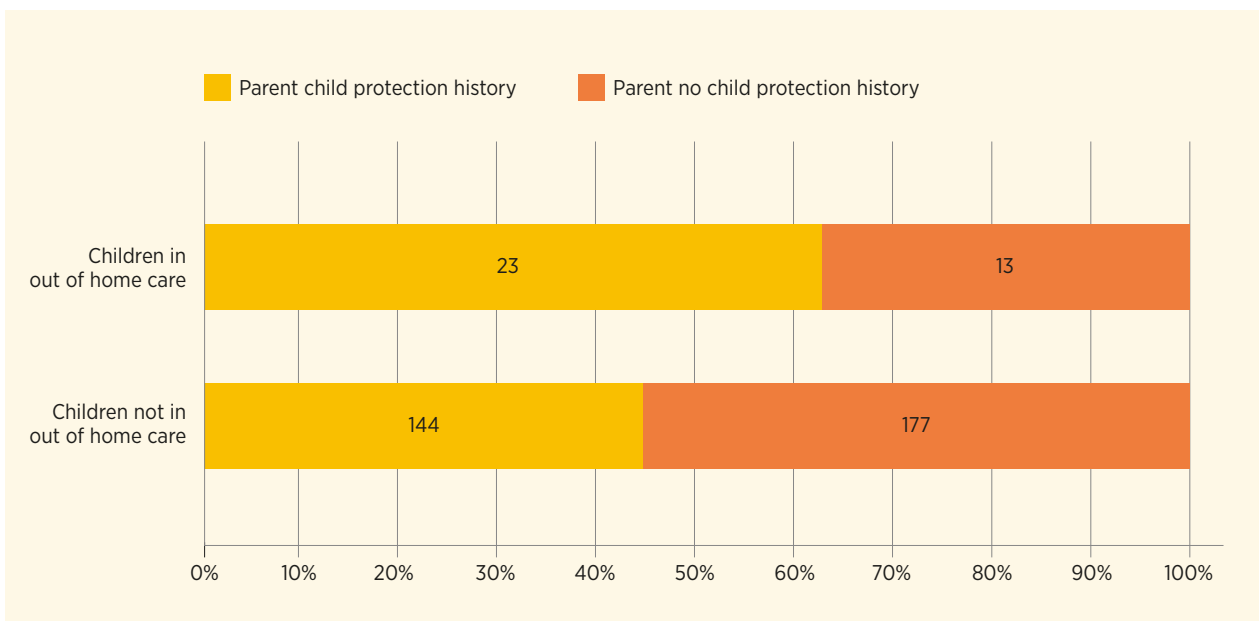
**Figure 6: Proportion of children known to DCJ who died and whose parents had a child protection history, 2015–2018**



### 3.1.1 Children in out of home care

Thirty-six children who died from 2015 to 2018 were living in out of home care at the time of their death. The proportion of children in out of home and whose parents had a child protection history was higher (64 per cent) than for those children not in out of home care (45 per cent).

**Figure 7: Number of children in out of home care and not in out of home care who died and whose parents had a child protection history, 2015–2018<sup>76</sup>**

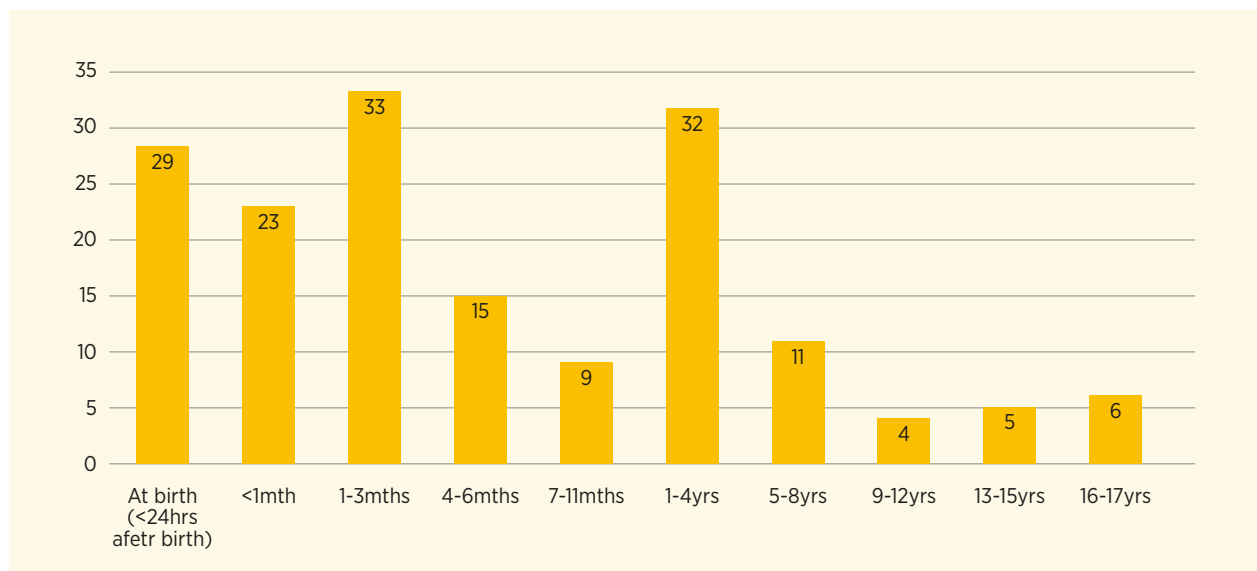


<sup>76</sup> Sixteen of the 23 children who were living in out of home care and whose parents had a child protection history died from an illness and/or disease.

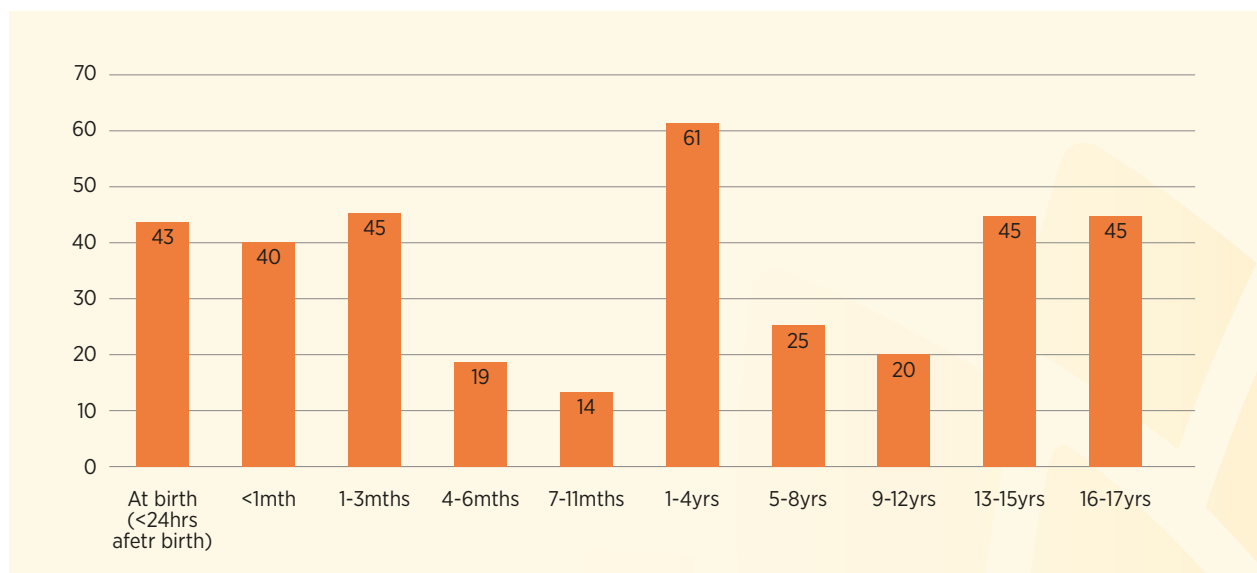
### 3.1.2 Age of children

Seventy-two per cent (121) of the children who died and whose parents had a child protection history were aged one year or under when they died. This compares with 52 per cent (186) of all children who died during the same period, and suggests age as a particular vulnerability for children whose own parents had a child protection history.

**Figure 8: Age of children known to DCJ who died and whose parents had a child protection history, 2015–2018**



**Figure 9: Age of all children known to DCJ who died, 2015–2018**



### 3.1.3 Gender

The gender breakdown of children who died and whose parents had a child protection history was similar to all children who died. In the four years considered, 89 (53 per cent) of children who died and whose parents had a child protection history were male and 78 (47 per cent) were female. These findings are consistent with the CDRT, which also notes a higher overall mortality rate for male children than for female children.<sup>77</sup>

77 NSW Child Death Review Team (2019).

### 3.1.4 Aboriginal status

Of the 167 children who died and whose parents had a child protection history, 81 (48 per cent) of the children were recorded as being Aboriginal. Information about a child's Aboriginal status is not always known or recorded, so this figure could be higher. In comparison, of the 190 children who died and whose parents did not have a child protection history, only 41 children (22 per cent) were recorded as being Aboriginal.

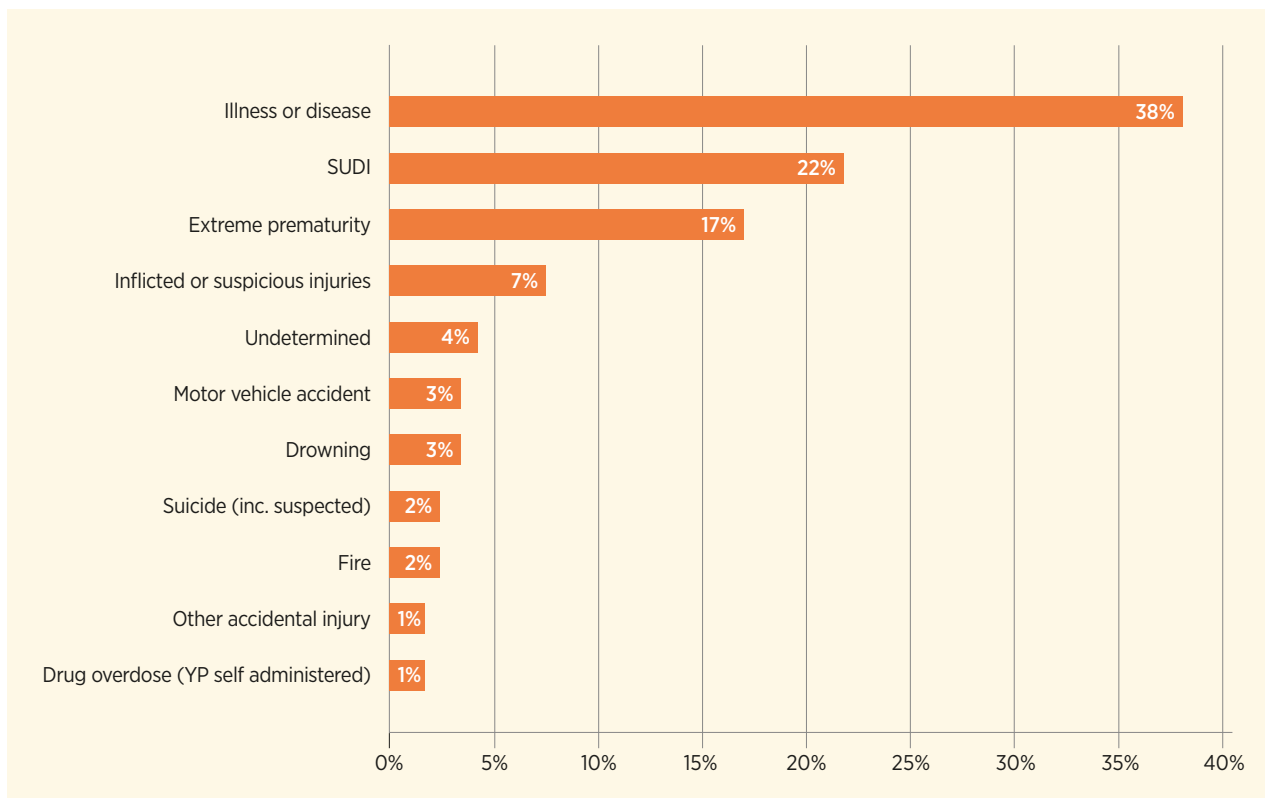
### 3.1.5 Circumstance of death

Most of the deaths of children from 2015 to 2018 whose parents had a child protection history were from illness and/or disease (63 children, 38 per cent), SUDI (36 children, 22 per cent) and extreme prematurity (29 children, 17 per cent) (Figure 10).

While this is consistent with the number of all child deaths known to DCJ during the same period (Figure 11), the proportion of children who died in circumstances of SUDI, extreme prematurity and inflicted or suspicious injuries was higher for those children whose parents had a child protection history.

Similarly for the 81 Aboriginal children whose parents had a child protection history, illness and/or disease (33 children, 41 per cent), SUDI (20 children, 25 per cent) and extreme prematurity (12 children, 15 per cent) were the most frequent circumstances of death.

**Figure 10: Percentage of children known to DCJ who died and whose parents had a child protection history, by circumstance of death, 2015–2018**





**Figure 11: Percentage of all children known to DCJ who died, by circumstance of death, 2015–2018**

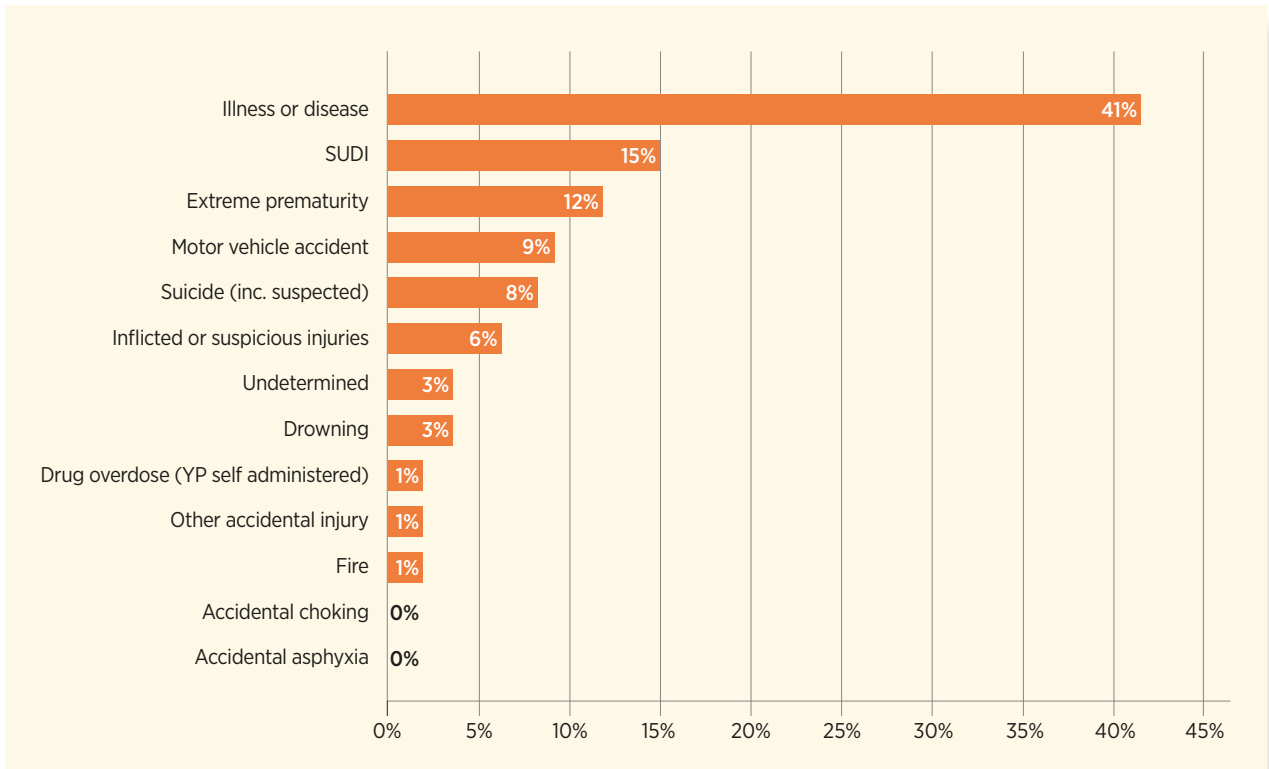
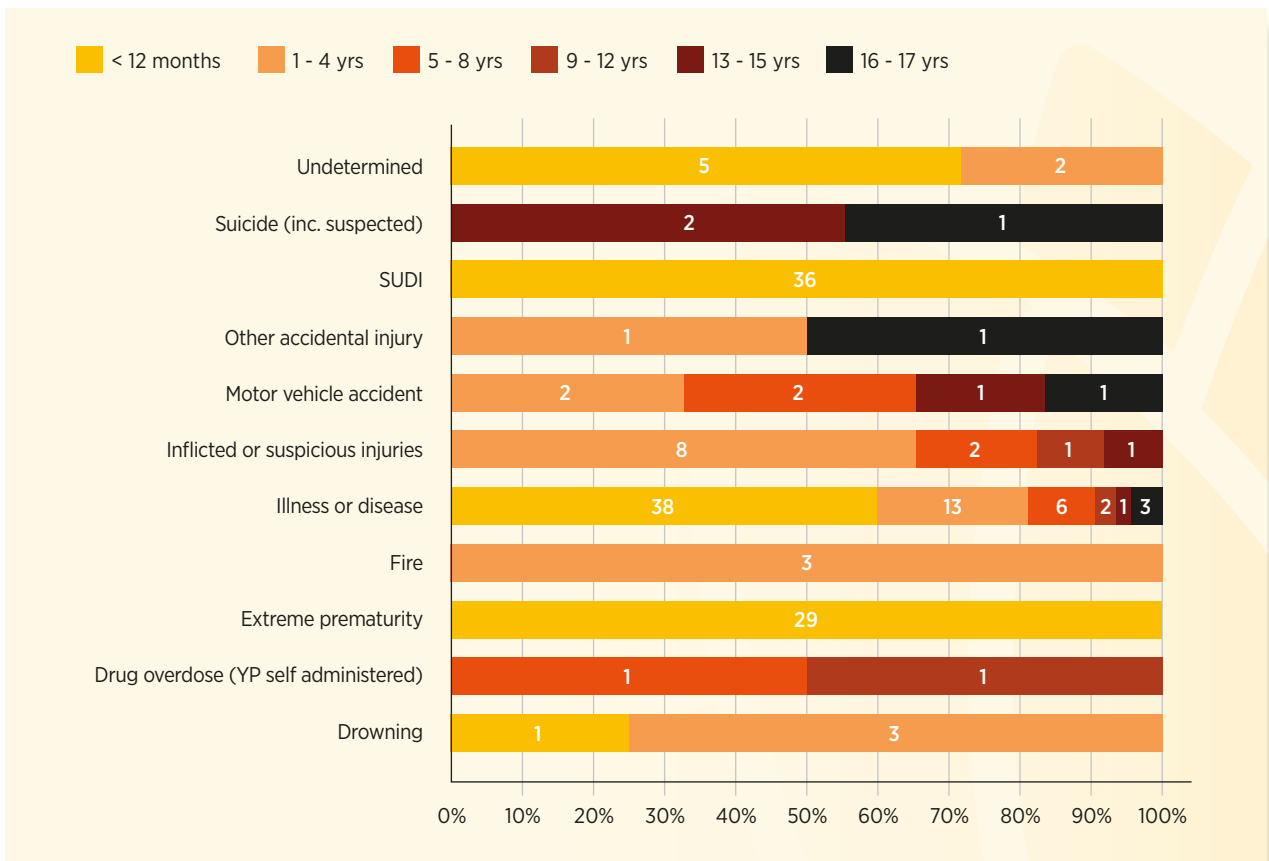


Figure 12 reveals differences in the circumstance of death by age group. Children aged less than one year died mainly from illness and/or disease, SUDI, or conditions arising in the perinatal period (extreme prematurity).

**Figure 12: Children who died and whose parents had a child protection history, circumstance of death by age group**

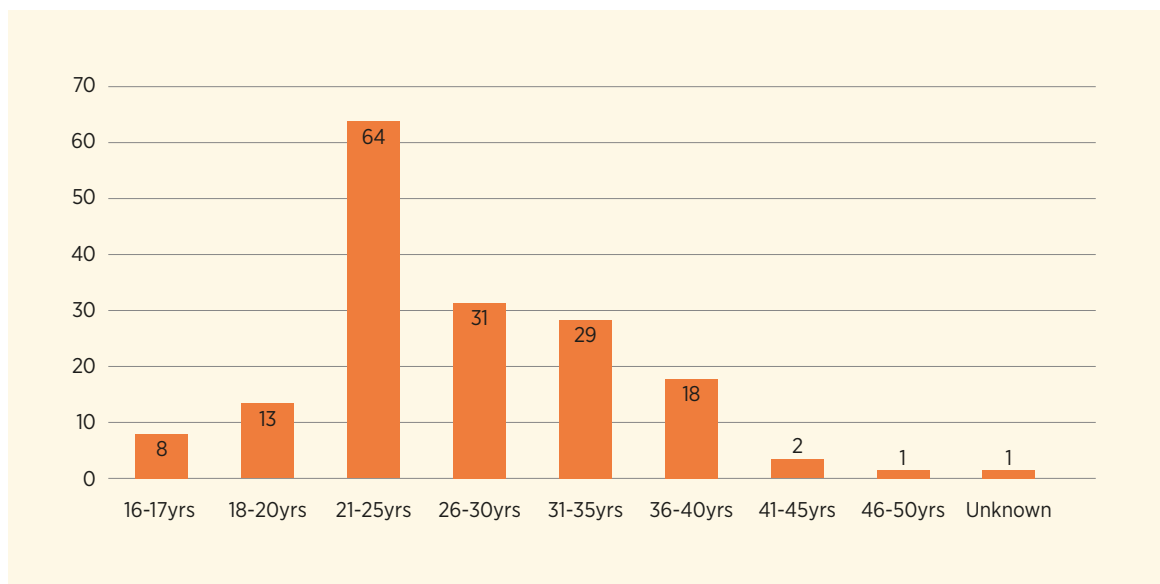


### 3.1.6 Family characteristics

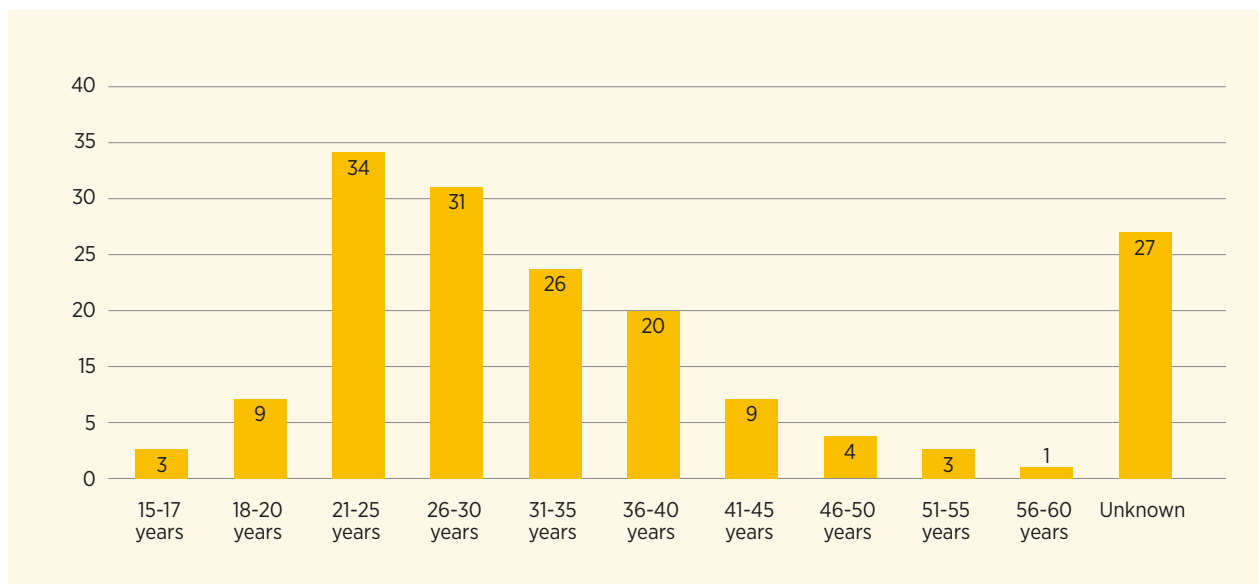
#### Age of parents

On the whole the mothers of the children in the cohort were younger than the fathers. Fifty-one per cent of mothers who had a child protection history (85 children) were aged 25 years or younger at the time of the child's death. This compares with 28 per cent of fathers who had a child protection history (46 children) and who were 25 years or younger at the time of the child's death.

**Figure 13: Age of child's mother at the time of the child's death**



**Figure 14: Age of child's father at the time of the child's death**



#### Parents who lived in out of home care as a child

Sixteen per cent (26) of mothers lived in out of home care as a child, compared with five per cent of fathers (9). Of the 26 mothers who lived in out of home care as a child, 17 were aged 24 years or younger when their child died. Of the 26 children whose mothers lived in out of home care as a child, 15 children died from illness and/or disease, five children died in circumstances of SUDI, three children died from inflicted or suspicious injuries, two children died from extreme prematurity and one child died in a motor vehicle accident.

Of the 17 children whose mothers were aged 24 years or younger, eight children died from illness and/or disease, five children died in circumstances of SUDI, two children died from extreme prematurity, one child died from inflicted or suspicious injuries and one child died in a motor vehicle accident.

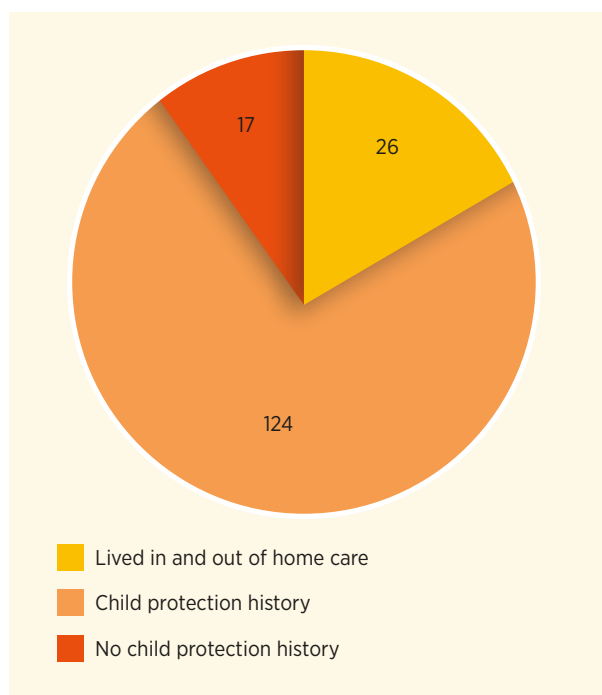
Of the nine fathers who lived in out of home care as a child only one was under the age of 25 years at the time of the child's death. The remaining fathers were aged between 25 and 40 years. Of the nine children whose fathers lived in out of home care as a child, three children died from illness and/or disease, three children died in circumstances of SUDI, one child died from extreme prematurity, one child died in a house fire and one child died in a motor vehicle accident.

### Parents' experiences of abuse as a child

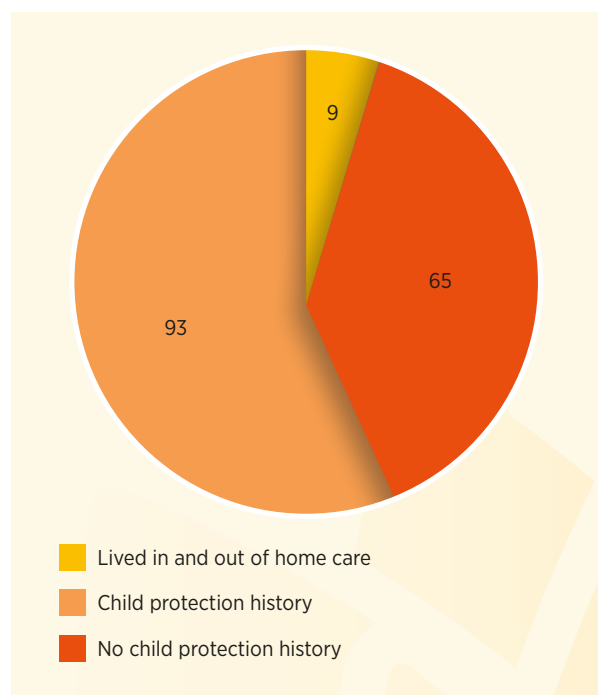
As noted earlier, 167 children who died between 2015 and 2018 had at least one parent either reported to child protection services as a child and/or who lived in out of home care as a child.

For these 167 children, 150 (90 per cent) of the children's mothers were either known to child protection services or lived in out of home care as a child (Figure 15), while 74 (44 per cent) of the children's fathers were either known to child protection services or lived in out of home care as a child (Figure 16). It is likely that mothers are over-represented in the figures because the identity of a child's mother is more often provided to DCJ than fathers when a ROSH report is made about their child.

**Figure 15: Number of mothers who had a child protection history**



**Figure 16: Number of fathers who had a child protection history**

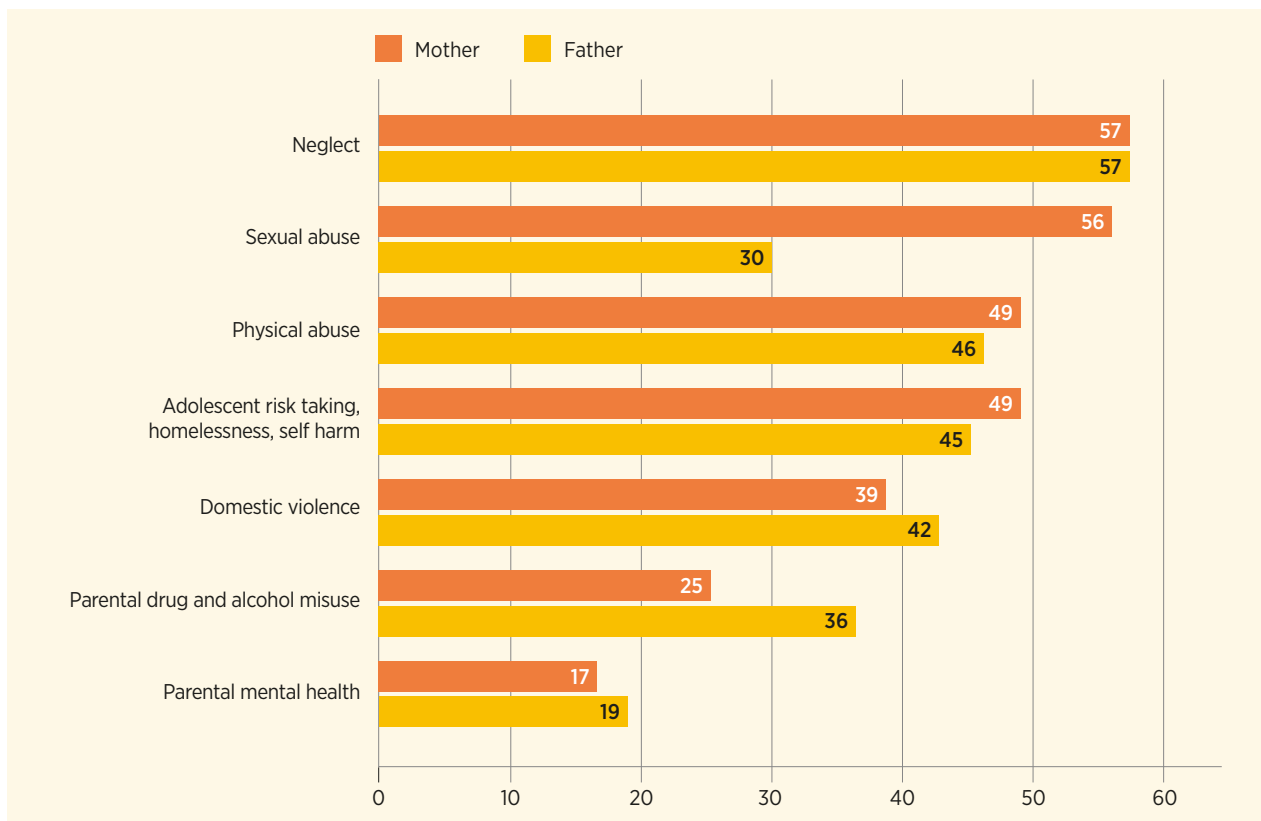


### Reported child protection history for mothers and fathers

Of the 150 mothers who were the subject of a report to child protection services as being at risk of harm when they were a child or lived in out of home care, neglect (86 mothers; 57 per cent) and sexual abuse (84 mothers; 56 per cent) were the two highest reported child protection issues. This was followed closely by physical abuse (74 mothers; 49 per cent), adolescent risk-taking, homelessness and self-harm (73 mothers; 49 per cent) and domestic violence (59 mothers; 39 per cent).

Of the 74 fathers who were the subject of a report to child protection services as being at risk of harm when they were a child or lived in out of home care, neglect (42 fathers; 57 per cent) and physical abuse (34 fathers; 46 per cent) were the two highest reported child protection issues. This was followed closely by adolescent risk-taking, homelessness and self-harm (33 fathers; 45 per cent) and domestic violence (31 fathers; 42 per cent).

**Figure 17: Per cent of mothers' and fathers' reported child protection issues**

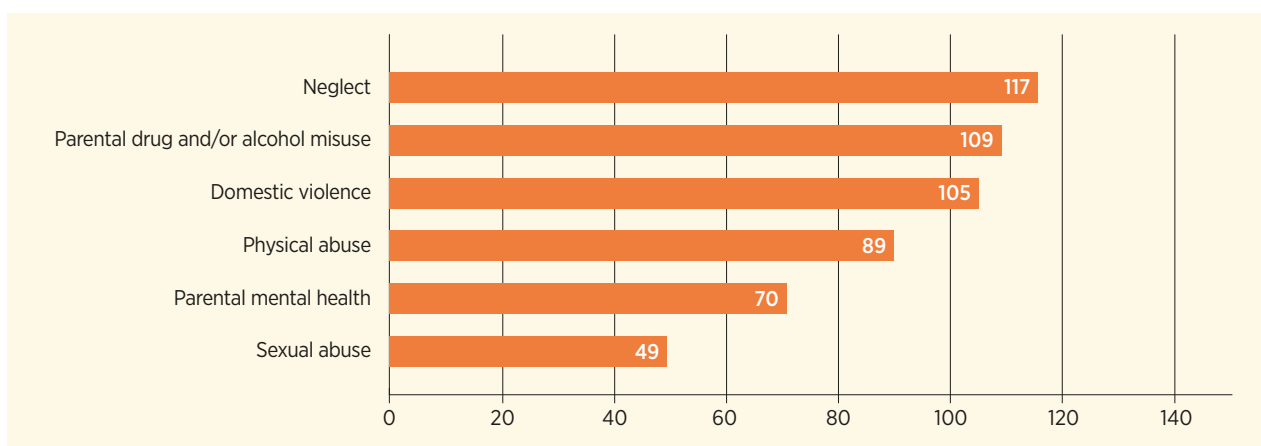


### 3.1.7 Reported concerns

The children in this review were known to DCJ because they lived in families where there were reported child protection concerns, or they were living in out of home care when they died. Of the 167 children and families in this cohort the following concerns were reported to DCJ:<sup>78</sup>

- neglect (117 families; 70 per cent)
- parental drug and/or alcohol misuse (109 families; 65 per cent)
- domestic violence (105 families; 63 per cent)
- physical abuse (89 families; 53 per cent)
- parental mental health (70 families; 42 per cent)
- sexual abuse (49 families; 29 per cent).

**Figure 18: Reported risk of significant harm concerns, by number of families**



<sup>78</sup> Numbers do not add to 100 per cent as families can have multiple reported concerns.

### 3.1.8 Allocation of cases

DCJ was working with the families of 52 (31 per cent) of the 167 children in the cohort when they died. The information known about these 52 families was examined to understand the reasons why DCJ was involved for this group of children at the time of their death.

Eighteen of the children were living in out of home care and receiving regular casework. The remaining 34 children had open child protection cases.

For the 34 children with open child protection plans, the following concerns had been reported:

- neglect (26 families)
- drug and alcohol misuse (26 families)
- domestic violence (25 families)
- physical abuse (17 families)
- parental mental health concerns (14 families)
- sexual abuse (8 families).

Of the 167 children in the cohort, another 17 children also had an open case with DCJ when they died, but these cases were not allocated to a caseworker. Of these children:

- three had open cases for the purpose of providing a relative with a supported care allowance or were in out of home care, case managed by a non-government agency
- one had an open case and was in out of home care and case management had transferred back to DCJ after the foster care agency with primary case management closed; a review of DCJ involvement found that the case should have been allocated and recommendations have been made to DCJ for this purpose
- 13 children had a recent ROSH report and were awaiting assessment, or had been assessed as safe and arrangements were being made to close the child's case.

Of the remaining 98 children in the cohort not receiving casework from DCJ when they died there had been a ROSH report about the child and/or their sibling in the last three years and the cases had been closed before the child died.

## 3.2 Experience of abuse across generations

This section of the review considers what can be learned from reviews of practice with the families of children who died, to understand the intersection of child abuse across generations, alongside some of the findings from current research about effective practice with families. This section also considers those child protection issues most prevalent for children in the study and a number of case studies are used to illustrate key issues for practice.

No single factor can fully explain the relationship between a parent's history of abuse and that of their children. While a number of theories have been used to try and understand it,<sup>79</sup> applying those to all children and adults who have experienced abuse risks labelling or making general assumptions about them based on their exposure to distressing events alone.<sup>80</sup> It is widely acknowledged more research is needed to understand how these factors contribute to risk.<sup>81</sup>

On a broader level, experiences of trauma across generations are common for the children and families DCJ works with.<sup>82</sup> However, this cohort review finds that for the families of children who have died and were known to DCJ, such experiences of trauma across generations may be even more common.

79 Social learning theory (Bandura, 1977). Trauma-based theory (Perry & Szalavitz, 2006). Attachment theory (Bowlby, 1979). Studies in neuroscience and brain functioning (Riha, Fnaskova, Barton & Rektor, 2018). Epigenetics – an emerging science about changes to genetic makeup (Bowers & Yehuda, 2016; Franklin et al., 2010). Ecological theory – interactions between genetics and structural inequality (Roberts et al., 2018).

80 DCJ Casework Practice: Understanding trauma and resistance.

81 Child Welfare Information Gateway (2016).

82 Butler & Cockburn (2017).

People respond to trauma and violence against them in different ways and it is the role of child protection practitioners to understand how a person's trauma and resistance shapes who they are and how they interact with others, and then how to connect children and adults to services that can help them heal from trauma.<sup>83</sup>

This section of the cohort review explores our findings and provides suggestions for improved practice.

### 3.2.1 Neglect

Neglect is characterised by a failure of a parent or carer to attend to a child's basic needs (e.g. supervision, medical care, nutrition or shelter) to such an extent that it has a negative effect on the child's safety, welfare or wellbeing. This lack of care can be a single act or oversight or a pattern of these.

This cohort review found that of the 167 children who died and whose parents experienced abuse or neglect as a child, neglect was the highest reported issue for both parents and their children. Eighty-six mothers, 42 fathers and 117 children in the cohort lived in families where concerns had been reported to DCJ about neglect of the child and/or their siblings across two generations. Research undertaken in the US as part of their National Longitudinal Study of Adolescent Health found that parents who reported that they were neglected in childhood were more than two and a half times more likely to report that their own parenting was neglectful and 'twice as likely to report physically abusive parenting'.<sup>84</sup> It also found that those parents who recalled that they were physically abused in their childhood were five times more likely to report that they used physically abusive parenting techniques and almost one and a half times more likely to report neglectful parenting of their own children.

As mentioned earlier there are many theories that have been used to improve understanding of the occurrence of child abuse across generations, including theories about how a parent's own childhood experiences may not fully equip them with the life skills to confidently parent.<sup>85</sup>

It is important to remember that children and adults can heal from their experiences. While practitioners cannot change what happened to parents in the past, practitioners can strive to see the person behind the 'traumatised' label and link them to those who can help them heal.

Interventions and services that focus on building social supports and teaching parents the skills to increase their 'effectiveness and constancy,'<sup>86</sup> in parenting practices may be an effective prevention strategy for neglect.

#### **BUILDING RESILIENCE IN THE FACE OF ADVERSITY**

'Caring and supportive relationships in various forms have emerged in the literature as a potential protective factor.'<sup>87</sup>

The *Child Deaths 2015 Annual Report* includes the findings of a cohort review on children who died and who had experienced neglect before their death. It provides information that supports practitioners to respond to families with confidence and compassion when neglect is present.

Practitioners play a critical role in assessing safety and risk for children who experience neglect. Responding to child neglect is a complex area of practice and, as this cohort review affirms, the association with a parent's own history of neglect will often require a range of targeted intervention responses.<sup>88</sup> Early intervention responses that seek to engage families when neglect is first identified are best, but even if neglect is not identified and becomes entrenched later, interventions can still have positive outcomes.<sup>89</sup>

*continued next page...*

83 DCJ Casework Practice: Understanding trauma and resistance.

84 Kim (2009) cited in Child Welfare Information Gateway (2016).

85 Thornberry & Henry (2013) cited in Child Welfare Information Gateway (2016).

86 Child Welfare Information Gateway (2016).

87 *ibid.*

88 Turney & Taylor (2014).

89 *ibid.*

Three key areas of practice that can improve responses to neglect and improve outcomes for children are:

- assessing the urgency of neglect
- understanding the child's experience of neglect
- building relationships to identify parental strengths and promote change.<sup>90</sup>
- For more information see the *Child Deaths 2015 Annual Report*.

For more information see the *Child Deaths 2015 Annual Report*.

### 3.2.2 Parental drug and/or alcohol misuse

One hundred and nine children in the cohort were reported to DCJ due to concerns about their parents' substance (alcohol and drug) use.

A literature review of patterns of child abuse across generations undertaken by the Child Welfare Information Gateway provided an overview of two studies, the first of which found that mothers who experienced physical or sexual abuse in their childhood were more likely to report substance use problems in adulthood.<sup>91</sup> The second study found that for those mothers who had experienced emotional, physical and sexual abuse, as well as emotional and physical neglect, their own children were three to five more times likely to experience physical maltreatment, while the mothers themselves were more likely to experience depression, substance use problems and domestic violence, among other issues.<sup>92</sup>

In the case reviews considered for the cohort, there were examples of parents using substances to cope with untreated or unresolved trauma symptoms of abuse and/or neglect in their childhood. Challenges included access to and maintaining stable housing after leaving home at a very young age, caring for children with limited support networks, financial difficulties and mental health issues.

Problematic parental substance use can often exacerbate existing mental health issues and place children at risk. However, for children who have also experienced child abuse or neglect, and who may have complex needs arising from this, problematic parental substance use may increase their vulnerability and place them at higher risk. Substance use can affect a parent's ability to recognise and meet a child's needs, supervise them and provide safety. These issues need to be considered in holistic assessment.

When planning to talk to parents, practitioners need to be mindful that people who use drugs have often experienced stigma, discrimination and shame associated with their substance use which may impact on their willingness to talk.

To understand the dangers and risk posed by a parent's problematic substance use, practitioners need to have upfront and frank conversations with them. This will involve looking at more than what and when they drink or use and include consideration of:

- the parent's story about how alcohol or drugs has taken control of their life
- how alcohol or other drugs might have been used to resist, cope and survive
- the triggers and reasons they drink or use in the past and now
- what their current use, behaviours, patterns and lifestyle look like
- how problematic use impacts on their parenting and bond with their child
- how children feel and see their alcohol or drug use
- options for treatment and recovery.

90 NSW FACS (2016a).

91 Appleyard et al. (2011).

92 Jaffee et al. (2013).

## DCJ CASEWORK PRACTICE

Substance misuse by a parent or carer can impact parenting capacity. While the extent of this impact and how it affects children in the home needs to be assessed – including attachment to children, disruption to routine, the financial impact of the substance misuse, and the capacity of the parent or carer to provide supervision and protection – the assessment also needs to consider the underlying reasons for parental substance misuse. Does the parent have underlying and unresolved childhood trauma that impacts on their mental health? If so, what supports may help them to work through that trauma?

Resources to assist practitioners to assess the impact of problematic parental substance use on children and effective interventions to support parents are included on Casework Practice in the **Alcohol and Other Drugs Practice Kit**.

### 3.2.3 Domestic violence

One hundred and five of the 167 children in this cohort were reported due to they or their sibling experiencing domestic violence, which in most cases involved witnessing (seeing or hearing) their father or another male's violence against their mother. The impact and effects of domestic violence on women and children are well documented, including the potential for it to be fatal.<sup>93</sup> For the children in this cohort, 58 mothers and 31 fathers reportedly experienced domestic violence in their own childhoods, while 84 mothers and 22 fathers experienced sexual abuse in their childhoods. Some studies have also shown 'an association between childhood abuse and adverse relationship outcomes in adulthood for women, including intimate partner violence'.<sup>94</sup>

Understanding the impact that a parent's experience of violence has on them and its impact on their children is fundamental in child protection work. Whether violence happened in the past or is current, comprehensive assessment is needed to understand its enduring impact on children and their parents.

When working with families where domestic violence has impacted on children and parents, it is important for practitioners to understand and assess the role that fathers and other adults have in the care of children, including involving them in home visits, assessments, safety and case planning.

## LIVING THE PRACTICE FRAMEWORK

Social responses to violence have the power to further reinforce violence and oppression, or validate positive experiences and support recovery. It is important for practitioners to learn about and recognise adults' and children's acts of resistance, because it allows them to understand how in any given moment a person exercises caution, creativity, deliberation or awareness that allows them to manage a difficult situation.

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

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

<sup>93</sup> Ackerson & Subramanian (2009).

<sup>94</sup> Australian Institute of Family Studies (2012).



## DCJ CASEWORK PRACTICE

Practitioners can refer to the Casework Practice topics **Working with fathers to keep children safe** and **New partners** for more advice on including fathers and new partners in assessment and casework.

### 3.2.4 Physical abuse

Eighty-nine of the children in the cohort were known to DCJ because they or their sibling had been reported to DCJ to be at risk of physical abuse. Seventy-four mothers and 34 fathers were the subject of a report to child protection services because of concerns that they were at risk of being physically abused when they themselves were children. A number of the studies considered in the Child Welfare Information Gateway review of research into abuse across generations suggest a strong link between those parents who experience physical abuse as a child, and going on to use 'harsh discipline' as adults toward one's own children.<sup>95</sup> Another study found that for both mothers and fathers, a history of 'physical and psychological aggression and abuse' predicted the risk of physical abuse of their children prenatally and when their child was a toddler.<sup>96</sup>

A common casework response to addressing physical abuse is to refer parents to universally available parent education programs. While parenting programs can be an effective intervention, for families experiencing intergenerational patterns of abuse, a more holistic and coordinated response that addresses the health, education and wellbeing needs of both parents and children is even more beneficial.<sup>97</sup>

## THEIR FUTURES MATTER

*Their Futures Matter* is the NSW Government's long-term strategy for improving outcomes for vulnerable children and families. Its vision is to create a service system that coordinates wraparound and evidence-based supports for children and families to improve their health, education, wellbeing and life course.

For more information about the progress of implementing *Their Futures Matter* see Chapter 4 of this report.

### 3.2.5 Parental mental health

Parental mental health issues such as depression, anxiety and substance misuse have been identified as risk factors for abuse across generations<sup>98</sup> that may impact on a parent's functioning.<sup>99</sup>

There were 70 children in the cohort who were reported to DCJ due to concerns about a parent's mental health. Effective assessment of a parent's mental health requires practitioners to balance gaining insight into a parent's own experience of their mental health – including signs of becoming unwell and how they access support – with speaking with other services that are working with parents such as doctors, psychologists and psychiatrists to understand how parental mental health issues are being clinically managed. Inter-agency collaboration with mental health services needs to focus on how a parent's mental health impacts on their ability to meet the needs of their own children through effective parenting.

95 Child Welfare Information Gateway (2016).

96 Rodriguez, Silvia, Gonzalez & Christl (2018).

97 Holzer, Bromfield, Richardson & Higgins (2006).

98 Thompson (2006); Mapp (2006); Egeland & Susman-Stillman (1996).

99 Rutherford, Wallace, Laurent & Mayes (2015).

## INVOLVING CHILDREN

It is important to speak with children about what life is like for them in the care of a parent who experiences mental health issues, and how this impacts on them. Safety plans that include what a child can do to get help if their parent becomes mentally unwell are good practice.

Children of Parents with a Mental Illness (COPMI) is a national organisation that has a range of online advice for practitioners about working with parents and children to aid their recovery, foster resilience in children and support the entire family living with challenges that parental mental illness can bring.

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

### 3.2.6 Sexual abuse

Forty-nine children or their siblings were reported to be at ROSH due to concerns about sexual abuse. For parents, 84 mothers and 22 fathers were the subject of a report to child protection services as being at risk of harm from sexual abuse. Research has shown that one of the only clear gender patterns to emerge from abuse across generations is that the transmission of child sexual abuse is more likely for girls than for boys.<sup>100</sup> The Child Welfare Information Gateway found a number of studies where a parent's own experience of physical or sexual abuse was associated with their children's experience of physical or sexual abuse, although the reasons for this remain unclear.<sup>101</sup>

Child sexual abuse occurs across all ages, genders, and cultural and socioeconomic groups. However, several studies have shown that offenders target children and families who have certain characteristics and are already under stress, marginalised and vulnerable.<sup>102</sup>

The children DCJ work with are particularly vulnerable to child sexual abuse. For children who experience other types of childhood maltreatment, research has shown that they are more likely to be sexually abused, and children in out of home care are particularly vulnerable to child sexual abuse.<sup>103</sup>

## DCJ CASEWORK PRACTICE

The Casework Practice **Child Sexual Abuse Kit** has been designed to help practitioners see, understand and respond to child sexual abuse. The kit provides practical guidance to support caseworkers' involvement with children, families, communities and suspected offenders.

The following case study highlights some of the issues that have been identified in many of the families where patterns of child abuse and neglect exist across generations.

### ***Kym and Amy***

*Kym first became known to DCJ when she was five. Her parents' marriage had ended, and her mother April had experienced mental health issues, including thoughts of harming her children, alongside dealing with violence and drug use by her husband.*

*When Kym was older, DCJ continued to receive reports about April's erratic behaviour, and then Kym's own behaviour at school, and her living*

100 McCloskey & Bailey (2000).

101 Child Welfare Information Gateway (2016).

102 Esposito & Field (2016).

103 Euser et al. (2013).

arrangements, mental health and criminal activity. Kym spent a couple of years in and out of juvenile detention and youth refuges, and fought with her mum when at home.

Kym became pregnant at 19, to an older man with other children who were the subject of reports to DCJ, about violence in the home, alcohol and drug misuse, neglect and unsafe living conditions. There were also concerns Kym was using drugs while pregnant. Kym's partner was arrested a year later for violence towards Kym that also involved her new baby. There were more concerns about alcohol and drug use in the home, impacting the care Kym and her partner Troy provided. Similar reports continued to be made across the next few years, although sometimes when DCJ engaged with the family, we only explored limited information about this complex history, or relied on other information (like the presence of apprehended violence orders) to determine safety in this family.

When Kym's third child, Amy, was born, health services noticed that Kym was co-sleeping with Amy, and they were worried Kym might also be using drugs. Kym's partner said all of his children had slept in the bed and he didn't think this was unsafe but, tragically, two weeks later, Amy was placed to sleep between her parents, and Kym woke to find Amy not breathing. The Coroner listed Amy's cause of death as 'undetermined' and consistent with sudden unexpected death in infancy (SUDI).

### **What could we have done differently?**

Talking to Kym and Troy about their holistic life experiences, including childhood experiences of abuse and neglect, may have helped to gather important detail about the origins of their own parenting practices and build relationships with them, while at the same time assessing safety and risk for Amy.

Exploring with Kym and Troy what they already knew about co-sleeping and discussing with them the associated risks may have opened a dialogue about their motivations and could have also enabled a discussion about protective factors.

While Troy was referred to counselling, a referral for Kym could have also been explored to give her opportunities to talk about her experiences of abuse and neglect and how these might be impacting on her now. Such support may have recognised that Kym's drug and alcohol use may have been a way of her self-medicating and managing past experiences of abuse and neglect.

## **3.3 Supporting children and their families and working well with those who care for them**

### **3.3.1 The importance of holistic assessment**

The families that DCJ practitioners work with are known to DCJ because current concerns exist for the safety and wellbeing of the child in their family. Research suggests that there is benefit in asking parents about their own histories of abuse as a clue to potential risks, but equally to assess potential resiliency factors. As this small cohort review and others like it have found, the children reported to DCJ will often also have a parent who has experienced abuse or neglect as a child and may still be experiencing some trauma from that abuse or neglect, or may not have learned the types of parenting and nurturing needed

to care for their own children safely. Considered alongside the research, it is likely that a parent who is still experiencing the trauma or impact of their own abuse will need specific and focused intervention to support them in their parenting role. A DCJ practitioner is well positioned to do this through the process of holistic assessment.

### DCJ CASEWORK PRACTICE

Ecological or transactional theories view child maltreatment as the result of multiple influences and systems, including family, community and societal factors. Research grounded in these theories looks for specific risk factors or pathways to better explain intergenerational patterns.<sup>104</sup>

The Casework Practice topic **Holistic assessment and family work** includes other important prompts and considerations to assist practitioners to undertake holistic assessment for the whole family.

### 3.3.2 Culturally responsive practice

The over-representation of Aboriginal children in all child protection and out of home care data is well known. The forced removal of Aboriginal children from their families has had a lasting impact on those children and families, and continues to impact on the safety and wellbeing of Aboriginal children. Caring about, respecting and understanding culture requires practitioners to acknowledge past injustices that took away Aboriginal families' basic human rights, their families and connection to country and ensures that current day practices do not repeat them. The values of healing within relationship and connection to country, articulated through ritual and story, are at the forefront of recovery and therapy for Aboriginal people.<sup>105</sup> Aboriginal consultation is essential in providing practitioners with insight into a family and/or community's context and to identify culturally safe supports for Aboriginal families who have experienced the impact of intergenerational abuse or neglect.

Understanding Indigenous experiences and culture can help inform ways of working to promote intergenerational healing that have been found to be effective. Culture contains values and insights that can support a family to identify and practice methods to break the cycle of intergenerational abuse and neglect.

### 3.3.3 Language

The ways in which parents recall and interpret their own abusive experiences has been found to impact on whether their children will also experience abuse and neglect. Studies have found that parents who were able to process and integrate their experiences of childhood trauma were better able to break the intergenerational cycle of abuse and neglect than those who distance themselves from their trauma.<sup>106</sup> Other research has identified that to recollect, talk about and address harm also helps families to heal and maintain resilience, and to transform their trauma from rumination and shame to pride in survival.<sup>107</sup>

The language we use when discussing parents' past trauma can create and propel meaning that empowers them to acknowledge the early trauma, reframe it with dignity and respect, and incorporate the experiences into their holistic identity.

### 3.3.4 Working with young parents

Fifty-one per cent of mothers who had a child protection history (85 children) were aged 25 years or younger at the time of their child's death. Research has consistently found an association between

<sup>104</sup> Child Welfare Information Gateway (2016).

<sup>105</sup> Atkinson (2002); Dockery (2010).

<sup>106</sup> Narang & Contreras (2005); Egeland & Susman-Stillman (1996).

<sup>107</sup> Lev-Weisel (2007); Fromm (2012).

women's childhood experience of abuse and disadvantage, and then later early parenthood.<sup>108, 109, 110</sup> While research also finds that parenthood can bring positive outcomes to young people when engagement happens early on and during pregnancy,<sup>111</sup> there is also evidence that children born to young mothers are at increased risk of a range of adverse outcomes such as low birth weight and premature birth, and with this the risk of death in the perinatal period.<sup>112</sup>

A cohort review about working with young parents undertaken as part of the *Child Deaths 2011 Annual Report* found three key themes for practice improvement:

- The need for holistic assessment.
- Engaging young people early to build parenting capacity.
- Keeping a focus on the child in the young parent family.

For more information see the *Child Deaths 2011 Annual Report*.

### DCJ CASEWORK PRACTICE

The Casework Practice topic **Working with young people** has good advice about engaging with young people to create relationships that are reliable, respectful, supportive and honest.

### 3.3.5 Working with parents who lived in out of home care as children

Of the 26 mothers who lived in out of home care as a child, 17 were aged 24 years or younger when their child died. Working with young adults who have lived in out of home care and have experienced the impact of trauma and grief across generations requires purpose, time and care. These young people may have had experiences that make them reluctant to work with DCJ, but are likely more vulnerable and in need of care, attention and stability. Casework responses should be proactive, recognise the young adult's need for independence, support them to gain the skills needed to look after themselves, and include advice, support and reassurance with learning how to become a parent. In short, young adults who have lived in out of home care need to be cared for in order to be able to provide care to their child.

A young adult's own child protection history coupled with their age often shapes their understanding of parenting. The need for clear parenting guidance and support to develop the parenting skills and bonds with their children cannot be overstated.

### 3.3.6 Relationship-based practice

Parents who were abused as children, and especially those who grew up in care, are also at higher risk of social and familial isolation. Family and community networks are protective factors in keeping children safe, serving to provide practical support during the challenges of parenting, and social connections that enhance overall wellbeing and functioning for parents.<sup>113</sup> Supporting families and children to rediscover and build relationships results in structures of emotional and physical support for families that last well beyond the period of casework.

Relationships with extended family and meaningful social connections have been found to moderate the potential that the child of a parent from adversity will experience abuse or neglect. Social support and interpersonal connection in parents who experienced abuse or neglect in their own childhood have been linked to higher levels of empathy for their children, reduced parental stress, and enhanced wellbeing and functioning.<sup>114</sup> The value of relationships and networks in keeping children safe can also not be overstated.

108 Mendes (2009).

109 Cashmore & Paxman (2007).

110 Woodward, Fergusson & Horwood (2001).

111 Ofsted (2011).

112 Beers & Hollo (2009).

113 Bartlett & Easterbrooks (2012).

114 Bartlett & Easterbrooks (2012); Li, Godinet & Arnsberger (2010).

## LIVING THE PRACTICE FRAMEWORK

Family Finding is an approach in the NSW Practice Framework that seeks to build a network around a child. This network is especially important for supporting children whose own parents have experienced abuse or neglect as a child, as 'identifying protective factors including healthier interactions with families is integral to prevention efforts'.<sup>115</sup>

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

### 3.3.7 Working with other services

Effective child protection practice relies on strong partnerships with wider service systems. Research has shown that the most successful parenting programs include a combination of strategies including parent skills training, cognitive retraining, child development information and concrete services.<sup>116</sup> Practitioners need to consider the involvement of services carefully and how they will create safety for children. Services should not be relied on to create a sense of security for DCJ about safety and risk for children and families where assessments show that high risk is evident. Our reviews found a number of examples where DCJ ended its involvement with a child and their family based on the involvement of other services, rather than evidence that positive change had occurred and risk had been alleviated. Some reviews found that little had changed for families when DCJ ended its involvement and the safety of children had not improved. Meaningful and sustained change takes time, particularly for families where intergenerational and complex trauma exists, and where child protection concerns are present for children.

Practitioners need to focus on purposeful case planning with families, with plans that describe clear and measurable goals toward increasing safety for children. Practitioners should develop strong partnerships with families and other services to ensure that the holistic needs of parents and children are understood and managed by the right services at the right time, and that each service is clear about its role.

## DCJ CASEWORK PRACTICE

A quality case plan creates purposeful and meaningful opportunities for sustainable change in families, which helps to keep children safe.

See the Casework Practice topic **Case planning for change** for more detailed practice guidance about working in partnership with families and other services to create meaningful change for children and families.

The next case study highlights the importance of holistic assessment that considers early and ongoing issues, and the importance of strong, purposeful partnerships with people, families and services.

### *Helen and Julia*

*Helen first became known to DCJ when she was 15. There was a report of violence in the home by her stepfather and, not long after, Helen left home to stay at a refuge. She then moved in with her grandparents, and quickly confided that her stepfather had been sexually abusing her for two years.*

*Helen had a baby at age 22, and when he was still young there were reports about little Harry's care and Helen's bond with him. Helen sought help from*

<sup>115</sup> *ibid.*

<sup>116</sup> Holzer et al. (2006).

*a residential support service, who worried about her current mental health, violence in the home, and her trauma as a child. They believed this was affecting her parenting.*

*As Helen grew older and had three more children, she continued to experience issues such as postnatal depression, as well as violence from two other partners. There were reports that Harry's father was sexually abusing him, and Harry was showing clear signs of his own trauma along with developmental difficulties.*

*Along the way, Helen became estranged from her mother and could no longer rely on her for support. Brighter Futures worked with the family for a time, but Helen's four children had high needs, and Helen's mental health continued to be a worry. Reports to DCJ over subsequent years included fresh concerns about neglect, and alcohol and other drugs misuse. DCJ often responded with risk assessments for the children that were 'high' or 'very high', and although Helen was willing to work with services, there seemed to be little positive change.*

*Helen's fifth child, Julia, required specialist medical attention and was eventually admitted to hospital with high needs. Helen and her children's physical and mental health deteriorated during this time, with reports of unsatisfactory living conditions at home, but Helen continued to engage, and Helen's mother was once again helping out too. Sadly, little Julia, aged less than 12 months, died one night while asleep in her cot. The Coroner determined Julia's death to be from epilepsy.*

### **What could we have done differently?**

*Holistic assessment may have enabled caseworkers to understand Helen's early traumatic experience of sexual and physical abuse, and learn from her what family support she received from her mother and grandparents after the abuse. As relationships with extended family and meaningful social connections have been found to moderate the impact of abuse and its repercussions across generations, gaining an insight into the support Helen received may have provided some avenues to explore further support with her own children, when reports were made.*

*Equally as important was for a holistic assessment to understand how Helen's early experiences were impacting on her as a parent. When assessments were completed they tended to focus on presenting issues such as the state of the home and hygiene. However, the issues being reported – such as Helen's mental health, experience of violence in childhood and as an adult and use of substances – needed to be explored in more detail through assessment to understand the impact these were having on her care of the children. The children's fathers were absent during most DCJ interventions and they needed to also be included in holistic assessments, to understand their role in the children's lives.*

*Purposeful case planning with Helen was needed which included plans that could describe clear and measurable goals toward increasing safety for the children. Practitioners needed to develop strong partnerships with Helen and the services that were supporting her, to ensure that the holistic needs of Helen and her children were understood and managed by the right services at the right time.*

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

Across 2018 and 2019, the NSW Government continued to implement vital reforms to the child protection and out of home care system in NSW. The work of DCJ in this sector has been informed especially by the redeveloped NSW Practice Framework (launched September 2017)<sup>117</sup> and *Their Futures Matter* (launched November 2016)<sup>118</sup> and the Permanency Support Program (launched October 2017).

The NSW Practice Framework, *Their Futures Matter* and the Permanency Support Program have been essential in guiding the department's approach and practice with vulnerable children and families. These strategies together promote a smart, connected system that provides evidence-based and needs-based supports to create meaningful relationships that sustain change and improve life outcomes.

Every child deserves to experience safety, permanency, and a home where they can develop strong relationships and a sense of belonging for the best start in life. The NSW Government continues to provide vital services and additional frontline workers to support the most vulnerable members of our communities.

### NSW State Budget 2019–20

In 2019–20, the DCJ cluster of departments and organisations will spend \$10.7 billion supporting children, adults, families and communities, and focus on breaking disadvantage to improve lives. This is part of an overall \$17.7 billion investment in the Stronger Communities cluster.<sup>119</sup>

The Stronger Communities cluster delivers community services that support a safe and just NSW. It supports safer, stronger communities through the protection of children and families; building resilience to natural disasters and emergencies; promoting public safety; breaking the cycle of reoffending; and promoting physical activity and participation in organised sport, active recreation and sporting events.

Specific state budget expenditure relevant to DCJ protecting children and families includes:

- \$30 million to help support the health and wellbeing of vulnerable children with complex needs in out of home care
- \$16.8 million to support the delivery of child protection services through the continuation of funding for 45 Child Protection Helpline workers and 66 case support workers
- \$5.6 million to reduce domestic and family violence reoffending and support victim safety through the continuation of the Men's Behaviour Change programs in NSW.

### 4.1 Departmental practice change in response to the deaths of children in 2018

There are three main types of recommendations made in response to individual reviews:

1. *Individual recommendations:* When reviews identify concerns for the siblings of children who have died, recommendations are made that attend to identified safety and risk concerns. For example, in one case it was recommended that a proposed care order for siblings be reviewed to ensure that the proposed order provided lasting permanency for the children.
2. *CSC and district recommendations:* Some reviews make recommendations about learning and development needs of CSCs and districts. For example, it was recommended that a district review its Aboriginal cultural consultation processes, in line with the DCJ Aboriginal Consultation Guide and NSW Practice Framework. Additionally all reviews are provided to district leaders to ensure recommendations are actioned. The OSP monitors the implementation of these recommendations

<sup>117</sup> NSW FACS (2017b).

<sup>118</sup> NSW Government (2016).

<sup>119</sup> See NSW Department of Premier and Cabinet (2019).



through the Quarterly Business review process, providing visibility of recommendations and ensuring accountability.

- 3. Systemic and state-wide recommendations:** Some reviews are considered by the Serious Case Review Panel (SCR Panel). These reviews are chosen for the Panel because their findings reflect broad practice and systemic themes. Panel recommendations are considered in the context of broader responsibilities and DCJs reform agenda. System-wide changes, such as the introduction of swimming pool compliance checks for authorised carers have been introduced as a direct result of review findings. In addition, to support learning, the OSP develops a training package based on the cohort review from that year's Child Deaths Annual Report. Examples of this training have been packages on neglect, vulnerable teenagers and DCJs response to families of children who have died. Learning from reviews has also been incorporated into state-wide group supervision training and is currently being incorporated into the revised Caseworker Development Program. Insights from reviews are also incorporated into Practice Mandates and Practice Advice Topics as required.

The information below summarises the key practice reforms and changes arising from the reviews of child deaths in 2018, and an update on key state-wide practice and reforms identified from reviews of children who died prior to 2018. It also provides a summary of the recommendations from reviews that were made to improve direct casework.

#### 4.1.1 Recommendations about improving direct practice

Of the 93 children who died in 2018 a number of key practice themes and recommendations were identified in the reviews. Key practice themes have been identified in Chapter 2 of this report. Key recommendations arising from practice are outlined below.

All file-based reviews completed were referred to the Executive District Director, Director Community Services and Director Practice Support to consider the casework practice issues highlighted in the review and to consider the need for a management response to those issues.

A number of the reviews also recommended that a contact record be placed on ChildStory so that any future casework with the child's surviving siblings could be informed by the serious case review undertaken.

The key themes for recommendations about improving practice included:

- holding a group supervision to talk about how to work best with a family, in the context of domestic violence, and drug and/or alcohol use
- using Family Finding to build the child's support network and connecting them with their Aboriginal culture and communities of belonging
- confirming a child and their family's Aboriginality and ensuring that DCJ records accurately reflect this
- joint group supervision across CSCs or practice units to consider issues around intra-agency work
- for the Helpline and/or CSC to update ChildStory records to correct inaccurate information about the child and/or their family members
- for the review to be provided to staff who worked with a family to facilitate their learning and reflection about their practice
- for the Director Community Services to identify if the need for training in Structured Decision Making tools and decision-making is needed across the CSC.

#### 4.1.2 Recommendations about state-wide practice and system reform

##### Children who died in 2018

The information below summarises the key practice reforms and changes arising from the reviews of child deaths in 2018, and provides an update on key state-wide practice and reforms identified from reviews of children who died prior to 2018.

## Role clarity and screening for risk factors about domestic violence

Several of the reviews in 2018 identified the need for greater role clarity when multiple agencies are working with a family where violence is identified, as well as the need for improved screening of risk factors for domestic violence. As a result of this review an audit of the Domestic Violence Kit and mandate for sharing information with police was undertaken to ensure that each provides clear guidance about identifying risk in the context of domestic violence, and working collaboratively with other agencies when domestic violence has been reported.

## End of life planning

A review about a girl who died from a congenital illness identified the need to update the End of Life Planning mandate. This update included practice direction on the steps to be taken for children who have been transferred to, or are transferring to an accredited out of home care agency. This mandate now ensures that the views of the child or young person, their carers and family members are sought and included in end of life plans.

## Sharing the learning from reviews to inform reforms already underway

A number of reviews considered by the SCR Panel were referred to internal DCJ units and external agencies to inform program design, including to:

- the Domestic Violence Death Review Team to consider the cross-agency issues about collaborative working and information sharing between police, the Family Court and DCJ.
- Commissioning to consider issues identified in reviews as part of the development of DCJs Domestic Violence Strategy.
- NSW Health to add to discussions about its own findings from a root cause analysis and any intersecting areas of practice with DCJ.
- a funded service provider to provide input about opportunities to strengthen DCJs stewardship function.
- the Children's Guardian to enable consideration of its role in the oversight of out of home care service provision.
- DCJ Housing to support Housing Services staff to strengthen their understanding of their obligations as mandatory reporters.

## Ensuring learning from reviews impacts practice of leaders

Reviews are regularly taken to the DCJ Community Services Operations Forum for discussion about key findings and recommendations. For example, one review focused on the critical role of leaders in overseeing the safety assessment process.

A practice leadership portal was developed that highlights the critical role leaders hold in safeguarding child protection practice. The portal provides practice advice, tools and strategies to support leaders to bring the evidence from child death reviews into decision-making for all children.

## Refining aspects of ChildStory

Reviews highlight the importance of accurate documentation and recording. Recommendations to support improved recording practices form part of the enhancements to ChildStory.

## Children who died before 2018

The Serious Case Review Panel commenced in 2016, and since then a number of state-wide practice and system reform recommendations have progressed significantly or were completed during 2018. A summary of these is provided below.

## Group Supervision and NSW Practice Framework

A number of serious case reviews in 2016 and 2017 identified the need for a consistent approach to decision-making for practitioners, particularly where critical decisions, such as taking a child into care,

need to be made. The reviews also identified the need for further skill development of practitioners and those who lead their practice. As a result, the Serious Case Review Panel recommended the development of a supervision policy, and further skill development across key approaches to our work with families as outlined in the NSW Practice Framework.

The group supervision model supports critical reflection, the participation of other services that are working with the family and, where appropriate, the involvement of family or community members. It allows for an exploration of all supports available to a family, under the Permanency Support Program, before a decision is made about taking a child into care and away from a parent or carer.

The NSW Practice Framework, launched in September 2017, shows how DCJ works with children and families in NSW. It outlines the principles, values, mandates, approaches and systems that underpin our work. In 2018, DCJ commenced a staged implementation of the NSW Practice Framework to support the skill and knowledge development of its child protection managers and practitioners, particularly in Family Finding, Structured Decision Making, Motivational Interviewing, Safety Centred Practice and Dignity Driven Practice.

In December 2017 the DCJ Board endorsed both recommendations and in 2018 the Supervision Policy for Child Protection Practitioners was published. It provides guidance on the types of decisions to be made in group supervision and requires all child removal decisions to be discussed in group supervision before action is taken. The only exception is where there are urgent safety considerations, and in these exceptions, decisions about the child and family must be discussed at the next available group supervision. To support the policy, group supervision training was delivered to all managers and practitioners across NSW in 2018. The NSW Practice Framework training commenced in 2018 and continued into 2019.

### **Responding to critical events – a policy for the non-government sector**

Since 2012 the non-government sector has had an increasing role in the case management and care of children in out of home care. A small number of serious case reviews identified the need for a more consistent approach by funded service providers when there is a critical event that involves a child who is in the parental responsibility of the Minister. As a result, the Serious Case Review Panel recommended the department's Commissioning division develop a set of guiding principles that provide clear direction for funded services about their responsibilities when a critical event (such as a child death) occurs. The DCJ Board endorsed this recommendation in December 2017 and in 2018 broad consultation occurred, alongside an update of the Permanency Support Program Permanency Case Management Policy.

### **Enhancement of the NGO Line at the Child Protection Helpline**

A number of serious case reviews identified a need for the Child Protection Helpline to offer a fuller service to the people who called the dedicated non-government agency support line at the Helpline to talk about child at risk concerns and the application of mandatory reporter guidelines. In December 2017, the DCJ Board endorsed a recommendation for an enhanced NGO Line.

From January 2018 the Helpline now offers a full service to non-government staff who call to talk through concerns about a child at risk of harm. The increased service involves entering the information into the Screening and Response Priority Tool, which identifies if the reported concerns reach the risk of significant harm threshold, and what response time is recommended. The Helpline staff member will also complete a history check to determine if there have been previous reports to the Helpline or intervention and supports provided by DCJ.

### **Improving referral pathways and case closures under competing priorities**

Several serious case reviews and recommendations from coronial inquests (into the deaths of children who were known to DCJ) have identified concerns about reports about children (who had had been assessed by the Helpline to be at risk of significant harm) being closed at local offices under competing priorities, and without further assessment or referral to support services.

The Serious Case Review Panel recommended the reviews be referred to *Their Futures Matter* for consideration in the Access System Redesign project. This recommendation was endorsed by the DCJ Board on 7 December 2017. In November 2018, Their Futures Matter released its Access System

Redesign: Evidence Review, and in December 2018 the Access System Redesign discussion paper: 'Moving the system from crisis to early help; connecting children, young people and families to the right support at the right time'.

More information about system transformations occurring under *Their Futures Matter* is available at [theirfuturesmatter.nsw.gov.au](http://theirfuturesmatter.nsw.gov.au)

## Improved engagement with fathers – Casework Practice

A number of serious case reviews identified concerns about the limited engagement of fathers in practitioners' work with families. The Serious Case Review Panel recommended the case practice mandate for working and engaging with fathers be reviewed to provide clear guidance to practitioners about the importance and legal obligation to include fathers in their work with families. This recommendation was endorsed by the DCJ Board on 7 December 2017. In March 2018 the new casework practice mandate **Working with fathers to keep children safe** was published to the DCJ intranet.

## 4.2 NSW Practice Framework: Implementation and progress

### 4.2.1 Overview of the Framework

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

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

Launched in September 2017, the redeveloped NSW Practice Framework (Figure 19) brings together practice approaches, reforms and priorities to guide DCJ child protection work across systems, policies and practice. It aims to improve the quality of DCJ child protection practice to generate the best outcomes for children and families across NSW.

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

### NSW PRACTICE FRAMEWORK MANDATES

#### Practice mandate

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

#### Leadership mandate

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

#### Agency mandate

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

Figure 19: NSW Practice Framework (launched September 2017)



## 4.2.2 Implementing the Framework

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

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

Ongoing implementation of the Framework involves training, establishing implementation teams within districts to drive and sustain change, further resource development and the introduction of a quality improvement model.

### Training and implementation teams

Training is the first phase of implementation and begins with readiness sessions prior to the Community Services Centres embarking on nine days of practice skills training.

District implementation teams are then established in trained districts to develop a plan to embed the Framework into systems and practice over time and to find solutions to barriers to implementation.

The training phase of implementation was completed in the New England District in November 2018, the Sydney, South Eastern Sydney and Northern Sydney districts in April 2019 and Hunter Central Coast District in November 2019.

The training phase of implementation in remaining districts will occur in 2020 and 2021. New caseworkers joining the agency will receive redeveloped Caseworker Development Program content (see the resource development section below) by July 2020.

### Resource redevelopment and new training modules

As we continue to implement the Framework, the OSP is threading the Framework's principles into revised and new resources. This includes the redevelopment of training modules, continuing professional development content, practice kits and practice advice. The redevelopment of the Caseworker Development Program is underway and will be underpinned by the Practice Framework.

The OSP has also adapted the DCJ group supervision model to incorporate the Framework's principles, approaches and capabilities. Training in the adapted group supervision model was delivered to more than 2400 practitioners across NSW in late 2017 and throughout 2018. The revised Framework has been integral to this ongoing professional development for practitioners.

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

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

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

These training sessions support practitioners to build their skill and confidence by demonstrating how the

five evidence-informed practice approaches can be applied to direct work with children and their families. This training is delivered over 10 weeks.

### Quality improvement model

The NSW Practice Framework also includes a quality improvement model that will be implemented over three years. An extensive evaluation will also occur over the same period. This evaluation will assess the fidelity of training and aspects of practice not currently measured by DCJ. The evaluation started with a readiness assessment, which shows that DCJ staff overwhelmingly accept the Practice Framework and believe it will make a difference to children and their families. Development of the quality improvement model is underway, with trained sites on track to begin using it at the beginning of 2020.

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

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

### Practice Framework Working Group

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

## 4.3 Their Futures Matter: Implementation and progress

### 4.3.1 Overview of the reforms

*Their Futures Matter* is a reform born out of recommendations made in David Tune's review into the out of home care system in NSW in 2015.<sup>120</sup>

On 5 July 2019, the Hon. Gareth Ward, Minister for Families, Communities and Disability Services, announced the transition of the *Their Futures Matter* Implementation Unit to the NSW Stronger Communities Investment Unit.

The NSW Stronger Communities Investment Unit (SCIU) is a new cross-government entity that will lead cross-government strategies and deliver *Their Futures Matter* reforms to improve outcomes for children, young people and families experiencing vulnerability. Its work is underpinned by an investment approach, which uses a comprehensive human services dataset and investment modelling to determine population groups most in need, in order to guide investment and social policy decision-making. Its aim is to deliver a well-coordinated and integrated service system that responds to needs early and achieves lasting change.

The SCIU will be advised by a cross-sector body known as the Stronger Communities Investment Coalition. The Coalition will consist of senior government representatives and non-government subject matter experts, who will drive efforts and provide the NSW Government with expert advice and knowledge. Minister Ward will appoint members to the Coalition.

### 4.3.2 Forecasting Future Outcomes

In 2018, the SCIU, in collaboration with other NSW human service agencies, compiled the first comprehensive human services cross-agency dataset in NSW – the TFM Human Services Dataset.

<sup>120</sup> Tune (2015).

The TFM Human Services Dataset contains anonymised linked data on all children and young people born in NSW on or after 1 January 1990 until 30 June 2017 and the key government services they and their families have engaged with. This includes child protection, housing, justice, health and education.

The SCIU released the Forecasting Future Outcomes Stronger Communities Investment Unit – 2018 Insights Report on 5 July 2019.<sup>121</sup> The report presents findings from the first modelling undertaken on the TFM Human Services Dataset and highlights the high service usage and poor social outcomes for vulnerable groups of children and young people in NSW. As such, the report provides NSW with crucial evidence to help build a service system that intervenes early, prevents harm and focuses particularly on those with the greatest need.

The analysis in this publication helped define six vulnerable groups that would benefit greatly from development of new support systems:

- **Vulnerable young children aged five or younger:** children with identified risk factors relating to their parents, perinatal factors or significant involvement in the child protection system.
- **Children and young people affected by mental illness:** children and young people up to the age of 18 who, in the last five years, have experienced mental illness or whose parents have experienced mental illness.
- **Vulnerable young adolescents:** children aged between 10 and 14 with identified risk factors in the last five years relating to their parents, significant involvement in the child protection system or interaction with the criminal justice system.
- **Vulnerable young people transitioning to adulthood:** young people aged between 16 and 18 who, in the last five years, have had significant involvement in the child protection system or have interacted with the criminal justice system.
- **Young mothers and their children:** mothers up to the age of 21 and their children.
- **1000 individuals** with the highest estimated future service cost.

The first two of these groups have been prioritised for the development of state-wide strategies aimed at addressing their vulnerabilities and poor social outcomes.

The SCIU has developed a series of DCJ district and local government area information packs, which provide insights into the two priority groups at a regional level to inform planning and design of supports and services.

The SCIU is also working towards refreshing and expanding the TFM Human Services Dataset to include more recent data and additional data, in preparation for the next round of investment modelling.

## System Transformation

System Transformation (formerly known as Access System Redesign) is a proposed 10-year multi-agency transformation of the child and family service system that aims to give children and families the support they need at the right time.<sup>122</sup> Over time, this approach will help to redirect service interventions and investment from crisis-driven responses towards prevention and early intervention.

The name was changed to System Transformation in recognition that ‘Access System Redesign’ suggested the reform was limited to a child or family’s initial entry pathway into the system (i.e. via the Child Protection Helpline). System Transformation is intended to be a more holistic approach, with the goal to design a child and family system where child wellbeing and protection is delivered in the context of family and community, and vulnerable children and families are connected with the services and supports they need at the earliest opportunity. This includes strengthening intake, assessment and referral pathways before children and families require a statutory intervention.

<sup>121</sup> Stronger Communities Investment Unit (2018).

<sup>122</sup> See NSW Government (2019).



### 4.3.3 Cohort approach

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

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

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

#### Current targeted cohorts

The Tune review of out of home care in NSW, which led to the *Their Futures Matter* reforms, identified that services weren't always addressing the complex needs of young people, or the devastating effects of abuse and neglect across generations, young people and families.

As such, *Their Futures Matter* has designed wraparound service supports for targeted cohorts, identified by data as being vulnerable, and therefore prioritised for assessment and service implementation. A description of each of the services is provided in the next section.

- **Thriving Families NSW** provides targeted support to meet the needs of vulnerable young parents aged 25 years and under, and their children up to the age of five years (including unborn children).
- **A Place to Go** provides targeted support to young people aged 10 to 17 years entering and exiting the youth justice system, with a focus on remand.

### 4.3.4 Programs and achievements

In the Tune review, it was predicted that without intervention the number of children in care would continue to increase. Since the implementation of the *Their Futures Matter* reforms in 2016, the number of children in care, as well as the number of children entering care, has been falling. It is likely that it is a combination of initiatives that are leading to this decline, and the following *Their Futures Matter* initiatives may be part of the reason.

A number of pilots are underway as part of the System Transformation principle of 'try, test and learn'. As these are new pilots, the data are not sufficient to share results.

Results so far for the evidence-based programs are described below.

#### Family preservation and restoration programs

Two evidence-based family preservation and restoration programs are currently underway, called Functional Family Therapy through Child Welfare<sup>123</sup> (FFT-CW<sup>®</sup>) and Multisystemic Therapy for Child Abuse and Neglect<sup>124</sup> (MST-CAN<sup>®</sup>). Both have been shown internationally to be successful with families.

##### **Functional Family Therapy through Child Welfare**

FFT-CW is a home-based family therapy treatment model for families where there has been physical abuse and/or neglect of a child or young person aged 0–17 years. FFT-CW works with families for an average of six to nine months and is provided to families in their homes or a suitable community setting.

##### **Multisystemic Therapy for Child Abuse and Neglect**

MST-CAN is a home-based intensive therapeutic treatment model for families where there has been substantiated physical abuse and/or neglect of a child or young person aged between six and 17 years.

<sup>123</sup> Functional Family Therapy (2017).

<sup>124</sup> Developed at the Medical University of South Carolina. See Global Family Solutions (2017).

MST-CAN is delivered in the home by highly skilled psychologists, who are available 24 hours a day, seven days a week, and who can work with the family for up to nine months.

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

Where it is suitable to restore a child or young person to their family, intensive support will be provided through FFT-CW and MST-CAN or other services to ensure the pathway home for children is successful. Step-down support will also be provided at the completion of the programs following the return of a child or young person to their family.

By reducing the number of children in out of home care – that is, by preserving and restoring families – funds can be invested into services that strengthen the capacity of families to care for their children. This creates a stronger long-term service system.

### **Service delivery and outcomes**

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

As at 30 June 2019, more than 1700 families (167 in MST-CAN and 1618 in FFT-CW) have been accepted into the programs since they started. This translates to at least 6000 siblings and other family members receiving benefits from the service.

Cumulative to the end of June 2019, 606 families have completed the programs, including 160 Aboriginal families.

Preliminary data<sup>125</sup> indicates that ROSH reports are reducing for families in the post-therapy follow-up, with an average reduction of 46 per cent for FFT-CW and 61 per cent for MST-CAN. Of the families who have completed both programs, only two per cent have entered care.

### **A Place to Go**

This initiative aims to improve supports and deliver a better response for 10–17 year olds entering and exiting the juvenile justice system, with a focus on young people in remand. It draws on NSW Government and non-government providers to deliver a coordinated and multi-agency service solution that can support a young person to change their life trajectory.

A Place to Go (APTG) focuses on using a young person's contact with police and/or the Children's Court as an opportunity to intervene and provide the supports they need to reach their potential. APTG is being implemented in the Nepean Police Area Command and the Parramatta Children's Court, with a trial to run until 30 June 2020.

The trial is funded by *Their Futures Matter*.

### **Service delivery and outcomes**

- 38 young people consented to receive service support and have their outcomes tracked.
- The former FACS Court Liaison Officer supported 357 young people on 641 occasions.
- The Education Court Liaison Officer supported 396 young people on 718 occasions.

### **OurSPACE**

Implemented in December 2018, the OurSPACE program is part of the needs-based supports pillar of *Their Futures Matter* and was strategically commissioned for children and young people in out of home care to enhance the needs and goals of these children, informed by the risks to their wellbeing and futures. The goal of the initiative is to stabilise placements.

<sup>125</sup> ROSH and out of home care data prepared by FACS Insights, Analysis and Research (FACSIAR). Data is sourced from production databases and analysis may use different counting rules, ageing schedules and quality assurance standards to published data. As a result, data are subject to change and may not match other published data.

OurSPACE targets children and young people aged 15 and under in statutory kinship or foster care who have experienced two or more placements in the past 180 days and who present with a combination of behaviours associated with trauma. The provider and Aboriginal partner organisation Ngaoara work together to identify a cohort of Aboriginal children and carers with complex and intensive needs who are assessed by trauma assessment, referral and rehabilitation outreach teams (TARROT).<sup>126</sup> TARROT is an Australian first approach to assessment using traditional Aboriginal and Western conceptualisations of trauma.

Based on a comprehensive assessment, a tailored therapeutic individual plan is developed, including a safety plan, to specifically address the child or young person's risk of harm or the risk they pose to others. The plan also focuses on improving the relationship between the child or young person and their carer.

Referrals come from multiple pathways including NGOs, out of home kinship care providers, DCJ caseworkers, kinship and foster carers, school teachers, juvenile courts and other professionals.

Referrals are made through a centralised intake number: 1300 381 581.

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

As at 30 June 2019:

- 42 young people consented to receive service support and have their outcomes tracked
- the DCJ Court Liaison Officer has supported 403 young people on 730 occasions
- the Education Court Liaison Officer has supported 434 young people on 880 occasions.

### **LINKS Trauma Healing Services**

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

LINKS was established to address trauma symptoms and improve psychological wellbeing for children under 16 years of age who are in out of home care and whose placements are unstable.

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

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

- Between June 2018 and June 2019, 151 children and young people were accepted into the program. Over 40 per cent are Aboriginal children and young people.

### **Thriving Families NSW**

This initiative provides targeted support to meet the needs of vulnerable young parents aged 25 years and under, and their children up to the age of five years (including unborn children).

The initiative aims to align resources across and within the Western Sydney Local Health District and DCJ to respond to the health, accommodation and safety needs of vulnerable children and families in a timely way. Thriving Families NSW aims to intervene before vulnerable families reach crisis point by considering earlier indicators of vulnerability. The initiative does this by ensuring young parents have access to age-appropriate, strengths-based wraparound services which meet the needs of the whole family.

The initiative is funded by *Their Futures Matter*. See the section below on 'Aboriginal children and their families' for information on the associated Aboriginal Thriving Families initiative.

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

- Surpassed the KPI of 30 families participating in the program between November 2018 and June 2019.

<sup>126</sup> For more information visit [ngaoara.org.au/tarrot](http://ngaoara.org.au/tarrot)

## Under 12s

In September 2017, *Their Futures Matter* launched the first elements of a wraparound service solution for children under the age of 12 in residential care without an older sibling. This cohort of children was identified in March 2016 by the interim report of the *Their Futures Matter* review as needing immediate action and investment in a range of initiatives to improve life outcomes.

### **Service delivery and outcomes**

The initiative has a number of key elements, but is founded on the principles of a shared understanding of need for children and young people who have experienced trauma and disrupted attachment, and leverages the expertise of professionals to share responsibility and create a consistent care approach. Key elements include:

- A 'Team Around the Child' comprising local inter-agency professionals and others close to the young person who work collaboratively to problem solve and support the young person with a shared understanding of need.
- A key worker (not client-facing) leads the Team Around the Child and acts as the 'incessant advocate' for each young person. They build on the efforts of the child's caseworker by streamlining access to supports and interventions via the cohort service package
- Individual educational needs supported through monitoring in-school progress and building capacity of school staff to adapt teaching and learning strategies according to individual need.
- A comprehensive health file review with tailored clinical recommendations, promoting a better response to health needs and enhanced continuity of clinical care.
- Access to psychological and other therapy services through the LINKS Trauma Healing Service or other trauma-focused treatment.
- Trialling a new foster care model called Professional Individualised Care, which uses carers who have industry recognised qualifications and professional work experience with the established skillset to appropriately respond to complex trauma and high needs behaviour.
- Flexible brokerage funds to tailor components of the wraparound service solution or source new services, according to the health, education and safety needs of the child.

As of June 2019, the number of children in this cohort in residential settings has fallen by 48 per cent (from 68 to 35 children) and 10 children have been restored to their parents' care.

## Aboriginal children and their families

*Their Futures Matter* reforms aim to intervene early to give Aboriginal children and their families the support they need so that children can stay with their families when it is safe to do so. Over time, this is intended to help reduce the over-representation of Aboriginal children in out of home care and help children live safely with their families.

*Their Futures Matter* is investing in the following evidence-based programs aimed at supporting Aboriginal children, young people and families:

- **Aboriginal Thriving Families** is enhancing services provided by two Aboriginal Child and Family Centres (ACFCs) in Minto (Waranwarin ACFC) and Nowra (Cullunghutti ACFC) to increase access and long-term outcomes for Aboriginal families through wraparound services. As at June 2019, the Family Connections Worker (Minto) has supported 65 community members and made 14 referrals.
- The **ID Know Yourself** is a cultural mentoring program for Aboriginal young people (aged 15 or more years) leaving care in the Redfern/Waterloo area. The aim of the program is to support Aboriginal young people to become strong and resilient and prepare them to reach their full potential in life after care. The program is currently engaged with nine young people and is funded for eight to 10 places for the 2019 calendar year.
- The **Aboriginal Family Mentoring Program** hosted by Link-Up NSW is an Aboriginal-led program designed by community aimed at strengthening and supporting vulnerable Aboriginal families in the

Redfern/Waterloo area. The program was established at the end of the June 2019 and has not yet launched. It is funded for 10 families and is expected to extend to approximately 60 family members.

- The **Nabu Demonstration Project** is a First Nations evidence-based early intervention and intensive family support program for Aboriginal families in the Illawarra Shoalhaven and Southern NSW districts. The project was established at the end of June 2019 and has not yet launched. It is funded for 64 families and is expected to extend to approximately 320 community members.
- The **Aboriginal Evidence Building in Partnership (AEBP) Project** is supporting the embedding of data collection processes and evidence building capabilities to enable continual service improvement with six Aboriginal organisations.

#### 4.3.5 Other relevant reforms within DCJ

##### ELVER Trauma Treatment Service

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

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

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

#### 4.4 Permanency Support Program

The Permanency Support Program, which started on 1 October 2017, is a key reform to the child protection and out of home care system in NSW. It represents a philosophical shift from a 'placement-based service' to a 'child and family centred service system'. The program supports children to find permanent, safe and loving homes.

The Permanency Support Program has three goals:

- Fewer entries into care – by keeping families together.
- Shorter time in care – by returning children home or finding other permanent homes for more children through guardianship orders or adoption.
- A better care experience – by supporting children's individual needs and their recovery from trauma.

There are four parts of the program which support children, young people and families to achieve permanency:

- Permanency and early intervention principles built into casework.
- Working intensively with birth parents and families to support change.
- Recruitment, development and support of carers, guardians and adoptive parents.
- Intensive Therapeutic Care system reform.

The program funds services to support children through five different permanency pathways: preservation, restoration, guardianship, open adoption and long-term out of home care. These pathways reflect the permanent placement principles outlined in the *Children and Young Persons (Care and Protection) Act 1998* (the Care Act). The pathway chosen for a child will depend on their permanency goals.

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

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

The *Children and Young Persons (Care and Protection) Amendment Act 2018* was passed in Parliament in November 2018 and came into effect on 4 February 2019. It amends the Care Act and the Adoption Act 2000 to support current child protection reforms, including the Permanency Support Program.

The amendments also support the NSW Practice Framework and further align practitioners and others around the goal of keeping children safe at home or, if that is not possible, working with urgency to find permanency.

## **PRACTICE GUIDANCE ON LEGISLATIVE CHANGES**

The Casework Practice resource on Leadership provides practice guidance on legislative amendments under the recent *Children and Young Persons (Care and Protection) Amendment Act 2018*.

This practice guidance has been developed to provide detailed information to DCJ staff about the changes, and implications for casework practice with children and their families.

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

## **My Forever Family NSW**

My Forever Family NSW recruits, trains and supports carers, guardians and adoptive parents across NSW. This includes providing emergency, short-term, respite, restoration, relative/kin or long-term care. My Forever Family NSW works closely with NGOs to support its work.

## 4.5 Improving our responses to children whose parents experienced abuse as a child

This section describes current and future initiatives that focus on increasing casework knowledge and improving practice and outcomes for children whose own parents experienced abuse as a child. This cohort of children was discussed in detail in Chapter 3 of this report. The section also includes a number of de-identified case studies to illustrate practice.

As we began to see in Chapter 3, understanding the extent to which child abuse in one generation might affect the risk of child abuse to the next, and considering the factors that help children and parents build resilience and heal, will assist practitioners to develop and target their work with families with children who are reported to be at ROSH.

Understandably, there is considerable overlap between the services and responses listed in this section and the *Their Futures Matters* initiatives detailed in Section 4.3.4.

### 4.5.1 Programs and achievements

#### Family preservation and restoration programs

FFT-CW and MST-CAN, introduced in Section 4.3.4, are transforming lives and making positive change for not only the families who come to the attention of DCJ but for their extended family networks and the wider community such as schools, police and other local health services. The programs support families experiencing complex or multiple needs including mental health, and drug and alcohol misuse. The programs' primary goals are to reduce the number of children entering out of home care and increase the number of children exiting out of home care, and they are the first programs in NSW to deliver in-home therapeutic service for the whole family focused on treating underlying causes of trauma, harm and concerning behaviours.

*Their Futures Matter* has received anecdotal feedback that DCJ has been able to close cases that they thought would never close. There are also reports about parents, who had been using from their early teens, who are now clean from using ice, marijuana and other substances. The program is showing signs that it may be life-changing for generations to come.

MST and FFT are funded by *Their Futures Matter*. Referrals can be made via DCJ Community Services Centres.

#### **Functional Family Therapy through Child Welfare**

As discussed Section 4.3.4, FFT-CW is a home-based evidence-informed therapeutic service for families with multiple risk factors where there has been physical abuse and/or neglect of a child or young person aged 0–17 years. The FFT-CW practitioner provides a tailored service to each family's circumstances and needs for a service period between six and nine months.

There are currently six providers delivering 18 FFT-CW teams in 11 locations across NSW:

- MacKillop Family Services (Goulburn/Queanbeyan, Shellharbour/Wollongong, Nowra/Ulladulla, Blacktown)
- The Benevolent Society (Sydney)
- OzChild (St Marys, Macarthur/Ingleburn, Edgeworth)
- Uniting (Fairfield)
- Nepean Community and Neighbourhood Services (Penrith)
- Riverina Medical and Dental Aboriginal Corporation (Wagga Wagga).

### **Multisystemic Therapy for Child Abuse and Neglect**

As discussed in Section 4.3.4, MST-CAN is a home-based evidence-based, 24/7 intensive therapeutic treatment model for families where there has been substantiated physical abuse and/or neglect of a child or young person age six to 17 years.

MST-CAN therapists meet with the entire family a minimum three times a week in their home at times convenient to the family for up to nine months.

There are currently six MST-CAN teams in six priority locations across NSW:

- Wandiyali (Edgeworth/Charlestown/Mayfield)
- Uniting (Coffs Harbour)
- Marathon Health (Dubbo)
- OzChild (Macarthur/Ingleburn)
- Life Without Barriers (Tamworth)
- CatholicCare (Wyong/Gosford).

### ***Cody and her kids***

*Cody is a single mother from the Hunter region with five children ranging in ages from one to 14 years. Three of the children identify as Aboriginal. Since 2011, the children have seen Cody harmed through domestic violence and have also experienced neglect due to Cody's substance use. In 2013, the children were taken from Cody's care and placed in the care of their grandparents.*

*The family undertook the MST-CAN program and Cody says it has changed her life. All five children are back at home and attending school. In Cody's words, 'We had a lot of verbal aggression in the home, but as soon as I started working with MST, they showed me how to bring that down. As soon as I started practising all the skills and putting them in place, the kids just followed.'*

### **LINKS Trauma Healing Services**

The LINKS Trauma Healing Services are available to children and young people under the age of 16 years who are in out of home care and living in the Nepean, Hunter and Central Coast regions, generally within a radius of 60 minutes from Penrith or Newcastle. The child or young person must have had two or more placements in the past six months and/or an increased need for respite care over the past 12 months. LINKS accepts referrals, which can be made by the carer, out of home care provider or DCJ out of home care team.

Many of the children and young people who access LINKS are from families where parents also have their own child protection history.

LINKS aims to help children and young people decrease trauma symptoms, feel better about themselves and improve their behaviour. It delivers trauma-focused, evidence-based support by a range of specialists including mental health practitioners, Aboriginal mental health practitioners, occupational therapists and speech pathologists. LINKS teams see participants in a variety of locations such as the LINKS office, schools and at home.

Understanding the impact of trauma on a child's wellbeing and behaviour will ensure that when there have been two or more placement breakdowns in the past six months and current placements may be at risk of breaking down, clients are referred for a service to support the child or young person and their carer.



Aims of the services include that children and young people:

- identify that their carer is understanding of their needs
- are able to form relationships with carers (and others) more easily
- experience connection within family and community, making them feel safer and accepted
- understand better the impact that trauma has on their life to help resolve some of these issues and participate more fully in school and community activities
- experience more stability with their placement and foster or kinship carers
- are eventually restored to their families.

### ***Tim and Links***

*Tim is a five year old boy with a history of neglect and physical abuse. He saw his stepfather using violence against his mother regularly. There are also concerns that his stepfather sexually abused him, and the home wasn't safe because his parents were using drugs and there were always people staying there.*

*Tim was taken into the care of the Minister when he was four. At the same time, his stepfather was sent to jail. Tim moved six times in 11 months until, in December 2017, he went to live with Karen, where he continues to stay.*

*Tim was referred to LINKS in Penrith in May 2018. He participated in an evidence-based program – eye movement desensitisation and reprocessing (EMDR) – developed for children who have experienced trauma. With a therapist, he was helped to recall a traumatic memory and then learn to generate what is known as 'bilateral sensory input', which involves moving the eyes from side to side or hand tapping. This helped to desensitise Tim's memory and lessen his feelings of trauma.*

*By Week 8 of the LINKS program Tim was demonstrably calmer and happier. His carers also heard him give a deep belly laugh for the first time. Tim completed the program after 14 sessions.*

### **Broadmeadow Children's Court Pilot**

This initiative works with young people appearing before the Broadmeadow Children's Court in Newcastle. The pilot includes a multidisciplinary court-based team with workers from DCJ in child protection and youth justice, health, education and NGOs. Its goal is to offer alternative service pathways for children and young people entering and exiting the justice system.

The multidisciplinary team works collaboratively, sharing information to support decision-making, assessments and interventions to reduce reoffending and improve outcomes for young people in the justice system. All young people that appear before the court can access support through the multidisciplinary team.

Funding is provided by the participating agencies, and *Their Futures Matter* has also allocated resources to support the initiative.

## Futures Planning and Support

Futures Planning and Support is targeted towards young people aged 17–24 years leaving or who have already left out of home care.

Anyone can make a referral to the service, including young people themselves. The service provider is also required to actively look for care leavers to offer them the service and seeks referrals from services and Aboriginal communities.

The program is starting as a three-year pilot, jointly commissioned by DCJ Child & Family and *Their Futures Matter*, to be run by the DCJ Mid North Coast District from November 2019.

### **Program goals**

- Improve the quality of supports for and safety and wellbeing of young people exiting or who have already left care.
- Identify best practice for supporting care leavers to reach their potential.
- Inform future investment in NSW.

### **Support provided**

Tiered support to care leavers includes:

- One-off connection service to link people to services and resources.
- Futures coaching for an estimated 60 per cent of eligible care leavers.
- Intensive casework to an estimated 10 per cent of eligible care leavers.
- Access to financial assistance of up to \$10,000 per year to assist the young person to achieve their personal goals.

## OurSPACE

### Thriving Families NSW

### Treatment Foster Care Oregon

These initiatives and programs (see Section 4.3.4 for more detail) are also being used by practitioners to help children whose own parents experienced abuse as a child.

### ***David and OurSPACE***

*David is a 13 year old Aboriginal boy who was living on the south coast of NSW. He is in the long-term care of the Minister, and was living with a non-Aboriginal foster carer, where he was very unhappy. He was also using drugs and involved in crime.*

*David was referred by DCJ to OurSPACE in March 2019. An Aboriginal therapeutic specialist from OurSPACE provided a wraparound service with DCJ, education, foster carers and David's extended kinship family, who agreed that David's placement was not meeting his needs. A kinship placement was identified with David's brother. David was supported to move to his new home by the Aboriginal therapeutic specialist.*

*OurSPACE provided dyadic development psychotherapy and trauma-focused cognitive behavioural therapy and helped David to engage with his community in Sydney. The therapy and support has led to David attending school full time, playing rugby league and building long-term, strong relationships with his family.*

# Glossary

## **Aboriginal**

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

## **Abuse**

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

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

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

## **Authorised carer**

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

## **Case closure**

Case closure is a considered casework decision that signals the end of DCJ 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 DCJ officer responsible for working with children, young people and their families, and other agencies in child protection, out of home care (OOHC) and early intervention. Caseworkers have day-to-day case coordination responsibilities. Caseworkers report to a manager casework.

## **Child**

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

## **Child Protection Helpline**

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

## **Children's Court**

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

## **ChildStory**

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

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

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

## **DCJ Community Services Centre (CSC)**

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

## **Domestic violence**

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

## **Engagement**

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

## **Manager casework**

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

## **Mandatory reporter**

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

## **Medical examination**

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

## **Mental health concerns**

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

## **Neglect**

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

## **Order**

An order of a court or an administrative order.

## **Out of home care (OOHC)**

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

## **Parental responsibility**

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

## **Parental responsibility to the Minister**

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

## **Physical abuse or ill-treatment**

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

## **Prenatal report**

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

## **Removal**

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

## **Report**

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

## **Reporter**

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

## **Restoration**

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

## **Risk of harm assessment**

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

## **Risk of significant harm (ROSH)**

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

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

## **Risk-taking behaviours**

Risk-taking behaviours include:

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

## **Safety and risk assessment (SARA)**

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

## **Sexual abuse or ill-treatment**

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

### **Structured Decision Making (SDM®)**

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

### **Supervision**

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

### **Supported care allowance**

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

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

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

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

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

### **Young person**

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

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## DCJ Casework Practice intranet resources

### **NSW Practice Framework**

<https://caseworkpractice.intranet.facs.nsw.gov.au/our-approach/practice-framework>

### **Aboriginal Case Management Policy**

<https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/aboriginal-case-management-policy/policy-statement2>

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

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

### **Child Sexual Abuse Kit**

<https://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/child-sexual-abuse/modules/overview>

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

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

### **Case planning for change**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/permanency/case-planning-for-change>

### **Cultural practice with Aboriginal communities**

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

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

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

**Leadership**

<https://caseworkpractice.intranet.facs.nsw.gov.au/leadership>

**New partners**

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

**Social justice and human rights**

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

**Swimming pools: Frequently asked questions**

[https://caseworkpractice.intranet.facs.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0011/338456/Swimming-Pools-FAQ.pdf](https://caseworkpractice.intranet.facs.nsw.gov.au/__data/assets/pdf_file/0011/338456/Swimming-Pools-FAQ.pdf)

**Understanding trauma and resistance**

<https://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/understanding-trauma-and-resistance#section-370155>

**Working with fathers to keep children safe**

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

**Working with young people**

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

# Appendix 1: Counselling and support services

| Service  | Description   | Contact   |
|--|---|---|
| <b>Child Protection Helpline</b>   | Report suspected child abuse or neglect to DCJ  | <b>132 111</b>  |
| <b>Aboriginal Counselling Services (ACS)</b>                             | Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW  | <b>0410 539 905</b>   |
| <b>Aboriginal Medical Service</b>  | Provides comprehensive health care to the Aboriginal community  | <b>Find local contacts at <a href="http://ahmrc.org.au">ahmrc.org.au</a></b>                                  |
| <b>Department of Forensic Medicine</b>                                   | Provides information, support and counselling for relatives and friends of the deceased person for deaths being investigated by the Coroner   | <b>(02) 8584 7800</b>   |
| <b>Kids Helpline</b>   | Telephone counselling   | <b>1800 55 1800 or visit <a href="http://kidshelpline.com.au">kidshelpline.com.au</a></b>                     |
| <b>Lifeline</b>  | Provides 24/7 telephone crisis support and suicide prevention services  | <b>13 11 14 or visit <a href="http://lifeline.org.au">lifeline.org.au</a></b>                                 |
| <b>My Forever Family NSW</b>   | The Care Support Team is available via phone or email   | <b>1300 782 975 or <a href="mailto:enquiries@myforeverfamily.org.au">enquiries@myforeverfamily.org.au</a></b> |
| <b>NALAG Centre for Grief and Loss</b>                                   | Provides free face to face and telephone loss and grief support   | <b>(02) 6882 9222 or visit <a href="http://nalag.org.au">nalag.org.au</a></b>                                 |
| <b>National Centre for Childhood Grief</b>                               | Free counselling for bereaved children; counselling also provided for bereaved adults, parents and caregivers (fee involved)  | <b>1300 654 556 or visit <a href="http://childhoodgrief.org.au">childhoodgrief.org.au</a></b>                 |
| <b>Red Nose NSW and Victoria</b>   | Provides 24/7 bereavement support to families who have suffered the loss of a baby  | <b>1300 308 307 or visit <a href="http://rednosegriefandloss.com.au">rednosegriefandloss.com.au</a></b>       |
| <b>Suicide Call Back Service</b>   | Free 24/7 phone, video and online counselling for anyone affected by suicide  | <b>1300 659 467</b>   |
| <b>The Australian Child and Adolescent Trauma Loss and Grief Network</b> | Resources to help caregivers understand and respond to the diverse needs of children and adolescents experiencing trauma, loss and grief  | <b>Visit <a href="http://tgn.anu.edu.au">tgn.anu.edu.au</a></b>   |
| <b>The Compassionate Friends</b>   | Self-help organisation offering friendship and understanding to bereaved parents, siblings and grandparents after the death of a child and fostering the physical and emotional health of bereaved parents and their surviving children | <b>1800 671 621 or visit <a href="http://tcfnsw.org.au">tcfnsw.org.au</a></b>                                 |





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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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