Communities and Justice

NSW GOVERNMENT

Child Deaths

2023 Annual Report

Learning to improve services

Acknowledgement of Country

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

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Acknowledgement

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

Sadly, Aboriginal and Torres Strait Islander children are significantly over-represented in the number of children who died in 2023 and who were known to the Department of Communities and Justice.

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

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

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

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

Minister's foreword

It's with deep sadness that I present the *Child Deaths 2023 Annual Report*.

The death of a child under any circumstance is heartbreaking, and I extend my deepest sympathies to the families and communities who knew and loved these children.

This report reveals the tragic stories of 96 children who died in 2023 and were known to the NSW child protection system.

It's with a heavy heart that I acknowledge the 42 Aboriginal children who died and are represented in this report. The over-representation of Aboriginal children in our child protection system is both heartbreaking and unacceptable. I know the death of each of these children has had deep and enduring impacts on families, kin and communities. I am deeply sorry for your loss.

Our government stands by its pledge to meet the targets set out in the National Agreement on Closing the Gap. In November 2023, we made progress on this commitment by implementing active efforts, and this dedication will only deepen as we continue to work with Aboriginal families and communities.

It is a core responsibility of this government to confront these truths with honesty and accountability. This report underscores the duty and ongoing commitment of the Department of Communities and Justice to reflect on, and reform, its practice and systems to better support the children and families it serves.

The report offers critical insights that will guide the substantial reforms underway to rebuild a child protection system that is safe and culturally responsive.

We will continue to work closely with health, education, justice and the non-government sectors to examine where we can do things differently, and to identify opportunities for lasting improvement.

I am grateful for the dedication and resilience of the DCJ workforce. The ripples from the tragedies set out in this report are felt by many. The NSW Government gives all those who've suffered our assurance that we will act on the insights in this report to keep more children safe.

Sincerely,

Kate Washington

Minister for Families and Communities, and Minister for Disability Inclusion

Secretary's foreword

I echo the heartfelt sentiments expressed by Minister Washington. The death of a child under any circumstances is heartbreaking. I also extend my deepest condolences to the families and communities of the children who have died.

As the Secretary for the Department of Communities and Justice, it is my responsibility to present the *Child Deaths 2023 Annual Report*. With this deep sense of responsibility, I carry thoughts of the grief of all families and communities who have lost children.

This report outlines the tragic loss of 96 children who died in 2023 and were known to the child protection system. It also outlines that tragically, of those 96 children, 42 were Aboriginal. Aboriginal children continue to be over-represented in the child protection and out of home care systems. It is with profound sadness that I extend my sympathies to the families, communities and kin of these children.

This report is important. It is in examining each case, reflecting on practice and connecting this with solutions for the system to better support children and families that we can make meaningful change.

To help enable change, this year the Department established a new System Reform division. One of the main focus areas of this division is to ensure children and families are receiving the support that is needed, at the time they need it, and crisis interventions are rare and a last resort. Another key priority of the new division is addressing the over-representation of Aboriginal children in out of home care. As the Minister has outlined, our commitment to meeting the targets outlined in the National Agreement on Closing the Gap and *Family is Culture* review has seen the proclamation of active efforts into legislation in November 2023. We are also working in close partnership with AbSec and other Aboriginal peak bodies to make our assessment approach culturally sound and equitable for Aboriginal families.

I thank everyone involved in producing and contributing to this report. It is through the steadfast commitment of everyone involved that we can make meaningful, lasting change.

Michael Tidball

Secretary

Summary

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

DCJ acknowledges the grief and loss experienced by families and communities when a child dies. This report includes stories based on real families to draw attention to the important learning for practitioners about child safety. Names have been changed to protect each family's privacy. These stories may be confronting for some readers. A list of support and counselling services is provided at Appendix 1.

Considerations when reading this report

In this report, unless otherwise specified:

- The *Children and Young Persons (Care and Protection) Act 1998* (NSW) (the Care Act) defines a 'child' as aged under 16 years and a 'young person' as aged over 16 years and under 18 years of age. In this report, the terms 'child' and 'children' are used to refer to both a 'child' and a 'young person'.
- 'Known to DCJ' includes children whose deaths met the criteria of 'reportable deaths' as defined in section 172A of the Care Act. This includes children (or their siblings) who were reported to DCJ suspected to be at risk of significant harm (as per section 23 of the Care Act) within three years of their death, and children who were in out of home care at the time of their death.

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

Child deaths in 2023

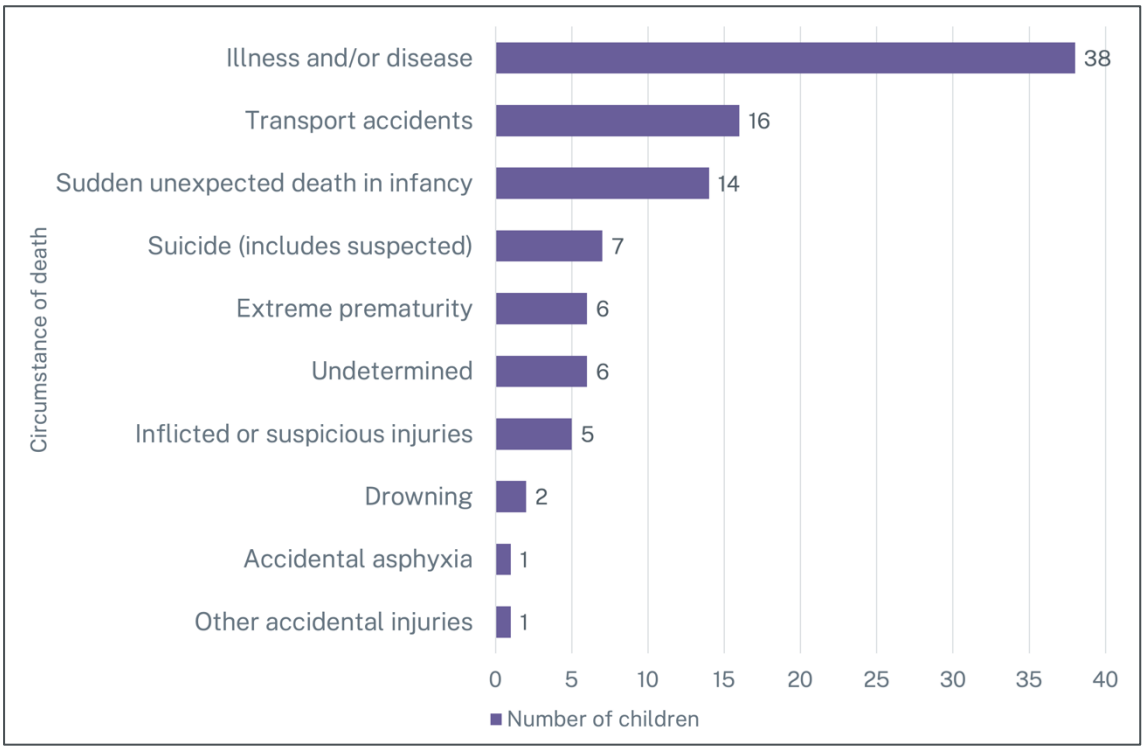
In 2023, 409 children aged from birth to 17 years died in NSW; 96 of these children were known to DCJ. Chapter 2 summarises information about these 96 children. As shown in Figure 1 below, and consistent with previous years, the most common circumstance of death for all children was illness and/or disease. Transport-related accidents were the second most common circumstance of death.

There was a marked decrease in the number of children who died in circumstances of suicide in comparison to previous years. Consistent with previous years, infants under 12 months of age made up a significant proportion of the children who died and were known to DCJ, with 36 children under 1 year of age.

Aboriginal children continue to be disproportionately represented in deaths of children known to DCJ. In 2023, 42 of the children who died were Aboriginal. This report considers these 42 deaths, both separately and within the larger cohort of the 96 children who died, providing specific detail about the children's circumstances of death, age and gender and the practice learning that has emerged from a review after these children's deaths.

For seven of the children who died in 2023, the Children's Court had made an order allocating parental responsibility to the Minister for Families and Communities, and for one child court proceedings were ongoing when they died. Two of these eight children were Aboriginal.

Figure 1: Children who died in 2023 and were known to DCJ, by circumstance of death



Note: the information in Figure 1 is also shown numerically in the column labelled '2023' in Table 1.

Improving the way DCJ works with children and families

Chapter 3 outlines DCJ responses to the learning that has come from child death reviews completed in 2023. It discusses the work of the Serious Case Review Panel and provides details about practice and policy changes that are taking place in response to recommendations made in child death reviews. Throughout 2023 and into 2024, DCJ continued to implement reforms to strengthen the child protection system and improve DCJ responses to vulnerable children and families. These initiatives are also described in Chapter 3.

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 reviews and oversight in NSW.

1.1 Child protection in NSW

DCJ is the lead agency in the Communities and Justice portfolio, which aims to create safe, just, inclusive and resilient communities through its services. DCJ works with the community, non-government partners and other agencies to improve outcomes for:

- people experiencing or who have experienced domestic and family violence
- people who have experienced sexual assault
- young people and adults in contact with the justice system
- people experiencing or at risk of homelessness and people in need of safe and affordable housing
- vulnerable children
- people with disability
- Aboriginal people, who are over-represented across services
- seniors, whom we support to live active and inclusive lives
- people from culturally and linguistically diverse backgrounds
- LGBTQIA+ communities.

The Community and Justice portfolio includes:

- Child Protection and Permanency
- Corporate Services
- Corrective Services NSW[1]
- Courts, Tribunals and Service Delivery
- Homes NSW
- Legal Reform and Legal Services
- Strategy, Policy and Commissioning (now System Reform)
- Transforming Aboriginal Outcomes, and
- a number of other entities.[2]

Child Protection and Permanency within DCJ works with other government departments, non-government organisations and the community to support families to keep children safe from abuse and neglect. DCJ enables services to work better together to support an individual's right to access justice and help for families and promote early intervention and inclusion.

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

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

Aboriginal peoples' strong connection to family, land and culture forms the foundation for wellbeing. DCJ acknowledges that many of the challenges faced by Aboriginal families need to be understood in the context of a sustained history of oppression, paternalism and cruelty. Many of the Aboriginal families who are in contact with child protection services today have been adversely affected by intergenerational trauma and its compounding effects.[3]

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

1.2 Examining child deaths

1.2.1 DCJ internal child death reviews

Reviewing child deaths is a requirement under section 172A of the Care Act. Each year, DCJ is required to report on the number and circumstances of death of children who have died and were known to DCJ. This includes children and/or their siblings who were reported to DCJ suspected of being at risk of significant harm within three years before the death of the child or a child who was in out of home care when they died.

Children in NSW with a child protection history have a higher mortality rate than those not reported to DCJ and account for a greater relative proportion of the children who die from certain causes in NSW. This includes Aboriginal and Torres Strait Islander children, those living in regional and remote areas and those from the most disadvantaged areas.[4] Other jurisdictions across Australia report similar findings.[5]

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

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

Serious Case Review Unit

The Serious Case Review (SCR) Unit is part of the Office of the Senior Practitioner (OSP) within DCJ. The SCR Unit reviews DCJ involvement with all children who have died and were known to DCJ. These internal child death reviews rely on a systems approach that is based on a case review model developed in England.[6] The reviews consider how local and organisational systems impact 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 positive practice. This in turn leads to broader system improvements. The findings from reviews are used to support organisational learning and system improvement.

The review process

When undertaking a review, the SCR Unit consults with practitioners who worked with the family prior to the child's death. Including practitioners in the review process increases the rigour of

reviews by including the local context and the perspective of practitioners who worked with and made decisions about a family.

An open and collaborative consultation process supports practitioner and organisational learning, leading to improved responses to other families. Throughout this process, the focus of review work remains on the broader systems that impact on practice and not the work of any one individual practitioner. Purposeful consultation encourages practitioner reflection, ensures the accuracy of information and supports strong analysis. If reviews are to lead to genuine learning and practice and system improvement, and support practitioners to think and work differently with other children, then a process that gives them the opportunity to understand and contribute to the interpretation of their work is crucial. When practitioners are consulted, they are more likely to accept the review findings, even those that are critical of practice. Consultation can also impact positively on the willingness of other practitioners engaging with the review process in the future.

Learning from internal child death reviews

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

Practice review sessions and other forums

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

Practice review sessions are held with practitioners 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.

1.2.2 Making and monitoring recommendations following child deaths

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

Making and monitoring recommendations within DCJ

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

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

Serious Case Review Panel

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

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

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

1.3 Child death oversight in NSW

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

1.3.1 Oversight bodies, agencies and teams

NSW Ombudsman

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

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

NSW Child Death Review Team

Convened by the NSW Ombudsman, the NSW Child Death Review Team (CDRT) registers, examines, analyses and classifies the deaths of all children in NSW with the objective of preventing and reducing child deaths. The CDRT includes the Advocate for Children and Young People, the Community Services Commissioner, representatives from other government agencies,[7] and individuals with expertise in relevant fields, including health care, child development, child protection and research methodology.

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

The CDRT advised DCJ that 409 children aged from birth to 17 years died in NSW in 2023; 96 of these children were known to DCJ. CDRT data differs from DCJ data, highlighting important differences between the way CDRT and DCJ report on child deaths. The CDRT reports on the deaths

of children with a child protection history if, within the three years before their death, the child and/or their sibling was reported to DCJ suspected of being at risk of significant harm, was the subject of a report screened as not meeting the suspected risk of significant harm threshold, was the subject of a report to a Child Wellbeing Unit or was a child in out of home care. By comparison, DCJ examines only the deaths of children who were the subject of a report that met the suspected risk of significant harm threshold or were children in out of home care at the time of their death. Both the CDRT and DCJ report on deaths that occurred in a calendar year.

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

NSW Police Force and the NSW State Coroner

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

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

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

DCJ routinely reports the deaths of children who were known to DCJ to the NSW State Coroner, and the two agencies regularly share information about child deaths under a letter of agreement.

The SCR Unit is responsible for coordinating DCJ responses to all coronial investigations and works closely with the DCJ Legal Inquests, Inquiries and Representation team on inquests into the deaths of children who were known to the NSW child protection system. Following an inquest, the SCR Unit coordinates the Department's response to coronial recommendations directed to DCJ.

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

NSW Domestic Violence Death Review Team

In July 2010, the NSW Domestic Violence Death Review Team (DVDRT) was established under the *Coroners Act 2009* (NSW). Domestic violence deaths are defined in the Coroners Act as a death caused directly or indirectly by a person who was in a domestic relationship with the deceased person. The overarching objective of the team is to examine domestic violence related deaths so as to reduce their incidence and facilitate improvements in systems and services. The death of a child in the context of domestic and family violence is also subject to review by the team. The Coroners Act provides that the functions of the team are to:

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

The DVDRT is a multi-agency committee convened by the NSW State Coroner. The team includes representatives from government agencies, including DCJ, the NSW Police Force and NSW Health, and representatives from non-government sectors and academia. The team undertakes comprehensive analyses of deaths occurring in a context of domestic violence to identify issues arising in individual cases or across cases, identify trends and patterns in quantitative data, highlight limitations or weaknesses in service delivery from its qualitative analysis and make recommendations.

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

Office of the Children's Guardian

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

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

1.3.2 Reviewing the deaths of children in out of home care

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

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. During 2023, this included children placed with carers authorised by DCJ or Permanency Support Program (PSP) providers, and children who died in a facility funded, operated or licensed by DCJ. These reviews consider the adequacy of the involvement of all agencies with the child and family before the child's death and the support and actions taken following the child's death.

The SCR Unit routinely works with PSP providers and non-government organisations as part of its review process. The deaths of children in non-government out of home care settings have led to a broadening of review mechanisms, with some reviews being undertaken jointly. This flexible and collaborative approach provides opportunities for DCJ and PSP providers to consider the practice lessons arising from reviews and deliver sector-wide practice and system improvements.

1.4 Public and interagency understanding of child deaths

In providing public information about the circumstances surrounding children's deaths, DCJ is committed to protecting the privacy of families who are impacted by the tragedy. The NSW Parliament has also responded by protecting privacy and confidentiality through a range of legislation that governs the disclosure of information on individual child deaths.[8] While DCJ cannot report publicly about individual children, it has a strong commitment to transparency and accountability. The publication of this report reflects this important and ongoing commitment.

1.4.1 Child deaths and the media

Child abuse and neglect is a problem for the whole of society, and the media plays a key role in the way they are portrayed in the public domain. Drawing attention to the stories of children who have died through the findings of rigorous review can help the community to understand the nature of child protection work and some of the complexities involved in working with children and families.

Most years, a small number of child deaths are the subject of considerable media attention. These deaths often involve children who died because of abuse or neglect by a parent or carer. Child abuse injuries, severe neglect and child deaths demand explication in the public domain. The media can

help to shape public and professional ideas of risk, and it can be difficult to separate what is known about child abuse from the media as compared to theory, research and practice.[9]

Media attention also has negative consequences. Understandably, the death of a child, particularly in circumstances of abuse or neglect, will provoke strong emotion and, in turn, the need for an explanation or for someone to be held accountable. This can lead to the increasing politicisation of child abuse, often responded to by political decisions to hold public inquiries, which can contribute to systems becoming risk averse and punitive in their orientation.[10] Recent literature about media reporting of child deaths advocates a more balanced approach that draws child protection risk to the public's attention, but then focuses on how the system could be improved.[11]

Review work by the SCR Unit has highlighted the impact the death of a child can have on practitioners when there has been extensive coverage in the media. Practitioners may adopt an unhelpful, defensive response, leading them to become too cautious, or they may adopt an overly intrusive approach with families and not recognise opportunities to improve the safety of a child.

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

Chapter 2: Child deaths in 2023

In 2023, 96 children died who were known to DCJ before their death. Chapter 2 provides summary information about these children and their families, including characteristics of the children, such as their age and gender. The accompanying analysis considers information that is known about the circumstances of the children's deaths, relevant information about their child protection history and DCJ responses to reports received about the children. Practice reflections, learning and case studies are included to strengthen current practice and future work with children and their families.

To maintain confidentiality for the children and their families, this chapter provides broad information about the circumstances of death and characteristics of the children.

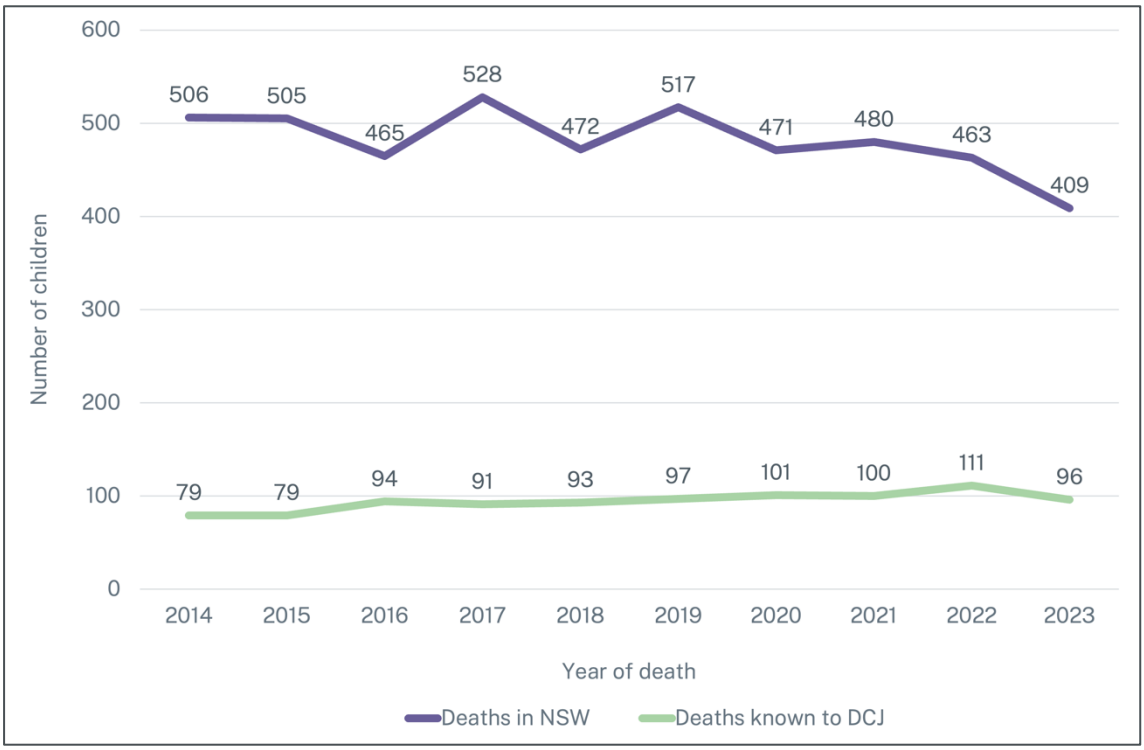
2.1 Child deaths in NSW in 2023

Between 1 January 2023 and 31 December 2023, the deaths of 409 children were registered in NSW. Of those 409 children, 96 were known to DCJ because they and/or their siblings had been reported to DCJ suspected of being at risk of significant harm in the three years prior to their death, or the child was in out of home care when they died. Of these 96 children, 42 were Aboriginal.

Figure 2 below shows the number of children who died in NSW and the number of children who died and were known to DCJ, across a 10-year period. The number of children in both groups decreased in 2023, compared to previous years. The number of children who were known to DCJ and died in 2023 represents 0.08 per cent of the total number of children reported to DCJ in that year.[12] This is consistent with previous years' findings.

DCJ receives information about the medical cause and circumstance of children's deaths from the NSW State Coroner and NSW Ombudsman. A child's cause of death may be different from the categories used in this chapter to describe the circumstance of death. For example, the cause of a child's death might be 'multiple traumatic injuries' while the circumstance of death might be 'transport accident'.

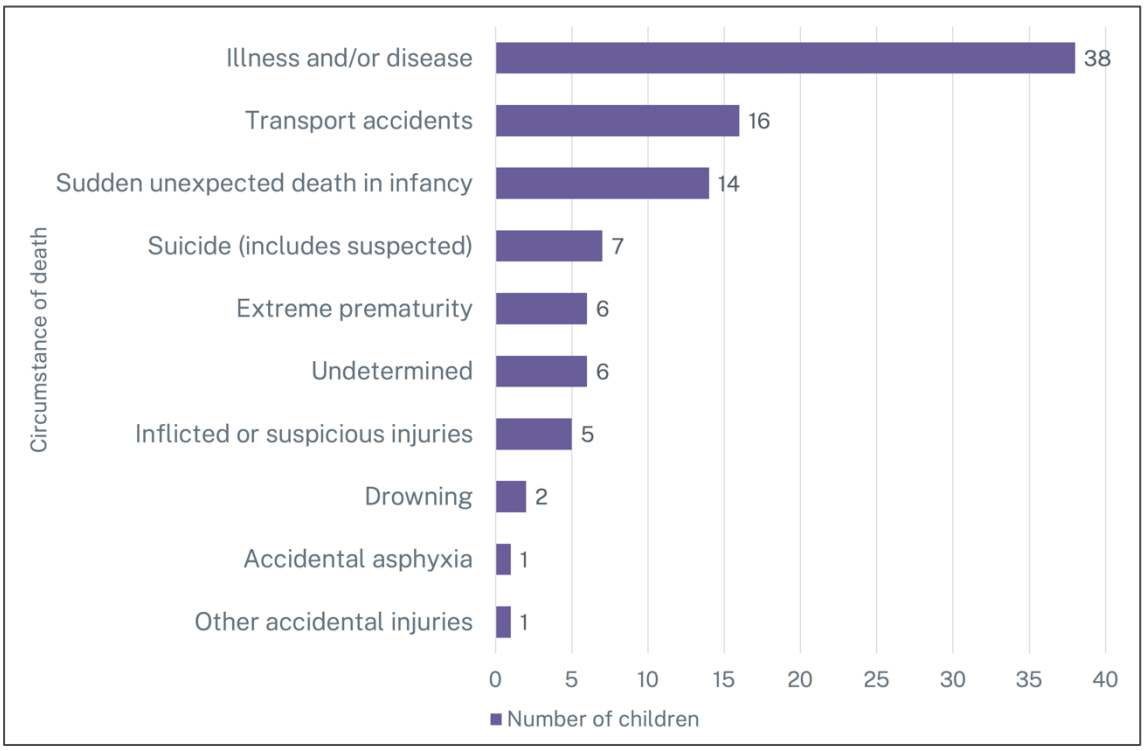
Figure 2: Children who died in NSW, by number of total deaths and whether they were known to DCJ



Note: the number of deaths in 2020 known to DCJ has been updated since prior child deaths annual reports based on newly reported information. The information in Figure 2 is also shown numerically in Appendix 2, Table A2.

Figure 3 below is a repeat of Figure 1 in this report and shows the circumstances of death for the children who died in 2023 and were known to DCJ. Of the 96 children who died, 68 children's deaths were attributed to three main circumstances. The most common circumstance was illness and/or disease (38 children). This was followed by transport accidents (16 children) and sudden unexpected death in infancy (SUDI) (14 children). Additionally, seven children died by suicide or suspected suicide, six infants died in circumstances related to their premature birth, five children died from inflicted or suspicious injuries, and four children died in accidental circumstances (drowning, asphyxia or other accidental injury). The circumstances of death for six children are undetermined, either because the post-mortem information is not yet available or because the NSW State Coroner was not able to determine a cause of death.

Figure 3: Children who died in 2023 and were known to DCJ, by circumstance of death



Note: the information in Figure 3 is also shown numerically in the column labelled '2023' in Table 1.

Table 1 below shows the number of children who died and were known to DCJ by the circumstance of death from 2019 to 2023.

Table 1: Children who died and were known to DCJ, by circumstance of death, 2019–2023

Circumstance of death	2019	%	2020	%	2021	%	2022	%	2023	%
Illness and/or disease	32	33%	36	36%	32	32%	40	36%	38	40%
Transport accidents	6	6%	12[13]	12%	16	16%	12	11%	16	17%
Sudden unexpected death in infancy	19	20%	15	15%	14	14%	17	15%	14	15%
Suicide (includes suspected)	8	7%	12	12%	12	12%	15	13%	7	7%
Extreme prematurity	10	10%	9	9%	8	8%	12	11%	6	6%
Undetermined	2	2%	6	6%	4	4%	4	4%	6	6%
Inflicted or suspicious injuries	7	7%	3	3%	5	5%	2	2%	5	5%
Drowning	3	3%	1	1%	6	6%	2	2%	2	2%
Accidental asphyxia	1	1%	2	2%	0	0%	1	1%	1	1%
Other accidental injuries	3	3%	1	1%	0	0%	3	3%	1	1%
Accidental choking	1	1%	0	0%	0	0%	1	1%	0	0%
Drug overdose	2	3%	2	2%	1	1%	2	2%	0	0%
Fire	3	3%	2	2%	2	2%	0	0%	0	0%
Total	**97**	**100%**	**101**	**100%**	**100**	**100%**	**111**	**100%**	**96**	**100%**

Note: the data for 2023 in Table 1 is also shown graphically in Figure 1 and Figure 3.

2.2 Characteristics of the children

2.2.1 Age

Consistent with previous years, infants under the age of 12 months made up a significant proportion of the children who died and were known to DCJ. As shown in Figure 4 below, 36 children (37 per cent) were aged under 1 year, 17 children (18 per cent) were 1 to 4 years of age, 16 children (17 per cent) were 5 to 12 years of age, 12 children (12 per cent) were 13 to 15 years of age, and 15 children (16 per cent) were 16 to 17 years of age.

2.2.2 Gender

Where information is available, children have been categorised according to the gender with which they identify. It is acknowledged that this may not be an accurate representation of the gender for each child. Many children are not afforded opportunities to discuss their gender identity openly, or they may feel unsafe or uncomfortable to do so.

DCJ Casework Practice

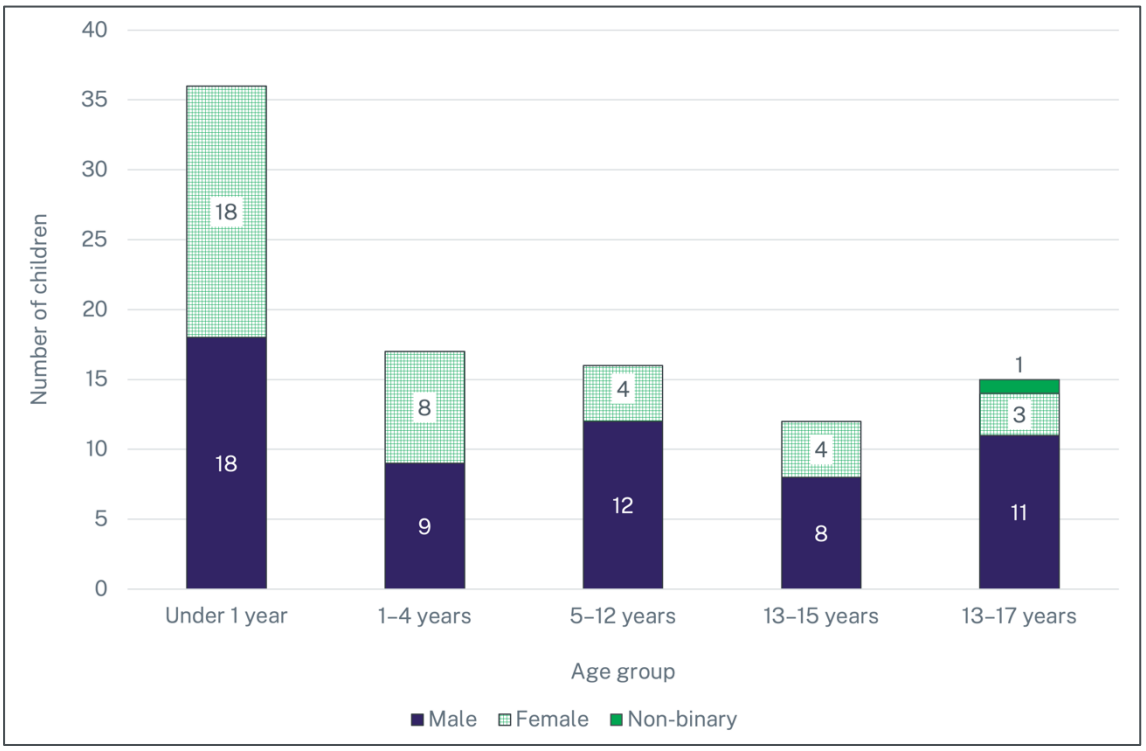
When speaking with children, it is important to normalise conversations about gender identity and record this information accurately. Always ask, then use the child's preferred gender and pronouns when talking with or about them, in a way that promotes their safety and psychological wellbeing.

In February 2022, DCJ enhanced the functionality of its ChildStory system to include new gender identifiers so that a child's gender identity can be accurately recorded.

For further advice about working with children who identify as gender diverse, DCJ practitioners can refer to the **Working with LGBTQIA+ Children and Young People** practice advice topic.

Of the 96 children who died in 2023 and were known to DCJ, 58 children (60 per cent) were male and 37 children (39 per cent) were female. One child identified as non-binary. Consistent with previous years, the male mortality rate for children known to DCJ was higher than for females. This trend is reflected in Australia-wide data, with the male mortality rate higher than the female rate for all age groups between 0 and 19 years (78 and 73 deaths per 100,000 population, respectively).[14]

Figure 4: Children who died in 2023 and were known to DCJ, by age and gender



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

2.2.3 Age, gender and circumstances of death

Infants aged under 12 months

Thirty-six infants were aged under 12 months when they died, with equal numbers male and female. This represents more than a third (38 per cent) of the 96 children who died in 2023. Twenty-three of the infants died within three months of their birth.

The most common circumstances of death for infants under the age of 12 months were SUDI (14 infants), illness and/or disease (8 infants) and extreme prematurity (6 infants). Three infants died from inflicted or suspicious injuries, two infants died in other accidental circumstances (asphyxia or drowning) and the circumstance of three infants' death remains undetermined.

Children aged 1 to 4 years

Seventeen of the children who died were aged 1 to 4 years. Of these 17 children, nine were male and eight were female. Most children (11 children) in this age group died from illness and/or disease. The circumstances of the six other children's deaths were accidents (transport accident, drowning or other accidental injury), inflicted or suspicious injury, or the circumstance remains undetermined.

Children aged 5 to 12 years

Sixteen of the children who died were aged 5 to 12 years. Of these 16 children, 12 were male and four were female. Most children (10 children) in this age group died from illness and/or disease. The other six children died in transport accidents.

Children aged 13 to 17 years

Twenty-seven of the children who died were aged 13 to 17 years. Nineteen were male, seven were female and one was non-binary. The equal leading cause of death for this age group was illness and/or disease (9 children) and transport accidents (9 children), followed by suicide (7 children). One child died from inflicted or suspicious injuries, and one child's circumstance of death is undetermined.

2.2.4 Cultural and linguistic diversity

Twenty-four of the 96 children who were known to DCJ and died in 2023 were culturally and linguistically diverse. Among the 24 children there was a broad range of ethnicity, languages and backgrounds. Information about a child's cultural background was taken from the information known to DCJ about the children and their families at the time they died. It is acknowledged that DCJ may hold incomplete or missing information about a child's culture. There may be other children who died in 2023 whose culture was not known to DCJ and therefore is not represented here.

Forty-two of the 96 children who died were identified as Aboriginal. These children are discussed in section 2.4 of this chapter.

DCJ Casework Practice

Recognising that **Culture is ever-present** is a principle of the NSW *Practice Framework* and is the first step toward culturally competent casework practice.

Culturally led practice requires practitioners to understand a family's culture, values and beliefs, to bring culture to the forefront, and to see a family's culture as a source of strength and connection. DCJ practitioners can use the **Culturally Responsive Practice with Diverse Communities** practice advice topic for further information about talking with children and families about their culture.

Multicultural consultation

Multicultural practitioners are the primary DCJ resource for cultural consultation. Consultation supports practitioners to understand cultural background and family practices. Practitioners can make requests for multicultural consultations in ChildStory.

2.3 DCJ response to risk of significant harm reports

This section provides information about DCJ involvement with the families of the children who died in 2023 and were known to DCJ. Information is provided about why their deaths were reportable, the nature of the reports received and DCJ responses to the reports.

When a report is made about a child, the Child Protection Helpline (the Helpline) screens the information to determine if the report meets the suspected risk of significant harm threshold. Those reports which meet the threshold are transferred to the CSC closest to where the child lives. In most cases, CSC practitioners undertake a triage process to determine the most appropriate response to each report. The data in the following section represents reports that were screened by the Helpline as meeting the suspected risk of significant harm threshold. DCJ may then conduct an assessment and work with a family. It is important to note that DCJ did not conduct a face-to-face assessment or work directly with all the families whose data is reflected below.

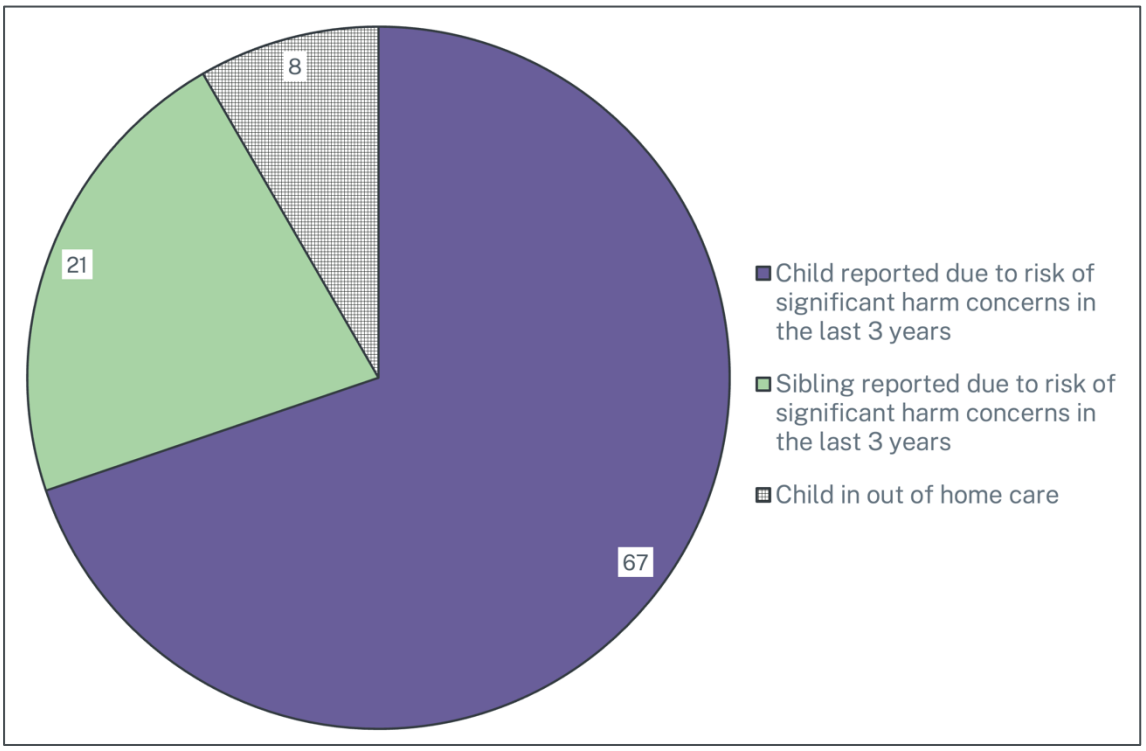
This section also includes information about the sibling safety policy and how DCJ identifies whether a family requires a sibling safety response after a child dies. Details of how DCJ responded to the families of the children who died in 2023 and which families required a sibling safety response are included.

2.3.1 Reported child protection history

Reportable deaths are defined in section 172A of the Care Act.

As shown in Figure 5 below, 67 (70 per cent) of the 96 children who died in 2023 were known to DCJ because they were reported to DCJ suspected of being at risk of significant harm in the three years before their death. Twenty-one children (22 per cent) had not been reported to DCJ, but their sibling/s had been the subject of a report of suspected risk of significant harm in the three years before the child died. Eight (8 per cent) of the children's deaths were reportable because the child was living in out of home care at the time of their death.

Figure 5: Number of children who died in 2023, and why their death was reportable



2.3.2 Reported issues of concern

Physical abuse, domestic and family violence and physical neglect were the most frequently reported concerns for the children who died in 2023. Most of the children who died in 2023 were reported for multiple types of harm. Twenty-two of the 96 children reported to DCJ were suspected of experiencing only one type of harm. When planning and conducting an assessment, practitioners must assess all harm categories to understand a child's immediate safety and future risk of harm.

For the 96 children and their families, the issues they were reported as experiencing or being at suspected risk of experiencing were:

- physical abuse (56 children)
- domestic and family violence (51 children)
- physical neglect (48 children)
- supervisory neglect (40 children)
- emotional abuse or neglect (39 children)
- parental alcohol or drug use (37 children)
- medical neglect (31 children)
- educational neglect (22 children)
- parental mental health (21 children)
- the child's risk-taking behaviour (21 children).

2.3.3 Decisions made in response to risk of significant harm reports

When a report made about a child is found to meet the threshold for suspected risk of significant harm, DCJ is required to take appropriate action to promote the child's safety, welfare and wellbeing.

Practitioners are guided by a triage process to make decisions about the most appropriate response. This includes collaboration with other services and/or the family to gather further information, where required, to ensure that appropriate action is taken and children at the highest level of risk are prioritised for an assessment. Considerations include:

- child factors, such as their age, development, functioning and vulnerabilities
- the cultural and other specific or unique needs of the family
- the observations of services, supports and organisations involved with the family
- the type of abuse and neglect, including any patterns known or multiple risk factors
- known strengths and protective factors
- the family's child protection history
- the parents' and/or carers' child protection history and experience.

Reports are considered as part of the triage process, either at a weekly allocation meeting (WAM) or equivalent peer review process. The CSC leadership team discusses the reports and prioritises reports for allocation to a caseworker.

Reports that contain information indicating imminent risk to the child are prioritised to be allocated for an assessment, which includes an assessment of the child's immediate safety and risk of future harm. To inform the assessments, practitioners speak with the child and their parents or carers, as well as extended family members, community members and professionals involved in providing care and/or support to the family. The practitioner will consult with their manager at key decision-making points in the assessment process.

Following the triage process, there may be some suspected risk of significant harm reports which cannot be allocated to a caseworker for assessment. A CSC leadership team may decide to refer a child and their family to another agency able to address the reported concerns or to hold an interagency case discussion (ICD). An ICD allows DCJ to bring together agencies which are (or could be) supporting a family to collaborate and agree on ways to achieve the best outcomes for children and their families. A report may be closed because the family was referred to another agency for support, or other reports at the CSC awaiting allocation were considered a higher priority.

DCJ response to risk of significant harm reports for the children who died in 2023

Of the 96 children who died in 2023, DCJ conducted a face-to-face assessment prior to the child's death for 53 families. For the 43 families for which DCJ did not conduct a face-to-face assessment before the child died, the reasons included that:

- the child who died was in out of home care, and there had been no reports about suspected risk of significant harm since the child entered care
- a CSC was triaging a new report and gathering information to inform a decision about the most appropriate response, but a decision had not been made before the child's death
- DCJ referred the child and their family to a DCJ-funded service provider for support to address the reported concerns before closing the report
- information was gathered from services and/or the family which indicated support was already in place for the family
- capacity issues at the CSC prevented allocation of the report. For many children, further information was gathered during the triage process to ensure supports were in place for the family before closing the report.

Open DCJ cases for the children who died in 2023

Of the 96 children who were known to DCJ and died in 2023, DCJ had an open and allocated case for 23 children and their families at the time of the child's death.

Of the 23 children, eight children were in out of home care and receiving required ongoing casework. Three of the children in out of home care were case managed by DCJ, and five children were in the primary case responsibility of a PSP provider, with secondary case responsibility to a DCJ Child and Family District Unit.

For the remaining 15 children, DCJ was in the process of completing an assessment or was providing ongoing casework aimed at addressing identified needs for the child or their family. For these families, casework involved safety and risk assessments, home visits, family meetings and Family Group Conferencing, the development of family action plans for change, referrals to funded service providers delivering family preservation programs and joint work with other agencies.

DCJ Casework Practice

Active efforts

In November 2023, legislative changes to the Care Act introduced the principle of 'active efforts'. The change requires practitioners to take active steps to prevent all children from entering out of home care. For children who are already in care, practitioners must actively work with their families so children can safely return home.

Active efforts means all DCJ actions and decisions in relation to a child and their family are:

1. timely in diverting a child and their family from further child protection involvement early, acknowledging that family/kin are expert in their own lives and being guided by them about the services and supports that are most accessible and appropriate
2. practicable, thorough, purposeful, aimed at addressing the grounds upon which the child is considered to be in need of care and protection and supported by realistic, measurable and achievable goals made with the full participation of the child's family/kin
3. to the greatest extent possible, conducted in partnership with the child, their family/kin and community, using Family Group Conferencing and (for Aboriginal children and families) Aboriginal family led decision-making
4. culturally responsive and supported by appropriate Aboriginal or culturally and linguistically diverse consultation to support thorough decision-making, and (for Aboriginal children and families) demonstrate an awareness of DCJ history with Aboriginal peoples and the power imbalances that impact on this relationship.

2.3.4 Sibling safety response

When a child dies and information known at the time of their death indicates that the death may have been because of abuse, neglect or suspicious circumstances, DCJ is responsible for assessing the safety and wellbeing of other children living in the same household. This assessment is guided by the **Sibling Safety Mandate**. It is not the role of DCJ to investigate the cause of the child's death, but DCJ can gather information about the child's death to inform the assessment of safety and risk for other children who live in or spend time in the household. As well as assessing the safety of other children in a house when a child has died, practitioners work with families to assess their need for support at a time of significant grief and loss for the family.

Sibling safety assessments in 2023

In 2023, DCJ completed sibling safety assessments for the families of 16 children who died.

Children from three of the families were assessed as 'unsafe' and taken into care. For the other 13 families, the children were assessed as 'safe' or 'safe with plan' in their parents' care. These 13 sibling safety assessments typically involved DCJ:

- providing ongoing case management to the families
- referring children and families to services for ongoing support
- ending its involvement because siblings were assessed as safe and no need for ongoing statutory intervention was identified.

For the remaining 80 families of children who died in 2023, a sibling safety assessment was not required because:

- there were no other children aged under 18 years living in the household
- no risk issues were identified for the child's siblings
- the Helpline assessed the information about the child's death as not being due to, or potentially due to, abuse, neglect or suspicious circumstances, and closed the report.

Understanding Sorry Business

'Sorry Business' is a period of cultural practices and protocols for Aboriginal families that occurs after the death of an Aboriginal person. When working with Aboriginal families following the death of a child, it is important for practitioners to seek Aboriginal consultation and adapt their practice to ensure they provide the right support as they assess the safety and risk of surviving siblings. Consultation supports practitioners to understand the obligations and responsibilities of Aboriginal people in the period following a death.

Supporting families after the death of a child

Coping with the death of a child can be a difficult, isolating and challenging experience. Practitioners can help families by providing information about the services available to support them. The following services are examples:

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

information or to arrange a referral, call the 24/7 Red Nose Grief and Loss Support Line on 1300 308 307 or visit the Red Nose Grief and Loss website.[15]

- The **Australian Parenting Website** by the Raising Children Network provides information about the grief that is experienced after the loss or death of a child and guidance for how to talk about death with children. Visit the Australian Parenting Website for more information.[16]
- **Aboriginal Counselling** provides therapeutic counselling for families, individuals and communities within NSW. Aboriginal Counselling can help Aboriginal people to deal with grief and loss. To access this service, call 02 4707 7989.
- **Bears of Hope** is an Australian registered not for profit based in Sydney managed by a dedicated team of bereaved parents. They provide ongoing comfort, support and counselling to parents and families who have experienced the loss of a baby during pregnancy, birth or infancy. Call 1300 11 2327 for general enquiries or 1300 11 4673 for grief support or visit the Bears of Hope website.[17]
- The Services Australia website[18] provides a list of support services for when a child dies.

Practice reflections and learning

Internal child death reviews completed for the children who died in 2023 highlighted the importance of holistic, sensitive and culturally responsive practice by DCJ practitioners when completing sibling safety assessments.

Reviews highlighted good practice in accessing multicultural and Aboriginal consultation at the point of responding to a family after a child had died. For many families, consultation supported practitioners to be aware of cultural practices at the time of a death, so they could complete the sibling safety assessment in a way that respected the family's cultural values while still focusing on the safety of surviving siblings. The following case study explores these themes.

Case study: Kalani's story

Kalani was 12 years old when she died suddenly from sepsis.

In the days prior to her death, DCJ received a report about Kalani's father, Martin, assaulting her mother, Vera. Kalani and her siblings Jess (17 years), Nathan (10 years) and Mali (4 years) saw the assault. DCJ allocated the report for assessment. While not known to DCJ at the time, on the day the report was received at the CSC, Kalani died in hospital.

The CSC planned to carry out a sibling safety assessment. Noting the family was Tongan, the casework team held a multicultural consultation. The consultant gave the caseworker information about grief and domestic violence in Tongan culture. They recommended that the caseworker offer the family a support person, and that they speak to all the children and both parents to inform the

safety assessment. The caseworker called Vera, who agreed to meet the caseworker in two days, after their week of mourning. Vera invited her sister, Tanika, to be there when DCJ visited.

Vera was distressed by Kalani's sudden death and told caseworkers she blamed herself for not taking Kalani to the doctor when she first developed symptoms of a virus. Tanika explained that domestic violence was 'not spoken about' in their family and Vera was carrying feelings of shame. The caseworker explained the violence was not Vera's fault, that it was Martin's choice, and talked to her about support services. Vera was upset but expressed relief that she was not being judged for the violence. The caseworker spoke to Jess, Nathan and Mali, who were feeling sad about their sister's death and were worried about Martin coming back to hurt Vera. Tanika and her husband agreed to stay with the family for the next week.

The caseworker and the multicultural consultant met with Martin the following day, with the support of his brother. Martin was defensive at first, and blamed Vera for Kalani's death. The caseworker was compassionate to Martin's grief and sought to understand Martin's views on his role as a father and husband, while explaining clearly that his violence was harmful to his wife and children. Martin said he was planning to stay with his brother for a while and felt shame about returning home. The caseworker planned to meet with Martin the following week to talk more about the violence and offer programs to support him to make change.

The caseworker assessed the children were safe in their parents' care.

Learning from Kalani's story

Kalani's story highlights the importance of balancing compassion and empathy towards a family's grief with a holistic assessment of children's safety. Engaging in a multicultural consultation prior to visiting the family meant the caseworker was informed of the cultural dynamics of domestic violence and was prepared to have conversations with Vera and Martin about keeping their children safe. By involving extended family members in the initial home visits, the caseworker began to create a safety network around Kalani's siblings that the caseworker could draw on to support ongoing work with the family.

2.4 Aboriginal children who died and were known to DCJ

Despite making up only 6.5 per cent of the population in NSW,[19] Aboriginal children are grossly over-represented in child protection systems. As of 30 June 2023, Aboriginal children made up 31 per cent (8,114 of 26,498) of the children in NSW recorded as receiving child protection services, and 45 per cent (6,563 of 14,721) of the children in NSW who were living in out of home care.[20]

The deaths of Aboriginal children also continue to represent a higher proportion of children who died and were known to DCJ. Of the 96 children who died in 2023 and were known to DCJ, 42 children (44 per cent) were Aboriginal.

The colonisation of Aboriginal land has had a devastating and long-lasting impact on Aboriginal people. Past policy and legislation leading to the forced removal of Aboriginal children from their families and Country has resulted in profound, intergenerational trauma. Ongoing, systemic disadvantage is reflected in the continuous over-representation of Aboriginal children in contact with child protection and out of home care systems. Despite extraordinary adversity and oppression, Aboriginal people have a strong connection to culture, which can provide safety and protection for children.

DCJ has a responsibility to work in partnership with Aboriginal communities and to encourage their autonomy and self-determination. Practitioners need to look for ways to understand and address the disproportionate number of Aboriginal children in the child protection system and to engage in culturally reflective and responsive practice. Interrogation of cultural bias and seeking to understand and appreciate how culture influences parenting and child-rearing practices is crucial when working with Aboriginal children and families. Aboriginal families are the experts of their experiences, and practitioners have a responsibility to create opportunities for family led decision-making at all points in casework.

DCJ Casework Practice

The NSW *Practice Framework* principle **Culture is ever-present** guides practitioners to work in partnership with Aboriginal families and communities by taking the family's lead and fostering self-determination so that Aboriginal children are safe and connected and have a lived experience of their culture.

DCJ practitioners can also refer to the **Cultural Practice with Aboriginal Communities** practice advice topic to ensure their approach is responsive, respectful and inclusive.

Aboriginal community controlled mechanism

In line with the continued implementation of the **Aboriginal Case Management Policy**, DCJ has supported the establishment of an Aboriginal community controlled mechanism (ACCM) based in the Illawarra called Aboriginal Children on Country (ACC). ACC launched in August 2023 and began service delivery in March 2024. It is led by volunteer Aboriginal people who have lived or professional experience working with children, families and communities. The group ensures child protection processes work to care for and protect Aboriginal children by applying Aboriginal standards and expectations.

DCJ is continuing work with ACC to establish pathways for consultation, with the purpose of ensuring Aboriginal children from the Illawarra who come to the attention of DCJ have access to support and advocacy.

In partnership with AbSec, DCJ has developed another five ACCMs across NSW. These are based in Wagga Wagga, Newcastle, Dubbo, Griffith and Leeton.

For further information, refer to the Aboriginal community controlled mechanism fact sheet[21] on the DCJ website.

Aboriginal Legal Service (NSW/ACT)

The Aboriginal Legal Service Care and Protection team provides culturally safe, expert legal and non-legal help to Aboriginal families who have had child protection involvement. The team helps families to understand the processes of child protection agencies and the Children's Court. It can also support families who want to change an order made by the Court or ensure that Aboriginal children who have been taken into care by DCJ are placed with family or within their community.

For further information, visit the Aboriginal Legal Service website.[22]

Waruuguma Barrmarrany

In early 2024 ,the DCJ Child Law team established an Aboriginal led, culturally responsive team called Waruuguma Barrmarrany. The team provides tailored, purposeful legal advice to practitioners working with Aboriginal children who are undergoing child protection assessments, or children who are in out of home care and are in the process of being returned to the care of their parents. Waruuguma Barrmarrany can support practitioners by guiding decision-making in line with active efforts, with the aim of Aboriginal children remaining with or returning to the care of their families. More information about Waruuguma Barrmarrany is included in section 3.3.4.

2.4.1 Age, gender and circumstances of death

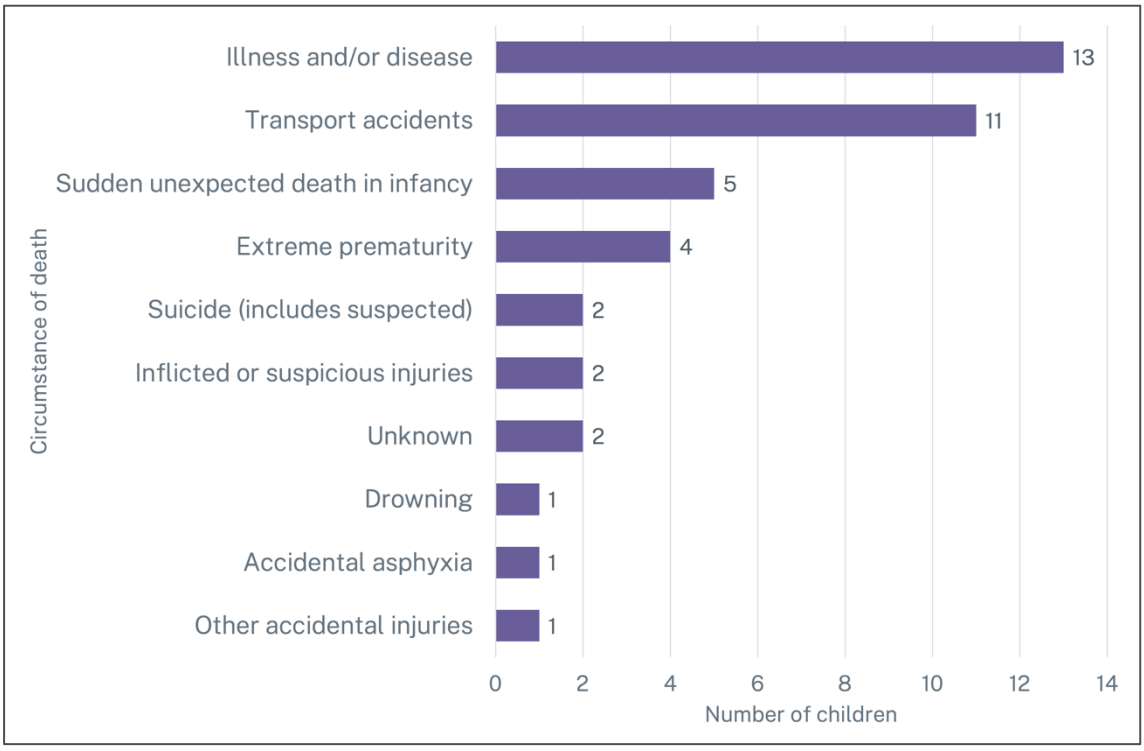
Of the 42 Aboriginal children who were known to DCJ and died in 2023, 28 were male and 14 were female. Sixteen of the 42 Aboriginal children were aged less than 12 months when they died. The most common circumstances of death for these infants were SUDI (5 children), extreme prematurity (4 children) and illness and/or disease (3 children).

Eight children were aged 1 to 4 years. The most common circumstance of death for these children was illness and/or disease. Six children were aged 9 to 12 years. Of these six children, three died from illness and/or disease and three died in transport accidents.

Twelve Aboriginal children were aged between 13 and 17 years when they died. Seven children died in transport accidents. For the other five children, the circumstances of death included illness and/or disease, and inflicted or suspicious injuries.

The overall number of children who died in transport accidents (16 children) was higher in 2023 compared to previous years. Four of the transport accidents resulted in multiple fatalities of children known to each other. Eleven of the 16 children who died in transport accidents were Aboriginal, and six of these Aboriginal children were involved in accidents where multiple people died. This is one possible explanation for the increased proportion of Aboriginal children who died and were known to DCJ in 2023.

Figure 6: Aboriginal children who died in 2023 and were known to DCJ, by circumstance of death



2.4.2 Aboriginal children in out of home care

Two Aboriginal children were living in out of home care when they died in 2023. This is a decrease from previous years.[23] The parental responsibility for both children was allocated to the Minister for Families and Communities. Both children died from illness and/or disease. One child was living in an intensive therapeutic care disability placement due to multiple complex disabilities, and an end of life plan was in place. The other child was living with kinship carers when they suffered an acute illness. Both children were case managed by PSP providers.

2.4.3 Practice reflections and learning

The internal child death reviews for Aboriginal children who died in 2023 and were known to DCJ identified the following common practice themes.

Aboriginal consultation

Internal child death reviews for Aboriginal children continued to highlight the importance of arranging Aboriginal consultation and addressing the recommendations. Aboriginal consultation provides practitioners with guidance, advice and support when making decisions about Aboriginal families. Consultation includes structured, internal consultation with Aboriginal practitioners and the Aboriginal Consultation Advisory Panel (ACAP), as well as consultation with significant family/kin and Aboriginal community controlled organisations (ACCO) or recognised community representatives who are cultural knowledge holders. Practitioners should consult regularly at points of decision-making. Consultation supports practitioners to have a deeper understanding of a child's Aboriginal culture and how connection to culture can increase safety. Since October 2023, Safeguarding Decision-Making for Aboriginal Children Panels (Panels) have been operating in DCJ districts. The Panels ensure that decisions about safety, removal of a child from their family and placement of a child are informed by diverse perspectives, sensitivities and independent consultation with senior practice leaders.

Child and family participation

Reviews about children who died in 2023 and were known to DCJ included examples of strong participation from children and families. However, some reviews highlighted that casework could have been improved through better participation from children and their families that upheld family led decision-making and self-determination.

Identifying family networks and undertaking Family Finding efforts ensures children have a network of adults who are connected to them, and to whom practitioners can consult with to support parents to make change and increase children's safety. When practitioners provide Aboriginal children with

opportunities to freely express their views about their safety, welfare and wellbeing, and participate in decisions made about them, children feel seen, heard and supported.

Holistic assessment

Some internal child death reviews highlighted quality, holistic assessments about Aboriginal children. Other reviews identified that spending time with children and families, considering a range of perspectives and harnessing a family's culture when conducting assessments was required.

In order to complete a holistic and balanced assessment, practitioners need to keep children at the centre of their assessment, while listening to multiple perspectives about what is happening for the family. Practitioners must understand the family's history and recognise strengths and acts of resistance when assessing a parent's ability to keep their children safe. It is important to understand a family's connection to culture and how this connection increases safety for children. Holistic assessment requires practitioners to challenge their biases and assumptions about children and families and think critically about how this impacts their assessment of a child's safety and risk when considering all reported risk concerns.

The following case study demonstrates the value of Aboriginal consultation, family participation and self-determination when making decisions about Aboriginal children.

Case study: Marley's story

Marley was a 4 month old Aboriginal baby girl living with her parents, Rebecca and Luke, and 3 year old brother, Jye. She was born with significant health conditions which impacted her ability to eat, and she needed a feeding tube. Rebecca and Luke had experienced abuse and neglect in their childhoods.

DCJ first received reports about the family when Marley was born. Reporters were worried about Luke's drug use and that the children's needs were being neglected. DCJ allocated the reports to a caseworker for a safety and risk assessment.

The caseworker met the family and learned Rebecca and Luke were worried about how to look after Marley properly given her additional health needs. Luke talked about his history of drug use in times of stress but said he did not have a problem with drug use at that time. The caseworker assessed the children as 'safe'.

The caseworker sought Aboriginal consultation to guide their work. The consultant recommended the caseworker explore whether extended family members were available to come together for a family meeting. Prior to completing the risk assessment, Marley's aunts, uncles and grandparents came together. The DCJ caseworker clearly explained their worries about Marley and Jye, and in particular that Rebecca and Luke were feeling overwhelmed and stressed about how to meet Marley's high needs. Luke was at risk of using drugs, and the caseworker was worried that both parents would struggle to focus on Marley's care.

During the meeting, the caseworker stepped out to give the family space to talk privately. Marley's aunt led the meeting, and the other family members talked about their worries and made decisions about how each person would support Rebecca and Luke to safely care for Jye and Marley. Together, they wrote a family plan that addressed their worries, and DCJ worries, about Jye and Marley. The meeting informed the risk assessment and subsequent family action plan for change. Rebecca and Luke decided they wanted to engage with a mental health service, enrol Jye in day care and continue to work with NSW Health to ensure they met Marley's medical needs. Luke agreed to work with a drug and alcohol counsellor. Family members recorded specific ways they planned to support Rebecca and Luke to work through the plan. Rebecca and Luke told the caseworker that the family meeting made them feel in control of what was happening for their family, attended to the worries they had about DCJ being involved and gave them confidence to attend to Marley's health needs.

Sadly, one month later Marley died at home in a choking accident related to her disability. The caseworker spoke to Marley's aunt to see how DCJ could support the family in their time of grief.

Learning from Marley's story

By following the Aboriginal consultant's recommendation to convene a family meeting, DCJ upheld the family's autonomy and self-determination when making decisions about their children in the face of worries for their safety. The plan included specific actions so that everyone knew how each family member would support Rebecca and Luke to address the worries and engage with health services to meet Marley's additional needs. The caseworker was also able to develop connections with Marley's extended family and could lean on them for advice on how to support Rebecca and Luke to keep Jye safe while grieving Marley's death.

2.5 Circumstances of all child deaths

This section considers the circumstances of death for the 96 children who died in 2023. The most common circumstances of death (illness and/or disease, transport accidents, SUDI, suicide and extreme prematurity) are considered in more detail. This includes relevant data and practice reflections from reviews completed about the children who died.

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

2.5.1 Illness and/or disease

Consistent with previous years, child deaths from illness and/or disease accounted for the greatest number of deaths in 2023. As shown in Table 2, 38 (40 per cent) children known to DCJ died from illness and/or disease in 2023. This is proportionately higher than the number of deaths attributed to illness and/or disease in the past five years.

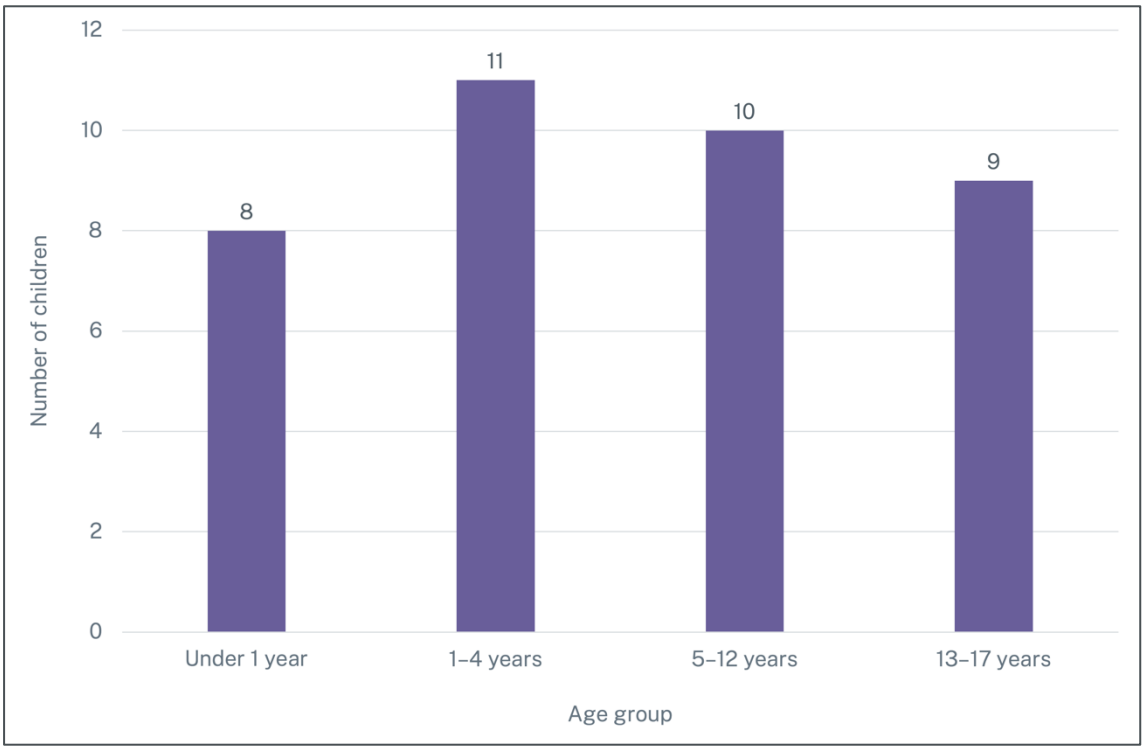
Table 2: Children who died from illness and/or disease and were known to DCJ, 2019–2023

Illness and/or disease	2019	2020	2021	2022	2023
Number of deaths	32	36	32	40	38
% of total deaths	33%	36%	32%	36%	40%
Age range	0–17 years	0–17 years	0–17 years	0–17 years	0–17 years

Of the 38 children who died from illness and/or disease, 22 were male and 16 were female, which is proportionally similar to the gender of children who died from illness and/or disease in 2022.
As shown in Figure 7 below, the greatest number of children who died were aged 1 to 4 years (11 children), followed by children aged 5 to 12 years (10 children) and 13 to 17 years (9 children). Eight children were under 1 year of age.

For 25 of the children who died from illness and/or disease, their death was due to a chronic health condition. These chronic conditions included cancer, congenital issues or complications from a diagnosed disease. Thirteen children died from an acute illness, such as an infection or asthma attack.

Figure 7: Children who died in 2023 due to illness and/or disease and were known to DCJ, by age



Children who died due to a chronic health condition

Chronic health conditions are medical conditions that cause ongoing substantial ill health, disability and premature death. They are usually not immediately life threatening but tend to develop gradually.[24]

For 25 of the 38 children who died from illness and/or disease in 2023, their death was due to a chronic health condition. Seven of the children who died due to a chronic health condition were receiving palliative or end of life care.

The cause of death for these 25 children was:

- a form of cancer (8 children)
- congenital illness (8 children)[25]
- congenital heart disease or abnormality (6 children)
- complications associated with a degenerative disease (3 children).

Children who died from an acute illness

Acute health conditions are medical conditions that usually develop quickly, have a specific cause and are time limited.[26] For 13 of the children who died in 2023 from illness and/or disease, their death was due to an acute health condition.

The cause of death for these 13 children was an infection, pneumonia, complications of a severe asthma attack or stroke. Four of the children who died from an acute illness and/or disease also had a chronic health condition that may have increased their vulnerability to becoming unwell.

Understanding sepsis

In 2023, two children known to DCJ died from sepsis.

In April 2024, NSW Health released a campaign to raise awareness of sepsis, a serious medical condition that can cause a rapid deterioration in health and subsequent death. The campaign encourages families and health professionals to ask the question, 'Could it be sepsis?'

Sepsis occurs when the body has an extreme reaction to any kind of infection that is present in any part of the body. For example, a virus, bacterial infection from an open cut, infection after childbirth or a fungal infection from nappy rash can lead to sepsis. Often people who develop sepsis will have been unwell and may have even seen a doctor, with advice to monitor their condition at home or take medication to treat the infection. Children are particularly susceptible to sepsis. The signs to look for include getting sick (or sicker) very quickly, being more sleepy than usual or difficult to wake, refusal to eat or drink, a rash or change in skin colour, confusion or difficulty breathing.

Child protection practitioners who are working with the family of a child who is unwell should encourage the family to take the child to see a doctor. If the child's condition worsens, it is important the family returns to the doctor, goes to the hospital emergency department or calls 000.[27]

Understanding pneumonia

In 2023, four children known to DCJ died from pneumonia.

Pneumonia is an infection in the lungs that makes it difficult to breathe and reduces the amount of oxygen that can enter the body. Pneumonia can affect anyone, although children under 5 years of age are more susceptible.

Signs and symptoms include fever, fast or difficult breathing, cough, irritability, tiredness, chest or abdominal pain and loss of appetite. Children should see a doctor or attend the hospital emergency department if they have these symptoms. Untreated, pneumonia can cause death.

Children with disability that includes difficulties with eating and drinking are particularly vulnerable to pneumonia caused by aspiration (inhalation of food, liquid or saliva into the respiratory tract). To avoid aspiration, it is important that a child's medical feeding protocols are understood and strictly followed. Child protection practitioners can collaborate with a child's health care professionals to support families to understand the importance of following medical advice about feeding and drinking. This is particularly important when DCJ has received reports about medical neglect or repeat hospital stays for pneumonia.[28]

2.5.2 Transport accidents

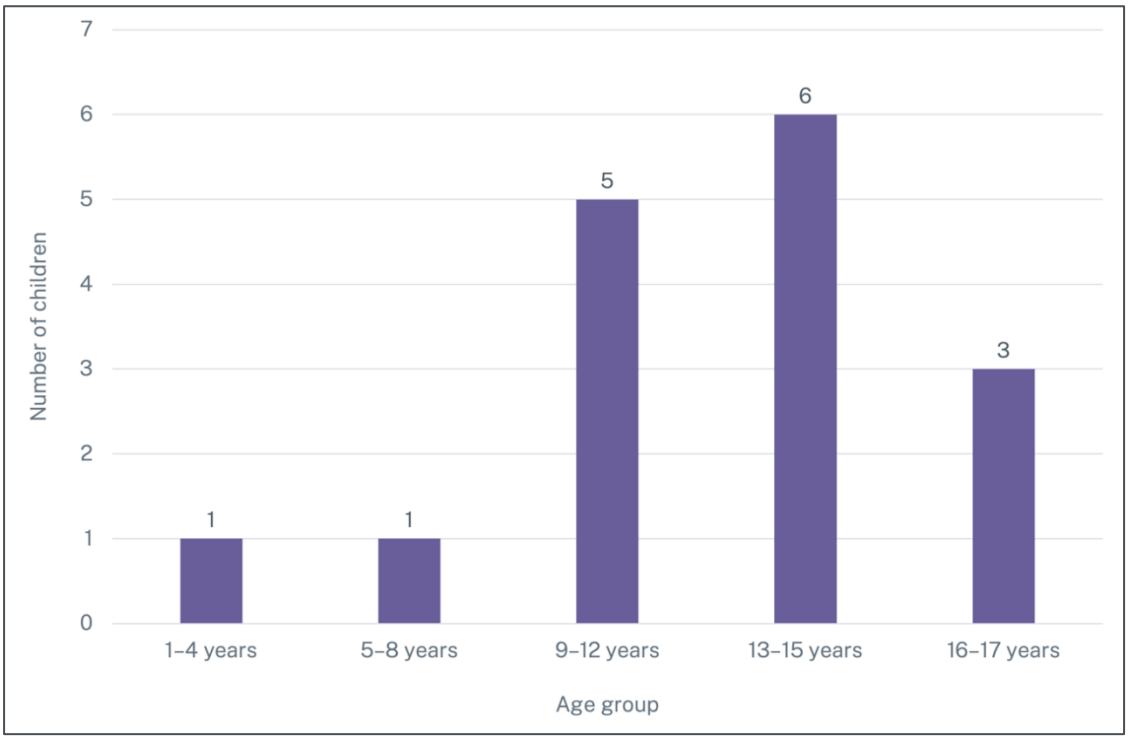
In 2023, 16 children known to DCJ died from injuries sustained in transport accidents. As shown in Table 3, this is one of the highest numbers of deaths from transport accidents since 2019. The total number of fatalities in NSW from motor vehicle accidents in 2023 was also the highest it has been since 2019.[29] This year, transport accidents included the deaths of children who were driving cars, were passengers in cars, were riding motorcycles or were pedestrians struck by a car.

Table 3: Children who died from transport accidents and were known to DCJ, 2019–2023

Transport accidents	2019	2020	2021	2022	2023
Number of deaths	6	12[30]	16	12	16
% of all deaths	6%	12%	16%	11%	17%
Age range	0–17 years	1–17 years	2–17 years	1–17 years	3–17 years

Of the 16 children who died in transport accidents in 2023 and were known to DCJ, 15 were male and one was female. As shown in Figure 8, 15 of the 16 children who died were over 5 years of age. The proportion of children who died from each age group and were known to DCJ is similar to previous years.

Figure 8: Children who died in 2023 from transport accidents and were known to DCJ, by age



Car accidents

Twelve children (aged 4 to 17 years) died in car accidents. Three of these children were the driver of the car involved in the accident. The other nine children were passengers. Four of the car accidents resulted in multiple fatalities and caused the death of eight children known to DCJ.

In many of these car accidents, there was evidence of risk-taking behaviour by the driver or passengers which was likely to have contributed to the accident, including driving at high speeds, dangerous driving, driving a stolen vehicle, being pursued by another vehicle or driving unlicensed and/or underaged. Five of the children who died in car accidents had prior involvement with Youth Justice and had demonstrated a pattern of dangerous and risk-taking behaviour. These five children were aged 13 to 15 years.

Other transport accidents

Two children (aged 16 to 17 years) died while riding a motorcycle and two children (aged 7 to 13 years) died as pedestrians when they were struck by a car.

Practice reflections and learning

In reviewing DCJ practice for children who died from injuries sustained in a transport accident, the following themes were identified for practice improvement:

- Understanding children's experiences of chronic abuse and neglect and the influence these experiences have on risk-taking behaviour.
- The need for holistic assessment, prioritising cultural consultation, and regular and meaningful collaboration with other agencies, such as Youth Justice, NSW Department of Education and NSW Health.

For many of the children who died in a transport accident, their risk-taking behaviour had been reported to DCJ, and reviews had identified the need to work in collaboration with other services to understand the child's experiences and support needs.

The following case study highlights the importance of collaboration for children who are at risk from their own behaviour.

Case study: Kael's story

Kael was a 16 year old boy who died in a transport accident.

Twelve months prior to his death, DCJ received a report about Kael. The report raised concerns about Kael's poor school attendance, his mother Jacqui not supervising him and Kael's risk-taking behaviour. The report was allocated for a safety and risk assessment.

The caseworker met with Jacqui, who said her mother was going to help her care for Kael, and Jacqui agreed to work with the home school liaison officer (HSLO) to improve Kael's school attendance. The caseworker arranged for a meeting with Jacqui, the HSLO and the school principal to talk about the barriers Jacqui was facing and how they could encourage Kael to attend and participate in school. The caseworker assessed that Kael was 'safe' and at 'moderate' risk of future harm in Jacqui's care. The case was closed.

Three months later, DCJ received another report raising similar concerns. Kael's school attendance was declining, and with a group of friends, he had stolen a car and assaulted another young person. A triage caseworker spoke with Jacqui by phone. Jacqui said Youth Justice was supporting her and working with Kael. She said the HSLO and Youth Justice caseworker were working together and had referred Kael to a mentoring program. Because of the support already in place, DCJ closed the report. In the months that followed, DCJ received three further reports with the same worries about Kael's risk-taking behaviour and poor school attendance. Kael had also been charged with assault and selling drugs. The CSC did not have capacity to allocate the reports and they were closed.

In February 2023, DCJ received a report that Kael had died in a car accident. He was one of three passengers in a stolen vehicle that was driven by his friend.

Learning from Kael's story

Like a number of the children who died in transport-related accidents in 2023, Kael was a teenage male with a history of risk-taking behaviour and involvement with Youth Justice.

Kael's story highlights that there are often multiple agencies working with children who are engaging in risk-taking behaviour. Practitioners need to pay attention to risk-taking behaviour and seek to understand what a young person is trying to communicate. Adolescence is a critical time for brain development, and often teenagers act impulsively and make poor decisions. Additionally, early childhood experiences of being frightened, hurt, hungry or lonely can stay with people throughout their lives and may influence young people to behave in ways that appear challenging. When working with young people, it is important to consider their perspectives and think holistically about how their experiences of violence, abuse or neglect have shaped their development and the way they react and respond to the world.

When reviewing subsequent reports about Kael and deciding the most appropriate response, in addition to talking with Jacqui, practitioners could have spoken to Youth Justice and Kael's school to

gather more information before deciding to close the reports. Seeking information from the people and services who knew Kael best and could share what support was being provided to Kael and his family would have better informed the decision about allocating or closing reports. Given the CSC did not have capacity to allocate reports for Kael again, an interagency case discussion (ICD) could have ensured a collaborative response to Kael and his family.

2.5.3 Sudden unexpected death in infancy

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

Following investigation, SUDI deaths can be further categorised:

- **Explained SUDI:** a cause of death was identified following investigation. These deaths may include infants who die due to disease or morbid conditions not identified as life threatening before death, threats to breathing such as accidental suffocation in an unsafe sleep environment, or other external causes, including deaths that occur in suspicious circumstances.
- **Unexplained SUDI:** the cause of death remains unidentified after all investigations are complete. This includes deaths classified as sudden infant death syndrome (SIDS).[31]

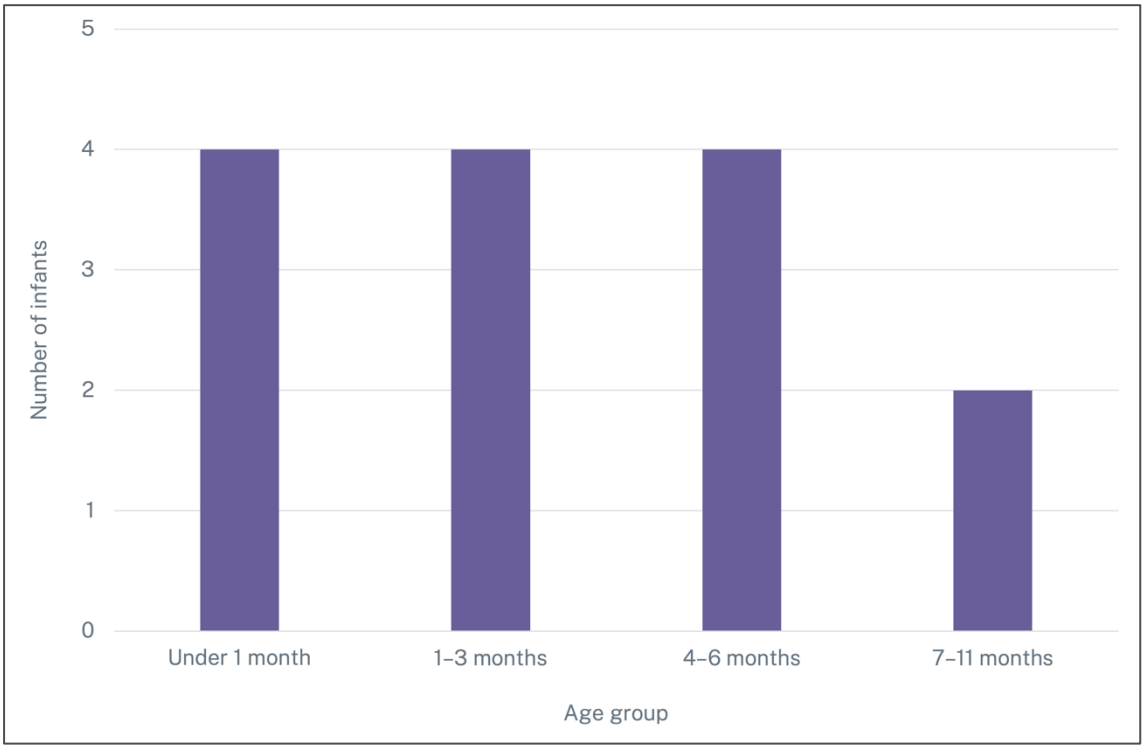
As shown in Table 4 below, 14 infants who died in 2023 and were known to DCJ died in circumstances of SUDI. Post-mortem reports or coronial certificates were available for eight of the children. Once a final post-mortem is received for the other six children, the circumstances of death may be better understood and the total number of SUDI deaths in 2023 may change. For example, a death classified as SUDI may later be confirmed to have occurred due to illness and/or disease. Numbers and the circumstances of death for previous years are then corrected.

Table 4: Infants who died suddenly and unexpectedly and were known to DCJ, 2019–2023

SUDI	2019	2020	2021	2022	2023
Number of deaths	19	15	14	17	14
% of all deaths	20%	15%	14%	15%	15%
Age range	0–12 months	0–8 months	0–9 months	0–9 months	0–11 months

As shown in Figure 9, 12 of the infants who died suddenly and unexpectedly were aged 6 months or younger. Four infants were younger than 1 month, another four infants were aged 1 to 3 months, four infants were aged 4 to 6 months, and two infants were aged 7 to 11 months. Six of the infants were male and eight were female.

Figure 9: Infants who died in 2023 suddenly and unexpectedly and were known to DCJ, by age



Risk factors associated with SUDI

All infants are at general risk of SUDI, but research has consistently identified risk factors that increase an infant's risk of SUDI. Intrinsic factors are individual characteristics that increase the risk of SUDI and are generally not modifiable. Intrinsic risk factors include premature birth, low birth weight and a preceding infection (within two weeks of death). Two of the infants who died in 2023 in circumstances of SUDI had been unwell with a fever in the week prior to their death.

Extrinsic factors can be modified in an infant's sleep environment and therefore can be avoided or changed. Modifiable factors include sharing a sleep surface, sleep position and loose items being present in the sleep environment. The internal child death reviews identified the following extrinsic risk factors for the 14 infants who died in 2023:

- Being placed to sleep in bed with a parent or sibling (8 infants).
- Having soft objects such as pillows, clothes or blankets in the sleep environment (3 infants).
- The infant falling asleep with their parent on a lounge while feeding (4 infants).
- Parent sleeping with a child while affected by alcohol or drugs (2 infants).

DCJ Casework Practice

It is important to have repeated conversations with parents about safe sleeping, particularly when there are worries about a parent's drug and alcohol use. The **Alcohol and Other Drugs** practice kit includes a section on safe sleeping and provides guidance to practitioners about how to assess a baby's sleep space and have clear and consistent conversations with parents about the risks of sleeping with their baby if under the influence of drugs or alcohol. If needed, practitioners should support parents to obtain appropriate bedding for their baby and create a safe sleeping environment.

NSW Health safe sleeping recommendations

It is important that child protection practitioners understand safe sleeping recommendations[32] and use this information to guide discussions with expectant or new parents about reducing the risk to babies. NSW Health recommends the following:

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

2.5.4 Suicide

Seven children who were known to DCJ and died in 2023 died in circumstances of suicide or suspected suicide. One child was in out of home care. As shown in Table 5, this is a decrease from previous years.

Table 5: Children who died by suspected suicide and were known to DCJ, 2019–2023

Suicide (includes suspected)	2019	2020	2021	2022	2023
Number of deaths	8	12	12	15	7
% of total deaths	7%	12%	12%	14%	7%
Age range	13–17 years	14–17 years	14–17 years	13–17 years	14–17 years

In Australia, suicide remains the leading cause of death for young people aged 15 to 24 years of age.[33] Practitioners working with children at risk of suicide need to be skilled in asking difficult questions about suicide and responding in protective ways that validate the child's experiences and engage their network. The stigma associated with mental health issues is often a barrier for children seeking help.

Research suggests that young people with a history of child abuse or neglect are more likely to have self-harmed or attempted suicide than their peers without a child protection history.[34] Six of the seven children who died from suicide in 2023 were reported to DCJ about risk of harm issues, including physical and sexual abuse, parental drug or alcohol use, poor mental health and domestic violence. One child was reported to DCJ because of concerns about their mental health only.

DCJ Casework Practice

The **Mental Health** practice kit includes a chapter on suicide and self-harm and provides information and advice to practitioners on understanding and responding to children at risk of harming themselves. The practice kit supports practitioners to understand the risk factors of suicide and self-harm in children, the role of social responses and structures in a child's experience of mental health, and strategies for how to listen to and talk with children about suicide and self-harm.

DCJ practitioners can request the support of a DCJ psychologist when assessing a child's risk of suicide and to help with safety planning. Practitioners can also make referrals to a NSW Health mental health service via the NSW Mental Health Line on 1800 011 511.

In July 2024, DCJ Psychological and Specialist Services released the workshop **Assessing and Responding to Suicide and Self-Harm**. This workshop provides practical guidance on asking direct

questions to assess risk and on developing safety plans around suicide and self-harm. Casework teams can request the workshop be delivered at a CSC via a DCJ psychologist.

More information about DCJ responses to children at risk of suicide is included in the cohort review of the *Child Deaths 2020 Annual Report*.

2.5.5 Extreme prematurity

In 2023, six infants who were known to DCJ died from complications related to their premature birth. Three infants were female and three were male. As shown in Table 6, the number of infants who died in circumstances of prematurity in 2023 has decreased in comparison to previous years. All six infants died within 24 hours of their birth.

Table 6: Infants who died in circumstances related to extreme prematurity and were known to DCJ, 2019–2023

Extreme prematurity	2019	2020	2021	2022	2023
Number of deaths	10	9	8	12	6
% of total deaths	10%	9%	8%	11%	6%
Age range	0–1 month	0–3 months	0–1 month	0–5 months	< 24 hours

Practice reflections and learning

Connecting expectant parents with the right support during the prenatal period can improve health outcomes for newborn babies and decrease the likelihood of future harm. The key themes identified in internal child death reviews for children who died in 2023 in circumstances of extreme prematurity included the importance of collaboration with services and the need to work effectively with parents who are using drugs and alcohol or experiencing domestic violence.

It is difficult to draw links between a mother's drug and alcohol use, or experience of violence, and a premature birth. However, these experiences are associated with poor pregnancy outcomes for vulnerable pregnant women.[35] When practitioners are allocated a case for an unborn baby, there is an opportunity to make responsive and targeted referrals for the family at a stage when parents are often motivated to make change.

Four of the six babies who died after their extremely premature birth were Aboriginal. This over-representation reflects the need for strong cultural practice and access to culturally appropriate services during pregnancy.

DCJ Casework Practice

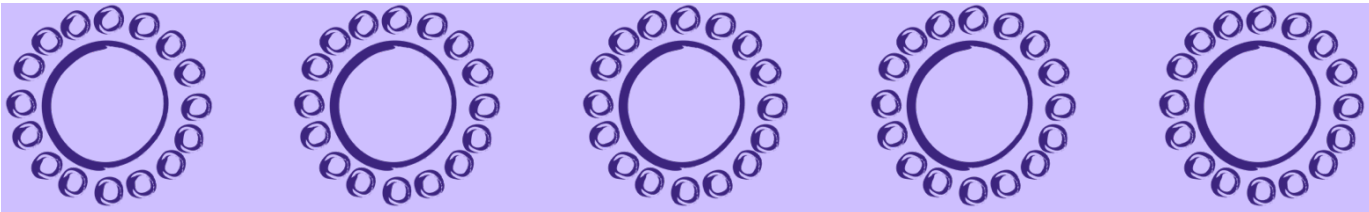
The **Assessing and Case Planning with Expectant Parents (Prenatal) Mandate** guides practitioners when working with expectant parents.

Pregnancy Family Conferencing

The Pregnancy Family Conferencing (PFC) program is a partnership between DCJ and NSW Health aimed at promoting early engagement and interagency planning with expectant parents. PFC has been expanded to rural and regional districts to make the program available to eligible families in NSW. PFC aims to build cultural safety for Aboriginal families. Meetings involve formal and informal supports, such as Aboriginal midwives and family. DCJ is working in partnership with NSW Health to expand PFC across the state. This is a key intergovernmental commitment under Brighter Beginnings.[36]

NSW Health also offers a range of programs aimed at providing expectant parents with the support needed to ensure their baby has a healthy start to life. These include:

- the Substance Use in Pregnancy and Parenting Service (SUPPS)
- the Domestic Violence Routine Screening (DVRS) Program
- Safe Start and referral pathways
- Perinatal Infant Mental Health Services (PIMHS)



Aboriginal families

Culturally safe maternity care is vital for Aboriginal pregnant women and/or women pregnant with an Aboriginal baby. NSW Health Aboriginal Maternal and Infant Health Services (AMIHS) supports pregnant women and their families and community from the moment they discover they are pregnant and until their baby reaches 8 weeks of age.

Visit the NSW Health website for AMIHS locations and information on services for Aboriginal families.[37]

Responding to Prenatal Reports Policy

The System Reform division is currently reviewing the DCJ **Responding to Prenatal Reports Policy**. The revised policy will include support for practitioners working with young people in out of home care who are expectant parents. DCJ is working in partnership with NSW Health and Aboriginal stakeholders on this review, which is expected to be completed in 2025.

2.5.6 Other circumstances of death

Inflicted or suspicious injuries

In 2023, five children known to DCJ died from suspicious or inflicted injuries. At the time of publishing this report, charges have been laid against the perpetrators for three of the deaths, and the other two deaths remain under NSW Police investigation.

Other accidental injuries

Four children died from other accidents (drowning, accidental asphyxia or other accidental injuries).

2.5.7 Undetermined deaths

At the time of writing this report, the circumstances of death for six children could not be reported. For one child, the NSW State Coroner has completed a post-mortem which states the cause of death as 'unascertained'. For the other five children, a final post-mortem report is not available, and the NSW State Coroner continues to investigate these deaths.

2.6 Children in out of home care

Eight children who died in 2023 were living in out of home care at the time of their death. This represents 8 per cent of all the children who died and were known to DCJ in 2023 and is similar to the number of children who were living in out of home care at the time of their deaths in previous years. Two of the eight children were Aboriginal. Five children were male and three were female.

Four of the children who died while living in out of home care died from illness and/or disease. Three of these children had multiple disability and complex care needs, with two receiving palliative care at the time of their death. The other circumstances of death included transport accidents, SUDI and suicide.

For each of the eight children who were in out of home care at the time of their death, the Children's Court had made an order allocating parental responsibility. Seven of the children had their parental responsibility allocated solely to the Minister for Families and Communities, and one child was still under interim care orders when they died.

At the time of their deaths, five of the children were living with a relative and one child was placed with a carer authorised by a PSP provider. Two children lived in intensive care placements specific to their needs.

Three of the children who died while living in out of home care were being case managed by DCJ. For the other five children, case responsibility had been transferred to a PSP provider.

Chapter 3: Improving the way DCJ works with children and families

As well as the requirement to report on the number and circumstances of children who died and were known to DCJ, section 172A of the Care Act requires the DCJ Secretary to report on the implementation of practice or policy changes made in response to or resulting from reportable deaths. Chapter 3 addresses this requirement and outlines DCJ responses to the learning from child death reviews completed in 2023.

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

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

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

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

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

Sections 3.2 and 3.3 provide an overview of some of the practice initiatives and reforms that are aimed at improving DCJ responses to all vulnerable children and families in NSW.

In 2024, DCJ introduced a new System Reform division to ensure a coordinated approach to the critical reform work that is being undertaken in child protection, out of home care and youth justice. The work of the System Reform division and the Transforming Aboriginal Outcomes division is described in these sections and is provided to give a fuller understanding and context to the recommendations that are made in response to the learning from child deaths.

Section 3.4 describes how child protection practitioners are supported in their work with children and their families and communities.

3.1 Practice change in response to cases considered by the Serious Case Review Panel in 2023

During 2023, the Panel met five times (one occasion was a meeting deferred from December 2022) and considered seven complex case reviews that examined DCJ involvement with a child and their family. Six of the cases were prompted by the legislative requirement under section 172A of the Care Act to complete a review following the death of a child. The other case was about a child who was seriously injured while living in out of home care.

The following information provides a summary of the Panel discussions in 2023. Deidentified information is used to describe the practice issues raised in the complex case reviews that were discussed by the Panel. Readers are urged not to draw conclusions from the information provided.

A description of the issues considered by the Panel alongside any existing work in DCJ to support systems and practice improvements is provided. Any new recommendations made in 2023 are listed, and a summary of the progress of those recommendations is included.

3.1.1 Improving practice at the Child Protection Helpline

Two of the reviews considered by the Panel in 2023 identified practice issues at the Helpline. The Panel directed three recommendations to the Helpline Executive for action.

The first review examined the processes available at the Helpline during periods of high call demand. The review highlighted the process used in periods of high demand whereby a community service officer (CSO) answers a phone call and gathers high-level information from a caller about their concerns for children to determine whether the call is transferred to the priority queue (where it would be answered by the next available Helpline caseworker) or to the 'general' queue (also to speak with a caseworker). The review noted that the call dropped out after the CSO gathered information and became what is referred to as an 'incomplete CSO record'. The incomplete CSO record was reviewed by a team manager that same day and then remained in a queue alongside e-reports, faxes, emails and other incomplete engagements to await processing by a caseworker.

In response to this review and the questions it posed about how periods of high call demand are managed and whether the existing (telephonic) queue management prioritising systems were adequate, the Panel discussed the strategies used by the Helpline to manage incoming work and acknowledged the different ways information is reported and the variety of calls received (e.g. those seeking general advice, requests for information or services, or making a child at risk report). The availability of an option for callers to choose to receive a 'call back' (if they do not want to be placed in a queue) was acknowledged, as was planned work to replace the Helpline's existing telephonic service. The Helpline contact centre will move to a new operating platform in the 2024–25 financial year. Through this process the Helpline is considering ways to enhance its service delivery.

The second review discussed by the Panel examined the work of the Helpline's After Hours Response Team (AHRT) and the work DCJ is doing to strengthen the team's role and function. The Panel acknowledged there was existing work underway to review the function and operational guidelines of the AHRT. This recent work has highlighted opportunities to enhance practice quality in the AHRT that will meet the needs of the community and the expectations of internal and external stakeholders. The Panel identified that the learning from this review would add value to this continuing work and redesign of the AHRT.

The Panel made the following three recommendations to improve systems and practice:

- The Helpline to undertake an analysis of 'incomplete CSO records' to understand how many of these resulted in the reported concerns being screened as meeting the suspected risk of significant harm threshold. Once completed, the analysis should be used to improve how these incomplete CSO records are assessed and prioritised in the future.
- The prioritisation system used at the Helpline (to ensure certain circumstances and categories of reports receive the timeliest attention) to be reviewed alongside contemporary research and other intake systems to consider whether it needs to be revised.
- The endorsed complex case review to be shared with the Director Helpline to inform the review of the AHRT function and operational guidelines.

The Helpline has completed all three recommendations. The outcomes are summarised below, alongside other ongoing work to improve processes at the Helpline.

Analysis of incomplete community service officer records

In response to this recommendation, the Helpline Executive team completed an analysis of incomplete CSO records and advised:

- All incomplete CSO records are reviewed by a team manager to determine the appropriate level of response priority allocation for processing by a Helpline caseworker. This system enables higher risk concerns to be prioritised for more immediate attention or another response. This includes a complete history check and assessment for all children reported and may include the

need to call back a reporter and get more information to help the assessment of whether the concerns meet the suspected risk of significant harm threshold.
- A dedicated section of the **Child Protection Helpline Process Guidance** supports practice for incomplete CSO records and prompts Helpline practitioners to consider the need for an urgent call back when a caller abandons their call and the information provided indicates a high level of concern.

The analysis found incomplete CSO records were less likely to result in a final suspected risk of significant harm determination when compared to annualised data. Specifically, 42 per cent of incomplete CSO records were later assessed to result in a final determination of suspected risk of significant harm (ROSH) with the remaining determined as non-ROSH (58 per cent).

Review of Helpline prioritisation processes

A review of Helpline processes showed that regardless of whether an incoming report is made via a phone call or an e-report, the most serious or urgent concerns get the timeliest service system response.

For incoming phone call reports, the Helpline has a priority queue that ensures urgent action is taken when immediate concerns are raised for a child. Certain circumstances and categories of callers are prioritised according to a priority caller list – for example, a child who calls the Helpline, a call about a significant non-accidental or suspicious injury to a child or a call about child sexual abuse where the perpetrator has imminent access to the child. Calls transferred to the priority queue bypass any existing callers and are answered by the first available caseworker.

Every e-report submitted to the Helpline by a mandatory reporter is subject to an initial review by a team manager to determine a priority for the information to be assessed by a caseworker.

The prioritisation of reports (from either a caller or an e-report) is supported by Helpline process guidance. Against the backdrop of an increasing volume of reports, this guidance:

- encourages consistency among team managers and supports child-focused response priority determinations
- recognises different response priorities are required depending on the reported risk concerns
- supports the identification of circumstances that may represent the need for an urgent assessment
- has a dedicated section to support practice for incomplete CSO records and prompts practitioners to consider the need for an urgent call back when the reporter abandons their call and the information provided indicates a high level of concern.

The Helpline has introduced an enhanced quality assurance process to ensure accuracy of decision-making practice for prioritisation of e-reports. This requires senior leadership to review a minimum

of 300 e-reports a month that have been subject to prioritisation. This will enable continuous improvement by identifying areas for practice uplift.

Review of the operational guidelines for the After Hours Response Team

The review was shared with the Helpline and was used to inform an options paper for a redesigned operating model for the AHRT. In June 2024, the DCJ Operations Executive team considered a preferred model that aims to increase the efficiency and effectiveness of the AHRT operations while safeguarding practice and decision-making. Implementation will take place in 2025.

Other Child Protection Helpline reforms

The Helpline is continuing to implement and pursue other opportunities for operational efficiencies aimed at supporting timely and accurate assessment of children and families who are reported to the Helpline. These are highlighted below:

- In December 2023, new practice and process support was provided to help practitioners to identify and assess multiple reports about the same children. This will reduce the time it takes for Helpline caseworkers to assess reports and create time-saving efficiencies while also ensuring decisions about a response to families and support provided is timelier.
- In May 2024, the **Helpline Practice Quality Supervision Guidelines** were finalised. These aim to strengthen and safeguard decision-making processes and sustain an effective, hopeful and skilled workforce.
- To build a culture of continuous improvement, Helpline practitioners are supported to participate in reflective practice sessions.
- In September 2024, an internal consultation line was launched that enables practitioners to have live and centralised access to consultation from a team manager. This will support access to timely decision-making.

Helpline Advanced Screening Program

In 2018, DCJ implemented a trial of an advanced screening protocol that was used to gather additional information about a child and family's circumstances to help improve the accuracy and efficiency of the Screening and Response Priority Tool (SCRPT).

In 2019, the trial was expanded to additional districts and became known as the Helpline Advanced Screening Program (HASP). Since then, HASP has contributed to some diversionary pathways for children and supported a localised approach to working with families, communities and sector partners.

Following a review of DCJ Structured Decision Making tools, the approach to safety and risk assessment, and the use of SCRPT by the Helpline (discussed more in section 3.2), it was determined the HASP process did not clearly align to key points of decision-making within

the Care Act. Options regarding the future of HASP were considered, and in May 2024 the Helpline stopped the HASP. The learning and contributions from HASP are being used to inform future reforms at the Helpline and other reforms being planned within DCJ.

3.1.2 Investing in practice leadership

Three reviews discussed by the Panel in 2023 raised issues for practice leadership. All three were about infants who died in 2022. Two of the families were known to the child protection system and were receiving child protection casework and support by non-government partners. The third review looked at the challenge faced by CSCs when allocating new reports to available staff and the use of alternate options to support families. It highlighted positive, holistic and confident practice in response to the reports that were allocated for a child protection response.

Practice leadership

Practice leadership blends universal leadership qualities (such as motivating, inspiring and creating a shared vision) alongside a set of specialist competencies in the use of child protection evidence, practice wisdom, skills and a strong ethical position. To achieve meaningful outcomes for children and families, DCJ practice leaders are expected to safeguard practice, lead effective systems, develop staff and practice, and lead open cultures.

The Panel made three recommendations in response to the discussions that were prompted by the issues raised about practice leadership in these reviews. Each of these recommendations is discussed under the relevant headings below.

Leadership development and training

The Panel identified the need for practice leadership development training and opportunities to be focused on manager casework positions. The Panel noted that since the statewide rollout of the Practice Leadership Development Program (PLDP) during 2023 there has been significant staff movement across manager casework positions and practitioners can 'act' in these roles for long periods. The Panel discussed the importance of the manager casework role and the skills required to lead teams and ensure casework mechanisms (such as consultation and group supervision) are used to safeguard decision-making and practice.

The following recommendation was made:

- OSP Practice Learning to consider options for new leaders to access the PLDP.

OSP Practice Learning is currently reviewing and updating the PLDP. The revised program will align with new individual and group supervision policy, the redesigned Caseworker Development

Program, and systems that support new assessment approaches with children and families. Following the review, the program will be offered to new and emerging leaders.

Using data to understand and drive practice

The Panel identified a need to help managers and those acting in management roles to understand how to incorporate available data-related resources to drive their work. The DCJ Resource Management Dashboard (RMD) and Client Information Warehouse (CIW) contain important data about children reported to DCJ that has clear implications for practice.

The Panel recommended that:

- Within six months, the OSP and the Deputy Secretary Operations develop a training package for new managers casework on the use of the RMD, its practice implications and link to child protection casework for children.

This recommendation is complete. A training package was developed and trialled in the Northern NSW District. The training focused on assessments and using the CIW to understand timeframes, and it aimed to help managers and practitioners integrate the RMD in their daily casework to improve practice, workload allocation and service delivery. Further rollout of the package will occur following the implementation of the new interim family based assessment (discussed in section 3.2.2). Delivery of this training will support the implementation of these changes.

Changes to child protection performance measures and the proposed introduction of new key performance indicators

The Panel discussed that the casework observed in two reviews reflected the impact on quality assessments and family work caused by the pressure to meet 'seeing more children' targets that CSCs were being measured against. These targets emerged through the (previous) Premier's Priorities and included statistics such as the number of new children seen and the number and percentage of children suspected to be at risk of significant harm and allocated for face-to-face assessments.

The following recommendation was made:

- The DCJ Executive to consider options for resetting the message on targets and practice expectations for 2024.

In 2024, the DCJ Office of the Deputy Secretary Child Protection and Permanency along with Family and Community Services Insights, Analysis and Research (FACSIAR) reviewed the Operational Business Review (OBR) Dashboard. The OBR Dashboard is produced by FACSIAR to support districts to track their performance against an agreed set of key performance indicators and prepare for their biannual OBR meetings. Instead of measuring key performance indicators via targets,

agreement was reached to use a benchmark approach. This work is continuing, and new key performance indicators are being developed.

Child protection quality assurance

While not a specific recommendation of the Panel, members discussed the work underway to build a quality assurance framework to safeguard child protection and out of home care casework.

A child protection quality assurance and continuous improvement model is in the early stages of development. The model aims to give DCJ leadership oversight and governance of the child protection system and child protection casework, similar to the out of home care quality assurance program. The model will bring together child protection capabilities, standards, benchmark measures and evidence sources. It will also rely on qualitative and quantitative data and use existing reporting systems to share progress and identify opportunities for improvement. This work includes quality assurance and improvement mechanisms for the interim family based assessment introduced in September 2024. The new quality assurance framework will be implemented from early 2025.

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

Several complex case reviews considered by the Panel in 2023 identified issues about DCJ systems and processes that are used to respond to children (and their families) after reports about them are screened as meeting the suspected risk of significant harm threshold. These include how children are prioritised for a face-to-face assessment, how referral systems and processes can be improved and how case closure decisions are made. DCJ is undertaking significant reform in these areas of practice and has begun critical reform work in 2023 and 2024 (outlined in section 3.2).

The Panel made three recommendations relating to referral, case transfer and allocation and prioritisation of risk of significant harm report processes. These recommendations and progress made against them are described below.

Referral systems and processes

The Panel discussed referral practices and the role of DCJ practitioners following a referral to a funded support program and noted these issues are well known. One review highlighted the need for DCJ to take a leadership role when new information suggests there are increased safety concerns for children with an open DCJ case who receive funded support services. DCJ should ensure the existing service is best placed to manage the escalating concerns or determine if more intensive services or intervention is required.

The Panel noted the current reform work (discussed further in section 3.2) and recommended the review be referred to the Child Protection Policy and System Reform areas of DCJ to be used to

inform the work happening on the **Prioritisation, Triage and Allocation Policy** review, and the Family Preservation Program Recommissioning.

This recommendation is complete, and the review has been shared with the relevant areas within DCJ.

Case transfer process

The Panel discussed the issue of delays in case transfers and the resulting gap in support for families that can eventuate. The discussion identified this had also occurred in other complex case reviews, as well as by the NSW Ombudsman and in coronial proceedings. The Panel made the recommendation for:

- The Office of the Deputy Secretary Child Protection and Permanency to issue a statewide communication about the importance of prompt case transfer between teams, CSCs and other business units, noting the existing requirements set out in the practice mandate **Transfer of a Child or Family Between Teams, CSCs, Interstate Out of Home Care and JCPRP**.[38]

This recommendation is complete. A statewide communication was sent to all DCJ child protection practitioners and managers; it included a link to the mandate. The communication made the connection between a case discussed by the Panel and the importance of timely case transfers.

Following the communication, the mandate was updated to reflect the Deputy Secretary's directive. It included the following new practice advice:

- Children and families deserve effective and timely casework based on their needs to help create safety and stability and support wellbeing.
- It is important that during transition periods we maintain consistent services, information sharing and active casework to the family while a transfer is pending.

The mandate was also updated to include the following new mandatory requirements for children in out of home care:

- Arrange a case transfer meeting with the receiving manager casework within 14 days of the initial request. The maximum timeframe for transfer of a case is 14 days from date of initial request. Where possible, case management transfer should occur close to the date the transfer request is made, to ensure continuity in services being provided to the child and their family.
- Limited or no capacity is not a reason for a receiving CSC to decline the transfer of a child who meets the transfer criteria.

Improving allocation of risk of significant harm reports and decision-making about prioritisation

The Panel acknowledged the difficult decision-making that takes place at triage and considered the systemic factors that influence decision-making. The Deputy Secretary Operations had previously identified a need to review the operations of the various hubs. The Child and Family Policy team had also identified the variation that exists in triage decisions and the different prioritisation systems across districts. The Panel recommended:

- The OSP to support Strategy, Policy and Commissioning (now System Reform) and the Deputy Secretary Operations to lead a mapping exercise of hub models currently in operation across NSW. The mapping exercise should identify what is working and potential issues to be rectified, and advise of next steps.

Work is continuing against this recommendation. DCJ has completed a comprehensive review of prioritisation, triage and allocation processes. This review incorporated mapping of the various hub models in use across districts and their implications on triage processes. Further decision-making about next steps for this recommendation will occur following consultation with stakeholders as part of the broader work underway within the prioritisation, triage and allocation policy review.

3.1.4 Improving DCJ response to children in out of home care

The Panel considered a complex case review about a child who had been hurt while living in out of home care. The review considered several areas of out of home care practice, and in response the Panel identified areas of practice and systems in the out of home care system that could be improved. Three recommendations were made in response to the review.

Panel members discussed the impact the lack of foster care placement options in NSW has on practice and decision-making about children's placements. It was acknowledged that for children with complex emotional and behavioural needs, placement options are often further limited.

The Panel also noted the additional workload for practitioners that accompanies actions to find and assess placement options and provide carer training and support, while also working with parents towards restoration goals. Panel members identified that the decision for DCJ to outsource foster care (following the transition of foster care to the non-government sector in 2012–13) had resulted in the unintended loss of practitioner knowledge and skills in the recruitment, development and support of foster carers. The Panel considered how DCJ practitioners can be best supported to complete thorough carer assessments, support carers and ensure children's needs remain the priority.

In July 2022, DCJ started emergency carer recruitment across all districts as a short-term strategy to reduce the use of alternative care arrangements and high-cost emergency arrangements

(HCEAs). These initiatives are now led by the High Cost Emergency Arrangements (HCEA) Strategy Unit, which was formed in October 2023 (after the Panel meeting).

The Panel agreed that while the intention of the family time policy is to support children who are living in non-family based out of home care to remain connected to their family and kinship networks, it was instead being used as a substitute respite arrangement without the correct authorisation process occurring. The Deputy Secretary Child Protection and Permanency requested an audit of the use of family time across the state.

The Panel made three recommendations:

- An audit be completed of all districts' use of family time as a short-term placement option to identify how prevalent the issue is across the state by requiring districts to review all 'whereabouts' records for children in out of home care (who were case managed by DCJ) between 1 May and 31 October 2023.
- For Child and Family Out of Home Care Programs to provide an update on its review of the Respite Policy Mandate and confirm details of how this will be communicated statewide to practitioners.
- OSP (Practice Quality and Psychological and Specialist Services) in consultation with the HCEA Strategy Unit and Strategy, Policy and Commissioning (now System Reform) to develop resources to increase practitioner knowledge and skills about provisional and full carer and placement assessments and their support of new carers.

These recommendations are discussed under relevant subheadings below, along with further information about the recruitment, assessment and support of carers.

Understanding the use of family time

In 2023, DCJ completed an audit on the use of family time across NSW. The audit showed there was a need to strengthen the parameters around how family time was being used to ensure it was not being used as a substitute to emergency or short-term care or a respite placement. The audit recognised the current work to update the **Respite Policy Mandate** (detailed below) and recommended additional opportunities, including targeted communication to DCJ staff and enhancements to recording in ChildStory that would allow greater visibility of family time arrangements.

Introduction of the DCJ Family Time Worker Program

Relevant to this recommendation, DCJ is also working to directly employ more than 100 family time workers to support and supervise family time for children in out of home care and their families. Twenty per cent of these positions are identified as Aboriginal.

The Family Time Worker Program aims to:

- improve the quality of family time provided to children and their families
- improve family time service delivery, resources and systems that support practice, particularly restoration
- better match the culture of children in care and provide more consistent workers
- increase employment pathways into caseworker and other DCJ roles.

Each family time worker will have a dedicated manager and receive training across a range of topics.

New and updated out of home care policy and practice mandates

The new **Home Visiting Children in Out of Home Care Mandate** was published in July 2023 and is used to support case planning as well as planning and carrying out home visits with children for whom DCJ holds case management responsibility. The mandate includes advice about using communications technology (such as video calls or FaceTime) when an in-person visit is not possible and allows the *occasional* use of technology to provide practitioners flexibility where circumstances require, while maintaining the need for regular in-person visits. Under this policy, children living interstate will continue to receive in-person home visits from either their NSW caseworker or an interstate caseworker via a request under the **Interstate Child Protection Protocol**. PSP providers each have their own policies about home visiting children for whom they have case responsibility.

The new **Alternative Care Arrangement Mandate**, the **Residential Care Worker Authorisation Mandate** and the **Residential Care Workers Register Mandate** were approved and published in August 2024.

The revised **Respite Policy Mandate** is expected to be published by January 2025 and will clarify respite timeframes and definitions, including how time (and sleepovers) with family and friends should be used, guidance on other planned absences and how respite is used in the context of restoration. The policy will be aligned with legislation and the NSW Child Safe Standards for Permanent Care.

The **Placing a Child in Out of Home Care Mandate** is under scheduled review and is expected to be published in June 2025.

High Cost Emergency Arrangements Strategy Unit

In October 2023, the HCEA Strategy Unit was formed; it started operating on 1 November 2023. The HCEA Strategy Unit ensures greater oversight and monitoring of these types of care arrangements and is made up of multiple teams working together to achieve a reduction in the number of children in HCEAs, scrutinise and reduce the costs associated with HCEAs and reduce the number of vacancies across the funded service system. Since the implementation of the HCEA Strategy Unit,

every child who was in an HCEA at 1 November 2023 received a focused review and case analysis to consider their circumstances and ensure all other alternate options were being explored.

The Triage and Emergency Care Arrangements team was established as the sole entry point for all HCEAs and is pivotal in managing the children entering and moving between HCEAs. This team consults with and provides advice to districts and PSP providers about alternate options and ensures HCEAs are only used as a last resort. Between 1 November 2023 and 1 June 2024, this team recorded that 50 HCEAs were avoided and children were placed in other suitable care options.

Since the implementation of the HCEA Strategy Unit, data has shown a decrease in the number of children living in HCEAs. The most notable decrease has been from alternative care arrangements, which is the least preferred care type.

This work is happening alongside the Emergency Foster Care Recruitment and Placement Stability project teams (described further below), which are working to increase placement supply, implement strategies to achieve stability within current out of home care placements, and build a pool of DCJ emergency foster carers as a strategy for avoiding and reducing HCEAs.

DCJ has expanded Intensive Therapeutic Care capacity and residential care placement options and recruited approximately 200 emergency foster carers to help support children being moved out of emergency accommodation.

On 3 September 2024, the Minister for Families and Communities announced that the use of alternative care arrangements will be phased out over the next six months and will end by March 2025.

Recruitment, development and support of carers

Recruitment of carers

The recruitment of carers is a common challenge across NSW, as well as nationally. At the end of 2023, there were 10,830 authorised carer households in NSW; 4,872 were managed by DCJ and 5,958 were managed by PSP providers. Data shows NSW would need approximately 1,000 new carer households in the next two financial years to meet expected demand.

In September 2024, DCJ started recruitment for longer term foster carers.

Assessment of carers

In June 2024, the creation of two Carer Assessment teams (placement and permanency) was approved. This will build DCJ capacity and capability to deliver relative/kin and foster care assessments for authorisation and increase permanency options. The teams will enable DCJ to work directly with children and families in the assessment process, support carers in their carer role and help support and stabilise placements. These teams will be centrally managed, offering consistency in practice. It is anticipated that the teams will be established by 2025.

DCJ is continuing to improve the carer authorisation process. The Emergency Foster Care Recruitment project team is delivering projects to streamline, reorder and enhance the carer authorisation process, including centralising the early administrative components so that districts can focus on relationship building with carers during training and assessment phases.

DCJ is also reviewing and refining the support offered to carers to address the financial cost of caring as a potential barrier to retaining carers and attracting new carers. The NSW Independent Pricing and Regulatory Tribunal (IPART) is reviewing the cost and pricing of out of home care in NSW. The scope of this review (taking place in 2024) will consider the carer allowance. Other work by the NSW Government to review the out of home care system is described further below.

Culturally safe recruitment of carers

DCJ continues to enhance its capacity to conduct culturally safe assessment of carers. The **Assessment Guide: Relative and Kinship Carer Full Authorisation** reflects current research and practice, highlighting the benefit of relative/kin placements, and is aligned closely with the NSW *Practice Framework*.

DCJ continues to collaborate with Winangay Resources Inc. to train DCJ caseworkers in the Winangay Kinship Carer assessment tool, a culturally sensitive approach to assessing carers. Winangay's mission is to reduce the number of Aboriginal and non-Aboriginal children in out of home care. They are a team of Aboriginal and non-Aboriginal members that have developed assessment resources and tools that enable organisations and practitioners to work in stronger, trauma-informed and culturally safe ways with Aboriginal kids, families and communities.

Carer support

A Carer Support Team has established a District Caseworker Reference Group to enhance carer practice and build consistency of carer support across DCJ districts and will share training, initiatives and examples of good practice for carer support. A key aim of the group is to promote the training and support options that are available in each district. The Carer Support Team is scheduling bimonthly online carer presentations for DCJ and PSP authorised carers.

DCJ Psychological and Specialist Services (PSS) offers online training for DCJ and PSP carers. This support offers consistent access to training packages throughout the year and is particularly significant in regional and remote areas where in-person training is not always available. In the 2023 calendar year, PSS received 212 carer registrations through the online training calendar and trained 58 non-government partners to deliver training packages.

PSS also delivers targeted services to the Emergency Foster Care program. Dedicated psychologists provide support specifically to new carers, including carer check-ins to discuss placement concerns, appropriate strategies, training opportunities and carer wellbeing.

In the second half of 2024, DCJ practitioners attended group supervision sessions focused on improving the lived experience of carers. The development of the group supervision sessions was informed by feedback from the 2022 My Forever Family survey and the 2023 Carer Forum that took place with the Minister for Families and Communities.

Youth Consult for Change (UC Change) developed a carer resource pack that provides practice advice from young people to carers about building and nurturing a relationship with a young person. This resource was first launched at the DCJ Practice Conference in November 2023. Since then, the resource has been shared with a variety of internal and external agencies.

NSW Government review of the out of home care system

The NSW Government has embarked on a range of reforms to improve the performance and financial sustainability of the out of home care system.

The NSW Government's 2024–25 budget included $224 million to continue work to build a better foster care system, to ensure more children can grow up in safe and loving homes.

The 2024–25 budget investment supports government to:

- expand its role as a foster care provider to move vulnerable kids out of emergency accommodation
- increase the recruitment of urgently needed long-term foster carers
- increase government-delivered residential care so there are more high-quality options for children who cannot be placed with family or in foster care
- roll out a statewide quality assurance framework for children in out of home care.

In October 2024, the government received an independent system review that reported on ways to improve the out of home care system, reduce reliance on unsuitable emergency accommodation and ensure that every dollar spent in child protection supports vulnerable children. This review will guide significant structural reform to the child protection system.

Further work to redesign the foster care system is also underway, with an overarching draft out of home care strategy for NSW to be developed by the end of 2024.

3.2 Improving responses to at risk children and families

During 2023 and into 2024, DCJ has continued to implement a range of practice initiatives and reforms aimed at improving responses to all vulnerable children and families in NSW. As mentioned earlier, the newly created System Reform division is coordinating these initiatives and reforms.

The System Reform division will ensure the reforms and initiatives that are taking place are coordinated, cohesive and implemented in an effective way. The division is working in partnership with peak bodies, including Aboriginal stakeholders, to ensure the reforms are efficient, sustainable and culturally responsive.

The following sections describe work happening across DCJ to improve responses to at risk children and their families. This information is provided to give greater context to the recommendations made and practice changes discussed in the previous section that resulted from reviews undertaken in response to child deaths.

3.2.1 Child safety and wellbeing system reform

In 2023–24, DCJ began critical reform work across the child safety and wellbeing system. A whole of government approach is needed to ensure all relevant systems are focused on supporting:

- child safety and wellbeing, not just identifying abuse and neglect
- whole families at an earlier stage, before problems become entrenched.

Several NSW Government agencies, including DCJ, the NSW Ministry of Health, the Department of Education and the NSW Police Force, all have important roles in supporting the safety and wellbeing of vulnerable children and families. A longer term cross-government strategy will leverage these partnerships to significantly overhaul the way services and supports are delivered to families, building on community and cultural strengths. The NSW Government is considering options on how such reform may be achieved with a view to developing a **Families Strategy** by mid-2025.

3.2.2 A new (interim) family based assessment

Between 2021 and 2023, the DCJ Better Decisions for Children project completed a quality service review of the Structured Decision Making (SDM) case management tools and approach to child protection assessment. During this process, issues were identified with the application of the tools, the absence of guiding policy and the need to align the tools with key statutory decisions. Aboriginal stakeholders advocated that continued DCJ use of the SDM risk assessment tool was contributing to inequitable outcomes for Aboriginal families. Throughout the project, Aboriginal stakeholders, including AbSec and the Aboriginal Legal Service, advocated that continued DCJ use of SDM and lack of partnership with Aboriginal people did not align with *Family is Culture*[39] recommendation 56.

In August 2023, the Minister for Families and Communities hosted the **Aboriginal Child Safety and Wellbeing Reform Forum** with Aboriginal stakeholders and community members. After the forum, the Minister directed DCJ to review the continued use of the SDM risk assessment and how statutory powers are used to remove children from their parents.

In February 2024, DCJ made a commitment to partner with Aboriginal people and communities to redesign a 'future approach' for child protection assessment and decision-making. A partnership agreement has been developed between DCJ, AbSec and the Aboriginal Legal Service to describe how DCJ will work in partnership with these agencies to review and redesign policies, practice, procedures and assessment frameworks that govern assessment and decision-making in child protection. This partnership is enabling Aboriginal organisations and communities to lead the design of solutions for assessment and decision-making about the safety, welfare and wellbeing of Aboriginal children and their families to ensure DCJ practitioners provide support to families that is culturally responsive, strengths based and family led while ensuring the safety of children.

Following review, in May 2024 the Minister approved the DCJ plan to make interim changes to the risk assessment process. The interim approach responds to concerns about the cultural bias within the previous SDM risk assessment, provides greater clarity for practitioners in decision-making and assessments and is clearly aligned with key legislative decisions. This interim approach will remain in place while a future assessment approach is designed with Aboriginal people and communities.

In September 2024, DCJ started using the new interim approach to risk assessment, the **family based assessment**. DCJ practitioners are being supported through implementation of the interim approach with briefings, webinars, a practice manual with guidance, e-learns, group supervision resources and coaching support for practitioners and practice leaders.

3.2.3 Family Preservation Program Recommissioning

DCJ is redesigning the family preservation service system in NSW to improve outcomes, experience, suitability and accessibility for families who want to access and would benefit from working with a family preservation service. For Aboriginal children and their families, this means increasing culturally safe, responsive and community led services that centre family decision-making.

In April 2024, DCJ released the **Redesigning Family Preservation in NSW Discussion Paper** for consultation. This paper sets out a vision for the future and proposes several changes. A range of stakeholders provided responses, including service providers which currently deliver or are interested in the delivery of family preservation, DCJ practitioners, peak bodies and other interested parties. Feedback is being analysed to inform the final design. Some changes will be settled in 2024, others will inform implementation of the design and contract arrangements, and others will be developed throughout the new five-year contract period, enabling a system that continuously improves outcomes for families.

Key changes proposed through the redesign

- The redesign proposes to retain three service models from the current suite of family preservation programs and introduces two new frameworks that use an evidence-informed core components approach. This will allow service providers to develop and iterate responsive and effective models.
- The redesign also includes a proposal to adopt simplified and improved eligibility and suitability across the program. Eligibility will be slightly narrowed and will include a focus on a family's suitability, to target finite resources and ensure families receive the support that is best suited to meet their needs and circumstances. Service providers must be able to work with families who are experiencing mental health issues, drug and alcohol misuse and domestic violence.
- The redesign will rely on the use of data to create a system that is evidence led and more responsive and effective. This includes improving data capture and quality and undertaking continuous analysis and evaluation to test and refine.

As part of the recommissioning, DCJ is considering improvements to the Universal Referral Form (implemented in July 2022) that will aim to further streamline the referral process, improve information sharing and enhance functionality.

infoShare

The IT solution infoShare has now been implemented with current family preservation service providers. infoShare helps to capture data more quickly, increases the consistency of data collected and offers service providers a visualisation of data in the form of reports.

The infoShare platform is used to collect a 'minimum dataset' from family preservation providers. This is a minimum set of mandatory data items about clients, and about services delivered by service providers. Data is submitted quarterly for annual reporting requirements and used to create insights about clients and service delivery that can inform future improvements to service design.

The new streamlined data collection platform went live in early 2024 and replaces other existing family preservation data collection mechanisms. Technical and implementation support has been provided to service providers to help with developing familiarity with the platform.

Enhancements are being made to the infoShare platform that will enable DCJ to continue to build and strengthen the evidence around what works for family preservation and drive continuous service improvement.

3.2.4 Prioritisation, Triage and Allocation Policy review

DCJ is undertaking a comprehensive policy review of prioritisation, triage and allocation processes (discussed in the *Child Deaths 2022 Annual Report*). The aims of the policy review are to strengthen

decision-making about the responses children receive, ensure children most at risk are prioritised for face-to-face assessment, consider where other responses are appropriate and enhance DCJ collaboration with other agencies.

DCJ has completed significant analysis and stakeholder consultation to consider and refine potential improvements to the triage process. Feedback from stakeholders on the key directions and outcomes of this review will be incorporated into the updated policy and casework mandate.

The aim of this policy review, alongside other reform work, is to develop system level improvement to:

- how DCJ prioritises reports of children suspected to be at risk of significant harm to improve the accuracy and timeliness of triage responses
- ensure children and families receive the right types of supports based on their needs
- strengthen interagency collaboration to support a child and their family, including improving information sharing with other agencies to ensure the right agency has the right information to respond to the concerns or needs of a child and their family effectively
- provide further guidance to child protection practitioners about appropriate responses to different types of risks, including enhanced guidance for responding to domestic violence
- ensure allocation and triage decisions are recorded systematically, transparently and accurately.

3.2.5 Improved approach to supporting expectant parents

DCJ is working to improve its prenatal engagement with expectant parents to ensure that children are safe when they are born and to reduce the number of newborns entering out of home care. DCJ aims to achieve this through a comprehensive prenatal policy review and the statewide implementation of Pregnancy Family Conferencing.

Prenatal Policy review

The DCJ **Prenatal Policy** and casework mandate governs how DCJ practitioners respond to prenatal reports is undergoing a comprehensive review. DCJ is working in partnership with NSW Health and Aboriginal stakeholders on this review, expected to be completed in 2025, which aims to:

- improve DCJ response to prenatal reports to increase children's safety when born
- actively involve expectant parents and their families in decision-making about a child's care arrangements if they need to enter out of home care
- improve outcomes for Aboriginal children by ensuring DCJ works more effectively with Aboriginal families as part of the DCJ commitment to addressing the over-representation of Aboriginal children in the child protection system.

DCJ released the **Prenatal Policy Review Discussion Paper: Supporting Expectant Parents to Keep Their Newborn Baby Safe** on 10 July 2024 for stakeholder feedback on the proposed policy directions.

While the policy review and consultation process is underway, in September 2024 DCJ released interim guidance to support practitioners when they respond to reports about unborn children. The focus of prenatal casework is to provide early support and help to expectant parents. The interim guidance provided additional clarification to practitioners about:

- working with expectant parents under the interim assessment approach given DCJ cannot make statutory decisions about a child until they are born
- ensuring expectant parents understand their engagement is voluntary and can only occur with their informed consent
- supporting expectant parents to access independent legal advice
- when working with Aboriginal families, ensuring an Aboriginal consultation occurs.

NSW Health remains the lead agency on maternal and child health and has its own policies and processes for governing its response to children at risk of harm.

Pregnancy Family Conferencing

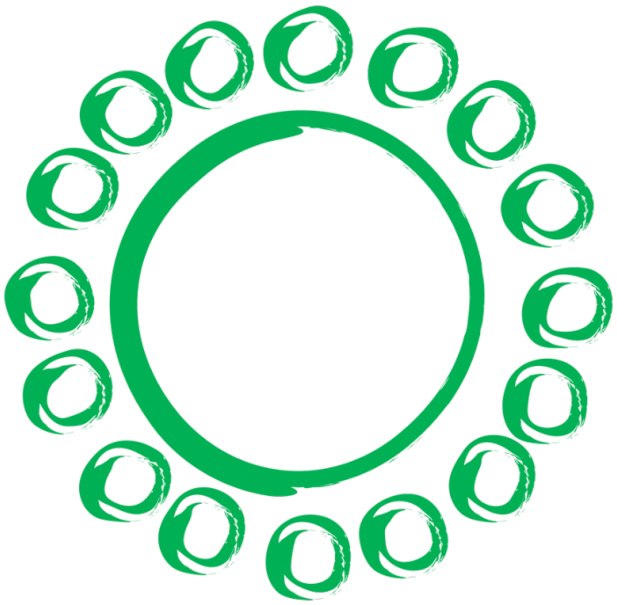
Pregnancy Family Conferencing (PFC) is a joint program between DCJ and NSW Health and provides wraparound support and case planning for expectant parents where there are concerns that an unborn child may be at risk of significant harm after birth. To be eligible, the unborn child must have an open case allocated to a DCJ caseworker.

Based on the success of the existing model, the NSW Government allocated $38.6 million in the 2022–23 budget to scale up delivery of PFC across NSW. DCJ is working in partnership with NSW Health to expand PFC, and it is expected to be operational in additional districts by the end of 2024.

PFC is designed to promote positive outcomes through:

- a collaborative approach between DCJ and NSW Health to increase safety for newborns by working with expectant parents to address concerns early
- a focus on family strengths and culturally responsive service delivery
- the use of independently facilitated meetings to develop and monitor a family led case plan, and the involvement of formal and informal supports to ensure expectant parents feel safe and are able to participate meaningfully in meetings.

The implementation of PFC has been underpinned by the development of a statewide draft model framework, development of clear program documents and resourcing of designated positions in both agencies.



3.3 Improving outcomes for Aboriginal children and families

The Transforming Aboriginal Outcomes division (TAO) is driving change within DCJ to achieve Closing the Gap commitments in child protection, justice, housing and family violence and to implement the Priority Reforms. Co-designed reforms that reflect community identified needs are prioritised for socio-economic targets. TAO promotes collaboration with all DCJ divisions and members of NSW Coalition of Aboriginal Peak Organisations (CAPO). TAO is helping DCJ work towards eliminating racism through the Anti-Racism Unit, partnering with Aboriginal organisations and communities, strengthening the Aboriginal community controlled sector, improving data sharing and involving Aboriginal people in decision-making. The Aboriginal Services Unit in NSW delivers culturally safe services within NSW courts, including the Walama List Pilot, Circle Sentencing and the Coroners Court of New South Wales.

3.3.1 Closing the Gap

Implementation of the action plan and achievements

In August 2023, the NSW Government, in collaboration with AbSec, held the **Aboriginal Child Safety and Wellbeing Reform Forum**, which brought together key stakeholders, leaders and community representatives over two days. The forum was a step towards a more equitable future for Aboriginal children and families. Participants called for a reorientation of the system from child removals to family support and wellbeing, a greater focus on restoration, sharing authority with Aboriginal people and communities, and investment in Aboriginal controlled community organisations. Following the forum, the Minister for Families and Communities made nine commitments to reform, which are being implemented.

One of those commitments is the establishment of a **Ministerial Aboriginal Partnership Group (MAP Group)**, which was created in December 2023. This group has been tasked with setting the road map for reform and overseeing changes to legislation, practice and investment with the overall aim of creating a family-centred system that builds on cultural strengths and connection to keep families together. The MAP Group is co-chaired by the Minister for Families and Communities and the AbSec Chief Executive Officer. AbSec is funded to provide secretariat support to the group and develop its terms of reference. The MAP Group has met six times and has identified its priorities for reform.

These actions build on the work program developed with CAPO to achieve Target 12 of the National Agreement on Closing the Gap: 'by 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out of home care by 45 per cent'. Other focus areas to achieve the outcome whereby 'Aboriginal and Torres Strait Islander children are not over-represented in the child protection system' include:

- family preservation and early intervention to reduce Aboriginal families' contact with the statutory child protection system
- ensuring high-quality casework with Aboriginal families and children by involving families and communities in decision-making and implementing the **Aboriginal Case Management Policy** developed with community
- growing the Aboriginal community controlled sector, ensuring the child protection system has the capability and capacity to meet the needs of Aboriginal communities and families
- establishing a monitoring framework to track and report on performance and be accountable for results
- identifying opportunities to seek additional investment in prevention and early intervention initiatives.

3.3.2 Family is Culture

Implementation to support legislative changes

On 15 November 2023, additional amendments to the Care Act in response to the *Family is Culture* recommendations came into effect. This included legislative changes requiring practitioners to take active efforts to prevent children from entering out of home care and to restore children to their families wherever possible.

In early 2024, an active efforts working group was established. The group includes members from the TAO, OSP and System Reform divisions and external members from the Aboriginal Legal Service, Legal Aid NSW and AbSec. The working group has prioritised the development of an **Active Efforts Rules and Practice Guide** in 2024 and will continue to be part of implementation and policy reviews.

In 2024, enhancements and changes were made to ChildStory to support compliance with active efforts and other key *Family is Culture* recommendations. System improvements will continue to be made in 2025 that enable better reporting on DCJ practice with Aboriginal children, families and communities and support compliance with the new legislative requirements.

Indigenous data sovereignty and governance

In November 2023, the **Ngaramanala: Aboriginal Knowledge Program** completed recommendation 1 of the *Family is Culture* report, that 'DCJ should convene a roundtable with the Aboriginal community and stakeholders to discuss the meaning of data sovereignty and the designing, collecting and interpreting of the Department's administrative data relevant to Aboriginal children and young people'. This roundtable created a space for sharing learnings, aspirations, assets and resources. Two discussion papers were commissioned to progress the findings, including opportunities to advance Indigenous data sovereignty and governance within existing legislation and policies, and to form a policy framework baseline.

In 2024, work on recommendation 2 started, to develop a policy which will result in improved partnership being implemented in the Department's design, collection and interpretation of data relevant to Aboriginal children and families. This work is resolving the need for an agreed way forward for DCJ to respond to Indigenous data sovereignty as directed by Aboriginal communities in NSW and generating best practice data sharing protocols and collaboration agreements.

DCJ Aboriginal Identification Policy

DCJ is developing an **Aboriginal Identification Policy** in response to recommendation 77 of the *Family is Culture* report. The policy will provide clear guidance for how issues around identification are to be managed – with care, sensitivity and involvement of Aboriginal families and organisations.

The policy is being developed through a working group that includes representatives from TAO, the State Aboriginal Reference Group and AbSec. Consultation took place with DCJ internal stakeholders and external stakeholders including the Aboriginal Legal Service, AbSec and Stolen Generations organisations. Finalising the role of Aboriginal entities in the process is being worked through with guidance from the Aboriginal leadership group of the Out of Home Care Transition Project. This reflects TAO's commitment to shared decision-making and working in partnership with a broad range of Aboriginal entities, consistent with the NSW Partnership Agreement on Closing the Gap.

3.3.3 Safeguarding Decision Making for Aboriginal Children Panels

The Safeguarding Decision Making for Aboriginal Children Panels (Panels) began operating in October 2023. From October 2023 to June 2024, 424 panels were held.

The Panels operate in all districts to improve how DCJ makes important decisions about Aboriginal children. The Panels consider decisions about the safety, removal and placement of all Aboriginal children in each CSC consistently across the NSW child protection system.

Decisions are informed by diverse perspectives and independent consultation with senior practice leaders before the Director Community Services can approve an Aboriginal child entering care.

Each of the Panels includes Aboriginal practitioners to ensure culture is at the front and centre of DCJ decisions. Districts develop Panels to fit with local structures and systems, and each of the Panels is guided closely by a central terms of reference.

The Panels reflect the **Aboriginal Case Management Policy** and its focus on Aboriginal people leading decision-making, as well as the *Family is Culture* legislative amendments and the need for DCJ to make active efforts to prevent children entering care.

Further training for managers to help them facilitate the Panels in a culturally safe way is being developed, along with consideration and consultation on the inclusion of community on the Panels.

3.3.4 Waruuguma Barrmarrany Legal Service

In early 2024, Waruuguma Barrmarrany – an Aboriginal led, culturally responsive legal team – was established. Waruuguma Barrmarrany is committed to reducing the rate of over-representation of Aboriginal and Torres Strait Islander children in out of home care (outcome 12 of Closing the Gap) and delivers purposeful and meaningful legal services for the preservation and reunification of Aboriginal and Torres Strait Islander children with family and culture.

Waruuguma Barrmarrany provides legal advice:

- in the early intervention space
- in cases where reunification to family and culture is possible
- when decisions are being made about the safety of Aboriginal and Torres Strait Islander children
- when guidance is required about the active efforts that should be made to allow Aboriginal children to remain with their families.

Waruuguma Barrmarrany is committed to making sure legal pathways are clear and understood, and they can deliver training where requested to ensure all parties understand their legal obligations under the legislative framework. The team endeavours to have a representative present at every Safeguarding Decision Making for Aboriginal Children Panel.

Waruuguma Barrmarrany is designed to be collaborative and works together with practitioners on solutions that provide everyday, practical support to ensure better outcomes and advocacy for Aboriginal families and to work effectively towards closing the gap.

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

During 2023, DCJ continued work focused on supporting the child protection and out of home care workforce in NSW. This includes DCJ practitioners and practitioners in non-government agencies that partner with DCJ.

3.4.1 Practice Leadership Development Program

In 2023, the Practice Leadership Development Program (PLDP) continued to be delivered across DCJ districts. The program was developed in 2022 and is delivered over 12 months to allow for opportunities to embed and consolidate new skills. The program is designed to support the development of practice leaders and Aboriginal and Torres Strait Islander practitioners who are culturally capable in practice with children, families and communities and who can operate effectively in the five public sector leadership impact areas of people, results, systems, culture and public value.

Over 600 managers client services, managers casework and identified emerging leaders have completed the program and developed their skills through mandatory e-learns, workshops and focused coaching sessions. The program has seven modules and an emphasis on managing and leading staff so that children receive the assessments, supports and services they need and deserve.

OSP Practice Learning is reviewing and updating the PLDP. The revised program will align with new individual and group supervision policy, the redesigned Caseworker Development Program, and systems that support new assessment approaches with children and families. Following the review, the program will be offered to new and emerging leaders.

3.4.2 Launch of supervision campaign

A staff supervision, wellbeing and support campaign was started in September 2024. The campaign focuses on increasing the use and quality of individual and group supervision. It will be rolled out over a six-month period and will include an update to the supervision policy to provide stronger guidance about the delivery of individual and group supervision, including the introduction of quality assurance mechanisms to provide governance and oversight of the delivery of individual and group supervision. The campaign includes several strategies to support staff and uplift the quality of individual and group supervision.

Group supervision has evolved to be more purposeful and support DCJ priorities. The group supervision record and structure, based on the Minnesota Model,[40] aims to uplift and strengthen

reflective practice and professional judgement. Resources have been developed to familiarise staff with changes and embed change within group supervision practice.

The campaign and updates to the policy will elevate messages about the purpose and role of individual supervision and align with the DCJ staff wellbeing strategy, in particular the frequency of how sessions are used to provide the four functions of supervision. Resources have been developed to support supervisors and staff to engage in meaningful supervision that supports staff wellbeing.

3.4.3 Group Supervision Action Learning Program

In 2023, OSP Practice Learning delivered the Group Supervision Action Learning Program (GSALP) to 62 participants, including practice leaders, consultants and emerging leaders. The GSALP is a four-day online workshop designed to develop the knowledge and skills of leaders, so they can facilitate effective group supervision with their teams.

The GSALP includes pre-learning activities and online workshops with opportunities to practise and receive feedback on key facilitation skills. It is envisaged that the GSALP will be integrated into the PLDP as part of its review and update. This will position the leadership of supervision to strengthen and safeguard practice with children and families as a core role of practice leaders.

3.4.4 Family is Culture

In 2023, OSP Practice Learning developed training and resources to support implementation of new *Family is Culture* legislation in practice. The content focuses on making active efforts in the work we do with all children and families. Making active efforts means doing everything possible to support change with families so children can remain safely at home, be cared for by family or be safely returned to their family.

Training includes a mandatory e-learn for all operational staff to help them understand the reforms and relate the practice changes to the NSW *Practice Framework*. The content also demonstrates how active efforts look in practice, including in family preservation, in out of home care and restoration, and in the five elements of the **Aboriginal and Torres Strait Islander Children and Young Person's Principle**. Over 3,000 staff have completed the e-learn as of July 2024. Other resources include guidance for managers, including a team discussion session about the changes and reflective prompts focused on safeguarding practice and developing staff.

Content in the Caseworker Development Program has also been updated to reflect insights and thinking from the *Family is Culture* report, including active efforts.

3.4.5 Caseworker Development Program

OSP Practice Learning currently delivers the Caseworker Development Program (CDP) to approximately 500 caseworkers a year. This program delivers foundational learning over 17 weeks to all new caseworkers via e-learns, workbooks, face-to-face learning and practice-based learning in the CSC.

The program is undergoing evaluation to determine how it can better prepare and support new caseworkers for the complex work of child protection. A redesigned CDP will be launched in 2025. It will consider the evaluation findings and current research in adult learning, and it will also incorporate recent legislative and policy changes. The primary focus for the redesign of the CDP is to ensure it meets the current needs of children, families, new caseworkers, leaders and the organisation.

In August 2024, DCJ opened new training facilities in a dedicated fit-for-purpose learning space in the Parramatta Justice Precinct. The new learning space provides participants with access to updated technology for improved hybrid learning, including online and face-to-face workshops. The space will also incorporate dedicated simulation areas where learners will be able to practise realistic simulations in core practice areas such as talking to children and families.

3.4.6 Student Development Program

OSP Practice Learning currently delivers the Student Development Program (SDP) to approximately 120 social work students on placement with DCJ. The program offers foundational learning over 14 weeks via e-learns, workbooks, online workshops, and coaching and practice-based learning in the CSC. The program is recognised as credit towards the CDP for students who successfully apply for a caseworker position after graduating from their degree, decreasing their time in the CDP by approximately nine weeks.

3.4.7 Casework Support Worker Development Program

OSP Practice Learning currently delivers the Casework Support Worker Development Program (CWSWDP) to approximately 60 staff a year. The program delivers foundational learning over eight weeks to casework support workers via e-learns, workbooks and online workshops.

3.4.8 Change Together

In 2023, the Change Together program continued to be delivered to practitioners from non-government early intervention, family support and family preservation services across NSW. The program was redesigned and relaunched in November 2021 as an online learning program with eight modules in a combination of e-learns and online workshops. Feedback remains positive, with

the online design of the program making it easily accessible for practitioners across the state. The ‘Foundations of child protection’ module has been the most frequently completed.

From its launch in November 2021 to 30 December 2023, 950 of the 1,000 available licences had been taken up by early intervention and family preservation services. In 2023, some 3,481 e-learns were completed and 51 facilitated workshops took place, attended by 265 individual practitioners from non-government organisations.

DCJ staff can also access Change Together e-learns via the Thrive learning platform. The e-learns are helpful to those new to child protection practice or DCJ staff who do not work directly with children.

Glossary

Aboriginal

Refer to the definitions in section 3[41] of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and section 4[42] of the *NSW Aboriginal Land Rights Act 1983* (NSW). DCJ recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. DCJ also acknowledges that Torres Strait Islander people are among the First Nations of Australia.

Abuse

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

Alcohol and/or drug use

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

Assessment

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

Authorised carer

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

Case closure

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

Case planning

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

Casework

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

Child

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a child as a person under the age of 16 years. Throughout this report the word 'child' is also used to refer to young people.

Child Protection Helpline

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

Children's Court

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

ChildStory

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

Child Wellbeing Unit (CWU)

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

Culturally and linguistically diverse

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

DCJ Community Services Centre (CSC)

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

Domestic and family violence

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

Engagement

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

LGBTQIA+

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

Manager casework

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

Mandatory reporter

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

Mental health concerns

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

Neglect

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

Non-binary

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

Out of home care

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

Parental responsibility

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

Parental responsibility to the Minister

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

Permanency Support Program (PSP)

The Permanency Support Program (PSP) provides services to vulnerable children so they can grow up in stable, secure and loving homes. A PSP service provider is contracted by the Department to arrange and supervise out of home care placements and/or exercise case responsibility for achieving children's case plan goals of preservation, restoration, guardianship, open adoption and long-term care. For definitions relevant to the PSP, see the PSP Permanency Case Management Policy (PCMP).[43]

Physical abuse or ill-treatment

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

Practitioner

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

Prenatal report

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

Removal

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

Report

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

Reporter

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

Restoration

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

Risk of significant harm

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

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

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

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

unwilling to arrange for the child or young person to receive an education in accordance with that Act

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

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

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

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

Risk-taking behaviour

Risk-taking behaviours can include:

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

Sexual abuse or ill-treatment

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

Triage and assessment practice guidelines

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

Young person

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

Youth Justice

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

Notes

1 From 1 October 2024, under NSW Machinery of Government changes, Corrective Services NSW left the Community and Justice portfolio and became a standalone public service agency, reporting directly to the Minister for Corrections.
2 John Williams Memorial Charitable Trust, Office of Sport, and Venues NSW.
3 M Davis, *Family is Culture: Independent review of Aboriginal children in out of home care in NSW.* NSW Department of Communities and Justice, 2019, accessed 21 November 2024. https://dcj.nsw.gov.au/children-and-families/family-is-culture.html
4 NSW Ombudsman, *Biennial report of the deaths of children in NSW: 2020 and 2021 – Incorporating reviewable deaths of children*, NSW Ombudsman, 2023.
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Appendices

Appendix 1: Counselling and support services

Table A1: Counselling and support services

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

Service	Description	Contact
NALAG Centre for Grief and Loss	Free face-to-face and telephone loss and grief support	Call 02 6882 9222 or visit https://www.nalag.org.au/
National Centre for Childhood Grief	Free counselling for bereaved children; counselling for bereaved adults, parents and carers (fee involved)	Call 1300 654 556 or visit https://childhoodgrief.org.au/
Suicide Call Back Service	Free 24/7 phone, video and online counselling for anyone affected by suicide	Call 1300 659 467
The Compassionate Friends NSW	An organisation offering friendship and understanding to bereaved parents, siblings and grandparents after the death of a child	Call 1800 671 621 or visit http://www.tcfnsw.org.au/
The Gender Centre	Provides a broad range of specialised services that enable the exploration of gender identity and help with gender dysphoria	Call 02 9519 7599 or visit https://gendercentre.org.au/
Twenty10	Provides a broad range of free, accessible mental health and psychosocial support programs for LGBTQIA+ young people in NSW	Call 02 8594 9555 or visit https://twenty10.org.au/about-us/
13 YARN	24/7 Aboriginal and Torres Strait Islander crisis support line	Call 13 92 76 (13 YARN)

Appendix 2: Tabular representation of graphs

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

Year	Number of children who died in NSW	Number of children who died and were known to DCJ
2014	506	79
2015	505	79
2016	465	94
2017	528	91
2018	472	93
2019	517	97
2020	471	101*
2021	480	100
2022	463	111
2023	409	96

The data in Table A2 is also shown graphically in Figure 2.

*This number has been updated since prior child deaths annual reports, based on newly reported information.

Table A3: Children who died in 2023 and were known to DCJ, by age and gender

Age group	Male	Female	Non-binary
Under 1 year	18	18	0
1–4 years	9	8	0
5–12 years	12	4	0
13–15 years	8	4	0
16–17 years	11	3	1
Total	**58**	**37**	**1**

The data in Table A3 is also shown graphically in Figure 4.

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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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