

**Embargoed until 1:45pm, 24 August 2011**

## **Report into reviewable child deaths 2008-2009**

Today the NSW Ombudsman, Bruce Barbour, tabled his report on reviewable child deaths in 2008 and 2009. This is the sixth such report by the Ombudsman, and the first since legislative amendments changed the scope of his responsibilities for reviewing the deaths of children.

The report considers the deaths of children that occurred as a result of abuse or neglect, or in circumstances suspicious of abuse or neglect, and the deaths of children who were living in care.

The report covers the two year period from January 2008 to December 2009. In this period, 1181 children died in NSW, and the deaths of 77 (6.5 per cent) of these children were reviewable.

- 20 children died as a result of abuse
- 23 children died as a result of neglect
- 14 children died in circumstances suspicious of abuse (6) or neglect (8)
- 20 children died while in care

The majority of these children were very young; over half (46) were less than five years old.

Aboriginal children were over-represented in reviewable deaths, and comprised a quarter (26 per cent) of reviewable deaths.

The Ombudsman said **'it is sobering to observe that most of the children who died in abuse-related circumstances died within the family, as a result of the actions of a parent, relative or carer.'**

Mr Barbour said **'Equally concerning is that most children who died in neglect-related circumstances were very young; aged two years or less. Children drowned because they were unsupervised and had ready access to pools, and a number of babies died while sleeping with drug or alcohol affected parents.'**

While the Ombudsman no longer has responsibility for reviewing the deaths of children on the basis that they had been the subject of a report of risk of harm to Community Services, just over half (30) of the 57 children whose deaths occurred as a result of abuse or neglect, or in suspicious circumstances, had been the subject of such a report within the three years prior to their death.

The Ombudsman said **'it is important to note that this report covers a two year period that pre-dates the recent significant reforms to the child protection system. For that reason we have not drawn conclusions about the operation of the new system, or made recommendations that relate to outdated practices.'**

## Information from the report

### **Abuse**

Most of the 26 children who died due to abuse, or suspected abuse were killed in family homicides (20).

### **Neglect**

Of the 31 children who died due to neglect, or suspected neglect, drowning and sudden unexpected deaths in infancy accounted for the largest number of deaths.

### **Drowning**

The deaths of 14 children due to drowning were reviewable; most of these (12) occurred in private swimming pools.

Consistent with previous years, our reviews identified inadequate supervision and child resistant safety barriers as the most significant issues.

### **Sudden Unexpected Death in Infancy (SUDI)**

The deaths of 10 infants due to SUDI were reviewable; most of these (8) occurred in sleep incidents.

Consistent with previous years, our reviews identified that parents co-sleeping with infants while substance affected was a significant issue. Our reviews also identified social and environmental challenges for many of the families (six of the parents were very young and four were either homeless or in marginal housing).

### **Transport incidents**

The deaths of five children in transport incidents were reviewable; in most cases (4) the child was a passenger.

Consistent with previous years our reviews identified that speed and dangerous behaviour were significant risk factors.

### **House fires**

The deaths of two children in house fires were reviewable.

Consistent with previous years, our reviews identified inadequate supervision, and easy access to lighters or matches as significant issues.

### **Children in care**

Most of the 20 children who died while in care died due to natural causes (17). Of these, 15 had high or complex needs in relation to disability or chronic health issues.

Ten of the children were in care subject to final orders of the Children's Court, three were subject to interim orders and seven children were in voluntary care.