NSW Ombudsman

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Embargoed until 12pm, Thursday, 9th December 2004

Release of NSW Ombudsman's Reviewable Deaths Annual Report

The NSW Ombudsman, Bruce Barbour, tabled his first *Reviewable Deaths Annual Report* in Parliament today. The report examines the deaths between December 2002 and December 2003 of:

- 161 children and young people where the majority died in circumstances related to abuse or neglect, or in suspicious circumstances, or had prior contact with the child protection system before their death; and
- 110 people with a disability living in residential care, or in licensed boarding houses.

Mr Barbour also tabled a separate report *Improving outcomes for children at risk of harm-a case study*, a report arising from an investigation into the Department of Community Services (DoCS) and NSW Police following the death of a child.

Mr Barbour said: "t**he care and protection of highly vulnerable children and adults is one of the most important responsibilities of government and the community.**"

"**Our annual report makes 28 recommendations targeted to the Department of Ageing, Disability and Home Care; NSW Health and DoCS. The recommendations focus on reducing risk factors that may lead to untimely death and improving the quality of assistance provided to children in need of care and protection and people with disabilities in care.**"

Reviewable deaths of children

The report examines the deaths of 161 children, 137 in detail. Of these 137 children –

- 83 (61%) died in circumstances related to abuse, neglect or in suspicious circumstances;
- 103 (75%) were of children where there had been a risk of harm report to DoCS for the child and/or a sibling within three years preceding their death; and
- 24 (17%) were Aboriginal children.

Mr Barbour said: "**the care and protection of children is the responsibility of the whole community – starting with parents and families. The community has invested in a child**

protection system to provide a safety net for children who are otherwise let down by their parents, families or carers. DoCS is the lead agency in child protection and our report focuses on their work."

"**In every death we reviewed there were a range of contributing factors. Often there were things that could have been done better but there is no guarantee that the deaths would not have happened. Having said that, our report highlights serious concerns about the capacity of the child protection system in NSW. Many of the deceased children reported to DoCS did not have the benefit of a thorough assessment of the risks they were facing.**"

"**It also concerns me**" said Mr Barbour, "**that Aboriginal children were significantly over-represented in the deaths we reviewed, and that issues of neglect, parental misuse of drugs and alcohol, and domestic violence in the Aboriginal community are not being adequately addressed.**"

"**I acknowledge that DoCS is implementing a significant reform program and funds are being rolled out to boost their capacity to respond to children at risk. However, it is unacceptable that until further resources become available, many children referred to DoCS will remain unsafe and unprotected.**"

Deaths of people with a disability in care

The report examines the deaths of 110 people with a disability in care. Of these people –

- most lived in large residential centres or in group homes;
- 76% had an intellectual disability;
- the primary cause of death for the largest group was respiratory illness; and
- seven people died from external causes, such as drowning, a fall or choking.

In commenting on the deaths, Mr Barbour said: "**overall, we found a system in which people's health care is not always well coordinated. For instance, in some cases people did not access the health professionals they needed in a timely way, in others the recommendations of health professionals took a long time to be acted on.**"

"**The people who died represent a highly vulnerable group in our community, and we need to learn from their deaths. Preventing or reducing premature deaths in disability accommodation services demands a robust approach to managing risk and minimising factors that compromise health. It also requires services to be delivered in a way that promotes the overall wellbeing of individuals and assists them to achieve their maximum potential as members of the community in which they live.**"

*Please refer to the brief document '**Reviewable deaths annual report 2003 – 2004: An overview** for ease of access to summary information*