NSW Ombudsman

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Report of Reviewable Deaths in 2007
Volume 2: Child Deaths

Media Release Part 2:

Today the Ombudsman Bruce Barbour tabled the second volume of his report on reviewable deaths in 2007.

The Ombudsman reviews the deaths of children if they or their sibling have been the subject of a risk of harm report in the three years before they die, or if they die in suspicious circumstances or as a result of abuse or neglect.

Special review of the deaths of children with no child protection history

Every year, approximately eight percent of the families of children whose deaths are reviewable have either no recent child protection history, or no history at all. These deaths are reviewable because they are suspicious, or a result of abuse or neglect.

Between 2003 and 2007, 180 children died in NSW as a result of abuse or neglect or in suspicious circumstances. Of these, 55 had no child protection history. We looked at 47 of these deaths, comparing them with the circumstances surrounding the deaths of 76 children from families with a child protection history to try and establish any relevant factors and trends.

We collected and analysed police records, health records, education records, coronial reports and transcripts, court records and information provided by non-government organisations. We also collected as much information as possible from GPs and other private practitioners who came into contact with the children and their families.

This was only a small sample, and we are careful not to draw any strong conclusions. However, what we have found will assist us with our future work and provide better information to relevant agencies and the communities

The following are some of the types of deaths we assessed. Many of the observations we make are consistent with research conducted by others in these areas.

Media contact: Lisa Du, Public Relations Officer, ph: 9286 1008 or 0417 233 320

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Fatal abuse

Between 2003 and 2007, 18 children with no child protection history were killed by a member of their family. In the cases we reviewed, there was evidence of mental illness or mental health problems among perpetrators, as well as family breakdown and use of firearms in murder suicides. These factors were also present in relation to the matters we reviewed where the family had a child protection history.

"While we were able to identify some common factors, it is difficult to point to any particular family type or circumstance or combination of factors where risk is likely to escalate to fatal abuse" said the Ombudsman.

Drowning

Between 2003 and 2007, 90 children drowned in NSW. 38 resulted from neglect, and of these 16 had no child protection history. We considered neglect to be an intentional or significantly careless failure to supervise.

The review found a lack of adult supervision or confusion around responsibility for supervision of children and inadequate safety barriers around pools were common contributing factors.

"Parents need to remain vigilant when their children are around water" the Ombudsman said. **"The Department of Local Government is reviewing the issue of pool fencing at the moment, it is hoped that a better inspection program for swimming pool barriers can be implemented."**

Transport fatalities

Between 2003 and 2007, seven children whose families had no child protection history died in road accidents that we considered constituted neglect.

All of the cases involved a high level of carelessness by the driver, often caused by excessive speed and/or drug and alcohol use or a failure to adequately restrain the child within the vehicle.

Co-sleeping

Between 2003 and 2007, six children whose families had no child protection history died while sleeping in the same bed as a parent or parents. We also considered the deaths of 21 children whose families had a child protection history.

In many of these cases, the parents were under the influence of drug and/or alcohol or had a history of drug or alcohol abuse.

"These cases clearly show the importance of effective pre and postnatal care" the Ombudsman said. **"Parents, particularly younger parents, must be made aware of the risks of co-sleeping, especially when they are under the influence of either drugs or alcohol."**

Both NSW Health and DoCS have developed public awareness materials, and we will continue to monitor both responses to parental substance abuse and pre and post natal support services.

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