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Report of Reviewable Deaths in 2006
Volume 2: Child Deaths

This morning I tabled volume 2 of my report on reviewable deaths.

I am required to review the deaths of children if they or a sibling have been the subject of a risk of harm report to the Department of Community Service (DoCS) at some time in the three years before they die, or if they die in suspicious circumstances or as a result of abuse or neglect.

In 2006, 622 children and young people died in NSW. Of these deaths, 123 (or 20%) were reviewable, and are the subject of this report.

114 of the children were either directly or indirectly known to DoCS. Many also had contact with other agencies, including the NSW Police Force and NSW Health.

Children who died in 2006

In regard to the children who died in 2006:

- the majority were very young - 73 of the 123 children were less than 12 months of age when they died, including 35 babies who were under four weeks old (26 babies were never discharged from hospital)
- Aboriginal children were again over-represented (20% of the child deaths we reviewed were Aboriginal children)
- as in previous years, many of our reviews found evidence of parental substance abuse, parental mental health problems, domestic violence and neglect - these factors often co-exist and present significant risks to children.

Importantly in most cases, the circumstances of the child’s death had no connection to the reported child protection concerns.

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Issues arising from reviews

Over the past five years, there has been important work undertaken by agencies to improve their response to children at risk. For example, DoCS has recruited more caseworkers, improved training and resources, and introduced an Early Intervention program – designed to assist vulnerable families.

However, notwithstanding this work, the child protection system in New South Wales is not as effective as it could or should be.

Capacity

I continue to hold concerns about the capacity of DoCS to respond effectively to risk of harm reports, particularly given the massive increase in reports in recent years. We observed again this year that too many reports raising serious issues about risks to children are closed on the grounds of "current competing priorities" without any adequate assessment or action.

The significant reform package that commenced in 2003 was based on 2001-02 levels of demand. However, the number of children reported to DoCS has increased by over 45% since then. The continuing trend of substantial increases in reports each year requires careful and regular examination of the capacity of DoCS to respond appropriately.

In assessing capacity, our reviews suggest we must look closely at what is being reported. The benchmark for reporting needs to be set at the right level so that the system does not get overloaded with unwarranted notifications. Coupled with this we need to ensure that reports contain the best information possible so that the most serious risks are clearly identified and acted upon.

Quality of decision-making

My report also highlights ongoing concerns about the quality of DoCS' risk assessment. While we saw examples of good practice, we also continue to see a range of problems including:

- staff not giving adequate consideration to a child's previous child protection history when making decisions about how to respond to a further report of that child being at risk, and
- inadequate information being gathered to inform an assessment of risk to a child, leading to decisions about how to protect the child being made without full knowledge of all relevant circumstances

For some time I have stressed the need for DoCS to better understand and measure how it responds to reports and makes decisions. I am pleased that DoCS is about to commence a quality assurance program to measure this across all its community service centres. We will closely monitor the results of this initiative.

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NSW Ombudsman

Using information as intelligence

Our review work over the past five years has continually identified cases where multiple reports are made about the same family. A large proportion of child protection reports relate to a relatively small percentage of families. Recent analysis undertaken by DoCS confirms this. Better and more strategic use of such information provides an opportunity for DoCS and other agencies to develop much more targeted responses to high risk families. This increases the likelihood of the most serious and urgent matters receiving the right response.

The Wood Inquiry

In the context of these ongoing issues, I note the commencement of the Special Commission of Inquiry headed by The Honourable James Wood. I have had preliminary discussions with Mr Wood. My aim is to ensure that the Commission is fully appraised of the issues my office has dealt with and I have offered him my full cooperation.

Finally, as Ombudsman, my statutory responsibility is to review child deaths, for the purpose of highlighting systemic problems and to make recommendations for improvement. The focus of my work, and this report, is therefore on weaknesses in practices and systems. However, in our work we nonetheless see many examples of good casework, well protected children and quality decision-making. The challenge is to identify ways to achieve these positive outcomes more consistently across the child protection system for all children.

Bruce Barbour
NSW Ombudsman

Mr Barbour will be holding a press conference at 10:30am at the Press Gallery, Parliament House.

NSW Ombudsman

Facts and Figures

Reviewable deaths

The NSW Ombudsman reviewed the deaths of 123 children who died in 2006. This represents 20% of all child deaths in NSW (622 children). The death of a child is reviewable if:

- a risk of harm report was made to the Department of Community Services about the child, or their sibling, in the three years before the child died (referred to in the report as the child being "known to DoCS")
- the child's death was, or may have been, due to abuse or neglect or occurred in suspicious circumstances (definitions of abuse, neglect and suspicious can be found on page 75 of the report)
- the child was in care when they died
- the child died in a detention centre or correctional centre

Why deaths were reviewable

Among the 123 deaths reviewed, there were 114 children (93%) whose families were known to DoCS:

- 81 children who died had been the subject of one or more risk of harm report(s)
- in an additional 33 cases, while the child had not been the subject of a risk of harm report(s), their sibling had

40 children died as a result of abuse or neglect, or in suspicious circumstances. In 31 of these cases, the child and/or their sibling were known to DoCS. Of the 40 deaths:

- 12 children died as a result of abuse
- 9 children died as a result of neglect
- 19 children died in suspicious circumstances

About the children who died

Most of the 123 children were very young when they died:

- 90 children (73%) were under the age of four
- 73 children (59%) were less than twelve months old
- 35 children (28%) were less than four weeks old - 26 of these children were never discharged from hospital after birth

Aboriginal children were over-represented in reviewable deaths (20% of reviewable child deaths)

- 58 children who died in NSW were Aboriginal, 25 of these deaths were reviewable, representing 43% of all Aboriginal child deaths
- 7 of these children died as a result of neglect or suspicious circumstances
- none of the reviewable Aboriginal child deaths were a result of abuse

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