NSW Ombudsman

NSW Ombudsman's 2003-2004 Reviewable Deaths Annual Report

Ombudsman's press statement

I have this morning tabled our first annual report on our reviews of the deaths of certain children and of people with disabilities in care. I have also tabled a separate report with more specific details of a particular case where a child died.

The annual report reviews in detail the deaths of 137 children and 110 people with disabilities, between December 2002 and December 2003.

What all these deaths had in common was that they were of vulnerable people in need of support and/or protection. People for whom the government had accepted at least some responsibility.

By reviewing the circumstances in which people died we are able to identify any trends or patterns. We can also determine whether existing services, relevant policies and practices provide appropriate levels of care, support and protection.

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.

The child deaths we have focused on are those where children died in circumstances related to abuse or neglect, or in suspicious circumstances. The details of many of these deaths are very disturbing.

Recently the Commissioner of Police spoke about the need for respect for women in the community and that violence against women is

unacceptable in our society. I agree with the Commissioner's observations and in the context of releasing this report about deaths, I would suggest that there is also much work we need to do to ensure that our children are safe and secure.

It is simply unacceptable that children continue to die of abuse and neglect. And until such time as we accept our responsibility, as a community to properly care for and protect our children, the tragic circumstances documented in this report will continue.

The data we have collected indicates high levels of domestic violence, direct physical abuse and neglect in the backgrounds of many of the children who died.

The responsibility for the safety, welfare and wellbeing of children will always rest primarily with parents and families. But government, most particularly through the Department of Community Services, provides an important safety net for those children whose families fail them. In the majority of cases where a child's death was reviewed, the child or their siblings had been reported to DoCS at some point in the three years preceding the deaths.

But DoCS only steps in when families have failed. Children are reported to DoCS when someone recognises that they may be at risk of harm. It is then DoCS' role to provide effective protection for children who are at risk. This report provides examples where, in our view, DoCS has not responded to particular circumstances as well as it should have.

Problems we have identified include:

- the failure to accurately assess risk to a child
- the failure to properly identify or consider a family's child protection history
- where risk to a child has been accurately identified, but the case is closed because that risk was determined as less urgent than other cases.

I do not accept that all of the problems we have identified can be attributed to a lack of resources. Some cases indicate poor decision

making and poor intervention. We have also identified cases where DoCS could have made more effective use of other agencies but did not do so.

And, while we understand with limited resources comes the need to prioritise work, we have recommended that DoCS establish a threshold of risk above which reports about children cannot be closed - without some form of protective intervention.

We are monitoring the work being done by DoCS to improve its systems, including the introduction of an early intervention program focused on reducing the entry or escalation of children into the child protection system. The analysis we have provided in this report, and our recommendations, are designed to assist in this process.

Equally important is the proper care and support of people with disabilities who live in residential care. Many of these people have complex health needs and require considerable support to ensure they are not only well, but have opportunities to lead fulfilling lives.

Our reviews of the circumstances of the deaths of 110 people with disabilities clearly indicate the need for:

- improved coordination of health care
- ensuring that vital appointments for specialist assessments are made and kept
- regular assessment of risk to individuals so that informed decisions can be made about the appropriate level of supervision
- much better documentation of health records.

We have made recommendations, initially directed to DADHC and NSW Health, aimed at reducing or limiting, wherever possible, circumstances that might lead to unnecessary deaths.

There are in all 28 recommendations in the report. We will monitor how agencies respond to these recommendations, and what action they take as a consequence.