FATAL ASSAULT AND NEGLECT OF CHILDREN & YOUNG PEOPLE

NSW CHILD DEATH REVIEW TEAM 2003

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CONVENOR'S FOREWORD

For the past six years the Child Death Review Team has been responsible for undertaking detailed reviews of the deaths of children due to, or suspicious of abuse or neglect. This responsibility transferred to the Office of the NSW Ombudsman on 1 January 2003.

This report presents the findings of the detailed reviews of the deaths of 75 children aged 0 to 17 years registered in the three year period 1 July 1999 to 30 June June 2002 in New South Wales. These 75 deaths represent the vast majority of deaths due to, or suspicious of abuse or neglect in the three year period. This has allowed the Team to describe the population of children and young people who die in these circumstances and to draw conclusions regarding patterns and trends in these deaths.

This study, together with the *Fatal Assault of Children and Young People (2002) Report*, constitutes a major body of work on the deaths of children and young people due to, or suspicious of abuse or neglect and significantly advances our understanding in this area.

The death of each child is tragic and distressing.

On behalf of the Child Death Review Team I extend my sympathy to the families and friends of all these children and to those professionals who provided care for and knew some of these children.

I would like to thank my colleagues on the Child Death Review Team for the knowledge and expertise they brought to the Team's deliberations and the Commission for Children and Young People's research staff, whose commitment and expertise made this report possible within tight deadlines.

The Team hopes that the information contained in this report will assist in reducing the number of preventable child deaths in New South Wales and will increase the commitment by all levels of society to promote the safety, welfare and well-being of children in this state.

Gillian Calvert
Convenor, Child Death Review Team
Commissioner for Children and Young People

CONTENTS

LIST OF TABLES

LIST OF FIGURES

2002-2003 CHILD DEATH REVIEW TEAM MEMBERS

Gillian Calvert (June 1999 onwards)
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Gillian Calvert is the New South Wales Commissioner for Children and Young People.

Dr Judy Cashmore (April 1996 onwards)
Deputy Convenor

Judy Cashmore is an Associate Professor, Faculty of Law, University of Sydney and an Honorary Research Associate at the Social Policy Research Centre, University of New South Wales. She was Deputy Chair of the review of the *Children (Care and Protection) Act 1987*, and is a member of the Ministerial Advisory Council to the Minister of Community Services and chairs the Association of Child Welfare Agencies Board.

Sandi Bredemeyer (February 2003 onwards)

Sandie Bredemeyer is the Clinical Nurse Consultant Perinatal Nursing at Royal Prince Alfred Hospital. She has been a nurse for 31 years with experience in midwifery, paediatric and neonatal specialities. Sandie has more than 13 years experience working with families utilising the Drugs in Pregnancy Service at Royal Prince Alfred Hospital.

Dr Ian Cameron (December 1999 onwards)

Ian Cameron is a General Practitioner, currently Chief Executive Officer of the NSW Rural Doctors Network, based in Newcastle. The Rural Doctors Network works with rural communities in NSW to meet their health needs through having a continuing rural medical workforce, to prioritise health needs and develop strategies to meet them in a sustainable way. Ian comes from Bourke in western NSW, where he spent eight years as a general practitioner.

Dr Michael Fairley (December 1998 onwards)

Michael Fairley is a Consultant Psychiatrist and Head of the Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital. His particular interests include psychiatric disorders in intellectual disability, the effect of chronic illness, emotional trauma following disasters and the provision of specialist clinical services to rural areas.

Dr John Feneley (December 2002 onwards)
NSW Attorney General's Department representative

John Feneley is the Assistant Director General (Policy and Crime Prevention) with the NSW Attorney General's Department. His current responsibilities cover a full range of justice, policy and legislative issues and also the Department's crime prevention program, including the Violence Against Women Specialist Unit. John is a lawyer and prior to his appointment with the Attorney General's Department he was working at the NSW Independent Commission Against Corruption.

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Jonathan Gillis is a Senior Staff Specialist in the Intensive Care Unit and the Chairman, Division of Critical Care, at the Children's Hospital at Westmead.

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Anne Maree Gleeson is the Area Director at the Hunter region of the Department of Community Services. She has extensive experience in child and family services in NSW both at a field level working with clients as well as working in a broad range of supervisory and executive positions. She has postgraduate qualifications in social studies focusing on advanced practice.

Pam Greer (May 1999 onwards)

Pam Greer has been a community worker, trainer and consultant since 1988, working in the Northern Territory, Queensland, and New South Wales. She has worked with several government departments including the Departments of Community Services, Police, Health and the Family Court on various projects for the Aboriginal community. Pam has been involved in child protection and domestic violence issues since 1989. She is a member of the Indigenous Women's Committee through the Women's Legal Centre.

Dr Ferry Grunseit (April 1996 onwards)

Ferry Grunseit is a Consultant Paediatrician. He was the chair of the NSW Child Protection Council for four years and was the NSW Child Advocate until 1996. At the Camperdown Children's Hospital, Ferry was the Director of Casualty and Outpatients, and Head of the Child Protection Unit (1979-1987).

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John Heslop is Manager, Investigation Support within NSW Police. He has been a Police Officer for 35 years with involvement in child protection policy and operational policing in child protection investigation since 1987. John is the National President of the National Association for the Prevention of Child Abuse and Neglect.

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Judith Irwin is Head of the School of Social Work and Policy Studies, in the Faculty of Education and Social Work at the University of Sydney. She has researched and written extensively on violence against women and children. Her most recent research undertaken collaboratively with Barnardos, Australia is on domestic violence and child protection.

Dr Dianne Little (March 2003 onwards)

Dianne Little is a forensic pathologist in the Department of Forensic Medicine at the Institute of Clinical Pathology and Medical Research in Westmead, where she has worked since 1989. She has a particular interest in paediatric forensic pathology.

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Helen Kerr-Roubicek is the Manager of Student Wellbeing in the NSW Department of Education and Training. She has a background in teaching, school counselling and student welfare and has specific responsibilities in the areas of student participation, student health, protecting and supporting children and young people and student welfare within the Department of Education and Training.

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Andrew McDonald has been a Staff Specialist Paediatrician with Macarthur Health Service since 1990. He trained at the Royal Alexandra Hospital for Children in Camperdown and in England. His main interests are in emergency paediatrics, community development and medical education.

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Elisabeth Murphy is the Child Health Clinical Advisor for the Primary Health and Community Care Branch of the Policy Division, NSW Health. Prior to this role she was the Manager of the Maternal and Child Health Unit, NSW Health.

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Alice Silva is a Mobile Aboriginal Casework Specialist for the Supported Accommodation Assistance Program and Families First Community Program Officer Orana Far West Region.

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Toni Single is Senior Clinical Psychologist at the Child Protection Unit of the John Hunter Children's Hospital in Newcastle with special interests in forensic assessment of child protection and custody matters and infant mental health.

NSW Commission for Children and Young People

The Child Death Review Team is supported by the staff of the Commission for Children and Young People. The analysis in this report was prepared by Dr Melissa Sankey and Sharon Bourke, in consultation with the Team. Claire Golledge provided administrative support and Jonathan Wood retrieved reference materials. Aboriginal cases were reviewed, as required under the Legislation, by an Aboriginal Team member, Pam Greer. Dr Ferry Grunseit was responsible for the ICD-10 coding of all deaths in this year's register.

The Team would like to acknowledge the contributions made by the following: the child protection consultants – Bronwyn Cintio; Elenora DeMichele; Susan Emmett; Dr Bronwyn Gould; and Caroline Quinn who assisted the Team in conducting the case reviews of the assault and neglect deaths; and the agencies who provided information – NSW Departments of Community Services, Health, Housing, Police, Education and Training, and Juvenile Justice; NSW Registry of Births, Deaths and Marriages; and the Office of the State Coroner.

EXECUTIVE SUMMARY

Research Purpose

The aim of this research project was to study the group of deaths of children and young people identified by the NSW Child Death Review Team as due to assault or neglect or suspicious of assault or neglect over a three year period (1 July 1999 to 30 June 2002).

The study consisted of a case file review of records from government departments, including the NSW Departments of Community Services, Health, Housing, Police, Education and Training, and Juvenile Justice; NSW Registry of Births, Deaths and Marriages; and the Office of the State Coroner.

Overview of assault and neglect deaths

Over the three year study period, 75 children and young people aged 0-17 years died as a result of assault or neglect or in circumstances suspicious of assault or neglect. Over this same period 2,175 children and young people aged 0-17 years died from all causes in NSW. Thus, 3.4 per cent of child deaths were a result of fatal assault or neglect or suspicious of assault or neglect.

Forty children died as a result of assault, 31 as a result of neglect and four in circumstances suspicious of assault or neglect. The following factors were found to be common to both the assault and neglect deaths:

Gender

The majority (61.3%) of assault and neglect deaths were of males.

Indigenous children and young people

Aboriginal children and young people were over-represented in assault and neglect deaths compared with their numbers in the population (16.0% of the population of this study compared with 3.5% of the NSW population).

Geographical location

Children and young people living in highly accessible regions were under-represented in assault and neglect deaths (69.3% of the study population compared with 82.1% of the NSW population).

Carer circumstances

Eighty-five per cent of the carers in this study had at least one documented health and well-being - related, violence and crime-related, or social and economic problem. More than half of the carers (54.4%) had experienced three or more problems.

There were several factors for which the assault and neglect groups were shown to differ.

Age

Seventy-one per cent of the children who died as a result of neglect were aged between one and four years. In contrast, 27.5 per cent of the children and young people who were fatally assaulted were aged between one and four years. Thirty per cent of fatal assault victims were aged under one year, compared with 9.7 per cent of fatal neglect victims.

Living arrangements

Just over half (56.0%) of the children and young people were living in intact families at the time of their deaths. Children and young people who were fatally assaulted were far less likely to be living in intact families than those who died as a result of neglect (45.0% of assault deaths compared with 67.7% of neglect deaths).

Method of death

Blunt force battery was the most common method of fatal assault for males and suffocation/strangulation was the most common method of fatal assault for females. In contrast, drowning or submersion was the most frequent method of death by fatal neglect for both males and females.

Criminal and coronial proceedings

The Coroner dispensed with an inquest in 67.7 per cent of fatal neglect cases (21 out of 31 cases). In contrast, just two fatal assault matters were dispensed with. Suspects were charged in 65.0 per cent of fatal assault cases, compared with 19.4 per cent of fatal neglect cases.

Clusters of assault and neglect deaths

The children and young people who were fatally assaulted, and those who were fatally neglected, could be classified into distinct groups based on an analysis of the precipitating incidents to their deaths. The four children who died in circumstances suspicious of assault or neglect were not classified.

Fatal assault

1) Non-accidental injury

Half (20; 50.0%) of the children who were fatally assaulted died from non-accidental injury. Seven were females and 13 were males. The injuries sustained resulted from either a series of assaults or one fatal assault. Eighteen of the 20 children were infants and toddlers (aged 0-4 years). Suspects were the children's family members in all but two of the deaths.

2) Parents affected by a mental illness

The deaths of six (15.0%) children were precipitated by a parent's or carer's mental illness. All six children were female. The child's biological mother was the perpetrator in four cases and the mother's de facto was the perpetrator in two cases. All six perpetrators had been diagnosed with mental health problems, including psychotic disorders (3), depressive disorder (2), and postnatal depression (1). The children were either killed in the context of depressive symptoms and psychosocial stress or due to the perpetrator's delusional beliefs that involved the child.

3) Family breakdown

Five (12.5%) children and young people in two families died in the context of parental dispute and family breakdown. Four were male and one was female. Both perpetrators were the children's biological fathers. The killings occurred in the context of separation or the threat of separation, with the fathers' inability to accept the end of the relationship.

4) Killings of teenagers

Eight (20.0%) young people aged between 13 and 17 years were killed by persons who were not family members or carers. Seven were male and one was female. Three of the fatal assaults of males involved group killings; two of those incidents involved altercations with rival gangs. Sixteen suspects were identified in the eight deaths, all of whom were male. Suspects were unknown to four of the eight victims.

Fatal neglect

1) Inadequate supervision

This group comprised 26 (83.9%) of the 31 neglect deaths. These children died in drowning accidents (17), motor transport accidents (5), house fires (2), accidental hangings (1), and firearm accidents (1). All but one of these children was being cared for by a biological parent, other relative, or another adult at the time of the fatal incident. In one case, there were no adults present at the time of the fatality. In all cases, carers made incorrect assessments of the child's supervision needs such as seriously underestimating the level of supervision required, some because of their intoxication by drugs and alcohol.

2) Negligent driving

Four (12.9%) children in three families died in incidents precipitated by a parent's negligent driving. The children were aged between three and six years and all were female. Three died in two motor transport accidents where the parent driver was affected by alcohol or other drugs at the time of the fatal incident.

3) Failure to provide medical care

One 14 month old female died as a result of starvation.

Agency contact

In this study, 80.0 per cent of families had prior agency contact. The agencies most commonly involved with the families were NSW Police (58.7%), the Department of Community Services (58.7%) and NSW Health (56.0%)[1]. The families with children and young people who died as a result of assault had more agency involvement than those families with children who died due to neglect. Over half (57.5%) of the families of the children and young people who were fatally assaulted had been involved with three or more agencies, compared with 32.3 per cent of the families of the children who were fatally neglected.

Prevention of assault and neglect deaths

The findings from this study suggest two avenues for the prevention of further child deaths due to assault and neglect: the children and their families and agency practice.

Children and their families

This study found that several characteristics were common to the children who died as a result of assault and neglect and to their families:

- age of victims;
- over-representation of Indigenous families;

1 Children, young people and their families attend health services for a range of reasons and contact with NSW Health is expected to occur over a person's life. These contacts present opportunities for health professionals to identify children and young people who may be at risk and to take appropriate action.

- family violence and criminal behaviour;
- family stress factors; and
- inadequate supervision of young children.

The findings from this study have particular implications for the prevention of one type of neglect death – those that result from inadequate supervision. In this study, 26 children died due to lack of carer availability that stemmed from a carer's incorrect assessment of the supervision needs of the child such as misjudging the level of supervision required, some because of their intoxication by drugs and alcohol. Not all these families require statutory intervention. Rather, they need to know that incorrect assessments about the supervision needs of young children such as seriously underestimating their supervision needs can be fatal and to act upon this information.

Agency practice

Not all of the children and young people who were fatally assaulted or neglected had prior agency involvement. In fact, the findings from this research suggest that there are some groups for whom child protection involvement may not be required. These are the inadequate supervision deaths that did not arise from parental intoxication by drugs and alcohol and the teenage fatal assaults.

For those children and young people who had prior agency involvement, ongoing issues were evident that required planned child protection services if families were to be assisted. Where practitioners came across abuse or neglect or risk of this, or were providing services in the child protection context, several inadequacies in agency practice were detected. The three most common errors made by agencies and practitioners were:

- not recognising and reporting serious and unstable situations;
- inadequate risk assessment; and
- poor interagency collaboration and coordination.

Recommendations

1. That the NSW Government considers undertaking a comparative research study to identify differences between reported children and young people who are injured and reported children and young people who are fatally assaulted to inform interagency practice and response.
2. That the NSW Government considers undertaking a research study into the factors that promote and hinder adherence to interagency policy and practice.

CHAPTER 1
FATAL ASSAULT AND NEGLECT: AN INTRODUCTION

1.1 Introduction to the study

Child deaths resulting from assault and neglect are rare events. The majority of these deaths are caused by a family member; a highly challenging fact given that the family is typically seen as being a safe place for children (Wallace, 1986; CDRT, 2002). While deaths of children and young people from assault have been researched extensively in recent years, there are a paucity of studies that have examined neglect deaths of children and young people.

The overall purpose of the study was to examine the deaths of children and young people which occurred as a result of assault and neglect or which occurred in suspicious circumstances over a three year period from July 1999 to June 2002. This report continues the NSW Child Death Review Team's examination of fatal assault commenced in the *Fatal Assault of Children and Young People* (2002) report. That report reviewed the fatal assaults of 60 children and young people who died between January 1996 and July 1999. Taken together, these two reports constitute a major body of work on child deaths from assault and neglect. A summary of similarities and differences in the findings of these two studies is summarised in Appendix 1.

1.2 Defining fatal assault and neglect

In many studies the definition of fatal assault (or fatal abuse) is taken as given. De Silva and Oates (1993) classified fatal abuse as those deaths in which there was a definite statement that the child had been injured by an adult and that the injury led to death. Alternatively, Strang (1996) classified fatal abuse based on the character of the event:

> 'The assault upon the child was sudden and impulsive, the offender was the caregiver at the time of the incident and the offender appeared to be expressing his or her rage or frustration through the imposition of 'punishment' or 'discipline' upon the child (d'Orban, 1979) (Strang, 1996).

This definition is, however, very narrow as it excludes any form of premeditated assault, such as deliberate torture of a child, cases of Munchausen-Syndrome-by-Proxy or other cases of planned homicide.

The Child Death Review Team defines fatal assault of a child or young person as a death resulting from acts of violence perpetrated upon him or her by another person. It includes acts by which the perpetrator intended to kill the child and acts from which the child died, even though the perpetrator may not have intended the outcome (NSW CDRT, 2002).

The distinction between deaths due to neglect and those due to assault has been made according to whether or not the cause of death was an error of omission (neglect) or an act of commission (assault) (Erikson & Egeland, 1995; cited in Bonner, Crow & Logue, 1999). Neglect has received less attention than physical abuse from practitioners, researchers and the media, possibly because of the difficulty in identifying neglect (National Clearinghouse on Child Abuse and Neglect Information, 2001).

There is no standard definition of death due to neglect. Failure to reach an agreed upon definition of neglect has been attributed to several factors, including a lack of social consensus over what forms of parenting are dangerous and unacceptable, as well as confusion as to whether different definitions should be used for scientific, legal and clinical purposes (United States National Research Council, 1993). Zigler and Berman (1983; cited in Tomison, 1995) claimed that narrow definitions of neglect are required for legal intervention in order to protect the rights of the family, while broad definitions are required when the intention is to focus on 'at risk' families and to provide such families with suitable services.

Fatal neglect has been defined as death due to failure of a caregiver to provide a reasonable standard of care (Bonner et al., 1999). Rosenberg (1994) defined three primary parental responsibilities that if not fulfilled may result in fatal neglect. These include the responsibility of caregivers to provide for the needs of the child, to supervise the child adequately and to intervene appropriately to prevent harm.

Although child neglect is commonly thought of as a pattern of maltreatment sustained over a long period of time, producing a relatively low level of immediate risk, fatal child neglect is best viewed as a multidimensional phenomenon, representing a wide range of care-giving deficits (Margolin, 1990). It is therefore important to determine the most life-threatening types of neglect. Margolin (1990), for example, found neglect fatalities were associated with a single life threatening incident rather than more chronic forms of neglect such as malnutrition and starvation.

Researchers distinguish between 'supervision neglect' deaths and 'chronic neglect' deaths. Supervision neglect deaths involve inadequate supervision at critical moments – the parent or caretaker is absent or unavailable and the child is killed by a suddenly arising danger. These fatalities include drownings, fires, gun accidents and choking. In contrast, 'chronic neglect' deaths are caused by slowly encroaching problems. These fatalities may include malnutrition, starvation and dehydration (Zuravin, 1991; Colorado Child Fatality Review Committee, 1993; Ewigman, Kivlahan & Land, 1993 cited in US Department of Health and Human Services, 1995).

It is, however, difficult to define what constitutes 'inadequate supervision'. Rosenberg (1994) defined inadequate supervision as the failure of parents or carers to carry out their duties to their children; that is 'a failure to provide attendance, guidance and protection to children who, lacking experience and knowledge, cannot comprehend or anticipate dangerous situations' (p. 39).

It is difficult to define supervision in more specific terms. Parental or carer duty is not defined by law, rather it is determined by unwritten standards in the community. The distinction between 'neglect' and 'inadequate supervision', if any, is difficult to determine as it relies on an interpretation of 'reasonableness.' What constitutes 'reasonable' supervision largely depends on the collective views of the wider community (Rosenberg, 1994).

The NSW Child Death Review Team has developed its own definitions in response to the difficulties in defining assault and neglect. These definitions, presented on page 15 in the Methodology section of this report, were developed by the Team using its expertise and experience in screening deaths.

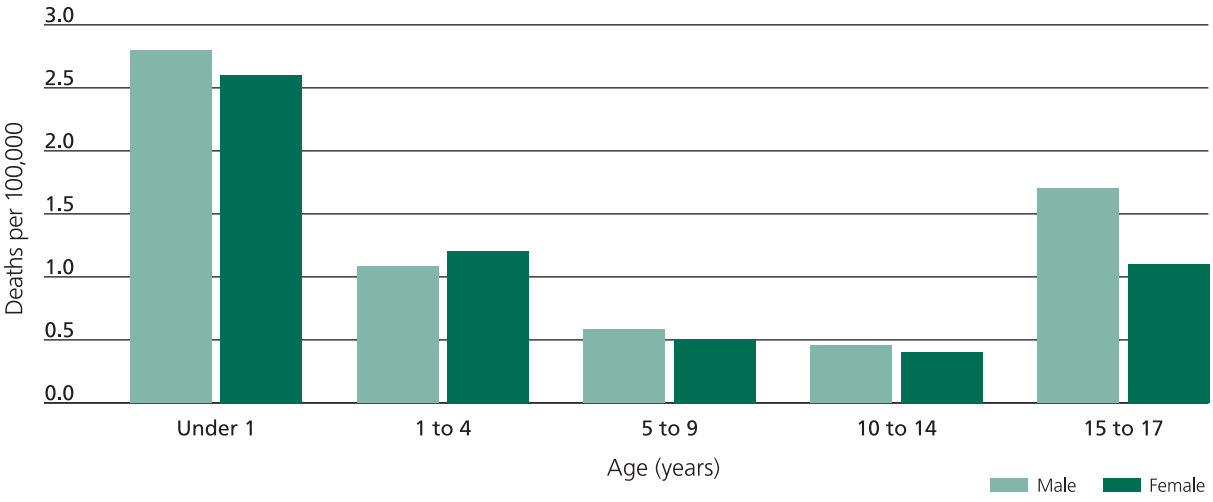
1.3 Fatal assault and neglect: The size of the problem

As recorded in official statistics, fatal assault in the general population is a rare event, occurring in Australia at a rate of 1.6 deaths per 100,000 population (ABS, 2001). Fatal assault rates vary across countries. Japan, for example, has particularly low rates (1.1 per 100,000 in 1998), while the United States has higher rates (6.3 per 100,000 in 1998; Mouzos, 2000).

Fatal assault of children and young people, as recorded in police data, is also a rare occurrence, with only 8.6 per cent of fatal assaults in Australia involving children 0-14 years of age. In NSW, just two per cent of deaths of children and young people aged 0-17 years were attributed to fatal assault between January 1996 and July 1999 (CDRT, 2002).

Since 1989, the Australian Institute of Criminology has been examining all homicides (fatal assaults) reported to the police, in order to examine patterns and trends in Australian homicide. (Strang, 1996). The incident rates for each group from birth to 17 years of age are shown in Figure 1.1 (Strang, 1996; Mouzos, 2000). A total of 316 children were killed over the 10 year period from 1989-1999, with between 25 and 39 children (0-14 years of age) being homicide victims each year in Australia (Mouzos, 2000). The Australian child homicide rate has been relatively stable over a 10 year period. By way of comparison, the United States child homicide rate has steadily increased since 1960 (Chew, McCleary, Lew & Wang, 1999; cited in CDRT, 2002).

Figure 1.1 Average incident rates 1989-99: Police reported child homicide victims 0-17 years



It is important to note that the figures reported in the literature are most likely an underestimate of child fatal assaults or homicides that occurred over this period. Problems in detecting homicides are well documented, particularly in the case of young children, and particularly within a family context. Reasons for this include the cause of death not always being apparent, the cause of death being misclassified, or remains not being located (Strang, 1996).

It has been internationally recognised that different data sources may lead to different rates of fatal assault or homicide being recorded. As with studies of any offence patterns, the record systems chosen as the data base for the study can influence study populations and conclusions regarding the patterns of homicide (Wallace, 1986).

In Australia, information about the number of child deaths from assault and neglect is not consistently collected across jurisdictions. For infants less than one year of age, the largest cause of death after natural causes is 'sudden death, cause unknown' ABS category 798 (ABS, 1999). A small proportion of these deaths may be deliberately inflicted (Mouzos, 2000; Strang, 1996). In NSW the deaths of infants are reviewed by the NSW Child Death Review Team. The number of deaths that are reported by the NSW Child Death Review Team as due to fatal assault or neglect do not necessarily accord with other official statistics, such as ABS data (CDRT, 2000; ABS, 1999a). While ABS data reports the autopsy cause of death, all deaths in the Child Death Review Team's Child Death Register are reviewed by one of the Team's paediatricians who codes cause of death according to international coding (ICD-10 coding).

As with assault, the difficulties associated with inaccurate or incomplete information, and the difficulties involved in defining and classifying deaths from neglect, may result in some uncertainty about the number of child neglect related deaths (Bonner et al., 1999). Cantwell (1997), however, reported that in the United States more children die from neglect than physical abuse. In contrast, Margolin (1990) claimed that physical abuse and neglect fatalities occur at approximately the same frequency, citing a study by Anderson, Ambrosino, Valentine and Lauderdale (1983) of 267 child maltreatment fatalities. Of those, 40 per cent were attributed to neglect, 39 per cent to physical abuse and 21 per cent to physical abuse and neglect combined.

Groups with high prevalence of assault and neglect

Specific groups are over-represented in fatal assault or homicide statistics. In Australia, the highest rate of child homicide victimisation is for those less than one year of age (Mouzos, 2000).

The Indigenous population is over-represented in terms of homicide statistics and the incidence of child abuse and neglect. As well, substantiated cases[1] of abuse occur in Indigenous children at a rate almost three and a half times greater than other children (Australian Institute of Health and Welfare, 1995).

The Australian Institute of Criminology also reports an over-representation of Indigenous persons in homicide statistics, with Indigenous persons being on average, 8.1 times more likely to be victims of homicide than non-Indigenous persons (Mouzos, 2000). Other data indicate that Aboriginal women and children are 45 times more likely than other Australians to be the victims of domestic violence and are over eight times more likely to be the victims of homicide (Huggins 2002, cited in Gordon, Hallahan, & Henry, 2002).

1.4 Fatal assault and neglect typology

Throughout the literature, typologies of fatal assault and neglect have been constructed according to identified patterns and profiles. There are certain parameters related to classifying these deaths including:

- the age of the child;
- the relationship of the child to the perpetrator;
- the intent of the perpetrator;
- the circumstances surrounding the incident (CDRT, 2002).

1 'Substantiated' means that a child or young person has been found to be at risk of harm within the meaning of Section 23 of the *Children and Young Persons (Care and Protection Act) 1998.*

Categories of fatal assault

Several major categories or types of fatal assault have been found repeatedly in research studies. All fatal assaults can be classified as either familial or non familial. Other classifications are based on the scenario around the child's death. For example, deaths are classified in terms of a family dispute if family conflict is the precipitating factor in the incident surrounding the death. Other social problems, such as mental health problems or child abuse, may also coexist but the child's death is seen to be triggered by family breakdown. Social problems may overlap in the categories but different types are based on the circumstances surrounding the child's death (CDRT, 2002).

In the Fatal Assault of Children and Young People report (CDRT, 2002), four categories of fatal assault emerged. These were non-accidental injury, victims of parents affected by a mental illness, of family breakdown, and killings of teenagers.

Non-accidental injury

A recognised pattern of child homicides is fatal child abuse in which the child is killed by one massive assault or a series of assaults over time. There are two major patterns in these deaths: escalating physical violence (which accounts for the majority of these types of deaths) and one-off assaults (CDRT, 2002). Children less than one year of age are particularly at risk (Wallace, 1986). The NSW Child Death Review Team (2002) found that these assaults were committed by both mothers and fathers of the children and de facto carers.

Parental mental illness

Some fatal child assaults are precipitated by the psychiatric illness of the parent. This includes instances in which the perpetrators are mothers who are shown to be suffering severe postnatal depression or psychoses (Wallace, 1986). The NSW Child Death Review Team (2002) found that mothers were the perpetrators in all of these assaults and that a majority were from culturally and linguistically diverse backgrounds.

Family breakdown

'Family dispute' (Strang, 1996) or 'domestic homicide' (Hore, Gibson & Bordow, 1996) is a category that includes cases of murder-suicide. In the family dispute category, the termination of the parents' relationship is usually the trigger. The male perpetrator reacts to a relationship breakdown with rage or depression, resulting in multiple murders (often involving more than one child and the wife) and murder-suicides (Strang, 1996). In contrast to these findings, the NSW Child Death Review Team (2002) found that mothers were the perpetrators in just over half of these assaults.

Teenage killings

The NSW Child Death Review Team (2002) found that a group of children and young people aged 13 to 17 years were killed in altercations mostly involving peers as perpetrators. Parents or caregivers were not involved in any of these assaults. Almost all of these assaults were perpetrated by males. The research noted that these assaults began to resemble adult fatal assaults and included violence committed in the course of a crime and drug-related deaths.

Other categories of fatal assault that have been identified in the literature include neonaticide and fatal sexual assault. Neonaticide involves the killing of a baby by her or his mother within the first

24 hours after birth (Wallace, 1986). The typical scenario involves a mother who is young, single and poor with an unwanted pregnancy (Adinkrah, 2000). Fatal sexual assault, or sexual homicide, is killing that occurs after a sexual assault (Mouzos, 2000; Wallace, 1986). Neither category was represented in the *Fatal Assault of Children and Young People* report (CDRT, 2002).

Categories of fatal neglect

There have been typologies suggested in the literature for classifying different types of fatal neglect (Cantwell, 1997). Bonner et al. (1999) identified a trend in distinguishing between neglect fatalities that result from lack of supervision and those that result from chronic neglect (Ewigman, Kivlahan and Land, 1993; Zuravin, 1991).

Fatal neglect resulting from inadequate supervision occurs when a child dies as a result of a parent or carer failing to provide a child with adequate protection or supervision. Deaths may result from incidents such as drowning, fire, fire-arms, falls or motor vehicle accidents. In the CDRT *2001-2002 Annual Report*, all fatal neglect deaths were classified as 'inadequate supervision'.

Much of the focus has, however, been on the classification of non-fatal neglect. Erickson and Egeland (1996) classified neglect under the headings of physical, emotional, medical, mental health and educational neglect.

Despite such efforts to classify non-fatal neglect, there has been a lack of research attention to the classification of fatal neglect. A primary focus of this study was therefore to investigate the extent to which there are different types of neglect-related deaths. The study also sought to confirm previous research regarding the classification of fatal assaults.

1.5 The NSW policy context regarding child protection

Historical context

The past 25 years have seen rapid growth and development in child protection knowledge and practice. This has resulted in part from greater advocacy by the survivors of abuse, ongoing research, a significant increase in community awareness about child abuse and neglect and increasing community concern about the child protection system's capacity to provide effective protection and intervention.

These developments have been reflected in changes to:

- the legislative framework;
- interagency collaboration;
- policy and practice; and
- training and development.

The legislative framework

One of the most significant factors influencing the policy and practice context has been the changing legislative framework in child welfare and criminal law. These changes are set out in Table 1.1.

Table 1.1 Changes in the NSW legislative framework

Year	Legislative change
1977	Doctors mandated to report child abuse and neglect.
1981	*Crimes (Sexual Assault) Amendment Act 1981* amended the Crimes Act 1900 to abolish the crime of rape and replace it with graded categories of sexual assault, each with prescribed penalties.
1985	*Pre-Trial Diversion of Offenders Act 1985*, established to Pre-Trial Diversion of Offenders Program involving the diversion into a two-year treatment program of certain intra-familial child sex offenders who plead guilty and who are assessed suitable.
1987	Principals, Deputy Principals, school counsellors, preschool teachers and teachers mandated to report sexual abuse.
1987	*Children's Court Act 1987* commenced.
1987	*Criminal Procedure Act 1986 No 209* relating to the prosecution of indictable offences, the listing of criminal proceeding before the Supreme Court and the District Court, committal proceedings and proceedings for summary offences and the giving of certain indemnities and undertakings.
1988	*Children (Care and Protection) Act 1987* commenced. This Act established the NSW Child Death Review Team.
1991	*Oaths (Children) Amendment Act 1990 No 93* provided that children may make a declaration instead of an oath when appearing as a witness and in participating in certain other proceedings.
1993	*Community Services (Complaints, Appeals and Monitoring) Act 1993* commenced. The Commissioner for Community Services was made responsible for reviewing children at risk of harm and children in care.
1996	*Children (Care and Protection) Act 1987* amended allowing greater exchange of information between child protection agencies.
1997	*Children (Protection and Parental Responsibility) Act 1997* commenced, impacting on parental responsibility and the welfare of children in public places.
1997	*Evidence (Children) Act 1997* provided for the use of closed circuit television for child witnesses in court and legal processes and the taping of children's out-of-court statements.
1998	*Children (Care and Protection) Act 1987* reviewed, leading to the *Children and Young Persons (Care and Protection) Act 1998*.
1998	*Commission for Children and Young People Act 1998* commenced, establishing the Commission for Children and Young People.
1999	*Evidence (Children) Act 1997* commenced, providing improved support for children giving evidence.
1999	*Ombudsman Amendment (Child Protection and Community Services) Act 1998*. The NSW Ombudsman given responsibility for overseeing and monitoring the handling of child abuse allegations and convictions against employees of designated agencies.
2000	Sections of the *Children and Young Persons (Care and Protection) Act 1998* commenced, providing the statutory framework for interagency collaboration, early intervention and flexibility in approach. The concept of 'child abuse' was replaced with 'risk of harm'. Mandatory reporting was extended and participation of children in decision-making was increased.
2000	*Children's Court Act 1987* reviewed, resulting in the appointment of additional Children's Magistrates, Children's Registrars and the establishment of a Children's Court Clinic.
2000	*Child Protection (Offenders Registration) Act 2000* commenced, requiring the Commissioner for Police to establish a Register of Offenders.
2000	*Child Protection (Prohibited Employment) Act 1998* commenced, preventing a 'prohibited person' from applying for, gaining or remaining in child-related employment.
2001	*Child Protection (Offenders Registration) Amendment Act 2001* proclaimed, specifying that people convicted of serious offences against children must keep the Police advised of any changes to their name, address, employment and car details.
2002	Main provisions of the *Children and Young Persons (Care and Protection) Amendment (Permanency Planning) Act 2001* proclaimed strengthening the long-term care arrangements for children and young people.
2002	*Crimes Amendment (Child Protection-Physical Mistreatment) Act 2001* proclaimed providing guidance to parents in disciplining their children.
2002	*Child Protection Legislation Amendment Act 2002* proclaimed, providing for an individual's Apprehended Violence Order history to be obtained as part of the Working With Children Check.

Table 1.1 Changes in the NSW legislative framework cont.

Year	Legislative change
2002	*Community Services Legislation Amendment Act 2002* introduced, providing for the incorporation of the Community Services Commission as a division within the NSW Ombudsman's Office. The responsibility for monitoring child abuse and neglect deaths is passed from the NSW Child Death Review Team to the NSW Ombudsman.
2003	The sections of the *Children and Young Persons (Care and Protection) Act 1998* relating to the Children's Guardians functions of monitoring and regulation of the out-of-home care system proclaimed.
2003	*Crimes Amendment (Sexual Offences) Act 2003* amended the *Crimes Act 1900* to provide for the equal treatment of sexual offences against males and females and to increase the penalties for sexual offences against children.
2003	*Criminal Procedure Amendment (Sexual Offence Evidence) Act 2003* amended the *Criminal Procedure Act 1986* to protect a complainant in certain sexual offence proceedings from being questioned directly by the accused person (commenced September 2003).
2003	*Crimes Legislation Amendment Act 2003* amends the *Criminal Procedures Act 1986* to prevent Magistrates directing persons under the age of 18 years to attend committal proceedings to be cross-examined, in respect of a child sexual assault offence allegedly committed on the person when they were under the age of 16 years.

Interagency collaboration

The past decade has seen increasing recognition that the protection and well-being of children and young people is a whole of government and community responsibility.

The first *Interagency Guidelines* were released in 1991. In 1996 the findings of the Wood Royal Commission highlighted the need for greater collaboration, coordination and training between government agencies and in 1997 the *Interagency Guidelines* were revised to provide a practical framework for this to occur.

In 2000 the *Interagency Guidelines* were again revised to reflect legislative changes and provide professionals and agencies with a guide for working with each other and with children and families to address child protection concerns.

Policy and practice

In recent years legislative changes, the move towards increased interagency collaboration and increasing recognition of the need for early intervention and prevention strategies have necessitated significant revisions in structure, policy, and practice among child protection response agencies.

Examples of the changes introduced by some of the key child protection agencies are outlined below.

The Department of Community Services

The Department of Community services introduced a range of initiatives including the Helpline, a telephone centre providing a single entry point for reporting child protection issues; the *Secondary Risk of Harm Framework* to assist caseworkers in risk assessment; casework tools such as Alternate Dispute Resolution and Care Plans; and changed staffing and supervision structures to support caseworkers.

The Department of Education and Training

In December 2000 the Department of Education and Training introduced the *Protecting and Supporting Children and Young People: Revised Procedures*, which outlined procedures to be followed when, in the course of their work, staff develop concerns about suspected risk of harm to a child or young person. In January 2003 the Department introduced *Handling Allegations Against Department of Education and Training Employees in the Area of Child Protection*, which set out the procedures to be followed if allegations are made against a Department employee of child abuse or a breach of discipline of a sexual, physical or non-physical nature.

The Child Protection Investigation Directorate was established as a directorate of the Department of Education and Training.

NSW Police

Key initiatives include Sex Offender Registration, the establishment of CrimTrac in 2000, an agency to support Australian policing through the provision of high quality national information services and investigative tools, and increased focus on staff training.

The Department of Corrective Services

The Department established the position of Child Protection Coordinator in June 2002 and is currently in the process of establishing a unit to coordinate and manage all child protection issues, including implementing the Department's *Strategic Framework on Child Protection 2003-2005*. In addition, a number of projects aimed at addressing child protection are underway, including the implementation of Stage II of the pilot *Child Visits Assessment Program*.

NSW Health

In December 2000 NSW Health introduced *NSW Health Frontline Procedures for the Protection of Children and Young People*. These procedures provided staff with help in recognising children at risk of harm, making a report to the Department of Community Services, responding to requests for service, and exchanging information with the Department of Community Services.

In March 2003 the *NSW Health Domestic Violence Policy* and accompanying procedures document were issued. This provided clear and comprehensive direction to NSW Health workers in relation to responding to the complex intervention and legal issues with victims, perpetrators and children.

Key initiatives included a *Mental Health Outcome and Assessment Tool* for use by mental health workers, *Neonatal Abstinence Syndrome (NAS) Guidelines* to promote best practice in the ongoing care of substance-using pregnant women and newborn babies, and an *Integrated Perinatal and Infant Care (IPC) Initiative*, to identify and provide care to those mothers and their infants who are most at risk of adverse physical and mental health outcomes.

Learning and development initiatives

Industry training

Since the mid 1980s there has been a significant emphasis on developing workers' capacity through training in child protection.

The 1997 Royal Commission into the NSW Police recommended a continued emphasis on training for those working with children, particularly training in casework that involved the participation of staff from several different agencies.

In 1998, a state-wide interagency training program was conducted to accompany the release of the updated *NSW Interagency Guidelines for Child Protection Intervention* and more than 5,000 staff were trained.

In 1999, a concerted attempt was made by government agencies to extend learning and development opportunities in child protection skills beyond staff who work directly with children who have been abused.

In 2000-2001, professionals from agencies with child protection responsibilities, including Children's Court Magistrates, received training on the *Children and Young Persons (Care and Protection) Act 1998*.

In 2001-2002, the NSW Government's Child Protection Chief Executive Officers' Group, which represents 10 key agencies with child protection responsibilities, endorsed a *Child Protection Learning and Development Framework* setting out the priorities and strategies for learning and development in child protection. The Child Protection Learning and Development Coordination Unit commenced operations in December 2002. The unit's purpose is to implement the strategic directions for child protection learning and development.

A review of the national child protection qualifications has been completed and a new *Community Services Training Package* has been prepared by the Community Services and Health Industry Training Advisory Board (CSHTA). The package was endorsed by the Australian National Training Authority in December 2002 and is now available to purchase from the CSHTA.

NSW Health has developed a work-based training program for treatment managers of non-government organisations to assist them to support their organisation's development in referral and assessment, including a set of tools to aid in assessing and referring drug and alcohol clients. The training is likely to become available to registered training organisations in 2003.

Monitoring and research

Monitoring, research and evaluation are essential to the development of an effective, responsive child protection system.

Child protection has become an established area of empirical research in the social sciences with an increasing number of publications, PhD theses and journals in the area such as *Developing Practice: the child, youth and family work journal*, (NSW Association of Child Welfare Agencies, 2001). Specialist research and information centres have been established, including the National Child Protection Clearing House.

In late 1999 the Australian Domestic and Family Violence Clearinghouse was established to provide information and resources to specialist and health and community workers and other interested parties to assist them in responding strategically to domestic and family violence.

Some examples of recent studies and activities that have contributed to the development of knowledge in the area of child protection in NSW in recent years include the University of Sydney's examination of practitioners' knowledge and understandings of domestic violence and child protection (2001) Association of Child Welfare Agencies Research Forum (2001), the NSW Child Death Review Team reports into the *Fatal Assault of Children and Young People* (2002) and the *Suicide and Risk-taking Deaths of Children and Young People* (2003), the Legislative Council Standing Committee for Social Issues *Inquiry into Child Protection Services* in NSW (2002), the Legislative Council Standing Committee on Law and Justice *Inquiry into circumstances surrounding the prosecution of child sexual assault matters* (2002), the Commission for Children and Young People's *Inquiry into the best means of assisting children and young people with no-one to turn to* (2002) and the Kibble Committee's review of the Department of Community Services (2002).

Information systems

The development of information technology over the last 25 years has generally improved NSW's ability to track and collate information about individual cases and to aggregate information so that trends and gaps can be better identified.

Examples of systems currently in place are the Police Computerised Operational Policing System (COPS), the Department of Ageing, Disability and Home Care Client Database and epidemiological and other databases in the health system. The Department of Community Services is currently developing a new client database titled the Key Information Directory System (KiDS) for release in the second half of 2003.

New approaches

Research shows that early intervention can produce a sustained improvement in children's health, education and welfare and that services have the greatest impact when they address a broad range of issues and are part of a coordinated network.

Families First[2] was introduced in 1998 and is being delivered jointly over the four-year period from 2002 to 2006 by five government agencies – Area Health Services, Community Services, Education and Training, Housing and Disability, Ageing and Home Care in partnership with parents, community organisations and local government.

Planning for *Families First* commenced in south western Sydney, the mid north coast and the north coast in 1998 and has progressively rolled out across NSW. In 2003/4, $23.3 million will be allocated to the strategy across NSW.

A total of 154 recurrent services have been approved under *Families First*. These include 62 Family Worker Services (some of which provide specialist support to Aboriginal families, fathers or families with children with disabilities), 31 Volunteer Home Visiting Services, 35 Supported Playgroups, three Parenting Centres, nine Parenting Educators/Community Workers and a Toy Library.

Funding has also been approved for an Internet site, and a number of fixed term projects which include some locally based research projects.

Looking to the future

In recent years the NSW Government has demonstrated an increasing recognition of the long-term societal benefits that flow from providing support to children in their early years. This recognition has resulted in an increased commitment to services and initiatives that provide early support to children and families or focus on early intervention and prevention.

In December 2002 the NSW Government announced a significant budget enhancement to the Department of Community Services for the improvement of prevention and early intervention child protection strategies and responses. The enhancement is designed, in part, to increase the number and types of family support agencies in the community. The enhancement will also enable the Department of Community Services to substantially increase the number of Case Workers and Managers available to respond to reports of children at risk of harm and other child protection and out of home care matters. The funding is to be staggered over five years to permit suitable service planning and the staged implementation of associated projects.

Conclusion

The past 25 years in NSW have witnessed major developments in legislation, interagency collaboration, policy, practice and learning and development in child protection. There remains considerable potential for further developments in all these areas if we are to improve children's safety and minimise the number of preventable deaths.

2 *Families First* is a coordinated strategy sponsored by the NSW Government which aims to support parents and carers, who have children under eight years of age, in raising their children and help them solve problems early before they become entrenched.

CHAPTER 2
METHODOLOGY

The aim of this research project was to study the group of deaths of children and young people identified by the NSW Child Death Review Team as due to assault or neglect or suspicious of assault or neglect over a three year period (July 1999 to June 2002).

The following research questions were addressed:

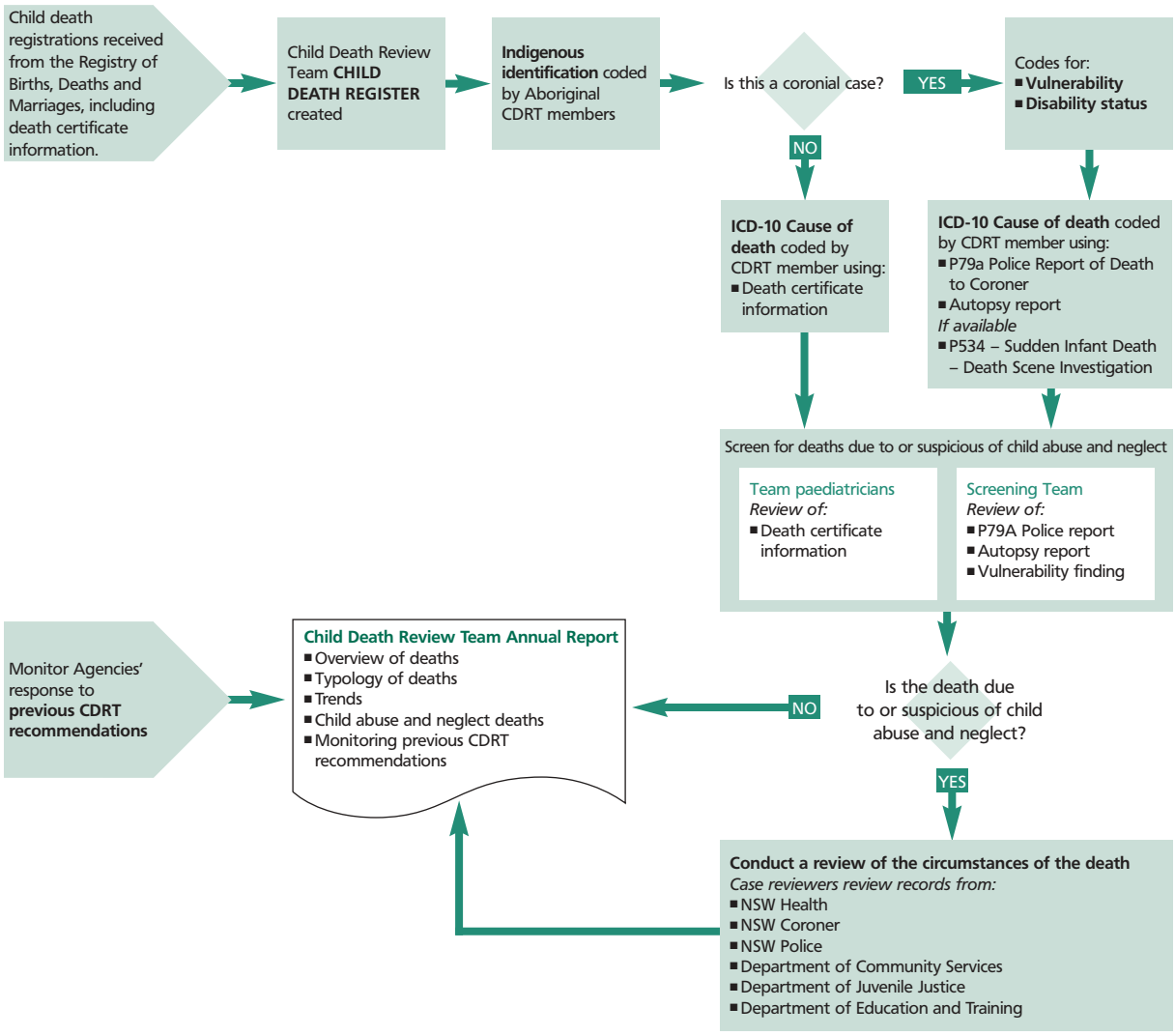
1. What were the characteristics of the children and young people who died from assault or neglect or in suspicious circumstances?
2. What factors were associated with this group of deaths?
3. Did the families have prior agency contact?
4. What can be done to prevent further assault, neglect and suspicious deaths of children and young people?

This Chapter describes the methodology used to analyse this group of deaths.

2.1 Child Death Review Team model

A summary of processes of the Child Death Review Team which led to this report follows in Figure 2.1.

Figure 2.1 Child Death Review Team Model: Process



2.2 Access to data

The study consisted of a case file review of records made available to the Child Death Review Team. *The Children (Care and Protection) Act 1987* imposes a duty on all government departments, statutory bodies or local authorities to provide the Team with 'full and unrestricted access' to records that the Team reasonably requires for the purpose of exercising its functions.

Accompanying the Team's privileged access to information is a duty of confidentiality that is specified in the legislation. Section 106 (Confidentiality of Information) of the *Children (Care and Protection) Act 1987* states that:

> 'A person who is a member of the Team or its staff must not, except for the purpose of the exercise of the function of the Team or in such other circumstances as the regulations may prescribe, make a record of, or directly or indirectly reveal to any person, any information (including the contents of any document) that was acquired by the person by reason of being a member of the Team or its staff.
> Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.'

With privileged access to information, the Team has exemption from Freedom of Information requests.

2.3 Child Death Register

The NSW Child Death Review Team has maintained a register of all deaths of children and young people less than 18 years of age since 1996.

(i) Coding of cause of death

For each death in the Child Death Register, one of the Team's paediatricians reviewed all the available information and coded the cause of death according to international coding.

The World Health Organisation has promoted an international classification system for coding mortality data, the International Classification of Disease or ICD (World Health Organisation, 1992). The most recent version of this coding was used for this report. The ICD-10 coding is a classification system that includes codes for deaths from external causes of injury and poisoning. A framework for grouping the external causes of death has been suggested by the US National Center for Injury Prevention and Control and the National Center for Health Statistics (Centers for Disease Control and Prevention, 1997). This framework is a matrix which specifies mechanism by intent of injury (for example: suffocation=mechanism; suicide=intent). The cases in this report were coded according to this framework.

(ii) Coding geographical remoteness

This report used the Accessibility/Remoteness Index of Australia (ARIA; Commonwealth Department of Health and Aged Care, 2001). The ARIA has been widely adopted as a national standard and was used to produce output from the 2001 Census. ARIA defines five categories of geographical remoteness based on road distances to service centres. These five categories are:

a) highly accessible – relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction;

b) accessible – some restrictions to accessibility of some goods, services and opportunities for social interaction;

c) moderately accessible – significantly restricted accessibility of goods, services and opportunities for social interaction;

d) remote – very restricted accessibility of goods, services and opportunities for social interaction; and

e) very remote – very little accessibility of goods, services and opportunities for social interaction.

(iii) Coding Indigenous status

Indigenous status is recorded on the NSW Registry of Births, Deaths and Marriages death registration data (the Police Report to the Coroner (P79A) includes a similar notation). It is probable that these sources undercount the number of Aboriginal and Torres Strait Islander child deaths.

To assist in the identification of these children, Indigenous status was also coded by the Aboriginal Team members. A child was coded as Aboriginal when a Team member could identify the family as an Aboriginal family.

The Child Death Review Team seeks to identify only Australian Aboriginal and Torres Strait Islander children and young people. The Team does not seek to identify Indigenous children and young people from other countries.

(iv) Analysis period

The report reviewed the deaths of children from assault or neglect, or those that occurred in suspicious circumstances, registered between July 1999 and June 2002. Analysis by date of registration is in line with other national datasets (such as ABS and NISU data).

To encompass the entire group of children and young people identified as having died from assault or neglect or in suspicious circumstances over the time period, 33 previously reviewed cases were included in the study.

2.4 Case reviews of assault and neglect deaths

(i) Cases included for review

While the CDRT is mandated to review child deaths due to assault, neglect or that occur in suspicious circumstances, two groups of deaths were not reported on in this study. First, the deaths that were identified by the CDRT as having occurred in suspicious circumstances after an infant had been placed for sleep are not included and will be reported in a research project currently underway.

The second group of deaths that were not included in this study were deaths due to suicide and risk-taking and where the child or young person had been a victim of prior child abuse or neglect. This group of deaths has been reviewed in a prior study by the CDRT, *Suicide and Risk-Taking Deaths of Children and Young People* (2003).

As there is a routine time lapse in the availability of documentation from coronial cases, only cases for which full documentation was received by the end of March 2003 were included in the study.

This resulted in seven children and young people whose deaths were registered in the chosen time period being reviewed based on incomplete documentation. Details of these seven cases are presented in Appendix 2. Information on these cases is not reported elsewhere.

(ii) Definitions of fatal assault, neglect and suspicious of fatal assault and neglect

The CDRT identifies and reviews child deaths caused by assault or neglect or deaths that are suspicious of assault or neglect. To assist with accuracy, the Team developed its own set of definitions and screening procedures. A review of the literature indicated that other researchers also found difficulties in defining assault and neglect that results in the death of a child and no universal definition was evident.

The definitions and guidelines that the Team developed were based on the expertise of the Team and their experience in screening deaths. In developing the definitions, the Team reviewed the NSW *Interagency Guidelines for Child Protection Intervention (2000)*; North Carolina Child Advocacy Institute's *Child Maltreatment Fatalities: Guidelines for Response (2000)*; and the US Study of *National Incidence and Prevalence of Child Abuse and Neglect (1988)*.

Definition of fatal assault

Fatal assault occurs where a child is fatally injured by beating, burning, shaking, stabbing, shooting, poisoning, suffocation, strangulation or other physical means. Fatal assault includes homicides and murder-suicides.[1]

Fatal neglect

Fatal neglect results from an act of omission by a parent or carer that involves refusal or delay in providing medical care; failure to provide basic needs such as food, liquids, clothing or shelter; abandonment; or inadequate supervision.[2,3]

Rosenberg (1994) defines inadequate supervision as the failure of parents or carers to carry out their duties to their children, that is: 'a failure to provide attendance, guidance and protection to children who, lacking experience and knowledge, cannot comprehend or anticipate dangerous situations' (p39).

It is difficult to define inadequate supervision in more specific terms. Firstly, it is often difficult to establish a causal relationship between the child's death and the parental act of omission especially when reviews are based on administrative records; and secondly, it is difficult to state exactly what is meant by parental (or carer) duties. Parental or carer duty is not defined by law, rather it is determined by unwritten standards in the community. Generally, the community disapproves of parents who act irresponsibly; yet the community also does not expect parents to be able to prevent all deaths. The CDRT plays an important role in representing the opinions of the general community and in helping to define what is acceptable in the community.

Rosenberg (1994) suggested that incidents in which a child has died as a result of inadequate supervision may also include instances in which the parents' capacity was impaired as a result of drugs, alcohol, mental illness, physical illness, immaturity or low intelligence. Also included were deaths that occur when older siblings were left to supervise younger siblings; deaths due to fires, falls, drownings, poisoning when children were left unsupervised; and deaths when children were left unattended in cars.

1 The relationship between the child and the perpetrator is not significant to this definition.
2 The relationship between the child and the perpetrator is significant. A carer can be any person responsible for the child, or in loco parentis for any period of time.
3 The act of omission by a parent or carer can be conscious or deliberate; or unconscious or not deliberate.

The Team has developed a rigorous screening procedure (see 2.4 (iii) CDRT screening procedure) to address the difficulties associated with determining the cause of death by neglect and in particular, inadequate supervision.

The following questions, as outlined by Rosenberg (1994) were considered by the Team when examining the context of deaths relating to neglect:

- the age and developmental stage of the child;
- the period of time that the child was left unsupervised;
- the circumstances in which the child was unsupervised, an assessment of the potential hazard and how obvious the danger was to a carer;
- the physical and mental condition of the carer;
- any previous history of chronic supervision neglect;
- the acceptability of the specific parental behaviour in his or her ethnic group;
- whether the supervision neglect was causal or related to any coexisting poverty (Rosenberg, 1994, p38-39).

Suspicious deaths

Suspicious deaths are deaths where there is insufficient evidence or information in the post-mortem to determine whether the cause of death was or was not clearly due to assault or neglect. Deaths were considered suspicious if there was a history of child abuse and neglect in the child's family background or other concerning circumstances in the context of the death incident.

(iii) CDRT screening procedure

The CDRT screens coronial and non-coronial cases to identify deaths caused by assault, neglect or suspicious of assault and neglect. The Team conducts case reviews of deaths that are determined to be caused by assault, neglect or in suspicious circumstances through the screening procedure.

The screening procedure consists of four steps:

- Step One – coding and initial screening of non-coronial deaths for cause of death by Team members with expertise in paediatrics;
- Step Two – initial screening of coronial cases for cause of death by the Team screening subcommittee;
- Step Three – further screening by Team members or child protection consultants of suspected abuse, neglect or suspicious deaths with additional information; and
- Step Four – a full Team discussion for deaths where the cause of death was unclear.

Step One: Initial screening of non-coronial cases for cause of death

For non-coronial deaths (or medical certificate deaths), three of the Team members with paediatric expertise reviewed the stated cause of death on the death certificate. Further information was requested if the cause of death appeared to be inadequate or suggested suspicious circumstances. No cases in this study were 'screened in' for review using this method.

Step Two: Initial screening of coronial cases for cause of death

The screening subcommittee screened each coronial case to determine whether it warranted a case review. This included cases of homicide, motor vehicle incidents, drowning, fire, choking, poisoning and those in which the cause of death was undetermined.

A case warrants review where the death results from child abuse or neglect or where this is suspected but there is not enough evidence to make a clear determination, for example, where the autopsy cause of death was 'unascertained' or 'not determined' but the forensic pathologist had noted that it was possible that the child was suffocated or smothered. Deaths due to adverse medical outcomes are not reviewed by CDRT during this process.

In screening cases for review, the subcommittee looked at information from the Police Report of Death to Coroner (P79A), which includes a narrative of the circumstances of the death, the final autopsy report and information from the Department of Community Services' Client Information System.

Step Three: Further screening of cases with additional information

Additional information was collected for each case requiring review. Relevant records were sought from the following organisations:

- NSW Police: records regarding the child; criminal records of parents, non-related partners and/or suspects; history of domestic violence incidents involving either or both parents during the course of the child's life, including non-related partners;
- NSW Health: birth records of the child; general medical records including admissions to hospital and mental health records of the child and their parents;
- NSW Coroner: records regarding the child including inquest transcripts and police briefs of evidence;
- Department of Education and Training: records regarding the children who attended government schools;
- Department of Community Services: records regarding the child, their siblings and parents;
- Department of Juvenile Justice: records of offences or detention if the child was aged between 10 and 17 years; and
- Department of Housing: information indicating whether the child's family was in Department of Housing accommodation during the course of the child's life.

Child protection consultants reviewed the additional documentation to make a more informed assessment about the cause of death. If reviewers were unsure about whether the cause of death was assault or neglect or suspicious, the case was taken to Step Four of the screening procedure.

Step Four: Screening cases where the cause of death is unclear

When reviewers remained unsure about the cause of death, the case was discussed at a full Team meeting. Further information was sometimes requested by the Team to assist in this determination. If the Team determined that the death was more likely to be suspicious of assault and neglect, then the case was fully reviewed.

Table 2.1 shows that in 75 of the 100 cases, initially identified for review the deaths were be fully reviewed. In the other 25 cases, neither the reviewers nor the Team found sufficient evidence to indicate that the death was due to assault, neglect or suspicious of assault and neglect. These deaths involved suicide, motor transport accidents, anorexia nervosa, electrocution, natural causes and deaths for which the cause of death was undetermined.

Table 2.1 CDRT screening process: Children screened and reviewed

	Number
Steps One and Two: Cases 'screened in' for review by CDRT	100
Step Four: Cases 'screened out' by CDRT after reviewing additional information	25
Cases reviewed by CDRT	75

(iv) CDRT case review procedure

Full case reviews were conducted when it was established that the cause of death was assault, neglect or was suspicious of assault and neglect. Child protection consultants conducted these reviews. Nine (12.0%) case reviews were subjected to an audit by a subgroup of Team members. In this way, quality and consistency was maintained.

Case reviews were based on individual administrative records only. The reviewers often requested additional information from relevant organisations to assist in reviews. The reviews followed a standard format that allowed for the collection of information regarding a case, as well as recording a narrative of the history and circumstances of the death. This is further elaborated below.

2.5 Research methods

(i) Data collection tools

The study consisted of a case file review of official NSW Government department records for each child and young person and used a combination of narrative (Lieblich, Tuval-Mashaiach & Zilber, 1998) and documentary (Sarantankos, 1998) research methods. First, narratives were developed for each child and young person by a review of the records obtained. Each narrative was organised around four areas:

1. death incident;
2. life history of child or young person (including family background, social circumstances, prior child abuse and neglect);
3. prior agency involvement; and
4. issues for prevention/intervention.

In addition, a data collection tool was developed to record quantitative information. The tool consisted of variables clustered around the following domains: demographics, circumstances of the death, individual circumstances, childcare-, education- and employment-related experiences, family background and prior agency involvement.

(ii) Data analyses

Data analyses were both quantitative and qualitative in nature. Data collected using the data collection tool were entered into the statistical package SPSS (SPSS, 1999). Due to the nature of the available information, descriptive statistics were the most appropriate to create an overall profile of the cases and to distinguish between groups (for example fatal assault and fatal neglect).

Incidence rates and trends were also calculated. This report used crude death rates, which showed how many deaths there were per 100,000 children in each age and gender group in the population. Rates allow comparisons over time, across states and internationally even though the size of these populations may be different. Consistent with the Australian Bureau of Statistics and the Australian National Injury Surveillance Unit, rates were not calculated on less than four cases, as such calculations are unreliable.

Narratives were entered into NVivo (Fraser, 2000), a software package for qualitative data analysis, and a content analysis was performed. This involved three stages. First, categories or themes were developed by reading the narratives and defining the content categories that emerged. Additional categories were developed from a literature review of the factors associated with child abuse and neglect. Second, each narrative was 'coded', which involved assigning relevant sections of the narrative to each category or theme. Finally, the themes or categories that emerged were analysed using a variety of techniques such as clustering, counting, comparing and contrasting, factoring and noting relations between variables (Miles & Huberman, 1994).

Case examples were used for illustrative purposes. Pseudonyms have been used throughout the report to protect the privacy of individuals and their families.

During the analysis of the child protection cases, the interagency child protection practice framework as specified in the *NSW Interagency Guidelines for Child Protection Intervention* (2000) was used. Analyses were conducted with regard to the specific stages in child protection work: recognition and reporting, assessment and investigation, protective intervention, ongoing care and support, and closure.

2.6 Methodological limitations and cautions

As with all data sets that rely on administrative data sources, there are omissions of information. As well as missing information, there is also likely to be a small number of errors. The validity and reliability of the information that was recorded for the Child Death Register has not been formally verified.

In addition, the quality and extent of information contained in the records was highly variable, with the incidence of family and social problems likely to be undercounted in government records. For example, violence in families is expected to be more prevalent than the incidence of Apprehended Violence Orders (CDRT, 2002). Similarly, coronial files typically contain detailed information about the death, while information about life circumstances is recorded less consistently. However, for all cases that are subject to case review, there are several different data sources, so the probability of reliable and valid data was increased.

Different agencies serve different roles for children and young people and have different procedures for recording information. This means that the extent of information documented on file will differ among agencies. As this study was restricted to information on file, for some cases there was a lack of information regarding agency involvement. In addition, there may have been an over-reliance on the more comprehensive records for some cases. As a result, during the analysis of agency involvement, this study sought to identify errors in agency practice, although no attempt was made to quantify the errors.

Finally, this study reviewed the deaths of children and young people from assault or neglect or deaths that occurred in circumstances suspicious of assault and neglect. It did not investigate those who were victims of assault and neglect but did not die. Thus, the study cannot draw conclusions about children and young people in similar situations who did not die.

CHAPTER 3
MAJOR FINDINGS

This chapter outlines the key findings from the population of 75 fatal assault, neglect and suspicious deaths over a three-year period. The deaths of the children and young people are first detailed, followed by a description of the demographic background, the circumstances of the deaths, family circumstances, an overview of whether there had been prior agency involvement with the deceased and their families, and an outline of criminal and coronial proceedings. The chapter ends with a classification of the fatal assault, neglect and suspicious deaths that occurred over the study period.

3.1 Deaths of children and young people from fatal assault and neglect

Consistent with the *Fatal Assault of Children and Young People* report (CDRT, 2002), this study found that the fatal assault and neglect of children and young people are rare events. Over the study period, July 1999 to June 2002, 75 children and young people aged 0-17 years died as a result of assault or neglect or in circumstances suspicious of assault or neglect. Over the three-year period, 2175 children and young people aged 0-17 years died from all causes in NSW. Thus, 3.4 per cent of child deaths were a result of fatal assault or neglect or suspicious of assault or neglect. Nine children and young people died from assault or neglect in the second six months of 1999, 32 in 2000, 26 in 2001 and eight in the first six months of 2002.

Taking into account the number of children aged 0-17 years in NSW, the crude death rates for children aged 0-17 years who died from assault and neglect in 2000 and 2001 were 2.0 and 1.6 deaths per 100,000 children aged 0-17 years in the population.

Table 3.1 shows that fatal assault accounted for just over half (53.3%) of the deaths of the children and young people in the study. Table 3.1 also shows that gender is a significant factor; 46 (61.3%) of the 75 deaths were of males.

Table 3.1 Category of death by gender

Category	Females		Males		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Fatal assault	15	51.7	25	54.3	40	53.3
Fatal neglect	13	44.8	18	39.1	31	41.3
Suspicious of assault or neglect	1	3.4	3	6.5	4	5.3
Total	**29**	**38.7**[1]	**46**	**61.3**[1]	**75**	**100.0**

1 Percentage of total deaths

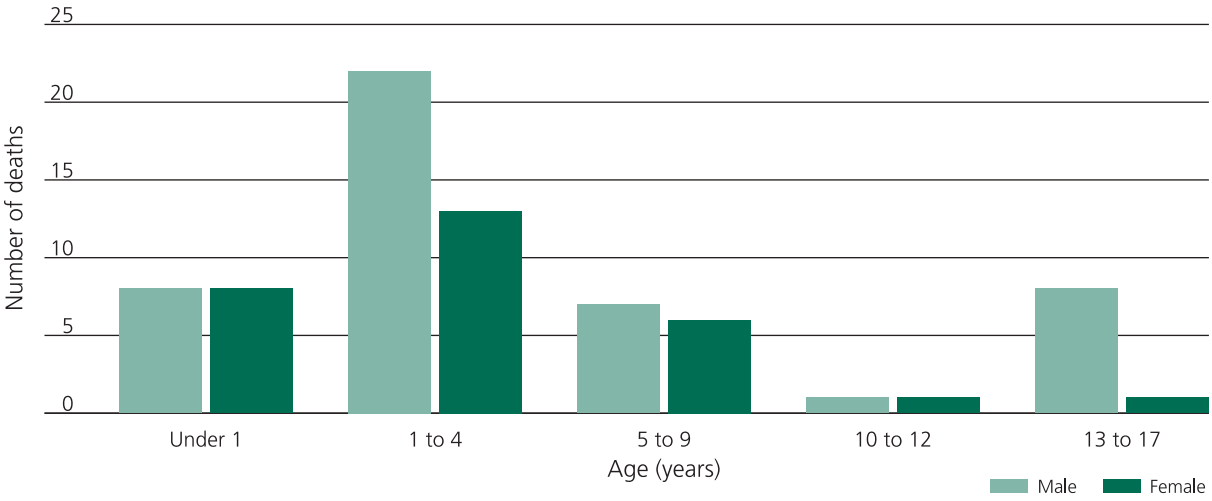
The classification of the deaths into assault and neglect groups based on the cause of death excluded the possibility of overlap between the groups. It is important, however, to point out that there was in fact an overlap; at least five (16.1%) of the 31 children who died as a result of neglect had also suffered abuse. Similarly, at least two of the 40 children and young people who died as a result of assault had experienced neglect.

3.2 Demographics

Age and gender

The age and gender distribution of the children and young people who died from fatal assault or neglect is shown in Figure 3.1. The highest number of deaths was among one to four year olds (46.7% of deaths) and infants under one year (21.3% of deaths). Children aged five to nine years made up 17.3 per cent of deaths and teenagers aged 13-17 years made up 12 per cent of deaths. More males than females died across the one to four, five to nine and 13-17 year age groups.

Figure 3.1 Children and young people's age and gender



Cultural and linguistic diversity[1]

In 2001, 84.1 per cent of 0-17 year olds in NSW were born in Australia (ABS, 2003). Of the 75 children and young people in this study, 71 (94.7%) were born in Australia. Children and young people who were born in Australia were therefore over-represented in assault, neglect and suspicious deaths compared with their numbers in the population ($X^2 = 6.3$, $p<0.5$). Of the children and young people in this study who were born overseas, two were born in New Zealand, one in Malaysia and one in Iran.

In 2001, English was the main language spoken in the family homes of 78.1 per cent of five to 17 year olds in NSW (ABS, 2003). In this study, English was the main language spoken in the family homes of 66 (88.0%) of the 75 children and young people. For the other nine families, main languages spoken at home were Arabic, Khmer, Korean and Vietnamese.

Indigenous children and young people

Twelve (16.0%) children and young people were identified as Aboriginal. No Torres Strait Islander children and young people were identified. Table 3.2 shows the means by which the Aboriginal children and young people were identified.

In 2001, 3.5 per cent of all children and young people aged 0-17 years in NSW were Indigenous (ABS, 2002). Aboriginal children and young people were therefore over-represented in assault, neglect and suspicious deaths (16.0%) compared with their numbers in the population ($X^2 = 34.7$, $p<.0001$).

1 This section has been written in compliance with the *Standards for Statistics on Cultural and Language Diversity* (ABS, 1999). The Standards are based on four core variables: country of birth, main language other than English spoken at home, proficiency in spoken English and Indigenous status.

Table 3.2 Indigenous child deaths: Method of identification by gender of child

Method of identification	Females	Males	Total
Recorded as Aboriginal by Registry & Team	0	4	4
Recorded as Aboriginal by Registry only	1	2	3
Recorded as Aboriginal by Team only	1	4	5
Total	**2**	**10**	**12**

Place of residence

The place of residence of the children and young people at the time of death was coded according to the Accessibility/Remoteness Index of Australia (ARIA; Commonwealth Department of Health & Aged Care, 2001). As described in the previous chapter, ARIA defines five categories of remoteness based on road distances to service centres. This classification does not take into account whether services are available in these centres.

As Table 3.3 shows, the overwhelming majority (92.0%) of children and young people in the study were living in highly accessible or accessible regions at the time of their deaths. The geographical distribution of the children and young people who died was significantly different to the geographical distribution of 0-17 year olds in NSW, with children and young people living in highly accessible areas being under-represented in assault, neglect and suspicious deaths, and children and young people living in all other areas being over-represented ($X^2 = 24.0$, $p<.0001$).

Table 3.3 Place of residence at time of death

	Children and young people in the study who lived in each area		0-17 year olds in NSW living in each area
	n	%	%
Highly accessible	52	69.3	82.1
Accessible	17	22.7	15.0
Moderately accessible	3	4.0	2.2
Remote	2	2.7	0.5
Very remote	1	1.3	0.1
Not classified	0	0.0	0.1
Total	**75**	**100.0**	**100.0**

Sources: ABS (2002a) 2001 *Census data*. Commonwealth Department of Health and Aged Care (2001) *Measuring remoteness: Accessibility/Remoteness Index of Australia (ARIA)*. Appendix F: ARIA values for 1999 Statistical Local Areas.

In summary,

- the highest number of deaths occurred among one to four year olds (46.7%) and infants under one year (21.3%);
- the majority of deaths were of males (61.3%);
- Aboriginal children and young people were over-represented (16.0% of study population versus 3.5% of NSW population);
- children and young people living in highly accessible areas were under-represented in assault, neglect and suspicious deaths (69.3% of study population versus 82.1% of NSW population).

3.3 Circumstances of the deaths

The 75 children and young people died in 68 separate incidents. Table 3.4 shows that in the majority of incidents, one child or young person died per incident (63 of 68 incidents). Five (7.3%) of the incidents involved multiple fatalities; no more than three children and young people died in the same incident.

Table 3.4 Number of incidents by number of child victims

Number of victims	Number of incidents	Number of children and young people	Percentage of incidents
One child victim	63	63	92.7
Two child victims	3	6	4.4
Three child victims	2	6	2.9
Total	**68**	**75**	**100.0**

In six incidents, victims other than the child or young person were involved. There were two incidents of spouse and child murders, one incident of murder-suicide and one incident where a parent murdered his three children and then attempted suicide. There was also one incident in which the child, mother and stepfather were murdered by an unrelated person and one incident where the child and mother were killed in a motor transport accident while the mother was drink-driving.

Table 3.5 shows the number of deaths that occurred in each month of the year. Although the numbers are too small to test for statistical significance, Table 3.5 demonstrates a trend towards an increase in the number of deaths in the months of January and February (19; 26.1%), and in the months of August, September and October (26; 35.7%). These findings are inconsistent with those of the CDRT *2000-2001 Annual Report*, which reported an increase in child deaths over the Christmas and New Year period.

Table 3.5 Number of deaths by year of death month

Month	1999 n	2000 n	2001 n	2002 n	Total[1] n	Total[1] %
January	–	4	2	2	8	11.0
February	–	3	4	4	11	15.1
March	–	1	–	1	2	2.7
April	–	2	–	–	2	2.7
May	–	1	1	1	3	4.1
June	1	2	–	–	3	4.1
July	1	3	3	–	7	9.6
August	1	3	4	–	8	11.0
September	1	3	6	–	10	13.7
October	1	4	3	–	8	11.0
November	1	2	2	–	5	6.8
December	5	1	–	–	6	8.2
Total	**11**	**29**	**25**	**8**	**73[2]**	**100.0**

1 Percentage of total deaths.

2 Total number of deaths is 73 (not 75) as one young person died in 1997 and one died in 1998.

Method of death

Table 3.6 presents the methods of the fatal assault, neglect and suspicious deaths by gender. Blunt force battery was the most frequently used method of fatal assault for males and suffocation/strangulation was the most frequently used method of fatal assault for females. Drowning or submersion was the most frequent method of fatal neglect.

Table 3.6 Methods of fatal assault and neglect deaths by gender

Method[1]	Females		Males		Total	
	Number	Per cent	Number	Per cent	Number	Per cent[2]
Fatal assault						
Blunt force battery	5	33.3	11	44.0	16	40.0
Suffocation/strangulation	6	40.0	6	24.0	12	30.0
Shooting	0	0.0	4	16.0	4	10.0
Drowning/submersion	1	6.7	2	8.0	3	7.5
Poisoning	2	13.3	0	0.0	2	5.0
Stabbing	1	6.7	1	4.0	2	5.0
Other assault	0	0.0	1	4.0	1	2.5
Total number of assault deaths	**15**		**25**		**40**	
Fatal neglect						
Drowning/submersion	5	38.5	11	61.1	16	51.6
Motor transport	4	30.8	5	27.8	9	29.0
Fire	2	15.4	0	0.0	2	6.5
Suffocation/strangulation	1	7.7	0	0.0	1	3.2
Bronchopneumonia	0	0.0	1	5.6	1	3.2
Starvation	1	7.7	0	0.0	1	3.2
Firearms	0	0.0	1	5.6	1	3.2
Total number of neglect deaths	**13**		**18**		**31**	
Suspicious						
Suffocation/strangulation	1	100.0	0	0.0	1	25.0
Drowning/submersion	0	0.0	1	33.3	1	25.0
Bronchopneumonia	0	0.0	1	33.3	1	25.0
Sudden death, cause unknown	0	0.0	1	33.3	1	25.0
Total number of suspicious deaths	**1**		**3**		**4**	

1 Deaths were classified according to ICD-10 external cause codes. The complete list of ICD categories is provided in Appendix 3.

2 Percentage of deaths within each death category (fatal assault, fatal neglect or suspicious).

Place of death incident

Table 3.7 presents the place of incidence of assault, neglect or suspicious deaths. Approximately three-quarters (74.7%) of the deaths occurred at either the child or young person's home or at another home. Over half of the neglect deaths (54.8%) and two out of the four suspicious deaths occurred at the child's home. Almost one-fifth (19.4%) of neglect deaths took place on roadways.

Table 3.7 Place of incidence of deaths

Place of incident	Assault		Neglect		Suspicious		Total	
	n	%	n	%	n	%	n	%
Child's home	19	47.5	17	54.8	2	50.0	38	50.7
Other home	12	30.0	6	19.4	0	0.0	18	24.0
Roadway	2	5.0	6	19.4	0	0.0	8	10.7
Bushland	5	12.5	0	0.0	0	0.0	5	6.7
Other	2	5.0	2	6.5	2	50.0	6	8.0
Total	**40**		**31**		**4**		**75**	

Suspects in the fatal assault, fatal neglect and suspicious deaths

In 30 of the 40 (75.0%) fatal assault deaths, the children and young people were killed in the context of care giving relationships. The suspects were one or both biological parents (23); biological mother and boyfriend/de facto (3); male de facto (2); foster mother (1); and another relative (1). The persons alleged to have committed the assault in the non-familial fatal assault deaths were unrelated and known to the victim (5); persons unrelated and unknown to the victim (4); and for one young person no information was obtained.

The private nature of deaths resulting from neglect or suspicious of assault and neglect, the lack of recorded information about these deaths and the conflicting accounts from those involved made it difficult to determine responsibility. However, one or both parents were caring for 29 of the 35 (82.9%) children and young people at the time of their deaths. In five of the six other cases, another relative or unrelated adult was caring for the child. In the other case, no adults were caring for the child at the time of death.

3.4 Family circumstances

Living arrangements

Just over half of the children and young people (42; 56.0%) were living with both biological parents. A further 20 (26.7%) were living with one biological parent only; nine (12.0%) were living in step-parent or blended families; three (4.0%) were living with relatives; and one child was living with foster parents.

Three children (1 female, 2 males), aged three, four, and 13 years were under the parental responsibility of the Minister for Community Services at the time of their deaths. Two of these children were living with relatives and one was living with her mother and maternal grandmother. A further three children (aged 2, 3 and 7 years) had been placed in temporary care in the 12 months prior to their deaths but had been returned to live with their parents before their deaths.

The living arrangements for the children and young people who died from assault and neglect were slightly different to the living arrangements for the overall population of children and young people in NSW. In 2001, 79.0 per cent of 0-15 year olds were living in couple families (ABS, 2002); by contrast, 68.0 per cent of the children and young people in the present study lived in couple families. In 2001, 21.0 per cent of 0-15 year olds in NSW were living in one-parent families (ABS, 2002). In the present study, 26.7 per cent of the children and young people were living with one biological parent only.

Number of children in family residence

The mean number of children and young people living in the households of the children and young people who died was 2.19 (sd = 1.3). Of the 75 children and young people who died, just under half (35; 46.7%) were the youngest of the children and young people in the family; 11 (14.7%) were the middle child; and 13 (17.3%) were the oldest child in the family. A further 12 (16.0%) were only children and no information was recorded for four children and young people regarding the number of children living in the household.

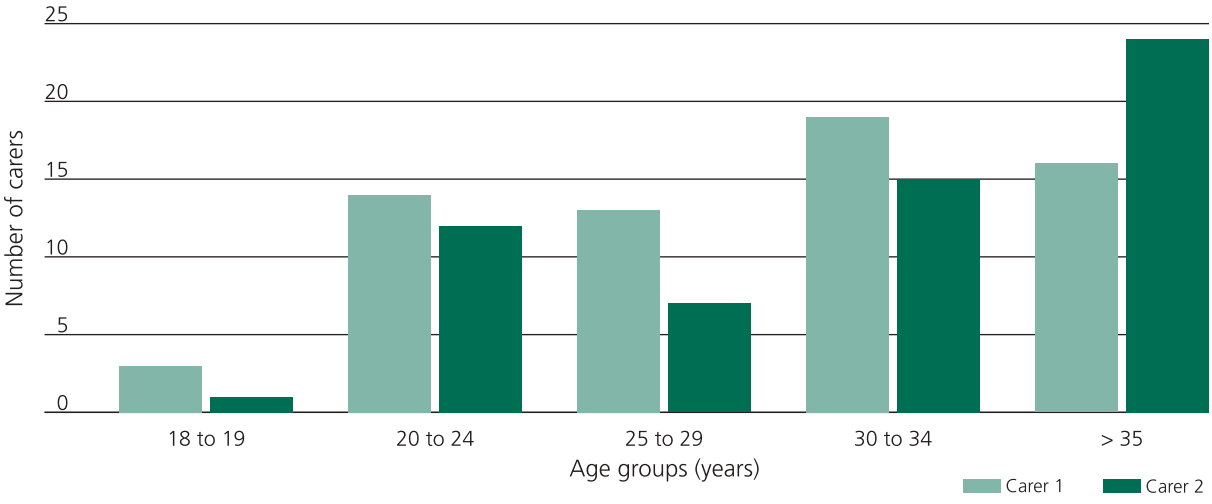
Twelve children and young people had siblings living in other households (23 siblings). This dislocation is suggestive of family disruption.

Two families had experienced the death of a previous child – one was stillborn and the other was attributed to SIDS one year before the child's sibling was killed by her mother's de facto.

Age of carers

Figure 3.2 shows the carers' ages at the time of the children's and young people's deaths. Just over half (53.8%) of the primary carers were aged 30 years and above, and 46.1 per cent were aged between 18 and 29 years. In contrast, two-thirds (66.1%) of secondary carers were aged 30 years or above.

Figure 3.2 Age of carers at time of child's death



Note: Carer 1 includes biological mother (78.7%), biological father (14.7%), grandmother (2.7%), foster mother (1.3%), and other adults (2.7%). Information was not available regarding the ages of 10 primary carers.

Carer 2 includes biological father (58.7%), biological mother (16.0%), mother's de facto (10.7%), stepfather (1.3%), foster father (1.3%), grandfather (1.3%), and other adults (4.0%). Five children and young people had just one carer. Information was not available regarding the ages of 11 secondary carers.

Circumstances of carers

Consistent with previous findings (CDRT, 2002), the 68 families in which these deaths occurred were generally characterised by ongoing issues with health[2] and well-being, violence and crime, and social and economic disadvantage. While not all the information collected during the case reviews was available for every child or young person, several factors were evident from the administrative records in the lives of the caregivers preceding the children and young people's deaths. These are recorded in Table 3.8.

Table 3.8 shows that all of the problems associated with health and well-being, violence and crime, and social and economic disadvantage factors (with the exception of accommodation difficulties) were more prevalent among the children and young people who died as a result of fatal assault than among those who died as a result of fatal neglect. Domestic violence, caregivers' criminal behaviour and stressful events were the most commonly experienced factors.

Table 3.8 Carer circumstances by category of death

	Assault		Neglect		Suspicious		Total	
	n	%	n	%	n	%	n	%
Total number of families	**34**	**50.0**	**30**	**44.1**	**4**	**5.9**	**68**	**100**
Health and well-being								
Alcohol abuse	7	20.6	5	16.7	1	25.0	13	19.1
Drug abuse	10	29.4	4	13.3	1	25.0	15	22.1
Intellectual Disability	2	5.9	–	–	–	–	2	2.9
Mental health problems[1]	6	17.6	4	13.3	–	–	10	14.7
Suicide attempts	7	5.9	1	3.3	–	–	8	11.8
Violence								
Victim of abuse or neglect as a child	11	32.4	9	30.0	–	–	20	29.4
Domestic violence (victim)	22	64.7	12	40.0	–	–	34	50.0
Domestic violence (perpetrator)	23	67.6	13	43.3	1	25.0	37	54.4
Criminal behaviour								
Offending as a juvenile	9	26.5	4	13.3	1	25.0	14	20.6
Offending as an adult	18	52.9	15	50.0	2	50.0	35	51.5
Social or economic								
Financial difficulties	10	29.4	7	23.3	1	25.0	18	26.5
Accommodation difficulties	4	11.8	8	26.7	–	–	12	17.6
Stressful events[2]	26	76.5	13	43.3	1	25.0	40	58.8

1 Includes diagnosed mental health problems only.

2 Includes change in family composition, death of family member, major illness in family, carer's loss of job, homelessness, relationship breakdown, and change in residence.

2 This study uses the World Health Organisation (1948) definition of health. The WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Of the 68 families, 58 (85.3%) had at least one documented health and well-being related, violence and crime-related, or social and economic problem, and more than half of the families (37; 54.4%) had experienced three or more factors.

In summary,

- Blunt force battery was the most frequently used method of fatal assault, while drowning submersion was the most common cause of fatal neglect.
- In three-quarters of the fatal assault deaths, the children and young people were killed in the context of care-giving relationships. One or both biological parents were caring for 82.9 per cent of the children and young people who died as a result of neglect or in suspicious circumstances.
- Just over half (53.8%) of the primary carers were aged 30 years and above at the time of the children and young people's deaths.
- More than half (54.4%) of families had experienced three or more health and well-being, violence, crime or social and economic disadvantage factors.

3.5 Agency involvement

The NSW Government is committed to a coordinated and comprehensive response to promote the protection of children and young people. The *NSW Interagency Guidelines for Child Protection Intervention* (2000) outline the roles and responsibilities for government and non-government agencies providing any form of child protection for children and young people and their families. The aim of the guidelines is to facilitate a coordinated approach and so promote good outcomes for children and young people. The Department of Community Services has the 'lead responsibility' and the mandate to coordinate responses and ask other agencies to provide appropriate care and support when such intervention is necessary. The Department of Community Services has 'wide-ranging statutory powers to enable it to carry out its role in protecting children and young people from abuse and neglect' (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.4). This lead role does not detract from the joint responsibility of all relevant agencies to work together to provide a coordinated and comprehensive response to protect children and young people.

Of the group of 75 children and young people, the families of 15 (20.0%) had no record of prior agency contact. Table 3.9 lists the agencies that were involved with the 60 families who had prior agency contact. As shown, NSW Police, the Department of Community Services and NSW Health[3] were the agencies most frequently accessed. Table 3.9 also shows that the families with children who died as a result of assault had more agency involvement than those families with children who died as a result of neglect.

3 Children, young people and their families attend health services for a range of reasons and contact with NSW Health is expected to occur over a person's life. These contacts present opportunities for health professionals to identify children and young people who may be at risk and to take appropriate action.

Table 3.9 Agency involvement by category of death

Agency	Assault n	Assault %[1]	Neglect n	Neglect %[1]	Suspicious n	Suspicious %[1]	Total n	Total %[2]
NSW Police	28	70.0	16	51.6	–	–	44	58.7
Department of Community Services	27	67.5	16	51.6	1	25.0	44	58.7
NSW Health	23	57.5	18	58.1	1	25.0	42	56.0
Department of Education and Training	11	27.5	5	16.1	–	–	16	21.3
Department of Housing	10	25.0	6	19.4	–	–	16	21.3
Catholic Education Office	1	2.5	–	–	–	–	1	1.3
Non-government organisations	3	7.5	5	16.1	–	–	8	10.7
Juvenile Justice	2	5.0	–	–	–	–	2	2.7
No agency contact	6	15.0	6	19.4	3	75.0	15	20.0
Total number of deaths in each category	**40**		**31**		**4**		**75**	

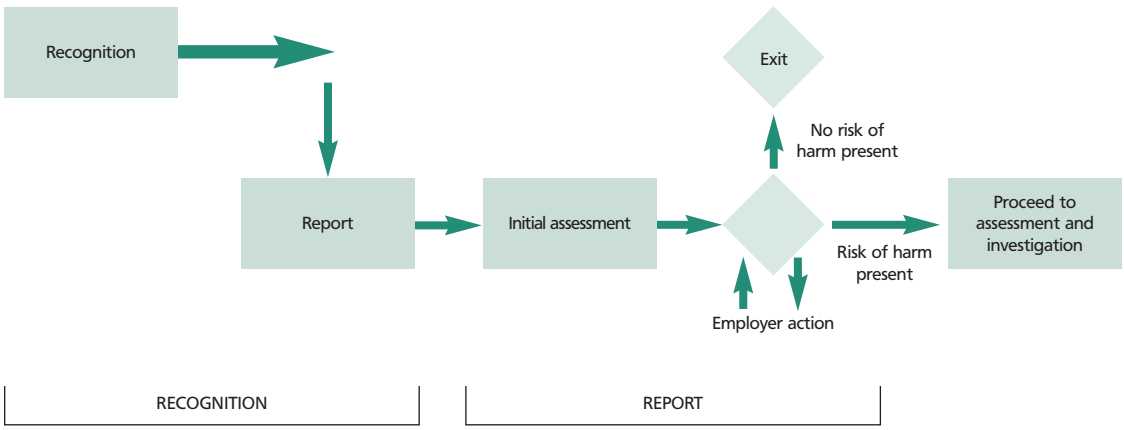
1 Percentage of children and young people in each category whose families had contact with each agency.
2 Percentage of all 75 children and young people whose families had contact with each agency.

The *NSW Interagency Guidelines for Child Protection Intervention* (2000) outlines the practice framework for child protection intervention and the roles and responsibilities of the various agencies. There are four broad stages in this framework: recognition and reporting; assessment and investigation; protective intervention and ongoing care and support.

Recognition and reporting

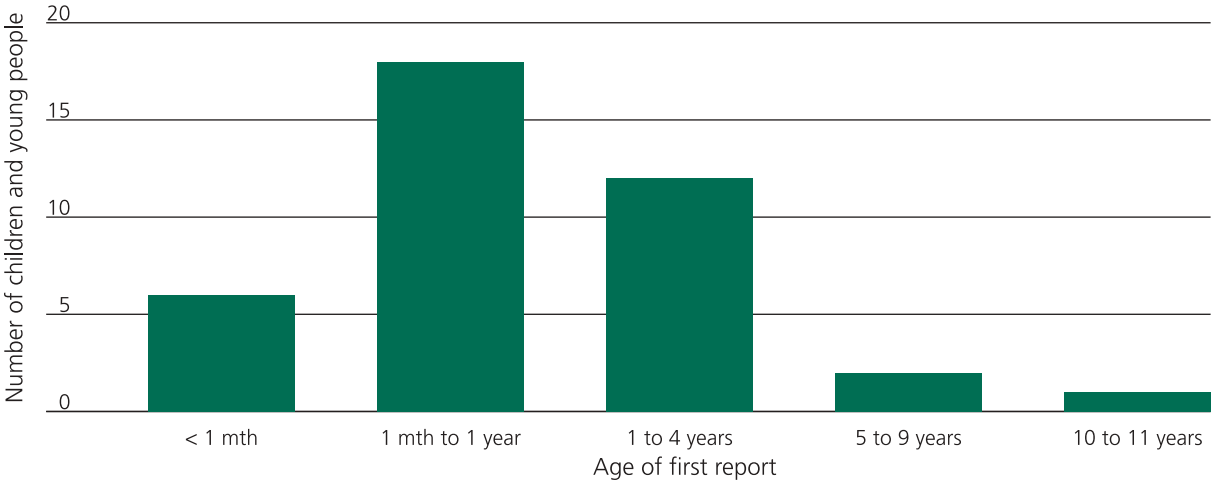
Recognising indicators of child abuse and neglect assists in forming a responsible concern or well-founded suspicion that there is a risk of harm from abuse or neglect, which is current or likely to occur. In such situations, action should be taken to protect the child or young person and assist the family by making a report. Reporting children under the age of 16 years is mandatory in NSW for the following professionals: health care, welfare, education, children's services, residential services, or law enforcement. In addition, any person including parents, relatives, friends, neighbours and acquaintances, who suspects on reasonable grounds that a child or young person is at risk of harm may report (*NSW Interagency Guidelines for Child Protection Intervention*, 2000). The recognition and reporting process is illustrated in Figure 3.3.

Figure 3.3 Recognition and reporting process



Source: NSW Interagency Guidelines for Child Protection Intervention (2000), p. 70.

Figure 3.4 Age of first report of risk of harm



Key facts

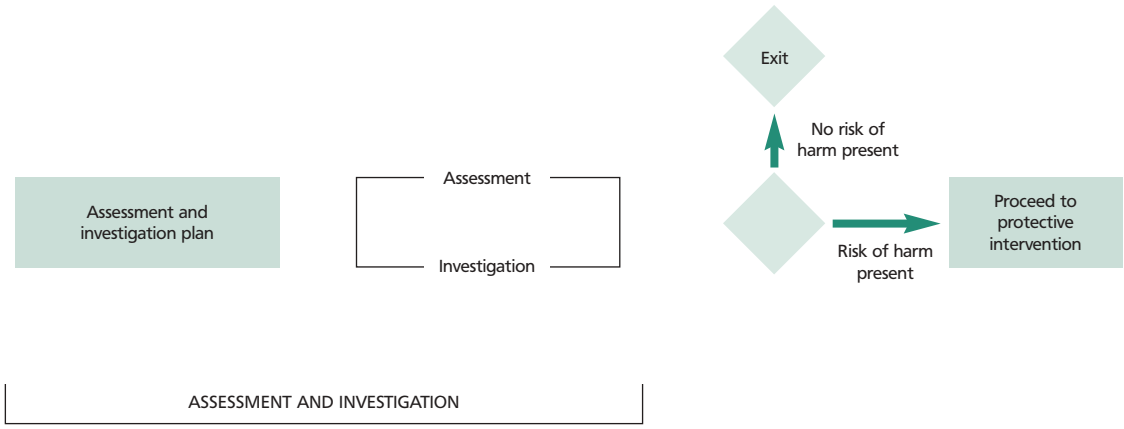
- 39 (52.0%) children and young people had been the subjects of 110 reports to the Department of Community Services prior to their deaths. Of these:
  - 23 (59.0%) died as a result of assault;
  - 15 (38.5%) died as a result of neglect;
  - one child died in suspicious circumstances.
- 24 (61.5%) of the 39 children and young people were first reported before the age of one year (see Figure 3.4).
- 16 (41.0%) had been reported once only (mean number of reports per child or young person was 1.5 (SD = 2.2).
- category of reports[4]
  - physical abuse: 15.0 per cent
  - psychological abuse: 3.3 per cent
  - sexual abuse: 8.3 per cent
  - neglect: 23.3 per cent
  - other: 50 per cent
    - carer: Adults behaviour – Domestic violence (40.8%)[5]
    - carer: Alcohol and/or other drug use (15.5%)
    - carer: Disability – Development (2.8%)
    - carer: Disability – Psychiatric (2.8%)
    - carer: Emotional state (4.3%)
    - carer: Suicide risk (1.4%)
    - family: Homelessness of family (1.4%)
    - family: Parenting skills development required (1.4%)

4 The categories reported here were those in use on the Department of Community Services' Client Information System at the time of this Report. They do not reflect the categories of risk of harm identified in Section 23 of the *Children and Young Persons (Care and Protection) Act 1998*.
5 Percentage of total "other" reports.

- family: Well-being concerns for child (15.5%)
- risk: Inadequate supervision for age (2.8%)
- risk: Domestic violence – Child witnesses violence (7.0%)
- risk: Risk of physical harm or injury to child (1.4%)
- risk: Risk of sexual harm or injury to child (1.4%)
- basic physical needs at risk (1.4%)

- of the 110 reports, 65 (59.1%) were made by professionals and 45 (40.9%) were made by community members.

Figure 3.5 Assessment and investigation process



Source: NSW Interagency Guidelines for Child Protection Intervention (2000), p. 70

Assessment and investigation

The purpose of the assessment and investigation stage is to identify the needs of the child, young person and family and to gather information to decide what, if any, protective intervention is required. An interagency approach is essential for effective child protection assessment and investigation. Each case requires a clear assessment and investigation plan that outlines what needs to be done, by whom and the timeframe for each activity (*NSW Interagency Guidelines for Child Protection Intervention*, 2000). Figure 3.5 illustrates the assessment and investigation process.

Key facts

- on the basis of the information obtained, it was decided by the Department of Community Services that there was sufficient risk to investigate and assess 103 (93.6%) of the 110 reports.
- an assessment and investigation commenced for 78 (75.7%) of the 103 reports.
- in 49 of the 78 (62.8%) reports assessed and investigated the risk of harm was substantiated[6].
- information on the decision following assessment and investigation was available for 65 of the 78 reports:
  - 24 (30.8%) were closed with no further action taken
  - 12 (15.4%) were closed after referrals were made to a service

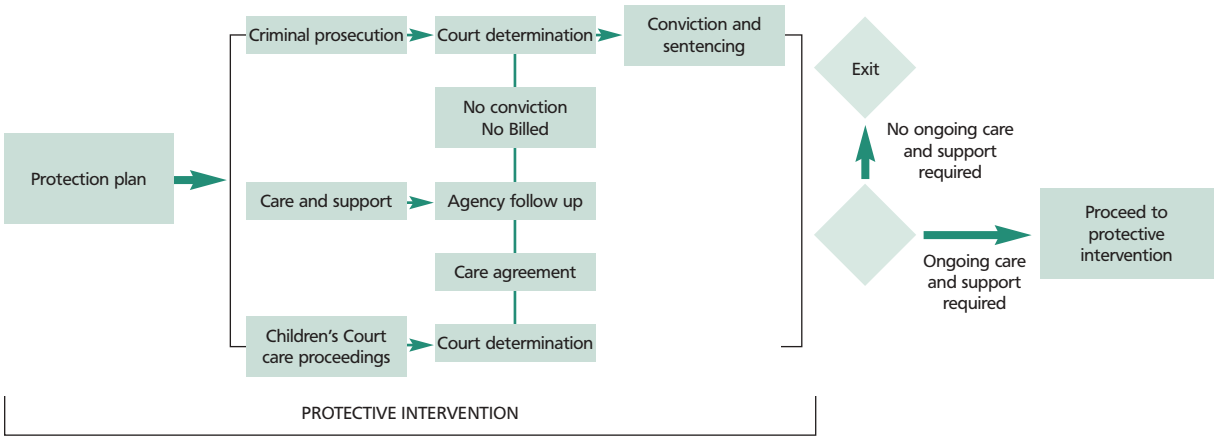
6 Under the *Children (Care and Protection) Act 1987*, 'substantiated' meant that the incident outlined in the notification was confirmed. Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* was proclaimed on 18 December 2000. Under this legislation, 'substantiated' means that a child or young person has been found to be at risk of harm within the meaning of Section 23.

- 8 (10.3%) were closed after referrals were made to a service and the family had commenced with the service
- 21 (26.9%) remained open for protective intervention.

Protective intervention

An interagency approach to protective intervention involves the coordinated involvement of agencies that are providing protection for a child, young person or family. The various activities undertaken by agencies during this stage should be based on a planned and coordinated response to the conclusions reached in assessments and investigations already completed. The first activity is to develop a protection plan, using an interagency approach by way of a protection planning meeting (*NSW Interagency Guidelines for Child Protection Intervention, 2000*). The protective intervention process is illustrated in Figure 3.6.

Figure 3.6 Protective Intervention process



Source: NSW Interagency Guidelines for Child Protection Intervention (2000), pp. 70-71.

Key facts

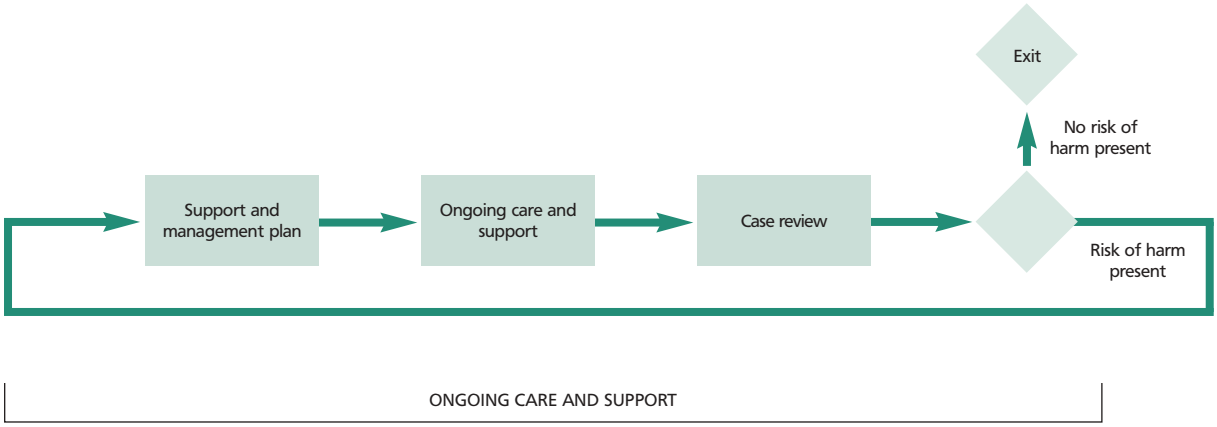
- protective planning meetings were held in 13 (61.9%) of the 21 cases that were not closed after the assessment and investigation process
  - eight of the 13 were interagency protective planning meetings
- from the information available it was possible to determine that:
  - five children had been assumed into care[7] in the 12 months prior to their deaths; and
  - three children had medical examinations ordered under Section 23 of the *Children (Care and Protection) Act 1987* in the 12 months prior to their deaths.

Care and support

Ongoing care and support is a critical stage that involves case planning and review for the child or young person. The aim is to coordinate the delivery of a range of care and support services that will work together over time to address the long-term needs of the child or young person and the family. A committed approach to care and support of children, young people and families is required (*NSW Interagency Guidelines for Child Protection Intervention, 2000*). Figure 3.7 illustrates the ongoing care and support process.

7 When a child or young person is currently in a place of safety such as a hospital, or with relatives or friends, but may be placed at risk of serious harm if they were to be removed from those premises, the Department of Community Services may assume care under Section 44 of the *Children and Young Persons (Care and Protection) Act 1998*.

Figure 3.7 Recognition and reporting process



Source: NSW Interagency Guidelines for Child Protection Intervention (2000), p. 70.

Key facts

- four children were receiving ongoing care and support services when they died:
  - three children were under the parental responsibility of the Minister for Community Services
  - one child was under a temporary care agreement.
- two of the four children were Aboriginal.

Agency involvement with Aboriginal and non-Aboriginal families

The over-representation of Aboriginal children and young people in the child protection system is widely acknowledged (Gordon et al., 2002). Table 3.10 compares the agency involvement of Aboriginal families and non-Aboriginal families. Although the numbers are small, Table 3.10 shows that Aboriginal families had more involvement with all agencies, with the exception of the Department of Education and Training. This finding is, however, a function of the ages of the Aboriginal children and young people in the study; 75 per cent were aged less than five years[8]. In comparison, 66.7 per cent of non-Aboriginal children and young people in the study were aged less than five years. Aboriginal families were more likely than non-Aboriginal families to have been clients of the Department of Community Services, NSW Police, NSW Health, Department of Juvenile Justice, Department of Housing and non-government organisations.

Although the numbers are small, 50 per cent of Aboriginal families had lived in Department of Housing accommodation. It is well recognised that public housing estates are often environments where people with multiple social problems are housed in close proximity. These may be difficult and dangerous environments, particularly for those families who do not have good social supports.

8 Children may enter kindergarten at the beginning of the school year in NSW government schools if they turn five on or before 31 July in that year.

Table 3.10 Comparison of agency involvement for Aboriginal and non-Aboriginal families

Agency	Aboriginal families		Non-Aboriginal families	
	Number	Per cent	Number	Per cent
NSW Police	10	83.3	34	54.0
Department of Community Services	9	75.0	35	55.6
NSW Health	11	91.7	31	49.2
Department of Education and Training	1	8.3	15	23.8
Department of Housing	6	50.0	10	15.9
Non-government organisations	4	33.3	4	6.3
Department of Juvenile Justice	2	16.7	0	0.0
No agency contact	0	0.0	15	23.8
Total number of deaths	**12**		**63**	

Although Aboriginal families had more contact with agencies than did non-Aboriginal families, there is insufficient information to draw any conclusions about any differences in the appropriateness of agency practice. For example, it has been acknowledged that the legacy of past mistakes by protective services has resulted in some child protection workers being fearful of taking action when an Aboriginal child is at risk of harm (Tomison & Stanley, 2001; cited in Gordon et al., 2002). Consequently, past removal policies continue to impact on current service delivery. Further, it has been argued that the views of Aboriginal workers are not always taken into account and that decision-making remains with non-Aboriginal workers (Cunneen & Libesman, 2000; cited in Gordon et al., 2002). Thus, the over-representation of Aboriginal families in agency involvement does not necessarily lead to more appropriate agency involvement.

In summary,

- eighty per cent of the families had prior agency contact.
- families of children who were fatally assaulted had experienced more agency involvement than families of children who were fatally neglected.
- just over half (52.0%) of the children and young people had been reported to the Department of Community Services.
- assessments and investigations commenced for three-quarters (75.7%) of the reports that were made. Of those, 62.8 per cent were substantiated[9].
- just over one-quarter (26.9%) of substantiated reports remained open for protective intervention and ongoing care and support.
- protective planning meetings were held in 61.9 per cent of the cases that remained open.
- four children were receiving ongoing care and support services when they died.
- Aboriginal families had more agency contact than non-Aboriginal families.

9 'Substantiated' means that a child or young person has been found to be at risk of harm within the meaning of section 23 of the *Children and Young Persons (Care and Protection Act) 1998.*

3.6 Criminal and coronial proceedings

The CDRT may not always come to the same findings as the Coroner. The Team has a fundamentally different role to the Coroner in that the Team reviews groups of deaths, and in some cases has information available to it that is not always accessed on a case-by-case basis by the Coroner. The Team looks at trends and patterns of deaths and is not required to adhere to civil or criminal standards of proof as the Coroner is.

Under the *Coroners Act 1980*, the Coroner can hold an inquest if one or more of the following statutory matters are not sufficiently disclosed:

- the identity of the deceased;
- the date and place of death;
- the cause of death;
- the manner of death.

If all the statutory matters are clear, the Coroner can still give consideration as to whether or not an inquest should be held, including whether a hearing may:

- provide important social and statistical information;
- dispel public controversy or satisfy public interest;
- resolve doubts or concern by relatives or other interested persons;
- determine unexplained facts or circumstances;
- produce evidence while it is fresh and available in a case where evidence may be required months or years later;
- establish a case for an indictable offence against any person;
- produce recommendations which could prevent similar deaths or improve health and safety procedures[10].

Where the Coroner has jurisdiction to investigate a death, the Coroner's role is determine the identity of the deceased, the date, place, manner and cause of death. If, during the course of an inquest, the Coroner is of the opinion that a known person may have committed an indictable offence in relation to the death, the Coroner may refer the matter to the Director of Public Prosecutions. The Coroner may make recommendations on a case-by-case basis regarding public health and safety and other relevant issues (*Coroners Act* s22A).

Following the enactment of the *Community Services Legislation (Amendment Act) Act 2002*, from 1 December 2002 the State Coroner and his Deputies have jurisdiction to examine the deaths of

- children in care;
- children at risk of harm, or who have been at risk of harm during the last three years and the siblings of such children;
- persons (whether or not children) who were living in, or were temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for handicapped persons (*Coroner Act 1980* s13AB).

10 *Coroners Act 1980*, ss 13, 14, 22.

These deaths are examinable by the State Coroner or his Deputies even if the child dies from an apparent natural cause. A medical practitioner cannot issue a medical certificate as to cause of death in these cases. The deaths are also reviewable by the NSW Ombudsman.

Inquests are required to be held in all homicide cases[11]. For deaths where an inquest is not required to be held, a Coroner generally dispenses with an inquest if he or she is satisfied as to those statutory matters of which he or she is required to be satisfied.

Coronial proceedings were commenced for all 75 children and young people. The coronial outcomes are listed in Table 3.11. In the majority of fatal assault cases (29; 72.5%), the inquest was terminated and the matter forwarded to the criminal system. In contrast, approximately 20 per cent of fatal neglect cases (6, 19.4%) were forwarded to the criminal system. An inquest was dispensed with in 21 (67.7%) of the 31 fatal neglect matters and three of the four suspicious matters. In comparison, an inquest was dispensed with in just two of the 40 fatal assault matters.

Table 3.11 Coronial outcomes by category of death

Coronial outcome	Assault	Neglect	Suspicious	Total
Matters dispensed with	2	21	3	26
Matters terminated s19				
Forwarded to criminal system	29	6	–	35
Findings given				
Accidental death (autopsy immersion)	1	–	–	1
Accidental death (autopsy drowning)		3		3
Accidental death (autopsy laryngeal obstruction)	1	–	–	1
Accidental death (autopsy hypoxic brain damage)	–	1	–	1
Murder (gunshot wound to head)	1	–	–	1
Undetermined (autopsy undetermined)	1	–	1	2
Ongoing				
Matters not finalised	5	–	–	5
Total	**40**	**31**	**4**	**75**

Criminal proceedings commenced in 35 (46.7%) of the 75 cases reviewed. Table 3.12 shows that suspects were charged in 26 of the 29 assault cases where the inquest was terminated. In three cases, the matter was forwarded to the criminal system, but no one was subsequently charged. In 20 assault cases, the suspect(s) was charged with murder, in a further five cases the charge was manslaughter, and one suspect was charged with affray. In those 26 assault cases, 15 perpetrators were found guilty; three were found not guilty for reasons of mental illness; one was found not guilty; in one case the charges were dropped; and six cases are not yet finalised.

All four perpetrators who were charged and convicted of manslaughter had been initially charged with murder. The charges were downgraded from murder to manslaughter as these cases proceeded through the criminal justice system.

Table 3.12 also shows that suspects were charged in all six neglect cases for which the inquest was terminated. Two suspects were charged with manslaughter and four were charged with negligent driving (occasioning death). Three perpetrators were found guilty, two were found not guilty, and in one case the charges were dropped.

11 *Coroners Act 1980*, s14B.

Table 3.12 Criminal proceedings by category of death

Criminal charge	Finding	Assault	Neglect	Total
Murder	Guilty	10	–	10
	Not guilty by reason of mental illness	3	–	3
	Charges dropped	1	–	1
	Not finalised	6	–	6
Manslaughter	Guilty	4	1	5
	Not guilty	1	1	2
Affray	Guilty	1	–	1
Negligent driving	Guilty	–	2	2
(occasioning death)	Charges dropped	–	1	1
	Not guilty	–	1	1
Total perpetrators		**26**	**6**	**32**

Table 3.13 shows the average length of time taken to finalise the coronial and criminal proceedings for the 75 cases. Autopsies were conducted on average 2.3 days after the death of the child or young person. The mean length of time taken to finalise the coronial process was 7.5 months. When the coronial process was terminated, suspects were charged on average 2.0 months after the death of the child or young person and sentenced on average 16.8 months after the death.

Table 3.13 Length of coronial and criminal proceedings

	Mean	SD	Minimum	Maximum
Coronial proceedings				
Autopsy conducted	2.3 days	5.8 days	0 days	51 days
Autopsy report received	2.8 mths	1.9 mths	1 day	8.9 mths
Brief of evidence received	2.9 mths	2.5 mths	28 days	9.9 mths
Coronial process finalised	7.5 mths	5.7 mths	0 days	22.5 mths
Criminal proceedings				
Suspect charged	2.0 mths	3.7 mths	0 days	19.5 mths
Suspect sentenced	16.8 mths	3.8 mths	9.8 mths	23.3 mths

Note: Numbers refer to the length of time from the date of death.

In summary,

- the inquest was terminated and the matter forwarded to the criminal system in 72.5 per cent of fatal assault cases. In contrast, 20 per cent of fatal neglect cases were forwarded to the criminal system.
- suspects were charged in 26 of the 29 fatal assault cases for which the inquest was terminated and in all six neglect cases for which the inquest was terminated.

3.7 Classification of fatal assault and neglect deaths

The CDRT definitions of abuse, neglect and suspicious of abuse and neglect were used to categorise the 75 deaths. Thirty-nine of the 40 cases of assault were further classified using the methodology developed in the *Fatal Assault of Children and Young People* (NSW Child Death Review Team, 2002) report. Based on the story of each child's death, these cases were clustered according to common characteristics within the group into the four categories of: fatal non-accidental injury, parents affected by a mental illness, family breakdown, and killings of teenagers. One child was unable to be classified as his death followed a different pattern to all of the other fatal assaults. This five year old boy was prescribed tablet medication for a minor condition. He did not want to take the tablets, but his mother allegedly forced a tablet into his mouth. The boy choked on the tablet and died.

Based on an analysis of the circumstances surrounding the 31 neglect deaths, these cases were grouped into three categories: inadequate supervision, negligent driving, and failure to provide medical care.

These fatal assault and neglect groups are presented in Table 3.14. A description of each category follows.

Table 3.14 Classification of fatal assault and neglect deaths

Category	Description	Number
Assault		
Non-accidental injury	Injuries sustained resulted from either a series of assaults or one fatal assault	20
Mental illness	Parental mental illness was the precipitant to the death	6
Family breakdown	Conflict and breakdown in the parents' relationship was the precipitant to the death	5
Teenage killings	Teenagers were killed by perpetrators who were not family members/carers	8
Neglect		
Inadequate supervision	Act of omission by the parent or carer	26
Negligent driving	Negligent driving by a parent was the precipitant to the death	4
Failure to provide medical care	Failure to obtain medical care was the precipitant to the death	1
Suspicious of assault or neglect	A history of child abuse and neglect or other concerning circumstances in the context of the death incident but there was insufficient information to be conclusive	4
Total		**74**[1]

1 Total number does not equal 75, as one fatal assault was unable to be classified.

Fatal assault

Non-accidental injury

Twenty children (7 females, 13 males), aged between seven weeks and six years, died from non-accidental injury. The injuries sustained resulted from either a series of assaults or one fatal assault. The deaths of these children were not precipitated by the parents' relationship breakdown or mental illness. All but two of the fatal non-accidental injuries occurred within the family. The suspects were the biological parent(s) (13), mother's de facto (3), foster mother (1), other relative (1), and persons unrelated but known to the child (2).

Parents affected by a mental illness

The deaths of six children (all females), aged between six months and nine years, were precipitated by a parent's or carer's mental illness. In four of the six cases, the perpetrators were the children's biological mother. The mother's boyfriend/de facto were the perpetrators in the other two cases. Two perpetrators were suffering from Depressive Disorder, one was suffering from Postnatal Depression and three had been diagnosed with psychotic disorders.

Family breakdown

Five children in two families (1 female, 4 males), aged between four and 13 years, died in the context of parental dispute and family breakdown. Both of the perpetrators were the children's biological fathers. One father killed his wife and two children and attempted suicide after learning that his wife was planning to leave him. He later committed suicide while in custody. Details of the second case are unable to be provided as the legal process has not yet been finalised. This father has been charged with the murder of his three children.

Killings of teenagers

Eight children and young people (1 female, 7 males), aged between 13 and 17 years, were killed by persons who were not family members or carers. Three of the fatal assaults of males involved group killings; two of those incidents involved altercations between rival gangs. One young person was killed as a result of violence committed in the course of a robbery; one was killed by his mother's friend; one was killed during an altercation after having consumed large quantities of alcohol; and one male was believed to have been killed by his stepfather's criminal associate. His stepfather and mother were also killed in the same incident. In one case, no information was obtained in relation to the person.

Fatal neglect

Inadequate supervision

Twenty-six children (8 females, 18 males), aged between six weeks and 11 years, died as a result of inadequate supervision.[12] Seventeen children died in drowning accidents, five died in motor transport accidents, two died in house fires, one child died in an accidental hanging and one child died from a gunshot wound. The firearm was accidentally discharged by the child's younger brother. These children were being cared for by a biological parent, other relative, or another adult. In one case, there were no adults present at the time of the fatal incident.

Negligent driving

Four children in three families (all females), aged between three and six years, died in incidents precipitated by a parent's negligent driving. Two siblings died in a motor vehicle accident in which their mother was driving with a blood alcohol level of 0.153g/100ml. A third child was killed in a motor vehicle accident in which her father was driving while affected by cannabis and amphetamines. A fourth child died in a motor vehicle accident when her mother fell asleep at the wheel. The child was not wearing a seatbelt at the time of the incident and was lying down in the back of the vehicle. The child's mother also died in the accident.

12 Rosenberg (1994) defines inadequate supervision as the failure of parents or carers 'to provide attendance, guidance and protection to children who, lacking experience and knowledge, cannot comprehend or anticipate dangerous situations'.

Failure to provide medical care

One 14 month old female died as a result of malnutrition after her parents failed to seek medical attention for her. Concerns regarding the girl's health had been reported to the Department of Community Services who ordered that a medical examination be carried out. The parents refused to seek medical care due to their bizarre lifestyle beliefs. She died the following week.

Deaths suspicious of assault or neglect

Four children (1 female, 3 males), aged between 11 months and five years, died in circumstances suspicious of assault or neglect. All were in the care of their biological parent or parents at the time of death. In two of these deaths, the parents were affected by alcohol or other drugs.

The following two chapters explore in detail the fatal assault and fatal neglect groups. Due to the small number of deaths that were suspicious of assault or neglect, these deaths are detailed below and are not the focus of a separate chapter.

3.8 Deaths suspicious of assault or neglect

Four children (1 female, 3 males) died in circumstances suspicious of assault or neglect. Two of the four deaths were suspicious of assault, one was suspicious of neglect and for one death it was not possible to make a determination as to whether the death was suspicious of assault or neglect. These deaths were considered to be suspicious for the following reasons:

- there was a history of abuse or neglect in the child's family background; or
- there were other concerning circumstances in the context of the death incident; or
- there was insufficient evidence or information in the post mortem to determine whether the cause of death was or was not clearly due to assault or neglect.

The four children were aged 11 months, two years (2), and five years when they died. All four children were born in Australia and the main language spoken at home was English.

Three of the four children were living with both biological parents at the time of their deaths. One child was living with his biological father only. The child's biological mother was the primary carer for three of the four children. The biological father was the primary carer for one child. The mean age of the primary carer was 31.0 years. All but one of the children were the only child in the family.

Of the four families, two did not appear to have experienced any health and well-being, violence, crime or social or economic disadvantage factors. Documentation showed that two families experienced at least one difficulty, including parental substance abuse (1), domestic violence (1), parental criminal behaviour (1), changes in family composition (1), and financial difficulties (1).

Just one of the four children came from a family that had prior agency involvement. The agencies involved with this family included NSW Health and the NSW Department of Community Services.

Circumstances of the deaths

Table 3.15 presents a summary of the circumstances surrounding the deaths, the autopsy cause of death and the coronial outcome for each of the four deaths. As shown, inquests were dispensed with in three of the four cases. One coronial inquest was held in which a finding was given. No criminal charges were laid in relation to any of the deaths.

Table 3.15 Suspicious group: Circumstances of the deaths

Age, gender	Death scenario	Cause of death	Coronial outcome
11 mths, male	Infant developed cold symptoms and was taken to hospital. He suffered a series of cardiac arrests. Subdural haemorrhages noted at autopsy. Although such haemorrhages may be seen in non-accidental injury, this possibility was not investigated.	Bronchopneumonia	Inquest dispensed with
2 years, male	Child's father and his friend were substance-affected at time of child's death and gave conflicting accounts as to how and when the child was found. Extensive history of prior child abuse. Autopsy cause of death was undetermined, despite finding that 'a focus of bruising was noted on the left side of the face' suggesting that 'the possibility of suffocation cannot be completely excluded.'	Undetermined	Finding given
5 years, male	Child was at a rugby match with his family nearby a river. Child wandered away from family with some other children. The details from this point are not entirely clear, but it is suggested that some of the children may have caused the child to enter the river. Child was able to swim, but was a weak swimmer. He was found in the river and was unable to be resuscitated.	Hypoxic encephalopathy due to immersion (drowning)	Inquest dispensed with
2 years, female	Child was put to bed by her mother. Mother and father sat down to dinner during which they could hear noise associated with child playing. The noise continued for about 10 minutes and then stopped. About one hour later, the mother went to check on the child and found her lying on the floor with a bathing cap over her face. The mother removed the cap and found a large amount of vomit in the cap and over the child's mouth.	Suffocation	Inquest dispensed with

The CDRT determined that these four deaths were suspicious of assault or neglect, although there was insufficient evidence to determine that the deaths were clearly due to assault or neglect. In three of the four cases, however, the Coroner dispensed with an inquest.

As described earlier in this chapter, under the *Coroners Act 1980* the Coroner can give consideration as to whether or not an inquest should be held. One possible reason for deciding to hold an inquest is the belief that the hearing may assist in determining unexplained facts or circumstances.

The CDRT is of the view that the holding of inquests in the three suspicious cases in which inquests were dispensed with may have assisted in determining the unexplained facts and circumstances in each case. Nick's case is illustrative.

Nick, 11 months

Nick developed cold symptoms two days prior to his death. His GP diagnosed him as having a mild chest and ear infection. Nick's condition deteriorated that evening to the point that his parents took him to hospital. His condition continued to worsen and he suffered a series of cardiac arrests, subsequent multi-organ failure and died.

At post mortem, several injuries were discovered that may have been indicative of physical harm. These included acute subdural and subarachnoid haemorrhages. The neuropathologist commented that 'although subdural haemorrhage may be seen as a component of non-accidental injury, none of the other features commonly associated with this condition, such as focal or diffuse axonal injury or retinal haemorrhages, are identified'. Despite the uncertainty regarding the origins of the brain haemorrhages, the Coroner dispensed with an inquest.

No explanation was recorded on file to account for the brain haemorrhages. There appears to have been inadequate investigation of these head injuries, even though the presence of subdural haemorrhages is well documented in the child abuse literature as suggestive of non-accidental injury (Moran, 2002). Neither parent appears to have been interviewed to provide explanation for the brain injuries.

Nick's death provides an example where a full coronial inquest may have resulted in a better understanding of the causes and issues underlying a child's death.

In conclusion, the small number of deaths that occurred in suspicious circumstances makes it difficult to draw conclusions about this group. These cases do, however, highlight the potential for coronial inquests to assist in better understanding the causes and circumstances underlying 'suspicious' deaths.

The following two chapters explore in detail the fatal assault and fatal neglect groups.

CHAPTER 4
FATAL ASSAULT OF CHILDREN AND YOUNG PEOPLE

Forty children and young people (15 females, 25 males) were fatally assaulted, comprising just over half (53.3%) of the group of deaths from assault and neglect over the three-year period. All but one of these children and young people were further classified into four groups, based on the circumstances of their deaths: non-accidental injury (20), parents affected by a mental illness (6), victims of family breakdown (5) and killings of teenagers (8).

The death of one child followed a different pattern to all of the other fatal assaults. This five year old boy was prescribed tablet medication for a minor condition. He did not want to take the tablets, but his mother allegedly forced a tablet into his mouth. The boy choked on the tablet and died.

This chapter provides an overall profile of the four fatal assault groups. It then details the circumstances of the deaths for each of the groups. The chapter ends with an account of each group's prior agency involvement. Similarities and differences among the four fatal assault groups are outlined.

4.1 Fatal assault group: Overall profile

Age and gender

The age distribution of the children and young people in each of the fatal assault groups is presented in Figure 4.1. Eighteen of the 20 children who died from non-accidental injury were infants and toddlers (0-4 years), including 11 infants who were under one year of age. This finding reflects the fact that non-accidental injury is more likely to produce a fatal outcome in young children who are the most physically vulnerable (NSW Child Death Review Team, 2002). In contrast, the children and young people in the other three assault groups were older. The mean ages of the children and young people in the mental illness, family breakdown and teenage groups were 3.8 years, 7.8 years, and 15.6 years respectively, compared with 1.3 years in the non-accidental injury group.

Figure 4.1 Fatal assault groups: Age distribution

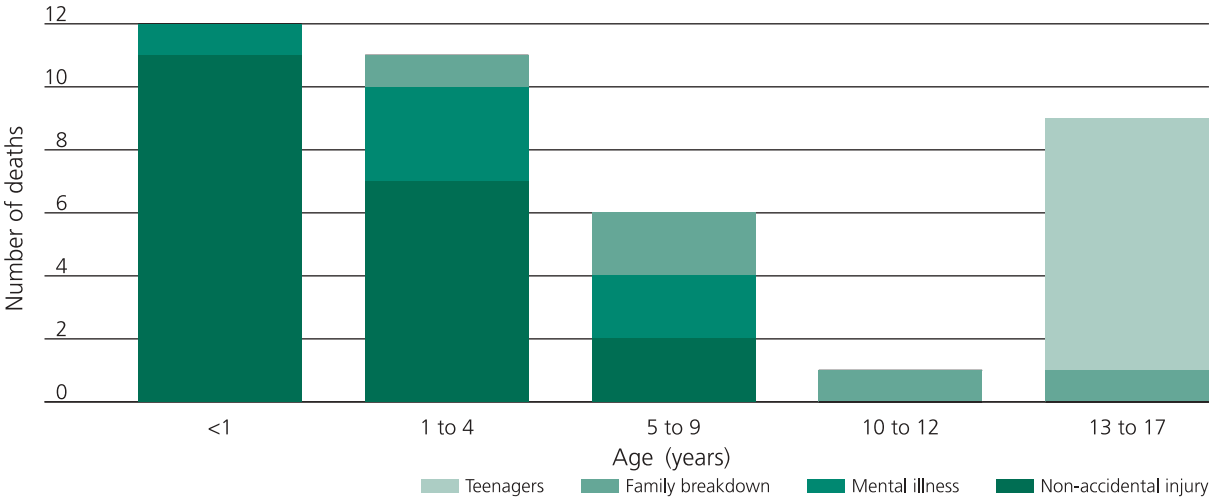
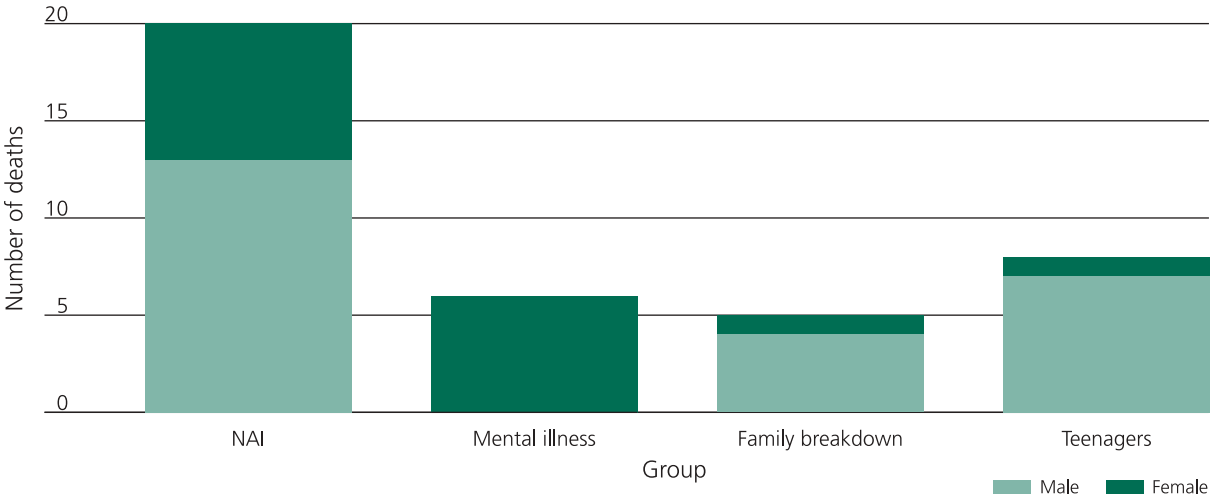


Figure 4.2 presents the gender distribution of the children and young people in each of the fatal assault groups. With the exception of the parental mental illness group, more males than females died in each group. In contrast, all six children whose deaths were precipitated by a parent's mental illness were female.

Figure 4.2 Fatal assault groups: Gender distribution



Cultural and linguistic diversity

All six deaths precipitated by a parent's mental illness or by family breakdown involved Anglo-Australian children. One infant in the non-accidental injury group and one young person in the teenage group were born in a country whose main language was other than English. For three of the eight young people in the teenage group, the main language spoken at home was not English.

Five of the 20 (25%) children in the non-accidental injury group, one young person in the teenage group, and the child who fatally choked on a tablet were Aboriginal.

Family circumstances

Living arrangements

Less than half (18 of 40; 45.0%) of the children and young people who died as a result of assault were living with both biological parents at the time of their deaths. A further 11 (27.5%) were living with one biological parent only and nine (22.5%) were living in step-parent or blended families. One child was living with relatives and one was living with foster parents. One young male in the teenage group was under the parental responsibility of the Minister for Community Services at the time of his death. There were no significant differences in the living arrangements of the children and young people in each of the four fatal assault groups.

Number of children in family residence

Most of the children and young people came from small to moderate size families with a mean of 2.0 children. Seven (17.5%) children and young people were the only child in the family. The fatal assault groups did not significantly differ with respect to the number of children in the household.

Age of primary carer

For 29 (72.5%) of the 40 children and young people who died as a result of assault, the primary carer was the child or young person's biological mother. For a further eight (20.0%) children and young people, the biological father was the primary carer.

The mean age of the primary carer for the 40 children and young people who died as a result of assault was 30.8 years. The primary carers of the children who died from non-accidental injury were significantly younger (M=26.8 years) than the primary carers of the children and young people in the mental illness (M=31.0 years), family breakdown (M=36.2 years), and teenage (M=39.5 years) groups (F=10.95, df=3, 35 p<.0001).

Circumstances of carers

Table 4.1 shows the number of families in each fatal assault group who experienced problems associated with health[1] and well-being, violence, crime and social or economic difficulties. As shown, problems associated with health and well-being, violence and crime, and social and economic disadvantage were prevalent among the families in each of the four fatal assault groups. With the exception of two families (one in the teenage group and one in the non-accidental injury group), all families of children and young people who died from assault had experienced at least one health and well-being, violence, crime, or social and economic disadvantage factor. Two-thirds of the families (22; 66.7%) had experienced three or more factors. The relationship between these difficulties and the death of the child is detailed later in this chapter in the 'context of death' section.

Table 4.1 Fatal assault groups: Carer circumstances

	Non-accidental injury	Mental illness	Family breakdown	Teenagers
Number of families	**17**	**6**	**2**	**8**
Health and well-being	11/17	6/6	2/2	2/8
Violence	12/17	6/6	2/2	5/8
Criminal behaviour	11/17	4/6	/	4/8
Social or economic	16/17	6/6	2/2	4/8

Note: The number of families does not total 40, as more than one child died in four families.
Health and well-being: includes alcohol and other drug abuse, intellectual disability, mental health problems and suicide attempts.
Violence: includes victim of abuse or neglect as a child, domestic violence (as victim or perpetrator).
Criminal behaviour: includes criminal behaviour as a juvenile and as an adult.
Social or economic: includes financial difficulties, accommodation difficulties and stressful events, namely change in family composition, death of family member, major illness in family, carer's loss of job, homelessness, relationship breakdown and change in residence.

In summary,

- age was a significant factor. The majority (90%) of the children who died from non-accidental injury were aged 0 to four years (M=1.3 years), with 55 per cent being under one year of age. In contrast, the mean ages of the children and young people in the mental illness, family breakdown and teenage groups were older; 3.8 years, 7.8 years and 15.6 years, respectively.
- more males than females died in each fatal assault group, with the exception of the mental illness group where all of the victims were female.
- two-thirds (66.7%) of families had experienced three or more health and well-being, violence, crime or social and economic disadvantage factors.

1 As described in Chapter 3, this study uses the World Health Organisation (1948) definition of health. The WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

4.2 Circumstances of the deaths

Method of death

Table 4.2 shows the methods by which the children and young people were killed. The most common methods of non-accidental injury were blunt force battery via manual assault; shaking; and suffocation/strangulation. Similarly, four of the six children whose deaths were precipitated by a parent's mental illness were killed by suffocation/strangulation. These two groups comprised the youngest children, reflecting the physical fragility of infants and very young children and their complete physical dependency on carers (NSW Child Death Review Team, 2002). Half of the teenage killings involved shootings.

Table 4.2 Method of death by fatal assault group

	Non-accidental injury	Mental illness	Family breakdown	Teenagers	Total
Blunt force battery	11	1	2	2	16
manual	(5)	(1)	(2)	–	(8)
shaking	(5)	–	–	–	(5)
weapon	(1)	–	–	(2)	(3)
Suffocation/strangulation	7	4	–	–	11
Shooting	–	–	–	4	4
Drowning/submersion	–	–	3	–	3
Poisoning	1	1	–	–	2
Stabbing	1	–	–	1	2
Other	–	–	–	1	1
Total	**20**	**5**	**5**	**8**	**39**

Coronial investigations

Coronial inquests were dispensed with in just two of the 40 fatal assault cases. In the majority of fatal assault cases (29; 72.5%), the inquest was terminated and the matter forwarded to the criminal system. Five cases are still proceeding and inquests were held in four cases. In one of the inquests, the finding was of death by gunshot wound to the head; in the second case, the finding was death by accidental immersion (drowning); in the third case, the finding was that the child died from laryngeal obstruction due to inhalation of a tablet, and in the fourth case, the finding was that the cause of death was unable to be determined.

Profile of suspects

Three-quarters (29; 74.4%) of the children and young people who were fatally assaulted were killed by parents, a parent-substitute in the family or another relative. One-quarter (10; 25.6%) were killed by individuals outside the family.

There were differences in the victim-suspect relationship across the four fatal assault groups. For all the deaths precipitated by a parent's mental illness or family breakdown, and for 18 of the 20 non-accidental injury deaths, the suspect was a family member. In contrast, all of the suspects in the teenage killings were persons outside of the family (see Table 4.3).

Table 4.3 Suspect's relationship to child by fatal assault group.

Suspects	Non-accidental injury	Mental illness	Family breakdown	Teenagers	Total
Familial					
Biological mother only	3	4	0	0	7
Biological father only	6	0	5	0	11
Mother and father	3	0	0	0	3
Mother and male de facto	2	0	0	0	2
Male de facto only	2	2	0	0	4
Foster mother	1	0	0	0	1
Male relative	1	0	0	0	1
Non-familial					
Male acquaintance/friend of family	1	0	0	2	3
Friend of family (gender unknown)	1	0	0	0	1
Group killings	0	0	0	3	3
Male, unknown to victim	0	0	0	1	1
Male, known to victim	0	0	0	1	1
No information about suspect	0	0	0	1	1
Total	**20**	**6**	**5**	**8**	**39**

The profile of the suspects for each of the four fatal assault groups is outlined below.

Non-accidental injury group

There were 22 suspects in the deaths of the 20 children who died from non-accidental injury. The ages of the suspects ranged from 13 to 39 years (Mean=25.8yrs).

More than half of the suspects (13, 59.0%) had a previous criminal history with a total of 115 charges. Compared with the other fatal assault groups, these suspects had the most extensive criminal histories with an average of 8.8 charges each. The number of charges per suspect ranged from two to 33.

Offences against the person, such as assault (25.0%) and theft (25.0%) were the most common offences, followed by drug offences (21.9%), driving offences (15.6%), offences against justice procedures[2] (9.4%) and property offences (3.1%).

Suspects were the children's family members in 18 of the 20 non-accidental injury deaths. The families in which these assaults occurred were characterised by enduring social problems, including domestic violence (in the families of 11 children), parental substance use (10), financial difficulties (6) and unemployment (4). Five of the carers had documented evidence of abuse and neglect in their own childhoods.

All but one of the mothers who were suspects in their children's deaths had been caring for their children since birth. The foster mother of one child had been caring for her foster child for just 10 weeks before the child's death.

2 The classification of offences in this report is based on the Australian National Classification of Offences (ANCO) issued by the Australian Bureau of Statistics (ABS Catalogue No. 1234.0). Offences against justice procedures include breach of bail, breach of parole, breach of domestic violence order, breach of other restraining order and breach of justice order.

In contrast, the pattern of care experience for the male suspects was quite different from that of the mothers. Six of the 11[3] male suspects of familial killings had exposure to the child for less than one year, and five of the six had exposure for less than six months. Of these six, four were the male de facto partners of the biological mother, one was a male cousin, and one was the biological father who had been released from gaol 10 weeks prior to the child's death. Previous research has indicated that parental inexperience is linked with increased risk of injury and death of children, as inexperienced parents often have little awareness of the stresses involved in caring for young children (Wilczynski, 1997; NSW Child Protection Council, 1995). While this may be true, it is also possible that limited exposure to the children was associated with reduced attachment to the children. Furthermore, parental inexperience was not a factor in the deaths of the children who were killed by their mothers, as six of the seven mothers had been caring for their children since birth.

Mental illness group

There were six perpetrators in the deaths of the six children that were precipitated by a parent's mental illness. Four were the children's biological mothers and two were the mother's male de facto partners. The ages of the perpetrators ranged from 21 to 38 years, with a mean age of 31.7 years. All of the mothers had been caring for their children since birth. The two male de facto partners had known the children for two months and two years, respectively.

All six perpetrators had a diagnosed mental illness. Three of the six were diagnosed with depression. Two had co-morbid diagnoses including Bipolar Disorder with schizophrenic illness, and Bipolar Disorder with psychotic depression. One mother had been diagnosed with Delusional Disorder.

Enduring social problems were present in the six families. These included domestic violence (5) and parental substance use (4). Four of the perpetrators (both de facto partners, two mothers) had experienced abuse and neglect in their own childhoods.

Three of the six perpetrators had a criminal history (both de facto partners, one mother) with a total of 18 charges. Offences included assault, theft, property damage and driving offences.

Family breakdown group

Five children were killed in two separate incidents precipitated by family dispute and breakdown. Both perpetrators were the biological fathers. They were aged 33 and 41 years respectively and both had been caring for the children since birth.

In contrast to the previous two fatal assault groups, neither perpetrator in this group had a criminal history. Both families were, however, characterised by domestic violence and financial difficulties.

In both cases, the perpetrators were experiencing a range of personal problems in the context of family breakdown. In the first case, the father killed his wife and two children and attempted suicide after learning that his wife was making plans to leave the family home with her two children because of his violence. Details of the second case are unable to be provided as the legal process has not yet been finalised. This father has been charged with the murder of his three children.

Teenage group

In the eight incidents involving the deaths of eight teenagers, a total of 16 perpetrators were identified. All were male. Their ages ranged from 17 to 44 years, with a mean age of 21.1 years.

3 Note that the number of male relative perpetrators does not equal the total number of male relative perpetrators in Table 4.3 (N=14) as two of the perpetrators killed more than one child.

For four of the victims, the perpetrators were unknown to the victim. Three of these teenagers were killed by groups of perpetrators, two of which involved altercations between rival gangs. Three of the teenagers knew their perpetrators and in one case no suspect was identified.

Ten of the 16 perpetrators had prior criminal charges, with 19 charges between them. The most common types of offences were offences against the person (including assault and robbery; 38.5%), driving offences (23.1%) and theft (23.1%).

Context of death

The context in which the children and young people were fatally assaulted differed among the assault groups. The following section details the context of the deaths separately for each group.

Non-accidental injury group: Context of death

The injuries sustained in the non-accidental injury deaths resulted from either a series of assaults or one fatal assault. Thirteen of the 20 non-accidental injury deaths were grouped into three scenarios. Five children died in the context of the suspect's drug or alcohol intoxication; four children died in the context of ongoing child abuse and neglect; and four children were killed in the context of their mother's history of multiple short-term relationships which were characterised by ongoing violence. It is important to note the lack of a clear boundary between these categories. For example, the parents of the children who died in the context of ongoing child abuse and neglect also had drug and alcohol problems, although they were not intoxicated at the time of the child's death. Thus, these categories are not mutually exclusive.

Information regarding the context of death was unavailable for seven of the 20 children who died as a result of non-accidental injury. Four of the seven were infants who died from shaking injuries that have been identified as 'shaken baby syndrome' (Alexander & Smith, 1998; Wyszynski, 1999). Shane's case is illustrative.

Shane, 11 months

Shane's foster carers reported that on the evening before his death Shane was vomiting and generally unwell. The next morning his condition reportedly deteriorated. Shane was shaking and coughing and starting to turn blue. His foster parents took him to their doctor's surgery. The doctor performed CPR, but Shane died.

Autopsy revealed evidence of traumatic head injury with recent bruising on the scalp, acute and older subdural haemorrhage, swelling of the brain, bruising of the abdomen and what appeared to be a traumatic rupture of the stomach. Neuropathological examination revealed injuries of several ages ranging from several hours to possibly several weeks. The neuropathologist reported that the appearances of the head injuries were consistent with shaken baby syndrome. The head injuries were, in the pathologist's opinion, the substantive cause of death.

Shane's foster mother was charged with the murder of Shane.

The following sections detail the death contexts for the remaining 13 non-accidental injury deaths.

Drug or alcohol intoxication. Five children died in the context of the suspect's drug or alcohol intoxication. In all cases the suspect was one or both biological parents. Three of the five children were half-siblings and were killed by their biological father on a weekend contact visit. Prior to the fatal incident, his care of the children had been described as loving and caring. None of the children's mothers reported being fearful for their child's safety while they were in his care.

Kim, 11 weeks; Tanya, 11 months; Lee, 6 years

These three children were murdered by their biological father, Dave while on a weekend contact visit. On the night of the fatal incident all three children were fed, bathed and placed into bed. During the course of the evening, Dave consumed a large amount of bourbon in the presence of his partner and mother. Witnesses claim that he expressed an escalating degree of emotionality. He had three arguments with different people during the night, two of which involved discussions about whether he was a failure because he had three children to three different women. Later that night, Dave sent a text message to his aunt and partner, saying goodbye from him and his children. He then suffocated all three children. Early the next morning Dave presented at the local police station and informed the officers on duty that he had killed his three children. The smell of alcohol was noted on his breath. Dave was charged and sentenced on three counts of murder.

Ongoing child abuse and neglect. Four children died in the context of enduring child abuse and neglect. All of the suspects were one or both biological parents. All children had been reported to the Department of Community Services prior to their deaths. Concerns were raised around inadequate supervision, the parents' substance abuse and criminal activity, domestic violence, and in two cases extreme physical abuse, including beatings with wooden spoons and inflicting severe burns. The following case illustrates as an example.

Rob, 2 years

After the fatal incident, Rob's parents told the police that Rob had vomited and fitted after falling from the kitchen bench. The autopsy report indicated that Rob died from a head injury. The pathologist's summary stated that "the pattern of recent subdural and subarachnoid haemorrhage with significant retinal haemorrhages is consistent with the whiplash shaken syndrome. Some bruises were observed, indicating some impact force on the body and head. There were fractures of the ribs that had occurred on at least two separate occasions and there was evidence of old fractures on the left forearm." Rob had been the subject of two reports made to the Department of Community Services prior to his death. He was reported at age one month after admission to hospital with injuries consistent with shaken baby syndrome including head injuries of two different ages. As a result of investigations following this report, Rob was placed under the parental responsibility of the Minister for Community Services for two years, to live with his paternal grandmother with the case plan for eventual full restoration to his parents. Rob returned to his parents' care seven months after the Order. Six months later he was reported to the Department of Community Services following admission to hospital with a head injury. He died the next day. Rob's father was charged with murder and his mother was charged with manslaughter.

Frequently changing violent partners. Four children were killed in the context of their mother's frequently changing violent relationships. These mothers had a history of multiple short-term partners and their relationships were typically characterised by ongoing violence. All children were killed by their mothers' de facto partners. All four suspects had exposure to the child for one year or less.

Gerry, 7 months

Gerry's mother's de facto partner, Sam, alleged that he awoke when he heard a thud and a gurgle. He found Gerry lying on the floor and called an ambulance. Gerry had extensive, clearly visible injuries to his face, head, mouth, trunk and limbs. The cause of death was vomiting and choking, although the extensive nature of his injuries were such that they were likely to have been fatal had he not choked. Gerry had been seen by the local doctor for routine vaccination the previous day. No abnormalities were noted at that time, suggesting that all of the injuries were sustained in the hours immediately prior to death. Sam was subsequently charged with Gerry's murder.

Gerry's mother had three children under the age of four years to three different fathers. The pregnancies were all unplanned. Gerry was the youngest and his mother and father began living together three weeks after they met. The relationship had ended before the confirmation of the pregnancy. Gerry's mother met Sam when Gerry was five months old. Records indicate that Sam's prior relationships had been extremely violent, with a history of criminal behaviour, including a group sexual assault of a woman at knife point. This occurred just one month prior to Gerry's fatal assault. At the time of Gerry's death, Sam had been living in the household for only six weeks.

Mental illness group: Context of death

As with the parental mental illness fatalities in the *Fatal Assault of Children and Young People* (CDRT 2002) report, these six fatalities involved two scenarios. Three children were killed by their mothers or their mother's de factos in the context of depressive symptoms and multiple stress factors. A further three children were killed in the context of a mother or her de facto experiencing delusional beliefs that involved the child.

Depression and psychosocial stress. Three children were killed in the context of their mother's (2) or their mother's de facto's (1) depressive symptoms. Psychiatric examination of the de facto undertaken after one child's murder described longstanding undetected and untreated depression. The mother of another child was experiencing severe depression relating to the sexual abuse of her daughter by her partner. Overwhelmed by sadness and guilt she murdered her daughter and then committed suicide. The mother of a third child had been experiencing Postnatal Depression. She discharged herself prematurely from hospital following the birth and concerns were noted on her hospital file regarding her attention to and care of her baby. In the few months after the birth, she requested voluntary care for her two young children from the Department of Community Services, stating that she was not coping. She suffocated her baby daughter when she was six months old. The diagnosis of Postnatal Depression was made after the fatal incident.

All three adults experienced their depressive symptoms in the context of significant levels of psychosocial stress, including relationship difficulties with spouses (conflict and domestic violence), lack of familial and social supports, relationship difficulties with members of their extended family, custody battles, and prior child deaths[4]. Information on file indicated that two of the three were using illegal substances at the time of the deaths.

4 A child of the male de facto perpetrator had died previously. The death was attributed to Sudden Infant Death Syndrome.

Psychotic illness. Three of the fatalities involved the mother or mother's de facto killing the child during a psychotic episode. Their delusional beliefs involving the child were the immediate precipitant to the fatal incident.

Ann, 20 months

Ann's parents had separated following her father's alcohol abuse and violence towards her mother. Ann's mother had two other children, one of whom was Ann's half-sibling. Ann's mother had been diagnosed with Delusional Disorder with no insight that her beliefs were abnormal. As a result, under a Family Court Order, all three children were in the care of the mother under the 'direct supervision' of the maternal grandmother. It is not known whether Ann's mother was receiving ongoing psychiatric care. Her primary delusion was that there was an extensive paedophile ring involving her former partners and others and that her children were being abused on access visits. She further believed that things relating to the paedophile ring were hidden in her ceiling and that her life was in danger as a result of having uncovered the ring. A few days prior to Ann's death, a psychiatric report recommended to the Family Court that the children be removed from their mother's care. A few days later, she acted on her delusions of danger to the children. Within her belief framework, she attempted to protect them from further harm by killing Ann and attempting to kill her other two children and herself.

Family breakdown group: Context of death

Five children from two families were in this group. One father killed his two children and one father has been charged with killing his three children. Both incidents occurred in the context of family dispute and breakdown. The father's distress relating to the end of the relationship was the primary trigger to the fatal incidents; other factors may also have contributed to the despair and hopelessness experienced by the fathers. These included one of the partners forming a new relationship, financial difficulties, conflict over the custody of the children, fear of losing contact with the children, domestic violence and cultural and religious differences. One father killed his wife and two children after learning that his wife was planning to leave him. He later committed suicide while in custody. Details of the second case are not provided as the legal process has not yet been finalised. This father has been charged with killing his three children.

Teenage group: Context of death

Three teenagers died in the context of group fights, two of which involved fights with rival gangs. Four fatalities occurred in diverse contexts and are detailed below. No information on the context of death was available for one case.

Group fights. Three young people were killed in altercations between groups of youths. Weapons were used in all three fatalities. From the available information, it would appear that cultural issues were a factor in all three fatal incidents. One Middle Eastern male was fatally shot by a group of Asian males after an argument regarding a stolen mobile phone.

The other two fatalities involved fights between rival gangs. All the young people involved in these fights were male. The first victim was of Middle Eastern origin. He belonged to a gang that had been in conflict with a gang of Asian young people for some time. On the afternoon of his death, the group of Asian teenagers met to retaliate against the rival group which had allegedly assaulted one of their members two days earlier. A fight ensued involving six or seven males from each side. It culminated in the victim being fatally shot.

The second victim was Asian and died during a fight between two groups of Asian males. During the fight, both groups produced a range of weapons, including steering locks, butcher knives, machetes and broken bottles. The young person died after being struck several times to the head with a club lock. The cause of the fight is not known.

Diverse death contexts. The other four teenage fatalities occurred in diverse circumstances. All perpetrators were male. In all but one incident, the perpetrator was known to the victim. One 13 year old male was fatally shot together with his mother and stepfather. Police investigations suggested that the family was killed by one of the stepfather's criminal associates. Although a prime suspect was identified, the police did not have sufficient evidence to proceed and no one has been charged with the murders.

A second teenage male (17 years) was killed after engaging in a fight with an older male, while both were in a state of extreme intoxication. The victim's autopsy report revealed a blood alcohol level of 0.208g/100ml[5]. A 14 year old male was killed by his mother's friend. He had left school and drifted between several homes, including the home of his mother's friend. The information on file suggests that this boy was sexually assaulted by this friend on several occasions. He had told his mother about the abuse. The mother's friend was subsequently charged with the murder.

One 17 year old male was fatally shot in a random act of violence. He and his girlfriend were parked in their car, when two males approached them, produced a handgun and demanded the male's wallet. He was shot twice after he informed them that he did not have a wallet on him.

In summary,

- the deaths of children from non-accidental injury occurred in three contexts: drug and alcohol intoxication, ongoing child abuse and neglect, and the mother's frequently changing violent relationships.
- deaths precipitated by a parent's mental illness occurred in the context of a depressive episode or a psychotic illness.
- five children were killed by their biological fathers in the context of family dispute and breakdown.
- three teenage killings occurred in the context of group fights between gangs of males. The other teenage fatalities occurred in diverse circumstances.

4.3 Agency involvement

Thirty-four (85.0%) of the 40 children and young people who were fatally assaulted came from families that had prior agency involvement. Over half (23; 57.5%) had been involved with three or more agencies.

The agencies most frequently involved were NSW Police (28; 70.0%), Department of Community Services (27; 67.5%) and NSW Health, including mental health services[6] (23; 57.5%). One quarter (10; 25.0%) of the families were in Department of Housing accommodation at the time of the child's or young person's death. By way of comparison, approximately five per cent of NSW households live in public housing (Australian Institute of Health & Welfare, 2003). Other services accessed by the families included Department of Education and Training (11), Department of

5 It is indicated on toxicology reports that 'more than 50% of persons would be grossly intoxicated at a blood alcohol concentration of 0.150g'.
6 Children, young people and their families attend health services for a range of reasons and contact with NSW Health is expected to occur over a person's life. These contacts present opportunities for health professionals to identify children and young people who may be at risk and to take appropriate action.

Corrective Services (3), Juvenile Justice (2), Catholic Education Office (1), and non-government organisations (3). The recorded number of families who had contact with non-government organisations is most likely an underestimate. This is because CDRT legislation currently restricts the obtaining of records to government agencies only.

As noted in previous Child Death Review Team reports, the children and young people and their families present challenges to practitioners and agencies. They often come to the attention of agencies after family dysfunction is already severe and entrenched. The parents tend to be poorly motivated, and due to the severity of the family dysfunction, they may not have the capacity to change their behaviour through counselling or support. Agencies need to continually search for new ways of working to assist these children and young people and their families.

An evaluation of the involvement of agencies most commonly accessed is outlined below. While this evaluation focuses on areas of inadequate practice, it is important to point out that there were examples of proactive practice. This centred around agencies, notably NSW Police and NSW Health, in some circumstances, fulfilling their obligation of mandatory reporting. For example, one infant was reported by a nurse to the Department of Community Services within days of his birth. The nurse recognised an aggregation of risk factors including a homeless 19 year old mother of a premature baby, no antenatal care, concerns by professionals regarding parenting skills, itinerant lifestyle, drug misuse, domestic violence and parental criminal behaviour. This resulted in the Department of Community Services assisting the mother to find accommodation and regular visits by an early childhood nurse until the mother left the accommodation. However, despite this early intervention, this infant went on to die following a later breakdown in service provision. The Department of Community Services closed the file after the mother and infant were placed in temporary accommodation. There was a note on file stating that the refuge workers would recontact if there were further concerns. The mother and infant left the accommodation when the infant was one month of age. There was no further agency involvement until three months later when the infant was fatally suffocated.

NSW Police

The role of NSW Police in child protection is to recognise, report and in some circumstances investigate child abuse and neglect, and initiate legal proceedings for child abuse and neglect offences. The NSW Police, with the Department of Community Services, is a designated statutory authority responsible for the care and protection of children and young people. It is also the designated authority for applying for Apprehended Violence Orders on behalf of children and young people (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.7).

NSW Police were involved with 70 per cent (28) of the families of the children and young people who were fatally assaulted. The families of 13 (65%) of the 20 children who died by non-accidental injury; all six children in the mental illness group; three of the five in the family breakdown group; five of the eight in the teenage group; and the family of the child who choked on a tablet were all involved with NSW Police. Contact with NSW Police concerned reports of domestic violence and parents' or young person's criminal behaviour.

Three main areas of inadequate practice emerged in relation to NSW Police involvement. These centred on:

- not recognising and reporting a serious and unstable situation
  - including limited awareness of the indicators of child abuse and neglect and not acting on obligations to report
- punitive treatment of vulnerable children and young people
  - including limited awareness of the indicators of child abuse and neglect and their consequences
- not engaging other services when required
  - including lack of exchange of relevant information with other services.

Not recognising and reporting a serious and unstable situation

There were several instances of NSW Police being called to at-risk situations but not recognising and/or reporting the serious risks for the infants and children involved. For example, Police Officers received 16 call-outs to one family in a five month period in relation to domestic violence between an infant's mother and her de facto partner. The infant was aged two months at the time of the first call-out. Although Police Officers put several Apprehended Violence Orders in place, only one report to the Department of Community Services was made during this time period. This report did not make reference to previous violent episodes and no attempt was made to jointly investigate with the Department of Community Services. In addition, the Department of Community Services did not seek further information from Police Officers as part of their initial assessment. The report never proceeded to investigation or assessment.

In another family, NSW Police noted concern on their records regarding a mother taking her infant with her during her drug-related criminal activities and the infant's presence during episodes of domestic violence, but they did not report their concerns to the Department of Community Services.

Part of the role of NSW Police in child protection is to recognise and report child abuse and neglect. These cases highlight the need for Police Officer training regarding the relationship between domestic violence and child abuse.

Punitive treatment of vulnerable children and young people

Daniel's case is illustrative of inappropriate response by NSW Police to at-risk children and young people.

Daniel, 17 years old

Daniel had an Aboriginal mother and a Southern European father. Daniel's father died from cancer when Daniel was one year old. After that, Daniel's home life became chaotic, with the family leading an itinerant lifestyle, moving at least 12 times. Daniel's mother became engaged in drug and alcohol abuse and criminal behaviour (17 charges). Daniel left school in Year 9, illiterate.

Daniel first came to the attention of NSW Police at 13 years of age for public mischief. Police contact became more frequent and included call-outs for violence between Daniel and his mother. On one occasion, Daniel's mother was charged with assaulting Daniel. He was 14 years old at the time. The Police Officer did not report the incident to the Department of Community Services.

Over the next two years, Daniel's life became increasingly chaotic. His mother's alcohol abuse and erratic behaviour meant that he virtually lived on the streets and frequently came to the attention of NSW Police and Juvenile Justice. From about the age of 16 years, Daniel began abusing alcohol. He frequently missed appointments with his Juvenile Justice Officer and had difficulties understanding the Court process.

There were 21 events recorded on Daniel's Police file. These chronicle Daniel's path from neglected child to unsupervised adolescent, leaving school early, unemployment, homelessness, alcohol problems, crime and finally to his violent death. Most of the NSW Police records in the year prior to Daniel's death related to Daniel being on the streets and being asked to move on, for living in an unused building at the local sports oval, and for wandering the streets intoxicated, not sure where he was and with nowhere to go. Daniel died during a fight with an older male while he was in a state of intoxication.

It appears that Daniel was invisible to agencies, except when he was causing trouble. The failure of the NSW Police to consider Daniel's actions within a child protection context severely limited the range of services provided.

Not engaging other services when required

Daniel's case is also illustrative of NSW Police not engaging other services. There was no planned or coordinated response. All work with Daniel was ad hoc and did not take place in response to assessments or investigations. Not reporting to child protection services that a 14 year old boy was being beaten by his mother and evicted from home meant that no assistance was provided for him. Lack of interagency work appears to have been at the cost of Daniel's safety and well-being.

Department of Community Services

The role of the Department of Community Services in child protection includes providing or arranging services to children, young people and parents when a request for assistance is received; receiving and assessing reports of child abuse and neglect; investigating those reports when there is a likelihood of risk of harm to the child or young person; acting to maintain the safety of children and young people; monitoring the safety of the child when serious harm has been identified; developing case plans; ensuring the provision of quality out-of-home care and support services for children and young people unable to live with their family; initiating action to protect children through alternative dispute resolution or care proceedings in the Children's Court and providing and arranging support services to children, young people and their families (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.5).

Just over two-thirds (27; 67.5%) of the families of the children and young people who were fatally assaulted had been previously reported to the Department of Community Services. The families of 13 (65%) of the 20 children who died by non-accidental injury; five of the six children in the mental illness group; three of the five in the family breakdown group; five of the eight in the teenage group; and the child who choked on a tablet had all been reported to the Department of Community Services.

Issues emerged regarding the Department of Community Services' involvement with this group of children and young people in the following areas:

- inadequate risk assessment
  - including not conducting any assessment, not conducting a thorough risk assessment, discounting reports, not reassessing the child's safety in light of new information, not assessing longer term needs and poor documentation
- ineffective case planning
  - including poor case planning and management and not requiring medical examinations to be undertaken

Inadequate risk assessment

From a review of the Department of Community Services files, examples of inadequate risk assessment included: no risk assessment at all, lack of thorough risk assessment, discounting reports, no reassessment of the child's safety given new information, no assessment of longer term needs, and poor documentation. The involvement of the Department of Community Services with Janet's family illustrates these inadequacies.

Janet, 2 years

Department of Community Services records revealed seven reports, the first of which was made when Janet was eight months of age. Two reports were assessed, substantiated and either closed with referrals made or with no further action taken. For instance, NSW Police made a report outlining concerns that Janet's mother (Julie) and her de facto (Michael) were drug affected and having a verbal argument. When Police Officers visited the home they reported that the front door was smashed with glass everywhere. There were broken plates and a broken iron that they had allegedly thrown at each other. The home was reported to be in a filthy state.

A Department of Community Services' Officer interviewed Julie and Michael at home. The file states that Janet, then aged 18 months, and her older brother, then aged five years, were not interviewed because of their young age. Michael was drinking alcohol when the Officer arrived. He admitted that he had kicked the door the previous day and expressed remorse. Both he and Julie admitted that they occasionally smoked marijuana but claimed they did not do so at the same time.

The Officer interviewed Julie again four days later. She said that Michael had been aggressive with her on a previous occasion but denied that the children were present. Julie was given information about child care, play groups and domestic violence groups. The children's exposure to domestic violence was substantiated and closed.

The other five reports were either assessed, not substantiated and closed, or not assessed at all. For example, Janet's biological father made a report to the Department of Community Services when Janet was 16 months old expressing concerns about Julie's marijuana and alcohol use. The Department of Community Services Officer confirmed some information with NSW Police, yet no action was taken. The report was not substantiated and closed. The Department of Community Services also failed to investigate a subsequent report regarding Julie's and Michael's drug and alcohol abuse.

Janet, 2 years cont.

In another instance, NSW Police made a report to the Department of Community Services. This occurred four months before Janet's death. Police Officers had responded to a call by Julie. When they arrived at the house, Julie had blood on her face from a cut to the back of her head and was unable to speak to the Officers coherently about what had happened. The children were observed by the Police Officers to be distressed. The surname of Janet and her brother was recorded on the Department of Community Services' Client Information System with a different spelling from that contained in previous reports. The children's file states that because of this, the information in the report was not assessed against any previous history. The case received no response.

Michael allegedly found Janet lying on the floor next to her bed in a semi-conscious state. Michael claimed that he was unable to revive her. Ambulance officers were called, but attempts at resuscitation were unsuccessful. Post mortem examination showed deep laceration to the liver. The pathologist noted that a heavy blow to the abdomen, such as from a punch, kick or stomp to the upper abdominal region might have produced such injuries; rolling or falling from a bed would not have caused these injuries. No charges have been laid in relation to Janet's death.

Although the Department of Community Services took some appropriate action in investigating some reports and conducting some form of risk assessment, the information on file indicates that the investigating Officer failed to assess all the available information and to develop an appropriate case plan. Work conducted in relation to assessment and investigation of this case was inadequate in four main areas. First, the Officer failed to recognise the patterns in the family that presented risk. For instance, had information been sought from NSW Police in relation to Michael, this would have shown an established pattern of violence. Michael had nine charges for drug and violent offences. Second, the Officer did not interview the children. The risk assessment report on file states that the children were not interviewed because of their age, although Janet's brother was five and a half years of age and possibly should have been interviewed. Janet should have been referred for an appropriate assessment. Third, the Officer failed to properly investigate and address Michael's and Julie's alcohol and other drug abuse. Fourth, the case was prematurely closed without consideration or assessment of the long-term needs of the children.

No assessment of the longer term needs of the child was evident in two cases where children received ongoing care and support services. The case of baby Shane is illustrative. Shane died of injuries consistent with shaken baby syndrome and his case has been described earlier in this chapter.

Shane, 11 months

Shane came from an Aboriginal family and was the fourth of five children born to his mother. There was a history of placements in out-of-home care over several generations. Prior to his birth, his siblings had been the subjects of numerous reports concerning parental drug use, inadequate supervision, neglect, exposure to domestic violence and homelessness. At the time of his birth, Shane's siblings were an allocated and registered case within the Department of Community Services. Records indicate that Shane and his siblings spent the majority of their lives away from their mother in voluntary care.

At two months, Shane was placed in voluntary care with an Aboriginal foster agency for a planned period of two to four weeks. Department of Community Services records indicate that he remained in this placement for several months. He and his siblings were then placed in the care of the maternal grandmother. Two weeks later Shane's grandmother reported that she was not coping with the care of Shane and his siblings. As a result, Shane was moved to an emergency three-day foster placement and then to a short-term placement with a non-Aboriginal family – the Smiths.

Shane, 11 months cont.

Records indicate that the foster care team had unsuccessfully explored 20 placement options before deciding to grant special approval to the Smiths to provide a placement for Shane and one of his siblings for a three month period. The Smiths were a non-Aboriginal family and had not completed their foster care training before the placement. Further, Police checks of the foster parents only commenced on the day of the placement and the foster care assessment did not commence until one month after the placement. Ten weeks later Shane died and Mrs Smith was charged with Shane's murder. The cause of death was head and abdominal injuries. The head injuries were said to be consistent with shaken baby syndrome.

Following Shane's death, the Departmental Casework Manager indicated that two home visits had been conducted within the first month of the placement. However, neither of these visits was documented on file. Furthermore, subsequent visits were for the purposes of completing the foster care assessment and it appears that the Caseworkers did not undertake a home visit to the Smiths' home until the children had been there for approximately one month. Thus, the placement appears to have been virtually unsupported for the first four weeks.

Ineffective case planning

Case planning refers to all planning relating to the safety, welfare and well-being of a child, young person or their family. Such plans should make certain there are no misunderstandings for a child, young person, family and practitioners about goals or responsibilities. Planning should focus on meeting the needs of the child, young person and family in terms of safety, welfare and well-being, the risks and the family's strengths, and should wherever possible be done collaboratively (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.56).

The interagency approach to child protection requires a case manager to coordinate the interagency intervention. The case manager will be from the Department of Community Services, except where there are no risk of harm concerns or the matter is subject to police investigation or criminal proceedings (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.60).

Of the 27 families who were reported to the Department of Community Services, there was evidence of lack of case planning coordination, monitoring and case plan management.

Jack, 13 years

Jack was the subject of five reports as a young boy for sexual assault and severe physical and verbal abuse. No risk was found following the report of sexual assault because Jack did not disclose. A more detailed assessment was not undertaken, despite the investigating officer believing that 'something had happened.'

Physical and verbal abuse were substantiated and as a result, Jack was placed in voluntary care four times before he was placed under the parental responsibility of the Minister for Community Services for 12 months. After this period, which he spent in foster care, he was returned to his parents' care. Within two months his mother was asking for him to be removed again. Less than one year later, at age 11, Jack was brought to the local Department of Community Services Centre by his parents and abandoned. He was again placed under the parental responsibility of the Minister for Community Services, although this time the order extended to the age of 16 years. Seventeen months later, Jack returned of his own accord to the care of his mother. One month later, he was killed with his mother and stepfather.

The risk factors present in this case should have resulted in well planned and monitored protective intervention. Jack had suffered physical, emotional and possibly sexual assault from the age of four years. There were ongoing episodes of scapegoating and rejection before the final abandonment. Yet this boy was 10 years old before any real alternative stable placement was considered. Nevertheless, less than two years after the extended Order, Jack restored himself to his parents' care and was killed

three months later. Poor protective casework resulted in the workers not recognising or considering his parents' capacity to change; or to make an assessment for his future well-being, especially the need for a stable long-term placement.

NSW Health

The role of NSW Health in child protection is to recognise and report children and young people who are suspected at risk of harm and to provide crisis counselling, ongoing counselling, medical examinations and psychosocial assessments for children and young people who have experienced abuse or neglect (*NSW Interagency Guidelines for Child Protection Intervention*, 2000, p.9).

Records indicated that NSW Health services were accessed by more than half 57.5% (23) of the families of the children and young people who were fatally assaulted. The families of 12 (60%) of the 20 children who died by non-accidental injury; five of the six children in the mental illness group; three of the five in the family breakdown group; two of the eight in the teenage group; and the child who choked on a tablet had all accessed NSW Health services.

Two main areas of inadequate practice emerged:

- not recognising and reporting a serious and unstable situation
  - including limited awareness of the indicators of child abuse and neglect and not acting on obligations to report
- inappropriate agency or individual actions
  - including premature discharge of patients, lack of a proactive approach to service provision, and limited awareness of the indicators of child abuse and neglect.

Not recognising and reporting a serious and unstable situation

Health professionals are mandatory reporters of risk of harm. Despite this, there were several examples of health professionals not reporting children who were clearly at serious risk of harm. One parent informed his treating doctor, a local general practitioner, that he was going to kill his child and commit suicide. The doctor noted on file that he believed the father's threats and recommended immediate psychiatric assessment, but he did not report the father's threats to harm the child either to the Department of Community Services or to NSW Police. The father did kill his child and attempted suicide.

Inappropriate agency or individual actions

Examples of inappropriate actions by health professionals included premature discharging of mentally ill patients and lack of a proactive approach to the provision of services, resulting in undetected mental illness.

In one case, a consultant doctor discharged a patient prior to a thorough psychiatric evaluation. Recall the case (mentioned above) where a parent was threatening to kill his child and himself. He was assessed as needing immediate psychiatric assessment in the Emergency Department. Nevertheless, the hospitals consultant doctor recommended a referral to the local Community Health Centre and then discharged the father.

In another case, lack of a proactive approach to the provision of services by mental health professionals resulted in lost opportunity for the detection of severe mental illness for one man. This man killed his de facto partner's five year old daughter. He and his partner had a child together who died from Sudden Infant Death Syndrome (SIDS) one year before the death. After the second child's death, he was assessed by two psychiatrists. Both reports describe longstanding undetected mental illness. They also stated that he was severely affected by the death of his child from SIDS. The availability and accessibility of timely and comprehensive counselling following the infant's death could perhaps have provided an opportunity to detect the severity of mental illness and offer appropriate intervention.

In summary,

- agencies most frequently involved with the families of the children and young people who were fatally assaulted included NSW Police, Department of Community Services and NSW Health services.
- for those who were involved with NSW Police areas of concern arose in relation to not recognising and reporting a serious and unstable situation, and inappropriate management of at-risk young people.
- inadequate practice by the Department of Community Services included poor risk assessment, poor protective casework and poor ongoing care and support services.
- areas of concern in relation to NSW Health services centred around not recognising and reporting at-risk children and young people and inappropriate agency and individual actions, including premature discharge of mentally ill patients and lack of a proactive approach to the provision of services.

4.4 Conclusion

This chapter has reviewed the circumstances of the 40 children and young people who were fatally assaulted. Consistent with previous work by the Child Death Review Team (NSW Child Death Review Team, 2002), this research has found that fatal assault of children and young people is not a homogenous phenomenon. The deaths could be grouped into four categories of assault: non-accidental injury (20), victims of parents affected by a mental illness (6), family breakdown (5), and killings of teenagers (8).

Almost all of the children and young people came from families living in situations of chronic violence, health-related problems and parental criminal behaviour. These families were also characterised by multiple indicators of social disadvantage including financial and accommodation difficulties, unemployment, relationship breakdowns and changes in family composition.

Three-quarters of the children and young people were killed by parents, a parent substitute, or another relative. The quarter killed by individuals or groups of individuals outside the family unit were almost all teenage deaths.

Eighty-five per cent of families had considerable agency involvement. Deficiencies in NSW Health, NSW Police and Department of Community Services practice were evident in many of these cases, highlighting lost opportunities for intervention. Agencies were at times aware of overt indicators of risk or danger, including serious prior abuse and violence, threats of suicide and threats of killing family members, but did not report these to the Department of Community Services or act on these.

It is not possible to know from this study whether these deficiencies in agency practice had any relationship to the deaths of the children. It is not known whether better practice could have prevented these deaths. Such a relationship can only be established within the context of a comparative research study.

This report now turns to a review of the children and young people who were fatally neglected.

CHAPTER 5
FATAL NEGLECT OF CHILDREN

Thirty-one children (13 females, 18 males) were fatally neglected, making up 41.3 per cent of the group of deaths from assault and neglect over the three-year period. Based on analysis of the circumstances surrounding these deaths, these cases were grouped in three categories: inadequate supervision by a caregiver (26; 83.9%), caregiver's negligent driving (4; 12.9%), and one child died as a result of the failure by a caregiver to obtain medical care.

This chapter provides an overall profile of the 31 children who died as a result of neglect. It then details the circumstances of their deaths and provides an account of the families' prior agency involvement. Similarities and differences between the fatal neglect and fatal assault groups are outlined.

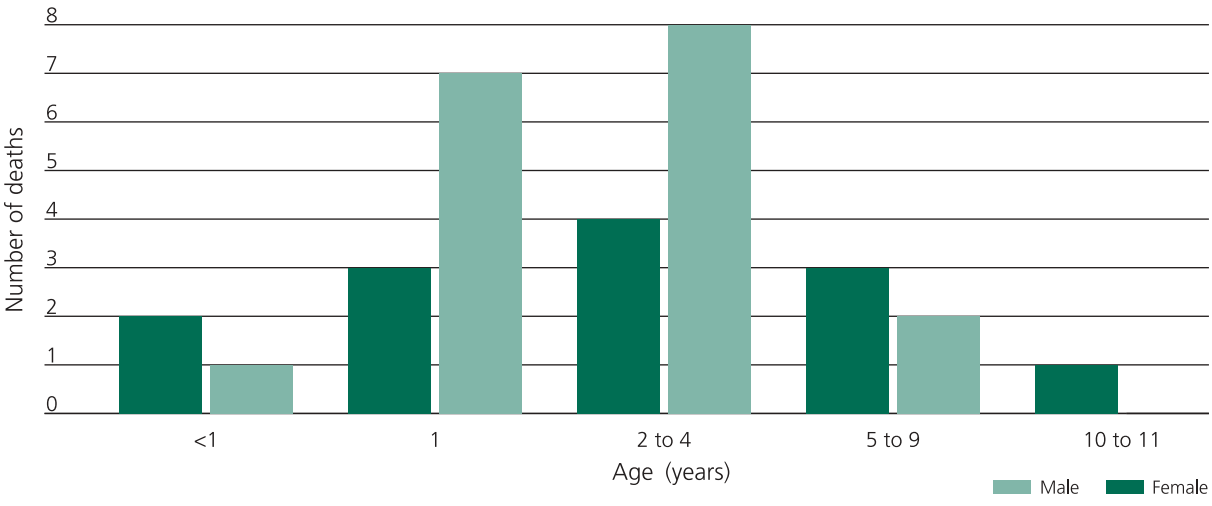
5.1 Fatal neglect group: Overall profile

Age and gender

Thirteen (41.9%) of the 31 children were female and 18 (58.1%) were male. The age and gender distribution of these children is presented in Figure 5.1. Consistent with existing literature (Margolin, 1990), just over 70% (22) of the children who died as a result of neglect were toddlers (aged 1-4 years). In contrast, 27.5 per cent of the children and young people who were fatally assaulted were aged one to four years. Just three of the children who were fatally neglected were aged under one year, compared with 30 per cent (12) of fatal assault victims.

The young ages of the children who were fatally neglected reflects the complete dependency of young children on their parents to secure their safety and the fact that neglect is most likely to produce a fatal outcome in the youngest children who are the most physically vulnerable. It also reflects the heightened risk of neglect death in a slightly older group (not infants), because developmentally these children are ambulant and so are more likely to access physically dangerous situations than are non-ambulant infants.

Figure 5.1 Fatal neglect group: Age and gender distribution



Cultural and linguistic diversity

All but two of the 31 children were born in Australia. For three children the main language spoken at home was not English. Five out of the 31 (16.1%) children were Aboriginal.

Family circumstances

Living arrangements

Just over two-thirds (21; 67.7%) of the children who died as a result of neglect were living with both biological parents at the time of their deaths. A further eight children (25.8%) were living with one biological parent only and two were living with relatives. Two children (aged 3 and 4 years) were under the parental responsibility of the Minister for Community Services at the time of their deaths. Both children were living with their grandparents.

This group of children were more likely to be living in intact families than were the children and young people who were fatally assaulted (67.7% of fatal neglect victims compared with 45.0% of fatal assault victims, $X^2 = 10.1$, $p<.05$).

Number of children in family residence

Similar to the children and young people who were fatally assaulted, the children who died as a result of neglect came from small to moderate size families with a mean of 2.6 children. Four (13.3%) children were the only child in the family.

Age of primary carer

The child's biological mother was the primary carer for 27 (87.1%) of the 31 children who died as a result of neglect. The biological father was the primary carer for two children and the grandmother was the primary carer for a further two children. The mean age of the primary carer was 29.3 years[1]. The fatal neglect and fatal assault groups did not differ with respect to the mean age of the primary carer.

Circumstances of carers

As previously mentioned, the children who died as a result of neglect were grouped into categories of inadequate supervision, negligent driving and failure to obtain medical care. Table 5.1 shows the number of families in each fatal neglect group who experienced problems associated with health[2] and well-being, violence, crime and social or economic difficulties. Problems associated with health and well-being, violence and crime, and social and economic disadvantage were common among the fatal neglect groups. Of the 30 families, 24 (80.0%) had experienced at least one health and well-being, violence, crime, or social and economic disadvantage factor. Thirteen (43.3%) families had experienced three or more factors.

Although such difficulties were prevalent among the families of children who died as a result of neglect, they were slightly more common among the families of the children and young people who were fatally assaulted (31/33 families; 93.9% had experienced at least one factor). This difference may be explained by the fact that the majority of neglect deaths in this study were inadequate supervision deaths, rather than chronic neglect deaths, which are caused by slowly building problems (Zuravin, 1991). In the inadequate supervision deaths in this study, carers made incorrect assessments of the child's needs, such as seriously underestimating the supervision required.

1 When the two grandmothers were excluded from the analyses, the mean age of the primary carer dropped to 27.4 years.
2 As described in Chapter 3, this study uses the World Health Organisation (1948) definition of health. The WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Table 5.1 Fatal neglect groups: Carer circumstances

	Inadequate supervision	Negligent driving	Failure to obtain medical care
Number of families	**26**	**3**	**1**
Health and well-being	12/26	2/3	1/1
Violence	13/26	2/3	1/1
Criminal behaviour	14/26	1/3	/
Social or economic	14/26	2/3	1/1

Note: the number of families totals 30, not 31, as two children who died were siblings.
Health and well-being: includes alcohol and other drug abuse, intellectual disability, diagnosed mental health problems and suicide attempts.
Violence: includes victim of abuse or neglect as a child, domestic violence (as victim or perpetrator).
Criminal behaviour: includes criminal behaviour as a juvenile and as an adult.
Social or economic: includes financial difficulties, accommodation difficulties and stressful events, namely change in family composition, death of family member, major illness in family, carer's loss of job, homelessness, relationship breakdown, and change in residence.

In summary,

- age was a significant factor. Twenty-two (70.1%) of the 31 children who were fatally neglected were aged between one and four years.
- gender was also a significant factor. More males than females died as a result of neglect.
- the children who died as a result of neglect were significantly more likely to be living in intact families than those who were fatally assaulted.
- just over 40 per cent of the families of children who were fatally neglected had experienced at least three health and well-being, violence, crime or social and economic disadvantage factors.

5.2 Circumstances of the deaths

Method of death

The methods by which the children died are presented in Table 5.2. Sixteen (61.5%) of the 26 deaths that resulted from inadequate supervision occurred by drowning. All four children in the negligent driving group died in motor transport accidents. They were all passengers in vehicles being driven by a caregiver.

Table 5.2 Method of death by fatal neglect group

Method	Inadequate supervision	Negligent driving	Failure to obtain medical care	Total
Drowning/submersion	16	–	–	16
Motor transport	5	4	–	9
Fire	2	–	–	2
Bronchopneumonia	1	–	–	1
Starvation	–	–	1	1
Firearms	1	–	–	1
Suffocation/strangulation	1	–	–	1
Total	**26**	**4**	**1**	**31**

Coronial investigations

Coronial inquests were dispensed with in 21 (67.7%) of the 31 fatal neglect deaths. A further six (19.4%) cases were forwarded to the criminal system. Inquests were held in four cases in which one finding of hypoxic brain damage as a result of near drowning and three findings of accidental drowning deaths were given.

Profile of suspects

Suspects were charged in all six cases that were forwarded to the criminal system. The criminal proceedings for the six cases are presented in Table 5.3. Interestingly, negligent driving was more likely to result in criminal proceedings compared with other forms of neglect, such as inadequate supervision. This finding may reflect the fact that parental duty is defined by unwritten standards in the community, not by law. Nevertheless, Table 5.3 also shows that just one of the three suspects who were charged with negligent driving was actually convicted. Overall, three of the six suspects who were initially charged were convicted.

Table 5.3 Fatal neglect group: Criminal proceedings

Death scenario	Suspects	Charge	Verdict
Fourteen month old female died as a result of starvation. She was severely malnourished, but her parents rejected medical advice due to their bizarre lifestyle beliefs.	Biological mother Biological father	Manslaughter	Guilty
Two female siblings aged three and five years killed in motor vehicle accident. Car driven by mother who had a blood alcohol level of 0.153g/100mL.	Biological mother	Negligent driving (occasioning death)	Guilty
Four year old female killed in motor vehicle accident. Car driven by father, who was subsequently found to have cannabis and amphetamines in his blood.	Biological father (occasioning death)	Negligent driving	Not guilty
Sixteen month old female put in bath by mother's friend. She was left unsupervised for somewhere between 2 and 10 minutes and drowned. Mother's friend had been smoking cannabis and drinking alcohol.	Mother's friend	Manslaughter	Not guilty
Twenty-two month old male playing ball on road unsupervised. He was hit by an oncoming vehicle.	Twenty-three year old male driver	Negligent driving (occasioning death)	Charges dropped

Although suspects were charged in just six of the 31 neglect cases, one or both parents were caring for 25 (80.1%) of the 31 children at the time of their death. In five cases, another relative or unrelated adult was caring for the child. In one case, there were no adults caring for the child at the time of death.

As mentioned, inquests were dispensed with in 21 (67.7%) of the 31 neglect deaths. In contrast, inquests were dispensed with in just two of the 40 assault deaths. This may be explained by the fact that the overwhelming majority (26; 83.9%) of the neglect deaths were inadequate supervision deaths, involving an incorrect assessment of the child's supervision needs, such as misjudging the level of supervision required and therefore may have been considered "tragic accidents".

As outlined in Chapter 3, however, the Coroner can decide to hold an inquest in those cases where a hearing may provide important social and statistical information, or produce recommendations which could prevent similar deaths or improve health and safety procedures. The Child Death Review Team considers that holding inquests in inadequate supervision deaths may serve to fulfil both purposes.

Context of death

Thirty of the 31 neglect deaths were grouped into three scenarios. For 13 children, there were no apparent stressors surrounding the deaths. The children were inadequately supervised, in that caregivers[3] made an inappropriate decision about the level of supervision that was required. A further 12 children died in the context of family stress and five children died while being supervised by alcohol or drug intoxicated parents. The death of a 14 month old female from starvation occurred in a different context to the other deaths. Her parents rejected medical advice due to their bizarre lifestyle beliefs. This case is not included in the following section, which details the three neglect death scenarios.

No current stressors evident

Thirteen (41.9%) of the 31 children died in the absence of current stress factors[4]. All but one of these children were being inadequately supervised. Caregivers incorrectly assessed the level of supervision that was required. Eight children died as a result of drowning (one occurred on a rural property), three were run over by motor vehicles, and one was shot by his brother when a loaded firearm was accidentally discharged. One six year old child did not die as a result of inadequate supervision. This six year old died in a motor transport accident; the vehicle was being driven by her mother who fell asleep at the wheel.

Several authors have distinguished between 'supervision neglect' deaths and 'chronic neglect' deaths caused by slowly building problems (Zuravin, 1991; Colorado Child Fatality Review Committee, 1993). The children who died in the absence of current stress factors died as a result of 'supervision neglect', where a parent or caregiver was not present when the child was faced with a sudden life or death situation. Jacob's case is illustrative.

Jacob, 2 years

Jacob's mother had taken Jacob and his older siblings to a local swimming pool complex, where the older siblings were involved in swimming club training. Jacob had a full swimsuit on with a bubble on his back for support. At some stage he asked his mother to remove his swimsuit so that he could go to the toilet. His mother did so and did not see him again. Jacob did not return to his mother after going to the toilet. It appeared that Jacob went back to the pool, entered via the steps and drowned. There was no record of the family's prior involvement with any agencies, nor were any ongoing risk factors noted on the file.

The deaths of these children highlight the risks of inadequate supervision of small children and the importance of parental education about the need for constant active supervision of toddlers. It also highlights the importance of all adults being watchful and aware of all children in their vicinity.

Family stress evident

In contrast to the above group in which no current stress factors were noted on file, 12 (38.7%) children died in the context of family stress, including parental substance abuse, parental criminal behaviour, parental mental illness, financial and accommodation difficulties, relationship difficulties with spouses (including domestic violence) and relationship difficulties with extended family.

These 12 children died as a result of inadequate supervision. Eight died as a result of drowning (two on rural properties); two were run over by motor vehicles; one child died in a house fire; and one child died in an 'accidental' hanging. Their inadequate supervision could have occurred in the context of multiple stressors.

3 Eleven of the 13 children were being cared for by biological parents, one was being cared for by another relative, and one was with a babysitter.
4 Six families had experienced stress factors dating back several years before the birth of the subject child. For example, one mother had been reported to the Department of Community Services as a child for sexual assault. Another family had a stillborn 11 years prior to the birth of the subject child.

Ben, 9 years

Ben's mother gave birth to Ben when she was 15 years old. The identity of the birth father is unknown. Ben's half sister was born three years later. Ben's mother was an intravenous heroin user and was well known to Police for her criminal behaviour. Her relationships were characterised by violence, including assaulting friends, neighbours and her children. Ben was first reported to the Department of Community Services at the age of one year and was the subject of four reports in his short life. The reports were for neglect, physical assault and psychological harm. The reports of neglect suggest limited parenting skills. When Ben was seven years old the mother presented to hospital having overdosed on alcohol and amphetamines. At this stage, she was Hepatitis C positive and on the methadone program.

Ben died when he ran into the path of an oncoming car. He was playing 'hide and seek' with some friends and hid himself behind some bushes on the median strip of a busy road. There were no supervising adults present while the children were playing near the roadway.

Ben's case highlights the fatal consequences for children of ongoing neglect. The extensive development of policy and training initiatives that have occurred over the past two years would likely result in Ben now being reported to the Department of Community Services.

Two of the seven drownings in this group, and one in the previous group, occurred in dams or creeks on rural properties. The children were aged two, three and four years respectively. None of the three children was able to swim and all were unsupervised by adults at the time of the fatal incidents. These cases highlight not only the importance of adequate supervision but also the importance of adequate separation of play areas from water on rural properties. The Child Death Review Team has previously recommended the development of strategies to reduce the number of child deaths caused by drowning on farms and especially in dams (CDRT *1999-2000 Annual Report*, Recommendation 2).

Drug or alcohol intoxication

Five (16.1%) children died in circumstances in which their parent or carer was intoxicated by alcohol or other drugs. The carers' levels of intoxication significantly impaired their ability to care for and adequately protect the children.

Three children were killed in two motor vehicle accidents. The vehicles were being driven by the children's parents, both of whom were grossly intoxicated at the time of the incident. Both were subsequently charged with negligent driving occasioning death. One child died in a house fire and one died as a result of drowning.

Chrissie, 16 months

Chrissie drowned when she was being supervised by her mother's friend. He had been smoking cannabis and had consumed about 12 glasses of wine. At some point, Chrissie's mother asked him to give Chrissie a bath. He placed her in the bath and left her alone for somewhere between two and 10 minutes. When he returned, Chrissie was face down in the bath. Chrissie's mother was known to the Department of Community Services for drug and alcohol abuse. Records indicate that when questioned by Department of Community Services' Officers prior to Chrissie's death, she did not deny the impact of her alcohol abuse on her ability to parent effectively. However, this matter was never followed up by the Department of Community Services. The mother's friend was charged with manslaughter, although was found not guilty.

In summary,

- just over half (16; 51.6%) of the neglect deaths occurred by drowning.
- suspects were charged in just six of the 31 (19.4%) neglect cases. Coronial inquests were dispensed with in 21 of the 31 (67.7%) cases.
- the deaths of the children from fatal neglect occurred in one of three scenarios – no stressors evident (13), family stress evident (12), and drug or alcohol intoxication (5).

5.3 Agency involvement

The families of 25 (80.6%) of the 31 children who were fatally neglected had prior agency involvement. Almost one-third (10; 32.3%) had been involved with three or more agencies. In contrast, over half of those children and young people who had been fatally assaulted had been involved with three or more agencies.

The most frequently involved agencies were NSW Health, including mental health services[5] (18; 56.1%), NSW Police (16; 51.6%), and the Department of Community Services (16; 51.6%). Other agencies involved with the families included Department of Housing (6), Department of Education and Training (5), non-government organisations (5), and the Department of Corrective Services (2).

An evaluation of agency involvement by those most commonly accessed is provided below.

NSW Health

NSW Health services were accessed by over half (18; 56.1%) of the families of the children who were fatally neglected.

As with the fatal assault group, two main areas of inadequate practice emerged:

- not recognising and reporting a serious and unstable situation
  - including no independent verification of information provided, limited awareness of the indicators of child abuse and neglect, and not acting on obligations to report
- inappropriate agency or individual actions
  - including premature discharge of patients, poor case management, unilateral agency action, lack of clarity regarding agency responsibilities, and no interagency engagement.

Not recognising and reporting a serious and unstable situation

Part of the role of health professionals in child protection is to recognise and report children who are at risk of harm. There were, however, at least three instances of health professionals not reporting children who were in unsafe environments.

In the case of Jo presented below, it is not known whether the fatal incident would have been prevented had the social worker sort advice from the hospital's Child Protection Team or reported the parents' possible drug use. Nevertheless, it was a lost opportunity for intervention. No comprehensive risk assessment was conducted and Jo's father's drug use remained undetected until her death. Her parents' explanation of the hypodermic needle incident was superficially accepted without independent verification.

5 Children, young people and their families attend health services for a range of reasons and contact with NSW Health is expected to occur over a person's life. These contacts present opportunities for health professionals to identify children and young people who may be at risk and to take appropriate action.

Jo, 4 years

Jo was brought into hospital at two years of age with a foreign body injury. She had been limping for several days prior to presentation. She underwent surgery to remove a hypodermic needle. Her parents were referred to a social worker but they denied any drug use in the household, although they revealed they had been the victims of a recent 'home invasion'. There was no follow up by the social work service, or consultation with the hospital's Child Protection Team even though the child had a hypodermic needle in her body, there was a recent unreported home invasion and a substantial delay in presentation of the child. The incident was treated as a medical accident instead of suspicious of parental drug use. Jo died two years later in a motor vehicle accident. The car was being driven by her father, who was subsequently found to have high levels of cannabis and amphetamines in his blood, and had been driving for a very prolonged period.

Inappropriate agency or individual actions

There were two cases in which health professionals acted inappropriately. These involved premature discharge of individuals prior to a comprehensive assessment and poor case management.

Recall the case of nine year old Ben who was hit by a motor vehicle while playing on a busy road, unsupervised. There were two incidents where health professionals discharged Ben's mother without conducting the necessary assessments. In the first instance, she was discharged from hospital 24 hours after the birth of Ben's younger half sibling. Hospital records noted that she was an ex-intravenous drug user and Hepatitis C positive. Midwifery records noted the mother's use of heroin, amphetamines, and sleeping tablets, and that she had consumed approximately 10 alcoholic drinks a night in the 12 months prior to the child's birth. There was no record of any assessment to consider the safety of the baby or Ben.

The second incident occurred four years later when Ben's mother presented to hospital following an overdose of amphetamines and alcohol. Hospital records note that she was on the methadone program and that she lived alone with two children. Once again, there was no record of any type of assessment being conducted in relation to the safety of the two children. Ben and his sibling do not appear to have been considered in assessment processes by the health professionals. This case further highlights the common practice of professionals acting in isolation, even within the one agency, and focusing on the needs of their client (the adult) to the exclusion of any children in the family. As the health professionals did not see the need to engage other services, no attempt was made to do so.

There was also one case of poor management by health professionals. One three year old boy and his siblings were placed under the parental responsibility of the Minister for Community Services after their mother was diagnosed with schizophrenia. The mother responded extremely well to medication and a decision was made to restore the children to their mother's care under two conditions. The mother and children were to reside with the maternal grandmother and the mother was to be closely monitored by the Community Health Centre (CHC).

CHC records indicate that regular contact with the CHC ceased about three months after restoration. A number of phone calls were made to the household, but these were either unanswered or the mother was not available. The CHC discharged the mother. It is not clear whether the Department of Community Services was advised that CHC involvement had ceased, nor is there evidence of any home visits being made by Department of Community Services Officers. The three year old boy died a few months later when he wandered off from his home and drowned in a nearby river.

This case highlights the importance of assertive follow-up for clients and their families involved with Community Health Teams and of informing the Department of Community Services when attempts to engage the client have been unsuccessful. This case also raises the issue about clarity of agencies' responsibilities. No home visits were made by either CHC staff or Department of Community Services' Officers. The Department seemed to consider that the CHC would monitor the restoration process, despite this not being a role of the CHC.

NSW Police

Records indicated that NSW Police were involved with just over half (16; 51.6%) of the families of the children who were fatally neglected. Issues emerged regarding NSW Police involvement with this group of children in the following area:

- not recognising and reporting a serious and unstable situation
  - including limited awareness of the indicators of child abuse and neglect and not acting on obligations to report.

Not recognising and reporting a serious and unstable situation

As with the fatal assault group, there were at least three instances of Police Officers not recognising and/or reporting to child protection services the serious risks facing children. NSW Police responded to a range of situations where children were clearly in unsafe environments, including domestic violence incidents, parents' drug use and criminal behaviour, and inadequate supervision by carers. NSW Police records indicate that the children were recorded as present during these incidents, although no information in relation to their safety is noted on file.

Ben, 9 years

Recall the case of Ben who died when he was playing on the road unsupervised and was hit by an oncoming car. Ben's mother was well known to NSW Police for drug use and criminal behaviour, including theft, assault and fraud. There were 50 events noted on NSW Police records in relation to Ben's mother. Further, Police Officers responded to eight domestic violence call-outs. Ben's presence in the home during the incidents was recorded on NSW Police records. Despite this knowledge and knowledge of the mother's extensive criminal records, only one of the eight call-outs was reported to the Department of Community Services.

There is no evidence that Police Officers used the information regarding the mother's criminal and drug use history to assess Ben's safety during the domestic violence call-outs. Rather, Police Officers treated each call-out in isolation, failing to take existing information into account.

This case highlights the need for Police Officer training in indicators of child abuse and neglect. It also raises the importance of Police Officers recognising children's safety needs when responding to domestic violence, even when the child is not directly assaulted. The case further highlights the importance of interagency engagement. In this case, NSW Police acted in isolation and did not seek to engage other agencies.

Department of Community Services

Just over half (16; 51.6%) of the families of the children and young people who were fatally neglected had been clients of the Department of Community Services. The issues of inadequate practice that emerged were similar to those that were evident in the fatal assault group:

- inadequate risk assessment
  - including not conducting an assessment, not conducting a comprehensive and timely assessment, not taking into account previous reports, inaccurate judgements of degree of risk, not assessing longer term needs, and poor documentation
- ineffective case planning and management
  - including poor case management and planning, poor documentation of case plans, not removing children from dangerous situations, and lack of understanding of roles and responsibilities of practitioners.

Inadequate risk assessment

Examples of inadequate risk assessment included no risk assessment at all or lack of a comprehensive risk assessment, including not conducting a timely assessment, not sighting the child despite policy requirement that this occur, not taking into account previous reports, inaccurate judgements of degree of risk, and poor documentation.

At least eight reports that were received by the Department of Community Services were never assessed at all. Four did not proceed to a full risk assessment and one was changed to this outcome after the time span between the alleged incident and the report was considered too great to act. A further three reports were closed without investigation or assessment, with no documentation on file to indicate how or why this decision was made.

Research evidence documents that judgements of risk made by individual workers vary widely in accuracy. Workers sometimes fail to identify high risk families during investigations and as a result, do not engage them in service intervention. It has been suggested that between 15 and 25 per cent of 'high risk' cases are not opened for agency services, while many low risk families are carried on caseloads for months or years (Baird, 1997).

There is a large body of research evidence indicating that risk assessment instruments are superior to the clinical judgement of an individual caseworker (Wagner, 1994; Dawes, Faust & Meehl, 1989; Holt, 1970). This is because some individual clinicians may not be able to thoroughly sort and effectively assess and analyse the large amounts of information available. In addition, individual workers often obtain their information from the one individual who makes the initial report and this may often occur in a highly charged environment. Thus, risk assessment instruments have proven to result in more consistent assessments by workers than procedures that rely heavily on clinical assessment (Baird & Wagner, 2000 cited in Johnson, 2003).

Full risk assessments and investigations did commence in other cases, although case reviews indicated the inadequacy of many of these assessments, as Eva's case illustrates.

Eva, 11 years

Eva was the eldest of five siblings. Her parents had separated and the children were living with their mother. Information on file indicates that Eva's mother was struggling to raise her children with few resources or supports. About seven weeks before Eva's death, Eva's father's de facto reported her concerns about the children to the Department of Community Services. The main concerns were that the children were being left unsupervised, meals were not being provided, the children were 'putrid and filthy', the older children were being kept home from school to look after the younger ones, and that Eva was doing most of the mothering. It was also alleged that the children had disclosed that their mother hit them with sticks and kicked their stomachs.

Following initial assessment of the information, the report was determined to require a response within 72 hours. However, the report remained unallocated. The only response was to call the school principal who confirmed that teachers were concerned about the children's hygiene and that one of the children had a bruise on her leg and had alleged that her mother had hit her with a shoe. There is no record of further follow up of this report or of any Departmental contact until Eva's death in a house fire seven weeks later.

This case raises the question about why a report that required a 72 hour response remained unallocated for seven weeks. The only response was to phone the school principal who provided supporting information to confirm the concerns raised in the report. There is no record on file as to why the report was not followed up and why no other services were engaged.

In several cases, there was no assessment past the immediate safety assessment. Recall the case of nine year old Ben described in detail earlier in this chapter. Deficiencies in Department of Community Services practice were evident upon Ben's restoration to his natural mother. This restoration occurred with virtually no support. The Department of Community Services seemed to consider that the Community Health Centre would assist with the restoration. No home visits were made by either Department of Community Services' staff or Community Health Centre staff following the restoration. This lack of clarity of agency responsibilities, which would have been overcome through interagency case planning, resulted in uncoordinated actions and no assessment of Ben's longer term needs.

Ineffective case planning and management

There was evidence of poor case planning and management for all cases that proceeded to assessment and investigation. Jade's case is illustrative.

Jade, 11 months

Jade was reported to the Department of Community Services by a psychologist at one month of age. Her mother was not coping with the new baby and had indicated at times 'she felt like throwing the baby'. The family was appropriately assessed on the day of the report and a referral was made to a Physical Abuse and Neglect of Children (PANOC) Service[6] to manage the case. The PANOC worker regularly updated the Department of Community Services worker on the family's progress. Jade's mother was diagnosed with depression and placed on anti-depressants. Throughout Department of Community Services/PANOC intervention, Jade's mother remained ambivalent towards Jade and ambivalent towards the protective intervention. She regularly cancelled appointments yet confided to the workers that she was feeling suicidal and depressed.

After 10 months of intervention, the Department decided to close the case. One month later Jade drowned in a bath where she had been left unsupervised by her mother.

In this case, the Case Manager functions were not adequately undertaken. In particular, the reason for the decision to close the case was not documented on file and appears to have arisen out of the worker's frustration with Jade's mother being seen as a difficult client rather than resolution of the issues present in the family. Also, there was no documentation relating to any discussions with Jade's mother regarding her feelings about the case being closed. Two months prior to the case closure, Jade's mother described herself as still depressed. The end result was that Jade was left in an unsafe and unsupported environment.

6 A PANOC Service is a specialised service provided by NSW Health to children who have been physically or emotionally abused or neglected.

In summary,

- agencies most frequently involved with the families of the children and young people who were fatally neglected included NSW Health, NSW Police, and the Department of Community Services.
- areas of concern in relation to NSW Health service provision centred around health professionals not recognising and reporting at risk children as well as inappropriate agency and individual actions (such as discharge of patients without adequate assessment and poor case management).
- inadequate practice by NSW Police centred around not recognising and reporting children at-risk.
- deficiencies in Department of Community Services practice included poor risk assessment, poor protective casework and poor ongoing care and support services.

5.4 Conclusion

Thirty-one children died as a result of fatal neglect. They were grouped into three categories of neglect – inadequate supervision by a carer (26), negligent driving by a carer (4), and failure of a carer to obtain medical care (1). Most (80.1%) of these children died while in the care of one or both parents.

There were several differences between the children who were fatally neglected and those (reported in the previous chapter) who were fatally assaulted. First, the fatally neglected children were more likely to be living in intact families than the children and young people who were fatally assaulted. Second, although common, health and well-being, violence and crime, and social and economic problems were slightly less frequent among the fatal neglect group than among the fatal assault group. Third, coronial inquests were dispensed with more often among the fatal neglect group, and suspects in the fatal assault group were more likely to be charged and sentenced. Fourth, children and young people in the fatal neglect group were less likely than those in the fatal assault group to have experienced multiple agency involvement.

These differences between the assault and neglect groups may be explained by the fact that the majority of neglect deaths in this study were inadequate supervision deaths that involved incorrect assessments by carers of the children's supervision needs, such as seriously underestimating the supervision required, rather than chronic neglect deaths that are caused by slowly building and ongoing problems.

Inadequate supervision of children may be the result of a number of different factors. In this study, 12 children whose deaths were due to inadequate supervision died in the context of family stress factors, including financial and accommodation difficulties, health-related problems and relationship difficulties. A further five children died while being supervised by drug or alcohol intoxicated parents. It is not known whether the children who died were being poorly supervised because of enduring health, social or economic difficulties. However, the presence of stress factors and parental substance use at the time of the children's deaths suggests that these were contributory factors in at least some of the deaths.

Inadequate supervision of children may also result from a lack of carer availability that is not due to family stress factors or substance abuse. In this study, 13 children died in such circumstances. As stated earlier, there has been a tendency to refer to these cases as "tragic accidents", the implication being that it is not always possible to provide the level of care required for very young children.

These families may not require statutory intervention. Rather, they need to be informed that incorrect assessments about the supervision needs of young children can be fatal.

Definitions of neglectful behaviour are dependent upon societal standards of acceptable parenting and so, the definitions of what constitutes ideal parental behaviour, the threshold for inappropriate parental behaviour, and what are considered to be adequate standards of care, vary across communities (Korbin, 1980; Drotar 1992; cited in Tomison, 1995). As a result, reaching an agreed upon definition of neglect is problematic.

Part of the role of the Child Death Review Team is to identify systemic issues in order to reduce child deaths. The results of this study have shown that some carers appear to have difficulties in making decisions about the level and type of supervision required for young children.

The Coroner can decide to hold an inquest in those cases where a hearing may provide important social and statistical information, or produce recommendations which could prevent similar deaths or improve health and safety procedures. Thus, holding inquests in inadequate supervision deaths may serve a preventative function by informing carers of young children.

CHAPTER 6
SUMMARY OF FINDINGS AND IMPLICATIONS

This study examined the group of deaths of children and young people identified by the NSW Child Death Review Team as due to assault or neglect or suspicious of assault or neglect between July 1999 and June 2002.

This final chapter summarises the study findings and draws attention to important implications for the prevention of deaths of children and young people from assault and neglect.

Consistent with previous research (NSW Child Death Review Team, 2002), this study found that deaths of children and young people from assault and neglect are rare. Over the three-year period, assault and neglect made up 3.4 per cent of deaths of children and young people (aged 0-17 years) from all causes in NSW. Assault deaths accounted for 1.8 per cent of deaths and neglect deaths accounted for 1.4 per cent of deaths from all causes[1]. Despite the infrequent nature of such deaths, the prevention of further assault and neglect deaths among children and young people requires that these deaths be investigated and understood.

6.1 Factors associated with assault and neglect deaths of children and young people

The following factors were found to be common to both the assault and neglect deaths:

Gender

The majority (61.3%) of assault and neglect deaths were of males.

Indigenous children and young people

Aboriginal children and young people were over-represented in assault and neglect deaths compared with their numbers in the population (16.0% of the population of this study compared with 3.5% of the NSW population).

Geographical location

Children and young people living in highly accessible regions were under-represented in assault and neglect deaths (69.3% of the study population compared with 82.1% of the NSW population).

Carer circumstances

Eighty-five per cent of the carers in this study had at least one documented health and well-being-related, violence and crime-related, or social and economic problem. More than half of the carers (54.4%) had experienced three or more difficulties. These difficulties were slightly more common among the families of the children and young people who were fatally assaulted than those who were fatally neglected (93.9% of fatal assault group compared with 80.0% of the fatal neglect group).

There were, however, several factors for which the assault and neglect groups were shown to differ.

Age

Seventy-one per cent of the children who died as a result of neglect were aged between one and four years. In contrast, 27.5 per cent of the children and young people who were fatally assaulted were

1 These numbers do not total 3.4 per cent as four children in this study died in circumstances suspicious of assault or neglect.

aged between one and four years. Thirty per cent of fatal assault victims were aged under one year, compared with 9.7 per cent of fatal neglect victims.

Living arrangements

Just over half (56.0%) of the children and young people were living in intact families at the time of their deaths. Children and young people who were fatally assaulted were far less likely to be living in intact families than those who died as a result of neglect (45.0% of assault deaths compared with 67.7% of neglect deaths).

Method of death

Blunt force battery was the most common method of fatal assault for males and suffocation/strangulation was the most common method of fatal assault for females. In contrast, drowning/submersion was the most frequent method of death by fatal neglect for both males and females.

Criminal and coronial proceedings

The Coroner dispensed with an inquest in 67.7 per cent of fatal neglect cases (21 of 31 cases). In contrast, just two fatal assault matters were dispensed with. In almost three-quarters (72.5%) of fatal assault cases the inquest was terminated and the matter forwarded to the criminal system. In contrast, approximately 20 per cent of fatal neglect cases were forwarded to the criminal system. Suspects were charged in 65.0 per cent of fatal assault cases, compared with 19.4 per cent of fatal neglect cases.

6.2 Circumstances surrounding assault and neglect deaths of children and young people

Consistent with the existing literature (NSW Child Death Review Team, 2002), this study found that children and young people who are fatally assaulted are not a homogenous group. This study has also extended existing knowledge regarding the classification of neglect-related deaths. The children and young people who were fatally assaulted, and those who were fatally neglected, could be classified into distinct groups based on an analysis of the precipitating incidents to their deaths.

Fatal assault

The four fatal assault groups that were identified were consistent with those that were identified in the *Fatal Assault of Children and Young People Report* (NSW Child Death Review Team, 2002):

- non-accidental injury;
- parents affected by a mental illness;
- family breakdown;
- killings of teenagers.

Non-accidental injury

Exactly half (20; 50.0%) of the children and young people who were fatally assaulted died from non-accidental injury. Seven were females and 13 were males. The injuries sustained resulted from either a series of assaults or one fatal assault. Eighteen of the 20 children were infants and toddlers (aged 0-4 years). Suspects were the children and young people's family members in all but two of the deaths.

Parents affected by a mental illness

The deaths of six (15.0%) children were precipitated by a parent's or carer's mental illness. All six children were female. The child's biological mother was the perpetrator in four cases and the mother's de facto was the perpetrator in two cases. All six had been diagnosed with mental health problems, including psychotic disorders (3), depressive disorder (2), and postnatal depression (1). The children were either killed in the context of depressive symptoms and psychosocial stress, or due to the adults delusional beliefs that involved the child.

Family breakdown

Five (12.5%) children in two families died in the context of parental dispute and family breakdown. Four were male and one was female. Both perpetrators were the children's biological fathers. The fatalities were directly related to different aspects of the parents' relationship breakdown. In both cases, the killings occurred in the context of separation or the threat of separation, with the fathers' inability to accept the end of the relationship. One father also believed that his partner was going to take his children overseas permanently. He attempted suicide and also fatally assaulted the children's mother.

Killings of teenagers

Eight (20.0%) children and young people aged between 13 and 17 years were killed by persons who were not family members or carers. Seven were male and one was female. Three of the fatal assaults of males involved group killings; two of those incidents involved altercations with rival gangs. Sixteen perpetrators were identified in the eight deaths, all of whom were male, four of the eight incidents the person/s alleged to have committed the assault was unknown to the young person.

Fatal neglect

Despite efforts to classify non-fatal neglect, there has been a lack of research attention to the classification of fatal neglect. This study found three distinct groups of fatal neglect:

- inadequate supervision;
- negligent driving;
- failure to provide medical care.

Inadequate supervision

This group was the largest, comprising 26 (83.9%) of the 31 neglect deaths. These children died in drowning accidents (17), motor transport accidents (5), house fires (2), accidental hangings (1), and firearm accidents (1). All but one of these children were being cared for by a biological parent, other relative, or another adult at the time of the fatal incident. In one case, there were no adults present at the time of the fatality. In all cases, carers incorrectly judged the child's supervision needs, some because of their intoxication by drugs and alcohol. A suspect was charged in just one of the 26 deaths that resulted from inadequate supervision. He was subsequently found not guilty.

Negligent driving

Four (12.9%) children in three families died in incidents precipitated by a parent's negligent driving. The children were aged between three and six years and all were female. Three died in two motor

transport accidents where the parent driver was affected by alcohol or other drugs at the time of the fatal incident. In the fourth case, the child died when her mother fell asleep at the wheel and the child was unrestrained in the back seat of the car. Suspects were charged in the two incidents involving substance affected drivers. One suspect was convicted and one was found not guilty.

Failure to provide medical care

One 14 month old female died as a result of starvation. She was severely malnourished. The Department of Community Services had intervened, although her parents rejected the necessary medical care for her due to their bizarre lifestyle beliefs. Both parents were charged with manslaughter and convicted.

A further four children died in circumstances suspicious of assault or neglect:

Deaths suspicious of assault or neglect

Four children, aged between 11 months and five years, died in circumstances suspicious of assault or neglect. Two of the four deaths were suspicious of assault, one was suspicious of neglect, and for one suspicious death it was not possible to make a determination as to whether the death was suspicious of assault or neglect. Three of the children were male and one was female. All were in the care of their biological parents when they died. Parents were affected by alcohol or other drugs in two of the fatal incidents.

6.3 Agency contact

In this study, 80.0 per cent of families had prior agency contact. The agencies most commonly involved with the families were NSW Police (58.7%), the Department of Community Services (58.7%), and NSW Health[1] (56.0%). The families with children and young people who died as a result of assault had more agency involvement than those families with children who died due to neglect. Over half (57.5%) of the families of the children and young people who were fatally assaulted had been involved with three or more agencies, compared with 32.3 per cent of the families of the children and young people who were fatally neglected.

For the families who had prior agency involvement, several inadequacies in agency practice were detected. These are discussed in the following section.

6.4 Prevention of assault and neglect deaths of children and young people

'Child protection is a responsibility of the whole community and one specifically shared by those government and non-government agencies which provide any form of care for children, young people and their families or which come into contact with them in the course of their work' (*NSW Interagency Guidelines for Child Protection Intervention*, 2000; p.2).

The findings from this study suggest two avenues for the prevention of further deaths of children and young people due to assault and neglect: the children, young people and their families and agency practice.

1 Children, young people and their families attend health services for a range of reasons and contact with NSW Health is expected to occur over a person's life. These contacts present opportunities for health professionals to identify children and young people who may be at risk and to take appropriate action.

Children, young people and their families

This study found that several characteristics were common to the children and young people who died as a result of assault and neglect and to their families:

- age of victims;
- over-representation of Indigenous families;
- family violence and criminal behaviour;
- family stress factors; and
- inadequate supervision of young children.

The following section details the study findings in relation to these child and family characteristics. It concludes with a discussion of how these findings can inform prevention of further assault and neglect deaths of children and young people.

Age of victims

International research has consistently found that children under one year are at the greatest risk of fatal assault, and that this risk declines steadily with age (Strang, 1995). Similarly, the NSW Child Death Review Team has previously found that fatal assaults are highest among infants (NSW Child Death Review Team, 2002).

Consistent with previous findings, this study found that fatal assaults were most frequent among infants under one year of age (30.0%), closely followed by toddlers aged one to four years (27.5%). This finding reflects the complete dependency of young children on their parents to secure their safety and that assault is most likely to produce a fatal outcome in the youngest children who are the most physically vulnerable. In contrast just over one fifth (22.5%) of the fatal assaults were of teenagers 13-17 years of age.

In contrast to the findings regarding the fatal assault victims, in this study the majority (71%) of children who were fatally neglected were toddlers (aged 1-4 years). This finding reflects the heightened risk of neglect death in a slightly older group (not infants). Developmentally these children are ambulant and so are more likely to access physically dangerous situations than are non-ambulant infants.

The finding that the majority of fatal assault and neglect deaths occur among children aged 0 to four years has been consistent across NSW Child Death Review Team Annual Reports.

Over-representation of Indigenous families

Previous research has found that Indigenous families are over-represented in fatal child assaults. The NSW Child Protection Council (1995) found that the proportion of Aboriginal and Torres Strait Islander suspects in fatal child assaults was 11.7 times greater than in the general NSW population. Similarly, the over-representation of Aboriginal children and young people in assault and neglect deaths has been a consistent finding throughout NSW Child Death Review Team Annual Reports.

In the present study, Aboriginal children and young people were over-represented in assault and neglect deaths compared with their numbers in the population. Aboriginal children and young people made up 16.0 per cent of the population of this study, yet only 3.5 per cent of the NSW population of 0-17 year olds are Aboriginal.

Aboriginal children and young people are over-represented in deaths from all causes. The findings from this study highlight ongoing issues regarding the safety and welfare of Indigenous children and young people.

Family violence and criminal behaviour

Research from the United States suggests that domestic violence is the single major precursor to child assault and neglect fatalities in the United States (US Department of Health & Human Services, 1995). In the *Fatal Assault of Children and Young People* report (NSW Child Death Review Team, 2002), ongoing severe domestic violence was evident in approximately half of the families of children who were in the non-accidental injury group.

Criminal behaviour has also been found to be characteristic of the families of victims of fatal child assault. Wilczynski (1993; cited in Wilczynski, 1997) found that 44.4 per cent of perpetrators of fatal child assaults had seven or more criminal convictions, 38.9 per cent had convictions for violent crimes, and 35.3 per cent had previously received a custodial sentence.

Consistent with previous research, this study found that 50 per cent of carers had been victims of domestic violence and 54.4 per cent had been perpetrators of domestic violence. Furthermore, more than half (51.5%) of carers had criminal histories.

The Child Death Review Team has found that family violence and criminal behaviour are consistently associated with deaths of children and young people from assault and neglect. In the *2001-2002 Annual Report*, domestic violence and criminal behaviour were the characteristics most commonly found in the families of the fatal assault and neglect victims.

Family stress factors

Research evidence indicates that stress factors are often present in the families of children and young people who are fatally assaulted and neglected. For example, Wilczynski (1993; cited in Wilczynski, 1997) found that relationship problems with partners existed in approximately three-fifths of the families of children who were fatally assaulted. In addition, two-fifths of the perpetrators of the fatal assaults were dependent on welfare for financial support and two-thirds had problems with accommodation. Similarly, the *Fatal Assault of Children and Young People* report (NSW Child Death Review Team, 2002) found a strong correlation between prior child abuse, prior spousal violence, financial difficulties, parental substance use and prior parental arrests.

In the present study, just under 60 per cent of families had experienced stressful events. These included changes in family composition, death of a family member, major illness in the family, loss of job, homelessness and relationship breakdowns. Stressful events were more common among the families of the children who were fatally assaulted (84.8% of families) than those who were fatally neglected (56.7% of families).

Inadequate supervision of young children

Previous research has found that the majority of neglect fatalities tend to be associated with a single life-threatening incident involving inadequate supervision rather than more chronic forms of neglect (Margolin, 1990; Bonner et al., 1999).

Similarly in this study, the majority (83.9%) of neglect deaths were associated with inadequate supervision. Such inadequate supervision appeared to result from two different factors. First,

12 children whose deaths were due to inadequate supervision died in the context of family stress factors, including financial and accommodation difficulties, health-related problems and relationship difficulties, and a further five children died while being supervised by drug or alcohol intoxicated parents. The presence of stress factors and parental substance use at the time of the children's deaths suggests that these factors were directly related to at least some of the deaths that resulted from inadequate supervision.

Inadequate supervision deaths also resulted from a lack of carer availability where no stress factors were evident. Thirteen children died in such circumstances. These findings suggest that some carers appear to have difficulties in making decisions about the level and type of supervision that is required for young children.

Children and their families: Conclusions

This study has identified several factors that were common to the children and young people who died as a result of assault and neglect and their families. The finding that Aboriginal children and young people were over-represented in assault and neglect deaths compared with their numbers in the population highlights ongoing issues regarding the safety and welfare of Indigenous children and young people.

The findings from the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Human Rights and Equal Opportunity Commission, 1997) implicated effective parenting as one of the intergenerational effects of past removal policies.

> 'Most forcibly removed children were denied the experience of being parented or at least cared for by a person to whom they were attached. This is the very experience people rely on to become effective and successful parents themselves' (p.222).

The impaired parenting capacity of some Indigenous parents due to the denial of a positive parenting experience when they were children is one possible explanation for the over-representation of Indigenous children in abuse and neglect injuries. Often many parents in a community have suffered the effects of past removal policies and so the general parenting capacity within the community is weakened. Where the community is unable to compensate sufficiently for the ineffective parenting of its members, it is clear that intervention needs to operate at a number of levels. This highlights the need for multi-faceted responses to the problems that exist in Indigenous communities. Such responses need to focus on a range of practical, emotional, social and structural factors (Tanner & Turney, 2003).

Family violence in Aboriginal communities is a significant problem. While the consequences of family violence are overwhelming for any community, Aboriginal families face additional difficulties when dealing with violence that may not be present for non-Aboriginal communities. These include the reluctance of some Aboriginal people to use mainstream services, the reluctance of some Aboriginal services to refer to mainstream services, the reluctance of some non-Aboriginal workers to intervene in Aboriginal families because they fear creating a new stolen generation, and the lack of culturally appropriate services to Aboriginal people (NSW Department of Aboriginal Affairs, 2003).

The NSW Government places a high priority on addressing family violence in Aboriginal communities and through various government agencies makes a substantial commitment to numerous targeted programs. Many of the programs are based in local areas and are in partnership

with the local community. There are also programs which cover family violence in a broader sense, including the *Ministerial Council on Aboriginal and Torres Strait Islander Affairs Indigenous Family Violence Strategy* and the *NSW Aboriginal Family Health Strategy*, which provides a framework for immediate government action including the provision and location of government funded services and the strategic development of Aboriginal community controlled responses to family violence and sexual assault (NSW Department of Aboriginal Affairs, 2003).

The NSW Child Death Review Team supports continued efforts in this area.

The finding that more than half of the families in this study had experienced ongoing domestic violence reinforces existing literature that domestic violence is a common characteristic in assault and neglect deaths.

Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* states that a child or young person is at risk of harm if the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm.

In March 2003, NSW Health introduced the *NSW Health Policy for identifying and responding to domestic violence*. The policy introduces a new preventative strategy involving routine screening for domestic violence for all women attending Antenatal Services, Early Childhood Health Services and women 16 years and over attending Alcohol and Other Drugs Services and Mental Health Services. Universal routine screening will be fully introduced by December 2004 (NSW Health, 2003).

The Child Death Review Team supports the introduction of this important initiative.

The *Partnerships Against Domestic Violence Strategy* was launched by Heads of Government at the National Domestic Violence Summit in 1997. This initiative is funding Commonwealth, National and State and Territory projects with the goal of preventing domestic violence. The projects are organised around six priority themes: helping children and young people who may have experienced or witnessed domestic violence to break the cycle of violence and develop healthy relationships, working with adult victims and perpetrators to prevent and reduce domestic violence, protecting people at risk by reforming legislation and improving responses by police and courts; educating the community against violence, researching what works and generating new information to support violence prevention, and helping people in regional Australia.

Currently funded projects in NSW include the *Domestic Violence Prevention Film Project*, which will use a skills based film-making model to work with young women who have experienced domestic violence and are living in transient accommodation, and the *Criminal Justice System Interagency Guidelines on Domestic Violence*. These guidelines aim to improve the response of the criminal justice system to victims of domestic violence. Included in this process is improvement of the Apprehended Violence Order scheme, by outlining the role of each agency at each stage of the process and developing protocols and guidelines for referrals. A national evaluation of the Strategy is ongoing and evaluation papers on key findings to date are available (Partnerships Against Domestic Violence, 2003).

Although this study has documented several family stress factors common to the children who died as a result of assault or neglect and to their families, the fatal assault and neglect deaths did not result from any one of these factors alone, but rather from multiple factors. This suggests that the prevention of further assault and neglect deaths depends on an understanding of how these multiple factors interact with each other.

It is, however, important to point out that these family stress factors cannot be used to predict those individuals who will go on to fatally assault or neglect their children. Many carers possess these characteristics but do not fatally assault or neglect a child. Alternatively, not all individuals who do fatally assault or neglect a child will possess these characteristics. This points to the need for a comparative research study that seeks to understand the fatal assault, neglect or injury of children. Such a study would examine the characteristics of children, carers and communities and provide information to inform policy and practice in this area.

The findings from this study have particular implications for the prevention of one type of neglect death – those that result from inadequate supervision. It is well documented in the injury prevention literature that inappropriate supervision of young children can lead to injury and death (Rivara, Bergman & Drake, 1989; Peterson & Saldana, 1996; Wills, Christoffel & Lavigne, 1997). In this study, 26 children died due to lack of carer availability that stemmed from a carer's incorrect assessment of the supervision needs of the child. Thirteen of these deaths occurred in the absence of any current stress factors. As previously mentioned, statutory intervention may not be required in these circumstances, rather, the parents and carers need to know that incorrect assessments or misjudgements about the supervision needs of young children can be fatal and to act upon this information.

There are many ways in which carers can gain such knowledge and subsequently change their behaviour. Two suggested ways are through coronial inquests, and the use of existing strategies such as *Families First*[2]. First, the Coroner can decide to hold an inquest in those cases where a hearing may provide important social and statistical information, or produce recommendations which could prevent similar deaths or improve health and safety procedures. The Child Death Review Team believes that public awareness raised through inquests into inadequate supervision deaths may provide carers of young children with information about the potentially fatal consequences of incorrect assessments about the supervision needs of young children.

Second, *Families First* is in an ideal position to provide information to parents to assist them to make correct decisions about the level of supervision that young children require. This information could educate parents about the preventability of child injury and death and the importance of appropriate supervision. It could also provide specific reminders to parents about the need for especially attentive supervision around known hazards, such as bodies of water or street locations that are particularly frequent sites of injury and death (Landen, Bauer & Kohn, 2003).

The Child Death Review Team considers that there is a need for community awareness programs to assist families to make correct decisions about the level of supervision required for young children.

Agency practice

Not all of the children and young people who were fatally assaulted or neglected had prior agency involvement. In fact, the findings from this research suggest that there are some groups of deaths for whom child protection involvement may not be required. These are the inadequate supervision deaths were there were no stress factors presents and the teenage fatal assaults. As previously mentioned, the children who died as a result of inadequate supervision where no stress factors were evident may not require statutory involvement. Rather, their carers need to know that incorrect assessment of children's supervision needs, such as under estimating the level of supervision needed, can be fatal and this knowledge needs to produce a change in their behaviour.

2 *Families First* is a coordinated strategy sponsored by the NSW Government which aims to support parents and carers who have children under eight years of age in raising their children and helping them solve problems early before they become entrenched.

In addition, child protection involvement may not be relevant to the teenage victims of fatal assault. Consistent with previous research (NSW Child Death Review Team, 2002), this study found that parents were not involved in the teenage fatal assaults. In addition, the *Fatal Assault of Children and Young People* (2002) report found that one half of the victims and offenders had previous contact with NSW Police through criminal charges. Consequently, it was suggested that the policing and criminal justice systems might be more relevant points of entry to services for this group.

The Child Death Review Team awaits the Government's response to this.

For those children and young people who had prior agency involvement, ongoing issues were evident in these families that required planned child protection services if families were to be assisted. Where practitioners came across abuse and neglect or potential risk, or were providing services in the child protection context, several inadequacies in practice were detected. The three most common errors made by agencies and practitioners were:

- not recognising and reporting serious and unstable situations;
- inadequate risk assessment; and
- poor interagency collaboration and coordination.

The following section details the study findings in relation to these three inadequacies in agency practice. The section concludes with a discussion of possible explanations for the inadequacies and avenues for prevention.

Not recognising and reporting serious and unstable situations

Findings from international research indicate that some professionals do not report to child protection agencies children who they suspect of being abused or neglected, even though they are legally mandated to do so (US Department of Health & Human Services, 1995). The two main reasons that practitioners gave for not reporting were lack of hard evidence of abuse or neglect and their belief that they could 'do better than the system' (Zellman, 1990; cited in US Department of Health & Human Services, 1995).

Similarly, research conducted by the Child Death Review Team on the fatal assaults of children and young people found that children were often not reported to the Department of Community Services, despite clear warning signs that the child's safety was in jeopardy (NSW Child Death Review Team, 2002).

In this study, there were instances of mandated persons not recognising and reporting children and young people who were clearly at risk of abuse or neglect. Guidelines exist for agencies that play a role in child protection, and training is regularly provided to workers to assist in the recognition and reporting of children at risk of harm. For example, in 2000 NSW Health introduced the *NSW Health Frontline Procedures for the Protection of Children and Young People*. The procedures provide NSW Health staff with information to help them in recognising children at risk of harm, making a report to the Department of Community Services, responding to requests for service, and exchanging information with the Department of Community Services. Agencies need to maintain vigilance and report all children and young people who may be at risk of harm.

The introduction of Part two of the *Children and Young Persons (Care and Protection) Act 1998* in December 2000 increased the range of persons required to report children and young people that

they suspect to be at risk of harm. At the same time, there was an escalation in the number of reports of children and young people. This led to discussions around the level of reporting that was acceptable and a feeling in some agencies that 'too many' reports were being made. This study found that some children were not reported who should have been, suggesting that the question for discussion should be how NSW can improve its reporting accuracy, not whether there are too many or not enough.

The seriousness of not reporting children who were at risk of abuse or neglect is highlighted by the fact that almost half (48%) of the children in this study who were fatally assaulted or neglected had never been reported to the Department of Community Services. It is important to reiterate, however, that not all of the children and young people who were fatally assaulted or neglected (in particular those who died as a result of inadequate supervision where no current stress factors were evident and teenagers who were fatally assaulted) may have benefited from statutory protective intervention.

The failure of professionals to report children and young people at risk of harm has been a consistent finding throughout the Child Death Review Team Annual Reports. The Child Death Review Team has previously recommended improvements to the recognition and reporting process (CDRT *2000-2001 Annual Report*, Recommendation 3; CDRT *2001-2002 Annual Report*, Recommendation 2).

Inadequate risk assessment

Workers need specialised training in identifying children who are at risk of harm. Early identification of risk is essential. Yet the findings from this study indicated that workers were often unable to reliably determine those reports that required a comprehensive risk assessment.

Workers also need to access necessary information that is available from all agencies in order to conduct an accurate risk assessment (Wilczynski, 1997). Nevertheless, inexperience, lack of training and unmanageable caseloads can preclude this (US Department of Health & Human Services, 1995).

In this study, risk assessments and investigations commenced for three-quarters (75.5%) of reports that were made to the Department of Community Services. Just over 60 per cent of investigated reports were substantiated.

This study found that inadequate risk assessment was a feature in almost all of the cases that proceeded to this stage of intervention. Consistent with previous Child Death Review Team reports, inadequate risk assessment included not conducting a risk assessment at all, lack of a thorough risk assessment, discounting reports, no reassessment of the child's safety given new information, not taking into account previous reports, inaccurate judgements of degree of risk, no assessment of longer term needs, and poor documentation.

While there were some examples of appropriate service provision, this was never sustained. As with the findings from previous Child Death Review Team reports (CDRT *2001-2002 Annual Report*), this study found that workers were trapped in a recognise-report-assess cycle, focusing on an individual report of risk of harm and the immediate issues that flowed from it to the exclusion of any previous reports. As a result, workers did not focus on the long term needs of the child and their family. This practice of operating on a 'get in, get out' model, which emphasises control of any immediate danger followed by rapid withdrawal, is well documented in the literature (NSW Child Protection Council, 1995; Department of Health, 1995; Wilczynski, 1997). In the United States,

for example, a risk of harm report often only results in a single visit to the home to establish whether the complaint is well-founded or not, with no subsequent follow-up to alter the child's circumstances so they are no longer at risk (US Advisory Board on Child Abuse & Neglect, 1995; cited in Wilczynski, 1997).

As with the failure of professionals to report children at risk of harm, inadequate risk assessment has been a consistent finding throughout the NSW Child Death Review Team Annual Reports. The Child Death Review Team has made previous recommendations for improvements to the assessment and investigation process (CDRT *1997-1998 Annual Report*, Recommendations 4.1 and 5.1).

In 2001-02 the Department of Community Services implemented a *Secondary Risk of Harm Framework* that is intended to support professionally guided practice and lead to clear statements about the safety, harm and risk to a child or young person. The framework includes practice tools for information gathering, risk of harm analysis, judgement, decision and case planning. The Child Death Review Team supports the Department of Community Services in its continued implementation of this framework. As has been acknowledged during the implementation of the Victorian *Risk Assessment Framework*, the introduction of new initiatives takes time and needs constant attention to maintain motivation and to continuously improve (Boffa & Armitage, 2001). In order to be effective, caseworkers require supervision by experienced managers and access to ongoing training so that knowledge and skills are constantly updated.

Poor interagency collaboration and coordination

Although child protection agencies have a central role to play in preventing child deaths, all agencies who have contact with children and families need to take responsibility for the welfare and safety of children and young people. Wilczynski (1997) reported that one of the most consistent themes of child death reports worldwide is that major improvements are required in interagency work. For example, agencies often fail to enquire whether their client family has had contact with other agencies or advise other agencies of important developments, agencies often argue over who should provide services to a particular family, agencies often fail to report to child protection agencies that a child may be at risk, and agencies often fail to take responsibility for the coordination of information and responses to a family and for making sure that all necessary action is carried out (Wilczynski, 1997).

Reder, Duncan and Grey (1993; cited in Wilczynski, 1997) identified four barriers to interagency collaboration and coordination. First, workers operated in a 'closed professional system', in which one group of practitioners developed a view about the case and ignored or minimised information that did not conform with this view. The second barrier was 'polarisation', where divisions arose between groups of workers due to different perceptions about the case and communication between them subsequently declined. Third, there tended to be an 'exaggeration of hierarchy', where presumed status differences between professionals were intensified and the view of those with perceived higher status dominated. The fourth barrier to interagency coordination was 'role confusion', where workers did not act because they believed that it was another agency's responsibility.

In this study, there were several examples of individuals and agencies acting in isolation, without engaging in the necessary interagency collaboration that is required for effective case planning and management. There was evidence in some cases of 'role confusion', where each agency assumed that the other was responsible for case management. Poor interagency collaboration was also evidenced

by the failures of professionals in agencies to report children and young people at risk of harm to the Department of Community Services and by the conducting of poor risk assessments and investigations.

Poor interagency work has been a consistent finding throughout NSW Child Death Review Team Reports. New South Wales has been working on an interagency response to child protection since the early 1990s. The first *Interagency Guidelines for Child Protection* were released in 1991 and the current Guidelines (third revision) were implemented in 2000. Each version of the *Interagency Guidelines for Child Protection* has been widely distributed to relevant agencies and major training and information sessions have been conducted. In addition, an evaluation of the 1997 *Interagency Guidelines for Child Protection* (second edition) found widespread support from practitioners for the direction provided by the Guidelines.

Taken together, NSW has had *Interagency Guidelines for Child Protection* for over 10 years. The direction of the revised Guidelines is endorsed by practitioners in the area of child protection. Yet, this study has shown that individual workers do not put these Guidelines into practice. Further, their managers do not take the necessary steps to correct this. There is a need to determine worker and manager impediments to properly following interagency practice and policy.

Agency practice: Conclusions

The *NSW Interagency Guidelines for Child Protection Intervention* (2000) outline the roles and responsibilities for government and non-government agencies providing any form of care for children and young people and their families. The analysis of agency practice in this study indicates that workers and managers often do not adhere to these guidelines.

It is not possible to determine from the study findings why this failure to follow protocols and practice standards occurs. Several possible explanations exist. Perhaps workers and managers are aware of the policies but either choose not to adhere to them or are so overworked that they do not have time to make contact with and discuss issues of concern with workers in other agencies. Alternatively, perhaps workers and managers are not provided with adequate knowledge and updated information.

In any case, whatever the explanation for these errors in practice, it is not possible to conclude that better compliance with agency protocols and practice standards would have prevented these assault and neglect deaths.

It is also not possible to conclude from the study findings why practitioners failed to effectively collaborate with each other. There was evidence that in at least some cases workers were confused about their particular role in the case planning and management process. The issue of interagency coordination can, however, only be fully understood within the context of a research study that seeks the views of workers and managers themselves as to the barriers that exist to effective interagency work.

6.5 Conclusion

This research study documented the profile of assault and neglect deaths of children and young people aged between birth and 17 years in NSW over a three-year period (July 1999 to June 2002). The findings suggest avenues for the prevention of further deaths from assault and neglect and have implications for agency practice. They also highlight areas that require further research if we are to better understand the assault and neglect deaths of children and young people.

6.6 Recommendations

1. That the NSW Government considers undertaking a comparative research study to identify differences between reported children and young people who are injured and reported children and young people who are fatally assaulted to inform interagency practice and response.
2. That the NSW Government considers undertaking a research study into the factors that promote and hinder adherence to interagency policy and practice.

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APPENDIX 1

Similarities and differences between the January 1996-July 1999[30] fatal assault findings and the July 1999-June 2002[31] fatal assault findings

January 1996-July 1999 fatal assault findings	July 1999-June 2002 fatal assault findings
■ Fatal assault is a rare event: Fatal assaults made up 2% of deaths of children aged 0-17 years from all causes in NSW.	This study also found that fatal assaults of children are rare events. These deaths made up 1.8% of deaths of children aged 0-17 years from all causes in NSW.
■ Categories of child fatal assault: Four categories of fatal assault emerged: 1) Non-accidental injury 2) Parental mental illness 3) Family breakdown 4) Killings of teenagers.	The fatal assaults in this study could also be classified into: 1) Non-accidental injury 2) Parental mental illness 3) Family breakdown 4) Killings of teenagers.
■ A developmental theory of fatal assault: The types of assault that occurred varied according to the child's age. 1) Non-accidental injury occurred only in infant and young children (0-4 years). 2) Parental mental illness and family breakdown fatalities occurred among primary school age children. 3) For teenagers, fatal assaults reflected the child's expanding social sphere; all of the assaults were committed by persons other than parents.	This study also found a developmental theory of fatal assault: 1) Eighteen of the 20 children who died from non-accidental injury were aged 0-4 years. 2) Parental mental illness and family breakdown fatalities occurred most frequently in the 0-5 group; with three of the children in the primary school aged groups. 3) All of the fatal assaults of teenagers were committed by persons other than parents.
■ The context of the fatal assault: 1) Prior violence was evident in a minority of families, although domestic violence was evident in just under half (47%) of the families in the non-accidental injury category.	1) In contrast to the previous findings, the majority (75.8%) of families had experienced prior violence, including domestic violence. Prior violence was evident in 70.6% of families in the non-accidental injury group, all of the families in the mental illness and family breakdown groups and in 62.5% of the families in the teenage group.

30 These cases were reported on in the Fatal Assault of Children and Young People (2002) report.
31 These cases were reported on in the present report.

January 1996-July 1999 fatal assault findings	July 1999-June 2002 fatal assault findings
■ The context of the fatal assault continued: 1) A majority (59%) of suspects did not have criminal records prior to the fatal assault of the child. 2) Poverty and social disadvantage were present across the categories of assault, although multiple social problems were most evident for families in the non-accidental injury group.	1) Inconsistent with previous findings, in this study a minority (43.5%) of suspects did not have prior criminal charges. 2) Consistent with previous findings, social and economic disadvantage factors were evident among all four fatal assault groups (94.1% of families in the non-accidental injury group, all of the families in the mental illness and family breakdown groups, and 50% of the families in the teenage group). Three-quarters of the families had experienced multiple social problems.
■ Human service agency involvement: 1) Many families had some formal contact with a human service agency or professional. Over one third (37%) of all children who were fatally assaulted had been the subject of intervention by the Department of Community Services. 2) There were instances where children were not reported to the Department of Community Services, despite clear warning signs that the child's safety was in jeopardy. 3) There were examples of inadequate intervention by the Department of Community Services, including inadequate assessment of safety and risk, case planning and casework. 4) In relation to the 60 deaths, there were 17 convictions of manslaughter and five for murder.	1) Consistent with previous findings, in this study 85% of the children who were fatally assaulted came from families that had prior human service agency involvement. However, in this study, children were more likely to have been clients of the Department of Community Services (59% of children in this study). 2) Consistent with previous findings, there were several instances where professionals failed to report to the Department of Community Services children who were clearly at risk of harm. 3) This study also found examples of inadequate service provision by the Department of Community Services, including inadequate risk assessment (for example, not conducting a comprehensive assessment, discounting reports) and ineffective case planning (including poor case planning and management and not ordering medical examinations). 4) In this study 40 children and young people were fatally assaulted. To date, there have been 10 convictions for murder and four for manslaughter. A further six persons have been charged with murder or manslaughter but these cases have not yet been finalised.

APPENDIX 2

Cases excluded from analyses due to documentation being received after the cut-off date

Age, gender, ATSI	Assault or neglect group	ICD-10	Autopsy	Description of death	Child/sibling reported to the Department of Community Services
7 months, female, non-ATSI	Fatal neglect – Inadequate supervision	Other accidental hanging and strangulation	Positional asphyxia	Infant was placed for sleep in a pram. She slipped under the transverse bar of the pram and was suspended by her neck. Resuscitation attempts were unsuccessful.	Yes, child
9 months, female, non-ATSI	Fatal neglect – Malnutrition	Pseudomonas as the cause of disease, eczema, unspecified severe protein-energy malnutrition, neglect and abandonment by parent	Sepsis due to combined effects of chronic eczema and malnutrition	Infant was admitted to hospital with history of chronic eczema, weight loss and eye infection. Evidence of malnutrition. Infant was treated, although died several days later.	No
18 months, male, Aboriginal	Fatal neglect – Inadequate supervision	Pedestrian injured in collision with car, pick-up truck or van	Laceration of the liver with haemorrhage in the abdomen	Child was run over by taxi driver who was reversing out of child's driveway.	Yes, child and sibling
2 years, male, non-ATSI	Fatal neglect – Inadequate supervision	Crushing injury causing injury to lungs and rupture of vessels, injury to liver, due to being a pedestrian injured in collision with car, pick-up truck or van	Extensive contusion of left lung with patchy contusion of right lung with rupture of the veins adjacent to the left hilum producing left pleural haemorrhage	Child was with his father at a gypsum mine. He was last seen playing behind his father's truck. There were other trucks moving around the area, which was dark, with no lighting. Child was fatally struck by one of the trucks.	No
14 years, male, non-ATSI	Fatal neglect – Inadequate supervision	Accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified	Acute narcotism	Death in Custody. Child was on day leave from a Juvenile Justice Centre. He was found lying face down on the lounge in his parents' home. Toxicology analysis revealed morphine (heroin) levels in the fatal range.	Yes, child and sibling
17 years, male, non-ATSI	Fatal assault – Teenage killing	Assault by sharp object	Haemorrhage due to multiple stab and incised wounds of head, chest and abdomen	Young person was in the kitchen area of the club in which he worked. He was fatally stabbed several times by a co-worker following a dispute.	No
17 years, male, non-ATSI	Fatal assault – Teenage killing	Assault by blunt object	Head injury	Young person was driving with his friends when a large group of young people approached the car on foot. One young person propelled a metal pipe through the driver's window, fatally injuring the young person.	No

APPENDIX 3

ICD-10 code classifications for method of fatal assault and neglect deaths

Fatal assault deaths

Methods of fatal assault deaths were identified by the following ICD codes:

Blunt force battery

- T74.1 Physical abuse
- Y00 Assault by blunt object
- Y04 Assault by bodily force
- Y07 Other maltreatment syndromes
- Y08 Assault by other specified means

Suffocation/strangulation

- X91 Assault by hanging, strangulation and suffocation
- W80 Inhalation and ingestion of other objects causing obstruction of respiratory tract

Drowning

- X92 Assault by drowning and submersion

Firearms

- X93 Assault by handgun discharge
- X94 Assault by rifle, shotgun and larger firearm discharge

Poisoning

- X85 Assault by drugs, medicaments and biological substances
- X88 Assault by gases and vapours

Stabbing

- X99 Assault by sharp object

Other assault

- W78 Inhalation of gastric contents

Fatal neglect deaths

Methods of fatal neglect deaths were identified by the following ICD codes:

Drowning

- W65 Drowning and submersion while in bath tub
- W66 Drowning and submersion following fall into bath tub

- W67 Drowning and submersion while in swimming pool
- W68 Drowning and submersion following fall into swimming pool
- W69 Drowning and submersion while in natural water
- W70 Drowning and submersion following fall into natural water
- W73 Other specified drowning and submersion
- Y21 Drowning and submersion, undetermined intent

Motor transport

- V03 Pedestrian injured in collision with car, pick-up truck or van
- V05 Pedestrian injured in collision with railway train or railway vehicle
- V47 Car occupant injured in collision with fixed or stationary object
- V57 Occupant of pick-up truck or van injured in collision with fixed or stationary object

Suffocation/strangulation

- W76 Other accidental hanging and strangulation

Fire

- X00 Exposure to uncontrolled fire in building or structure

Firearms

- Y23 Rifle, shotgun and larger firearm discharge, undetermined intent

Starvation

- T73.0 Effects of hunger

Bronchopneumonia

- J18.0 Bronchopneumonia, unspecified

Deaths suspicious of assault and neglect

Methods of suspicious deaths were identified by the following ICD codes:

Drowning

- W69 Drowning and submersion while in natural water

Suffocation/strangulation

- Y20 Hanging, strangulation and suffocation, undetermined intent

Ill-defined and unknown causes of mortality

- R96 Other sudden death, cause unknown

Bronchopneumonia

- J18.0 Bronchopneumonia, unspecified

GLOSSARY AND ABBREVIATIONS USED

ARIA	The Accessibility/Remoteness Index of Australia (ARIA) has been widely adopted as an Australian national standard for measuring remoteness in Australia. ARIA defines five categories of remoteness based on road distances to service centres.
CDRT	NSW Child Death Review Team
Child Death Register	Register of all the deaths in NSW of children 0-17 years occurring after 1 January 1996.
Children	Persons aged 0 to 17 years
Children's Court	The court designated under the *Children's Court Act 1987* to hear care applications and criminal proceedings concerning children and young persons.
Crude death rate	The number of deaths in a certain age group per 100,000 children in the population.
Culturally and linguistically diverse (CALD)	Culturally and linguistically diverse refers to the background of persons who were either born, or one or both parents were born in a country where the main language spoken is other than English.
Fatal abuse	Fatal abuse occurs where a child is fatally injured by beating, burning, shaking, stabbing, shooting, poisoning, suffocation, strangulation or other physical means. Fatal abuse includes fatal assaults, homicides and murder-suicides.
Human service agencies	Those agencies that provide services to people that promote their safety, welfare and well-being. In NSW they include the NSW Department of Community Services, NSW Health, Department of Education and Training, Department of Juvenile Justice and related non-government organisations.
ICD-10	The International Statisical Classification of Diseases and Related Health Problems (ICD-10) is a classification system that includes codes for deaths from external causes of injury and poisoning.
Indigenous	Persons who identify as being of Aboriginal or Torres Strait Islander origin.
Infant	A person under 12 months of age
Mandated reporter	A person is mandated to report to the Department of Community Services if he or she has reasonable grounds to suspect that a child is at risk of harm and those grounds arise during the course of or from the person's work. Work covered under mandatory reporting includes health care, welfare, education, children's services, residential services and law enforcement.

Neglect	Fatal neglect results from an act of omission by a parent or carer that involves refusal or delay in providing medical care; failure to provide basic needs such as food, liquids, clothing or shelter; abandonment; or inadequate supervision.
Parental responsibility	All of the duties, powers, responsibilities and authorities which parents generally have in relation to their children. Parental responsibility is defined in section 3, *Children and Young Persons (Care and Protection) Act 1998*.
P79A	NSW Police Report of Death to the Coroner
Perpetrator	Person or people who have committed the fatal assault on the subject child, whether or not they have been convicted of an offence.
Risk of harm	Of the type specified in section 23, *Children and Young Persons (Care and Protection) Act 1998*.
Risk of harm assessment	The process of reorganising, synthesising and assimilating the essential information to determine the severity of harm, vulnerability of the child or young person to harm, likelihood of harm occurring and the safety of the child or young person.
Risk of harm report	Under the *Children and Young Persons (Care and Protection) Act 1998*, people must report to the Department of Community Services if they believe a child or young person is at risk of harm, that is, if current concerns exist for the safety, welfare or well-being of the child or young person.
SAAP	Supported Accommodation Assistance Program
SIDS	Sudden Infant Death Syndrome (SIDS) is the term used to refer to "sudden death in infancy unexplained after review of the clinical history, examination of the circumstances of death, and post mortem examination" (Rognum & Willinger, 1995).
Substantiation of harm or risk of harm	To make a decision that harm or risk of harm has either been suffered or is likely to be suffered in the future.
Suspect	Person or people who have not yet been charged with a criminal offence, but who are person/s of interest.
Suspicious deaths	Suspicious deaths are deaths where there is insufficient evidence or information in the post mortem to determine whether the cause of death was clearly due to abuse or neglect or was clearly not due to abuse or neglect. In this Report, deaths were considered suspicious if there was a history of child abuse and neglect in the child's family background or other concerning circumstances in the context of the death incident.
Team	NSW Child Death Review Team
Toddler	A person aged 0 to 4 years

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