COMMITTEE ON CHILDREN AND YOUNG PEOPLE

THE FATAL ASSAULT OF CHILDREN AND YOUNG PEOPLE

AN EXAMINATION OF A REPORT BY THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM

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Chair's foreword

David P. Campbell M.P., Member for Keira
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This report, the seventeenth by the Committee on Children and Young People, examines the issues raised in a report published by the Commission for Children and Young People of research by the New South Wales Child Death Review Team into the fatal assault of children and young people. Under s.28 (1)(c) of the Commission for Children and Young People Act 1998 (NSW), the Committee on Children and Young People is required to examine reports of the Commission for Children and Young People, and to report any matter arising from such reports to both houses of Parliament. The Commissioner for Children and Young People is the convenor of the Child Death Review Team, and the Commission provides research and administrative assistance to the Child Death Review Team.

The report was released in June 2002. It is, in the Committee's view, a significant contribution to the understanding of the nature, causes and fatal consequences of violence to children and young people.

The report establishes and describes a social and demographic profile of the population of all child deaths identified by the Child Death Review Team due to assault over a three and a half year period (January 1996 to July 1999). The Child Death Review Team felt that by studying the population of deaths over this length of time, trends would more apparent in the larger group of cases than in the year-to-year analysis reported in the Team's annual reports.

The Child Death Review Team's study involved the examination and review of selected records from New South Wales government departments, including records of births and deaths, coronial records, and records held by New South Wales Health, New South Wales Police, and the Department of Community Services. While details of individual deaths were reviewed, only collated population data was reported.

The Committee's examination of the report into the fatal assault of children and young people commenced with public announcements and a call for submissions commenting on the report and its conclusions. The Committee received two submissions that address various aspects of the report. Public hearings into these and other matters arising from the report were held at Parliament House Sydney on 20 September 2002 and 27 September 2002. Full transcripts of the hearings are included in this report, as is the full text of one submission received (from the Community Services Commission).

In addition to the findings and recommendations made in the Child Death Review Team's report into fatal assaults of children and young people, the Committee notes and highlights the further recommendations made by the Community Services Commission.

The Committee will continue to monitor and review the response of the New South Wales government to the findings and recommendations arising from the Child Death Review Team's report and the further recommendations made by the Community Services Commission as part of its general oversight of the Commission for Children and Young People.

Acknowledgements

I thank my fellow Members of the Committee on Children and Young People for their contribution to this inquiry.

I am also grateful for the assistance of the secretariat to the Committee on Children and Young People, Mr Ian Faulks, the Committee Manager, and the secretariat staff, Mrs Cheryl Samuels, Ms Jodie Young and Ms Susan Tanzer.

I commend this report to Parliament.

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A report required under the Commission for Children and Young People Act 1998 s.28 (1)(c) relating to the statutory function of the Parliamentary Joint Committee to examine each annual or other report of the Commission for Children and Young People Act and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report.

1

THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM'S REPORT INTO FATAL ASSAULTS OF CHILDREN AND YOUNG PEOPLE

Introduction

1.1. The Child Death Review Team is an independent body responsible for monitoring trends in child deaths in New South Wales and for making recommendations to promote the safety and welfare of children. The Child Death Review Team reviews the available information about every death of a child in New South Wales, and releases annual and other research reports and fact sheets that aim to increase public awareness about ways to reduce the number of preventable child deaths.

1.2. The Commissioner for Children and Young People is the convenor of the Child Death Review Team, and the Commission for Children and Young People provides research and administrative support to the Child Death Review Team. The members of the Child Death Review Team are drawn from a variety of disciplines and areas of expertise and particular knowledge, including police, psychologists, psychiatrists, general practitioners, paediatricians, community services workers, social workers, child protection specialists, legal and justice specialists, and representatives of Aboriginal communities in New South Wales.

1.3. In June 2002, the Child Death Review Team completed a research report into the fatal assault of children and young people. The following summary is drawn from the executive summary and related descriptive and discussion sections of the Child Death Review Team's report.

Purpose of the research into the fatal assault of children and young people

1.4. The Child Death Review Team indicated that the aim of the research project into fatal assault in children and young people was to establish a social and demographic profile of the population of all child deaths in New south Wales due to assault over a three and a half year period (January 1996 to July 1999). It was felt that by studying the population of deaths over this length of time, trends would more

apparent in the larger group of cases than in the year-to-year analysis reported in the Child Death Review Team's annual reports.

1.5. The study consisted of case file review of selected records from New South Wales government departments, including records of births and deaths, coronial records, and records held by New South Wales Health, New South Wales Police, and the Department of Community Services.

Findings of the Child Death Review Team's research

1.6. The Child Death Review Team organised and reported its findings under four broad headings:

- A description or overview of the fatal assaults of children and young people;
- A developmental theory of fatal assaults in children and young people;
- The context of the fatal assaults in children and young people; and
- The human service agency involvement prior to the fatal assault of a child or young person.

Overview of the fatal assault of children and young people

The fatal assault of a child or young person is a rare event

1.7. Sixty children (0–17 years of age) died as a result of fatal assault between January 1996 and July 1999 out of 2,757 deaths of children from all causes in New South Wales. That is, 2% of deaths of children in New South Wales were attributed to fatal assault.

Categories of fatal assault of a child or young person

1.8. The Child Death Review Team found there were four categories of fatal assault of a child or young person, each with distinct features. Each category of assault had an identified demographic profile and victim-perpetrator dimensions. The Child Death Review Team concluded that efforts aimed at reducing the likelihood of an assault of a child or young person will be more successful if there is a differentiation between these categories of assault.

1.9. There were three categories of parental assault.

1.10. Non-accidental injury: Fatal non-accidental injury comprised 19 of the 60 fatalities (32%), and only involved children from birth to four years of age. Fatal non-accidental injury accounted for half of the assaults involving parents as suspects (19 of 40, 48%). Both mothers and fathers of the children, and de-facto caretakers, committed these assaults. Nearly all fatal non-accidental injuries occurred in families of Anglo-Australian background.

1.11. Victims of parents affected by a mental illness: The effects of a parent's mental illness precipitated fatal assault in 11 of the 60 deaths (18%). In this category

of assault the child was killed as a result of the suspect's mental health problems, including depression or schizophrenia involving delusional beliefs. Mothers were the perpetrators in these assaults and a majority were from culturally and linguistically diverse backgrounds.

1.12. Family breakdown: Ten children in seven families died as a result of parental dispute and family breakdown (17% of the child assaults). These deaths accounted for one quarter of the familial assaults on children from birth to 12 years of age. All the perpetrators were the biological parents of the child (both mothers and fathers). The deaths included five parent-child murder-suicides. The majority of these families were from culturally and linguistically diverse backgrounds.

1.13. In contrast to these three categories, one category of assault was non-parental.

1.14. Teenagers: One third of the assaults were of teenagers 13–17 years of age (20 of 60, 33%) and parents were not suspects in this category of assault. Males perpetrated nearly all of these assaults, and the vast majority of the assaults did not involve group killings. The victims included both males and females, and half the teenage victims had prior criminal charges.

Gender patterns

1.15. The Child Death Review Team found there were distinct gender differences in both the suspects (or alleged perpetrators) of the fatal assaults and the fatally injured victims.

1.16. Suspects: Although similar numbers of primary suspects were male and female, the category of assault varied by the suspect's gender. Both males and females were suspects in the family breakdown and non-accidental injury categories. In contrast, only females were suspects in the mental health category; and fatal violence against teenagers was perpetrated almost entirely by males.

1.17. Victims: The majority of the victims were males (62% of the assaults), and this included twice as many infant boys as girls who died from fatal assault. Victim gender may be a factor when the assault occurs in the context of a parenting relationship and the suspect is male - very few female victims were killed by male parents or de facto caretakers (3 out of 40 fatalities).

Cultural and linguistic background

1.18. The cultural background of the victim varied according to the category of assault: nearly all victims of non-accidental injury were from an Anglo-Australian background; while in the family breakdown and parents with a mental illness groups, the majority of the victims were children from culturally and linguistically diverse backgrounds. Overall, 53% of the victims were Anglo-Australian background, 28% were from culturally and linguistically diverse backgrounds, and 8% were Aboriginal.

Towards a developmental theory of fatal assault in children and young people

1.19. The Child Death Review Team argued that the data support a developmental theory of fatal child assaults, that is, the types of fatal assault that occur vary according to the child's age.

1.20. The Child Death Review Team suggested that this is due to evolving physical capabilities and an expanding social sphere as the child grows older:

- Fatal non-accidental injury occurs only in infants and very young children (0–4 years of age).

- During the primary school years, the rate of assaults falls as the child becomes increasingly robust, and his or her social sphere expands. The fatalities within this age group occurred in the context of parent's mental illness and family breakdown.

- For teenagers, all the assaults were committed by suspects other than parents and reflect the child's expanding social sphere.

1.21. The Child Death Review Team noted that the cause of death also varied according to the child's age and the category of assault. Manual assault without a weapon, including suffocation and battery, was concentrated in the infant and pre-school years, and weapon use increased with the age of the child.

The context of fatal assaults in children and young people

1.22. While overall prior violence was evident in a minority of families, there was evidence of ongoing severe domestic violence in approximately half the families in the non-accidental injury category (9 of 9, 47%) and prior abuse of children in over two-thirds of these families (13 of 19, 68%).

1.23. A majority of suspects (n=40, 59%) did not have criminal records prior to the fatal assault of the child.

1.24. 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 category. There was a strong association between prior child abuse, prior spousal violence, financial difficulties, parental substance use and prior parental arrests.

The human service agency involvement prior to the fatal assault of a child or young person

1.25. The Child Death Review Team found that the degree of human service agency involvement across the categories of fatal assault in children and young people was quite varied.

1.26. With the exception the family breakdown category, many families in which a fatal assault occurred to a child or young person had some formal contact with a human service agency or professional prior to the death.

1.27. However, only a minority of the families ended up having contact with the child protection intervention system.

1.28. The Child Death Review Team found there were instances where children were not notified to the Department of Community Services despite clear warning signs that the child's safety was in jeopardy.

1.29. This was most evident for two categories of fatal assault: non-accidental injury and mental health. In both these categories there were instances where health professionals did not focus on the ongoing safety of the child. There were examples of children who had prior non-accidental injuries but were not notified to the Department of Community Services by health professionals. There were also examples where the mother was suicidal or the child was involved in the mother's delusions and the mother was in contact with mental health professionals. These professionals do not appear to have considered the social context of the mother and her child's safety, as they did not notify the child.

1.30. The Child Death Review Team felt that because of the origins of child protection in the 'battered child syndrome', the child protection system has evolved to more fully respond to the non-accidental injury of children, rather than to children who are victims of assault in the context of family breakdown and parental mental illness, or to teenagers who are victims of non-parental violence.

1.31. The Child Death Review Team found that the child protection system does not focus on three of the four categories of fatal assault. This raises the question of whether it is solely the role of the child protection system to respond to these situations, or whether the broader human service agency system must adopt an approach that responds, as part of their range of services, to situations where children are victims of assault.

1.32. Approximately a third of all children who died of fatal assault were the subject of intervention by the Department of Community Services (22 of 60, 37%). In the fatal assault cases reviewed, there were examples of inadequate intervention by the Department of Community Services, which included inadequate assessment of risk, case planning, and casework. This analysis cannot determine whether adequate casework could have prevented the child's death in each case; however, the cases show areas of serious deficiency in child protective intervention.

1.33. The Child Death Review Team concluded that as the analysis is restricted to the study of one type of case (child deaths), it is not possible to determine whether inadequate casework is typical of the child protection system.

1.34. The Child Death Review Team argued that ongoing monitoring of service systems (not just of those children with fatal outcomes) is needed to evaluate the effectiveness of the child protection system. In particular, ongoing monitoring of the implementation of the new *Children and Young Persons (Care and Protection) Act 1998* is necessary to determine its impact on child protection practice, service provision and policy.

1.35. The Child Death Review Team found that families going through marital breakdown did not appear to access human service systems. As a majority of these families were from culturally and linguistically diverse backgrounds, this may reflect the cultural isolation of these families from formal and informal helping systems within the wider community.

1.36. The families of teenagers 13-17 years of age who were victims of fatal assault had minimal contact with human service agencies. However, the policing and criminal justice systems were relevant points of contact for the victims and perpetrators of this group: half the victims and half the offenders had previous contact with police (through having been previously charged with criminal offences).

1.37. In relation to the 60 deaths, there were 17 convictions of manslaughter and five for murder. The investigation and prosecution of cases involving fatal non-accidental injury of infants and toddlers appears to pose particular challenges for the legal and coronial systems. Of the 19 children who died from non-accidental injury, only five of the perpetrators have received criminal convictions to date. The outcome of criminal charges relating to the assault appears to vary between the categories of assault.

1.38. The Child Death Review Team argued that the research findings posed a number of challenges for policy, services and practice.

1.39. The Child Death Review Team recommended that over the next twelve months the New South Wales government, in consultation with relevant government and non-government agencies, parents, children and youth groups, should lead the process of developing a response to the findings and challenges raised in this report.

2

THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE'S EXAMINATION OF THE REPORT INTO FATAL ASSAULTS OF CHILDREN AND YOUNG PEOPLE

Introduction

2.1. One of the functions of the Committee on Children and Young People is to examine each annual or other report of the Commission for Children and Young People. The Committee, at an appropriate time after the release of a report, commences a public consultative process to assess the response of the general community and other any particular relevant individuals, organisations or agencies to the findings and recommendations arising from the report. The Committee places advertisements in the major Sydney metropolitan dailies, contacts individuals, organisations or agencies who have a specific interest or responsibility associated with the matters examined in the report, and after a period of time to receive submissions may conduct a public hearing to take further testimony before reporting to both Houses of Parliament on any matter appearing in, or arising out of, the report.

2.2. The Child Death Review Team report into the fatal assault of children and young people was released by the Commission for Children and Young People in mid-June 2002. The Committee on Children and Young People advertised the inquiry in August 2002, and conducted two public hearings in September 2002.

Submissions received

2.3. The Committee received two submissions that addressed issues raised in the report.

2.4 Mr Robert Fitzgerald, the New South Wales Community Services Commissioner, wrote that the deaths of children and young people in New South Wales reinforced needs for:

- a strategic investment in practice and procedural improvements in the Department of Community Services' services as the human service agency with lead responsibility in child protection;
- stronger interagency relationships between government human service agencies to enhance communication and reinforce quality child protection practice;

- a network of preventative, early intervention and intensive family support initiatives to vulnerable families and programs aimed at ameliorating the extreme social and cultural isolation experienced by some families;
- the development and strengthening of relationships between the Department of Community Services and the Family Court of Australia to enable a co-ordinated response to child protection matters within the Family Court jurisdiction;
- a stronger focus on the safety and wellbeing of children who live with parents/ carers with a mental illness and/ or drug and alcohol dependency;
- practice and procedural improvements in adult mental health and drug and alcohol services to recognise and improve reporting of children at risk of harm who live with parents or carers with a mental illness or drug and alcohol dependency;
- the provision of a range of support and practical assistance for young people who are at risk as a result of abuse and neglect, risk taking behaviour or drug and alcohol abuse.

2.5 The Community Services Commission submission focused on the key areas of: very young children at high risk; interagency approaches; families experiencing extreme social isolation; Family Court issues; mental health issues; and the deaths of teenagers.

2.6 The Community Services Commission argued that the findings of the Child Death Review Team's report into fatal assaults in children and young people meant that consideration should be given to:

- effective implementation and resourcing of the legislative provisions in place in the *Children and Young Persons (Care and Protection) Act* 1998 to support families and act decisively for children at risk
- appropriate resourcing and implementation of mandatory reporting;
- promotion of pre-natal reporting and requests for assistance, which could have a positive impact on appropriate responses to children and young people at high risk;
- building and resourcing a more robust and extensive infrastructure for family support services across New South Wales in order to extend access to support services for extremely isolated families and children;
- improving interagency connections and relationships between the Department of Community Services as the lead agency for child protection and other government and non-government agencies with responsibilities around child protection;
- developing strategies to ensure that adult mental health and drug and alcohol services have a focus on the impact of these conditions on their clients' parenting capacity; and
- ensuring that a strong co-operative relationship exists between the Department of Community Services and the Family Court of Australia through appropriate protocols and procedures so that there is a timely response to children at risk whose families are involved with the family court. (Submission FAOC 001)

2.7. The full text of the Community Services Commission's submission is included as Appendix 1.

2.8. Mrs P. Wagstaff wrote of her own experience as a victim of domestic violence and sexual abuse as a child. Her submission canvassed a large number of issues, including:

- every child death should be investigated so as to prevent other deaths from occurring;
- there was a need for family counselling and education of parents about the responsibilities that they have towards the safety of their children;
- the need for human service agencies to study the literature on the subject of fatal non-accidental injury and to adjust that information for their own purposes;
- there should be mandatory reporting to appropriate agencies, noting the importance of taking vulnerable children out of the home where they are at risk;
- the need for reassessment and inquiry into the actions of the Department of Community Services caseworkers and supervisors involved in cases where children 'known to DoCS' suffer injuries or death;
- there was a need to carry out spot checks on families with histories of violence against their children, both by phone and in person;
- the need for inter-agency child protection groups to work with one another and the police to protect children;
- recognition of the isolation that is faced by many women of multi-cultural backgrounds, and for services to tailored to their needs;
- the need to extend the professional duty owed by health workers and mental health workers to the children of clients and patients;
- the need for mental health professionals to be aware of any children of a parent with a mental illness and for co-operation between health service agencies and mental health professionals and workers;
- the need for mental health professionals to recommend the removal of children from danger in the home;
- the need for teachers to notify the appropriate agencies if they believe a child's actions point to distress within the home situation;
- the need to scrutinse departments that are involved in the care and protection of children; and
- the need to help and encourage teenagers who have been victims of violence and abuse (Submission FAOC 002).

The testimony of the Commissioner for Children and Young People

2.9. On Friday 20 September 2002, the Committee heard the testimony of the Commissioner for Children and Young People, who, as Convenor of the Child Death Review Team, was responsible for the conduct of the research into fatal assaults of children and young people. The transcript of her testimony follows; a copy of the PowerPoint presentation used by the Commissioner to illustrate her comments is included at the end of the transcript record.

CHAIR: The Committee welcomes Ms Gillian Calvert to the table. She will testify on matters relating to the findings and recommendations of the report by the New South Wales Child Death Review Team into the fatal assault of children and young people. The Committee has received a copy of the report that was tabled in

the Parliament. Do you wish to table any further documents relating to the matters under examination by this hearing at this time?

Ms CALVERT: No, I do not.

CHAIR: … I invite you now to make an opening statement.

Ms CALVERT: Thank you. I thought I would give a longer than usual opening statement because I think there is a lot of detail in the report. I am aware that you are very busy people and that you may not have had the time to fully read the report. So it would be helpful if I went through some of the major findings in the report. I want to thank you for the opportunity to present the findings of the study by the Child Death Review Team into the fatal assault of children and young people. As you know, the team is an independent team of experts who look at the deaths of children in New South Wales and make recommendations about ways to prevent fatalities.

The team's annual report examines deaths over a 12-month period. The team also conducts in-depth reviews of deaths of children who die from abuse, neglect or in suspicious circumstances. This report, however, is different. This report looks at fatal assaults on children and young people over a period of 3½ years—from January 1996 to July 1999. The cases of all 60 children who died of fatal assaults in that period were examined. Some of these children's cases have been reviewed previously in the Child Death Review Team's annual reports, but the value of this report lies in reviewing the entire population of all deaths from fatal assault of children over a 3½ period.

Looking at these children's deaths over a longer period has provided a larger number of cases than year-to-year reviews provide and it has allowed us to make some important new discoveries about fatal assaults on children and young people. I would like to start by providing an introduction to the study, to look at the methodology that we used and to provide an overview of the major findings and the implications of findings for service delivery. What is fatal assault? Fatal assault is defined as "any death resulting from acts of violence perpetrated upon him or her by another person." It includes acts intended to kill the child and also acts where the child died when the perpetrator may not have intended the outcome.

The team is required, by law, to identify and conduct in-depth case reviews of the deaths of children who die from child abuse and neglect, or in suspicious circumstances. This study aimed to establish an accurate social and demographic profile of this population of children and their families over a 3½-year period. The purpose of the research was to profile the population in order to make recommendations to prevent deaths. As I have already said, we reviewed all deaths that occurred over the study period and we employed a case file review methodology. The case files of the 60 children were obtained and were reviewed. We obtained the records from State government departments, which included the Births, Deaths and Marriages, the Coroner, the Department of Health, New South Wales Police, and the Department of Community Services.

These records, where they existed, were reviewed and an analysis was completed around the fatal incident. This included looking at the precipitating factors

to the death and the context of the death. We also looked at and reviewed them in relation to the characteristics of the victim and perpetrator, including their age and gender. We looked at the social and demographic characteristics of the child and their family, including their human service agency history. The strength of this study methodology was that it was population research reviewing all the deaths. Therefore, there are no errors due to sampling and the findings apply to all the children who died as a result of the assault. A limitation of the study is that the children in the same circumstances who did not die were not studied. Therefore, the findings can only apply to children who died.

The study provides new information about fatal assault and the main findings were that fatal assault is a rare event. We also found that it is not a homogenous phenomenon. I will come back and talk about these in more depth. We also found that age, gender, cultural and linguistic background, and social disadvantage are important. I will now provide some detail about each of these findings. First, fatal assault is a rare event. Even though it is a rare event, nevertheless, over the study period 60 children did die as a result of fatal assault.

The 60 deaths represent just over 2% of all 2,757 children who died during the period of study. This equates to a crude death rate of just over one death resulting from fatal assault for every 100,000 children in New South Wales. By way of comparison, the crude death rate from deaths resulting from motor vehicle accidents is approximately 4.5 deaths per 100,000. Because it is a rare event it means that few professionals have experience in working with situations that lead to fatal assault, even though many of them may have worked with families that share a similar profile. One of the implications of it being a rare event is that very few professionals have an experience of working with families where a child is assaulted.

The second finding is that fatal assault is not a homogenous phenomenon. We found with our research—this is a new finding—that there are four distinct types under the heading of fatal assault, each with its own dynamic and profile, and they are listed on the overhead. I will deal with each of those categories. The fatal non-accidental injury category: 19 children died, 13 males and six females as a result of extreme physical abuse. These children were very young, aged from birth to four years of age. Many of these children had high physical care needs or birth-related complications. The average age for the child in this category was 1.1 years of age.

All these children were killed by their caregivers, with approximately equal numbers of male and female carers killing the children. This was the only group in which suspects included non-biological carers. While all female perpetrators were biological mothers of the child, five of the nine male perpetrators were non-biological carers, such as de facto carers. Less than half the incidents were one-off events with fatal outcomes, including shaken babies. For 11 of the children the abuse was ongoing. They suffered severe prior injuries and the final attack caused their death. Violence was evident in the families, eight perpetrators had prior assault charges, and apprehended violence orders had been taken out by a parent in seven of the families. The households in which these children were killed were characterised by poverty and social disadvantage, and the familial and social resources available to many of these families were extremely limited.

Moving on to parents affected by mental illness where a child was killed: 11 children out of the 60 were killed by parents affected by mental illness, five female and six male children. They ranged in age from three months to 10 years, although five of the children were aged less than one year. All children were killed by their mothers. Six of the fatalities involved mothers killing during an episode of deep depression and these feelings were set against significant levels of psychosocial stress, including a lack of familial and social supports, feelings of personal isolation, relationship difficulties and financial concerns. Five of the fatalities involved the mother killing the child while experiencing acute psychotic symptoms of schizophrenia, with delusional belief the primary trigger of these fatal assaults. The children killed by mothers experiencing depressive illness were on average 1.9 years of age or younger, whereas the children killed by their mothers with schizophrenia were on average 4.5 years of age.

I turn now to family dispute and breakdown: 10 children in seven families died as a result of a breakdown of the spousal relationship or conflict between the spouses leading to the parent killing the child. On average these children were five years of age, older than either the children in the non-accidental injury category or the mental illness category.

The perpetrators were all biological parents of the child, and included four mothers and three fathers. The parent killed the child or children as a response to the circumstances associated with the parental relationship.

The separation problems were compounded by other factors that together, we believed, created a context of despair, hopelessness and rage for the perpetrator. Parents often expressed sentiments that because of these hopeless circumstances the children were better off dead. These feelings of hopelessness and despair were dramatically indicated by five of the seven incidents involving parent-child murder suicides.

There were gender patterns evident for the perpetrators. Female perpetrators predominantly experienced being a victim of domestic violence, financial crisis brought on by separation, and social and cultural isolation. The male perpetrators predominantly expressed feeling displaced and abandoned as a result of relationship changes, a loss of dominance in relationship, and the threat of having a diminished relationship with the child.

I now turn to the final category, teenagers. Twenty teenagers aged 13 to 17 years were killed, and almost equal numbers of males and females were killed. While this is the only group that is defined by the age of the victim, there are other characteristics which differentiate this group from the other three categories. Parents were not suspects in any of these deaths. That is quite a contrast to the other three, where parents or carers were always the suspects.

Most of the deaths in this category involved suspects who were known to the victim, and included friends, acquaintances, the victim's de facto and brothers. There were a small number of cases in which a suspect was not previously known to the victim or has not yet been identified.

Half of the teenagers were killed in altercations involving peers as perpetrators, and all but two of the deaths involved a male suspect. In five cases male victims were killed by another male acting alone, and in three cases male victims were killed by multiple male suspects. The male victims were killed by males acting alone in all but one death, and that involved a female perpetrator. There were two abductions of females by unidentified offenders, and it is not known whether these deaths involved sexual assault.

The pattern of these types of assaults begins to resemble adult fatal assault, and includes fatalities committed in the course of other crime—in other words, killings committed by a de facto, drug-related deaths and assaults occurring in the context of altercations between friends, siblings and acquaintances.

Weapons, including guns and knives, featured in most of the deaths, whereas they did not in the others. Criminal histories were a feature of the histories of both the victim and the suspect. Ten of the victims had been charged with criminal offences as juveniles, the most common being property damage and assault. Twelve of the 25 suspects had prior criminal charges, and the most common type of offence was theft and drug offences.

So far, we have discussed two findings: first, that it is rare; and second, that it is not homogenous but is made up of these four different categories.

The third finding is that age is important. It is a critical dimension of fatal assault incidents, as you can see from the graph. The highest number of assaults were of infants under one year of age and teenagers. For children aged between five and 12 there were significantly lower numbers of assaults. Infants under one year of age have by far the highest rate of fatality, occurring at over five times the average rate for all children 0-17 years.

This is a high-risk time, largely because babies and toddlers are completely dependent on their parents for their survival and because they are physically vulnerable. During the preschool and middle childhood years the rates of fatal assault drop quite dramatically as children become increasingly robust and begin to expand their social sphere through school. Rates climb again for 15- to 17-year-olds. This is expected, because the fatality rates for the whole population reach a peak in the early to mid twenties.

The Child Death Review Team's research also shows that the types of fatal assault vary according to the developmental age of the child. Fatal non-accidental injury—what one might call typical child abuse—occurred exclusively in infants and very young children. As I have already said, that is because they are physically vulnerable and therefore most likely to be killed when they are being physically abused. The primary school-aged children in this report died in the context of parental mental illness and family breakdown. Reflecting their expanding social sphere, all the teenage assaults were committed by suspects other than parents. Thus, at this stage there were no deaths from non-accidental injury—none in the context of family breakdown or as a result of the parents' mental illness.

The other finding we made is that gender is important. A gender bias is evident in the profiles of victims and suspects. Almost two-thirds, or 62 per cent, of the victims were males. This included twice as many infant boys as girls. Although a similar number of primary suspects were male and female, the category of assault varied by the suspects' gender.

Both males and females were suspects in the family breakdown and non-accidental injury category. In contrast, only females were suspects in the mental illness category. The fatal violence against teenagers was perpetrated almost entirely by males. Again, one begins to see why gender is important.

Cultural and linguistic background is also important. There were cultural dimensions to the fatalities and the type of assault. Overall for the 60 deaths, 53 per cent of the victims were of Anglo-Australian background, 28.3 per cent were from linguistically and culturally diverse backgrounds, and 8.3 per cent were of Aboriginal origin.

The cultural and linguistic backgrounds of the victims varied according to the category of assault. The majority of non-accidental injury victims were of Anglo-Australian background. In contrast, the majority of victims in the family breakdown and parental mental illness categories were from diverse cultural and linguistic backgrounds. Teenage victims were from Anglo-Australian, diverse cultural and linguistic, and Aboriginal backgrounds.

Our final finding with regard the victims, the perpetrators and their families is that social disadvantage is also important. Social disadvantage, indicated by the presence of a number of psychosocial stresses, was evident in more than half of the families of children aged 0-12 years of age. In 37 households where the victims were aged younger than 12, there was no adult in paid employment and 15 of the households had a main income earner in an unskilled or semiskilled occupation.

Multiple social problems were evident in almost three-quarters of these families, and they were most evident in the families of the non-accidental injury group. Many of the fatalities occurred within the context of ongoing intra familial violence. One-third of the families had documented spousal violence in the home, and in one-third of the households a child, including the siblings of the victim, had been reported to the Department of Community Services for child abuse or neglect at some time.

In all categories except teenagers, prior physical abuse of the child or sibling was strongly associated with spousal violence and parental alcohol and substance abuse, and moderately associated with financial problems and prior parental criminal arrest. This is a consistent finding of the Child Death Review Team reports.

Poverty and social disadvantage were present across the categories of assault, but poverty alone was not the precipitating factor in the fatal incidents. The next slide graphically illustrates the social factors present in these families. We see that 26 of the families had financial difficulties, 20 of them had physical abuse of a child or sibling, and 14 had domestic violence.

To summarise so far, the categories of assault, the aged and gender profile of fatalities, and the extent of social disadvantage in families have important implications for how we structure and deliver our services to children and young people, their families and communities.

Two questions that arise are: What prevention efforts can be made to reduce the fatal assault of children given that it is a rare event, and how do you prevent a rare event? Secondly, how do we get practising human service agencies to take account of those important things that we have found: the age dimension, the gender dimension, social disadvantage and the cultural dimension? I wonder whether you would like to discuss and ask questions about the data and then I will talk about the service side of things. It is quite confronting data.

Ms BEAMER: I have read the report and I note that it contains findings not recommendations. The first question—which you are probably still asking yourself—is how to prevent a rare occurrence. Will the Child Death Review Team make recommendations?

Ms CALVERT: We highlighted a number of findings and raised questions and suggested to the Government that it lead a process of reviewing policies and practice in light of those findings. We felt that, as a group of independent experts talking only to each other, we could not cover and work out solutions to some of the issues we raised. Because we cannot make our reports public until they are tabled in Parliament we decided to table this report in Parliament and then invite government to lead a process of thinking through what needed to change. We have tried to give the Government some guidance about what to look at in these questions that appear throughout the report.

I do not think some of those questions will be answered easily. The question of how to prevent a rare event is very difficult. There is no easy answer to that. I think it will be an ongoing question and the answer will be developed over a long period. If there is an accumulation of risk factors around social disadvantage, spousal violence, the age of the child, the history of reports to the department and so on you probably need to be more alert than if there is a family that seems to be travelling well, not having financial difficulties and so on. I do not know how you identify in the Family Court system those families who are likely to be involved in murder suicide. They are very difficult questions to answer. I think we must start trying to answer them, and it may require much more research by other people.

Ms BEAMER: This report is about fatal assaults and you said that you did not gather information on assaults that led to police investigations or criminal charges. Would some sort of comparison of those two groups be helpful?

Ms CALVERT: I think it would be very valuable to match a group of serious re-injury kids with the same things that we have identified here and the group of kids who died to see whether we can identify any differences that might explain why one group was seriously re-injured but lived and the other group died.

Ms BEAMER: Or the similarities between them.

Ms CALVERT: Yes. It may be because of the way services are delivered or it may just be luck. For example, someone who was physically abused was hit on the shoulder rather than on the head. The kid who was hit on the head died and the kid who was hit on the shoulder did not. I think it would be very useful to undertake that research and it could potentially identify some of the things to focus on in order to prevent deaths.

Turning to the human service system, the team's research shows that just over one third of the children were involved with the child protection system—so about 20 of the 60 children or their siblings were involved with that system. The remaining two-thirds were unknown to the child protection system. However, for that remaining two-thirds generally other key people, such as police or professionals in hospitals and mental health services, were involved with some of these families and this may have presented an opportunity for them to ask further questions and get more information about the safety of these children.

Looking at the human service system, the Department of Community Services was notified of 22 of the 60 children or their siblings. Five children were placed in alternative care arrangements and care applications had been made for six children. New South Wales Health provided intensive postnatal services for 17 of the 56 families, eight of the children received medical services because of non-accidental injury and eight families had contact with mental health services. Looking at the police and juvenile justice system, half of the teenage victims had contact with New South Wales police as offenders and the police attended domestic violence call-outs for 12 families. The court granted apprehended violence orders to protect persons in nine of the 56 families.

You will not be surprised to hear that contact with human service agencies varied across each category of assault. I think the patterns of response are best understood within each fatal assaults category. If we look at the non-accidental injury category, we can see that 19 children were seen by a range of agencies, including community services, health and police. There were only two infants where the first contact with the human service system apart from their birth was the fatal incident. So only two infants had not had any contact with the human service system. For the other infants there was generally an established pattern of violence. Eight perpetrators had prior assault charges, nine families had documented domestic violence, 11 children had prior non-accidental injuries and 14 perpetrators had prior criminal histories with an average of 19 charges each.

There was also evidence that some of these children were not reported when there were clear risks to the child. Six children were seen by health providers who did not report. In two cases there were clear non-accidental injuries, including black eyes and fractures, and no report was made. Five children had a total of 18 police visits to their homes. There was also evidence of inadequate casework by the Department of Community Services, which included: in five cases workers did not recognise patterns in families that presented risks to the child; in five cases workers did not sight the child; in two cases workers accepted the parent's explanation of the injury without verifying the information provided; and in five cases workers appear to have underestimated the parent's capacity to change.

This research raises six questions for the delivery of services, three of which are listed. How do we take age into account? How can children, especially infants, who do not come to the attention of the human service system be protected? How can inadequate casework be improved? How can the safety of families be increased when there is long-term violence? These last two are very important. Are the police and criminal justice system adequately detecting, investigating and prosecuting cases of fatal non-accidental injury because there is quite a low charge and prosecution rate? Lastly, does the system successfully detect multiple suspicious child deaths in the same system and therefore protect the surviving siblings in fatal child abuse cases?

With the mental health category, eleven children were killed. Four of the families did not access mental health services. This was a particular issue for mothers from culturally and linguistically diverse communities. It raises questions about access to and appropriateness of services. The research also identified that mental health and child protection workers did not adequately take into account the effects of the mother's mental illness on the child or children. Mental health professionals did not recognise or report on seven families involved with mental health services. Of those seven families, four of them involved private psychiatrists and in two of those instances the child was still not notified following a suicide attempt by the mother.

The report identifies in adult mental services the need to identify the social context and assess whether a child is at risk because of the mental illness of the parent. In five families reported to the Department of Community Services there was evidence that professional casework services were not provided. This included four children who had a superficial assessment. For three children there was an inappropriate reliance on another agency to monitor or assess the mother's mental illness and the child's safety. In two of these cases the school was given this responsibility. There was also poor co-ordination between mental health and child protection agencies in all the cases. For three children the hospital discharge plan did not assess the risk to the child, that is the mother's hospital discharge plan. In one case, child protection casework was closed prematurely with no ongoing support to the family, despite the known mental health issues. This research raises three questions. First of all, is access to the mental health services adequate, especially for people from diverse communities? How can mental health professionals be encouraged to recognise children at risk of harm when the parent has a mental illness? Thirdly, how can the assessment of child safety be improved when the parent has a mental illness?

In relation to family dispute and breakdown, there were 10 children from seven families. Although these families were experiencing multiple social problems, such as financial problems, violence, isolation and conflict over caring for the children, the majority were isolated from help. Only two of the seven families had contact with human service agencies. In this category, as with the mental illness category, parents who were in a particular set of circumstances may threaten their child's safety but it is not traditionally referred to or seen as part of the child protection system. Research and data on the risk to children in that set of circumstances is only now beginning to emerge.

Human service systems need to recognise warning signs of unsafe situations, including times when parental stress and anxiety are enmeshed with despair about children, even when there has been no prior abuse of a child. For those children where child protection concerns were expressed, there was an inadequate assessment of the child's safety and in the two families where both the Family Court of Australia and the Department of Community Services were involved, child protection concerns were minimised and dismissed as family law matters. Further, the human service agencies—that is the Department of Community Services and the Family Court—failed to co-ordinate and communicate effectively regarding the situation of these two children and their families. This raises three questions. First of all, how well are professionals recognising parental separation at a time when the safety of children needs to be assessed? Secondly, are adequate supportive services available to vulnerable families undergoing separation and, thirdly, how clear are the jurisdictions and rolls of the Family Court and the Department of Community Services.

The final category was the teenagers. They had very limited involvement, their families had very limited involvement, with human services. Four of 20 teenagers had an extensive history of serious and prolonged child abuse and neglect and involvement with the Department of Community Services. These four teenagers developed risk-taking behaviour including substance abuse and juvenile offending. They were on a negative life trajectory, and human services intervention was unable to alter that course. They all died very violent deaths. However, half of 20 teenagers had prior criminal charges, and the Department of Juvenile Justice was involved with three of them. Twelve of the 25 suspects had prior criminal histories, with a total of 140 charges. Clearly, the police and juvenile justice systems are the primary contact points for teenagers killed. They are the agencies that have contact with this group of kids. They could turn out to be points of contact that could help them out of that risk-taking behaviour.

The human services system does not appear to recognise fatal assaults of teenagers, yet after infants, teenagers have the second-highest rate of fatal assault in the State. We need to look at other frameworks for understanding fatal assaults of teenagers; the child abuse perspective does not fit with fatal assaults of teenagers. We need to find a more appropriate or relevant framework for this group of fatal assaults. Essentially the question raised out of this research is what can be done to prevent fatal assaults of teenagers and how can we use the police and criminal justice systems as relevant points of entry to other services for this group of kids?

The report poses a number of challenges for policy, services, and practices. We recommended that over the next 12 months the Government, in consultation with relevant agencies, parents, children and young people, lead the process of developing a response to the findings and challenges raised in this report.

As I have said, this report shows us that fatal assaults of children are not homogenous, that there are four categories with distinct characteristics, and this has really important implications on how we structure and deliver our services to children and young people, their families and communities. One size does not fit all in this case.

Given the broader government issues raised in the report, the Minister for Community Services plans to consult on how government and the communities can best respond to the issues and findings. She advises that considerable work is currently being undertaken to improve services to vulnerable children and families. Strengthening interagency relationships, providing more front-line resources and the regular review of policy and procedures are some of the measures being undertaken.

I hope you found this useful and informative in understanding the work of the Child Death Review Team. We need to get our service systems to appreciate that it is not one group, that there are differences and they require different responses. If we could move the service systems in that direction, it would be a positive move and we would have achieved something through this report.

CHAIR: How will the different agencies respond to those privacy issues?

Ms CALVERT: The Department of Community Services has legislation that allows them to access any information it requires for protection of children. It has quite strong legislation around privacy. Similarly, the police do as well. Perhaps that is one of the challenges for the Privacy Commissioner, given that we need to have an interagency response to these kids if we are to prevent their deaths. How do we overcome those privacy issues?

The testimony of the Community Services Commission

2.10. The Committee held a further public hearing on 27 September 2002, where the Community Services Commissioner, Mr Robert Fitzgerald, and Ms Christine Flynn, an Acting Senior Project Officer with the Community Services Commission, testified on the issues raised in the Child Death Review Team report into fatal assaults of children and young people. As noted earlier, the text of the Community Services Commission's submission is included as Appendix 1.

CHAIR: Could I invite you to make an opening statement or to speak to the submission that has been tabled?

Mr FITZGERALD: In relation to the fatal assaults of children and young people report our submission, I think, positively endorses many of the observations contained in the reports in relation to this matter by the Child Death Review Team. I would just like to highlight a couple of issues or conclusions, if I might, from our report.

What is obvious but needs to be restated many times, I think, is three things. The first and most important issue is that we need to make sure that the current child care and protection legislation works and works robustly. The legislation passed in 1998 does provide a sound foundation for improving the quality of child protection and, as a consequence of acting, to reduce the incidence of children at risk in our society. To date, as you are well aware, only part of that Act has been proclaimed, part of it has never been resourced and part of it operates in a highly dysfunctional manner, yet the legislation remains reasonable and robust. Until that legislation works, the driving force for improvements in the protection of children in New South Wales will remain more of a desire rather than a reality. So our first point very clearly is that the overwhelming duty of all of us involved in community services is to make the current child care and protection legislation work and the committee in relation to social issues that is examining child protection is well aware of that.

The second but related issue is the absolutely critical issue of developing appropriate infrastructure and capacity within the family support services in New South Wales. The Government, both through Families First and through its ongoing funding of family support services, has demonstrated a commitment in this area, but the commitment falls well short of what is actually required to meet the increasing need of vulnerable families in New South Wales and here I want to be very clear: This extends to families where children have been removed. The greatest tragedy at the moment is a system that removes children from the family, treats the parents almost as if they are criminals and refuses to provide ongoing support to the natural birth families. The consequence of that is to increase considerably the chances of at risk harm occurring to a further generation of children. There is a high likelihood that the natural mother will have another child. There is a very high likelihood that the de facto father will go on to father further children. The pain, grief and unresolved issues will exacerbate, not decrease, over time. Society has to acknowledge the needs of vulnerable parents even where they have been responsible for abuse or neglect of children and the ultimate removal of their children, so family support is not only about those families where there are potential risks of harm but also where

there has been a risk of harm demonstrated. At the moment nobody accepts responsibility for those families, there are no caseworkers appointed and nobody in a government or non-government sector acknowledges the needs of birth families where children have been removed. It is a significant issue if we are going to deal with fatal assaults and ongoing abuse and neglect.

The third comment is that the continuing emphasis on interagency assumes that the lead agency, the Department of Community Services itself, can start to act in a robust and effective manner, but it is equally true that considerable work has to be done in relation to the mental health services in this State. There is no question at all that there is a dysfunction in relation to the provision of mental health services in this State that work on the basis of crisis intervention rather than preventative and supportive approaches. Overwhelmingly the system does not act well to prevent crisis, it only acts at the point of crisis. It is not that the mental health system that we have provides a poor service, it provides a disconnected service. What we know in many of these cases is that both families and those associated with these children do have other problems: mental health conditions, including substance abuse issues, substance abuse disorders. We do have to make sure that the services are available to prevent crisis rather than simply reacting to crisis.

Of the issues that we have raised in our submission I would simply put those three on the top: making the current Child Care and Protection Act work, providing more effective family support including to birth families where children have been removed and ensuring that the interface with the mental health system is much more focused to prevention of crisis rather than intervention when crisis occurs. I think if we could achieve that we would start to make a real impact on the current level of harm or potential harm to children. If we do not do that then I think both the health service and the community service system will continue to fail to provide the necessary response for children at risk and the consequences of that are, of course, the death of some children.

I want to make one last point. Death is not a good indicator of the performance of health systems or of the Department of Community Services. I have never maintained a position that you should look at the position of either department based on death, but I can say that what we do know is that poor practice will ultimately contribute to death, and so whilst I do not think the number of children who die is a valid indicator of performance, because children and young people will continue to die, I do think the poor practice that we currently have, both in the health system and the community services system, contributes to an environment where harm, including death, is more likely. They are different and it is about trying to prevent rather than to deal with crisis all the time that we should be focused on.

They are some opening comments and I am happy to take questions in relation to the short submission that we have put in if there are issues.

CHAIR: The report indicates that health care professionals perhaps do not adequately report cases of suspected abuse despite mandatory reporting provisions. Can you comment on what we should be doing to increase performance in that area?

Mr FITZGERALD: If I can make a couple of comments, our report indicates that mandatory reporting remains an essential feature of dealing with children at risk. What we have indicated in our report is that we need to have a much better understanding of the way in which mandatory reporting is operating in the State, and this is a comment that we have made to the Social Issues Committee. We believe that there is room for the mandatory reporting arrangements to be reviewed but we have insufficient data and insufficient analysis to make that decision at this time.

The comment in relation to health workers is that there has been a considerable increase in the mandatory reporting by health workers in the last couple of years. So it is not clear to me that there is a significant under reporting currently by health workers. That, I think, needs to be further investigated. If that were the case, and I say that there is not really enough analysis to make a definitive statement, then what we need to be doing is educating our front line health professionals about the risk indicators. The issue here is that the risk indicators that the Department of Community Services have recently developed need to be widely disseminated to health care workers and other workers. Those risk indicators have only been recently redeveloped and there does need to be a strong education campaign for health and other workers about what are appropriate risk indicators.

We support the contention that you need to increase the level of community education amongst mandatory notifiers, both so they are picking up children that should be picked up and conversely not reporting children that should not be reported, and at the moment I think we have got both. We have got over reporting by some and we have got under reporting by others, and I think that applies across the board. The problem we have is, going beyond that statement, the analysis just is not there yet, and I am not sure whether the Kibble report or the Kibble committee, which was appointed by the Government, is further on in tackling those issues. That report, as you know, is looking into certain aspects of the Department of Community Services.

Ms FLYNN: I have additional information on the mandatory reporting issue and mandatory reporting by professionals. Australians Against Child Abuse, a non-Government/academic organisation, has done some research into the reporting behaviour of professionals and I think they analysed in that research the reasons why people report or why they do not report, what goes on in their heads and what influences their behaviour. I think one of the critical factors is the perceived effectiveness of what happens after they make a report, what will happen to the child and is the child protected by the fact of having a report made on it. They are saying that a pattern of previously reporting and not finding a satisfactory report or not knowing the outcome of what happens to the children or young person can impact on a decision whether or not to report another matter later on.

I think that could be a part of what might be going on in New South Wales at the present time with the overwhelming number of increased reports. Some questions, obviously serious ones, are being asked about the effectiveness of the response to those reports and the adequacy of that response and whether in fact it helps to protect the child. So there might be professionals who are over reporting and need education about that, as the Commissioner has said, but there could also

be professionals who are under reporting because they have no faith in the system that it will work in the best interests of the children.

I think what is needed is some other research into this, if Kibble or other Department of Community Services mechanisms are not looking at that. There is a need to have a research base that goes alongside all these sorts of initiatives so that we can understand what is happening, and in particular about the mandatory reporting behaviour of people and the response that the Department of Community Services has to those reports.

CHAIR: Can I ask either of you to make a comment on who should be doing the research? I think you both have said that there should be some research.

Mr FITZGERALD: At the end of the day, the lead agency in relation to these matters remains the Department of Community Services. Whether the department itself simply does the research I doubt, but it actually engages the research to be done, which I think is very important, and there are a number of independent bodies that can do that sort of research throughout Australia.

Secondly, we need to do it comparatively with other States where there are some levels of mandatory reporting. One of the things we tend to do in New South Wales is that we only navel gaze in relation to what we do here, when in fact there are child protection systems everywhere which have various elements of what we do. I think the short answer is that the department has the overall carriage of that matter.

The alternative is that bodies such as the Commissioner for Children and Young People can well in fact engage that research as an independent party. One of the difficulties the department faces has been a lack of credibility. That is both obvious and real. In mandatory reporting the lack of analysis to date has been concerning. So the other part might be the engagement by the Commissioner for Children and Young People, again not necessarily to do the research itself, but to engage, if there was a question as to whether the Department of Community Services was sufficiently impartial to do it.

Having said that, it is in the Department of Community Services' interest to understand who is reporting to it, what is effective reporting, what is ineffective reporting and what is happening, and I have no reason to doubt that the new Director General and the new Minister would not have a robust and keen interest to obtain impartial information about that because it is essential to the operation of the department. They would be my thoughts.

Ms FLYNN: I think there is a need for two different sorts of things. One is evaluation of things and the other is research that is more objectively driven, not just evaluating particular programs. The Department of Community Services has a very small budget allocated to research. I do not even know whether they have a budget allocated. They have some people in a research unit, only one or two people. They do far less than they used to do ten years ago, and that has been commented on by Dr Judy Cashmore, in particular, and others. I think they could commission more research and have research partnerships between the Department of Community

Services and academics, or the Department of Community Services and other agencies to have a look at some of these matters, but it does require resources and they need to come from somewhere, and I can understand that in the order of things research is not seen as a high priority, but I think obviously it will underpin how you develop good practice.

Mr SMITH: Just about the over reporting by some groups and the under reporting by others, do you feel that the over reporting groups have had the education in terms of indicators that they should look for, or the other, for example, factor with teachers, is it perhaps a fear factor, "If I don't report, I could get into strife further down the track"?

Mr FITZGERALD: Anecdotally, and that is all I can give you, because the analysis has not yet been done, there is a view that in relation to the area of education, firstly, there has not been enough ongoing education to inform teachers and principals about what are the appropriate risk factors. That would be disputed by some, but I think that is true.

The second thing in relation to the education area, there is no doubt at all that there is a fear element that is operating, so people are inclined to report anything and everything, but I want to be very careful about that. The converse used to be the case, where in fact there was significant under reporting, hence mandatory reporting. What I think in relation to the education area is that we do need to have much better education of the risk factors and the identifiable risk areas for all of the education professionals, both teachers and principals. Secondly, I think there may be a reason to look at whether or not the notifying should be done by the principal rather than by the individual teacher, so that there can be a screening of that assessment. That is all I could say in relation to that.

The other area in relation to mandatory notifying is in relation to police. Currently, all domestic violence matters where there is a child involved, those children are automatically mandatorily notified. There may be cause to look at that area as well, to say: Is that effective notifying or is it only in certain circumstances? Again, the analysis has not been done, but there has been a massive rise in the amount of reporting by police, and it has largely been the fact that if you go to a domestic violence incident and there is a child involved in that family or environment, that is automatically notified. That is another area that we could look at. The health one I have already commented on.

Everyone has got to be very careful in this area. The reason we have mandatory notifying, and we still do, and most States do, is because of the under reporting that took place previously. My view is that effective reporting requires an informed base by which you make that decision, and I would think in the education area there tends to be a fear, "If I don't report it, there will be a consequence."

That is all anecdotal and I cannot give you any more precise information than that. I think you are meeting with the Teachers Federation in relation to other matters this afternoon, and they will undoubtedly have views about these areas.

CHAIR: Just one last question: I understand that there has been some work recently on developing some risk factors for the Department of Community Services. Can you just briefly, more for our information more than anything else -

Ms FLYNN: I think these things are articulated fairly well in the Department of Community Services' submission to the inquiry by the Legislative Council Social Issues Committee into child protection services, and I recommend you look at that submission. They have two parts to their risk assessment. One is the risk or checklist assessment that goes on at the help line when people first contact. That material has not been made public or available to reporting people, mandatory reporters or others, although extracts of it probably have been put into different forms.

The other thing is the secondary risk assessment framework that goes on if a matter is referred to the community services centre, and that is quite a comprehensive framework. It does look at all sorts of things. It is a guided professional decision-making model, not an actuarial model, so it is not just based on ticking boxes and then because you have got so many ticks that means you have got a problem. It is obviously looking at a whole range of protective factors that might be helping to keep that child safe versus factors that are influencing a child being at risk of harm, and they then work through a process of judging whether that child is at risk of harm and what needs to be done about it and there is the case worker involved and the next level up would be involved in the decision of what you do about it.

I think that framework is quite a positive thing and it has been developed quite comprehensively over a couple of years based on work in Victoria and other countries and other States. I think the problem with it is whether they can realistically implement it at the Department of Community Services and whether it is being implemented. I think it was rolled out through training late last year, the November/December period, and to be implemented by the Department of Community Services' staff from early this year, and they intend to evaluate how it goes and get feedback about it. I have not seen any documentation or any reports on how effectively it is being implemented. That would be important to have a look at. I believe that the workers are under such pressure, that they may not be able to fully use and apply that framework to their work. Whether or not it is being done I do not know.

The secondary risk assessment framework is a good tool. It has quite good potential to help in the protection of children and in the planning of what you do in response to that. We do not know whether it is being effectively implemented. You would need to ask the Department of Community Services that question.

APPENDIX 1

THE COMMUNITY SERVICE COMMISSION SUBMISSION CONCERNING THE CHILD DEATH REVIEW TEAM'S REPORT INTO FATAL ASSAULTS IN CHILDREN AND YOUNG PEOPLE

The Community Services Commission is the independent government watchdog for consumers of community services in New South Wales. The Commission was established under the *Community Services (Complaints, Reviews and Monitoring) Act* 1993. The aim of the Commission is to improve the quality of community services that are provided or funded through the Department of Community Services or the Department of Ageing, Disability and Home Care.

The proclamation of the *Community Services Legislation Amendment Act* (2002) later this year will expand the role of the Commission to include:

- individual systemic reviews of deaths of certain children, young people and people with disabilities (known as 'reviewable deaths'); and
- community service complaints about child protection, out-of-home care, disability services, SAAP services, children's services and home care.

Summary of major issues

The deaths of children and young people in New South Wales reinforces the need for New South Wales to make a strategic investment in:

- practice and procedural improvements in the Department of Community Services' services as the human service agency with lead responsibility in child protection;

- stronger interagency relationships between government human service agencies to enhance communication and reinforce quality child protection practice;

- a network of preventative, early intervention and intensive family support initiatives to vulnerable families and programs aimed at ameliorating the extreme social and cultural isolation experienced by some families;

- development and strengthening of relationships between the Department of Community Services and the Family Court of Australia to enable a co-ordinated response to child protection matters within the Family Court jurisdiction;

- a stronger focus on the safety and wellbeing of children who live with parents/ carers with a mental illness and/ or drug and alcohol dependency;

- practice and procedural improvements in adult mental health and drug and alcohol services to recognise and improve reporting of children at risk of harm who live with parents/ carers with a mental illness and/ or drug and alcohol dependency; and

- the provision of a range of support and practical assistance for young people who are at risk as a result of abuse and neglect, risk taking behaviour and/ or drug and alcohol abuse.

The submission focuses on the following key areas:

- very young children at high risk
- interagency approaches
- families experiencing extreme social isolation
- Family Court issues
- mental health issues
- deaths of teenagers.

1. Very Young Children at High Risk

- The Report highlights the extreme vulnerability of very young children, particularly infants less than 12 months of age.

- Risk factors that increase vulnerability include:
  - social problems including financial difficulties and parental substance abuse
  - domestic violence and financial difficulty
  - prior involvement with child protection services
  - previous abuse notifications

- The lack of appropriate interagency responses is evident in the Report. For example, a number of children and / or their siblings presented to health services with injuries consistent with abuse, but were not notified to the Department of Community Services by health professionals.

a) Assessing the Risk to Very Young Children

- Continuous monitoring within the Department of Community Services of appropriate responses to very young children is needed to ensure that risk of harm to these children is recognised and responded to in a timely and effective way.

- It is critical that all relevant family history is available to Department of Community Services' caseworkers undertaking risk assessment or child protection interventions. This ensures that workers have a more complex picture of the issues that are relevant to the child and their family.

b) The Legislative Framework for Risk Assessment

- The legislative framework for reporting supports improved information gathering about children's circumstances by moving it away from responding to incidents of abuse to reporting of risk of harm. Risks of harm should be considered in relation to:
  - the age and developmental needs of the child; and
  - the family history, including relevant factors such as domestic violence.

- The findings of the Report strengthen the case for mandatory reporting, emphasising the gaps in services resulting from inadequate reporting by health professionals (including doctors, pediatricians, psychiatrists and hospital staff).

- In some cases, maternal, pre-natal, antenatal and early childhood services may be the only contact that a child has with a human service agency. The assessments of those agencies and the responses from the Department of Community Services are critically important to ensuring that children at risk have access to appropriate protective services.

- The Report states that, in some of the cases examined, the Department of Community Services made an inadequate response to reports made by health professionals. This highlights the need for effective interagency relationships and referral processes.

- Contact reports from mandated groups should be analysed to determine whether there are any patterns in the nature of these reports and the types of responses required. This will determine:
  - whether most contacts from mandatory reporters are about reporting children at risk. If this is the case, then these matters clearly need to be dealt with, and the objectives of mandatory reporting are being fulfilled.
  - whether reports from mandatory reporters are inappropriately driven by procedural imperatives, or do not require protective intervention. If this is the case, then the issues may be addressed through education or administrative changes.

2. Interagency Responses

- The Report highlights the importance of interagency work, particularly between maternal and early childhood health services and the Department of Community Services.

- As the Department of Community Services is the lead agency in New South Wales for child protection, the Department of Community Services' relationship and collaborative work with other human service agencies is critical to reducing the risk of harm for children and young people and intervening earlier with families.

- An additional focus on the role of health, police, education and non-government agencies in identifying and reporting risk of harm of children and young people is required. Interagency training concerning professional judgements about risk of harm, information sharing and a shared commitment to working together could result in improved and accurate reporting of risk of harm.

a) The Legislative Framework for Interagency Work

- The pre-natal reporting provisions of the Act allow reporting where there are reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm. The Act makes it clear that the purpose of this type of report, which is not mandatory, is to provide assistance and support to pregnant women. This reporting approach may be particularly useful for facilitating work between health and community services for families where there are identified child or maternal health concerns. Pre-natal reporting could occur in cases where:
  - there is concern about the effect of drug and alcohol dependency on infant well-being
  - there is concern about the effect of maternal mental and/ or physical health needs on post-natal infant care
  - there are known risk factors such as premature birth, infant medical issues or prior history of post-natal depression

2. Families Experiencing Extreme Social Isolation

- The Report highlights the extreme social isolation experienced by a number of families. Examination of the child protection/ support system's capacity to respond to extremely isolated families with risk of harm factors is required.

- A more extensive family support infrastructure could provide entry points for families who are vulnerable and socially isolated. Family support services provide a range of services that are preventative (e.g., parenting education and playgroups), but are also able to address child protection issues through home visiting, counseling and other targeted intervention.

- The Report highlights the gaps and inadequacies in how possible ongoing risk of harm to siblings in these high-risk families is dealt with. Family support services have the capacity to be involved in the lives of children and their families and can support and assist towards change within vulnerable families where there may be ongoing risk.

a) Working with Culturally and Linguistically Diverse Families

- The Report also highlights the isolation some parents from culturally and linguistically diverse backgrounds experience. In some families, this was compounded by mental illness or family background.

- A locally based network of family support services with expertise in working with these families, including a focus on particular cultural and language groups, is

required. Building on well-resourced family support services with extensive ethno-specific services or outreach could provide helpful services for these particularly isolated families.

b) The Legislative Framework for Supporting Families Experiencing Social Isolation

- The recent reported decrease in referrals from the Department of Community Services to family support services and the lack of appropriate resources to deal with requests for assistance by the Department of Community Services suggests that these processes are not being adequately utilised.

- Building on a better-resourced infrastructure for mainstream family support services, new strategies should be developed with a greater focus on families experiencing extreme social isolation and associated risk factors. Service models should include:
  - respite care for vulnerable families
  - intensive family support, including in-home support and intensive casework for families who have been assessed as at risk of serious harm with their children likely to enter the out-of-home care system

4. Family Court Issues

- The Report considers the systemic and procedural inadequacies facing children who have been involved in matters before the Family Court of Australia and who are 'known to DoCS'.

- In order to ensure that the Family Court and the Department of Community Services can work together effectively, a joint operational protocol is required to determine the roles and responsibilities of the two agencies.

- There must be adequate guidelines for the Department of Community Services management and staff regarding the importance of ensuring that appropriate risk assessment is conducted where warranted.

5. Mental Health Issues

- The Report identified a lack of assessment and planning about reducing and managing the impact of illness/ drug use on a parent's capacity to provide safety and appropriate care to dependent children. This included:
  - a lack of supportive services to enhance parenting capacity
  - a lack of focus on the impact of illness on parenting
  - poor interagency co-ordination and planning for children whose parents were ill

- Training for primary health care providers is needed to address:
  - parenting issues arising out of mental health concerns

- trans-cultural issues in mental health for families with dependent children where a parent has a mental illness

6. Deaths of Teenagers

a) Legislative Framework

- Chapter 7 of the *Children and Young Persons (Care and Protection) Act* 1998 provides a range of mechanisms to support families dealing with family conflict and young persons at risk without needing recourse to court proceedings. Implementation of this chapter of the Act is vital to ensuring that there is a comprehensive response to the need of older children and young people at risk and a range of pathways for them into appropriate services.

Overall Recommendations

1. Effective implementation and resourcing of the legislative provisions in place in the *Children and Young Persons (Care and Protection) Act* 1998 to support families and act decisively for children at risk; appropriate resourcing and implementation of mandatory reporting; pre-natal reporting and requests for assistance could have a positive impact on appropriate responses to children and young people at high risk.

2. Building and resourcing a more robust and extensive infrastructure for family support services across New South Wales in order to extend access to support services for extremely isolated families and children.

3. Improving interagency connections and relationships between the Department of Community Services as the lead agency for child protection and other government and non-government agencies with responsibilities around child protection.

4. Developing strategies to ensure that adult mental health and drug and alcohol services have a focus on the impact of these conditions on their clients' parenting capacity.

5. Ensuring that a strong co-operative relationship exists between the Department of Community Services and the Family Court of Australia through appropriate protocols and procedures to ensure that there is a timely response to children at risk whose families are involved with the family court.

EXTRACTS FROM THE MINUTES OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE REGARDING THE INQUIRY INTO THE FATAL ASSAULT OF CHILDREN AND YOUNG PEOPLE

No. 21

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 30 AUGUST 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Primrose	Mr Campbell
Ms Burnswoods	Ms Andrews
	Mr Smith
	Ms Beamer

The Chair, Mr Campbell, presiding.

Also in attendance: Mr Faulks, Committee Manager.

1. Apologies

Apologies were received from Mr Cull, Mr Tsang, Mr Harwin, Mr Corbett and Mrs Hopwood.

2. Previous Minutes

On the motion of Ms Beamer, seconded by Mr Primrose, the minutes of meeting No. 20, having been distributed previously, were accepted unanimously as being a true and accurate record.

….

5. Report of the Commission for Children and Young People on the fatal assault of children and young people

The Chair reported that the following report was tabled by the Commissioner for Children and Young People on 14 June 2002:

> Lawrence, R., Fattore, T. & Joung, W. (2002). Fatal assault of children and young people. Report for the New South Wales Child Death Review Team. Surry Hills, NSW: Commission for Children and Young People.

Under Part 6 and Schedule 1 of the *Commission for Children and Young People Act 1998*, the Committee on Children and Young People is required, in part, to report upon any matter appertaining to the Commission or connected with the exercise of its functions (s.28(1)(b)) and to examine each annual report or other report of the Commission and report on any matter appearing in or arising from any such report (s.28(1)(c)).

The Chair indicated that he had decided to advertise for submissions relating to the Lawrence, Fattore and Joung (2002) report immediately, given the constraint of the approaching end of the Parliamentary term, and the need to allow an appropriate time for the preparation of submissions from relevant parties and the general community. The advertisement of the inquiry was published on Saturday 10 August 2002, with submissions requested by Thursday 5 September 2002.

On the motion of Mr Primrose, seconded Ms Beamer:

> That pursuant to the *Commission for Children and Young People Act 1998* s.28(1), the Committee conduct an inquiry into the report on the fatal assault of children and young people.

Passed unanimously.

The Chair indicated that the public hearing to examine this report would be scheduled for Friday 20 September 2002.

….

10. General business

…

There being no further business, the Committee adjourned at 10:10 a.m.

Chair **Manager**

No. 22

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 13 SEPTEMBER 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Tsang	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Election of Acting Chair

The Manager advised that the Chair was assisting the Premier in Wollongong , and would not join the Committee until later in the morning.

On the Motion of Mr Tsang, seconded, Ms Burnswoods:
That Ms Beamer be Acting Chair until the arrival of the Chair.
Passed unanimously.

Ms Beamer, Acting Chair, presiding.

2. Apologies

Apologies were received from Mr Primrose, Mr Corbett, Mrs Hopwood, Mr Cull and Mr Smith.

3. Previous Minutes

On the motion of Ms Beamer, seconded by Ms Andrews, the minutes of meeting No. 21, having been distributed previously, were accepted unanimously as being a true and accurate record.

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6. Chair's report

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Report of the Commission for Children and Young People on the fatal assault of children and young people
The Chair indicated that two submissions had been received relating to the Lawrence, Fattore and Joung (2002) report.

….

7. General business

There being no further business, the Committee adjourned at 4:50 p.m..

Acting Chair

Chair **Manager**

Amended No. 23

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 20 SEPTEMBER 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Primrose	Mrs Hopwood
	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Cull, Mr Smith, Mr Tsang and Mr Corbett.

2. Previous Minutes

On the motion of Ms Beamer, seconded by Mr Campbell, the minutes of meeting No. 22, having been distributed previously, were accepted unanimously as being a true and accurate record.

….

5. Inquiry into the report into the fatal assault of children and young people

Ms Gillian Calvert, Commissioner for Children and Young People

was called and sworn.

The witness acknowledged receipt of a summons issued by the Chair under the Parliamentary Evidence Act 1901.

The witness was examined by the Chair and Members of the Committee.

Evidence completed, the witness withdrew.

6. General business

There being no further business, the Committee adjourned at 3:30 p.m..

Chair **Manager**

No. 24

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 27 SEPTEMBER 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
	Mrs Hopwood
	Mr Smith
	Mr Cull

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Primrose, Ms Andrews, Mr Tsang and Mr Corbett.

2. Previous Minutes

On the motion of Mr Harwin, seconded by Mr Smith, the minutes of meeting No. 23, having been distributed previously, were amended and accepted unanimously as being a true and accurate record.

….

6. Inquiry into the report into the fatal assault of children and young people

Mr Robert Fitzgerald, Community Services Commissioner
Ms Christine Flynn, Community Services Commission

were called and sworn.

The witnesses acknowledged receipt of a summons issued by the Chair under the

Parliamentary Evidence Act 1901.

The witnesses were examined by the Chair and Members of the Committee.

Evidence completed, the witnesses withdrew.

….

7. General business

There being no further business, the Committee adjourned at 4:05 p.m..

Chair **Manager**

No. 26

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

9:30 A.M., THURSDAY 14 NOVEMBER 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Primrose	Mrs Hopwood
	Mr Smith
	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Corbett and Mr Cull.

2. Previous Minutes

On the motion of Ms Beamer, seconded Mr Primrose, the minutes of meetings No. 24 and No. 25, having been distributed previously, were amended and accepted unanimously as being a true and accurate record.

….

4. Chair's report

The Hon. Henry Tsang MLC
The Chair noted that with his appointment on 11 July 2002 as Parliamentary Secretary to the Premier on Investment, Mr Tsang was ineligible to be a Member of the Committee. The Commission for Children and Young People Act 1998 s.29 (3) precludes a Member who has been appointed as a Parliamentary Secretary from being a Member of the Committee on Children and Young People:

> 29 Membership of Committee
> …
> (3) A person is not eligible for appointment as a member of the Parliamentary Joint Committee if the person is a Minister of the Crown or a Parliamentary Secretary.

The Committee is awaiting the appointment of Mr Tsang's replacement.

….

6. Chair's draft report: The fatal assault of children and young people: An examination of a report by the New South Wales Child Death Review Team.

The Chair presented the draft report: "The fatal assault of children and young people: An examination of a report by the New South Wales Child Death Review Team".

The draft report was accepted as having been read.

The draft report was examined by the Chair and Members of the Committee:

Chapter 1: read and agreed to.
Chapter 2: read and agreed to
Appendix 1: read and agreed to

On the motion of Ms Beamer, seconded Ms Burnswoods:

> That the draft report: "The fatal assault of children and young people: An examination of a report by the New South Wales Child Death Review Team", be read and agreed to.

Passed unanimously.

On the motion of Ms Beamer, seconded Ms Burnswoods:

> That the draft report: "The fatal assault of children and young people: An examination of a report by the New South Wales Child Death Review Team" be accepted as a report of the Committee on Children and Young People, and that it be signed by the Chair and presented to the House.

Passed unanimously.

On the motion of Ms Beamer, seconded Ms Burnswoods

> That the Chair and Manager be permitted to correct any stylistic, typographical and grammatical errors in the report.

Passed unanimously.

….

8. General business

There being no further business, the Committee adjourned at 10:00 a.m..

Chair **Manager**

REPORTS OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE

The first steps ... Review of the first annual report of the Commission for Children and Young People, for the 1999-2000 financial year. (Report 1/52, May 2001).

The global agenda for children - what role is there for us? Michael Jarman - The 1st Macquarie Street Lecture for Children and Young People, 6 April 2001. (Report 2/52, May 2001).

The development of wellbeing in children – some aspects of research and comment on child and adolescent development. Proceedings of a seminar, Parliament House, Sydney, 7 March 2001. (Report 3/52, June 2001).

Amendments to the *Commission for Children and Young People Act 1998* and *Commission for Children and Young People Regulation 2000* regarding employment screening. (Report 4/52, October 2001).

The importance of education for children in out-of-home care. Sonia Jackson - The 2nd Macquarie Street Lecture for Children and Young People, 31 October 2001 (Report 5/52, December 2001).

Learning to run ... Review of the second annual report of the Commission for Children and Young People, for the 2000-2001 financial year. (Report 6/52, February 2002).

Amendments to the *Child Protection (Prohibited Employment) Act 1998* regarding convictions for serious sexual offences and other matters. (Report 7/52, March 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 1 – Background issues. (Report 8/52, May 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 2 – Administration of prescribed drugs and over-the-counter medications to children and young people by non-parental carers and self-administration. (Report 9/52, May 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 3 – Children and young people and the misuse and abuse of prescription drugs and over-the-counter medications. (Report 10/52, May 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 4 – Use by children and young people of prescription drugs and over-the-counter medications developed for adults. (Report 11/52, May 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 5 – Use of prescription drugs as a mental health strategy for children and young people. (Report 12/52, May 2002).

The use of prescription drugs and over-the-counter medications in children and young people. Issues Paper No. 6 – Alternatives to the use of prescription drugs and over-the-counter medications by children and young people. (Report 13/52, May 2002).

Society and early child development. Daniel P. Keating - The 3rd Macquarie Street Lecture for Children and Young People, 9 May 2002. (Report 14/52, August 2002).

Voices: The education experience of children and young people in out-of-home care. (Report 15/52, September 2002).

Promising practice strategies for family foster care and current policy challenges. Peter J. Pecora. The 4th Macquarie Street Lecture for Children and Young People, 30 August 2002. (Report 16/52, October 2002).

The fatal assault of children and young people – An examination of a report by the New South Wales Child Death Review Team. (Report 17/52, November 2002).