ACT Children & Young People
Death Review Committee

CHANGING THE NARRATIVE FOR VULNERABLE CHILDREN:

Strengthening ACT systems

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Letter to the ACT Legislative Assembly

ACT Children & Young People Death Review Committee

Minister for Disability, Children and Youth
ACT Legislative Assembly
London Circuit
CANBERRA ACT 2601

Dear Minister

In accordance with section 727T (1) of the *Children and Young People Act 2008* I am pleased to present to you the report 'Changing the narrative for vulnerable children: Strengthening ACT systems'.

I hereby request that this report produced by the ACT Children and Young People Death Review Committee be tabled in accordance with section 727T (3) of the *Children and Young People Act 2008*.

Sincerely

M Carmody

Ms Margaret Carmody PSM
Chair,
ACT Children and Young People Death Review Committee

11 July 2018

The ACT Children and Young People Death Review Committee is established under the *Children and Young People ACT 2008*

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Acknowledgements

This report is based on the lives of 11 children who died prior to 2014. The Australian Capital Territory (ACT) Children and Young People Death Review Committee would like to acknowledge the children and their families whose cases were analysed. Their lives provided a moving insight into the types of vulnerabilities that children and their families experience and how the ACT support systems interacted with them to meet their needs.

We hope that their experiences are reflected respectfully in this report. They add to our collective understanding and contribute to the existing research about child deaths. They present what is distinct and distinctive about the ACT experience, helping our community to better prevent child death in the future.

The Children and Young People Death Review Committee thanks ACT Government Directorates for their willingness to provide information that assisted in the preparation of this report.

In undertaking this review, the Children and Young People Death Review Committee would like to acknowledge the work of Michelle Waterford, Crispin Walker and Vicky Saunders. Particular thanks go to Children and Young People Death Review Committee Members, Ms Louise Freebairn, Mr Eric Chalmers and Dr Sue Packer and the Chair of the Committee, Ms Margaret Carmody for the significant work undertaken in this review.

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About the Children and Young People Death Review Committee

The ACT Children and Young People Death Review Committee (the Committee) is established under the *Children and Young People Act 2008* to work towards reducing the number of deaths of ACT children and young people. The Committee reports to the Minister for Disability, Children and Youth.

The legislation sets out the requirement for the committee members to have experience and expertise in a number of different areas, including paediatrics, education, social work, child safety products and working with Aboriginal and Torres Strait Islander children and young people.

The Committee aims to find out what can be learnt from a child or young person's death to help prevent similar deaths from happening in the future.

To assist with this aim, we keep a register of all the deaths of ACT children and young people who die before they turn 18, and use the information on the register to learn more about why children and young people die in the ACT.

The Committee can make recommendations about changes to legislation, policies, practices and services to both government and non-government organisations.

The Committee does not investigate or determine the cause of death of a particular child or young person. We do not place blame or seek to identify underperformance but seek to identify systemic issues, help raise awareness and to spread prevention messages among professionals and in the broader community.

The Committee is keen to receive advice and feedback from interested ACT community members

Enquires about this publication and other Children and Young People Death Review matters should be directed to:
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0-3 Years Group Review: In Brief

The ACT Children and Young People Death Review Committee (the Committee) is established under the *Children and Young People Act 2008* to work towards reducing the number of deaths of ACT children and young people. A key task of the Committee is to undertake research aimed at preventing child deaths. The legislation requires the Committee to report to the Minister on the number, age and sex of children and young people who died during the year. In addition to this the Committee must report on children and young people who, within 3 years before their death were, or had a sibling who was, the subject of a child protection report and on any other matters considered relevant.

Research has consistently found that the youngest children are the most vulnerable to early and often preventable deaths (Frederick, Goddard & Oxley 2013; Welch & Bonner, 2013). Consistent with this finding, the Committee's Annual Reports highlight the high number of deaths of children occurring in the perinatal period and the early years of childhood within the ACT (ACT Children and Young People Death Review Committee, 2017 & 2018). Given the above, it is important that service providers and the Canberra community are made aware of the possible risk factors in the deaths of children aged 0 to 3 years.

A purposive sample consisting of eleven children aged 0 to 3 years who died in the ACT prior to 2014 and who were subject to a closed coronial inquiry were selected for this review. The aim of this review is not to consider the cause of death of children. This was determined by the Coroner. The aim of this review is to:

- Examine the key risk factors evident in family's lives up until the time of the child death.
- Consider how long the risk factor was present and the types of intervention provided by support and statutory services.
- Identify learnings to improve policy, programme or practice responses for infants and children and their families.

A mixed method approach was used in the collection of data. Descriptive statistics regarding the characteristics of child deaths were obtained from the Child Death Register and National Coronial Information System. A constant comparative thematic analysis of the qualitative data contained in Child and Youth Protection Service, ACT Housing, ACT Health and ACT Policing files, where available, was conducted. Consultation with ACT Health and the Community Services Directorate was also undertaken. Details of the background and methodology of the review can be found in Section 2.

When considering this review, it is important to keep in mind that there are certain limitations on how the data provided in this report may be appropriately interpreted and used. While the review benefited from access to detailed records and official reports, not all official records for all children were available to the Committee, resulting in a number of gaps in information. Furthermore, some degree of caution is

required in the interpretation of these results, in that these results are not necessarily representative of all child deaths and cannot be generalised across the population.

In addition to the methodological limitations identified within this review, it is important to understand the policy and practice context within which these children's deaths are situated. The deaths of children reviewed in this report occurred prior to 2014. Access to the historical information about the death of children is determined by the time lapse between child deaths and closure of coronial inquiries and the need to ensure confidentiality of children and their family is maintained. The length of time to investigate a death differs substantially from case to case and depends on the nature of the death and the number of factual inquiries and medical examinations or tests involved. Whilst some cases may be resolved within a few months, the majority of cases take considerably longer. Over this time extensive changes and reforms may have been made to the systems which support children and families. How families are supported now in the current service context may be considerably different to how the families in this review were supported. This is particularly so for statutory child protection and health services which have undergone a number of reforms since 2014.

Over the past five years a number of reviews have been undertaken in the ACT that have considered policy and practice responses to some of the Territory's most vulnerable children (Phillips, 2012; Auditor General, 2013; Glanfield, 2016). The reports undertaken in 2012 and 2013 specifically looked at Child and Youth Protection Services responses to providing adequate and immediate support to children and young people deemed to be at high risk and vulnerable. The Glanfield Inquiry in 2016 looked closely at the child protection sector and the domestic violence sector to consider how the two sectors interact. Key recommendations were made in these reviews and have since been implemented by the Community Services Directorate. Such changes to policy and practice for many of the children included in this review were not in place at the time of their death. A summary of these changes can be found in Appendix A.

Nonetheless, the Committee found that the complex characteristics of the lives of the 11 children echoes the extensive findings in national and international research as outlined in the literature review in Section 3. It is noted that just over half (55%) of the children were known to the ACT child protection system, public housing and other services. All families' received health care interventions at some point in the child's life. All families were identified as experiencing one or more risk factors. The critical risk factors identified in the children's file data (sourced from multiple points in the broader service system) highlight the co-occurrence of multiple social and environmental factors in a substantial number of child death incidents, irrespective of the child and families socio-economic status. Through developing a more nuanced understanding of the risk factors evident in a child's life, this review makes an important contribution to informing the ACT community and service sector about how we may better support families and children. Where the recommendations made in this review are found to be consistent with those made in earlier reviews,

the Committee has provided information outlining the current policy and practice responses and progress relative to these.

Implications for policy and practice

While all families in this review were reported as experiencing one or more risk factors, the significance of the risk factors in children's lives differed amongst the families. Individual and family level risk factors, while not necessarily related to the child's cause of death, were found to considerably increase the child's vulnerability. The Committee's analysis of the risk factors identified at the broader systemic level highlighted a range of issues that also contributed to increasing the child's vulnerability.

Key findings of the review and opportunities to strengthen systems designed to identify, respond and support children and their families are discussed below.

Child Characteristics

Of the eleven cases, five children were males and six female. Eight of the children were from ethnically diverse backgrounds. Just under half of the group of children had never engaged with Child and Youth Protection Services (n=5). Six families had both current and/or past involvement in Child and Youth Protection Services. Six families were clients of public housing. The children who had died and who had received child protection concern reports experienced much higher numbers of risk factors than those who had not come to the attention of Child and Youth Protection Services.

Multiple risk factors in children's lives

The coroner reports indicated that for many of the child deaths there is frequently no apparent or obvious reason as to why the child died. The cause of death for the majority of children was recorded as undetermined or unascertained.

International research has identified many risk factors which contribute to child death and although the evidence is far from definitive, there are a number of key risk factors that have been seen to contribute to poorer outcomes for children (Australian Institute of Family Studies, 2017). The analysis of 16 principle risk factors evident prior to birth and in the time leading to each child's death indicates that for six of the 11 children, life was chaotic with 12 or more risk factors being present(see Appendix B). The Committee noted that given the gaps in records this critical contextual information is likely to be understated.

Difficulties in pinpointing the influence or effect of particular risk factors makes it problematic for workers when assessing families. Yet, co-existing risk factors were evident in a high number of families in this review and these included, poverty, unstable housing, parental drug and alcohol use, limited social supports, mental and physical health concerns, parental history of and current involvement with statutory child protection services and parent relationships with high conflict and/or family and domestic violence present.

Parents who experienced multiple risk factors were frequently reported as demonstrating high levels of stress. It was apparent also in a number of cases that parents demonstrated a lack of understanding of their child's needs which resulted in children not being responded to appropriately by their parents or being cared for in unsafe ways.

Age of the child

The vulnerability of infant children was evident, in that the majority of children in this review died before the age of one. Infants are totally dependent on caregivers for their safety and wellbeing. This report illustrates that children under one year with their limited communication and mobility are at much greater risk of not having their needs identified or met. Particular attention is required to protect this group of children.

Safe-sleeping

Co-sleeping continues to present a risk to children. A high number of parents in this review continued to sleep with their children despite the strong evidence associated with child death. The vulnerability of the children sleeping with their parents was further increased due to characteristics of some parents, which included, high body mass and the use of prescription medications, alcohol, tobacco and illicit drugs such as cannabis.

Assessment of cumulative risk

Assessment of cumulative risk is challenging when so many agencies are typically involved with a family. A better system for sharing information is needed. For the children known to Child and Youth Protection Services, their files indicated that decision making was often based upon episodic assessments of single events of abuse and risk. There was less focus on the cumulative risk to children's developmental wellbeing from the patterns of abuse and neglect experienced by the subject child and their siblings over time. Despite sometimes high numbers of reports being made to Child and Youth Protection Services, the assessment of cumulative harm was frequently lacking in file notes. A range of reforms to address this issue have been implemented since 2014.

Recognition and responses to intergenerational trauma

Many of the parents of the children included in this review had experienced abuse and neglect in their own childhoods. Half of the group of parents had previous histories of involvement in the criminal justice and the statutory child protection systems. It was evident that a number of families, parents and grandparents of the child, had experienced considerable challenges over their lifetime. Their lives were characterised by ongoing issues of limited positive role models, domestic violence, drug and alcohol use, housing instability and statutory child protection intervention.

Assessment of parenting capacity

File records show that a number of assessments of parenting capacity were related to whether or not a parent was able to keep a child safe from episodic events of

abuse, rather than considering the parents' capacity to meet the child's needs. Yet, it was evident that for a number of parents, their understanding of the developmental needs of their child was limited. It is important for health and welfare services to identify and work with parents to understand and adequately respond to the changing needs of their child.

Child focussed assessment

The information reviewed in case files indicated a dominant adult focus, concerning responses to domestic violence, drug and alcohol use, housing instability and the criminal activity of parents, often at the expense of the child. Ideally any decision-making should be undertaken in relation to the 'best interest's principle', yet much of the information made available in the risk assessment and appraisal process focused on parent concerns. In these cases, it was evident that the child's experience of the above risk factors was not fully explored in either the assessment or decision making process.

Gendered service responses

Records show that the majority of service provision and support by Child and Youth Protection Services and Maternal and Child Health nurse services was focused on maternal and child interactions. File data indicated that men frequently remained absent in assessments and interventions despite their continued involvement with their child. In contrast, women were often seen as protectors of children, even when they were also understood to perpetrate physical violence, or exhibit risky behaviours, such drug use, that considerably impacted their capacity to care for their child.

Issues experienced by parents as a result of childhood trauma were also noted in file data. However, worker analysis and understanding of this issue lacked a gender perspective. Understanding gendered perspectives of trauma is necessary to ensure that policy and practice development pays attention to the different perceptions, experiences and needs of both fathers and mothers.

Recording and sharing information

The review identified that sometimes critical information was often not shared between service providers. There was frequently a lack of documentation to suggest that information was sought from or shared amongst services involved with family in order to adequately inform a comprehensive assessment of the risks to the child. For a number of children there was often an over reliance on one source of information informing the decision making process.

The Committee also noted that Child and Youth Protection Services 'child concern report' and appraisal documents were sometimes incomplete and had missing information related to children and their families. There were also instances of critical Information provided in earlier assessments not being reviewed or carried forward into new assessments. Furthermore, many files lacked a clear rationale for decisions

made by workers about children. A range of reforms to address this issue have been implemented since 2014.

Inadequate and unstable housing

A major influence on a child's life is a safe and secure environment and this is directly influenced by a family's housing conditions (Dockery, et al, 2013). It was evident that for a number of these children, unstable and unsuitable housing was a significant issue for both them and their parents. Not only did insecure and hazardous housing conditions contribute to unsafe sleeping practices, but also contributed to a less than optimum safe sleeping environment for infant children. These children were exposed to squalid conditions such as, mould, damp, fleas, building work, and unwanted pollutants. Housing debt also impacted upon a number of parents and their children's housing stability. There is a critical need for parents to be supported to obtain stable and adequate housing prior to the birth of their child and to be supported to maintain this.

Supports for families under pressure

The information reviewed by the Committee found that many of the children's families lacked positive natural support groups. This was due to either living far away from extended family and close friends or because family relationships were identified as problematic. Subsequently, in times of crisis, parents in this review either relied on formal services for support or in many cases, relied on their own limited resources. Long wait lists and extensive delays in being able to access services created barriers to accessing necessary support. Access to affordable and timely Mental Health services were of particular concern for a number of families.

There is a clear need for services to provide timely responses to parents of young children so that early intervention opportunities are realised sooner. Where timely access may be delayed, referring agencies need to take responsibility to support and check in with families until parents and children have been allocated the supports they require.

Within the scope of parental health, parental stress is a well-established risk factor for adverse child outcomes (Crum & Moreland, 2017). There was an apparent high level of parental stress noted within the files reviewed. Parental warmth, consistency and self-efficacy have been identified as important elements for a child's wellbeing (Zubrick, 2014). It is critical that education and training be provided to workers about the impact of stress on capacity. Understanding how toxic stress may be assessed and appropriately responded to will assist with interrupting pathways to increased vulnerability. Timely and appropriate assessments of parental warmth, consistency and self-efficacy as well as hostile and overprotective parenting is critical in achieving this.

More details on the findings can be found in Section 4.

Conclusion

The Committee acknowledges the considerable work of ACT services working with families with children under the age of three years as well as the considerable challenges that professionals and families face day-to-day. Similar to other jurisdictions, the ACT Child Protection System receives a significant and growing number of reports concerning children each year. Many of the issues reported are often complex and demand considerable time and expertise of workers.

The service systems designed to meet the needs of families and address the risks to children were frequently identified as lacking capacity to meet these demands. In addition the Committee recognises that their work is done in a continually changing service delivery context. The Committee also recognises that the ACT Government has a significant ongoing reform agenda underway as a result of previous reviews undertaken in the last five years (Phillips, 2012; Auditor General, 2013; Glanfield, 2016) and that considerable changes have been made within the statutory Child and Youth Protection Services since the deaths of the children included in this review.

The Committee further acknowledges that due to the methodology of this review, the emphasis of the findings and recommendations focus on key services, in particular, Child and Youth Protection Services and ACT Health Services. The Committee recognises that this approach does not account for the work of other services which may have been involved with families who also have considerable responsibility for the safety and wellbeing of children. However, this review of children who died prior to 2014 echoes many of the findings of previous reviews undertaken in the ACT and across Australia and highlights that the challenges experienced by the ACT are similar to many other jurisdictions. The challenges raised in this review are systemic issues that sit against the social and economic circumstances of vulnerable families living in the ACT.

Based upon the findings of this review, the Committee recommends action be taken to further improve the systems intended to support children and their families and to ensure that they are effective at preventing harm. Reducing the risks children and young people experience is a critical strategy to preventing child death. Any child death is a tragedy, and made all the worse when the death was preventable. Anything that can be done to reduce the risks to children is, in the Committee's view, immeasurably worthwhile.

The Committee has made 19 recommendations in relation to these findings. Detailed recommendations are detailed next.

1. Recommendations

The following recommendations are made based on the historical data reviewed for this report. The Committee acknowledge that considerable service reforms have been undertaken since the deaths of these children. The Community Services Directorate has provided considerable information to the Committee about current reforms. Where reforms have been initiated in response to recommendations from previous reviews, information about these changes is provided in the boxes following each recommendation and in Appendix A.

Addressing the risk factors in children's lives

1. That current practice models with parents following prenatal reports be reviewed to:

- Ensure that early intervention strategies across ACT Health and Community Services Directorates are maximised before the birth of the child, including access to GPs and prenatal health checks - non-attendance should be followed up.
- Enhance engagement of culturally appropriate services for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse Families.

Under the ACT Governments 'A Step Up for Our Kids: Out of Home Care Strategy 2015-2020', new services have been established. Uniting provides services and supports to assist families to address vulnerabilities that may place children at risk including:

- Managing the home and family
- Building relationships
- Parent child interactions
- Setting boundaries
- Addressing mental health, drug and alcohol and domestic violence concerns

Uniting has established the Newpin Program and the Intensive Family Based Service in the ACT. Both programs are evidenced based and work with pregnant women and their families to provide intensive trauma informed practice that is underpinned by attachment theory. The programs engage therapeutically with parents and supports them to make significant changes in their lifestyles and in their relationships with their children, their peers and other adults.

During 2017-18, Child and Youth Protection Services developed a Family Group Conferencing model for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with Child and Youth Protection Services. In the 2018-2019 budget, the ACT Government committed $1.44m funding over four years for the ongoing delivery of Family Group Conferencing, so that Aboriginal and Torres Strait Islander families can be supported to make decisions to keep their children safe, strong and connected to family and culture.

More information is at Appendix A

2. That ACT services review current practice to identify and respond to cases of cumulative harm. This includes:

- A review of the current legislation to test whether it is sufficient in protecting children where risks do not meet current thresholds for intervention but where cumulative harm is identified.
- Providing enhanced training and mandatory refresher courses for workers to ensure that they are aware of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.

A Cumulative Harm Guide is in the final stages of completion and will be released to all Child and Youth Protection Services staff to support improved understanding of this issue. This guide has been strongly influenced by the work undertaken in Victoria and will be supported by an eLearning package currently in development. A strengthened focus on face to face training to assist staff to recognise and understand the impact of cumulative harm is in development.

3. That the Community Services Directorate establish a mechanism to identify and review children who have been reported to Child and Youth Protection Services where four reports or more have been made and where the following co-existing risk factors have been identified:

- domestic and family violence
- substance misuse
- unstable housing
- limited parental service engagement.

Funding was provided by ACT Government following the Glanfield Inquiry for the establishment of a Case Analysis Team. The Case Analysis team has as their key objective to undertake independent case analysis of individual cases at key decision making points and / or during periods of perceived heightened risk for a child or young person. More information is at Appendix A

Safe Sleeping

4. For the ACT jurisdiction to ensure that safe-sleeping guidelines are consistent across Directorates and delivered consistently across the continuum of services by:

- Ensuring cross directorate agreement is established about safe sleeping guidelines.
- Professionals/providers have access to evidence-based training and resources concerning safe sleeping guidelines.

5. Safe infant sleeping promotion, co-sleeping and bed-sharing messages need to be provided to all caregivers prior to and after the birth of the child by health and social welfare professionals. Vulnerable families should be provided with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.

Assessment of Parenting Capacity

6. The ACT jurisdiction should consider the introduction of standardised empirically validated assessment tools to use in the pre and post-natal periods in order to identify vulnerable families requiring further support. This should include the necessary training for practitioners.

7. The ACT jurisdiction should consider establishing a high-quality parenting capacity assessment service and support for parents with children where four reports have been received about a child by Child and Youth Protection Services, including any prenatal reports.

8. All information and reports from parents provided to services need to be tested through accessing information from other services, particularly in regard to reports of parental drug and alcohol use or instances of domestic violence.

Gendered service responses

9. The presumption of the mother as the 'protective parent' as observed in records and applied by workers needs to be critically reviewed. The participation of both parents/caregivers in assessments and interventions should be required where it is evident that both parents/caregivers are involved in the care of the child.

10. Professional development opportunities such as supervision and in-service staff training should be provided in organisations working with vulnerable families to ensure that workers utilise current knowledge of the impact of gender in assessment and interventions and incorporate gender sensitive strategies into routine practice, particularly in relation to client experiences of trauma, domestic violence and service utilisation.

Child and Youth Protection Services have a supervision framework in place and provide training to all staff on this framework. Training currently includes a six and half hour face-to-face training for staff. Learning outcomes are related to the principles and uses of Performance Management and Supervision Processes.

With the implementation of A Step up for Our Kids, the Community Services Directorate contracted the Australian Childhood Foundation to deliver a broad range of trauma specific training to Child and Youth Protection Services staff, carers and service providers. This remains an ongoing focus.

Recognising and responding to intergenerational trauma

11. That vulnerable families with an intergenerational history of abuse should be offered trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.

12. That the ACT jurisdiction identifies innovative and evidence informed approaches to working with individuals who have experienced intergenerational trauma particularly in relation to the following groups:

- children who are identified as experiencing cumulative harm
- young parents who were engaged in statutory child protection services and/or corrective services
- male and female perpetrators of family violence.

In June 2018 the ACT Government launched a trial of Functional Family Therapy Child Welfare. Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild will deliver this evidenced based program.

Functional Family Therapy is proven by research to improve family dynamics, communication and supportiveness, while decreasing intense negativity and dysfunctional patterns of behaviour. In clinical evaluations, Functional Family Therapy has demonstrated to be more efficient and more effective in meeting treatment goals whilst also avoiding adverse outcomes, when compared to traditional approaches to care.

More information is at Appendix A

Child focussed practice

13. There is a need to build organisational and workplace cultures within the ACT that embrace a range of practices and attitudes that aim to keep the 'child in mind'. Further work is required to develop and support all professionals and adult services, such as Corrective Services and ACT Housing, to be aware of and to act with the best interests of the child as a primary consideration.

14. Organisations and professionals working with young children need to be supported to recognise that all children, including very young children, have rights as set out in the *United Nations Convention on the Rights of the Child (1989)*. Professionals need to be supported to build capacity, skills and knowledge to work, think and act in a way that supports the implementation of children's rights.

Enhanced supports for families under pressure

15. Caseworkers making referrals for vulnerable families should provide follow up support to families while they wait for services to commence.

16. That services across the ACT increase the awareness of professionals to recognise and respond to stress in families and to better understand the impact that this has on children when other risk factors are evident.

Recording and Sharing Information about children and families

17. For information sharing arrangements to operate effectively, they must be supported by organisational and professional cultures with strong governance and practice leadership, which observe and understand the guiding legislation. The ACT jurisdiction should consider providing training to relevant organisations concerning appropriate information sharing.

18. That the Community Services Directorate review quality assurance systems to ensure client documents are complete, information is recorded fully and accurately and that assessments are documented in a manner that records the justification of decisions made by professionals in regard to the safety of the child.

19. That the ACT continue to encourage the Commonwealth and other state jurisdictions to make nationally consistent legislative and administrative arrangements, including the development of a national data base, to enable the sharing of information related to the safety and wellbeing of children.

Following the Auditor-Generals Performance Review in 2013, Child and Youth Protection Services received funding for the development of a new client management system. The new client management system will integrate with key stakeholders, enabling real time exchange of risk, safety and wellbeing information about children and young people.

The new client management system is in development and will significantly assist staff to enter information and access it in many different ways to ensure staff are able to make more informed decisions, share information more easily, improve chronologies of information and activities undertaken by staff, and improve availability of client history.

It is anticipated that the system will decrease the administrative burden for staff allowing them more time to focus on client work, and provide a better holistic view of children and young people. More information is at Appendix A

2. Introduction

Research has consistently found that the youngest children are the most vulnerable to early and often preventable deaths (Frederick, Goddard & Oxley 2013; Welch & Bonner, 2013). This finding aligns with data from the ACT 2016 and 2017 Annual Reports, which also highlight the high number of deaths of children occurring in the perinatal period and the early years of childhood (ACT Children and Young People Death Review Committee, 2017 & 2018).

Children who die follow many different pathways and the research literature describes that children have often experienced a number of challenges (Brandon, 2008). Understanding the similarities and differences in pathways to a child's death and the experiences of their families is a valuable basis for considering the range of preventative and early intervention strategies needed to avoid future deaths.

The purpose of this review was to explore the risk factors and the levels of support evident in a sample of children who died aged between 0-3 years and who were subject to a closed coronial review. The aim of this review was to:

- Examine the key risk factors evident in family's lives up until the time of the child death.
- Consider how long the risk factor remained present and the types of interventions provided by services.
- Identify learnings to improve policy, programme or practice responses for infants and children and their families.

The key research questions for this review are:

- What were the critical risk factors that existed in the child's life around the time of death?
- Were these critical risk factors in any way related to the child's death?
- Could the death have been prevented with the amelioration of particular risk factors?
- What is the implication of the relationships between critical risk factors and death for the provision of services to children and families?

2.1 Scope of reporting

Similar to a number of other reviews, a socio-ecological approach was utilised as the analytical framework to inform this review (Bronfenbrenner, 1977; Fraser, Sidebotham, Frederick, Covington & Mitchell, 2014). Data were collected using a mixed method approach. Descriptive statistics regarding characteristics of child deaths were obtained from the Child Death Register (CDR) and National Coronial Information System (NCIS) and quantitative demographic data relating to the families in which a child death had occurred were extracted from the CDR.

International research has identified many risk factors which contribute to child death and although the evidence is far from definitive, there are a number of key risk factors that have been seen to contribute to poorer outcomes for children. The case files and the CDR were examined for these specific risk factors divided according to the ecological levels of the socio-ecological model described above.

Individual risk factors:

- child characteristics
- pregnancy and birth factors
- poor child health
- unsafe settling practices

Parental risk factors:

- parent characteristics
- domestic and family violence
- illicit drug and problematic alcohol use
- parental Child Protection history
- current Child Protection intervention
- criminal activity
- poor family relationships
- disability
- mental illness
- poor physical health.

Socio-economic and community risk factors:

- economic disadvantage
- inadequate housing
- limited service engagement
- poor social support.

A constant comparative thematic analysis of the qualitative data contained in the following available case files was also undertaken:

- Child and Youth Protection Services records - child concern reports, child protection reports and appraisal outcome reports
- ACT Health records –records relating to domestic violence, drug and alcohol use, mental health and any other incident involving the child, parents/carers and any siblings
- ACT Policing – records relating to domestic violence, drug and alcohol use, mental health and any other incident involving the child, parents/carers and any siblings
- ACT Housing - records relating to domestic violence, drug and alcohol use, mental health and any other incident involving the child, parents/carers and any siblings.

2.2 Protecting confidential information

This report draws on 11 in-depth case studies of deaths of ACT children aged 0 to 3 years prior to 2014. It is designed to provide useful information to the public while, at

the same time, meeting the requirement of section 727T (2a and 2b) of the *Children and Young People Act 2008* to report data in a manner consistent with protecting the identity of a child by not disclosing their identity or allowing their identity to be worked out. Therefore, in accordance with statutory requirements designed to protect confidentiality, qualitative file data have been aggregated and only the broader themes are reported. Quantitative data which identified specific child and family characteristics have not been included in this report in order to avoid possible recognition.

2.3 Use of summary information

This review analyses the key critical risk factors identified in the children's file data. However, it is important to keep in mind that there are certain limitations on how the data provided in this report may be appropriately interpreted and used. While the review benefited from access to detailed records (for example, Children and Youth Protection Services and ACT Housing) and official reports (Police Records, Autopsy Reports, Toxicology and Coroners records), not all official records for all children were available to the Committee, resulting in a number of gaps in information.

In addition to the methodological limitations identified within this review, it is important to understand the policy and practice context changes within which these children's deaths are situated. The deaths of children reviewed in this report occurred prior to 2014. The historical information that the Committee reviews is constrained by the time lapses between child deaths and closure of coronial inquires and the small numbers of deaths we record each year.

In this time, a number of reviews have been undertaken in the ACT that have considered policy and practice responses to some of the Territory's most vulnerable children (Phillips, 2012; Auditor General, 2013; Glanfield, 2016). The reports undertaken in 2012 and 2013 specifically looked at Child and Youth Protection Services responses to providing adequate and immediate support to children and young people deemed to be at high risk and vulnerable. The Glanfield Inquiry in 2016 looked closely at the child protection sector, the domestic violence sector to consider how the two sectors interact. Key recommendations were made in these reviews and have since been implemented by Child and Youth Protection Services. Such changes to policy and practice for many of the children included in this review were not in place at the time of their death. Nevertheless, the case studies are informative on a number of fronts, in particular in the recurrence and prevalence of key risk factors.

3. Understanding why children die

Over the past century, child mortality in high income countries such as Australia, the United Kingdom and the USA have fallen to very low rates (Fraser, Sidebotham, Frederick, Covington & Mitchell, 2014). Deaths in early childhood in Australia have reduced substantially over the past 100 years and this improvement is linked indisputably to better health care such as improved access to neonatal healthcare and increased community awareness of the risk factors for infant and child deaths (Australian Institute of health and Welfare (AIHW), 2017). However, despite this decline in mortality, across Australia in 2015, around 1020 children died before their fifth birthday with over 800 of these children dying before the age of one(ABS, 2016). Within the ACT, approximately 30 deaths occur each year for children aged 0-17 years. The majority of these deaths (approximately 70%) occur for children under the age of one year (ACT Children Young and People Death Review Committee, 2017). Nearly half (48%) of all child deaths in 2012 were considered potentially avoidable (AIHW, 2012) suggesting that greater prevention efforts need to be developed.

Child deaths from most conditions are influenced by a range of factors in addition to health system performance, including health behaviours, the underlying prevalence of conditions within the community, and environmental and social factors including parental vulnerabilities (Australian Health Ministers' Advisory Council, 2015). The potential for preventing childhood death may involve multiple and complex interactions between factors such as the physical health of the child, their social and physical environment as well as the services and systems that provide support to them and their families (Wolfe et al, 2014, p.3). Subsequently child death is not solely a medical problem and professionals in public health, education, criminal justice and child welfare have important roles to play.

Preventable child deaths are unacceptable and through enhanced understanding and better responses to such complexities this research aims to improve the life chances of all children born in the ACT.

A brief review of the literature relating to risk factors associated with child death between the ages of zero and three years was undertaken. This literature was used to inform and provide context for the data collection phase of the review, and to describe the evidence regarding the key risk factors associated with child death. The literature review addressed the following research question:

- What are the key risk factors associated with the death of a child aged three years and under?

3.1 The current context

The National Framework for Protecting Australia's Children 2009-2020 (Council of Australian Governments, 2009) represents an unprecedented level of collaboration between the Commonwealth, state and territory governments and non-government

organisations, putting children in the centre of future planning and providing a foundation for national reform. Against this background, there is a clear imperative for Commonwealth and other service systems to provide a more coordinated and collaborative response to the needs of vulnerable children and families.

In Australia, states and territories have the responsibility for statutory child protection and similar to a number of other state and territories, the ACT has had increasing demands on the child protection system. The Australian Institute of Health and Welfare 2015-2016 Child protection Report shows a significant increase in the number of children receiving child protection services with the ACT. The number of children receiving services rose from 1,703 in 2014-2015 to 2,388 in 2015-2016 (AIHW, 2017a).

As noted earlier, the past five years has seen a number of reviews being undertaken in the ACT that have considered policy and practice responses to some of the most vulnerable children and young people (Phillips, 2012; Auditor General, 2013; Glanfield, 2016). In addition to these reports, the Domestic Violence Prevention Council undertook a review of domestic and family violence deaths in the ACT, providing a number of recommendations in relation to culture and attitude change towards domestic and family violence in the ACT, service delivery to victims, survivors and perpetrators and improvements to the legal and justice system's responses to family violence. Since 2015, the Community Services Directorate has undertaken a change agenda in order to better support and improve outcomes for children and young people living in the ACT. The following information on reforms has been provided by the Community Service Directorate:

- *Progression of a five-year Out-of-Home Care Strategy.*

  One Step Can Make a Lifetime of Difference (Out of Home Care Strategy 2015-2020) is the ACT Government's five-year strategy to reform the out of home care sector. A Step Up for Our Kids is a large scale, transformational Strategy which aims to: improve outcomes for children and young people in out of home care by providing more flexible, child focussed services; and to reduce demand for out of home care places. The Strategy places a strong emphasis on preventing children and young people from entering care by providing intensive family preservation services, and on transitioning children and young people out of care and into permanent, stable, family settings as quickly as possible. There are three domains of the Strategy:

  - *Strengthening High Risk Families*
  - *Creating a Continuum of Care*
  - *Strengthening Accountability and ensuring a high functioning system.*

In addition to this, the Strategy commits child protection and out of home care services to hearing the voice of the child or young person, ensuring a better understanding of their needs, and providing personalised therapeutic services, that can scale up and down in intensity as the child or young person's needs change over time.

- *Enhanced early intervention services and supports for pregnant women, as well as for young people, through the implementation of case conferencing and services that include:*
    - *The Uniting Newpin service which has a focus on supporting families with very young children. Where families have been separated, and children taken into care, Newpin aims to restore children home to their parents, as quickly and safely as possible, through an intensive family preservation and reunification program.*
    - *The Intensive Family Based Service is a safety focused preservation service delivered in the family's home using the Homebuilders model. Uniting staff work intensively with the family for up to 15-20 hours per week and provide support where the family needs it.*
    - *Family Preservation Services to flexibly support families in their home to sustain preservation and work towards reunification.*
    - *A strengthened approach to developing cultural plans that are relevant and meaningful for Aboriginal and Torres Strait Islander children and young people in care. Cultural leadership and support through Jaanimili which is the Uniting Aboriginal Service and Development Unit supporting Uniting's work with Aboriginal and Torres Strait Islander families.*

Consistent themes were identified across these reports and in response, the ACT Government released a comprehensive response outlining a commitment to system wide reforms aimed at changes to legislation, policy, practice and culture that focus on leadership and cultural change; prevention and early intervention; information sharing; collaboration and integration and transparency and accountability. These changes aim to improve the child and family services system and forms an important step in both the short and long term response to protecting children.

3.2 Snapshot of child deaths – National, State and Territory

The Australian Bureau of Statistics (2016a) reports that the number of deaths across Australia for children aged 0-3 years over the past three years continues to decline. Table 1 details the number of deaths for each age group under three years across

Australia. It is evident from this data that the highest rate of child death under three years occurs before the age of one.

Table1 Child deaths under three years by Year of death and age Australia

Age	2013	2014	2015
0	1094	1012	991
1	96	67	77
2	59	45	58
3	37	33	32
Total	1286	1157	1158

Across states and territories a similar pattern emerges with higher rates of children dying under the age of one as compared to any other age group under 18 years. Within the ACT, 91% of children that died under the age of three, died before the age of one.

In Australia, State and Territory Registrars are responsible for registering all deaths in their jurisdiction and data concerning the cause of death are compiled and reported by the Australian Bureau of Statistics. Data collection within Australia about the cause of death for children and young people is problematic as no national legislation or guidance exists and every state and territory has different legislative and operational frameworks and different reporting laws. Most child death reviews that are undertaken within Australian jurisdictions focus on child protection concerns (Fraser, Sidebotham, Frederick, Covington & Mitchell, 2014).

The most recent national data comes from the Australian Institute of Health and Welfare (AIHW). Using ICD-10 coding to categorise causes of death, three-quarters of child deaths under the age of one year in 2010–2012 arose due to certain conditions originating in the perinatal period and congenital conditions. These include, for example, conditions related to short gestation and low birth weight, birth trauma and viral diseases acquired in utero (AIHW, 2014).

Sudden Infant Death Syndrome (SIDS) was the second most common cause of death among this group of children, accounting for 6.7% of deaths in 2010–2012. Deaths due to SIDS have more than halved since 1997–1999, from 58 deaths per 100,000 to 25 deaths per 100,000 in 2010–2012 (AIHW, 2012).

The ACT reports data on the indicative cause of death and the ICD-10 code. The 2017 Annual Report presents data from over a five year period 2013-2017 about causes of death. The majority of deaths occurring in the ACT originated in the perinatal period. Neoplasms were the most frequently reported cause of death for children over the age of one and under four years. Causes of death for children less than four years between January 2013 and December 2017 are detailed in Table 2.

Table 2 Indicative and ICD-10 cause of death by age bracket for children usually residing in the ACT for the five years between January 2013 and December 2017[1]

CAUSE OF DEATH	< 28 days	28 – 364 days	1-4 years	TOTAL
Certain conditions originating in the perinatal period	46	7		53
Chromosomal or congenital anomalies	9	•	•	9
Diseases of the musculoskeletal system and connective tissue	•			•
Diseases of the nervous system	•		•	•
Endocrine, nutritional and metabolic disease	•	•		•
Neoplasms			5	5
Respiratory diseases			•	•
Symptoms, signs not elsewhere classified	•	5		5
No data	•		•	•

3.3. Preventable child mortality

Preventable child mortality refers to child deaths occurring from conditions that are considered avoidable if provided with timely and effective intervention (AIHW, 2010). The myriad of potential causes and the inability to accurately predict child death for many children makes prevention often challenging. The last five decades have seen significant progress in the prevention of child deaths from SIDS, with certain risk factors such as parental smoking and the child's sleeping position being understood as contributing factors to the child's death (Task Force Sudden Infant Death Syndrome, 2016). Frederick, Goddard and Oxley (2012) argue that while it may be the case that these risk factors contribute to a child's death there is also a proportion of SIDS cases that are homicides. It is widely accepted that young children are most at risk of death caused by a family member (Douglas, 2017) and it is believed that between one and twenty per cent of Sudden Infant Death Syndrome cases may be cases of child homicide (Alder & Polk, 2001). Nevertheless, a strong public health campaign about these risk factors has resulted in a considerable reduction of child deaths from SIDS (Sidebotham, Fraser, Fleming, Ward-Platt & Hain, 2014).

3.4 Recording cause of death

Despite this achievement it remains evident that a failure to accurately recognise or record the cause of death impedes the capacity for building preventative strategies both at policy and practice level. Research persistently reports the lack of systematic coding and reporting of children's deaths for Sudden Unexpected Death in Infancy (SUDI), for where deaths are recorded as unascertained or where there

[1] The symbol • is used to indicate that fewer than five deaths occurred

appears to be an unintentional cause of death (Fraser et al, 2014; Gould,Weber & Sebire, 2010). Garstang, Ellis, Sidebotham and Griffiths (2015) examined the death of all SUDI cases over two years in one area of the UK and found that most deaths labelled as unascertained fulfilled diagnostic criteria for SIDS. Furthermore, unascertained deaths had a significantly higher total family and environmental risk factor scores compared to SIDS, and many SUDI occurred in families with mental illness, drug or alcohol misuse, chaotic lifestyles and unsafe sleep-environments. Ninety six percent of these unascertained deaths were considered to be preventable (Garstang, Ellis, Sidebotham and Griffiths, 2015). Other research indicates that often there are circumstances that may have significantly contributed to the death such as bed sharing or other conditions that may have caused asphyxia. Without all the information, a report of an 'unascertained' cause of death may be made concealing significant factors that if known would prevent future deaths (Gould,Weber & Sebire, 2010).

The child protection and child maltreatment literature also reports recurrent concerns about coding and the systematic lack of recognition of child maltreatment deaths (Palusci & Covington, 2014). In addition, it has been reported that emergency department and hospitalisation records have also been shown to capture only a fraction of all medical encounters arising from child abuse or neglect. Mackenzie, Scott, Fraser & Dunne (2012) undertook a medical record review and database linkage of 884 child records from 20 hospitals and the Queensland Child Protection System. This study along with a number of other US studies report that children with an unexpected death or what appeared to be an unintentional cause of death frequently experience preventable risk factors similar to those families where maltreatment has been identified. The under-ascertainment of nonfatal and fatal child maltreatment highlights the problematic nature of correctly identifying cause of deaths, particularly where neglect occurs (Putnam-Hornestein et al, 2013).

3.5 Risk Factors

The research on child death is in its infancy with regard to addressing possible risk and contextual factors, and much of the research we have looked at has emerged from fields focusing on child maltreatment and child protection as well as the social determinants of health.

Risk factors can be defined as the measurable circumstances, conditions or events that increase the probability that a child will have poor outcomes in the future (Child Welfare Information Gateway, 2014). The assessment of risk and protective factors enable practitioners and policy makers alike to view the lives of children in a more holistic way and to consider the many contexts that families live within. Numerous child maltreatment and child protection studies describe the risks associated with poor child outcomes (Doidge, Higgins, Delfabbro, Segal, 2017; Widom, 2014). However, it is important to recognise that risk factors are not causes of child

maltreatment or child death, and the presence of one or more risk factors does not necessarily result in child maltreatment or child death.

One of the challenges of understanding the effect of risk factors that exist in the lives of children is that risk factors are often interrelated and intersect at multiple levels (Scott, Lonne & Higgins, 2016). Current literature highlights the use of Bronfenbrenner's socio-ecological model as a useful way of understanding the different levels which include individual characteristics and developmental stage, family environments, community and neighbourhood environments and societal values and cultural beliefs (Australian Institute of Family Studies, 2017).

The following section outlines the key risk factors identified in the literature concerning the risk factors associated with child death.

3.5.1 Child characteristics

Over the past few decades the ideology of childhood and the 'best interests of the child' have obtained a prominent place in policy and practice, particularly in the fields of legal, welfare, medical and educational institutions (James & Prout, 2015). Children's lives are shaped by a range of factors and the institution of childhood is influenced by both cultural and structural components of society. Overwhelming evidence has found that children's health and development outcomes follow a social gradient: the further up the socioeconomic spectrum, the better the outcomes (Moore, McDonald, Carlon & O'Rourke, 2015).

Children's vulnerability changes during the life course and at each developmental stage children are at risk of different causes of death. Given their physical vulnerability, research has consistently found that the youngest children are the most vulnerable to abuse and neglect related deaths (Welch & Bonner, 2013). International studies also describe other child characteristics that may increase the risk of child death (Damashek, Nelson & Bonner, 2013). In general, male children are overrepresented among victims of fatal child abuse (Miyamoto et al, 2017). Low birth weight, disability and premature birth have also been identified as increasing the risk of child death (Jonson-Reid, Chance, & Drake, 2007). In the US some ethnic minority groups are also over represented (Welch & Bonner, 2013) and within Australia, Aboriginal and Torres Strait Islander research indicates that poorer pregnancy outcomes are frequently experienced by Aboriginal mothers (Duong, Davis & Falhammar, 2015). Research highlights that Aboriginal women are considerably less likely to receive intervention during labour and delivery and have higher rates of still birth, prematurity and low birth weights (Australian Health Ministers' Advisory Council, 2015). In addition, health and behavioural risk factors such as excess alcohol consumption, active and passive smoking, poor maternal nutrition and a lack of maternal health care before or during pregnancy are also associated with poorer birth and child outcomes (Titmuss, Harriss & Comino, 2008; Brown et al, 2016; Ashman et al, 2016).

Comino and colleagues (2012) argue that current explanations of risk for Aboriginal infants are unhelpful and limited to conventional risk factors. Previous research does not address the complexity of risk factors, nor the context within which these women and children live. Furthermore, limited research considers the complex inter-relationships between risk and protective factors. Comino and colleagues highlight that there is a need to move beyond just looking at antenatal care and birth outcomes if we are to understand and develop a more comprehensive and inclusive model of risk factors to improve the health and wellbeing of Aboriginal infants.

3.5.2 Parent and caregiver characteristics

A key feature of the environments in which children develop is the extent to which parents and caregivers provide protection and support to their children. Concern about the influence of parental risk factors on child fatalities has resulted in research being undertaken to consider how parental characteristics either protect children or expose them to adverse experiences.

Parent age is consistently reported within Australian and international studies as a risk factor for a child fatality (Douglas & Mohn, 2014; Australian Institute of Family Studies, 2017). A US study identified that parents and caregivers of children who die are mostly in their early 20s, with a minority in their teens or 30s (Damashek et al., 2013). These parents are younger than parents of non-fatally maltreated children (Douglas & Mohn, 2014). There is also evidence that lower levels of maternal education impact child outcomes, with research from the US (Oberman & Meyer, 2008) describing that children whose mothers do not have a high school education are at an increased risk of fatal maltreatment when compared to children who died of natural causes (Douglas, 2017). However, an Australian study identifies that parental education does not appear to have a significant impact upon child health (Khanam, Nghiem & Connelly, 2009), rather it is the importance of maternal health behaviours that influence child outcomes.

Parent attachment and parent child relationships are also influential for outcomes for children. Strong parent bonds and high levels of support are associated with better outcomes for children (Wynter, Rowe, Tran & Fisher, 2016). Although how a parent understands and interprets their child's behaviour and the expectations a parent has of their child may influence the risk of negative outcomes and child death (Douglas, 2013). A US study about child death in child protection cases found that 65% of the child welfare workers interviewed identified that parents had age-inappropriate expectations of their child. Furthermore, where a significant life event has occurred or if high levels of parental stress are also identified, this stress increases the risk by a factor of seven (Douglas, 2017).

Another important protective factor for children is the quality of the relationship between their parents. Moore and colleagues (2014), report that children have better health and development outcomes when their parent's relationships are

strong and supportive, both in the pre and postnatal period. Children are placed more at risk where there is high conflict and unresolved hostility between parents.

Unsurprisingly, the more adverse a child's life experience is, the more likely the incidence of health and developmental problems. The most frequently mentioned parental characteristics reported when a child dies include, parental alcohol and substance use and parental mental health (Douglas, 2013). A recent Australian study, which undertook an analysis of 16 child death reviews, considered the co-existing parental risk factors of mental illness, domestic and family violence and substance abuse and the impact these had on children (Frederico, Jackson and Dwyer, 2014). Frederico, Jackson and Dwyer (2014) describe that each of these risk factors have their own consequences for children but when presented together, provide considerable complexity. Workers frequently find this combination difficult to address with the families.

Additionally, this study highlighted that the lack of engagement in services by parents was also problematic and there was no consistent narrative in the files about which services would be involved with families who experienced this trio of risk factors. Where services were involved, service contact with families often took the form of surveillance and monitoring. Few services had contact with children or demonstrated understanding of their developmental needs. This study also highlights the critical role of gender in relation to service intervention. Frederico and colleagues (2014) argue that the gender of the parents influenced engagement patterns and intervention by care and protection services, with workers often not engaging with fathers. Other findings of this study highlight the limiting adult focus of support and the apparent lack of child sensitive assessment.

While this 'toxic trio' of domestic violence, mental illness and substance abuse (Frederico, Jackson and Dwyer, 2014 p.106) has been found to have significant life consequences for children, current research describes the challenges that exist in understanding how these risks contribute to a child's death. A large scale US study reports that risk factors such as drug and alcohol use, mental health, housing and domestic violence are frequently characteristics of non-fatal child abuse and that what is not known is how these characteristics are potentially related to levels of risk for fatal child abuse and neglect (Douglas & Mohn, 2014). It is evident within the literature that a range of perspectives exist about the influence and importance of such risk factors.

A small number of studies, predominantly from the US, have considered the characteristics of families and the risk factors that separate non-fatal child abuse and neglect cases from fatal child abuse and neglect cases (Welch & Bonner, 2013; Douglas & Mohn, 2014). Such studies identify that fatal child abuse and neglect can range from beatings, shaking and suffocation through to not providing necessary medical attention, leaving a new born unattended or not providing adequate care or supervision. These studies provide further exploration of parental risk factors.

Douglas (2017) argues that presently there is limited understanding about how a parents mental illness contributes to a child's death. It is well established that the mental health of women during the postpartum period is one of heightened vulnerability. During this period, disorders of mental health are common and vary in severity and duration and many women experience the 'baby blues'. Furthermore, Woolhouse, Gartland, Mensah and Brown (2014) argue that maternal depression frequently extends beyond this post-natal period and maternal depression is more common at 4 years postpartum than at any time in the first 12 months postpartum.

Parental mental illness is found to exist in a significant number of parents who have children that die. Yet, US control studies find that parental mental illness is as much evident in parents of non- fatal child abuse as it is in fatal child abuse cases and the relationship between mental illness and child death is largely unknown (De Bortoli, Coles, Dolan, 2013). This literature review confirms that there is limited research about the association of mental illness with child death and there is variance amongst research findings.

Similarly, domestic and family violence is another area where there is limited information. It is evident that domestic and family violence is identified as form of child maltreatment, and has significant short and long term negative impacts for children (Richards, 2011). Furthermore, while there is evidence about how domestic violence may result in fatalities for women, its level of risk for child death is unclear and currently as far as the Committee is aware there is no systematic Australian data collected on this. A recent Australian review into family and domestic violence and child death found that the impact of family violence on children was by no means addressed and that there was often inadequate assessment by child protection services (Commission for Children and Young People, 2016). For the most part, this Victorian review describes children as largely invisible to systems prior to their death.

The small amount of research that has looked at child death and domestic violence compares fatal and non-fatal victims of maltreatment (Chance & Scannapieco, 2002; Douglas & Mohn, 2014). This research found the presence of domestic violence did not increase risk of death for the child in that it was as prevalent in non-fatal cases as fatal. Miyamoto and colleagues, (2017) further argue in their study that parent/caregiver involvement with family and domestic violence reduced the risk of serious maltreatment and child death. While the authors identify that this maybe counter intuitive, they highlight that many of the families, where domestic and family violence was identified, may have effectively removed the perpetrator or may have mitigated the risk through involvement in some kind of protective intervention.

Conversely, evidence about cannabis, smoking, illicit drug use, and apparent exposure to second-hand smoke, separately or in combination, during pregnancy highlights the increased risk of stillbirth, and child developmental disability (Varner et al, 2014; Williams & Smith, 2015). Furthermore, the co-occurrence of parental substance abuse and problematic parenting is recognised as a major public health

concern. Research indicates that the prevalence of substance abuse is higher in parents where there are substantiated cases of child abuse (Thurston et al, 2017). Data from Australia indicates that approximately five per cent of women use substances during pregnancy and these estimates are likely to be lower than actual rates due to limited screening (Bartu, Sharp, Ludlow, & Doherty, 2006; Anthony, Austin, & Cormier, 2010). Substance-use frequently continues in the postnatal period and a number of Australian Child Death Reviews of children known to Statutory Child Protection Services repeatedly demonstrate that infants under twelve months of age are most likely to come to harm (Victorian Child Death Review Committee, 2012). Although to our knowledge, the prevalence of parental substance abuse in child maltreatment deaths is not known.

3.5.3 Family characteristics

Families have been affected by the profound social changes that have occurred in society. Children are now born into and grow up in a diverse range of family structures. Research on household characteristics of children who die indicate that the most children live with their biological mother, with approximately a third to a half of children also living with their biological father (Douglas, 2017). Living with adults not related to the child increases the risk of death for a child (Palusci & Covington, 2014). In the US, Miyamoto and colleagues (2017) undertook a matched case-control study of 234 children who had sustained fatal or serious non-fatal child maltreatment. They found that children who had young parent/caregivers, children who were in families with three or more children under the age of five living in the home and children in families in which another biological child was no longer living with either parent had much higher odds of serious injury or death.

The changes in family conditions are also important to understand because of the considerable evidence that social factors have profound influences on children's health (Moore et al, 2015). The circumstances in which children are born determine their exposure to environments that promote or compromise healthy development (Marmot & Wilkinson, 2006). Children are particularly vulnerable in the early years and their health, development and wellbeing can be compromised by a number of direct adverse experiences during the prenatal and postnatal periods (Moore, McDonald & McHugh –Dillon, 2014). This is particularly evident in the increasing number of families with multiple and complex needs.

Families who have multiple and complex needs frequently are unable to meet the needs of their children and this increases a child's risk of abuse or neglect. Children who die are often known to child protection services (Douglas, 2017). In fact, having been the subject of a report considerably raises the risk of a child death (Palusci & Covington, 2014). Overwhelming evidence also highlights that Indigenous children are more likely to be victims of child abuse, neglect and sexual assault; and are more likely to be involved with the child protection system, be in out-of-home care, or be homeless (Moore et al, 2015; Wise, 2013, AIHW, 2014a). As far as the

Committee is aware, there is no research that focuses on the potential differences between children who have been reported to child protection services and who have died and children who were never reported, but also who have died due to abuse or neglect.

3.5.4 Socio-economic and community characteristics

Two other profound social issues that have a significant impact on child wellbeing and development are poverty and housing. In particular the effects of poverty on health have been found to significantly impact children's experiences of toxic stress and a variety of other child health problems, including developmental delay, asthma and heart disease (Moore et al, 2014). Australian and international research also finds that poverty, financial hardship, and income are risk factors for child death (Blakely, Atkinson, Blaiklock & d'Souza, 2003; Oberman & Meyer, 2008; Douglas & Mohn, 2014). Moore, Mcdonald & McHugh –Dillon (2014) report that living in a lower socio-economic community has been associated with the following child health-related factors: the risk of very preterm birth (Bonet et al., 2013); higher rates of maternal smoking during pregnancy (Phung et al., 2003); poorer rates of breastfeeding (Amir & Donath, 2008); a higher risk of SIDS (Highet & Goldwater, 2013) and higher levels of infant mortality (Hollowell et al., 2011).

Thurston and colleagues (2017), report that while no research has yet examined housing density and child maltreatment, housing density has been explored in child related public health research and there are strong links between a range of housing variables and child development outcomes. Children living in inadequate or overcrowded housing conditions have up to 25% higher risk of severe ill-health and disability during childhood (Harker, 2006; Shepherd et al., 2012). There is an association between overcrowded housing conditions and preterm delivery (Niedhammer et al., 2012). Poor housing, renting and frequent moves also impact parenting practices particularly for infants who spend most of their time indoors under parental supervision (Dockery, Ong, Kendall, Li & Colquhoun, 2013).

A significant proportion of Australians, especially single parents, experience disadvantage and social exclusion across their life time (McLachlan et al., 2013). Poorly resourced parents can find the demands of parenting overwhelming and this can impact negatively upon children (McFadden, et al 2013; Garfield et al, 2015). Overwhelming evidence has identified social exclusion and social isolation as a risk factor for child maltreatment (Kim & Maquire-Jack, 2015). A recent Australian study using the Child Social Exclusion Index found that children aged 0–14 years living in areas with a high risk of child social exclusion have higher rates of both potentially preventable hospitalisations and avoidable deaths (Mohanty, Edvardsson, Abello & Elridge, 2016). However, a small number of US studies argue that social exclusion has not been strongly linked to fatal maltreatment (Douglas, 2013; Chance & Scannapieco, 2002).

Summary

As Wolfe and colleagues (2014) argue, understanding why children die and taking action is important. As evidenced in this review, a nascent literature has begun to consider the possible risk and contextual factors associated with child death. However, the level of risk in each of these factors remains contested. What is consistently evident across national and international is that children who die:

- tend to be very young; the vast majority are under the age of four years and close to half are under the age of one year;
- are more likely to be males than females in cases of child abuse and neglect;
- are more likely to be from a minority group. Aboriginal and Torres Strait Islander children have higher odds of serious injury and death;
- are usually cared for by their mothers and that overall, women are more responsible for deaths that result from neglect and men are more responsible for deaths that result from abuse;
- from maltreatment are more likely to live in households where non-family members are present; and
- are underestimated in the number of fatal child maltreatment cases.

4. Characteristics and risk factors evident for children who died

The following section describes the key risk factors identified in the 11 subject children and their parent's lives, leading up to their birth and which were present when they died. It is important to reiterate that the risk factors identified have been considered by the coroner and unless otherwise stated, are not identified as the cause of death of the child. Using a socio-ecological lens, the findings are reported at the individual, parent and community levels.

The higher risk to infants is clear in that 10 of the 11 child deaths in this sample occurred before the children were twelve months old. Five of the deceased children were male and six were female. The coroner reports indicate that for many of these child deaths there was frequently no apparent or obvious reason as to why the child died and many of these child's deaths were recorded as undetermined or unascertained. Yet, all families were identified as experiencing one or more risk factors present in their lives at the time of the child's death (see Risk Matrix in Appendix B). In addition, there was clear indication that many of these families experienced structural and societal disadvantage. Due to the small numbers of this group of children other demographic data was not reported to maintain the confidentiality of children.

4.1 Individual risk factors

Although young children are not responsible for their health or any harm inflicted upon them, certain characteristics have been found to increase their risk of death. Individual risk factors are those characteristics associated with biological development, health and wellbeing, in utero and across childhood, disability and temperament (Australian Institute of Family Studies, 2017). This section of the report looks at the key individual risk factors which were identified in the 11 child deaths reviewed:

- child characteristics
- pregnancy and birth factors
- poor child health
- unsafe sleeping practices

4.1.2 Child characteristics

International studies describe a number of child characteristics that may increase the risk of child death (Damashek, Nelson & Bonner, 2013). Given their physical vulnerability, international and national research has consistently found that the youngest children are the most vulnerable to abuse and neglect related deaths as well as other causes such as Sudden Infant death Syndrome and Sudden Unexpected Death in Infancy (Welch & Bonner, 2013; CYPDRC, 2017). This was evident in this review where all but one child died under the age of one year old.

The international and Australian literature also highlights the over representation of some ethnic minority groups in child death due to the disadvantage and inequality

that they experience (Welch & Bonner, 2013). Aboriginal and Torres Strait Islander research indicates that poorer pregnancy outcomes are frequently experienced by Aboriginal mothers (Duong, Davis & Falhammar, 2015). Over three quarters of the sample of children in this review were identified as ethnically diverse children, with a number identifying as Aboriginal.

4.1.3 Pregnancy and birth factors

A lack of parental engagement in antenatal care was identified in a number of cases and was considered to be of particular concern where other risks were identified. Drug use, domestic violence and previous parent involvement in Child and Youth Protection Services were three key risk factors evident in files for mothers who had prenatal reports made to Child and Youth Protection Services.

While it is evident that services working with such parents undertake prenatal reporting, it was also apparent that prenatal reporting did not necessarily assist women to engage in antenatal care services except until very late into their pregnancy.

Low birth weight, disability and premature birth are also known to increase the risk of child death (Jonson-Reid, Chance, & Drake, 2007). Complications at birth, emergency caesarean and /or premature birth were evident for a number of the children. Approximately half the children were reported as experiencing physical conditions that compromised their health at birth.

The World Health Organization and the National Health and Medical Research Council in Australia recommend exclusive breastfeeding (i.e. no other fluids or solids) for six months and then continued breastfeeding combined with solid foods for 12-24 months or as long as mother and baby desire (National Health and Medical Research Council in Australia, 2012). Over half the children in this review were reported to begin breast feeding their child from birth with a very small number changing to a formula feed after a number of weeks. A small number of mothers bottle fed from birth.

4.1.4 Poor child health

Over half of the children were identified as immediately unwell prior to their death. Illnesses included colds, ear infections, breathing difficulties and runny stools. A number of children also were identified as failing to thrive in the early weeks of their life, although at the time of their death this had mostly been remedied.

Parents not accessing medical services and/or follow up treatment for their child was also a considerable issue identified in a number of the files. This meant for some children existing conditions were left untreated which exacerbated their health condition. It was also evident that a number of parents who had disengaged early from MACH services also failed to have their children immunised.

4.1.5 Unsafe sleeping practices

It is evident that co-sleeping was the preferred way to settle the child for many families in this review. Police reports described over two thirds of children as having unsettled behaviour hours prior to their death. These children were all described as requiring more attention than usual from parents and caregivers in order to settle them. Parents responded by supplying extra feeds, a change of nappy, extra warmth or most frequently, bringing the child into bed with them.

Research has shown that the child's sleeping position is a contributing factor to Sudden Infant Death Syndrome (Task Force Sudden Infant Death Syndrome, 2016). Co-sleeping was found to occur on the night of approximately three quarters of children who died. Illustrating that this practice is used by parents to settle their child, despite education programs over the last five decades highlighting the risks to children.

4.2. Parental risk factors

A key feature of the environments in which children develop is the extent to which parents and caregivers provide protection and support to their children. Concern about the influence of parental risk factors on child fatalities has resulted in research being undertaken to consider how parental characteristics either protect children or expose them to adverse experiences (Moore, McDonald & McHugh-Dillon, 2014).

This section of the report looks at the key parental risk factors which were identified in the 11 child deaths reviewed:

- parent characteristics
- domestic and family violence
- illicit drug and problematic alcohol use
- parental child protection history
- current child protection intervention
- criminal activity
- poor family relationships
- disability
- mental illness
- poor physical health

4.2.1 Parent Characteristics

Parent age is consistently reported within Australian and international studies as a risk factor for a child fatality (Damashek et al., 2013) and this was also apparent for parents of children in this review, where many parents were aged in their late teens and early twenties.

Parent attachment and parent child relationships are also influential for outcomes for children. Strong parent bonds and high levels of support are associated with

better outcomes for children (Wynter, Rowe, Tran & Fisher, 2016). A number of parents were identified as having strong attachment with their children, by workers. Case notes described parent child relationships such as "mother meeting child's needs" or "parent aware and responsive to the needs of the children". Yet it was also noted in the file data that parent's stress, limited understanding of child development, neglect and lack of empathy were evident in their parenting styles.

4.2.2 Domestic and family violence

Over half the families were noted to have experienced physical domestic or family violence both prior to the birth of the child as well as afterwards. It is evident from the police and child protection data that significant violence occurred for half of the families in the lead up to the child's death. The file data highlights that the majority of physical violence was perpetrated by the father or ex-male partner. Furthermore, a small number of male perpetrators had clearly engaged in violent relationships with other partners prior to the current relationship with the child's mother. This information was not always evident or carried forward in later file reports.

In addition, there were a number of families where it was apparent that both parents engaged in physical violence and that parents were described as being equally volatile. This violence was described as occurring after drug or alcohol use by both of the parents.

A small number of female perpetrators were also identified in the file data. Police records indicated that for a small number of women, coercive and controlling behaviours as well as physical violence was instigated by them towards the male partner. These women were also likely to be described as aggressive towards their children.

The majority of families refused to engage with domestic violence services. Those services that were engaged with families such as Child and Youth Protection generally noted that domestic violence was a risk factor but no further evidence was available in the files regarding interventions to reduce or prevent this issue. Limited case notes identified or reflected on the child's experience.

Alongside the experience of physical domestic violence, parental emotional, coercive and controlling behaviours were also noted in a number of children's files. Such behaviours included the father preventing the mother and subject child from accessing services. As a result, services often disengaged from the child and their family. While such services reported this concern to Child and Youth Protection Services, this issue did not typically meet the threshold to take action.

Mothers of children in these cases were also understood by workers to be the protectors of children, regardless of their own ongoing issues or problematic behaviours. Frederico and colleagues (2014) argue that the gender of the parents influences engagement patterns and intervention by care and protection services,

with workers often not engaging with fathers and assuming mothers to be the 'protector' of the child.

File data revealed that services focused their interventions on the mother/ child care-giving relationship and that fathers of children had the capacity to withdraw from or not engage in Child and Youth Protection assessment and intervention. Furthermore, where domestic violence was identified, services such as Maternal and Child Health nurses were required to visit families with two nurses. Due to staff shortages and service demands this meant that some of the most vulnerable families did not receive services as two nurses were not always available to visit.

4.2.3 Illicit drug and problematic alcohol use

Consistent with other research, children whose parents smoke tobacco or expose them to cigarette smoke have a higher risk of sudden infant death (Williams & Smith, 2015). Co-sleeping with a child greatly increases the risk for SIDS if one or both of the parents smoke (Zhang, & Wang, 2013). Nearly three quarters of the families in this review smoked tobacco, with five of them reporting co-sleeping with their child at the time of death.

File data also noted regular parental marijuana use for a number of families. Though marijuana itself is quite different from tobacco, the smoke produced when smoking marijuana, still contains many of the same chemicals as traditional cigarettes. For this reason, smoking marijuana around a newborn is thought to increase the risk of SIDS (Varner et al, 2014; Williams & Smith, 2015). Police reports provided after the death of the child also highlight the drowsy effect that drug use has on parents.

For those families where alcohol use was identified, alcohol was reported to be used by both fathers and mothers. Just less than half of the families were identified to have problematic alcohol use pre and post birth of the subject child.

The mothers use of alcohol was seldom reported in Child and Youth Protection file notes, although it was evident in police records after the death of the child, that a number of mothers had used alcohol at the time of their child's death, potentially altering their capacity to care for their child in the time leading up to the child's death.

A smaller number of families were reported to have been using other illicit drugs such as methamphetamines, ICE, crack cocaine, cocaine, and prescription and over the counter drugs and methadone. Assessment of parental drug use or planned interventions were frequently absent from file notes. A limited number of referrals to support services were apparent, although not specifically relating to substance use. It was apparent in many of the files which reported parental drug use that workers overly relied on the parent abstaining from using drugs or alcohol. In a very small number of cases, workers made a 'safety plan' developed with parents to protect children should the parent use drugs. However, it was also evident from a small number of Police reports that parents continued to use drugs while caring for their

child despite Child and Youth Protection and Corrective Services file notes indicating that parents were abstaining.

4.2.4 Parental child protection history

A number of the parents had been themselves previous clients of Child and Youth Protection. These parents had experienced significant sexual, physical and emotional abuse as well as neglect which resulted in them being placed in out of home care for varying periods of time.

Many of these parents were reported to have family members, siblings and half siblings living in a range of locations. However, all of these parents returned at some point in their child or young adulthood to live with their biological parents. Although few stayed for any length of time.

All mothers who had had previous involvement with Child and Youth Protection and the out of home care system were noted in Child and Youth Protection files to want a different childhood for their children than the one that they experienced.

4.2.5 Current child protection intervention

Families who have multiple and complex needs are frequently unable to meet the needs of their children and this increases a child's risk of abuse or neglect. Many of the children who died in this review were reported to Child and Youth Protection Services at the time of their death. However, half of the subject children who were known to Child and Youth Protection Services prior to their death had received multiple child concern reports within their life time, with a number receiving prenatal reports prior to their birth.

A small number of subject children had siblings who had also received multiple reports. Voluntary and mandatory reports are received by statutory child protection services. Mandatory reporters are required under the legislation to report non-accidental physical injury and sexual abuse (*Children and Young People Act 2008*). It is evident within the child concern reports for six subject children that a range of voluntary and mandatory reports were made to Child and Youth Protection Services. Types of abuse reported for these children included physical, sexual, emotional abuse and neglect. Alongside these categories, reports were also received about parental drug use, future risk concerns and family violence.

Furthermore, while sometimes only one category of abuse or neglect is reported to Child and Youth Protection Services, it was also common that a number of categories of abuse and neglect were reported. The types of abuse and neglect reported for children also differed across time revealing the increasing complexity of issues that the families experienced.

4.2.6 Criminal activity

All families who were known to Child and Youth Protection Services were also known to corrective services for their involvement with the police and/ or juvenile and adult corrective services. These families had both mothers and fathers involved in the

criminal justice process. Most parents had either been in prison or charged and convicted with offences such as drug use, theft, driving offences, assault or property damage.

File data highlights that most probation and parole interventions with the fathers in this review focus on drug use, anger management and other supervision orders such as accommodation requirements. The needs of the subject children were not evident in these interactions or in any file record.

4.2.7 Poor family relationships

Research on household characteristics of children who die indicate that most children live with their biological mother, with approximately a third to a half of children also living with their biological father (Douglas, 2017). Living with adults not related to the child has been found to increase the risk of death for a child (Palusci & Covington, 2014).

The Child Death Register reports on the relationship status of the parents; however, this data does not provide information about the quality of these relationships nor the child's living circumstances. Information regarding the living circumstances of the subject child is provided in Child and Youth Protection Service and ACT Housing files.

Parents known to Child and Youth Protection Services and ACT Housing clients were more likely to be in defacto or separated relationships than other parents. Limited data are available about the relationships of parents of subject children who were not either Child and Youth Protection Service or ACT Housing clients. However, the couple relationships of Child and Youth Protection Service or ACT Housing clients were reported in both ACT Housing and Child and Youth Protection Service files, as turbulent with significant conflict occurring that frequently lead to domestic violence episodes. Parents were reported as separating and reconciling repeatedly, partly due to the violent nature of their relationship and the need for safety. While the subject children in these families consistently lived with their mother, their relationship with both their parents was frequently reported as unpredictable and inconsistent.

Relationships with grandparents, aunts and other extended family members were also identified within the Child and Youth Protection Service files. Genograms represented often large families that included grandparents, aunts, uncle, cousins and siblings. The assemblage of families, the roles which family members offered and the levels of support provided, differed within the sample. The type of support provided by extended family included:

- social support - providing mothers of the subject child with company, family support and parenting advice
- care giver support - where usually grandparents or aunts provided care
- housing support - where parents and the subject child lives with grandparents and other siblings.

While the available data indicate that positive support was provided by extended families members, the data also highlight that there could be significant conflict as well as unhelpful interactions occurring at times within families. Such interactions included, drug and alcohol use, criminal activity and family and domestic violence.

4.2.8 Disability

The number of children who are living with a parent with cognitive impairment and who are referred for protective services is thought to be increasing. Parents with other disabilities are more likely than parents without disabilities to have their children removed (Office of the Public Advocate, 2015). While a small number of mothers identified with a disability, it was not recorded how this disability impacted them or their parenting. However, it was evident that available government financial support was not accessed by all those who identified with a disability despite their engagement with support services.

In addition data from youth detention and corrective service files also highlight that a number of parents had been identified when they were younger as having possible cognitive challenges. No diagnosis or further assessment was evident in files, but this data suggests that further follow up is required to ensure parents access the supports they need to parent.

4.2.9 Mental health

Parental mental illness is found to exist in a significant number of parents who have children that die. Yet, US control studies find that parental mental illness is as much evident in parents of non- fatal child abuse as it is in fatal child abuse cases and the relationship between mental illness and child death is largely unknown (De Bortoli, Coles, Dolan, 2013).

Over three quarters of the families of children in this review were reported as having one or more parents with a mental health issue. Under half of this group were found to have both parents with a mental health issue. A range of diagnoses were reported in the files and related to pre and post-natal depression and anxiety, post-traumatic stress disorder, psychosis and bipolar disorder.

Most files acknowledged that the parents mental state was a risk factor, however, there is limited information collected in the files regarding any interventions or treatment that address these concerns. Medication is discussed in a small number of files, with parents being reported as taking medication to manage anxiety and depression. Yet, a number of the most vulnerable mothers refused to take medication but it is unclear in the files if there were any other interventions provided to these parents.

Access to counselling for mental health conditions and domestic violence was noted in a number of files. Direct referrals made to counselling services were seldom evident and warm referrals were never reported on. It would appear from the file data that Child and Youth Protection Service workers provided information about

mental health services to individuals but there is no evidence to suggest if this was followed up by either a worker or the parent.

Waiting lists were another issue that prevented access to support when it was most needed. The small number of mothers who did make initial contact with a service about their mental health were referred on to another service where the waiting list was at a minimum three weeks and sometimes a number of months. There were no reports available in the files to indicate that accessing these services had been followed up by either the worker or parent.

The recognition of mental health issues in parents by family members and services was also identified as problematic. A small number of parents in the preceding weeks to their child's death contacted services and were identified in files as "*very flat*", "*financially destitute and* "*very depressed due to social circumstances*". Yet there was no indication that these parents received any follow up for mental health referrals or offers of support other than for them to contact community agencies for food vouchers.

4.2.10 Poor physical health

All families were recorded to have a parent with some type of physical health condition that either was present prior to the pregnancy or became apparent during the pregnancy. Some of the more common conditions included asthma, epilepsy, thyroid conditions, renal issues, and sexually transmitted infections. None of these conditions were reported in the files to have impacted upon the health and wellbeing of the mother or her child at the time of pregnancy or during child birth.

New conditions or issues that impacted upon the mother during the pregnancy included gestational diabetes and external injuries. Again, these conditions were reported in the files to have not impacted upon the health and wellbeing of the mother or her child at the time of pregnancy or during the child's birth.

A further issue that was evident in the files was the high Body Mass Index (BMI) of a number of parents. With eight of the families being reported to have high to very high BMI's.

4.3 Socio-economic and community risk factors

The circumstances in which children are born determine their exposure to environments that promote or compromise healthy development (Marmot & Wilkinson, 2006). The impact of socio-economic differences between children from advantaged and disadvantaged backgrounds is evident from a very early age and may account for considerable discrepancies across intergenerational health and welfare outcomes (Moore, et al, 2014).

This section of the report looks at the key socio-economic and community risk factors which were identified in the 11 child deaths reviewed:

- economic disadvantage
- inadequate housing
- limited service engagement
- poor social support

4.3.1 Economic disadvantage

Australian and international research finds that poverty, financial hardship, and low income are risk factors for child death (Douglas & Mohn, 2014). Living in a lower socio-economic community has been associated with the risk of very preterm birth and higher levels of infant mortality (Hollowell et al., 2011).

Half the number of the families in the sample were dependent on Centrelink as the main income for their family. These families also identified using non-government services for extra financial support and food vouchers. Half of the families were reported to have large personal debts.

The CDR reports on the employment of parents. Only half of this sample of fathers were being regularly employed at the time of the child's death and the majority of mother's identified as being on home duties. File data also indicated that these same families frequently reported financial stress that impacted upon their emotional and psychological health as well as the child's physical environment. File data highlights that a number of families struggled to supply their children with adequate and safe sleeping arrangements, nappies and baby formula milk.

4.3.2 Inadequate housing

Thurston and colleagues (2017), report that there are strong links between a range of housing variables and child development outcomes including pre-term delivery, a 25% higher risk of severe ill-health and disability during childhood (Shepherd et al., 2012).

A number of the families in this review experienced poor quality and/or insecure housing during their pregnancy and leading up to the subject child's death. The file data indicates that ACT Housing tenants and private tenants experienced considerable difficulties with the availability and the suitability of their housing. This required frequent moves (local and interstate) during the pre and post-natal period.

Unstable housing was a key feature of just over half of the cases. Records indicate that these families had no permanent secure housing, either due to not having a residence to live in or because the residence they had was deemed by the parent as unsuitable. Subsequently it was evident in the file data that a number of family members resided with each other as undeclared tenants, either staying with relatives or with their separated partner. This led to issues such as overcrowding and unsafe accommodation with violent ex-partners. Insecure housing after the birth of the subject child frequently remained present for mothers. Subsequently a number of children were identified as not having somewhere safe to sleep, instead they were being placed on unsuitable mattresses or sharing beds with parents.

Adequate housing was also compromised by family or neighbour conflict and many of the ACT Housing tenants were reported to have considerable housing debt and were in rental arrears. File data indicates that this provided further stress for family members and impacted upon their housing security. This was also particularly evident for fathers when coming out of jail.

The condition of the property was also another issue identified across cases. A number of families experienced poor housing conditions such as mould on the walls or fleas in the carpets. This required the house to be fumigated or refurbished.

Poor parental hygiene levels were also reported as an issue for a small number of subject children. A number of properties were described as in 'complete disrepair' with extreme clutter, rubbish, mould and broken household items being evident to workers who visited. Such parenting practices are particularly problematic for infants who spend most of their time indoors under parental supervision (Dockery, Ong, Kendall, Li & Colquhoun, 2013).

4.3.3 Limited service engagement

The broad picture of services involved with the children and their parents subject to this review is described below. Interventions on behalf of the children's siblings are not included here.

4.3.3.1 Universal and targeted services

File data describes that all parents of subject children in this review were voluntarily engaged in (universal) health services at some point, either during the subject child's pregnancy or leading up to the subject child's death. Health services were used for the parents and child's health concerns and included General Practitioners, hospital emergency departments and antenatal care.

While there was a range of Aboriginal and culturally diverse families in the sample, few were reported to have used culturally defined services in either the pre or post-natal period.

Although few subject children or their families were engaged in targeted services, a small number of mothers voluntarily engaged in paediatric clinics and with psychologists, family support services and parenting programs. File data highlights that targeted drug and alcohol services were only provided to fathers if it was directed through probation and parole, or if they were using the methadone program. No interventions were described as being accessed by mothers, despite frequent child concern reports of their drug use. However, a number of parents did describe to workers that they did not rely on services for drug interventions but relied upon themselves or their partner to reduce or monitor their drug use.

4.3.3.2 Post-natal care

All families who went home with their children from hospital after their birth received MACH services in the home and through clinics at the Child and Family Centres and other local health clinics.

Targeted health services were also provided to children who had a parent with a specific issue such as a problematic drug and/or alcohol use or who were considered a 'young parent'. These targeted services were provided through the Pregnancy Enhancement Program (PEP), the Blue Star Clinic and Winnunga Nimmityjah Aboriginal Health Services.

A key issue for a number of subject children was that their parents did not always attend appointments with these clinics or attend their appointments for immunisations. Where possible MACH and PEP nurses would sometimes make unannounced home visits, however, this was not always fruitful either and parents were either not home or refused to answer the door. Subsequently a number of children did not receive regular post-natal checks once they returned home from hospital.

4.3.3.3 Non-voluntary service engagement

Many of the families of the subject children in this review were involved with services in a non-voluntary capacity. Children and Youth Protection Services, Corrective Services and the Police were key services identified in file data that frequently interacted with just over half of the parents. It was evident that while these services did not provide any therapeutic or ongoing family support, they did offer parents referrals to other services such as family support and domestic violence services. It is unclear in the file data as to how many of these referrals were actively made by these services or followed up by the parent or, if in fact, they were just suggested to the parent as possible avenues of support.

For other cases it is evident that Child and Youth Protection Service workers have gone to great lengths to try and engage parents in services but that the parent refuses to participate in any intervention. Despite this, these cases were frequently closed due to insufficient evidence of any significant harm to the child or that the level of abuse or neglect was not deemed significant enough for Child and Youth Protection Service to take further action.

Not meeting the threshold was commonly reported in files as the reason for case closure in this sample of children. This was despite often large numbers of reports of domestic violence and drug use and worker accounts of squalor, neglect and disinterest of engaging with any service.

Cases were also closed when other services such as schools were able to observe families and report back to Child and Youth Protection Service. Services with surveillance opportunities which assist in the ongoing monitoring of the family (although not necessarily the subject child) were considered important factors in determining case closure.

4.3.3.4 Assessment and outcomes

For parents to be fully engaged in services there must be a shared purpose and understanding of what the issue is and what outcomes are being sought. How parents and care-givers define and appraise the problems they face is clearly a key

issue in relation to seeking out and engaging with support services (Featherstone & Broadhurst, 2003).

It was evident in Child and Youth Protection Service file data that while case notes and appraisal documents indicate that referrals for further support have been offered by workers, the purpose of this support was sometimes unclear. For example, case workers commonly talked about offering referrals for 'further support' or for 'family support' yet file notes did not indicate the specific type of support required or the outcomes that workers or the families were seeking.

For those families where an appraisal was undertaken, it was unclear as to how workers made their assessment concerning the needs of children and parents. Assessment reports predominantly focus on the observations of workers and the information provided by parents. Inconsistency of workers who provided these subjective reports was also problematic. Furthermore many of the assessments only reported on the advised abuse or neglect and did not report on what was possibly missing in the parent child relationship such as parental warmth, empathy, consistency or self-efficacy.

Where attachment and parental skills and knowledge are addressed in case notes it is unclear how this was assessed. File notes of parental attachment, skills and knowledge include reports such as 'Mother *appears to respond to child's needs' or 'Parents respond appropriately to child'*. There do not appear to be any consistently used assessment processes or validated assessment tools utilised by case workers to assess parents and children and reports vary in the amount of information provided by workers.

Services (other than probation and parole) rely heavily on feedback and assurances by parents about issues such as drug use and domestic violence. This was despite evidence to suggest that the parent was unable to guarantee the safety of the child due to either their drug use or the violence that was occurring in the home. Police reports at the time of child's death indicated that parent reporting about their drug use and domestic violence to Child and Youth Protection Services may not have been correct.

Robust justification for the decisions made about children was also absent from many files. While decisions are recorded in case notes, there is frequently limited reasons given as to why case workers came to this conclusion. A number of files also highlight protective factors evident in the subject child's life as reasons to close cases. Evidence to suggest that these protective factors had been tested by workers was absent. It was apparent for a number of children that sibling protective factors were used as a justification to not intervene for the subject child. However, some of these factors such as contact with school, were also untested and possibly irrelevant for the subject child.

4.3.4 Poor social support

Poor social support and low levels of social capital have all been associated with increased rates of postnatal maternal depressive symptoms and poorer maternal health. Furthermore, children from families that report low social support have a higher risk of poor health outcomes (Moore et al, 2015).

File data about the children subject to this review largely identified that their families had lower levels of social support at the time of the subject child's death. In two thirds of the cases it was evident that families identified feeling socially excluded or isolated and frequently did not engage in any service despite sometimes experiencing considerable social issues.

Moving house was reported by parents as not only increasing their stress levels but also frequently reducing the family's social connections, leaving them feeling alone and without familiar and trusted friends and family members. Families who moved multiple times also were reported as often choosing to stay home as it was also stressful to engage in new adult social interactions.

Peer groups were also another important factor identified in the file data. It was evident in some files that peers were an important part of parents support, however, not all peer groups had a positive influence on parents, particularly for those who used illicit drugs. Parents who in their effort to not use drugs also reported that they lost many of their friendship groups by keeping away from these peer groups. Subsequently a number of families were mostly reliant on formal services for support.

5. Implications for Policy and Practice

The Committee reviewed 11 child death cases of children aged between zero and three years of age. Five of the children were males and six female. Three quarters of the subject children were identified as having ethnically diverse backgrounds. All but one of these children died before their first birthday.

This group review was not about determining the cause of death, as this had already been determined by the Coroner, nor was it focused on who to blame. On the contrary, this review provides a comprehensive mechanism to consider the complex interrelating risk factors that existed prior to the child's death. It aims to offer a better understanding of the risk factors involved in children's lives and provide ways in which policy and practice could be developed or enhanced to better protect and meet the needs of vulnerable children.

The risk factors identified in the lives of subject children in this review are not new to those working with children and their families. International and Australian research and other recent reviews[2] highlight that child characteristics, parental risk factors, service engagement and practice issues are key factors contributing to child deaths. In addition, the findings of this review align with many of the findings from these earlier reviews.

This review adds to our contemporary knowledge about the extent and nature of risk factors experienced by children in the ACT prior to their death and highlights the complexity of issues experienced by parents and subject children leading up to their death. This review also illustrates the systemic and procedural challenges that exist and which may exacerbate conditions in which children live in.

This chapter identifies a number of opportunities to strengthen the way children and their families are supported and responded to by the systems that they engage with. Consistent with the functions of the Committee set out in the legislation, this chapter draws attention to the key issues identified within lives of children who died. It discusses the implications for policy and practice and considers possible ways to enhance responses to children and their families in order to address the risks evident in children's lives.

Recommendations can be found in Section 1.

[2] The 2016 Review of System Level Responses to Family Violence in the ACT, the 2016 Muir Report, the 2016 Child Protection Systems Royal Commission in South Australia and the 2016 Victorian Inquiry into issues of family violence in child deaths

5.1 Key risk factors in the lives of children

All families were identified as experiencing one or more risk factors present in their lives at the time of the child's death. Such risks considerably increased the vulnerability of children.

5.1.1 Age of the child

Consistent with the ACT Annual Report data (CYPDRC, 2017), and other child death reviews (Murray & Mackie, 2006), the vulnerability of infant children continues to be evident, in that the majority of children in this review died before the age of one. For a number of children the identification of risk of future harm relating to domestic violence and drug use was reported multiple times prior to the birth of the child. Infants are totally dependent on caregivers for their safety and wellbeing. This review further illustrates that younger children's limited communication and mobility do not provide any measure of self-protection against the risks that confront them. There is a continued need for services to review how they may better respond to the needs of vulnerable younger children in order to reduce the likelihood of child death in the first two years of life.

5.1.2 Unsafe sleeping environments

Unsafe sleeping surfaces have been implicated in child deaths for many years and parent and professional education strategies concerning co-sleeping and legislation and regulation changes in regard to children's bedding to meet Australian safety standards have been two key approaches utilised to reduce the risk of child death (Moon, Hauck & Colson, 2016). This review revealed that despite strong evidence concerning the risks associated with co-sleeping and child death (Task Force on Sudden Infant Death Syndrome, 2016), many of the parents of these children continued to engage in this practice, particularly when breast feeding or when trying to sooth their child. In addition, this review found that a number of subject children were being placed on unsafe sleeping surfaces either due to parents using inadequate bedding that did not meet Australian safety standards, or because children did not have bedding of their own and were placed on shared sleeping surfaces. Moreover, overheating was also identified as a key risk to children. A number of children were placed in over warm conditions, intensified by portable electric heaters or with the use of thick blankets and loose covers.

Across Australia, a number of states have developed guidelines and safe sleeping standards designed to be implemented across systems. These are informed by the available evidence about risk factors in the infant sleeping environment as well as current professional practice and consumer needs which apply to all families with infants from birth through to 12 months of age (Government of South Australia, 2011; Queensland Health, 2013).

In 2006, the ACT Murray-Mackie review recommended that a joint project between the Office for Children, Youth and Family Support and ACT Health be undertaken to develop and implement a territory wide policy to be followed by all relevant staff

about the provision of information to new and expecting parents about safe sleeping practices. This recommendation was also to include the development of a training package by ACT Health that includes culturally appropriate materials and communication strategies that convey consistent messages about safe sleeping, particularly to high risk and vulnerable families.

Currently both ACT Health and Child and Youth Protection Services provide safe sleeping advice based upon guidelines from RedNose. Child and Youth Protection Services also have practice guidelines that indicate that in some instances, they may provide assistance to families to purchase a bassinet or cot for the infant. However, the provision of this type of support was not evident in the children's files.

There is a continued need to emphasise safe infant sleeping promotion, co-sleeping and bed-sharing messages and to ensure that these are delivered consistently across the continuum of services by ensuring professionals/providers have access to evidence-based training and resources. Furthermore, parents on low incomes need to be supported to access safe and appropriate bedding for the children.

5.1.3 Multiple risk factors in children's lives

The co-existence of multiple risk factors for children was evident for over half of the families in this review. Children experienced a range of individual, family, community and socio-economic risk factors, irrespective of socio-economic status. These risk factors were also evident in the lives of many of the families prior to the birth of child and frequently remained in the lives of subject children in the lead up to their death.

The analysis of 16 principle risk factors evident prior to birth (see Appendix B) and leading to child's death indicates that for six of the 11 children, life was chaotic with more than half of the 16 risk factors present. The Committee noted that given the gaps in records, this critical contextual information is likely understated.

Many of the risk factors associated with child maltreatment and child death such as younger caregivers, three or more children under the age of five living in the home, children who live with a non-biological caregiver (Miyamoto et al, 2016) were identified in the lives of the subject children. Child characteristics such as low birth weight, poor health and prematurity were also apparent for many children. Parental risk factors evident in families included parental drug and alcohol use, mental and physical health concerns, parental history of and current involvement with child protection services and parent relationships with high conflict and/or family and domestic violence present. Community and socio-economic risk factors included limited social supports, poverty and disadvantage and unstable housing.

It is important to note that the presence or absence of these risk factors does not necessarily mean that child death will or will not occur. However, parental risk factors which included, domestic violence, drug and alcohol use and unstable housing were prominent issues that affected at least half of the subject children in this review and were understood to considerably increase the subject child's vulnerability. Where this combination of risk factors are identified in children's lives, it

is critical that services working with families assess each of the parent's capacity to understand and respond to the child's needs. Furthermore it is important that services work holistically to reduce the impact of this combination of risks on the child.

5.2 Systemic factors

5.2.1 Recognising and responding to cumulative risk

While the risk factors experienced by children are well documented in the file data, the Committee found there to be considerable concerns with how services assess and respond to cumulative risks experienced by children. Data analysed from child concern and appraisal reports highlight that many assessments focus on the episodic events of abuse and neglect and are less focused on children's developmental wellbeing and the patterns of abuse and neglect of the subject child and their siblings over time. There is little evidence that the risk of cumulative harm was considered or that the vulnerability of the subject child and their family was assessed. It is also of concern that for a number of cases, certain risk factors such as parental drug use and domestic violence escalated over the time of the child's life but that this was not recognised or responded to in new child concern report assessments or decisions.

The findings also indicate the complexities of working with families where cumulative risks are evident, as well as the challenges of engaging parents in interventions to address these concerns. Due to many of these events not meeting the 'threshold' to intervene, most responses to these reports tended to focus on referrals to family support services. What was evident in the file data was that a pattern of reporting and referral was established between external services and Child and Youth Protection Services, resulting in high numbers of reports for children and a continued lack of effective interventions for families.

A number of parents in this review were unwilling to engage in services, however, there was little analysis provided in file data to understand parent reasons for this. Parents are less likely to engage in services if they feel inadequate, stressed or threatened by the service, or cannot see its practical benefits. However, international research indicates that any persistent displays of avoidant, hostile or resistant behaviour should be taken very seriously. Research consistently shows that this behaviour can be a predictive factor for fatal child abuse and neglect (Chance & Scannapieco, 2002). The file notes illustrated a lack of documentation regarding whether or not referrals were followed up by workers for families where there was no official statutory intervention. it was evident from further child concern reports that services either had failed to engage with families, or that families did not connect with the service after referral. This left key issues such as parental drug use and domestic violence unresolved and subject children remained at risk.

For those families engaged in statutory services, it was apparent that difficulties in pinpointing the influence or effect of particular risk factors makes it problematic for workers when assessing and responding to families. However, recent research from Europe and the US, highlights the importance of recognising that there is not one single factor that is solely related to child abuse and neglect and that most child abuse occurs in families where there is a combination of risk factors (Patwardhan, Hurley, Thompson, Mason, & Ringle, 2017).

Current research indicates that the effect of cumulative risk may follow a non-linear threshold effect where by once a family reaches a critical number of risk factors (three risk factors) the chances for child abuse and neglect significantly increases (Lamela & Figueiredo, 2015). This hypothesis challenges previous ideas that every additional risk experienced by the family increases the probability of negative child outcomes and highlights that actions need to be taken to decrease the number of risks, rather than targeting certain family risk factors independently. Subsequently it is imperative that responses to cumulative risk target accumulated risks simultaneously and focus on decreasing the number of risks rather than only targeting certain risk factors individually.

5.2.2 Recognising and responding to intergenerational trauma

Childhood trauma is one of Australia's most important public health concerns and is associated with substantial costs to the individual and society (Magruder, McLaughlin & Borbon, 2017). The recognition of such costs has resulted in reforms to ACT Child and Youth Protection Services, and the development of trauma informed services for vulnerable children and young people. However, this review found that a considerable number of parents of subject children had also experienced trauma across their own lifetime.

Of concern to the Committee were the patterns of harm amongst parents and children and the intergenerational involvement of statutory systems. In nearly all cases of cumulative harm, it was evident that the risk factors identified in the subject children's lives had also been evident in their parent's lives when they were children, and for some, in their grandparent's lives, particularly where there were issues of domestic violence, drug and alcohol use, housing instability and statutory child protection intervention.

Research indicates that childhood trauma can have consequences on the functioning of an adult brain and subsequently can, in some individuals, affect their capacity to parent (DeGregio, 2013). File data revealed that despite case notes often acknowledging the child abuse and neglect that parents had themselves been subject to, the assessment and responses to this were often inadequate or absent. Frequently these parents were described as perpetrators and/or uncooperative and hard to engage. Furthermore, it was evident that these parents were often younger in age and were either involved in the Criminal Justice System or had previously been a client the Child and Youth Protection System in the three

years preceding the birth of their child. Many of these parents indicated that they wanted different futures for their children. However, there was also evidence of families being re-traumatised by some of the services they came into contact with.

While the introduction of a trauma informed service system in the ACT is to be applauded, it is imperative that services working with parents who have experienced intergenerational trauma, respond to their needs in ways that are sensitive to the trauma that they have experienced. There is a need for all services working with vulnerable children and their families to ensure that their involvement with statutory services does not lead to re-traumatisation and that opportunities for intervention are realised early, so that young people becoming parents can break the cycle of intergenerational trauma.

5.2.3 Assessment of parenting capacity

Mothers' and fathers' perceptions of their ability to parent is a critical mechanism guiding their interactions with their child (Morawska, Sanders, & Haslam 2014). The Committee found that the assessment of parenting was often inadequate and predominantly focused on whether the reported abuse or neglect was evident and whether the risks to the child met the 'threshold' for statutory child protection to take action. Parenting assessments rarely reflected the parent's capacity and ability to take on new parenting skills to care for child and improve their child's outcomes. As noted above, the assessment of the impact of intergenerational trauma on parents own parenting skills and knowledge was also inadequate.

The Committee found that a number of parents demonstrated low levels of understanding about the needs of their child which was not addressed by workers. This included cases where parents did not reflect the necessary empathy with their child, often placing their child at significant risk of harm through either neglecting their needs or by placing them in unsafe situations. However, in many of these instances, the file data reported that these actions did not meet the threshold for statutory services to intervene. This was particularly evident with cases involving domestic violence and drug and alcohol use. Despite sometimes significant harm perpetrated by one or both parents towards one another, many of the parent relationships continued. While the parenting assessments acknowledged this risk was present, they did not demonstrate any appreciation of the risk of harm to the child.

A further complication that was recognised within the assessment of parenting capacity was that in cases where multiple child concern reports were made, it was frequently different workers that undertook new assessments and appraisals of parents. This change in worker may have resulted in a lack of consistency of knowledge about the family situation and a lack of consistency in the assessments being undertaken, as most assessment appeared to be based upon worker observation of the parent and child.

While the observations of child protection workers and experienced staff hold considerable weight, validated and objective measures also provide critical evidence of a parent's perception of their ability to understand and care for their child as well as being sensitive to the developmental needs of their child. Adopting the use of standardised empirically validated assessment tools would provide more consistency across assessments and appraisals, reduce the risk of value based judgements and accommodate for staff changes. Furthermore, this type of assessment would also provide concrete and measurable data for parents and workers to understand the types of behaviours or issues that need to change. It would also allow a comparison of any changes to parent attributes, behaviours, feelings or skills when new concern reports are received.

5.2.4 Invisible children

A recent focus upon children's rights and sociological understandings of children and childhood has led to the acknowledgement that children deserve at least the same right to protection and support as adults. Article 12 of the *UN Convention on the Rights of the Child,* states that children have the right to be heard and to have their views given in all matters affecting them (United Nations Committee on the Rights of the Child, 1989). In all of Australia's statutory child protection systems, the States and Territories have incorporated the Convention's principle of participation and it is widely accepted within child protection practice that to understand and adequately assess the risks to children, children must be provided with these rights (Cashmore, 2002; Willow, 2010).

Ferguson (2017) argues that in child protection cases in which children have died or been seriously injured, the professionals working with the family have not sufficiently connected or engaged with the children. As a result, the child's experiences are not understood and they have become invisible to the services surrounding them. The file data of subject children in this review frequently illustrated that all children reported to statutory child protection services were observed by a caseworker if the report reached the threshold for the appraisal process. However, child assessments undertaken by the child protection worker were generally based upon a brief observation of the child and the child/ parent interaction. File data also showed that case workers were often adult focused in their assessment and interventions and were frequently found to over-identify with parents, losing focus on the needs of the child.

The ability for young children to have a voice in or participate in decisions is limited due to their developmental stage (Coyne, Amory, Kiernan & Gibson, 2014). File data illustrated that frequently the child's experience and the impact of, in particular, domestic violence, parental drug and alcohol use and inadequate housing, was largely unexplored by professionals and rarely responded to. Subsequently it remains critical that child protection workers ensure that they are extra vigilant when assessing the care needs of young children and that children's experiences remain at the centre of any assessment and interventions.

In addition to the invisibility of children found in child protection case work, adult services such as ACT Housing and Corrective Services who work with parents, were also found to be often unaware of the children of parents connected to their services. Apart from reports to statutory child protection, services rarely considered the child's experience or demonstrated any understanding about the impact that the parent problems may have had on the subject child. There is a need to build organisational and workplace cultures that embrace a range of practices and attitudes that aim to keep the 'child in mind'. Further work is required to develop and support systems to be aware of and to engage with young children in more meaningful ways.

5.2.5 Gendered service responses

The absence of any analysis within the file data which places gender at the core of child protection and health care practice raises serious questions about how mothers and fathers are constructed and their roles defined by the services they interact with. It is evident that constructions of femininity and masculinity within services underpin understandings of and responses to children and young people.

The dichotomies of mothers as protectors and victims and fathers as absent or perpetrators were apparent in many of the files. When an appraisal is undertaken by Child and Youth Protection Services and where assessments of parenting capacity are made, the Committee found that the mother is most commonly seen by workers as the carer and protector of the child. Subsequently it is the mother who is held responsible for the child's safety and who is required to participate and engage in the appraisal process. Mothers are also commonly the focus of any service interaction or intervention. This responsibility was further reinforced by fathers being systematically excluded from services, despite the clear evidence that they were parenting the subject child and maintaining a relationship with the mother.

The Committee also found that workers continued to focus on the mother as a protector despite any issues that the mother may be experiencing, such as problematic drug or alcohol use. This review found that a number of mothers experienced considerable issues and engaged in risky behaviours which significantly impacted upon the safety and wellbeing of the subject child. Such behaviours were seen to be overlooked and unchallenged by workers. This was particularly evident in cases of neglect, physical abuse, domestic violence and drug and alcohol use.

As noted earlier, intergenerational trauma was also noted in the lives of a number of both mothers and fathers. Research highlights that it is critical that a gender perspective be taken regarding the impact of trauma on individuals as there are also important gender differences in the rates and impact as well as responses to trauma for both males and females. Both males and females are found to respond to trauma with anger and disassociation, and females are also considerably at risk of anxiety and depression (Asscher, Van der Put & Stams, 2015). International research indicates that sensitivity to gender and the variation of responses to trauma

between genders is not to excuse a person's behaviour or remove the need to hold them accountable, but to ensure that policy and practice development recognise the different perceptions, experiences and needs of women and men.

5.2.6 Recording and sharing information

Workers from both government and non-government services provide critical supports to families in often very challenging circumstances and with limited resources. This work is essential to the prevention of child deaths as well as keeping children safe and enhancing their wellbeing. The Committee wishes to recognise the critical nature of this work and the positive contribution that workers across these organisations make to the lives of children and their families.

One of the key ways that government and non-government organisations services work together to support families is through the recording and sharing of information. Research highlights that there are considerable benefits to the exchange of personal information about children and their families, and that this has been found to improve quality of care, the safety of children and remove the burden on clients of retelling their story multiple times (Keeley et al, 2015).

However, numerous inquiries have found that the failure to share personal information in the child protection context has led to serious injury or death of a child or young person (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; State of Victoria, 2016). Moreover, other State and Territory child death reviews have frequently found that there is a tendency to emphasise the protection of the information in legislation and policy (Adams & Lee Jones, 2017 p.1355). Structural and regulatory elements such as a lack of agreed processes and legal frameworks that govern information sharing as well as risk aversion from staff and stakeholders also prevent the sharing of information where necessary and appropriate.

The Committee has observed that critical information may not have been shared with important stakeholders and that in some instances information was not followed up on or adequately tested. The Committee noted that the Child and Youth Protection Services file documents sometimes lacked information which had previously been recorded elsewhere in earlier reports and that incomplete and blank documents meant that workers did not always review information previously provided about a child.

Access to relevant information is a significant issue for those making informed decisions about the safety and wellbeing of children. Limited information was available concerning the views of extended family or other professionals, suggesting that these sources of information were not accessed or utilised. Conversely, there was a considerable reliance by workers on parent self-reports in relation to the child's needs and about the issues that they or the family were experiencing, many of which remained untested, particularly in relation to drug use.

As noted earlier, the Committee acknowledges that due to the methodology of this review, the emphasis of the findings and recommendations focus on key services, in particular, Child and Youth Protection Services and ACT Health Services. However, half of the children included in this review were not known by Child and Youth Protection Services. Yet health files and reports received from police after the death of the child indicated that children had been exposed to a range of risk factors before their death. A range of support services are available to children and their families living in the ACT and it is important to recognise and reiterate that all services working with children and their families have a responsibility for the safety and wellbeing of children.

For those children who were clients of Child and Youth Protection Services, there is a need for an approach to be taken to find an appropriate balance between competing rights in privacy and child protection legislation. This approach differs across the Australian states and territories. In South Australia, the Government has endorsed Information Sharing Guidelines for Promoting Safety and Wellbeing (South Australian Government, Ombudsman SA, 2013, p. 5). These provisions establish a flow of information to and from the child protection agency. In the ACT, prescribed bodies—which include parents, guardians, police, health, education, and other service providers—are required to provide information to, and can request information from Child and Youth Protection Services (*Children and Young People Act 2008* ss. 860 (2), 862). In order for such prescribed bodies to share information with each other, however, Child and Youth Protection Services must establish a care team with defined membership (*Children and Young People Act 2008* (ACT) div. 25.3.2). Members of the Committee strongly support crosswise information sharing in a positive framework, where it is understood by the client to be in their best interests, and in particular, the interests of the child who is potentially at risk.

5.2.7 The need for safe and affordable housing

A major influence on a child's life is a safe and secure environment which is directly influenced by a family's housing conditions (Dockery, et al., 2013). There is a wide range of housing situations that can affect children's health, including insecurity and frequent moves, crowding, low and high indoor temperatures (related to poverty), dampness, and features increasing the risk of physical injuries (Ormandy, 2014).

It is evident that for a number of subject children, unstable and unsuitable housing was an issue for both them and their parents. Not only did insecure and hazardous housing conditions contribute to unsafe sleeping practices, but these also contributed to a less than optimum safe sleeping environment for infant children who were exposed to squalid conditions, mould, damp, fleas, building work, and unwanted pollutants. Housing debt also impacted upon the parents and subject children's housing stability.

Unsatisfactory housing is dangerous and can have serious health outcomes, particularly for children. At the broader system level, it is clear that early intervention to prevent homelessness occurring in the first place is critical. There is a clear need

for parents to be supported to obtain stable and adequate housing prior to the birth of their child and to be better supported to maintain this. Averting homelessness is much less damaging for the families involved and far more efficient in terms of community resources.

For those parents leaving care or who have been clients of Child and Youth Protection Services, there needs to be early planning concerning the provision of stable housing and for parents to receive on-going services by Child and Youth Protection Services if required as well as from other support services parents maybe engaged in. It is suggested that priority housing services are likely to be needed for this group of parents.

All services need to take responsibility for assessing and responding to the needs of children. Many services, including housing services, incorrectly see Child and Youth Protection Services as having the 'magic wand' to protect a child, which they lack. Increasing safety for children is a community responsibility and it is important that all professionals working with vulnerable families look beyond their role to ensure that a child is safe and to act with the best interests of the child as a primary consideration.

5.2.8. Supporting families under pressure

The information reviewed by the Committee found that many of the subject children's families did not have the necessary natural support groups that underpin good parenting outcomes. This was particularly evident for sole parent families or where the support from partners was unavailable. While universal health services were accessed by all parents of subject children at some point over the life of the child, many parents considerably relied on their own limited resources to address the challenges they faced.

Irrespective of socio-economic status, families in this review also experienced significant emotional stress and physical and mental health issues. Such experiences were seen to have a direct impact on children, in that for many of the parent's, their availability and capacity to respond to their children's needs were often seen to be comprised. For those parents with limited income this also resulted in basic necessities such as safe bedding and formula feed not always available for children. As noted earlier, housing was also a considerable issue. Low incomes and limited housing affordability also meant that a number of children experienced housing instability and frequent moves both within Canberra and from interstate.

Despite having contact with both health and statutory services, parents often identified as unsupported and isolated and experiencing considerable stress. Within the scope of parental health, parental stress is a well-established risk factor for adverse child outcomes (Crum & Moreland, 2017). Stress results from the pressure of challenging and difficult circumstances and can result in individuals not being able to meet the demands placed upon them. Stress can be seen to have a negative effect on the mood or behaviour of a person and for parents, this may extend beyond the impact on themselves and negatively impact upon their relationship

with their child (Maguire-Jack & Negash, 2016). Yet, parental stress was not explicitly identified as a risk factor in files, nor was there evidence that this risk factor was taken into consideration in how it might affect parental availability and responsiveness in either the appraisal or referral process.

It is critical that education and training should be provided to workers about the important role parenting stress plays in child abuse and neglect, how this may be assessed and the possible opportunities to interrupt the pathway from stress to abuse and neglect.

Research has shown that parental engagement in services provides a protective effect for children, particularly in relation to neglect and physical abuse (Maguire-Jack & Negash, 2016). While a number of parents who came into contact with services were identified as having referrals made for them to access support services, particularly services focused on mental health support, extensive delays and waiting lists to access these services were noted in case files. For those families where there were no statuary concerns identified, and the case was closed, it was seldom evident that the referral had been successful or that parents had accessed the support service before the case was closed. On-going and seamless support services are critical for vulnerable families.

5.2.9 Conclusion

This review set out to consider the risk factors evident in the lives of 11 children who died in the ACT prior to 2014 and who were subject to a closed coronial inquiry. As outlined in the *Children and Young People Act 2008*, the recommendations of this review have been made to improve policy, programme or practice responses for children and their families in order to reduce the likelihood of child death and to decrease the number of preventable deaths of children in the ACT.

The Committee acknowledges the considerable work of the ACT services working with families with children under the age of three years. Similar to other jurisdictions, the ACT child protection system receives a significant and growing number of reports concerning children each year. Many of the issues reported are often complex and demand considerable time and expertise of workers. Current service systems designed to meet the needs of these families and address the risks to children frequently lack capacity to meet these demands.

This review echoes many of the findings of previous reviews undertaken in the ACT and across Australia and highlights that the challenges experienced by the ACT are similar to many other jurisdictions. The challenges raised in this review are systemic and procedural issues that sit against the social and economic context of vulnerable families.

Specific recommendations can be found in Section 1.

6. References

Adams, C. & Lee-Jones, K. (2017) Sharing personal information in the child protection context: impediments in the Australian legal framework. *Child and Family Social Work*. 22, 4, p. 1349-1356 8 p.

Alder, C., & Polk, K. (2001). Child victims of homicide. Cambridge: Cambridge University Press.

Amir, L. H., & Donath, S. M. (2008). Socioeconomic status and rates of breastfeeding in Australia: evidence from three recent national health surveys. Med J Aust, 189(5), 254-256.

Anthony, E. K., Austin, M. J., & Cormier, D. R. (2010). Early detection of prenatal substance exposure and the role of child welfare. Children & Youth Services Review, 32(1), 6–11.

Ashman, A. M., Collins, C. E., Weatherall, L., Brown, L. J., Rollo, M. E., Clausen, D., ... & Lumbers, E. R. (2016). A cohort of Indigenous Australian women and their children through pregnancy and beyond: the Gomeroi gaaynggal study. *Journal of developmental origins of health and disease*, *7*(4), 357-368.

Asscher, J. J., Van der Put, C. E., & Stams, G. J. J. M. (2015). Gender Differences in the Impact of Abuse and Neglect Victimization on Adolescent Offending Behavior. *Journal of Family Violence*, *30*, 215–225. http://doi.org/10.1007/s10896-014-9668-4

Auditor General (2013) Care and Protection System. REPORT NO. 01/2013. Retrieved from: https://www.audit.act.gov.au/__data/assets/pdf_file/0007/1179871/Report-1-2013-Care-and-Protection-System.pdf

Australian Bureau of Statistics (2016) 3301.0 - Births, Australia, 2015. Births by State and Territory. Retrieved From:http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3301.0Main%20Features52015?opendocument&tabname=Summary&prodno=3301.0&issue=2015&num=&view

Australian Bureau of Statistics (2016a) Deaths, Australia 2015 retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3302.0

Australian Capital Territory Children and Young People Death Review Committee (2017) Annual Report 2016. ACT children and Young people Death review committee. Canberra

Australian Institute of Health and Welfare (2010). *National Health-care Agreement: P20-Potentially avoidable deaths, 2010,* viewed 20/11/2014, <http://meteor.aihw.gov.au/content/index.phtml/itemId/394495>

Australian Institute of Health and Welfare (2012). *Premature mortality in Australia 1997–2012*. Retrieved from http://www.aihw.gov.au/deaths/premature-mortality/ages-0-1/

Australian Institute of Health and Welfare (2014) Deaths. Retrieved from: http://www.aihw.gov.au/deaths/

Australian Institute of Health and Welfare (2014a). Indigenous Child Safety. Cat. No. IHW 127. Canberra, ACT: AIHW. Retrieved from: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547837.

Australian Institute of Health and Welfare (2017a). Child protection Australia 2015–16. Child Welfare series no. 66. Cat. no. CWS 60. Canberra: AIHW.

Australian Institute of Health and Welfare (2017) Age at Death: Child deaths. Retrieved from http://www.aihw.gov.au/deaths/age-at-death/#child

Australian Institute of Family Studies (2017) Risk and protective factors for child abuse and neglect. Retrieved from https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect

Australian Royal Commission into Institutional Responses to Child Sexual Abuse, (2015). Final Report: Volume 8, Recordkeeping and information sharing. Retrieved from https://www.childabuseroyalcommission.gov.au/sites/default/files/final_report_-_volume_8_recordkeeping_and_information_sharing.pdf.

Bartu, A., Sharp, J., Ludlow, J., & Doherty, D. A. (2006). Postnatal home-visiting for illicit drug-using mothers and their infants: A randomized controlled trial. The Australian and New Zealand Journal of Obstetrics and Gynaecology, 46(5), 419–426.

Blakely, T., Atkinson, J., Kiro, C., Blaiklock, A., & d'Souza, A. (2003). Child mortality, socioeconomic position, and one-parent families: independent associations and variation by age and cause of death. International Journal of Epidemiology, 32(3), 410-418.

Bonet, M., Smith, L. K., Pilkington, H., Draper, E. S., & Zeitlin, J. (2013). Neighbourhood deprivation and very preterm birth in an English and French cohort. BMC Pregnancy and Childbirth, 13. Retrieved from: http://www.biomedcentral.com/1471-2393/13/97.

Brandon, M. (2008). Analysing child deaths and serious injury through abuse and neglect: what can we learn?: a biennial analysis of serious case reviews 2003-2005.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American psychologist, 32(7), 513.

Brown, S. J., Mensah, F. K., Kit, J. A., Stuart-Butler, D., Glover, K., Leane, C., ... & Yelland, J. (2016). Use of cannabis during pregnancy and birth outcomes in an Aboriginal birth cohort: a cross-sectional, population-based study. *BMJ open*, 6(2), e010286.

Cashmore, J. (2002). Promoting the participation of children and young people in care. Child abuse & neglect, 26(8), 837-847.

Chance, T. & Scannapieco, M. (2002) Ecological Correlates of Child Maltreatment: Similarities and Differences Between Child Fatality and Nonfatality Cases. *Child and Adolescent Social Work Journal,* Vol. 19, No. 2.

Child Welfare Information Gateway. (2014). Protective factors approaches in child welfare. Washington, DC: US Department of Health and Human Services.

Comino, E., Knight, J., Webster, V. et al. (2012) Risk and Protective Factors for Pregnancy Outcomes for Urban Aboriginal and Non-Aboriginal Mothers and Infants: The Gudaga Cohort *Maternal and Child Health Journal* 16: 569. doi:10.1007/s10995-011-0789-6

Commission for Children and Young People (2016). Neither seen nor heard – Inquiry into issues of family violence in child deaths. Melbourne: Commission for Children and Young People,

Coyne, I., Amory, A., Kiernan, G., & Gibson, F. (2014). Children's participation in shared decision-making: Children, adolescents, parents and healthcare professionals' perspectives and experiences. European Journal of Oncology Nursing, 18(3), 273-280.

Council of Australian Government. (2009). *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*. Retrieved from <www.fahcsia.gov.au/our-responsibilities/families-and-children/publications-articles/protecting-children-is-everyones-business>

Crum, K. I., & Moreland, A. D. (2017). Parental Stress and Children's Social and Behavioral Outcomes: The Role of Abuse Potential over Time. Journal of Child and Family Studies, 26(11), 3067-3078.

Damashek, A., Nelson, M. M., & Bonner, B. L. (2013). Fatal child maltreatment: Characteristics of deaths from physical abuse versus neglect. Child abuse & neglect, 37(10), 735-744.

De Bortoli, L., Coles, J., & Dolan, M. (2013). Maternal infanticide in Australia: mental disturbance during the postpartum period. Psychiatry, Psychology and Law, 20(2), 301-311.

DeGregorio, L. J. (2013). Intergenerational transmission of abuse: Implications for parenting interventions from a neuropsychological perspective. Traumatology, 19(2), 158-166.

Dockery, M., Ong, R., Colquhoun, S., Li, J. and Kendall, G. (2013) Housing and children's development and wellbeing: evidence from Australian data, AHURI Final Report No. 201, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/201.

Doidge, J. C., Higgins, D. J., Delfabbro, P., Edwards, B., Vassallo, S., Toumbourou, J. W., & Segal, L. (2017). Economic predictors of child maltreatment in an Australian population-based birth cohort. Children and youth services review, 72, 14-25.

Douglas, E. M. (2013). Case, service and family characteristics of households that experience a child maltreatment fatality in the United States. *Child abuse review*, 22(5), 311-326.

Douglas, E. M., & Mohn, B. L. (2014). Fatal and non-fatal child maltreatment in the US: An analysis of child, caregiver, and service utilization with the National Child Abuse and Neglect Data Set. Child Abuse & Neglect, 38(1), 42-51.

Douglas, E. M. (2017) Child Maltreatment Fatalities in the United States: Four Decades of Policy, Program, and Professional Responses. Dordrecht: Springer Netherlands

Duong, V., Davis, B. And Henrik Falhammar, H. (2015) Pregnancy and neonatal outcomes in Indigenous Australians with diabetes in pregnancy. World journal of Diabetes. 6 (6). 880-888

Featherstone, B., & Broadhurst, K. (2003). Engaging parents and carers with family support services: What can be learned from research on help-seeking? Child and Family Social Work, 8(4), 341-350. DOI: 10.1046/j.1365-2206.2003.00289.x

Ferguson, H. (2017). How children become invisible in child protection work: Findings from research into day-to-day social work practice. The British Journal of Social Work, 47(4), 1007-1023.

Fraser, J., Sidebotham, P., Frederick, J., Covington, T., & Mitchell, E. A. (2014). Learning from child death review in the USA, England, Australia, and New Zealand. The Lancet, 384(9946), 894-903.

Frederick, J., Goddard, C., & Oxley, J. (2013). What is the 'dark figure' of child homicide and how can it be addressed in Australia? *International Journal of Injury Control and Safety Promotion*, *20*(3), 209-217.

Frederico, M., Jackson, A., & Dwyer, J. (2014). Child Protection and Cross-Sector Practice: An Analysis of Child Death Reviews to Inform Practice When Multiple Parental Risk Factors Are Present. Child abuse review, 23(2), 104-115.

Garfield, L., Holditch-Davis, D., Carter, C. S., McFarlin, B. L., Schwertz, D., Seng, J. S., ... & White-Traut, R. (2015). Risk factors for Postpartum Depressive Symptoms in Low-Income Women with Very Low Birth Weight Infants. Advances in neonatal care: official journal of the National Association of Neonatal Nurses, 15(1), E3.

Garstang, J., Ellis, C., Sidebotham, P., & Griffiths, F. (2015). G421 The current causes and risk factors for sudi. British Paediatric Allergy Immunology and Infection and British Association for Community Child Health. Retrieved from

Glanfield, L. (2016). Report of the Inquiry: Review into the system level responses to family violence in the ACT. Retrieved from http://www.cmd.act.gov.au/__data/assets/pdf_file/0010/864712/Glanfield-Inquiry-report.pdf

Gould, S. J., Weber, M. A., & Sebire, N. J. (2010). Variation and uncertainties in the classification of sudden unexpected infant deaths among paediatric pathologists in the UK: findings of a National Delphi Study. Journal of clinical pathology, 63(9), 796-799.

Government of South Australia (2011). Safe Infant Sleeping Standards. Retrieved from http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+health/safe+infant+sleeping+standards.

Harker, L. (2006). Chance of a lifetime: The impact of bad housing on children's lives. London, UK: Shelter.

Highet, A. R., & Goldwater, P. N. (2013). Maternal and perinatal risk factors for SIDS: A novel analysis utilizing pregnancy outcome data. European Journal of Pediatrics, 172(3), 369–372.

Hollowell, J., Kurinczuk, J. J., Brocklehurst, P., & Gray, R. (2011). Social and ethnic inequalities in infant mortality: A perspective from the United Kingdom. Seminars in Perinatology, 35(4), 240–244.

James, A., & Prout, A. (Eds.). (2015). Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood. Routledge.

Jonson-Reid, M., Chance, T., & Drake, B. (2007). Risk of death among children reported for nonfatal maltreatment. Child Maltreatment, 12(1), 86-95.

Keeley, M., Bullen, J., Bates, S., Katz, I., & Choi, A. (2015). Opportunities for information sharing: Case studies: Report to the NSW Department of Premier and Cabinet. Sydney: Social Policy Research Centre, University of New South Wales.

Khanam, R., Nghiem, H. S., & Connelly, L. B. (2009). Child health and the income gradient: Evidence from Australia. Journal of Health Economics, 28(4), 805–817.

Kim, B., & Maguire-Jack, K. (2015). Community interaction and child maltreatment. Child abuse & neglect, 41, 146-157.

Lamela, D., & Figueiredo, B. (2015). A cumulative risk model of child physical maltreatment potential: Findings from a community-based study. Journal of interpersonal violence, 0886260515615142.

McFadden, K. E., & Tamis-Lemonda, C. S. (2013). Maternal responsiveness, intrusiveness, and negativity during play with infants: Contextual associations and infant cognitive status in a low-income sample. Infant Mental Health Journal, 34(1), 80-92.

McKenzie, K., Scott, D., Fraser, J. A., & Dunne, M. P. (2012). Assessing the concordance of health and child protection data for 'maltreated' and 'unintentionallyinjured' children. Injury Prevention, 18, 50–57.

McLachlan, R., Gilfillan, G., & Gordon, J. (2013). Deep and Persistent Disadvantage in Australia, Productivity Commission Staff Working Paper. Canberra, ACT: Productivity Commission.

Magruder, K. M., McLaughlin, K. A., & Elmore Borbon, D. L. (2017). Trauma is a public health issue. European Journal of Psychotraumatology, 8(1), 1375338.

Maguire-Jack, K., & Negash, T. (2016). Parenting stress and child maltreatment: The buffering effect of neighborhood social service availability and accessibility. Children and Youth Services Review, 60, 27-33.

Marmot, M. & Wilkinson, R.G. (2006) Social Determinants of Health (2nd ed), Oxford University Press, New York.

Miyamoto, S., Romano, P. S., Putnam-Hornstein, E., Thurston, H., Dharmar, M., & Joseph, J. G. (2017). Risk factors for fatal and non-fatal child maltreatment in families previously investigated by CPS: A case-control study. Child abuse & neglect, 63, 222-232.

Mohanty, I., Edvardsson, M., Abello, A., & Eldridge, D. (2016). Child Social Exclusion Risk and Child Health Outcomes in Australia. PloS one, 11(5), e0154536.

Moon, R. Y., Hauck, F. R., Colson, E. R., Kellams, A. L., Geller, N. L., Heeren, T., ... & Corwin, M. J. (2017). The effect of nursing quality improvement and mobile health interventions on infant sleep practices: A randomized clinical trial. Jama, 318(4), 351-359.

Moore, T., McDonald, M. & McHugh-Dillon, H. (2014). Early childhood development and the social determinants of health inequities: A review of the evidence. Parkville, Victoria: Centre for Community Child Health at the Murdoch Childrens Research Institute and the Royal Children's Hospital.

Moore, T. G., McDonald, M., Carlon, L., & O'Rourke, K. (2015). Early childhood development and the social determinants of health inequities. Health promotion international, 30(suppl_2), ii102-ii115.

Morawska, A., Sanders, M. R., Haslam, D., Filus, A., & Fletcher, R. (2014). Child adjustment and parent efficacy scale: Development and initial validation of a parent report measure. Australian Psychologist, 49(4), 241-252.

Murray G & Mackie, C., (2006). Study into the Deaths and Near Deaths of Children Known to Care and Protection and the Government Response. Recommendations from the Murray-Mackie Study into the Deaths and Near Deaths of Children Known to Care and Protection and the Government Response. Presented by Katy Gallagher MLA, Minister for Disability and Community Services, September 2006. Available: www.hansard.act.gov.au/hansard/2006/week09/3027.htm.

National Health and Medical Research Council., (2012). Infant Feeding Guidelines. Canberra: National Health and Medical Research Council.

Niedhammer, I., Murrin, C., O'Mahony, D., Daly, S., Morrison, J. J., & Kelleher, C. C. (2012). Explanations for social inequalities in preterm delivery in the prospective Lifeways cohort in the Republic of Ireland. European Journal of Public Health, 22(4), 533–538.

Oberman, M., & Meyer, C. L. (2008). When mothers kill: Interviews from prison. NYU Press.

Office of the Public Advocate. (2015). 'Rebuilding the village: Supporting families where a parent has a disability'. Office of the Public Advocate: Victoria

Ormandy, D. (2014). Housing and child health. Paediatrics and child health, 24(3), 115-117.

Palusci, V. J., & Covington, T. M. (2014). Child maltreatment deaths in the US national child death review case reporting system. Child abuse & neglect, 38(1), 25-36.

Patwardhan, I., Hurley, K. D., Thompson, R. W., Mason, W. A., & Ringle, J. L. (2017). Child maltreatment as a function of cumulative family risk: Findings from the intensive family preservation program. Child Abuse & Neglect, 70, 92-99.

Phillips, A. (2012) Who is looking out for the Territory's children? Review of the emergency response strategy for children in crisis in the ACT. Canberra : Public Advocate of the ACT.

Phung, H. N., Bauman, A. E., Young, L., Tran, M. H., & Hillman, K. M. (2003a). Ecological and individual predictors of maternal smoking behaviour – Looking beyond individual socioeconomic predictors at the community setting. Addictive Behaviors, 28(7), 1333–1342.

Putnam-Hornstein, E., Wood, J. N., Fluke, J., Yoshioka-Maxwell, A., & Berger, R. P. (2013). Preventing severe and fatal child maltreatment: making the case for the expanded use and integration of data. Child Welfare, 92(2), 59+. Retrieved from http://go.galegroup.com.ezproxy1.acu.edu.au/ps/i.do?p=AONE&sw=w&u=acuni&v=2.1&it=r&id=GALE%7CA439953108&asid=2da899f1f4186befc1646381fb7c53c6

Queensland Health (2013). Guidelines for Safe Infant Sleeping, Co-sleeping and Bed Sharing. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0025/147634/qh-gdl-362.pdf

Richards, K. (2011). Children's exposure to domestic violence in Australia. Trends & issues in crime and criminal justice no.419 Canberra: Australian Institute of Criminology.

Scott, D., Lonne, B., & Higgins, D. (2016). Public health models for preventing child maltreatment: applications from the field of injury prevention. Trauma, Violence, & Abuse, 17(4), 408-419.

Shepherd, C. C. J., Li, J., Mitrou, F., & Zubrick, S. R. (2012a). Socioeconomic disparities in the mental health of Indigenous children in Western Australia. BMC Public Health, 12(1). Retrieved from: http://www.biomedcentral.com/1471-2458/12/756.

Sidebotham, P., Fraser, J., Fleming, P., Ward-Platt, M., & Hain, R. (2014). Patterns of child death in England and Wales. *The Lancet*, *384*(9946), 904-914.

South Australian Government, Ombudsman SA, (2013). Information Sharing Guidelines for promoting safety and wellbeing. Retrieved from: http://www.ombudsman.sa.gov.au/wp-content/uploads/ISG-Guidelines1.pdf

State of Victoria, Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132 (2014–16).

Task Force on Sudden Infant Death Syndrome. (2016). SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. *Pediatrics*, e20162938.
Titmuss, A. T., Harris, E., & Comino, E. J. (2008). The roles of socioeconomic status and aboriginality in birth outcomes at an urban hospital. *Medical Journal of Australia, 189*, 495–498.

Thurston, H., Freisthler, B., Bell, J., Tancredi, D., Romano, P. S., Miyamoto, S., & Joseph, J. G. (2017). Environmental and individual attributes associated with child maltreatment resulting in hospitalization or death. *Child Abuse & Neglect*, *67*, 119-136.

United Nations General Assembly. (1989). Adoption of a convention on the rights of the child. New York, NY: United Nations.

Varner, M. W., Silver, R. M., Hogue, C. J. R., Willinger, M., Parker, C. B., Thorsten, V. R., ... & Stoll, B. (2014). Association between stillbirth and illicit drug use and smoking during pregnancy. *Obstetrics and gynecology*, *123*(1), 113.

Victorian Child Death Review Committee (2012). Annual report of inquiries into the deaths of children known to child protection. Melbourne: Office of the Child Safety Commissioner

Welch, G. L., & Bonner, B. L. (2013). Fatal child neglect: Characteristics, causation, and strategies for prevention. Child Abuse & Neglect, 37(10), 745–752.http://dx.doi.org/10.1016/j.chiabu.2013.05.008

Widom, C. S. (2014). Longterm consequences of child maltreatment. In Handbook of child maltreatment (pp. 225-247). Springer Netherlands.

Williams, J. F., Smith, V. C., & Committee on Substance Abuse. (2015). Fetal alcohol spectrum disorders. Pediatrics, 136(5), e1395-e1406.

Willow, C., (2010). Children's right to be heard and effective child protection, Save the Children Sweden, p30

Wise, S. (2013). Improving the early life outcomes of Indigenous children: implementing early childhood development at the local level. Issues paper no. 6. Melbourne, Victoria: Closing the Gap Clearinghouse, Australian Institute of Family Studies. Retrieved from:

http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-ip06.pdf.

Wolfe, I, Macfarlane, A., Donkin, A., Marmot, M., & Viner, R.. (2014). Why children die: death in infants, children, and young people in the UK—Part A. *Royal College of Paediatrics and Child Health*.

Woolhouse, H., Gartland, D., Mensah, F., & Brown, S. J. (2015). Maternal depression from early pregnancy to 4 years postpartum in a prospective pregnancy cohort study: implications for primary health care. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(3), 312-321.

Wynter, K., Rowe, H., Tran, T., & Fisher, J. (2016). Factors associated with father-to-infant attachment at 6 months postpartum: a community-based study in Victoria, Australia. Journal of Reproductive and Infant Psychology, 34(2), 185-195.

Zhang, K., & Wang, X. (2013). Maternal smoking and increased risk of sudden infant death syndrome: a meta-analysis. *Legal Medicine, 15*(3), 115-121. http://dx.doi.org/10.1016/j.legalmed.2012.10.007

APPENDIX A

Statutory Child Protection Reform

Over the past five years, a number of reviews have been undertaken in the ACT that have considered policy and practice responses to some of the Territory's most vulnerable children (Phillips, 2012; Auditor General, 2013; Glanfield, 2016). The reports undertaken in 2012 and 2013 specifically looked at Child and Youth Protection Services (CYPS) responses to providing adequate and immediate support to children and young people deemed to be at high risk and vulnerable. The Glanfield Inquiry in 2016 looked closely at the child protection sector and the domestic violence sector to consider how the two sectors interact.

As a result, a number of activities were initiated against each of the recommendations provided in this review. Consultation with the Communities Services Directorate undertaken at the completion of this review has indicated that these activities have either moved to business as usual, or have been substantially completed. Section 3.1 outlines the key reforms and the following section provides further information related to these and other activities.

The following information has been provided by the Community Services Directorate regarding recent reforms.

Case Analysis

Funding was provided by ACT Government following the Glanfield Inquiry for the establishment of a Case Analysis Team. The Case Analysis team has as their key objective to undertake independent case analysis of individual cases at key decision making points and / or during periods of perceived heightened risk for a child or young person.

A case analysis is an in-depth, point in time assessment of a child or young person's situation. Through a cumulative harm lens, the team develop an enduring chronology for each child or young person, explore the young person's trauma history, and provide quality assurance on decision making as well as guidance to CYPS case managers and their team leaders. A separate case analysis allows workers to think about long term cumulative abuse rather than a single incident of immediate risk, and ensure the voice of the child is at the front and centre of the work of CYPS. The case analysis also explores the risks and vulnerabilities to a child's safety and whether there are sufficient protective factors to mitigate these vulnerabilities.

The team leader commenced in the role in October 2016 and undertook consultation with the NSW Office of the Senior Practitioner and the Office of the Professional Practice in Victoria. Staff commenced in February 2017 and have, as at June 2018, undertaken 41 case analyses on 75 individual children. The team has identified practice and training themes which have recently been presented to the

Child and Youth Protection Services Quality Assurance and Improvement Committee.

Child and Youth Protection Services Quality Assurance and Improvement Committee

This Committee is an independent advisory body and was established by the Community Services Directorate to strengthen the quality of child protection policy and practice in the ACT. The membership consists of experts from across Australia and includes the Coordinator General – Family Safety. CYPS is able to draw on this expertise when making decisions about policy and practice improvements.

Policy and procedures

Over the course of 2016, CYPS also reviewed key policies and procedures, specifically the intake module, appraisal module and Risk Assessment Framework. Language was strengthened in both highlighting the importance of collaboration and referral to support services for families experiencing family / domestic violence. New intake and appraisal modules and revised Risk Assessment Framework were launched on 28 November 2016.

In October 2017, CYPS finalised and launched the Family Violence Guide. The guide articulates the CYPS approach to understanding and managing family violence in the context of child protection and youth justice work. It articulates:

- a definition of family violence drawn from the latest research;
- our understanding of the impacts of family violence on children and young people;
- our practice approach to the assessment of family violence and the impacts on children and young people;
- the role of staff, community partners and other key people in addressing family violence in our work; and
- our approach to working with families and perpetrators.

A Cumulative Harm Guide is in the final stages of completion and will be released to all staff to support improved understanding of this issue. This guide has been strongly influenced by the work undertaken in Victoria and will be supported by an eLearning package currently in development. A strengthened focus on face to face training to assist staff to recognise and understand the impact of cumulative harm is also in development.

Partnerships

To improve information sharing, referrals processes and collaborative working, CYPS has a number of partners that co-locate for periods of time. Key partners include:

<u>OneLink</u>

CYPS funds two part-time community based child protection workers. These OneLink staff co-locate with CYPS in order to facilitate improved referral pathways for families

known to CYPS. The OneLink workers provide information about and referrals to services including:

- Child, youth and family services
- Tenancy support
- Support for people who are homeless including emergency accommodation
- Legal services
- Financial counselling
- Mental health services
- Other support services.

Australian Federal Police

The Sexual Assault and Child Abuse Team of the AFP attends CYPS half a day per week to consult on and discuss possible referrals to their agency.

Education Directorate Liaison

This position commenced in February 2017 with a focus on improving coordination and collaboration between CYPS and the Education Directorate. This position provides support to schools who are seeking to consult on matters they believe requires a Child Concern Report to CYPS. The liaison officer works with the school to determine whether a report should be made, or whether other community based supports and services would be better to respond to the needs of the family.

ACT Health Liaison

As part of a combined strategy between the ACT Health Directorate and CYPS two liaison officers positions were established in 2006. The CYPS Health liaison position is co-located at the Canberra Hospital one day per week, and the Health liaison position is based in CYPS offices two days per week.

On a day to day basis, the work of the liaison officer is to provide education about each organisation's role and responsibility and to identify system issues in the working relationship between the two organisations, improve engagement protocols and processes and facilitate interaction between the two agencies through forums and training.

One key function of the CYPS Health liaison position is to provide a consultation service to health staff when they are considering making a report to CYPS.

Canberra Rape Crisis Centre

On 1 May 2017, the Canberra Rape Crisis Centre commenced attending CYPS offices for half a day on a fortnightly basis. They provide face to face consultation to CYPS on matters that relate to child sexual abuse.

Domestic Violence Crisis Service

Since mid-August 2017, staff from the Domestic Violence Crisis Services (DVCS) have been attending CYPS for half a day on a fortnightly basis. These staff are available to consult on matters that relate to domestic and family violence to determine the most appropriate response to the presenting issues, including referrals into specific DVCS programs. CYPS send a staff member to DVCS offices one day per month to facilitate improved information sharing and knowledge of CYPS. The co-location of these services provides for enhanced collaboration and appropriate referrals, particularly during the intake and appraisal phases.

Training

Child and Youth Protection Services established an internal training and development team in February 2016 to deliver on commitments made through various reforms, including the implementation of *A Step Up for Our Kids* strategy, Glanfield Inquiry and other independent and internal reviews and audits. The Child and Youth Protection Services Training and Workforce Development team has developed, implemented and maintained a significant number of training programs since that time.

It is of note that CYPS continues to deliver a five-day intensive training program on working with families experiencing violence, in partnership with the DVCS, and a five-day intensive program on responding to child sexual abuse. Other training programs delivered include forensic interviewing, having difficult conversations with children and young people, and undertaking family assessments. In addition, the Institute of Child Protection Studies delivers the Kids Central toolkit to CYPS staff to improve how case managers are able to engage with children.

Child and Youth Records Information System (CYRIS)

Following a number of recommendations from the Auditor-General's Performance Audit Report (March 2013), the ACT Government provided funding of $5.3 million over four years in the 2015-16 budget for the development of a new client management system. The current Children and Young People's System (CHYPS) is a legacy information system and has a number of limitations.

The ACT Government further invested additional funding of $2.7 million over four years in the 2018-19 budget to expand the scope of the new client management system, to integrate with key stakeholders, enabling real time exchange of risk, safety and wellbeing information about children and young people.

The new client management system is in development and will significantly assist staff to enter information and access it in many different ways to ensure staff are able to make more informed decisions, share information more easily, improve chronologies of information and activities undertaken by staff, and improve availability of client history.

It is anticipated that the system will decrease the administrative burden for staff allowing them more time to focus on client work, and provide a better holistic view of children and young people. It is anticipated the new client management system will be implemented in a phased approach commencing in late 2018.

Cultural Development Program

In 2015 CYPS developed a cultural development program for staff that runs over a three month period. The program is managed and delivered by the Cultural Services team within CYPS. Since the commencement of the training, 117 CYPS case workers have completed the program.

The cultural development program is core training for staff, using an online training program developed by the Institute for Aboriginal and Torres Strait Islander Studies. This online training is complemented by face to face to discussions, a day on country with ACT Parks, and includes other engagement activities with ACT Aboriginal organisations.

The outcomes from the training include:

- developing and applying an understanding of Aboriginal and Torres Strait Islander cultures, which will ultimately improve participants' case management practice and CYPS service outcomes;
- gaining an understanding of protocols and processes used to collaborate in partnership with Aboriginal and Torres Strait Islander families, children and community services;
- understanding the importance of establishing positive working relationships with Aboriginal and Torres Strait Islander families, children and services;
- identifying and analysing legislation, policy and work practices relating to Aboriginal and Torres Strait Islander people.

The training is designed to provide staff with an understanding of Aboriginal and Torres Strait Islander cultures, with a strong focus on collaboration and the establishment of positive working relationships.

This program has been specifically designed for CYPS staff to assist them to develop a better understanding of the history, spirituality and importance of the land for Aboriginal people.

Our Booris, Our Way

In June 2017, the Minister for Disability, Children and Youth announced an independent review of Aboriginal and Torres Strait Islander children and young people involved with the child protection system. The "*Our Booris, Our Way*" review will focus on systemic improvements needed to address disproportionality in the ACT.

A Steering Committee has been established and the project team has commenced work. The review will report in approximately August 2018 with an interim report, with a final report due in late 2019.

Family Group Conferencing

In November 2017, Child and Youth Protection Services commenced a Family Group Conferencing model for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with Child and Youth Protection Services. This work was undertaken in partnership with Curijo, an Aboriginal owned company with expertise in this work. In the 2018-2019 budget, the ACT Government committed $1.44m funding over four years for the ongoing delivery of Family Group Conferencing, so that Aboriginal and Torres Strait Islander families can be supported to make decisions to keep their children safe, strong and connected to family and culture.

The aim of Family Group Conferencing is to provide families with the opportunity to develop effective family plans that will keep their children safe. Conferencing is typically used before and as an alternative to Children's Court action being taken.

Family Group Conferencing ensures all members of a child's extended family are contacted and encouraged to be involved in the decision-making process about their child's situation. This process is considered in line with Aboriginal and Torres Strait Islander cultural values of family and community responsibility.

Functional Family Therapy Child Welfare

Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild and Child and Youth Protection Services have commenced a twelve month trial of Functional Family Therapy (Child Welfare) for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with Child and Youth Protection Services.

The objective of the trial is to reduce the number of Aboriginal and Torres Strait Islander children and young people entering, or remaining in out of home care, through interventions that strengthen families and communities.

Functional Family Therapy specifically targets families with children and young people aged 0-17, at risk of entering the out of home care system and to support reunification of a child or young person from care. The program is a culturally adaptive family based program. The framework for Functional Family Therapy provides the context for integrating and linking behavioural and cognitive intervention strategies to the specific familial and ecological characteristics of each family.

Functional Family Therapy is appropriate for families where there is minimal provider engagement and may have a history of difficulty accepting services; families struggling with mental health diagnoses; families with a history of abuse/neglect; family violence; substance abuse and criminal justice involvement. The program is proven by research to improve family dynamics, communication and supportiveness, while decreasing intense negativity and dysfunctional patterns of behaviour. In clinical evaluations, Functional Family Therapy has demonstrated to be

more efficient and more effective in meeting treatment goals whilst also avoiding adverse outcomes, when compared to traditional approaches to care.

This program will support children and families who are facing vulnerable times in their lives, to achieve sustainable outcomes which prevent children and young people entering, or remaining in out of home care.

The role of Functional Family Therapy is to reduce or eliminate the need for ongoing services and for the family experience to be a positive one. The model seeks to move families through a theory of change process where negativity is reduced, hope is in increased and family dynamics are recognised and shifted to reduce risk.

Functional Family Therapy focuses on the systems around families and how they can support and motivate change. Work is done at the parental, peer, school and community level. Functional Family Therapy is about tackling the problems that may result in a child or young person entering care, abuse and neglect, substance abuse, family violence, mental health, emotional regulation and self-control and violent behaviour.

RISKS PRESENT IN ELEVEN INDIVIDUAL CASES

APPENDIX B