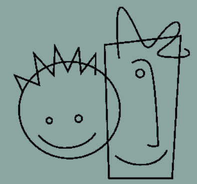
Fatal Assault of Children and Young People



nsw commission for children & young people

The NSW Child Death Review Team has tabled two reports concerning the fatal assault of children and young people; *Fatal Assault of Children and Young People 2002* and *Fatal Assault and Neglect of Children and Young People 2003.*

The reports span a 6½ year period from January 1996 to June 2002. One hundred children in 89 families died in this period.

The following research questions were addressed:

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

Fatal assault is….

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

KEY FINDINGS

- ***Fatal assault is a rare event***

  Over the 6½ year study period, 100 children died from fatal assault, making up 2% of all deaths of children and young people aged 0 to 17 years in NSW. This equates to a crude death rate of just over one death from fatal assault per 100,000 children and young people. In comparison, children die from cancers, motor transport fatalities and drowning at a rate of about three deaths per 100,000.

  Consequently, few professionals have experience working with situations that lead to fatal assault, even though many have worked with families that share a similar profile to the families of the children that were fatally assaulted.

- ***Fatal assault is not a homogenous phenomenon***

  There were four categories of fatal assault:

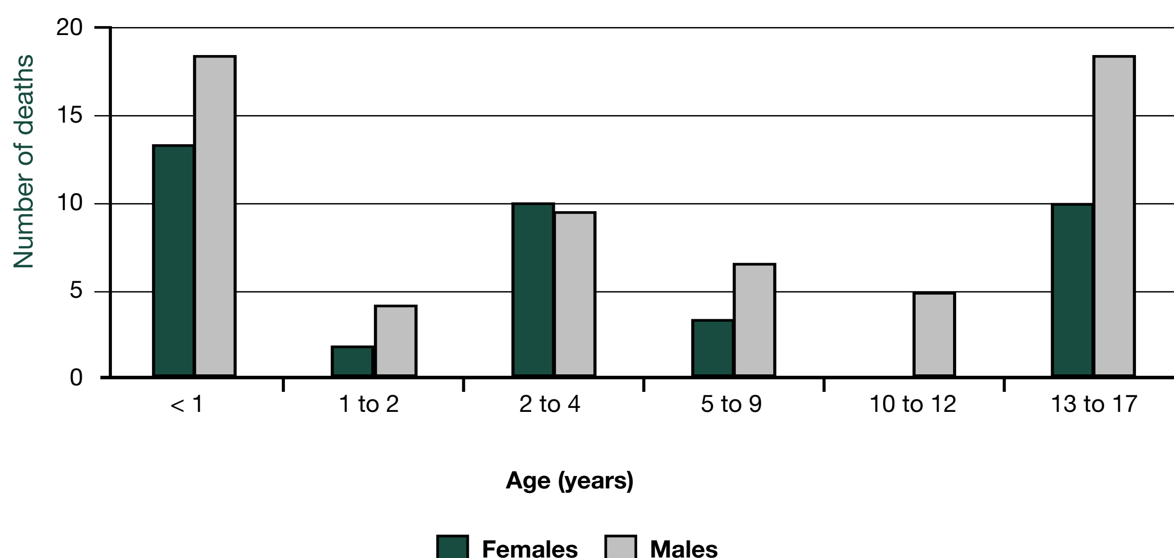
  1. Fatal non-accidental injury (39; 26 males, 13 females)
  2. Parents affected by mental illness (17; 6 males, 11 females)
  3. Family dispute and breakdown (15; 11 males, 4 females)
  4. Teenagers (28; 18 males, 10 females)

  Each of these categories are described in detail later in this paper.

- ***Age is significant***
  The age of the child was a critical dimension of the fatal assault incidents. The frequency and types of fatal assaults varied according to the child's age.

The highest number of assaults (30) was of infants under one year of age. Infants also had the highest rate of fatality at 5.8 deaths per 100,000. Infants in particular are vulnerable; they are physically fragile and completely dependent on their carers.

Children and young people's age and gender



Teenagers aged between 13 and 17 years were the next most likely age group to be fatally assaulted (28).

There were a significantly lower number of fatal assaults of children aged between five and 12 years.

- ***Prior violence, criminal behaviour and poverty and social disadvantage were evident in many families***
  Fatal assault may occur within families across the entire socio-demographic profile. However, many of the households were characterised by enduring social problems and the familial and social resources available to these families were extremely limited.

  Of the 89 families:

  - Carer substance use was evident in 22 households
  - Carer alcohol use was evident in 15 households
  - Domestic violence was evident in 36 households
  - A carer had a diagnosed mental illness in 19 households
  - Financial difficulties were evident in 37 households
  - Criminal behaviour was evident in at least 34 households

Fatal Assault of Children and Young People

- ***Aboriginal children and young people were over-represented***
  Of the 100 children and young people who were fatally assaulted, 12 were Aboriginal (12%). In 2001, 3.5 per cent of all children and young people aged 0-17 years in NSW were Indigenous. Aboriginal children and young people were therefore over-represented in assault deaths.

- ***Agencies had been involved with most of the families***
  Excluding the teenage category in which the fatal assaults occurred outside of the family context, 30 of the 66 (45.5%) families had no prior contact with agencies.

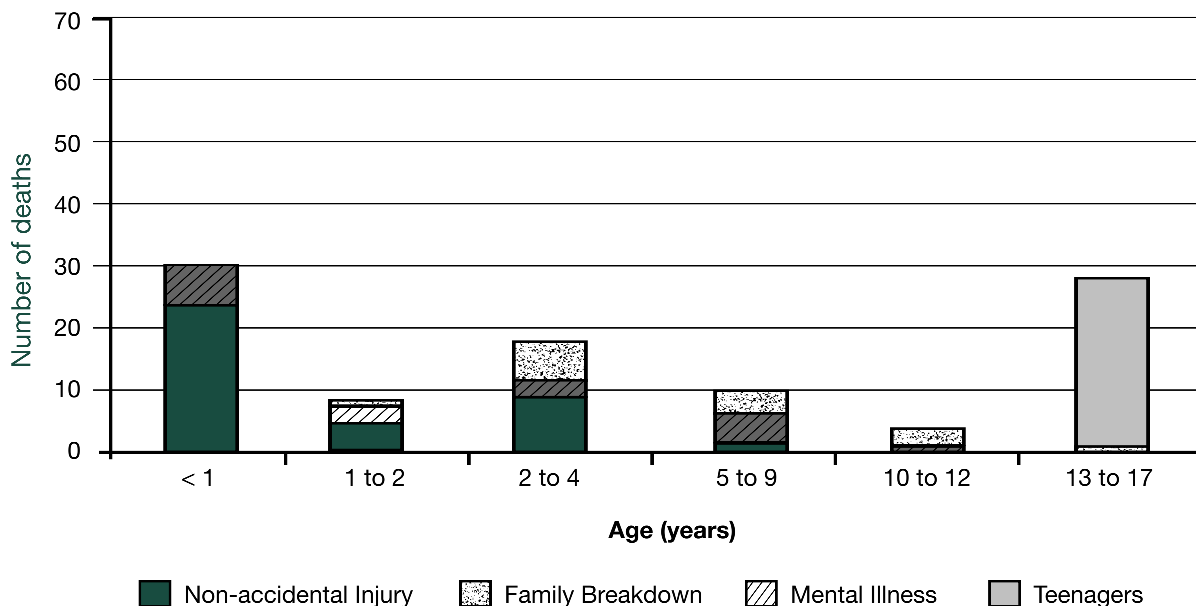
The agencies most frequently accessed were NSW Police, the Department of Community Services and NSW Health (including mental health services). Little is known about the families that did not come to the attention of human service agencies.

FATAL ASSAULT GROUPS

An important study finding was that fatal assault is not a homogenous phenomenon. Four distinct categories emerged, each with their own dynamic and profile. It is, however, important to note that the categories were determined based on the circumstances surrounding the death incident.

Some children who died from non-accidental injury may have experienced family dispute and breakdown or parental mental illness. For these children, however, the family breakdown or parental mental illness was not the precipitating factor to the fatal assaults.

Fatal assault groups: Age



Fatal non-accidental injury

Fatal non-accidental injury accounted for 39 of the 100 fatalities (26 males, 13 females). The injuries resulted from either a series of assaults or one fatal assault.

The children who died as a result of non-accidental injury were aged from birth to six years. The mean age was 1.3 years and 24 (61.5%) children were less than one year old.

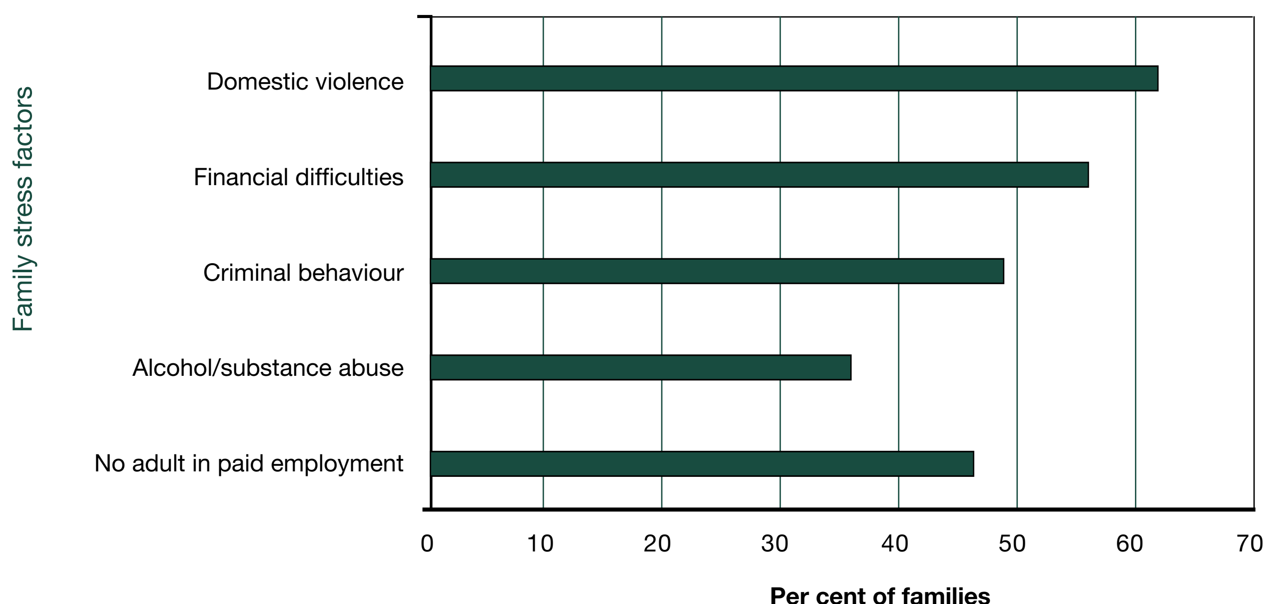
All but two of the fatal non-accidental injuries occurred within the family.

The suspects were the biological parents (24), mother's de facto (7), foster mother (1), other relative (1) and persons unrelated but known to the child (3).

High levels of existing intra-familial violence were evident including:

- Domestic violence in 24 of the 39 families;
- Nineteen suspects with prior offences against the person; and
- Sixteen families had a combination of domestic violence, a parent with a criminal history and a child who was four years of age or less.

Non-accidental injury: selected family stress factors



Twenty of the 39 families had prior agency contact, of which NSW Police, the Department of Community Services and NSW Health (including mental health) were the most commonly accessed.

The following deficiencies in agency practice were evident:

- **Failure to recognise and report serious and unstable situations**
  There were situations of children not being reported to the Department of Community Services, despite clear warning signs that the child's safety was in jeopardy. Examples include professionals not acting on information given by parents that they were going to kill the child and commit suicide, children presenting with clear indicators of physical abuse and violent situations where there were serious risks for children.

- **Failure to conduct an adequate risk assessment**
  Inadequate risk assessment was a feature in almost all of the cases that proceeded to the assessment and investigation stage. Issues included the Department of Community Services not conducting a risk assessment at all, not conducting a thorough risk assessment, discounting reports, not reassessing the child's safety (given new information), not taking into account previous reports, failing to recognise patterns in families that presented risks to the child, accepting the parent's explanation of injuries without verifying the information provided, not assessing longer term needs and poor documentation.

- **Failure to provide services to children and families so that their circumstances change and risk is reduced**
  Very few cases proceeded to protective intervention or care and support. Workers were trapped in a recognise-report-assess cycle, focusing on an individual report of risk of harm and the immediate issues that flowed from it to the exclusion of any previous reports. Workers did not focus on the long term needs of the child and their family.

Where protective intervention did occur, there was evidence of ineffective case planning and management.

- **Failure to plan effectively**
  There were many examples of workers failing to plan for and monitor protective intervention. For example poor case planning, inappropriate time frames, inadequate record keeping and lack of maintaining of high risk cases.

- **Failure to work together with other agencies**
  There were several examples of individuals and agencies acting in isolation, without engaging in the necessary interagency collaboration that is required for effective case planning and management.

  Poor interagency work has been a consistent finding throughout NSW Child Death Review Team Reports.

Parents affected by mental illness

Seventeen children (6 males, 11 females) were killed by parents affected by mental illness. The children ranged in age from three months to 10 years, with a mean age of just over three years.

Fifteen of the 17 children were killed by their biological mother and two were killed by the mother's male de facto. Four of the families were from culturally and linguistically diverse communities.

The fatalities involved two broad scenarios:

- Fatalities that occurred during an episode of parental depression (9); and

- Fatalities that occurred while the parent was experiencing acute psychotic symptoms (8).

Only four of the 17 families had no contact with mental health services. The primary deficiency in service provision for this group involved a failure to consider the safety implications for the child of the parent's behaviour:

- Only a few children at risk whose parents were in contact with mental health professionals were reported to the Department of Community Services. Mental health professionals failed to adequately consider the possible effects and dangers to children of the patient's mental illness. For example, there were two instances where mothers were admitted to a psychiatric hospital following a suicide attempt and the hospital did not report the child to the Department of Community Services.

- In cases where a parent had a mental illness and the child's safety was recognised to be at risk, there were inadequacies in the assessment undertaken by the Department of Community Services and mental health services. Assessments failed to adequately consider the interaction of the parent's mental illness on their parenting ability.

Family dispute and breakdown

Fifteen children (11 males, 4 females) in nine families died in the context of parental dispute and family breakdown. The mean age of these children was six years. None of the children were less than one year in age.

All of the perpetrators were the biological parents (5 fathers, 4 mothers).

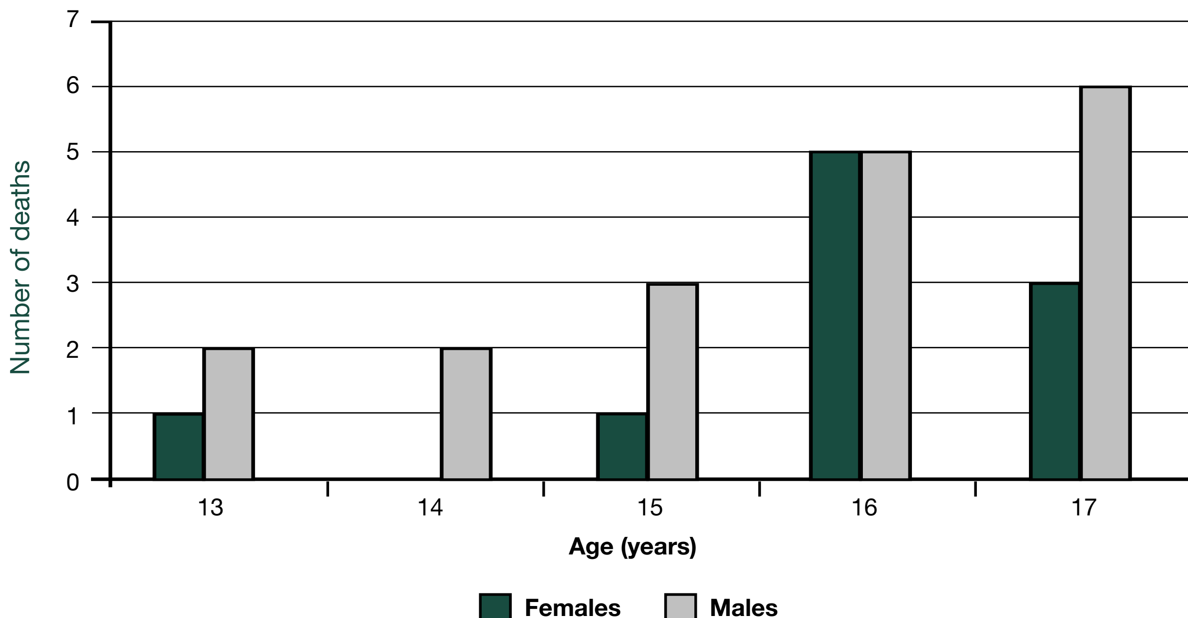
Over the 6½ year study period, only two of the nine families had prior contact with human services. Deaths from family breakdown occurred in families with no service contacts, with little history of violence and soon after a precipitating event.

As a result, there may be limited success in reducing this category of fatal assault via service system improvements. It is clear, however, that parental stress and anxiety enmeshed with despair about children can be warning signs of unsafe situations.

Teenagers

Twenty-eight teenagers (18 males, 10 females) aged 13 to 17 years were killed. The average age of these young people was 15.7 years.

Teenagers age and gender



Criminal histories were a feature of both the victims' and suspects' histories:

- Twenty-two of the 41 suspects (53.7%) had prior criminal charges; and
- Thirteen of the 28 victims (46.4%) had prior charges.

While the Department of Juvenile Justice was extensively involved with at least three victims and almost half of the victims had prior criminal charges, the range of services offered was extremely limited; agency involvement was premised on their criminal actions rather than on their needs.

For these young people, the criminal justice system was a point of contact with services that could have helped them reduce their risk-taking behaviours, but they did not receive these services.

Developmental prevention approaches to crime may have some relevance to reducing some of the fatal assaults of teenagers.

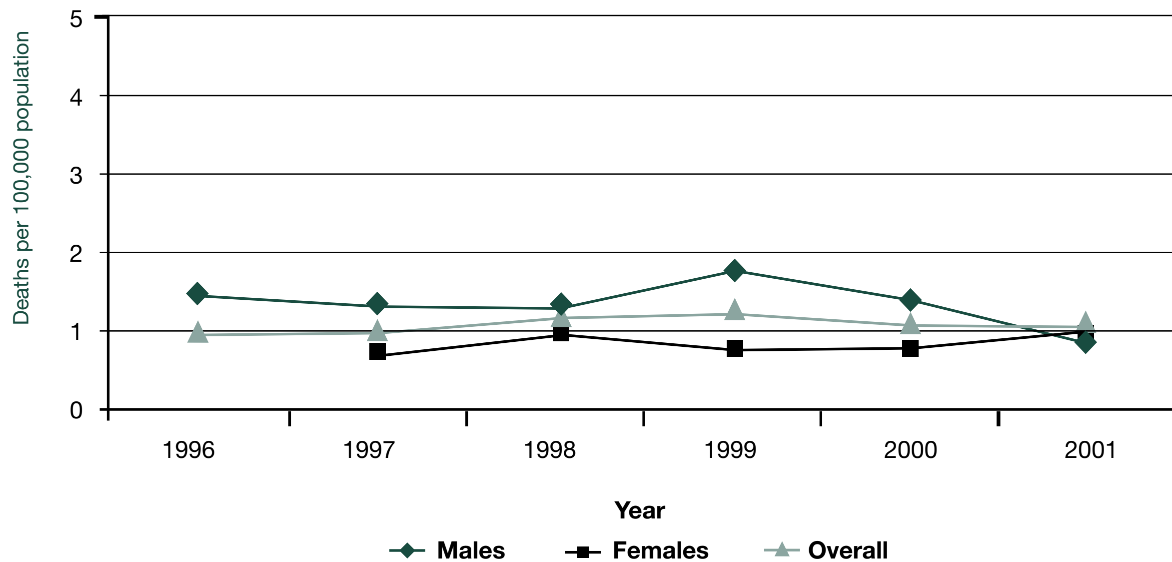
TRENDS IN FATAL ASSAULTS 1996 TO 2001

Due to the small number of deaths of children and young people from assault in a given year, trends must be interpreted with caution as even a few extra deaths in one year can double the observed rate.

However, over the six-year period 1996-2001 the following trends were evident:

- With the exception of 2001, more males than females died by fatal assault each year.
- Over time the rate for females has been quite stable ranging from 0.8 to 1.0 deaths per 100,000 population 0 to 17 years (6 to 8 deaths). The rate for males has been slightly more variable, ranging from 0.9 deaths per 100,000 population 0 to 17 years in 2001 to 1.7 deaths per 100,000 in 1999 (7 to 14 deaths).

Trends in fatal assaults 0 to 17 years: Gender



Note: The rate has not been calculated for females in 1996 because it is unreliable (n<4)

PREVENTING FURTHER FATAL ASSAULT

Child deaths from assault are rare events and cannot be predicted with certainty. This makes it challenging to design effective prevention strategies.

Prevention strategies need to consider the finding that fatal assault of children and young people is not a homogeneous phenomenon. The four categories identified from the research require different response – a statutory child protection system may not be relevant for all categories:

- An improved child protection system and a child and family support system that could prevent issues escalating in families, could help reduce fatal non-accidental injury;
- A better mental health system with a renewed focus on the effects and dangers to children of their parent's mental illness could help reduce mental illness related deaths;
- Crime prevention activities when children are first reported to the police may reduce teenage risk-taking;
- Concerted efforts to strengthen young people's connections to education could also help reduce teenage risk-taking.

This research has identified one group of children at particular risk – those less than four years of age living in families with a history of violence and crime. Support and intervention services to this group should be prioritised.

Not all the children and young people who were fatally assaulted had prior agency involvement. Children and young people who die may not be representative of those who enter the child protection system. A comparative study is required of those who die and those who are injured to inform practice and response.

Finally, although NSW has interagency guidelines for working with children and young people and their families, workers and managers often do not adhere to these guidelines. A study into the factors that promote and hinder adherence to interagency policy and practice is required.

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