

**A report prepared for the  
Western Australian  
Child Death Review Committee**

**Group Analysis of Aboriginal Child Death Review  
Cases in which Chronic Neglect is Present**

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## Executive summary

### Introduction

The purpose of this group analysis – which was commissioned by the Western Australian Child Death Review Committee (CDRC) – was to enhance the quality and timeliness of intervention by the Western Australian child protection service system in future instances where chronic neglect is a major presenting risk factor.

***The terms of reference*** were to:

1. provide an extension of the Victorian Child Death Review Committee (CDRC) analysis of the evidence of the impact of chronic neglect on child development and best practice approaches to chronic neglect to include a greater focus on Indigenous children and families;
2. identify and document themes and issues arising from the sample group of children, including the issue of inter-generational abuse;
3. examine the effectiveness of the responses by the Department for Child Protection to chronic neglect in relation to the sample children and their families;
4. examine to the extent possible the effectiveness of other services in responding to chronic neglect in relation to the sample children and their families; and,
5. identify specific mechanisms and opportunities to enhance service responses to children at risk of chronic neglect.

### Methodology

A mixed method approach involved: a comprehensive literature review of neglect and chronic neglect; descriptive statistical analysis of all 21 (involving 22 child deaths) cases of Aboriginal child deaths reviewed by the CDRC; and a systematic qualitative analysis of CDRC case files using a framework adapted from that used by the Victorian Child Death Review Committee, comprising the child's characteristics, those of the family, structural and societal factors, the child protection response, and the broader service systems involved. Limitations include the lack of comparative analysis with non-Indigenous child deaths and with those notified cases where a successful outcome was achieved. The limited time available for this analysis was compounded by the difficulty of gaining timely access to data. Another limitation was lack of access to primary data from which case files were derived.

### Literature review

An extensive review of relevant literature highlighted the difficulty of reaching universal definitions of neglect, due to the problem of establishing thresholds agreed to by service providers and complying with community standards. Despite this, there is clear evidence of the detrimental effects of particular behaviours on the development of young children, including: alcohol misuse during pregnancy leading to foetal alcohol spectrum disorder; failure to provide adequate food or shelter, emotional sustenance,

or access to appropriate medical attention; and exposure to violence. The cumulative effect of harm can result in mental health disorders, poor cognitive functioning, behavioural problems, poor school attainment, and even death.

Recent focus upon children's rights and sociological understandings of children and childhood, have led to acknowledgement that children deserve at least the same right to protection and support as adults. Despite this, statutory authorities and service providers continue to minimise the harms resulting from chronic neglect in comparison to other forms of maltreatment and abuse. This is particularly alarming with respect to Indigenous children and families, among whom substantiations for neglect are higher than among the general population, due to the greater incidence of known risk factors, including poverty, low educational levels, family violence, substance misuse, and mental health problems.

While there is limited research evidence of the efficacy of preventing and reducing neglect in Indigenous families, there is general agreement that measures to improve the general living conditions of Indigenous people are fundamental to any improvement, as well as addressing the interpersonal context of neglect, including family violence, substance misuse, social isolation, and mental illness. Key indicators for risk are largely intergenerational, and attempts at addressing them must acknowledge the harms associated with dispossession, institutionalisation, and separation from family and have a focus on healing and restoration. Recent reviews of child deaths in England, Ireland and Australia stress the need for child centred practices that ensure that cumulative harm associated with chronic neglect informs decision making of statutory authorities. This requires more rigorous risk assessment including major stakeholders.

### **The context of neglect**

The majority of the children who died were aged one year or less, pointing to a greater vulnerability in this age group. Slightly fewer female children (45%) than male children (55%) are included in this group. At the time of death, half the group (50%) were living with both biological parents, almost a third (32%) with their mothers, and the remainder with one biological parent and a step-parent (9%) or with extended family members (9%). Almost two thirds of the group (63%) had more than three siblings, and three of the children had siblings who had died. Half of the children (50%) were from remote communities, more than a third from rural regions (36%) with the remainder from the metropolitan region. Other characteristics of the children included disability in three cases (14%), premature births for three cases (14%), chronic illness and complex health needs for another two cases (9%), with previous hospital admissions recorded for five children (23%).

The identified cause of death was not available for all cases, but the circumstance surrounding the children's deaths included: co-sleeping (45%), drowning (14%), vehicular accident (14%), homicide (9%), and other factors (18%). All families had a long history with the Department for Child Protection (the Department) with the average length of contact with the Department being 10.5 years. Parents of the deceased had their own histories of child abuse or neglect in four of the families (19%), and 17 (81%) had a histories of out-of-home care including the placement of the

parents themselves as children. In 12 (57%) of the cases the deceased had one or more siblings who had been previously placed in out-of-home or relative-care. All 21 families had previous notifications for child abuse/neglect, 11 (52%) of which were substantiated 'Child Maltreatment Allegations', seven (33%) were recorded as 'Child Concern Reports' and three were 'logged contacts' resulting in an open period of contact with the Department. Of the 22 children who died, 16 (73%) had previous notifications recorded on file. Health professionals and police officers made the majority of the notifications. Family members made other notifications with the remainder being made by medical social workers, youth services and child protection officers. Five (24%) cases were closed before the children's deaths, nine (43%) cases were still open and it was not possible to determine the case status at the time of the children's deaths in the other seven (33%) cases. Each of the children who died was living in families where there were a number of interrelated risk factors. There was only one case where either alcohol and other drug dependence and/or family violence was not a significant factor in the family circumstances leading to chronic neglect. Other risk factors included homelessness, mental health problems and financial hardship. Supportive extended families were evidenced in 12 (57%) cases, however intra-familial conflict was also recorded in seven (33%) cases and intra-community conflict in a further two cases. From the evidence available, it appears that the children were much more likely to have been in contact with universal services for children and families (73%) such as maternal and child health services, the education system, or organised child care, than targeted supports for the children or their families.

### **The service system response**

Limitations of the service system response to Indigenous families in crisis were considerable; in particular the history of dispossession, institutionalisation and separation of families. With extreme social disadvantage including poverty, welfare dependence, and substance misuse, coupled with the difficulties of providing quality services in remote regions, any service will struggle. However, the Department has acknowledged that these factors should not impair action to protect the health and wellbeing of children. Given this undertaking it is of concern that overall service system response in all 21 cases was inadequate. Based upon the evidence to hand, these inadequacies related to a focus upon family centred practice that minimised the potential cumulative harms for children and the proper assessment of their needs and wellbeing. There was a common practice of giving families who were clearly struggling to care for their children additional responsibilities with very little additional support. In particular alcohol and other substance dependence seem to have been accepted rather than addressed. There was also a tendency for caseworkers to overemphasise small improvements often without sighting the children and there was a very worrying absence of any assessment of the potential harms being done to children. In large part this stemmed from a focus upon single incidents of neglect rather than the possible presence of cumulative harm. The lack of proper risk assessments in many of the cases was equally worrying and even when a risk assessment did take place it rarely included examination of the family's social history or the involvement of other carers in relation to the potential risk of harm to the child. Case management record keeping was *ad hoc* and insufficient in many cases and, based on what was documented, there seems to have been inadequate interagency coordination, inadequate referral

processes or monitoring of referrals to other agencies. Nevertheless it is important to note that in a minority of cases there were some instances of thoughtful holistic case planning.

Common themes arising from the analysis of the service system response can be summarised as:

- unresolved tension between child centred and family focused practice;
- a focus upon single incidents of neglect and the 'start again' syndrome;
- an over optimistic emphasis on small improvements leading to case closure;
- the absence of any direct assessment of the impact of neglect upon the child;
- inadequate risk assessment and management; and,
- inadequate case or safety planning.

### **Implications for safer practice**

Implications for safer practice arising from this group analysis include the following:

- recognition and identification of the intergenerational context of neglect for Indigenous children;
- geographic location, age of child, substance misuse, and co-sleeping recognised as risk factors;
- the provision of targeted support for children and families;
- an increased role for extended families and support networks;
- particular attention paid to the way in which strengths-based, family-focused practice is interpreted and enacted;
- routine child impact assessment;
- greater use of collaborative partnerships in the processes of decision making and case planning, especially with Indigenous organisations;
- acknowledgment of the nature of neglect and its implications for long term Departmental involvement in cases; and,
- an increased emphasis on early intervention through 'shared care' between families, statutory authorities, Indigenous child care agencies and communities.

### **Recommendations**

The analysis of the data provided to us by the CDRC and evidence drawn from the available literature lead us to make the following recommendations. As requested by the CDRC the recommendations are operationalised with regard to the Department's current reform agenda. Each recommendation is listed under the categories set out in the reform agenda and where applicable the projects to which they have particular significance are indicated.

#### ***Category 1. Field Service Delivery DCP Reform Implementation (Projects 5a, 6a 6b & 32a)***

1. That the implementation guidelines for the Signs of Safety risk assessment approach provide clear processes for assessing the additional risk of chronic neglect associated with:
  - a) intergenerational child abuse and neglect;
  - b) living in rural and remote communities;

- c) the increased vulnerability of infants and toddlers;
  - d) the presence of chronic substance dependence; and,
  - e) the presence of family violence.
2. That the review of Service Delivery Policy and Field Worker Guidelines include the development of a clear and specific procedure for undertaking a:
- a) formal and documented child impact assessment of the risks associated with cumulative harm in cases where neglect is indicated – including a rigorous assessment of their current wellbeing and development as well as any associated risks to their continuing development;
  - b) formal and documented assessments of the family/carer/community's capacity to care for the child which would include a proper and rigorous assessment of both the family/carer/community strengths and weaknesses; and,
  - c) evidence of sustained care for the child over time before cases are closed.
3. That, where neglect or chronic neglect is indicated, the implementation guidelines provide clear processes for ensuring that the child's immediate and extended family and community are actively engaged in the processes of risk assessment and case planning.
4. That the scope for the 'Interagency Early Intervention: At risk new born babies (Project 32a)' includes attention to the increased vulnerability to the harms associated with neglect and chronic neglect for infants and toddlers.

***Category 3. Aboriginal Engagement DCP Reform Implementation (Projects 2 & 19)***

5. That the newly constituted Aboriginal Reference Group include as part of its work plan:
- a) an implementation framework for the development of partnerships between the Department and appropriate Indigenous agencies similar to those arrangements in place in Queensland and Victoria with regard to risk assessment and case planning;
  - b) an examination of the findings of this report and provide a response to it to the Department for inclusion in the direction the Department gives to the Family Support Services Strategic Framework and State Plan; and,
  - c) consider the utility and practicality of a formalised 'shared care' approach to family support for Aboriginal families which are clearly struggling to provide adequate care to their children. This would require consideration of how respite services, family support agencies and the Department can enter into formal and legally binding contracts with each other and families to ensure adequate care is provided to children where chronic neglect is indicated.

***Category 5. Whole of Government Partnerships DCP Reform Implementation (Projects 14 & 26)***

6. That the Department provide specific direction to the Family Support Services Strategic Framework and State Plan:
  - a) regarding the need for long term intervention strategies and programs aimed at addressing the intergenerational effects of abuse and neglect – particularly those that address alcohol and other substance dependence and family violence (Project 14);
  - b) regarding the development of a ‘shared care’ program similar to that which operates in the United Kingdom for families/carers who are obviously struggling to provide adequate care to their children – this will require respite services, family support agencies and the Department entering into formal and legally binding contracts with each other and families to ensure adequate care is provided to children where chronic neglect is indicated (Project 14); and,
  - c) regarding the need for an increase in the number of Aboriginal and Islander Child Care Agencies operating in Western Australia, particularly in rural and remote locations (Project 14).
7. That the Department develop policies and guidelines for developing leadership with regard to case planning and management through collaborative arrangements with other lead agencies (Project 26).

***Category 6. Corporate Support Systems DCP Reform Implementation (Projects 11 & 9)***

8. That the Department:
  - a) establish a rigorous process for the full documentation of case management decisions and follow-up strategies (project 11);
  - b) provide training and development to front line workers regarding the harms to children resulting from chronic neglect in particular those that are associated with alcohol and other substance misuse and the witnessing of family violence (project 9); and,
  - c) demonstrate leadership in case planning and management through taking responsibility for case management and the facilitation of collaborative arrangements with other lead agencies.

## 1. Introduction

This project can be seen as fulfilling one of the functions of the Western Australian Child Death Review Committee (CDRC), which is to highlight the identification of 'particular classes of child deaths or related issues that may benefit from further investigation or research'. There is increasing recognition of the 'neglect of neglect' both in the literature and in practice, and so the opportunity to undertake a group analysis of this particular cohort of children where neglect and chronic neglect is indicated marks an important turning point in child protection research. In 2006, the Victorian Child Death Review Committee undertook a similar group analysis of ten child death cases in which chronic neglect was present. Only one of the cases reviewed by the Victorian study involved an Aboriginal family. Thus, the Western Australian CDRC commissioned this group analysis to build upon and extend the Victorian Group Analysis by focusing solely on Aboriginal child death cases in which chronic neglect is present.

### 1.1 Purpose of this group analysis

The purpose of this group analysis is to enhance the quality and timeliness of intervention by the child protection service system in future instances where chronic neglect is a major presenting risk factor. In particular, the CDRC hopes that learning from this analysis will inform policy and program development associated with the Department for Child Protection's reform agenda and the introduction of the Department's *Policy on Neglect*.

### 1.2 Terms of reference

The terms of reference for this project are to build on and extend the Victorian study by:

1. providing an extension of the Victorian literature review of the evidence of the impact of chronic neglect on child development and best practice approaches to chronic neglect to include a greater focus on Indigenous children and families;
2. identifying and documenting themes and issues arising from the sample group of children, including the issue of inter-generational abuse;
3. examining the effectiveness of the responses by the Department for Child Protection to chronic neglect in relation to the sample children and their families;
4. examining to the extent possible the effectiveness of other services in responding to chronic neglect in relation to the sample children and their families; and,
5. identifying specific mechanisms and opportunities to enhance service responses to children at risk of chronic neglect.

## 2. Methodology

A mixed method approach was used in the collection of data. Descriptive statistics regarding the incidence of child deaths were obtained from the annual reports of the Western Australian Child Death Review Committee (CDRC) and quantitative demographic data relating to the families in which a child death had occurred in the presence of chronic neglect or where there was a risk of chronic neglect in the case of infants were extracted from the CDRC case files. A constant comparative thematic analysis of the qualitative data contained in the case files was also undertaken. In addition to this, a systematic review of the literature relating to neglect and chronic neglect was carried out to establish current understandings of the context of neglect, key indicators of neglect and best practice with reference to the assessment and treatment of child neglect, particularly with reference to Indigenous children and families. The literature was located using electronic search engines to search key social science data bases including Blackwell Synergy, JSTOR, Pro-Quest 5000 International, Academic search premier, Science Direct, APA-FT, Social Science Index Full Text and Periodicals Archive On-Line. Relevant health and medical literature was searched using AMED, Australian Medical Index, APAIS-health, ATSI-health, CINAHL, Embase, Medline, Web of Science and Science Direct. This review was then broadened to include a selective review of literature directly relating to Aboriginal and Torres Strait Islander children, families and communities in Australia and key Australian government reports and briefing papers.

Ethical approval for the research was obtained initially from Curtin University of Technology (approval no HR 03/2008). At the suggestion of the CDRC the proposal was also submitted to the Western Australian Aboriginal Health Information Ethics Committee (WAAHIEC) with a comprehensive statement on values and ethics based upon the Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NH&MRC, 2003). WAAHIEC approval was granted on March 6<sup>th</sup> 2008.

### 2.1 Analytical framework

Drawing upon the ecological framework utilised in the Victorian Group Analysis of Child Deaths and the key themes identified in the literature search described above, an analytical frame of reference and coding scheme was developed to facilitate a constant comparative thematic analysis of the qualitative data contained in the CDRC case files. Particular attention was paid to factors such as inter-generational effects of abuse and trauma and the key contributing role of alcohol and other drug misuse in child neglect and child deaths. This frame of reference and coding scheme was then submitted to an external Indigenous child care expert for review.

#### 2.1.1 The sample

The sample consisted of all case files (n= 21 cases and 22 child deaths) of the Western Australia Child Death Review Committee of Aboriginal child deaths reviewed by the

CDRC since its commencement in 2003 up to the 30<sup>th</sup> of June 2007 in which chronic neglect was evident (or where there was a risk of chronic neglect in the case of an infant) and where there was a completed chronology of events and a report forwarded to the Minister. The case files are developed in the course of the CDRC case review process and thus do not contain original case material completed by contact staff or case managers. CDRC case files comprise a letter from the Coroner advising the CDRC of a child's death, in many cases an internal review report from the Department, a case chronology, a narrative summary of the case chronology (including in many cases summary data), the Director General's response (including covering letter), and a final report to the Minister (including a covering letter). Analysis of the data within the case files was limited to an in-depth examination of the narrative summaries of the case chronologies.

### **2.1.2 Analysis**

Quantitative demographic data were extracted from each of the case files and entered into a spread sheet. Qualitative data from each of the case summaries were extracted at source and entered into an electronic data base so that any identifying markers could be removed. The process of removing identifying markers also aided in adopting a 'layered reading' approach to the data which as Brandon and colleagues (2008, p11) explain, assists with reviewing each child's circumstances 'respectfully but systematically'. This is important as the circumstances surrounding child deaths can have a powerful impact upon a reader and without a systematic approach it is possible for one particular feature of an individual case to take on disproportionate significance (Brandon et al, 2008, p.11). The particular locations in which the families reside were also de-identified and allocated to broad regional areas. Once all the case files had been de-identified, the data from each file were entered into the data base and organised according to the four major categories drawn from the Victorian study; that is according to: the child's characteristics; those of the family; structural and societal factors; the child protection system response; and the broader service systems involved. Following this, a second level analysis was undertaken in which the data in each category were coded and then sorted according to the dominant themes that arose. These themes were then used to form the major areas for discussion in the report.

### **2.2 Limitations**

There is increasing recognition of the 'neglect of neglect' both in the literature and in practice and so the opportunity to undertake a group analysis of a particular cohort of children where neglect and chronic neglect is indicated marks an important turning point in child protection research. Nevertheless, while the homogenous nature of the sample provided an opportunity for a detailed analysis of this particular cohort of children, the study is limited by two important factors. First, the lack of opportunity for a comparative analysis between Indigenous and non-Indigenous child deaths where chronic neglect is present prevents an analysis of the similarities and differences in both the contexts of neglect and case management of the two groups. Second, the analysis is limited through the lack of opportunity to examine and undertake a comparative analysis between those families where a child death occurred and those where a successful outcome was achieved. In order for a comprehensive analysis of the context of child deaths where chronic neglect is present a comparative

analysis of all types of abuse and all family circumstances including those relating to ethnicity and culture should be undertaken.

Other limitations of the study relate to the time frame for the project (limited to a three month review process), the difficulty of achieving timely access to the data from the Department for Child Protection for such a short-term project, and the lack of access to primary data. A more robust analysis of the cases could have been achieved if there had been time to provide an analysis of the accuracy of the narrative summaries against the chronology of events. In addition to this, a more rigorous methodology and analysis could have been achieved if access to the primary data from which the case files are compiled had been granted.

In addition to these limitations some degree of caution is required in the interpretation of these results, for the following reasons.

**1. Generalisation**

These results are not necessarily representative of all Aboriginal child deaths. The sample includes only those cases where the, now named, Department for Child Protection had contact with the family.

**2. Accuracy**

Information sources for the sample of 21 cases (involving 22 children in total, two of whom were siblings) were reliant upon what was known by the Department for Child Protection (and hence the Child Death Review Committee) at the point of notification of the death.

**3. Under-reporting**

The gaps in information for the reasons stated above mean there is the potential for under-reporting of certain child and family characteristics and other relevant factors. Absence of information does not indicate a lack of any particular feature, simply that it is not recorded.

### **3. Literature review**

The focus of this literature review is specifically on child neglect and chronic child neglect. It provides an overview of the topic and defines the concepts of child neglect and chronic child neglect; it contextualises these concepts within statutory child protection services and provides Western Australia's legislative definitions; and, it provides a brief overview of both developmental and sociological theories of children and childhood. Whilst families in which chronic neglect and/or chronic maltreatment is present share some common characteristics, the review of literature has a particular focus on neglect issues and causal and/or risk factors which are relevant to Aboriginal communities.

#### **3.1 An overview of child neglect and chronic child neglect**

Neglect is a serious form of child maltreatment, existing on a continuum ranging from reactive, episodic and short-term instances to chronic, persistent and severe failures to meet a child's basic developmental, physical and/or emotional needs (NSPCC, 2007; Tanner & Turney, 2003). It is as serious as other forms of child maltreatment resulting in harmful consequences in both the short- and long-term, with all forms of neglect having the potential to result in, or contribute towards, a child's death (NSPCC, 2007; Victorian Child Death Review Committee, 2006). All neglect is not chronic neglect (Wilson & Horner, 2005). However, whilst the severity (degree of harm) as well as the chronicity (frequency, repetition and duration) of the neglectful behaviour are important considerations (Straus & Kantor, 2005), it can also be argued that even a single incident can constitute neglect. Thus, whilst a severe injury is apt to be seen as the result of a more serious case of neglect than a minor injury, equally as neglectful can be, for example, leaving a pre-schooler unsupervised for several hours whether it is a single incident or has occurred several times (Dubowitz, Black, Starr, & Zuravin, 1993; Zuravin, 1999).

Neglect refers to acts of omission (usually by a parent/primary carer) to provide for a child's basic needs (Tanner & Turney, 2003). Reactive, episodic and short-term instances of neglect are often regarded as 'only human', occurring when some parents are struggling to deliver appropriate care at times of crisis (Dubowitz, Black, Starr, & Zuravin, 1993; Tanner & Turney, 2003). Here, there is an inference of non-intentionality on the part of the parent/primary carer and, according to Dubowitz and colleagues (1993), clinical experience suggests that most neglect is not intended. Straus and Kantor (2005) note, however, that there is an implicit cultural tolerance for rarely occurring neglectful behaviour.

Chronic neglect, on the other hand, is persistent and generally experienced over time, with harm developing insidiously, cumulatively and often without obvious and immediate impact (thus making its identification more elusive) (Dubowitz, 2007). Factors increasing the likelihood of chronic neglect are addressed in a later section of this report but it has been noted that parents/primary carers who are chronically

neglectful are 'intractable to treatment' and as such the neglect is 'likely to reoccur' (Wilson & Horner, 2005, p. 476). In other words, chronic neglect is, by definition, likely to reoccur whether or not treatment or services are offered or provided to these families by child welfare agencies (Wilson & Horner, 2005, p. 472). One of the reasons put forward for this is the lack of ongoing and/or appropriate support and service provision to such families (Wilson & Horner, 2005). Parents/primary carers who practice chronically neglectful behaviours are characterised by an ingrained sense of hopelessness and an unremitting low level of care for the children (Tanner & Turney, 2003; Wilson & Horner, 2005).

In terms of child deaths, a distinction is made between two types of neglect fatalities. Critical incident or accident deaths are usually due to 'supervisory neglect' and involve, for example, accidental drowning, road traffic accidents, fires, gun accidents, choking, and ingesting pills. 'Chronic neglect' deaths, on the other hand, are due to preventable issues such as malnutrition, starvation and dehydration. Whilst it might be difficult to predict and prevent supervisory neglect deaths, fatalities due to chronic neglect, while less common, have a greater chance of being prevented due to increased predictability (DoCS, 2006, p. 9). Problems arise in this regard, however, due to a number of factors which result in the non-identification of chronic neglect in the first place. These factors are addressed further on in this literature review.

### **3.2 Defining child neglect and chronic child neglect**

The contribution of multiple and interacting factors is central to any definition of neglect (Dubowitz, Black, Starr, & Zuravin, 1993; Jack, 2000). Definitions of neglect vary according to type, severity and chronicity; with the roles of parents, families, communities and society, generally, being factors in its existence/occurrence (Dubowitz, Black, Starr, & Zuravin, 1993). At least fifteen types of neglect have been described, which include: refusal or delay to provide physical health care; refusal or delay to provide mental health care; lack of attention or interaction resulting in a child not meeting its developmental milestones; emotional neglect; supervisory neglect and/or inadequate protection from physical harm or danger; custody refusal; custody related neglect; abandonment/desertion; failure to provide a stable home; neglect of personal hygiene; housing hazards; inadequate housing sanitation; nutritional neglect; education neglect; and witnessing family violence (Dubowitz, Black, Starr, & Zuravin, 1993; Gaudin, 1993; M. James, 1994).

### **3.3 When do 'neglectful' behaviours become 'child neglect' for statutory child protection services?**

The point at which the above behaviours become 'child neglect cases' such that the state (through statutory child protection services) intervenes to protect a child depends on the legal definition of when a child is deemed to be 'in need of care and protection'. The definition of 'a child in need of care and/or protection' is prescribed in legislation in each jurisdiction. In general, the concept of 'a child in need of care and/or protection' provides the legislative grounds for intervention, and it is these grounds that form the basis of what is substantiated following a child protection investigation (Holzer & Bromfield, 2007).

A major obstacle to the establishment of a general definition of child neglect is the problem of threshold: that is, establishing what may be considered minimally adequate levels of care. Not only is there disagreement between professionals and some members of the community, including ethnic and minority groups, on how to establish thresholds of minimal care but it is also unclear how frequent episodes of neglect need to be in order for them to be considered episodic, intermittent or chronic. Each can involve significant harm (Watson, 2005) with the likelihood of serious harm increasing the more pervasive the neglect (Perry, 2002). There is, however, general consensus that neglect is more likely to be chronic than other forms of maltreatment (Wilson & Horner, 2005) with the cumulative effect of harm contributing exponentially to the risk of mental health disorders, poor cognitive functioning, behavioural problems, poor school attainment and, in the worst case scenario, death (Appleyard, Egeland, van Dulman, & Sroufe, 2005; Mackner, Starr, & Black, 1997).

Another major problem is the minimisation of child neglect compared to physical and/or sexual abuse and this can take several forms. First, neglect, even chronic neglect, is less incident-based than other forms of maltreatment (for example, physical and sexual abuse). It manifests over time, with each incident too trivial to provide a 'trigger event' of sufficient concern, with the risk often remaining unrecognised (Tanner & Turney, 2003). The cumulative effect of chronic neglect is, however, damaging with (as previously mentioned) sometimes fatal consequences. Second, otherwise unacceptable levels of neglect are just written off as 'cultural practice', or as an act required by 'the culture' (Gordon, Hallahan, & Henry, 2002). Third, the pressure on workers to avoid incorrect classifications, due to the grave consequences for the families, as well as requiring overwhelming evidence of abuse before action is taken, becomes a critical issue in cases of suspected neglect (Watson, 2005). Fourth, a focus on the rights of the parents to the detriment of the rights of a child can result in the child's marginalization in the assessment/investigation process (Victorian Child Death Review Committee, 2006), and/or the denial of the child's right to protection, even when the case is classified as a 'child in need'. In such cases, where children experiencing neglect are referred to statutory agencies as 'children in need' they often receive little or no service due to the concentration of resources on 'child protection' (Jones & Gupta, 1998; Lewin & Herron, 2007; UNCRC, 1989). Fifth, is the misclassification of cases in order to give a family eligibility to a particular sort of treatment. For instance, if there is both 'risk of sexual abuse' and 'neglect', the sexual abuse may be put forward as the primary concern so that the court can become involved. If there is both physical abuse and neglect, the abuse label may be minimised and neglect put forward. In such instances, neglect cases are generally dealt with by the provision of family support rather than the more stringent child protection measures. It is, thus, easier for children's needs to fall through the gaps (Tomison, 1995). Fifth, is the phenomenon of children being left without services, despite ongoing negative effects, such as when social workers become accustomed to unacceptable low standards, or in the normalising of detrimental and harmful parental and/or environmental factors. The result of this is that incidents have to be increasingly severe to be identified as causing concern at all and the cumulative effect on a child is overlooked (Ayre, 1998; Gordon, Hallahan, & Henry, 2002; Watson, 2005).

Failure to identify cumulative effects by those providing services to children experiencing chronic neglect is a result of several factors. These include: incidents giving rise to concern laying scattered through the relevant files, recorded and responded to separately with no-one making cumulative connections between them; they may lie unshared on the files of a variety of different interested agencies or unremarked within the files of a single agency; the notion of proportionality with the response to any transgression being in some way proportionate to the transgression itself; and, again, the normalisation of unacceptably low standards of parenting (Ayre, 1998; Victorian Child Death Review Committee, 2006).

### **3.4 Legislative definitions of child neglect in Western Australia**

According to section 28 (1) of the *Children and Community Services Act 2004*, a child – defined as any person under the age of 18 – is in need of protection when thresholds of ‘harm’ and ‘neglect’ have been breached. ‘Harm’ refers to ‘any detrimental effect of a significant nature on the child’s wellbeing’. ‘Neglect’ includes ‘failure by a child’s parents to provide, arrange, or allow the provision of adequate care for the child; or effective medical, therapeutic or remedial treatment for the child’.

Under Part 4, Division 1, Section 28 (2) of the Act a child is in need of protection if:

- (a) the child has been abandoned by his or her parents and after reasonable inquiries —
  - (i) the parents cannot be found; and
  - (ii) no suitable adult relative or other suitable adult can be found who is willing and able to care for the child;
- (b) the child’s parents are dead or incapacitated and, after reasonable inquiries, no suitable adult relative or other suitable adult can be found who is willing and able to care for the child;
- (c) the child has suffered, or is likely to suffer, harm as a result of any one or more of the following —
  - (i) physical abuse;
  - (ii) sexual abuse;
  - (iii) emotional abuse;
  - (iv) psychological abuse;
  - (v) neglect,
 and the child’s parents have not protected, or are unlikely or unable to protect, the child from harm, or further harm, of that kind; or
- (d) the child has suffered, or is likely to suffer, harm as a result of —
  - (i) the child’s parents being unable to provide, or arrange the provision of, adequate care for the child; or
  - (ii) the child’s parents being unable to provide, or arrange the provision of, effective medical, therapeutic or other remedial treatment for the child.

(pp. 24–25)

Part 2, Division 2 of the Act – sections 7 to 10 – includes various principles which must be observed. Among these are a set of guiding principles: the principle that the best interests of a child are paramount; and, the principle of ensuring that the child is able to participate in the decision making process (pp.8–12). In addition, Part 2,

Division 3, Section 12 of the Act also includes an 'Aboriginal and Torres Strait Islander child placement principle' which states the following.

- (1) The objective of the principle in subsection (2) is to maintain a connection with family and culture for Aboriginal children and Torres Strait Islander children who are the subject of placement arrangements.
- (2) In making a decision under this Act about the placement of an Aboriginal child or a Torres Strait Islander child, a principle to be observed is that any placement of the child must be considered as far as is practicable in the following order of priority —
  - (a) placement with a member of the child's family;
  - (b) placement with a person who is an Aboriginal person or a Torres Strait Islander in the child's community in accordance with local customary practice;
  - (c) placement with a person who is an Aboriginal person or a Torres Strait Islander;
  - (d) placement with a person who is not an Aboriginal person or a Torres Strait Islander but who, in the opinion of the CEO, is sensitive to the needs of the child and capable of promoting the child's ongoing affiliation with the child's culture, and where possible, the child's family.

(p. 13)

Part 2, Division 3, Section 11 states that 'The principles set out in this Division are in addition to, and do not derogate from, the principles set out in Division 2' (p. 13). In addition, the Department for Child Protection (Western Australia), in its *Policy on Neglect* (2008) provides the following operational description of neglect.

When a child is not provided with adequate food or shelter, effective medical, therapeutic or remedial treatment, and/or care, nurturance or supervision to a severe and/or persistent extent. The deliberate deprivation of a child's basic needs should be considered within the context of physical, emotional or psychological abuse. For a child to be considered in need of protection, the level of harm must be detrimental in effect and significant in nature to the child's wellbeing. This can be due to the refusal or inability of the child's parents or carers to respond appropriately resulting in significant, immediate or potential risk of harm (p. 3).

### **3.5 Child abuse and neglect in Aboriginal communities: the statistics**

It is well documented that Aboriginal and Torres Strait Islander children are over-represented in the statutory child protection and care systems of all states and territories in comparison to the Australian population as a whole (AIHW, 2008; Stanley, Tomison, & Pocock, 2003). For example, in 2006–07, in all jurisdictions, except Tasmania, the substantiation rate for Indigenous children was more than five times higher than the rate for other children (AIHW, 2008).

Furthermore, the proportion of substantiations for Indigenous children which were recorded as neglect was generally higher than that among other children. For example, in Western Australia (2006–07), 50 per cent of Indigenous children in substantiations were the subject of a substantiation of neglect, compared with 36 per cent of other children (AIHW, 2008). In 2005–06, 40 per cent of Aboriginal and Torres Strait Islander children were the subject of substantiated neglect, compared with 30 per cent among non-Indigenous children (AIHW, 2007).

It is suggested, however, that official figures are likely to be underestimates owing to several factors, including: probable non-reporting of much child abuse and neglect due to fears of racist responses from the system; the high number of Indigenous deaths in custody; diversity of police response; pay-back from relatives; and reprisal from the perpetrator due to closely linked communities. As Indigenous children are more likely to remain in their communities, with proportionally more children being placed at home or with relatives compared with non-Indigenous families, this may add to the reluctance to report (Stanley, Tomison, & Pocock, 2003).

### **3.6 Causes/risk factors of child neglect and chronic neglect in Aboriginal communities**

As previously noted, in most situations there are several and interacting contributors, at different levels (the child, parent(s), family, community and society), to neglect. In the context of Aboriginal communities many of the causal factors of child neglect and chronic neglect (including child abuse and family violence) arise from historical issues (as noted below) and current social disadvantage (Gordon, Hallahan, & Henry, 2002). All families where chronic neglect and/or chronic maltreatment exists have some common characteristics, the most important of which include: almost always living in poverty (the poverty of families is frequently of long duration, that is, 'entrenched' and severe (Wilson & Horner, 2005)); low educational levels; experience of parental break-ups and violence in childhood; severe psychological and emotional impairments, usually including substance misuse and mental health problems such as depression; and, high rates of domestic/family violence (Ethier, Couture, & Lacharité, 2004; Sidebotham, 2001; Zuravin, 1999). Ethier and colleagues (2004) have also put forth the hypothesis that chronic abuse and neglect is associated with the presence of a greater number of risk factors that are related to the history and current living situation of the parents.

Members of Aboriginal communities themselves have identified the following issues as factors contributing to child abuse and neglect: breakdown of traditional Aboriginal society and loss of child-rearing practices; perceptions arising from cultural differences in child-rearing practices; deprivation of culture and loss of identity arising from previous generations of child removal from families and forced relocation of communities; poor socio-economic status; racism; inadequate housing and housing facilities; and alcohol and other substance misuse (De Maio et al., 2005; Elliott, 2007; Gordon, Hallahan, & Henry, 2002). Westerman and Hillman (2003) note the importance of acknowledging the Indigenous view of child abuse and neglect as being located within the overarching context of family violence. In other words, family violence is not limited to unacceptable levels of maltreating behaviours of individuals, or the group as a whole, but to external factors such as those listed above. In this sense, abuse and neglect comprises both direct forms of (mal) treatment (physical, sexual, psychological abuse and neglect perpetrated by members against each other) as well as indirect forms of (mal) treatment perpetrated against Indigenous persons as a whole (such as deprivation of culture, deprivation of culture and loss of identity arising from previous generations of child removal from families and so on).

In addition, the Secretariat of National Aboriginal and Islander Child Care (SNAICC) has noted the following factors in the life circumstances of parents or carers when considering indicators, or risk factors, of child neglect:

- The lifestyle of the parent or carers, i.e., transient, dependency on alcohol, drugs and gambling;
- Parents who are consistently asking for help but seem unwilling to meet their children's most basic needs of food, safety and shelter;
- Parents who blame their children for most things;
- Leaving children on their own, and not making adequate care arrangements for them;
- A high degree of stress around children (Elliott, 2007).

Indicators of neglect in children and young people include: frequent hunger, scavenging or stealing food; seeming constantly tired or lacking life or energy; and looking generally run-down (Elliott, 2007).

The Indigenous experience of all of these factors, together with past government policies has a devastating impact on the health and wellbeing of all Aboriginal persons. This is illustrated in both the poor health outcomes on a broader scale and the over-representation of Aboriginal children in the child protection system, especially in relation to neglect (Australian Health Ministers Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004.; Eades, 2004). Thus, it is important to understand how each risk factor acts in a cumulative way to increase the chances of a negative outcome for a child and that many of the risk factors are likely to be inter-related. The existence of one risk factor, increasing the chance of another risk factor occurring, often compounds the negative effects (Watson, 2005).

### **3.7 Parental drug and alcohol misuse**

A study conducted by Western Australia's Department for Child Protection in 2004 (then named the Department for Community Development) explored parental drug and alcohol use as a contributing factor in applications to the Children's Court for protection orders. The study showed that parental drug and alcohol use was a contributing factor to the protection application in 57 per cent of the 175 cases studied (Leek, Seneque, & Ward, 2004). A Senate Inquiry into Children in Institutional Care in 2005, claimed that drug and alcohol misuse among parents of children who enter the out-of-home care system is endemic and is a critical issue confronting child protection services (Senate Community Affairs Committee, 2005).

It has been noted that levels of substance misuse are significantly higher among Aboriginal Australians than their non-Aboriginal counterparts – with commensurately higher levels of associated health and social problems (Gray, Saggers, Atkinson, & Wilkes, 2008). Excessive consumption of alcohol and/or the use of other drugs (including volatile substances) in Aboriginal communities is variously described as both a result and cause of: poverty; unemployment; a clash of culture, occasioned by various means, which can lead to a sense of hopelessness and low self-esteem; lack of education; boredom; overcrowded and inadequate housing; a weakening of the traditional and cultural values in modern Australian society; and, the lack of opportunity and other advantages enjoyed by many in non-Aboriginal communities

(Wild & Anderson, 2007; Gray, Saggers, Atkinson, & Wilkes, 2008) – some of the same causal factors associated with child neglect and chronic child neglect. Child neglect and chronic child neglect (as well as violence, including physical and sexual violence), thus exist within a context of high levels of substance misuse in Aboriginal communities (Wild & Anderson, 2007).

The wide range of social consequences associated with substance misuse include: loss of income due to inability, or limited ability to work; diversion of family income to purchase tobacco, alcohol and/or other substances; increased levels of theft to directly obtain the money to purchase them; disruption of children's education; community disorder; violence, especially family violence; family breakdown; and increased levels of incarceration (Gray, Saggers, Atkinson, & Wilkes, 2008).

Another problem associated with the misuse of alcohol is the increasing prevalence of foetal alcohol spectrum disorder among Aboriginal people (O'Leary, 2002). Foetal alcohol spectrum disorder is an umbrella term that encompasses a range of lifelong disabilities resulting from prenatal alcohol exposure and is recognised as one of the foremost, non-genetic causes of intellectual impairment (Abel & Sokol, 1986); one which is potentially preventable (O'Leary, 2002). At one end of the spectrum is the full foetal alcohol syndrome, involving facial anomalies (particularly mid-facial anomalies), growth deficiency, and abnormalities of the central nervous system (including intellectual impairment). Less visible, but equally disabling, can be alcohol-related neuro-developmental disorders. Other children along the spectrum tend to exhibit limited or absent facial anomalies but may have significant abnormalities in brain function, ranging from intellectual disability to more subtle but significant alterations in memory, judgment, and motor function. Although a number of the specific facial features may diminish over time, central nervous dysfunction, including long-term intellectual and behavioral problems and psychological and social maladjustment, remain throughout life (O'Leary, 2002).

Foetal alcohol spectrum disorders occur as a result of heavy drinking during pregnancy. Researchers generally agree that *full* foetal alcohol spectrum disorders are seen only in patients whose mothers have histories of chronic, daily, heavy alcohol use or frequent, heavy, intermittent alcohol use. Heavy alcohol use is defined as six or more drinks per day or at least five to six drinks per occasion, with a monthly intake of at least 45 drinks (O'Leary, 2004).

### **3.8 The effects of child neglect and chronic child neglect**

The available literature indicates a significant and congruent negative relationship between neglect and good developmental outcomes for children. At the most basic level of development, persistent neglect has significant neuro-developmental consequences for young babies, potentially affecting all areas of cognitive, social and emotional functioning (Ethier, Lemelin, & Lacharité, 2004; Perry, 2002). While later negative life events also have an impact, it is during the pre-natal and first three years of life that they have the greatest capacity to change the way the brain develops (Perry, 2002). Neglect, especially emotional neglect, can have more negative consequences than other forms of maltreatment (Hildyard & Wolfe, 2007). In addition, the negative consequences appear to be cumulative (Hildyard & Wolfe, 2002).

The following provides a summary account of the consequences of neglect, which may occur alone or in various combinations.

*Neurological developmental impairment.* Early childhood experiences have a decisive impact on the architecture of the brain, and on the nature and extent of adult capabilities (Shore, 1997). Negative early experiences, such as neglect and chronic neglect, can cause important regions of the brain to fail to form properly, resulting in impaired physical, mental and emotional development (Bloom, 1999; Perry, 2001).

*Cognitive difficulties.* Cognitive capacity, language development and academic achievement are all impacted by early failure to provide intellectual stimulation and communication, emotional security, and disrupted schooling (Erickson & Egeland, 2002; Hildyard & Wolfe, 2002; Polonko, 2007).

*Emotional health.* The immediate emotional effects of abuse and neglect – isolation, fear, and an inability to trust – can translate into lifelong consequences, including low self-esteem, passivity, depression, suicidal ideation, self-harming behaviours, and relationship difficulties (Dubowitz, Papas, Black & Starr, 2002; Toth, Cicchetti, Macfie & Emde, 1997; Watson, 2005).

*Psychological conditions* include panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, self punishing behaviours and reactive attachment disorder (Egeland, 1997; Hildyard & Wolfe, 2002; Polonko, 2007).

*Attachment difficulties.* Children who are abused and neglected by caretakers often do not form secure attachments to them, which can result in insecure attachments, indiscriminate attachments or disorganized attachments. These early attachment difficulties can lead to later difficulties in relationships with other adults as well as with peers (Erickson & Egeland, 2002; Watson, 2005; Wilson & Horner, 2005).

*Behavioural difficulties during adolescence* include delinquency, teen pregnancy, low academic achievement, drug use and mental health problems (Polonko, 2007; Rodgers et al, 2004).

*Aggression, juvenile delinquency and adult criminality.* There is an increased likelihood of arrest as a juvenile, with a concomitant increase in adult criminal behaviour and violent crime (Egeland, 1997; Erickson & Egeland, 2002; Hildyard & Wolfe, 2002; Maxfield & Widom, 1996).

*Substance misuse.* There is an increased likelihood of smoking, alcohol and other substance misuse (Dube et al, 2001; Dube et al, 2003; Egeland, 1997).

*Death or serious physical injury* as a result of poor supervision, malnutrition and dehydration, exposure to infection through poor hygiene and medical neglect (Erickson & Egeland, 2002; Watson, 2005).

*Poor physical health* consequences can include pneumonia, other chest infections, low weight, skin conditions and gastroenteritis through poor hygiene, failure to thrive and inadequate nutrition and fluids (Glaser, 2002; Watson, 2005).

*Physical developmental delay* can result from lack of appropriate stimulation, and failure to thrive (Dubowitz, Papas, Black & Starr, 2002; Erickson & Egeland, 2002; Wilson & Horner, 2005).

### **3.9 Child development and sociological theories of childhood**

The common broad elements in the literature pertaining to definitions of neglect are predicated upon notions of children's basic developmental needs not being met through acts of omission on the part of those responsible for them (Watson, 2005). The primary question in this regard revolves around the issue of 'what constitutes meeting the basic developmental needs of children?' Whether a child's basic developmental needs have or have not been met is, to some extent, socially and culturally constructed (James & Prout, 1997; Woodhead, 1997). However, there is general consensus that, in order for children to not only survive, but to flourish, they child need: basic physical care, affection, security, stimulation, guidance, control and discipline, responsibility and independence (Pugh, De'Ath, & Smith, 1994). Children's 'needs' will, however, vary with age (with younger children requiring, for example, higher levels of physical safeguards than older children), with circumstances (for example, a child who is disabled), and environment (Hill & Tisdall, 1997).

Conceptualising childhood in developmental terms places emphasis on how children change over time according to specified patterns of development. It is these changes which become the focus of attention rather than what a child is, and what a child is experiencing, at any given moment in time (James & Prout, 1997; Lee, 2001). Thus, within the developmental perspective, childhood has come to be regarded as being of paramount importance since it is the time of most rapid change and development and is perceived as being critical or at least a highly sensitive period in terms of its impact on our adult selves. However, developmental psychology rarely places its understandings of children and childhood in historical, cultural, structural or social contexts (James & Prout, 1997; Woodhead, 1997). Furthermore, it universalises theories of 'the child', 'the mother-child relationship' and 'the family' in such a way that children and childhood are thought to be the same whoever and wherever they are (James & James, 2004; Mayall, 1994). Additionally, with much of the literature on neglect addressing the protection of and/or developmental needs of infants and toddlers, older children's experiences of neglect become even more difficult to define and identify (Dubowitz, Black, Starr, & Zuravin, 1993).

The problems of applying the developmental model to all children regardless of context resides within the assessment of (ab)normality of children's development and (in)adequate parenting standards when those particular normalised behaviours are not being met (James & James, 2004). It also exposes the dilemmas inherent in the artificial divide in child protection systems between 'children in need' and 'children at risk' leading to a focus on one at the expense of the other (DoCS, 2006). As Daniel has noted, neglected children are 'simultaneously in need and at risk, with the risks flowing both directly from the unmet needs and indirectly from the dangers associated with lack of care and supervision' (Taylor & Daniel, 2005, cited in DoCS, 2006, p. 11–12).

However, children's 'needs' tend to be taken for granted by health and welfare professionals' statements as 'authoritative statements of facts' about a child's current situation and future requirements whereas, it is argued, 'beneath the veneer of certainty there lies a complicated array of personal and cultural values alongside empirical claims about childhood' (Woodhead, 1997, p. 72). In other words, thinking about 'needs' is not inevitable, it is something that we choose to do within a child

development framework and it has certain consequences – in particular, a tendency to frame issues in terms of parent (typically mother)-child relationships (James & James, 2004; Woodhead, 1997). In this context, one of the most widely applied conceptual schemes for understanding the early socio-emotional development of children is attachment theory. Attachment is regarded as significant in shaping our capacity for interpersonal relationships, as well as in the formulation of our views of the world and of others around us. Bowlby, a British psychologist credited with developing attachment theory, argued that attachment is biologically based and represents a child's instinctual need for a reliable, ongoing relationship with a primary caregiver and that if this attachment is interrupted, lacking or lost, lasting emotional damage may occur (Bowlby, 1980).

The central focus of attachment theory has been on the dyadic relationship between the infant and the mother or primary caregiver. But since many cultures involve other family members or even members of a wider community in significant parenting roles, these cultures offer an opportunity to explore the implications of shared parenting for attachment security (Neckoway, Brownlee, & Castellan, 2007; Soo See Yeo., 2003). For example, Aboriginal kinship and child-rearing practices integrate, rather than isolate, children and the rest of the community. In this sense, Aboriginal children are the responsibility of a whole extended family and community and do not merely rely upon their mothers as primary caregivers (Elliott, 2007; Gordon, Hallahan, & Henry, 2002). The *Gordon Report* (2002) also notes that:

...generally speaking, autonomy is promoted in children from an early age in Aboriginal culture. Once children are old enough to walk around they are often pushed out into their wider peer group. They then become accustomed to making their own decisions and setting their own course in life. This 'traditional practice' involves a fine balance between individuality and connectedness to the group and can be a good thing if balanced with proper care. This care is provided by different relatives depending on the child's stage of life. When this is working well, there is a consistency of care and moral learning that accompanies the encouragement of autonomy. Problems begin to occur, however, when one of those things start to outweigh the other. When this consistent care is not present, the children become highly autonomous and eventually rebel against later intervention. This traditional method of child rearing, however, was reported to be breaking down due to a lack of appropriate people available at the right time of the child's development (Gordon, Hallahan, & Henry, 2002, p. 72)

However, attachment theory has a central role as a model that informs social work practice with Aboriginal, as well as non-Aboriginal parents, even though the applicability of the model for working with Aboriginal peoples has not been established (Neckoway, Brownlee, & Castellan, 2007).

In addition, ambiguity generated by the gap between the middle classes and the poor heightens the risk of an inaccurate assessment of neglect. Two problems arise in this context, both of which can have disadvantageous consequences for the child and family concerned. The first is the imposition of an Anglo, middle-class notion of 'children's needs' on a social and cultural minority, and the attribution of 'neglect' where it is not necessarily warranted. Second is the increased chance of overlooking neglect on the grounds of cultural relativism, or on social workers' hesitation to 'blame' minority group families or those living in poverty (Tanner & Turney, 2003; C. Taylor, 2004; Tomison, 1995).

### **3.10 A culturally appropriate, child-focussed ecological framework of neglect and chronic neglect**

From an ecological perspective (Bronfenbrenner & Ceci, 1994), it is presumed the presence and severity of multiple risk factors increase the likelihood of chronic abuse and neglect. These factors include:

- individual characteristics – break-ups and violence in childhood, low education, low level of intellectual functioning, little parent-child interaction, low levels of emotional warmth and nurturing for a child, or consistent harsh physical punishment coupled with a negative and harsh attitude towards the child;
- family characteristics – large number of children, low income, single-parent family, violent partner; and,
- environmental characteristics – social isolation and low social support, stress resulting from racism, institutional abuse, ignorance of the complexity of Aboriginal communities – increase the likelihood of chronic abuse and neglect.

If the concern is adequate care for children, then it is necessary to consider all instances in which children's basic needs are not met. Thus, it is not sufficient to focus on any single aspect of the problem (e.g., parental behaviour, poverty, and so on) (Dubowitz, 2007; Dubowitz, Black, Starr, & Zuravin, 1993), nor solely on an assessment of risk factors (DoCS, 2006). Efforts to reduce and prevent the incidence of neglect should, therefore, be based on a holistic understanding of its causes and effects (Watson, 2005). Contextualising these understandings within the framework of a culturally appropriate ecological model includes a focus on the child (with the detrimental effects of neglect of whatever kind at the forefront in considerations of any interventions), the family and the influences of the broader social, historical and cultural context of Aboriginal experiences. This approach requires a broad definition of neglect as the intention is to provide appropriate services and responses to families and children experiencing a range of detrimental and disadvantageous factors, including those of a socio-economic, historical and cultural nature (Dubowitz, Black, Starr, & Zuravin, 1993).

### **3.11 Effective and best practice in relation to neglect and chronic neglect in Aboriginal families and communities**

One of the terms of reference for this group analysis was an expansion of the Victorian review of the best practice approaches to chronic neglect to include a greater focus on Indigenous children and families. The term best practice is used widely in child protection discourse but there is little agreement upon what it actually means. Kessler and colleagues (2005, p.245) highlight the problems associated with determining best practice in child protection and note that the term often refers to practice wisdom, the emulation of other systems, the use of expert consultants to establish practice guidelines as well as evidence based practice. While evidence-based practice is the most reliable source of information there is little available with regard to the issue of child neglect (Berry, Charlson & Dawson, 2003; Chaffin & Friedrich, 2004; Kessler et al, 2005). One of the reasons for this is the short term nature of funding agreements that do not facilitate the evaluation of programs over time. Nevertheless, there is a small but increasing amount of literature that does identify the efficacy of particular approaches and programs. One approach to documenting these that has been used in

the literature is the adoption of the term 'promising practice' (Berry, Charlson & Dawson, 2003; Higgins & Butler, 2007). As Higgins and Butler (2007, p.3) explain, this term is used to describe programs that have been successful in meeting their goals and objectives but may not have been formally evaluated.

Promising practices identified by the Secretariat National Aboriginal and Islander Child Care (SNAICC) in relation to the protection of Aboriginal and Torres Strait Islander children (Higgins & Butler, 2007) are those that:

- a) take a community-centred, family-inclusive approach to child protection concerns;
- b) advocate for an Indigenous perspective for child protection processes (such as case planning);
- c) provide for an understanding of child protection issues to families and communities;
- d) build collaborative relationships with child protection departments and other agencies; and,
- e) ensure children are culturally safe as well as physically and emotionally safe.

### **3.12 Acknowledging the context of neglect**

Berry, Charlson & Dawson (2003) identify promising practices in programs aimed at preventing neglect as those that focus upon material hardship and needs, emotional and mental stress of parents, and social relationships. This three pronged approach recognises the importance of acknowledging the context of neglect which – unlike other forms of abuse – is far more likely to occur in families which are poor, unemployed, socially isolated and living with mental illness and/or where substance misuse is a problem. Thus both assessment and intervention practices should focus upon these factors. The context of neglect for Indigenous children in Australia has been detailed earlier in this report. It is critical that programs directed at protecting children from neglect are directed at improving the broader social, cultural, spiritual and emotional context in which Indigenous children live. To this end SNAICC (2006) has developed a framework for a national action plan to address the problem of child abuse and neglect.

### **3.13 A national action plan**

This national action plan (SNAICC, 2006) identifies ten points that detail SNAICC's approach to best practice in preventing the abuse and neglect of Aboriginal and Torres Strait Islander Children. The first point of the action plan states that the safety of children is paramount and that first and foremost all allegations of child abuse and neglect must be investigated in a 'child centred' way. The other nine points focus on the importance of supporting children by removing the risks rather than the children from their families and communities, effective policing so that community members are not fearful of making a report, the importance of early intervention and access to services for children and their families, an emphasis on healing and restoration which includes proper and appropriate referrals to drug and alcohol rehabilitation and mental health services, attention to what is working and Indigenous knowledges and understandings, and the development of a national response to the 'crisis' present in many Indigenous communities.

### **3.14 Child impact assessment**

The term 'child centred' itself along with the term 'the best interests of the child' are used widely and yet are open to much interpretation and are rarely defined in terms of concrete practices. As Bamblett & Lewis (2007) note the term 'best interests of the child' may be even less useful with regard to Aboriginal and Torres Strait Islander children as it rarely accounts for the importance of family, community and culture in Indigenous children's lives. SNAICC's reference to 'child centeredness' in its national action plan can best be interpreted as a need to focus upon the impact of neglect upon a child. Horwarth (2005) argues that many social workers, rather than attending to the impact of neglect upon a child, focus on assessing whether or not particular instances of neglect have taken place and if so, the extent of the neglect in that particular instance. Thus an adult's behaviour becomes the focus of attention rather than the child.

This is often despite a long history of neglectful practices within a family. Brandon and colleagues (2008, p.5) refer to the practice of focusing upon single incidences of neglect as the 'the start again syndrome' which, they argue, prevents practitioners and their managers from establishing a clear and 'systematic understanding of the case informed by past history'. One reason put forward for this is the overwhelming nature of the problems confronting families that tend to defeat practitioners who respond by being 'underwhelmed' with regard to the possible impact of neglect upon a child.

Berry, Charlson & Dawson (2003, p.13) also emphasise the importance of practitioners understanding the impact of neglect upon a child and point out that 'child neglect is more common, lasts longer, and has longer-term consequences than physical abuse for children'. A best practice approach focuses upon investigating the impact of neglect on a child over time. This requires switching attention from the adult to assessing the child's experience on a daily basis and consulting with immediate and extended family members, the child in question and other service providers who have continuing contact with the child such as health professionals, teachers and child care staff. The task, according to Brandon and colleagues (2008) is to develop 'a video' of the child's circumstances as opposed to a snap shot.

Unfortunately, it is not unusual for practitioners to feel threatened by uncooperative parents and to fear making home visits which hampers their ability to actually make contact with a child directly (Brandon *et al*, 2008). This is despite the general agreement in the literature that a proper assessment of the impact of neglect upon a child cannot take place without physically seeing and observing the child and where possible observing the interactions between the child and his or her carers. There is a need to fully understand the circumstances of a child's daily activities, what is happening in the child's life over a period of time and the child's developmental needs as well as the parent/carer/community's capacity to meet these needs.

### **3.15 Assessment of the capacity to care for the child**

A proper assessment of the capacity of the parent/carer/community to care for a child also needs to be made. For example, Horwath (2005) notes that often in cases of neglect case workers identify the presence of alcohol, mental health issues and family

violence but fail to make an assessment of the extent to which the presence of these issues impairs the parent's ability to care for the child. Assessments made on the basis of the amount, frequency and pattern of alcohol consumption do not provide an accurate picture. She advocates for a strengths-based approach to this assessment focusing upon the absence or presence of other support available to the carer and the child, the parent's ability to make arrangements for the care of the child when his or her own ability is impaired, and the child's own resilience. SNAICC (2007) also advocates for strengths-based approach, arguing that even when families are not able to meet all children's needs they still possess some strengths and it is these that must be supported and fostered. For example, SNAICC (2007, p.5) points out that 'families may provide their children with a sense of belonging within their broader family and community and a connection to their cultural and spiritual heritage' and these things are central to Indigenous children's wellbeing.

### **3.16 Whole of family/community approach**

Bamblett & Lewis (2007) draw attention to the individualistic approach to child welfare within mainstream child protection systems and argue that this is at odds with Aboriginal and Torres Strait Islander cultural perspectives and often overlooks the importance to a child of those outside the child's immediate family. They argue that a promising practice approach includes a due recognition and assessment of the ability of an extended family and community resources to care for a child.

Others have noted the gendered nature of approaches to chronic neglect where the focus has been placed upon mothers alone even when the behaviour of fathers has been a cause for concern (Horwath, 2005, p.106). Horwath (2005) notes that the failure to assess the extent to which the extended family may be able/unable to provide support to a child is all the more disappointing given that many reports of suspected neglect are made by members of the extended family. SNAICC (2006) also stresses the importance of involving extended family and community in child protection processes and emphasises the importance of state government's and statutory authorities working with local communities and not doing things to them. They argue it is important to 'recognise and build on the strengths of Aboriginal and Torres Strait Islander families, communities and kinship systems', a point reiterated in their response to the Western Australian Department for Child Protection's draft policy on neglect (SNAICC, 2007, p.5). SNAICC (2007) underlines the centrality of family and community to the development of identity, spirituality and culture leading to resiliency for Aboriginal and Torres Strait Islander children. Thus, it is even more critical that a whole of family and community approach is embedded in all child protection practices and processes.

### **3.17 Early intervention**

While Aboriginal and Torres Strait Islander children are over represented in the child protection system they remain severely under represented in family support and early childhood care and education programs. SNAICC (2006) has included in its National Action Plan the need for better access for Indigenous children and their families to Indigenous children's services that promote children's wellbeing. Evidence from Canada (Sims *et. al*, 2007) demonstrates the efficacy of indigenous specific early

childhood services in promoting better family functioning. These programs take a holistic approach to service provision and not only provide child care and early childhood education but maternal health services, parenting programs and family support services. The importance of holistic programs is all the more clear considering the evidence that targeted programs aimed at families which have already been identified as being at risk have much greater success in decreasing the incidence of physical abuse than they do when chronic neglect is present (Berry, Charlson & Dawson, 2003). Berry and colleagues (2003) note that interventions aimed at ameliorating neglect must take into account the complex issues inherent in neglect and be more comprehensive and of longer duration than those associated with physical abuse. The need for long term services and programs for Aboriginal and Torres Strait Islander children has also been emphasized by Scougall (2008) in his review of the Australian Government funded *Stronger Families and Communities Strategy 2000–2004*.

### **3.18 Focus on healing and restoration**

There is also widespread recognition that while best practice approaches must include efforts to improve environmental conditions that often lead to neglect (poor housing, poverty, and unemployment) it is also important to attend to the interpersonal context of neglect. Most commonly family violence, social isolation, mental illness and substance misuse are thought to be key indicators of the risk of neglect and it is important that families receive proper and appropriate referrals to agencies that can assist with these matters (Berry et al, 2003). SNAICC (2007) and Scougall (2008) both note the importance of a focus on healing and restoration in Indigenous communities.

Strengthening Indigenous families and communities is as much about healing the effects of trauma, attitude and behavioural change, rebuilding confidence and self belief as it is about the transfer of particular knowledge and skills (Scougall, 2008, p.vii).

Programs centred on healing and restoration recognize the importance of restoring the social and emotional health of those affected by trauma and, according to Scougall (2008, p.20), provide hope with regard to complex and difficult issues such as those associated with addiction, domestic violence and child abuse and neglect. A healing approach focuses upon both the victim and the perpetrator.

### **3.19 Aboriginal and Torres Strait Islander input in decision making and case planning**

A key aspect of promising practice with regard to Aboriginal and Torres Strait Islander children is the inclusion of Aboriginal and Torres Strait Islander peoples in decision making and case planning. Bamblett & Lewis (2007, p.46) point out that, in the USA, this principle is enshrined in state court proceedings where 'the child's Tribe or American Native custodian must be notified and can intervene and participate at any point in the proceedings...' SNAICC provides three examples of where this is established practice in Australia. In Victoria, Lakididjecka Aboriginal and Child Specialist Advice and Support Services (ACSASS) has formal protocols in place with the Department of Human Services that ensure it is informed of all notifications relating to Indigenous children. An agreement with the Department requires that it must consult with ACSASS before making any key decisions relating to a child

thought to be at risk of abuse or neglect. ACSASS provides advice to Departmental staff with regard to whether or not a notification should be investigated, what risk factors may be present, how these can best be addressed, the best approaches to engaging a child and his or her family, strategies for ensuring the child's safety and ways in which the community can be involved as well as advice regarding possible placements and the development of a cultural support plan and what action should be taken when an allegation of abuse in care arises for Indigenous children.

In Northern Queensland, Remote Area Aboriginal and Torres Strait Islander Child Care (RAATSICC) is directly involved in the Suspected Child Abuse and Neglect (SCAN) team. This is a multidisciplinary team which investigates child abuse concerns. In addition to this, Queensland also operates a 'Recognised Entities' scheme which enables community-based perspectives to be included in decision making processes. Unlike the other two programs, Tangentyere Council's Safe Families Program in the Northern Territory is not involved in the initial assessment of concern reports but is active in ensuring appropriate response once a child is identified as being 'at risk'. Perhaps more importantly, due to its close association with the communities which it services it is able in some cases to prevent the necessity of statutory child protection involvement by offering voluntary family placements.

SNAICC (2006) points out that the establishment of Aboriginal and Islander Child Care Agencies in the late 1970s and early 1980s was an important step in providing better support to families at risk of child abuse and neglect. The lack of agreement between the states, territories and the Australian Government, however, has resulted in little development of these services. In 2006, only thirty of these organisations existed, many of them very small and constrained by government policy to provide placement services rather than support and advice to child protection agencies before a child is in need of a placement (SNAICC, 2006). It is also important to note that Western Australia is particularly badly served in this respect as, currently, it only has one such service, Yorganop, which only operates in the metropolitan area of Perth and is limited to the management of foster placements for children already in the care of the Department.

### **3.20 Multidisciplinary practice and collaborative partnerships**

Kessler and colleagues (2005) point out that the context of child abuse and neglect decision making is extremely complex and yet little attention is given to decision making processes in training programs or practitioner education. Consequently, decision making tends to focus upon the need for evidence to support a particular position rather than also considering evidence to refute it. Kessler and her colleagues (2005) point out that social workers often make decisions about the kind of action to be taken or not taken based upon their own beliefs about how things are or the way they think they should be, rather than upon an evaluation of the facts. Brandon and colleagues (2008) note that in order for practitioners to properly understand the risks to children they must be encouraged to think critically and systematically and to be mindful of the nature of individual factors that can coalesce to form a greater risk of harm to a child. For example, there is now evidence that there are particular risk and protective factors that operate within Indigenous communities and families (Walker &

Shepherd, 2008) and it is these that should form the basis of decision making where there are concerns about the possible neglect of a child.

The role of supervisory staff is believed to be key in ensuring that decision making is systematic and based upon evidence (Horwath, 2005; Kessler, 2005). However, Horwath notes that supervisors often relegate neglect to the bottom of their supervisory duties. She argues that practitioners need time and space to reflect upon their decisions with their supervisors in a supportive environment of continual learning. In addition to this, the importance of multiple perspectives and collaborative arrangements with other professions and service providers is essential for a rigorous assessment of potential risks and harms. In her study, Horwath found that social workers tended to consult only those professionals or service providers to whom they had easy access (Horwath, 2005, p.103).

### **3.21 Culturally competent service systems**

Bamblett & Lewis (2007) underline the importance of culturally competent services systems and argue that children and their families often fall victim to 'cultural abuse' in the form of agencies and practitioners intentionally and unintentionally ignoring, denigrating and even attacking their culture. Cultural competence is defined by the US National Association of Social Workers (2001, p.9) as the ability of:

Individuals and systems to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

Important to the notion of cultural competence is the embedding of cultural information and practices in standards, policies, practices and attitudes. Bamblett & Lewis (2007) provide several examples of cultural competence established within child protection systems in Canada, the USA and New Zealand. For example, they point out that in Canada several First Nations communities have been successful in negotiating with provincial governments in order to establish control of the development and operation of culturally appropriate child welfare service models. In New Zealand, the 1989 *Children, Young Persons and Their Families Act* enshrined the importance of making reference to a child or young person's kin group, extended kin group, descent group as well as family group when considering his or her wellbeing. The four key principles of the Act, according to Bamblett and Lewis (2007) are:

- a) the participation of family, kin, extended kin and descent group in all decisions affecting the child;
- b) an understanding that intervention in a child's family life should be the minimum necessary to secure their safety and protection;
- c) the impact upon the child's family, kin, extended kin and descent group is considered; and,
- d) wherever possible, if removal is necessary the child should be placed with family or kin group and if this is not possible with someone who has the same tribal, cultural background and location.

### **3.22 Aboriginal child placement principle**

The Aboriginal child placement principle has been endorsed by SNAICC and largely adopted by Australian state and territory governments (Bamblett & Lewis, 2007). At the core of the placement principle is the need to keep children in their communities and with their families wherever possible. In the event of this not being possible, statutory authorities are required to consult with the appropriate Indigenous agency within the state or territory with regard to appropriate placement options for children.

### **3.23 Summary**

The review of relevant literature has highlighted the difficulty in reaching universal definitions of neglect. The difficulties relate to the problem of establishing thresholds that are agreed by service providers and comply with community standards. Nevertheless there is an increasing amount of evidence to suggest that particular behaviours have long term detrimental effects on the development of young children. For example, excessive alcohol misuse during pregnancy can lead to foetal alcohol spectrum disorder, including severe intellectual impairment. Similarly it is agreed that both the immediate and long term effects of failure to provide adequate food and shelter, emotional sustenance, appropriate medical attention and freedom from violence has both immediate and long term consequences for children. The cumulative effect of harm from the neglect of these basic provisions often results in mental health disorders, poor cognitive functioning, behavioural problems, poor school attainment and even death. In addition to this, the recent focus upon children's rights and sociological understandings of children and childhood has led to a better understanding of the immediate consequences of neglect for children's general wellbeing and a recognition that children have at the very least the same right to protection and support as adults. Despite this evidence however, there exists still the propensity for statutory authorities and service providers to minimise the harms resulting from chronic neglect in comparison to other forms of maltreatment and abuse.

This is particularly alarming with regard to Indigenous children and families as the rate of substantiations for neglect is higher than other forms of maltreatment or abuse among Indigenous children than it is among non-Indigenous children. The higher incidence of neglect in Indigenous families and communities is not surprising given that the known risk factors for neglect – including poverty, low educational levels, family violence, substance misuse and mental health problems – are also found disproportionately in Indigenous communities. While there is little research evidence for the efficacy of various approaches to preventing and reducing the incidence of neglect in Indigenous families and communities there is agreement that measures should be directed at improving the general living conditions of Indigenous families as well as the interpersonal context of neglect. This includes family violence, substance misuse, social isolation, and mental illness. These key indicators for the risk of neglect are largely intergenerational and interventions aimed at ameliorating the long term effects of neglect must acknowledge the harms associated with dispossession, separation and institutionalisation and have a focus upon healing and restoration.

In addition to this, recent reviews of child deaths in England, Ireland and Australia demonstrate that there needs to be a concerted effort to develop child centred practices that ensure that cumulative harm associated with chronic neglect is acknowledged and used to inform the decision making of statutory authorities in cases where neglect or chronic neglect has been reported. This will require a more rigorous risk assessment process that includes all the major stakeholders as well as an assessment of the risk of harm to a child, the parent/carer/community's capacity to care for the child and the likelihood of the reoccurrence of neglect.

## 4. The context of neglect

### 4.1 Introduction

The importance of understanding the context in which neglect and chronic neglect occur has been emphasised earlier in this report. The research evidence clearly demonstrates that efforts at preventing child neglect must address the circumstances in which it occurs. The following analysis of the characteristics of the deceased children who are the focus of this report and the context in which they (and their siblings) were living at the time of their deaths, provides the basis for understanding what can be done to prevent other children suffering the same fate as well as informing approaches that support those children who continue to live in such circumstances.

### 4.2 Characteristics of the children who died

#### 4.2.1 Age and gender

Data on age and gender are presented in Table 1. Twelve of the deceased were male and 10 females – a difference that was not statistically significant. The ages of the children ranged from six weeks to 16 years. Almost 60% (13) were aged less than one year at the time of death and all but two of these children were aged less than six months.

A six week old baby was placed in his mother's bed with his brother at approximately 10.00 p.m. on the night/next morning he died. When his mother awoke she found him not breathing. The deceased was conveyed to hospital but could not be resuscitated. The mother was known to child protection services as a child but had no history with the Department as a parent (Case P).

The parent's of a two month old baby awoke to find the deceased, who was sleeping in their bed, not moving or making a sound. The deceased was not breathing. The deceased was conveyed to the Clinic. CPR was conducted but was unsuccessful. The Department has had an extensive involvement with the mother as a child and with her family of origin but has had no history with the mother as a parent (Case K)

Another six children were aged between one and less than five years of age.

The nearly three year old child had been playing in the backyard at his relatives' home, who he and his parents had been visiting. At some point he had entered the below ground unfenced swimming pool area and was found lifeless in the swimming pool. It is not known how long he was in the pool before being pulled out by his father. His parents, the ambulance officers and doctors attempted to resuscitate him unsuccessfully. The Department has had a long history of involvement with the father, his partner and the mother as children and with their families of origin and then more sporadic contact with them as adults and parents (Case H).

Of the remaining three children, one was a male aged 12 years and two were females aged 5 years and 16 years.

The Coroner's notification indicated that the 12 year boy was a passenger in a stolen motor vehicle in company with three other juveniles being pursued by police. The offending vehicle, traveling west on a metro north highway, contravened a red traffic control light and collided with a Holden utility. A seat belt was not worn. The Department had an extensive history with the parents and their children (Case F).

Table 1: Age at death by gender

Age deceased	Gender				Total	
	Male Number	Male Percentage	Female Number	Female Percentage	Number	Percentage
<3 months	2	17%	2	20%	4	18%
3 – 11 months	5	42%	4	40%	9	41%
12 – 59 months	4	33%	2	20%	6	27%
≥ 60months	1	8%	2	20%	3	14%
Total	12	100%	10	100%	22	100%

#### **4.2.2 Persons with whom the children were living**

The data in Table 2 show that, at the time of death, half of the children were living with both their parents (11). A total of seven children appeared to be living with a lone mother and two with a mother and stepfather. Two were living with extended family members. One of the children living with extended family was a ward of the state, placed with the family member by the State.

Table 2: Person(s) with whom the child was living at the time of death

Living circumstances	Number	Percentage
With biological parents	11	50%
With lone parent – mother	7	32%
With one biological and one step-parent	2	9%
With extended family members	2	9%
Total	22	100%

#### **4.2.3 Siblings**

Information recorded on the number of siblings was quite comprehensive, and in some instances included information on half-siblings. One was an only child, five had one sibling, two had two siblings, and, the 15 (63%) had three siblings or more. One of the young children in the sample was a twin. Although in some cases, quite detailed information was available on the siblings' circumstances, it was not always clear whether the children were living with the siblings.

Table 3: Number of siblings of deceased children

Number of siblings*	Number	Percentage
0	1	4%
1	5	23%
2	2	9%
3	7	32%
4	4	18%
5	3	14%
Total	22	100%

\*Note: includes half siblings, where known,

Three of the children had siblings who had died. Those deaths were reported to have occurred as the result of: pneumonia; natural causes; and other (reported as co-sleeping with parent/carer at time of death). The ages of the siblings at time of death ranged from between one month to two years.

#### **4.2.4 Place of residence**

To protect the identities of families and communities, the places of residence of the deceased children have been classified (in accordance with Department of Child Protection's current practice) as follows: Country North (Kimberley, Murchison, Pilbara); Country South (Great Southern, Peel, Southwest); Country East (Goldfields, Wheatbelt) Metro East (Armadale, Cannington, Midland); Metro North (Joondalup, Mirrabooka, Perth); and, Metro South (Fremantle, Rockingham)

Eleven of the children (n=22) were reported as living transient lifestyles in remote communities in Country North region. A further eight were reported as living in rural communities, with six of those children also reported as living transient lifestyles. Two children, one of whom was transient, were living in Metro East region, and one in Metro North region.

Table 4: Place of residence

Location	Number	Percentage
Remote	11	50%
Rural	8	36%
Metropolitan	3	14%
Total	22	100%

#### **4.2.5 Other characteristics of the children**

Disability was recorded in three (14%) cases and included: one with mild intellectual disability; one with developmental delays, and one with special needs owing to premature birth. There was a question as to whether or not this latter child's special health needs were the result of alcohol misuse by her mother during pregnancy.

Chronic illness and complex health needs were listed for two of the children. Previous hospital admissions were recorded for five of the children, with two of them requiring neo-natal care due to premature births. There was a total of three premature births recorded, with these children recorded as having spent time in hospital for neo-natal care.

### **4.3 Age of parents**

At the time of her child's death the youngest mother was aged 17 and three of the mothers were below the age of 18 when they gave birth to the deceased children, thus being officially children themselves at that time. At least another five mothers were under the age of 17 when they gave birth to their first children, the deceased's siblings – the youngest of these mothers being 14 years of age. Data on their ages at the time of the birth of their first children for the remaining mothers and fathers were missing.

Table 5: Age of parent(s) at time of child's death

Age (yrs)	Number	Mother	Number	Father	Percentage
		Percentage		Number	
≤19	4	18%	-	-	-
20-24	3	14%	3		14%
25-29	3	14%	1		4%
30-34	6	27%	2		9%
35-39	1	4%	4		18%
≥40	2	9%	1		4%
Unknown	3	14%	11		50%
Total	22	100%	22		100%*

\* Errors due to rounding

### **4.4 Child protection histories**

All child deaths occurred in the context of a long history of Departmental involvement with the children's families. Before providing an analysis of the history of the Department's history with these families it is important to provide some definitions of the terms used by the Western Australian Department for Child Protection.

#### *Child Concern Report (CCR)*

According to the Department's case practice manual

A classification of CCR is used only when the exact nature of the referral or the reason for contact is not clear from the presenting information at Duty. A CCR classification will, as implied by its title, always involve concerns in relation to children. The classification of CCR however means that the nature or basis of the concern for the child and the response required by the Department for Community Development in relation to that concern is unclear or uncertain. Where the reason for contact and response required by the Department are clear from the presenting information, the referral would then be classified using a family support or child maltreatment classification (reason for contact), whichever is appropriate. A CCR classification is in this way a temporary holding category, used only until further assessment clarifies what the actual nature of the

presenting problem or concern is and what type of response or intervention is required from the Department ...

The assessment of a CCR seeks to establish the following

- The exact nature of the problems being experienced by the family and/or the situation which led to the referral.
- Whether the identified problems relate to family support or child maltreatment concerns.
- How the family is functioning and how this might be impacting upon any children in the home.
- Whether the parents are experiencing parenting problems.
- Whether the family require or would benefit from services to enhance the family functioning.
- Whether there is a role for the Department.

#### *Child Maltreatment Allegation (CMA)*

The Department's Case Practice Manual states:

If at any stage of the assessment process... [of a CCR] indicators of child maltreatment or risk of maltreatment are determined then the assessment process and classification must be immediately changed to a CMA investigation...

A referral should be classified as a Child Maltreatment Allegation when the information is sufficient to indicate that a child:

- may have been physically or emotionally harmed or injured,
- is at risk of significant physical or emotional harm or injury,
- may have been exposed or subjected to sexual behaviour or activities which are exploitative or inappropriate to his or her developmental level, and/or
- may be the subject of persistent actions or inaction's which are likely to result in the child's development being significantly impaired ...

The description of child maltreatment includes situations where a child is denied available food, shelter, medical attention or supervision to the extent that the child has suffered or is at risk of significant harm or injury.

#### *Notification*

The term notification is used throughout the report to describe the instances where a person external to the Department has contacted the Department to discuss his or her concerns for the wellbeing of particular children.

#### *Logged contact*

A logged contact refers to the documentation of such notifications by departmental staff.

#### *Open contact period*

Describes a period of time in which the Department considers itself actively involved in the children's lives.

#### *Chronic neglect*

As of the 1<sup>st</sup> May, 2008 the Department's operational description of neglect is as follows:

Neglect is when a child is not provided with adequate food or shelter, effective medical, therapeutic or remedial treatment, and/ or care, nurturance or supervision to a severe and/or persistent extent. The deliberate deprivation of a child's basic needs should be considered within the context of physical, emotional or psychological abuse. For a child to be considered in need of protection, the level of harm must be detrimental in effect and significant in nature to the child's wellbeing. This can be due to the refusal or inability of the child's parents or carers to respond appropriately resulting in significant, immediate or potential risk of harm.

The effects of neglect may not be apparent at an early stage except in the most extreme situation. However the ongoing effects of neglect are harmful and can cause cumulative and long term harm to a child's development, particularly in circumstances of chronic neglect and where neglect exists with other forms of abuse.

Neglect can be further described on a continuum of episodic, reactive or chronic. It can also be categorised as:

- Physical neglect of basic needs and abandonment, including poor supervision, malnutrition and dehydration, exposure to infection through poor hygiene and medical neglect. This can lead to poor physical health, developmental delays, serious injury or death.
- Supervisory neglect can result in serious accidents or accidental deaths including drownings, gun accidents, choking, ingestion of pills or fires. Supervisory neglect of very young children is of particular concern because of their increased vulnerability.
- Emotional neglect consists of inadequate nurturance or affection, permitted maladaptive behaviour and other emotional neglect. This can lead to inappropriate self-soothing behaviours and aggression in children.
- Psychological neglect includes the lack of any emotional support and love, chronic inattention to the child, exposure to family and domestic violence or alcohol and drug abuse. Children who experience psychological neglect may show signs such as neurological impairment and high anxiety level.
- Educational neglect relates to permitted chronic truancy, failure to enrol and inattention to special educational needs. This can lead to cognitive, language and communication delays. However referrals are not usually accepted by the Department where educational neglect is the only concern. Consistent with the School Education Act 1999, schools are responsible for addressing nonattendance issues with families.

#### **4.4.1 Presence of neglect**

Using the operational definition of neglect provided above it is clear that chronic neglect was present in all cases. Psychological (85%) and physical neglect (76%) were characteristic of the majority of families over time. Within the context of chronic physical and psychological neglect – often resulting from family violence and alcohol and other drug misuse – episodic neglect in the form of supervisory neglect, educational neglect and emotional neglect were also found to feature in the lives of the children who died and their siblings.

Table 6: Types of neglect present in family history

Type of neglect	Number	Percentage
Physical	16	76%
Supervisory	10	47%
Emotional	2	9%
Psychological	18	85%
Educational	2	9%

#### **4.4.2 History of Department's involvement with families**

For four of the families in the sample, the Department's involvement in their lives began when the deceased children's mothers or fathers (and in one case both) were the victims of child neglect, physical or sexual assault themselves. Departmental involvement with all families ranged from a minimum of five years to a maximum of 25 years with an average length of Departmental involvement being 10.5 years. Three of the 21 families had previously had a child death in the family, and all families had a

record of previous notifications for child neglect or abuse. Five of the children who died had siblings who at some time had been placed in out-of-home care by the Department. A further seven had siblings who had been placed in relative-care, sometimes at the instigation of the Department but also through private arrangements when family members assumed responsibility for children after becoming concerned for their wellbeing. A further five children had mothers or fathers who had themselves been placed in out-of-home care as children. In all, seventeen of the twenty-one families had histories of children being placed in either relative or State care.

Table 7: Child protection histories

Family history	No. of families	Percentage
Previous notifications for child abuse/neglect	21	100%
Family history of out-of-home care	17	81%
Previous substantiated child maltreatment allegations	11	52%
Deceased's siblings placed in relative-care	7	33%
Previous child concern reports with substance	7	33%
Deceased's siblings placed in out-of-home care	5	24%
Parental childhood placement in out-of-home care	5	24%
Childhood abuse/neglect of parent	4	19%
Previous child death in family	3	14%
Deceased placed in out-of-home or relative-care	1	5%
Unspecified logged contacts leading to 'open contact'	3	14%

#### **4.4.3 Previous notifications**

Eleven of the families had previous child maltreatment allegations substantiated and a further seven had child concern reports that were investigated and found to have some substance leading to an 'open contact' period with the Department. Numerous 'logged' contacts were made for the remaining three families but it seems these were not recorded as Child Concern Reports (CCR). The purpose of the classification CCR is to highlight the need for further investigation and the possibility of upgrading them to a Child Maltreatment Allegation (CMA) or, if this is not required, possibly classifying them as 'family support case'. In these three families the contacts rather than being logged as CCR and thus requiring further investigation were classified immediately as 'family support problem' and while this led to an 'open contact' period with the Department the specific issue of the neglect of children was not followed up. For example, in case K both the children's school and health workers had notified the Department on a number of occasions with respect to their concerns about the children. These contacts were logged as 'family support problem' but no consequent action was evident.

Similarly in case E there were two occasions that could have been logged as either a CCR or, indeed, a CMA. On one occasion the police reported that the child had been left alone in a car and on the second occasion the mother disclosed to mental health professionals that she had neglected her children by leaving them unattended while

she was away drinking. As the mother had disclosed this to the mental health professionals who then notified the Department, it was put down to stress and not recorded as a CCR or a CMA.

In addition to this, many more 'logged contacts' that – in the opinion of the Western Australian Child Death Committee – could have been upgraded to either Child Maltreatment Allegations or Child Concern Reports were not classified. For example, one family had a total of 67 notifications. Of these only 11 were recorded as Child Maltreatment Allegations – two of which were substantiated and three of which were recorded as Child Concern Reports.

#### **4.4.4 Notifications related to the children who died**

Of the 22 children who died, 16 had previous notifications recorded on file, and no notifications were recorded for six. Ages at first notification to the Department ranged from between birth and eight years of age. Of these, seven (32%) children were aged less than three months – six of these at, or within a few days of, birth. A further eight were reported to the Department when aged between three and less than 12 months. The other case was notified when the child was aged eight years. Of the 16 cases notified to the Department, 11 (69%) had been notified once, two (12%) twice, and three cases three times.

Table 8: Age at first notification

Age at first notification	No.	Percentage
<3 months	7	32%
3–11 months	8	36%
≥ 12 months	1	5%
No notifications	6	27%
Total	22	100%

#### **4.4.5 Source of notifications**

Direct notifications to the Department mainly came from health professionals, medical social workers, police officers, youth services and child protection officers. Members of the children's extended families were also a source of direct notification in some of these cases.

Table 9: Referred cases by agency/profession

Agency/profession	Number of cases	Percentage
Health professionals	13	59%
Police officers	12	55%
Extended family members	4	18%
Medical social workers	2	9%
Youth services officers	2	9%
Child protection officers/health professional from other state/territory jurisdictions	2	9%

#### 4.5 Case status at the time of death

Five of the children died during a 'closed contact' period with the Department. Nine children were the subject of 'open contact' with the Department at the time of their death but it is not possible to tell from the data whether the remaining seven cases were open or closed at the time of the children's deaths. The difficulty of establishing the status of their cases at the time of death stems from there being evidence that cases were opened and then later closed and possibly reopened at some time before the children's deaths, but how or when this occurred is missing from the data. For example, in case I there is a note to indicate the case had been closed at one point but there is also a note to say that it was an open contact/family support case at the time of the child's death. There is a similar ambiguity in the status of case O which had been closed because the child had been placed in relative-care but subsequent to that placement there is a record of ongoing contact with the Department.

It seems that cases are opened in response to particular sets of circumstances and then closed when these circumstances change, but there is little assessment of whether or not these changed circumstances were going to have any chance of permanency or, indeed, of whether case closure was warranted. For example, in case A the case was closed at the time of the child's death because the mother had not been complying with the Department's request that she voluntarily participated in a program of family support. This program of family support was provided to her after a Child Maltreatment Allegation was substantiated for another of her children and two more Child Concern Reports had been made for other siblings. Because the action to be taken at the time of the reports was classified as family support, and therefore voluntary, it was seen to be appropriate to close the case when the mother did not comply with the directions of the Department.

In case B the case was closed 'due to a lack of resources' despite there being three Child Concern Reports recorded for the deceased and one for another sibling. Significant in this case closure was the response to the father's concerns for the safety of his child. The concerns he raised were put down to a 'custody conflict' and largely ignored. As the CDRC noted:

In respect of the above events it is the Committee's observation that the father's concern for his children's welfare appeared genuine. It is also the Committee's view that the Department appropriately classified the father's concerns about his children's welfare as

a Child Concern Report and gave a clear indication that the Department would contact the schools and follow up on whether the children were "going without food". These matters however were not followed up by the Department.

In the third case that had been closed before the death of the child occurred, several serious notifications were simply recorded as 'logged contacts – family support problem' rather than Child Concern Reports (case J). Similarly, in case L, even though there were two substantiated Child Maltreatment Allegations for the child's siblings and numerous 'logged contacts', the case was closed for no apparent reason.

The fifth instance in which the case was closed at the time of the child's death was a little different. The case itself relates to the mother of the child who died. She was known to the Department to be a child 'at risk' as she and her siblings had been the subject of ten substantiated Child Maltreatment Allegations between them and had a long history with the Department. She had been the victim of sexual assault before puberty and apprehended by the Department as a teenager and placed in out-of-home care. However, shortly before the birth of her first child (the deceased) she was a young adult (under twenty years of age) living independently. While pregnant with this child she had expressed a desire that she wanted the Department to stay out of her life and thus the case was closed.

#### **4.6 Circumstances surrounding death**

The official 'cause of death' was available for only two the cases reviewed. One of these was reported by the Coroner to have been the result of pneumonia (case Q). The other remained an 'open finding' as the Coroner was unable to ascertain the cause of death. Circumstances surrounding all the deaths, however, were recorded and were taken from the Coroner's notifications of child deaths to the CDRC. Of the 22 children, 10 were co-sleeping with a parent or carer at time of death; three deaths occurred by drowning; two deaths (same case) by homicide – unlawful killing; three vehicular accident deaths; and four 'unknown' (with one noted with suspicions by a medical practitioner of non-accidental injury).

Table 10:Circumstances surrounding the deaths

Circumstances surrounding death	Number	Percentage
Co-sleeping	10	45%
Drowning	3	14%
Vehicular accident	3	14%
Homicide (unlawful killing)	2	9%
Unknown	4	18%
Total	22	100%

As noted, the highest proportion of deaths occurred when a child was co-sleeping with a parent or carer (45%), with the ages of the children ranging from between six weeks to six months. In four of these cases, it was reported that the parent or caregiver

present at the time of death had been, or there was a suspicion of, either drinking alcohol or smoking cannabis. Whilst these figures refer to the circumstances surrounding the death, there was often a combination of contributory factors, which included chronically neglectful care, parental histories of family violence, substance misuse, homelessness/transience and in some cases mental health issues.

#### **4.7 Presence of multiple risk factors**

All of the children who died were living in families in which a number of interrelated risk factors were present. Eighteen of the families had long histories of family violence and 17 had equally long histories of alcohol and other drug dependence. In addition family violence was a significant feature in the notifications of concern reported to the Department for 14 of the families and alcohol and other drug misuse was also indicated in 14 cases. There is only one case in which either alcohol or other drug misuse or family violence was not a significant factor in the neglect experienced by the child or the child's siblings before his or her death. This child was an infant whose mother was just eighteen when she gave birth and she was only just living independently of a household where substance misuse and violence were present. Thus, it is safe to say that substance misuse or family violence and in most cases, both of these, were significant factors in the chronic neglect of the children who died and, in many cases, their siblings.

Table 11: Risk factors

Risk factors	Number	Percentage
Family violence	18	86%
Homelessness/transience	18	86%
Financial hardship	18	86%
Substance misuse	17	81%
Refuge accommodation	16	76%
Parental childhood abuse	9	43%
Mental health problems	8	38%
Care history (excluding extended family care)	8	38%
Failure to thrive in infancy and early childhood	7	33%
Previous child death	3	14%
Poor standard/living conditions in the home	3	14%

In addition, there is a clear indication that many of these families experienced structural and societal disadvantage. These issues have been reported in the Gordon Inquiry (Gordon, Hallahan & Henry, 2002), and within the CDRC's reports. These issues include: the effects of marginalisation, dispossession, loss of land and traditional culture, and the forced removal of children which has led to ongoing trauma within Aboriginal communities and is coupled with extreme social disadvantage (Gordon, Hallahan & Henry, 2002). These broader factors are reflected in

the high level of homelessness/transience and in the history of use of refuge accommodation. In addition, financial hardship was recorded as a feature of 18 of the families, with the most common request reported as requiring assistance to buy food.

#### **4.8 Heighted vulnerability of infants**

The higher risk to infants is clear – with 13 (59%) of all child deaths in this sample occurring before the children were twelve months old. The analysis of the circumstances of these children's deaths points to two particular concerns. The first is in relation to the incidence of co-sleeping in environments where substance dependence is evident. The definition of Sudden Infant Death Syndrome purposefully excludes children who have died while co-sleeping as it is recognised that even though it may have important benefits to young children it becomes a dangerous practice when combined with intoxication. In none of the cases was there a finding that a death was caused by a parent suffocating a child during the night, However, there is always a heightened risk of this occurring when a parent is intoxicated. The second concern raised in relation to the increased vulnerability of infants and toddlers is the presence of the diagnosis 'failure to thrive' which was indicated in seven of the families and often for more than one child in a family. Although once again, it is not possible to make a definitive finding with regard to this based upon the data to hand, it does appear that the concern for the wellbeing of these infants raised by medical staff was not given the same weight by case workers. In a climate of voluntary reporting it would seem judicious to take the concerns of health and medical staff with regard to an infant or toddler's wellbeing extremely seriously. For example in case L:

It was noted at this time (Nov 2004) that the mother was in hospital with her two youngest children, child three and four (the deceased). The centile charts for child three on file showed her weight at 12 months as under the 3rd percentile and the worker with AHS noted in a letter to the Department that child three:

currently weighs the approximate weight of a 6 month old at the age of 12 months. If allowed to continue the ultimate outcome is death and brain damage as the child becomes so weak and malnourished that they can't sustain life. During the periods of hospitalisation the children are fed appropriately and gain weight accordingly only to lose weight once out of hospital again. On this basis I feel they are not being offered the food at home resulting in their poor growth. The mother's 'mother crafting' also leaves a lot to be desired. She has a very rough manner with her children when handling them. She also likes to ignore them when they need her. The mother is also very hostile towards health professionals and refuses at times to allow us access to her children when there have been serious concerns. These include Non Organic Failure to Thrive (no medical reason for this), anaemia, speech delays, profuse skin infections resulting in hospitalization and septicaemia due to lack of early intervention and treatment.

#### **4.9 Extended families and support networks**

Reported information relating to family environmental characteristics revealed some positive as well as negative features. In 12 of the 21 families, extended families were recorded as playing a supportive role. This support was generally characterised as providing care to the children, when necessary, owing to the mother's inability to provide adequate care due to substance misuse and/or to provide a safe place in the event of family violence.

The next day the officers spoke with the mother's sister who agreed to be available for her sister should she and the children need protection (Case G)

The Department received a call from the maternal grandmother who was concerned about her daughter's (the mother's) mental health, her drug and alcohol abuse and the welfare of her children. Child S was transported to the care of his maternal grandmother who was thought to be protective (Case S).

There were also reported incidents of conflict between family members on the basis of a mother's neglect of her children due to substance misuse:

They feel the mother's bad behaviour is caused by her misuse of drugs and alcohol. Her communication skill in terms of her growling and use of physical abuse of child one reflects poorly on her parenting. Although sister and grandmother found no bruises on him they feel very bad for the child. However, mother's inappropriate parenting of her children has raised some concerns for both sister and grandmother, which often leads to conflict within the family (Case U)

In 1999 the maternal grandmother contacted the Department's country north office raising concerns about her daughter's ability to care for her granddaughter. On the same occasion the mother contacted the Department seeking accommodation as she was in conflict with her mother. The mother described the conflict as arising from her mother being unhappy about her leaving Child E in her care while she went out with friends (Case E)

It is apparent that there was some level of conflict between Child M's maternal grandmother and Child M's mother in relation to the quality of care the mother was able to give the children. This is evidenced by the fact that she has not reared them herself, rather that the maternal grandmother has cared for them, and they remain in her care (Case M)

One mother was recorded as having positive community links in one location where she resided; whilst in another, where she also frequently resided, concerns were expressed about her capacity to adequately care for her children.

It is also evident from the file record that the variation in the mother's behaviour in different locations resulted in conflicting opinions regarding her suitability as a parent. Depending on the location in which the mother was residing, she was viewed as either an individual who was an 'alcohol abusing, homeless, irresponsible and neglectful parent' or as a woman 'who could accept responsibility for the care of her children, providing appropriate domestic and medical care for them, living a sober and productive lifestyle' (Case D)

Seven of the families were recorded as experiencing intra-familial conflict.

The reason given for the children being placed with the maternal grandmother at the Safe House was that the extended families were in conflict and it was not safe for the children to be camped with them on the outskirts of the town (D).

The officer noted that one Refuge, in country south, advised that other residents (extended family members of the mother) did not want another family member there due to existing conflict (A)

Two families were reported to experience intra-community conflict.

CCU spoke with the mother who said that she had been staying with her sister in country south but had been asked to leave following conflict. The mother said that whilst walking away from her sisters home several Aboriginal men in a car had stopped and threatened her and her children. She said this had occurred because her family were feuding with several other families (Case A)

A number of interrelated and complex cultural/social factors including conflict and jealousy between the mother and her partner and between the mother and other community members which appear to have contributed significantly to this 'incapacity and inability to parent adequately and consequently to the detriment of Child L's development (Case L)

Information about positive community links was generally absent from the reports.

**Table 12: Family environment**

Family environment	Number	Percentage
Supportive extended family	12	57%
Intra familial conflict	7	33%
Intra community conflict	2	10%

#### **4.10 Agency involvement**

The broad picture of services involved with the children subject to this analysis is described below. Interventions on behalf of the children's siblings are not included here. However, a more detailed discussion of departmental and/or agency involvement with the families overall is provided in the following chapter. To capture a sense of which professionals were involved in a child's life, this section is structured to take account of different levels of intervention. Levels of intervention have been interpreted broadly as universal services for all children and families; targeted supports to family (family support cases); and, services for children identified as 'in need of care and protection' (the Department's statutory intervention threshold).

##### **4.10.1 Universal services for all children and families**

Available information indicated that there were 16 children who had contact with health professionals. Two of these children also had contact with health professionals and/or other services in the Northern Territory. One was made a ward of the state. Of these, maternal and child health nurses played a crucial role in monitoring the children's health, including their weights. Six of the children were also involved with emergency and acute hospital services. Two of the children were of school age, and in one of those cases, the Education Department became involved in case planning with the Department. Three of the children (two of whom were siblings) at some point in their lives were in child care organised by the Department. Care arrangements, overall, however, were provided by and between extended family members with, at times, the Department's involvement.

##### **4.10.2 Targeted supports to the family and child**

Overall, the level of targeted supports to the families was low. One child was recorded as having received targeted supports, in the form of admittance to a respite care service for children with special needs. Another was transferred to foster carers before being transported to extended family members. Two primary reasons recorded in the CDRC's reports for the relative lack of targeted supports included parental unwillingness to engage with support services despite, in several cases, evidence of attempts by Departmental staff to assist those families, and the lack of supports services available in communities where many of the families lived.

There were other examples where the Department had identified the types of support services that might benefit parents, such as drug counselling, mental health services and Aboriginal family support, with some evidence of the Department's efforts to link families with those services. In many cases, however, the outcomes were not recorded in the CDRC's reports.

Other services known to be involved with some of the families, although how extensively is not known in many cases, include: public housing, income security (Centrelink), the police, mental health services, specialist Aboriginal community services, youth services, refuge accommodation, Department of Justice, early parenting services, child placement services, and general community service organisations.

#### **4.11 Summary**

The majority of the children were aged less than one year, pointing to a higher vulnerability in this age group. Slightly fewer female children (45%) than male children (55%) are included in this group. At the time of death, half of the children (50%) were living with both biological parents, almost a third (32%) with their mothers, and the remainder with either one biological parent and a step-parent (9%) or with extended family members (9%). Almost two thirds of the group (63%) had more than three siblings, and three of the children had siblings who had died. Half of the children (50%) were from remote communities, more than a third from rural regions (36%) with the remainder from the metropolitan region. Other characteristics of the children included disability in three cases (14%), premature births for three cases (14%), chronic illness and complex health needs for another two cases (9%), with previous hospital admissions recorded for five children (23%).

The cause of death was not available for all cases, but the circumstance surrounding the children's deaths included: co-sleeping (45%), drowning (14%), vehicular accident (14%), homicide (9%), and other (18%). All families had long histories with the Department – with the average length of contact being 10.5 years. Parents of the deceased had their own histories of child abuse or neglect in four of the families (19%), and 17 (81%) had histories of out-of-home care including the placement of the parent's themselves as children. In 12 (57%) of the cases the deceased had one or more siblings who had been previously placed in out-of-home or relative-care. All 21 families had previous notifications for child abuse/neglect, 11 (52%) of which were substantiated Child Maltreatment Allegations, seven (33%) were recorded as Child Concern Reports, and three were 'logged contacts' resulting in an open period of contact with the Department. Of the 22 children who died, 16 (73%) had previous notifications recorded on file. Health professionals and police officers made the majority of the notifications. Family members made other notifications with the remainder being made by medical social workers, youth services and child protection officers. At the time of the children's deaths, five (24%) cases were closed before the deaths, nine (43%) cases were still open, and it was not possible to determine the status of the other seven (33%) cases. Each of the children who died was living in families where there were a number of interrelated risk factors. There is only one case where either alcohol and other drug dependence and/or family violence was not a significant factor in the family circumstances leading to chronic neglect. Other risk

factors included homelessness, mental health problems and financial hardship. Supportive extended family were evidenced in 12 (57%) cases however intra-familial conflict was also recorded in seven (33%) cases and intra-community conflict in a further two cases.

## 5. The service system response

Departmental file records indicate that the deceased's mother led a crisis oriented lifestyle of which transience and chronic homelessness were key features; obtained accommodation by living with and moving between relatives and friends; was the subject of family violence; became involved in volatile relationships; abused alcohol. The mother had been reviewed by a visiting Consultant who believed she needed treatment for severe depression. History of alcohol abuse within the family (Case A).

This description of a child's family lifestyle was typical of many of the cases reviewed. Understanding which features constitute serious and life threatening risk to children is not a straightforward matter. In particular, it is important to acknowledge the effects of marginalisation, dispossession, loss of land and traditional culture, and the forced removal of children which has led to ongoing trauma within Aboriginal communities and is coupled with extreme social disadvantage including poverty, passive welfare, drug, alcohol and substance misuse (Gordon, Hallahan & Henry, 2002p. xxiii). It is also acknowledged at the outset the Department's difficulties in working and engaging with people in remote communities. However, as noted by DCP:

Such understandings [of the above factors] should not impair the need to take action to ensure the wellbeing and protection of individual children affected. Where the neglect of children is endemic within a community, consideration should be given to an approach that seeks to work with the community to address the underlying risk factors contributing to neglect and to strengthen the community's capacity to meet the needs of the impact of neglect on a particular child or young person and his or her safety (DCP, 2008, p. 1).

This chapter identifies common themes arising from the data with regard to the service system responses to Aboriginal children and families where chronic neglect is present. These themes relate to:

- an unresolved tension between child centred and family focused practice;
- a focus upon single incidents of neglect and the 'start again' syndrome;
- an over optimistic emphasis on small improvements leading to case closure;
- the absence of any direct assessment of the impact of neglect upon the child;
- inadequate risk assessment and management; and
- inadequate case or safety planning.

### 5.1 Unresolved tension between child-centred and family-focused practice

One of the Department's core responsibilities in relation to neglect is to 'ensure a child-centred family focused approach' (DCP., 2008, p. 1). Tomison (1998) notes how 'child centred, family focused' strategies affirm the primary importance of ensuring the safety and wellbeing of children, yet also recognises the mutual significance of the child and family to each other. There is, however, a need to ensure that a balance is maintained between child-centred and family focused practice such that a child's

immediate wellbeing and developmental needs are not overshadowed in attempts to deal with parent and family problems (Powell, 1997). There is some research evidence which suggests that improvements in child outcomes cannot be achieved when relatively little attention is paid to a child's wellbeing or his or her developmental needs (Powell, 1997). Thus, too much focus on a family's acts of omission or commission can essentially result in the under-protection of the child.

A key finding from review of the case histories is that the impact of the severity and chronicity of neglect upon a child was often minimised through an overemphasis upon adult behaviour rather than an assessment of the child's needs and the parent's capacity to meet these needs. In many of these cases, attention was focused upon the parents (usually mother's) or caregivers' acts of omission or commission. The implications of focusing on parental acts of omission or commission, for children, has been identified as threefold: the lack of (demonstrable) understanding of what constitutes neglect; the minimisation of neglect; and, the lack of (demonstrable) understanding of the effects of chronic neglect and cumulative harm on a child's immediate lived experiences and his or her developmental trajectory. For example, the excerpts below illustrate just one case where instances of specific and grave concerns were raised in relation to a child where chronic neglect was present, and the impact of this on the future development of the child.

In 2003 Dr X specifically mentioned that because child two was so frail she would be seriously ill (and may not survive) types of chest infections, abscess, or gastro enteritis that children of her age may contract.(Case L).

When child three was hospitalised in 2004 there were concerns that her mother may 'pull the drip'. In November 2004 the worker from Aboriginal Health Services stated that child three currently weighs the approximate weight of a 6 month old at the age of 12 months. If allowed to continue the ultimate outcome is death and brain damage as the child becomes so weak and malnourished that they cannot sustain life (Case L).

The unambiguous acknowledgment of the potentially fatal outcomes to the children in this family experiencing chronic neglect were amongst at least seven other issues of concern expressed by health professionals to the Department in relation to the family. The concerns were classified as Child Maltreatment Allegations for child two and later for the other children, and meetings were held between staff of the Department and key agencies. However, the major focus was not on the children themselves but on the family's access to basic resources, such as a refrigerator and, later, a house. Whilst access to basic resources would have had an impact on the parent's ability to provide necessities to their children, this response did not reflect an analysis of the impact of the effects of chronic neglect and cumulative harm on the children's immediate lived experiences and/or their developmental outcomes.

## **5.2 A focus upon single incidents of neglect and a 'start again' syndrome**

In the absence of a focus on the children themselves and an analysis of the effects of chronic neglect and cumulative harm on their immediate lived experiences and developmental outcomes, there was evidence that behavioural approaches focusing on the present, and on family strengths, were utilised. This approach, however, seems to have led to the focus upon single incidents of neglect and the assumption that families were in a position to take on increased responsibility for the care of their children. For example, in the following case:

The agreed plan was for the allocated officer to meet with the children's parents to discuss the Department's concerns and to emphasise the parent's responsibilities. The plan also indicated that safety issues were to be reinforced with the children and further details about the events were to be obtained (Case J)

The mother was located one month after this plan was agreed upon. Some three months later, the file records indicate that the mother's children were accommodated at a youth refuge service due:

to a misunderstanding in regards to care arrangements ...the matter had been addressed with the mother who had given the necessary undertakings to act responsibly in ensuring appropriate care arrangements are made for her children and that the person is a suitable carer.

Given the repeated reported concerns for the children's health, and the impact on their care by the presence of family violence and alcohol misuse, it would seem that the responsibility placed upon the mother for ensuring her children were put in the care of an appropriate carer when she was intoxicated and the children were unsupervised and unfed was unrealistic. Similarly, in another case the:

DCD workers explained to the mother that the Department could help her with things like washing, fridge, letter of support for housing, counselling and working with her and her family (Case M).

Eight days after this meeting, Child M died. Due to her alcohol misuse and incapacity to care for them, the mother's other children were all in the care of their maternal grandmother at the time of this child's death. The Department had a history of contact with the family, and extended family, in regard to Child M's siblings.

One of the major problems associated with a focus upon single incidents of neglect in which current circumstances of the family are foregrounded and previous history deemphasised, is the lack of acknowledgment of the chronic nature of alcohol and other substance dependence in the families of the deceased children. Alcohol and other drug dependence seems to go untreated even though the cumulative harms the children are experiencing as a result of that neglect are directly associated with their parent's alcohol or other drug misuse. Following good harm minimisation practices designed to provide protection for children during known drinking episodes, case officers respond to particular incidents by encouraging parents to make alternative arrangements for the children's care while they 'go drinking'.

The mother was subsequently located with the partner and advised of the concerns for child three's health. At the time of this contact child three was still being breast fed. The mother and her partner stated that they would take more care, access the Aboriginal Medical Service and leave child three with relatives when they 'went out drinking' (case D)

When released from the lock-up, the mother attended the Department's Office and the importance of making appropriate arrangements for her children when she went 'drinking' was discussed. The mother is recorded as stating that she would leave them with a relative in the future. The case notes identify that the contact period was then closed with senior officer endorsement and no further action was recommended. No Child Concern Assessment Report appears to have been completed in respect of this contact. The outcome recorded on the Department's client information system was that the contact was 'substantially resolved' (case J)

Concerns were again expressed as alcohol abuse was still a factor in limiting the mother's ability to care for her child adequately. Family members regularly stepped in to look after child three and complained to the Department about the mother's neglectful parenting. The Department remained involved on a Family Support basis, attempting to monitor the child's progress and oversee that suitable care arrangements were put in place when the mother was drinking (case Q).

The mother did not remember pulling child one's hair but did recall hitting him on the shoulder. The mother denied an anger problem but admitted that she did 'a lot of growling and shouting at the children because they don't listen to her'. She claimed that the children went to her sister's house and came back 'bossing her around and swearing' which she did not like. When informed that there were some concerns raised regarding her drinking alcohol and smoking gunja, the mother denied drinking alcohol but admitted smoking gunja 'sometime'. She indicated that when she did smoke she waited until the children were asleep (case U).

What appears to be missing, however, is acknowledgment of the contribution of the mothers' substance misuse to their children's ongoing neglect and the need to address those harmful patterns of alcohol and other drug use.

Another difficulty arising upon the focus upon single incidents evident in a number of cases is the practice of contracting parents to take on more responsibility when they were clearly struggling to care for their children. For example, in case S, the file record contains an unsigned agreement, dated [date removed] November 2004, outlining actions that had been discussed to help maintain the safety of the children:

- consent to an exchange of information between relevant professionals;
- not to drink or become violent in front of the children;
- undertake counselling/rehabilitation;
- regular and random urinalysis;
- enrol the deceased in day care; and,
- keep regular contact with the Department (Case S).

Shortly after this plan had been developed, Child S died, at age 11 months. The Department had extensive contact with the parents over a ten year period. During this contact the Department intervened and apprehended the deceased's older siblings when they were young children following a series of incidents substantiated physical abuse Child Maltreatment Allegations. The Department was aware of intergenerational problems including alcohol and other substance misuse, homelessness, physical assault, and offending. Similarly in case T, the CDRC report notes that:

On file is an agreement dated [date removed for confidentiality] which was signed by the parents and the Department. The contract required:

- all five of their children to attend day care five days per week from 8.30 am to 3.00 pm;
- child two, their eldest child, to continue at school;
- the mother and father to attend to cleaning their Homeswest house, to be completed by [date removed];
- DCD to arrange a contract cleaner to assist with rubbish removal;
- the father to contact Anglicare regarding the Changing Tracks program and to engage in counselling by no later than [date removed];
- DCD to provide the father with transport to and from counselling; and,
- upon return to their house, the mother to engage with a Best Beginnings worker and work on parenting and attachment issues with her son (the deceased) (Case T).

The Department had considerable contact with this family over a long period of time and, prior to this contract being put in place, had previously apprehended another of their children. It appears that the contract did not bring about the desired changes and, some three weeks after this meeting, the deceased child was placed by the Department for a period of two to three weeks.

Whilst the principle of concentrating on parental strengths and breaking down desired parental change into small achievable targets is appealing and appears to offer families a chance to prove their abilities as parents, it can have serious drawbacks when used with families with deeper, more entrenched problems (Brandon et al, 2008). This is particularly so when there appears to have been little assessment of the real strengths of the family or community. Indeed strengths seem to have been assumed rather than identified through any formal assessment of the evidence. As many of these parents were themselves experiencing multiple and complex interacting risk factors, the additional responsibility placed upon them to meet the Department's objectives to become more 'responsible parents' was unlikely to produce the long term changes needed in families to protect children from the harmful impact of serious neglect (Brandon et al, 2008).

### **5.3 An over optimistic emphasis on small improvements leading to case closure**

There was a tendency for practitioners working with families the of the deceased children to see a positive report as effectively cancelling out a concern:

A Child Maltreatment Allegation Investigation report was completed on the [date removed] August 2003 and substantiated neglect of child two ... On [date removed] August 2003, the mother's attitude had changed for the better and as a result child two's weight has steadily risen over the past 2 months... child two now weights 8.9kgs and is doing well and the Paediatrician is very happy with her progress and only wants to see her again if she regresses and becomes unwell. She is still classed as severe failure to thrive and has a long way before she is no longer compromised but appears to be heading in the right direction at the present time. (Case L).

As a result of this entry, and despite ongoing concerns for the children, it was proposed that the period of contact and involvement be closed. Health professionals noted that ongoing involvement was required, as child two was still at risk and needed to be given support. There was no further contact with this family until August 2004 when a Child Concern Report was recorded after a health professional contacted the Department to express concerns for child three, then aged 10 months.

It would appear that in-between these events, community health professionals were responsible for monitoring the children and family's situation and that this practice is not confined to this case. For example

On the [date removed] December, the regional hospital's social worker's primary concerns were as follows: the baby had a low birth weight, which had not been followed up with regular checkups; there was a history of domestic violence resulting in serious injury (and had presented to the hospital on six occasions in the past twelve months with assaults requiring medical attention; the mother's itinerant lifestyle and an apparent lack of family social supports in the country north area ...The social worker felt that immediate follow up was required ...On the [date removed] December, it was also advised by an Aboriginal officer that the mother had left the deceased in the care of a friend while she went out

and the deceased appeared well and healthy. Further, that "though the deceased was very small her parents were small people" (Case C)

Whilst Child C's case was allocated some five days later – with a report that concerns regarding Case C's safety were followed up – there is no evidence on file to indicate that this occurred. It would seem that community health professionals were requested to ask the mother if she wanted support from the Department. It was reported that the mother was afraid of the Department's involvement. It would also seem that face to face contact between the Department and the mother did not take place until some three months later.

There were also examples of optimism on the part of Departmental staff, despite warranted concerns regarding the children's safety and wellbeing. For example, in case T, the

... decision was made in June 2004 to apprehend the children, including newly born Child T. Given the parent's history and previous events, this decision was warranted. However, the mother and father contacted the Department indicating their willingness to sign an agreement outlining conditions to be met to ensure the children's safety. The Department's optimism saw the decision to apprehend changed (Child T).

While there is evidence that reports of small improvements in children's wellbeing were given much emphasis, it is disturbing to note that in the majority of cases, the Department had minimal direct contact with the children concerned. Very little was known about them apart from information given by health workers and, on rare occasions, the Departmental case workers.

File records indicate that the deceased was sighted only once by the Department between the time of her birth and prior to her death (Child R died at 3 months of age). Child R was born premature and undersize. There was a history of chronic neglect in respect of Child R's siblings, including 'failure to thrive'. It would appear that the Department relied on the community health nurse to advise about Child R's health. Child R was clearly a child at serious risk of harm (Case R).

In some instances, parental bonding and other characteristics of the child/parent interaction were noted but, generally, this information was absent from the cases analysed.

#### **5.4 The absence of direct assessment of the impact of neglect upon the child**

For the majority of the children it was evident that information was available on possible causes of harm but there was very little assessment of the possible impact of these harms upon them. Where information on the likelihood of future harm was available this tended to be reported by health professionals.

The file records indicate that the doctor was concerned about child four's health and he could not guarantee that the mother would continue with the medication to increase child four's iron level and that he 'needed a constant stable home'. The doctor's report, a copy of which was sent to the Department, commented that 'while child four looked quite chubby and well, there was concern about the lesion and the pneumonia'. The file records indicate that the mother's older children, when young, suffered from respiratory and chest infections, and that child four was predisposed to catching these infections and was anaemic. This meant a commitment by the mother to attend to child four's health needs was necessary (Case A)

What appeared to be missing from the cases analysed, however, was information on the multiple consequences of the harm already suffered. Rather, information tended to

be gathered and assessed according to single-event incidents, as previously noted and as illustrated by case R.

During January and February 2005 child three, at two years of age, had continued to lose weight and consideration was given to readmitting her to hospital. This incident was not raised as a CMA for neglect. Prior to this, it was reported on numerous occasions by health professionals that there were concerns about child three's health, including 'failure to thrive', and she was subjected to repeated episodes of neglect. In March 2005, child three was found unkempt and dirty and 'no one was wanting to care for her'. At the time of Child R's death, child three was not listed on the Department's information system as being the subject of any Child Concern Reports or Child Maltreatment Allegations. Any officer accessing this system to check her history, would be under the impression that no serious concerns for her welfare existed (Case R)

There are many recorded instances of children being directly caught up in violent fights between their parents. While these incidents were often recorded as serious and prompted some intervention on the part of the Department, there is no evidence in any of the cases of an assessment being made of the cumulative psychological and emotional harms that might be done to children who witness such violent episodes. For example in case D:

.... the Department was advised by country north police of an incident which had occurred on the [date removed] June 2003 at an Aboriginal Community concerning the mother, the partner and the deceased. The police reported that the mother had thrown a rock at the partner while he was holding the deceased. It was further reported that the police had witnessed the partner accidentally hit the deceased on the head while he was trying to assault the mother.

While this incident was recorded as a Child Maltreatment Allegation of physical abuse and the parents were accordingly interviewed, there seems to have been no consideration of the emotional or psychological impact of such events upon this child or indeed the child's siblings who were known to have witnessed similar episodes over a period of time. Similarly, in case 0, even though case workers confronted the mother about the risks to her children of witnessing violent episodes, there is no evidence that the children's psychological and emotional wellbeing were assessed.

Following the teleconference on [date removed] August 2004, there was a contact visit between the mother and child two. The co worker then met with the mother and discussed solvent abuse, the impact of her behaviour and that of violence, and the possibility of child two being accidentally harmed during fights. The mother agreed to have child two in a safe place (with other family members) when she 'wanted to become intoxicated'.

The lack of any assessment of the cumulative psychological and emotional harms that children experience is even more worrying in the cases where children self-referred to the Department as a result of violent episodes of family fighting. For example, in case B, the deceased at one time contacted the Department's Crisis Care Service herself advising that she was fearful of going home due to fighting that was occurring.

The Department's Crisis Care Unit was contacted by the deceased, now aged 15 years, on [date removed] August 2002. The deceased advised that she had left her aunt's house in Metro East after the family started fighting and wanted to return to one of her aunts in another region of metro east. Also present with her was another girl. Public transport had stopped. The Crisis Care Officer attempted to contact the deceased's mother in metro south but could get no answer. The deceased was asked to wait at the phone box while the Crisis Care Unit arranged for the police to collect the girls to ensure their safety.

In case F, it was a ten year child who took responsibility for finding refuge from family violence:

On the [date removed] March 2000 child two (then 10 years) telephoned the Department and reported that his parents were fighting and asking about a refuge. The mother then requested refuge as the father had hit her and threatened to burn the house down. The mother and her children were provided with accommodation and arrangements were made for the family to be moved to a refuge in country south the following day. Country South MHS was advised that child one was vulnerable and possibly suicidal. MHS provided support to the refuge workers and the mother. In order to manage the other children who were running uncontrolled in the refuge, the Department contributed payment for a child care worker to assist the refuge to cope. The Crisis Care Unit was advised of the current situation and the family's location. ....there were also further incidents of family violence during this period. From November - December 2002 there were four episodes of family violence recorded. Three incidents involved the mother and the children requesting assistance and one incident concerned contact from the Department of Justice to advise that the mother had been stabbed by the father. Following the latter incident the mother was referred to the Aboriginal Family Violence Program and the Departmental worker had a discussion on the matter with the metro north Police.

In this case there is evidence that the mother was referred to the Aboriginal Family Violence Program. Apart from the note regarding one child's suicide risk, however, there is no evidence that any assessment of the children's resiliency or the cumulative harm that may have been done to them took place or indeed that any arrangements were put in place to provide psychological support to these children.

## **5.5 Inadequate risk assessment and management**

All of the CDRC's reports noted the absence or limited application of the Department's Risk Assessment and Risk Management (RARM) framework, or the alternative assessment framework in place before RARM was implemented. The lack of a comprehensive social history on which to base a more coherent and developmentally informed assessment has also been identified as a recurring theme both by the CDRC and other child death inquiries. The relationship between accumulating risks and the assessment of a family and child's social history has already been discussed above, but these are inextricably linked with risk assessment and management, particularly as they relate to families with which the Department has had multiple contacts.

The absence of risk assessments was found in at least 16 of the 21 cases subject to this analysis. In one of the cases where a risk assessment was undertaken, it was for the purposes of assessing the child's parents as relative-carers, and not to ascertain if the children in the family were at risk.

It appears that the children were potentially at risk due to their mother's alcohol abuse, their young ages, their lack of supervision and inadequate clothing and food. However the contact appears to be closed without any plan to address the concerns or offer services. It appears that the decision may have been based on information that the family was due to return to community two and an assumption that the children would be safe at the community (Case J).

In other cases where risk assessments did take place they were limited because insufficient evidence and information had been collected.

It appears apparent from the information received about Child L's death that the family had no furniture when they relocated. Further, it can be assumed that as the family had to seek financial assistance to relocate, that money was an issue. This begs the question

of how the children's parents were financially providing for the needs of the five children, one of whom was three and a half months old (Child L). It would have been appropriate, given this family's need for financial assistance over its periods of contact with the Department that an assessment of its circumstances, including practical circumstances, and need for ongoing support be undertaken, particularly given the tender age of the children (Case I).

Even when information was available, Departmental staff failed to examine the evidence and formulate an understanding or explanation of what was taking place – despite significant histories of parental substance misuse and family violence – resulting in a series of concerns regarding the protection of the children, in many of these cases.

Domestic violence as an issue impacting on the family was not assessed. There was a lack of clarity about why the father was incarcerated and his role in the family when he was released. There was no assessment of his circumstances and of the relationship between the mother and father. It was proposed in plans that this occur. The case was closed in 2005 even though there had been an allegation that the mother was assaulted by the father just prior to the case being closed (case L).

Whilst protective factors were explored in some cases, for example the identification by the Department of strong extended family support, the effects of vulnerability and risk to the children, typified in the cases of G and L, were rarely explored.

Departmental officers saw and spoke with the mother and father in August 2004. They stayed overnight at the community and were awoken in the early hours of the morning by the Clinic Health Nurse who advised that the mother was 'visibly intoxicated and could not keep her eyes open'. It was agreed that the mother would stay at the clinic for about an hour and for her to then go back home. The next day the officers spoke with the mother's sister who agreed to be available for her sister should she and the children need protection. They also spoke with the father's family regarding setting up long term support for the mother and father and advised that that they would visit to set this process up in the near future. When the officers saw the mother that day she had a 'thick upper lip and the inside of her lip had been lacerated. She had marks above her eye and on her cheek'. The officers arranged for her to be seen at the Clinic and advised that they would contact the police so she could have the father charged. There is no record on the file to indicate that Child G and the other children were seen or assessed (Case G)

An issue raised in several of the cases, including cases B and C, was the exclusive reliance placed on parents to determine their own capacities in managing the risks and/or protective concerns for their children and the lack of involvement of other carers in the risk assessment process.

Relating to the 8th notification of concern regarding the deceased... On a different occasion during the same time span, an officer from JAG contacted the Department's office on in September 2002 with concerns about the deceased. The officer advised that JAG wished to make a "welfare concern referral", stating that the deceased 'had been picked up from the street a number of times and had been intoxicated. Her mother did not know what to do about the issue'. The Department's District officer faxed a response form back to JAG asking for the deceased's mother to contact the Department if she wanted support and/or advice regarding 'child management issues' (Case B)

Where extended family and other carers were involved there tended to be an exclusive focus upon the mothers and female extended family members which effectively rendered the children's fathers and their paternal relatives 'invisible', despite their involvement in the children's lives.

The mother had four children by three different fathers at the time of the deceased's death. There is evidence on the file that from time to time the fathers/paternal relatives of child two, and the deceased's father cared for the children. There are also references on the file at various times to the mother escaping domestic violence. However there is no evidence on the file that the Department ever made contact with either the children's fathers or their paternal relatives to obtain their input into consideration of the children's wellbeing or to explore the issue of family violence (case U)

Not only were the protective qualities of the male carers not examined but also there was a failure in several cases to identify the risks that male carers may have presented. For example there were three cases in which the issue of male perpetrated sexual abuse was raised, with no assessment of the risks to the children in the care of these men. For example in Case C:

... the mother had left Child C in the care of a relative who was believed by the Department to be a "perpetrator of sexual abuse". No action was taken by the Department to remove or assess Child C in this placement, as it was considered by the Department to be "a family arrangement" (Case C).

Even in cases where there was evidence of extended family and/or community engagement/consultation – particularly when children were being cared for by extended family members – these consultations did not necessarily focus on the children's safety as the paramount issue. As noted by the CDRC review of case G:

While the Department's approach to the CMA investigation in respect of Child G, which saw numerous interviews being undertaken with key people in the community, the family, other service providers and involved Aboriginal workers, was commendable, the children's safety should have been the paramount consideration (Case G).

There were also examples where full consultation with Aboriginal staff and extended family members would have provided insights into the mother's circumstances and history, but where this did not occur.

There was no assessment of Child N's safety with her extended family, particularly with regards her mother coming to take her from family members, despite prior concerns having been raised about this. There was also no action taken to apprehend Child N at birth which resulted in her being in a high risk situation for 8 weeks (Child N).

## **5.6 Inadequate case and safety planning**

From the evidence contained in the CDRC files, it appears that there was inadequate case and safety planning in many of the cases reviewed. Given the Department's newly implemented policy on neglect, however, it is important to draw attention to the lack of a systematic approach to record keeping noted previously by the CDRC and to premise the following discussion with an acknowledgment that our analysis is confined to the data available and may not reflect the actual and current practice of case and safety planning. The lack of documentation regarding case planning was an issue in 18 of the cases, including missing data and in extreme instances this meant that basic child demographics were not collected and/or recorded. In many other instances, the issue revolved around a lack of evidence in case notes provided to the Committee to support documented actions/events that were reported to have occurred.

Given the high risks and protective issues in this case it is very concerning to the Committee that no documented assessment in this case occurred. There was no detailed recorded contact with any of the significant people who needed to be contacted in order to

do a full assessment in this case such as medical staff at metro north hospitals, location two Hospital and Child Health. It was not even clear from the file who would be living in the home with the deceased on her release from hospital and where she would be sleeping (Case M).

During the visit in September 2004, the father arrived and was asked about 'safety plans'. He nominated some family members (mother and aunty) when they were at one of the communities the family resided at and maternal grandmother at another. It was noted that there had been no further violence since the mother had returned. Departmental workers were to meet with the father's family the following week at community three to develop a safety plan. There is no record in the file notes that this meeting occurred and no written record of the safety plan (Case O).

Whilst the Department's case planning sometimes referenced other support services from which families could benefit, there was very little indication that monitoring of situations had occurred, either with the families themselves or with the referred agencies.

Although case supervision notes document case planning information and that the Case Officer was to follow up on the children's school attendance and visit the community where the family sometimes resided, the case was closed on [date removed] May 2003 without these matters being attended to. The Case Closure Summary identified that the concerns pertaining to the initial referral had been addressed with the primary carer, the mother (Case J)

The parents were advised by Departmental officers that assistance would be provided to care for Child D and to protect him from potential harm if they were to stay at the Camp and continue drinking. The parents advised that they were planning to travel to another location that afternoon where the partner's family would assist them in caring for the deceased. They were advised of the importance of ensuring that the deceased was seen by the Community Nurse when they arrive. Given the mother's history and the seriousness of these events the Committee is of the view that the Department needed to put in place a clear monitoring plan to ensure Child D's safety and well-being (Case D)

The Department's renewed focus upon neglect – as reflected in its 2008 policy – will depend upon effective management of cases where child protection concerns are raised, and the extent to which effective inter-agency coordination and communication is achieved.

There is evidence that service providers as well as members of the children's extended families were able to report their concerns to the Department. Despite this, however, there was very limited evidence to suggest that they were involved in the assessment of risks and/or suggested interventions/support strategies.

There was limited contact with the mother until May 2002 when the Department was contacted by the Mental Health Service concerning the mother's self admitted neglect of her children. The children were Child E, then aged four years, and child two who was born in September 2000. There is no further reference on file or within the maltreatment investigation report concerning the mother's mental health and her reported suicidal ideation. Whilst there was reference to her seeking mental health services, however, there was no evidence of further attempts by the Department to discuss the seriousness of her mental health condition, particularly in relation to her ability to care for her children and any evidence of risk to them (Case E).

Even so, there is some evidence that other service providers and health professionals did participate in some case conferences – for example in cases L, M, F and E.

At birth, Child L's case was classified to a Child Concern Report on an open period of contact. On the [date removed] November 2004 at an interagency meeting organised...Concerns regarding the mother's bonding with Child L were raised at the meeting [present were also health professionals involved in Child L's case]. It was stated that the mother 'was reluctant to feed and engage with her children, even refusing to

wake up when the deceased requires breast feeding' and that she ignored her children when they needed her. There was no assessment of this and there are no file records which note observations by departmental workers of the mother with her children (Case L).

Nevertheless there is some evidence, although only in a small minority of cases, of thoughtful case planning where clear attempts were made to engage families with other support services. For example, the CDRC noted that in case F:

There is an extensive history of involvement by the Department with Child F's family prior to his death. This contact relates to a broad range of issues including financial difficulties, alcoholism and family violence, homelessness, child protection concerns which included health concerns such as Failure to Thrive, neglect, physical abuse, allegations of sexual abuse and safety concerns in relation to the children's welfare as well as suicide attempts by child one. The family were assisted by a number of agencies including the Hospital, a Day care Centre, Community and Child Health Services, and the Special Housing Assistance (SHAP) Aboriginal Liaison Officer. The Department assisted with financial support and the coordination of the various agencies. In response to these issues the Department's intervention was continuous and at times comprehensive and in most situations included a broad inter-agency approach (Case F).

In those cases, however, it was clear that outcomes were not very effective due to the family's unwillingness to engage.

... throughout the case files there was a sense of helplessness given the extensive support made available, particularly during the earlier years, which appeared not to make a difference. The overwhelming nature of the case was evident in the files ... the Department's intervention was continuous and at times comprehensive and in most situations included a broad inter-agency approach. However, this often proved to be short-lived and somewhat ineffectual (F)

In some cases, it was the families themselves who thwarted Departmental attempts to provide a holistic approach to case planning, intervention and support strategies. However, in the majority of cases, there was a failure by the Department to establish the necessary communications and collaborative arrangements.

Attempts by the Department and other agencies to work together appear limited to the exchange of information concerning each presenting crisis, which required an immediate response. Ongoing interdepartmental planning and co-ordinated preventative and therapeutic service provision appears not to have occurred (Case D).

## **5.7 Summary**

Limitations to the service system response to Indigenous families in crisis are considerable – in particular responses to the effects of the history of dispossession, institutionalisation and separation of families. With extreme social disadvantage including poverty, welfare dependence, and substance misuse, coupled with the difficulties of providing quality services in remote regions, any service will struggle. However, the Department has acknowledged that these factors should not impair action to protect the health and wellbeing of children. Given this undertaking, it is of concern that the overall service system response in all 21 cases was inadequate. Based upon the evidence to hand, these inadequacies relate to a focus upon family centred practice that minimised the potential cumulative harms for children and the proper assessment of their needs and wellbeing. There was a common practice of giving families, which were clearly struggling to care for their children, additional responsibilities with very little additional support. In particular alcohol and other substance dependence seem to have been accepted rather than addressed. There was

also a tendency for caseworkers to overemphasise small improvements often without sighting the child and there was a very worrying absence of any assessment of the potential harms being done to children. In large part this stemmed from a focus upon single incidents of neglect rather than the possible presence of cumulative harm. The lack of proper risk assessments in many of the cases is equally worrying and even when a risk assessment did take place it rarely included examination of the family's social history or the involvement of other carers in relation to the potential risk of harm to the child. Case management record keeping was *ad hoc* and insufficient in many cases and based on what was documented there seemed to have been inadequate interagency coordination, inadequate referral processes or monitoring of referrals to other agencies. Nevertheless it is important to note that in a minority of cases there were some instances of thoughtful holistic case planning.

## **6. Implications for safer practice and recommendations**

### **6.1 The intergenerational context of neglect for Indigenous children**

Examination of the CDRC case files provides some insights into the context of neglect and, based upon the data available to us there appear to be some trends regarding the context of neglect, but further research is necessary to confirm that these trends could be considered generalisable risk factors. Twelve of the adults represented in the 21 case files had previous contact with protective services as children. This provides some evidence to support the thesis that the higher levels of neglect in Indigenous families (compared to non-Indigenous families) is related to the intergenerational effects of neglect and maltreatment, and this needs to be recognised.

### **6.2 Location, age and other risk factors**

The young age at which several of the parents became parents may be a risk factor however the gender of the child and the marital status of the parents appear not to be so. Living in rural or remote locations seems to be a factor, if not for neglect then for death associated with neglect. Death associated with neglect is also inversely related to the age of a child, with half the children dying in their first year. This information provides some clues about the increased vulnerability of infants rather than the incidence of neglect. In addition the suspected presence of alcohol and other substance misuse together with co-sleeping practices – implicated in almost half the deaths – also points to an increased likelihood of death associated with these factors rather than to a direct link to neglect. The analysis of the case files also points to a strong link between alcohol and other substance dependence, family violence, homelessness, and mental health problems and the chronic neglect of children.

### **6.3 Lack of targeted support**

All 21 families had a long history of contact with child protection services. The minimum time period that the Department was involved in the lives of these families was five years and the maximum was 25 years – with an average time for all families of 10.5 years. Eleven of the families had previous Child Maltreatment Allegations substantiated and a further seven had Child Concern Reports that were investigated and led to an ‘open contact’ period with the Department. Numerous ‘logged’ contacts were made for the remaining three families. Sixteen of the children who died had previous notifications and 15 of these were the subject of notifications before they were twelve months old.

Despite the fact that many of the families were recorded as having been in contact with health professionals, only two were noted to have received any targeted support or intervention. One of these families was provided with short-term respite services and the other received various kinds of assistance, including child care, housing assistance, specialist family support services including drug and alcohol services.

#### **6.4 Extended families and support networks**

In 12 of the 21 cases, extended family members were recorded as having provided a supportive role. However, there is little evidence of these family members being actively engaged in either assessing risk or advising on appropriate and effective forms of support. Indeed in some instances where families were noted to be involved in the care of the children, their involvement was used as an indicator that no further support or intervention from the Department was necessary.

#### **6.5 Strengths based family centred practice**

The recent adoption of the Department for Child Protection's policy on child neglect is welcomed. Its success however is dependent upon its interpretation and translation into practice. Indeed the key to its success or failure will be the way in which strengths-based and family-centred practice is interpreted and enacted. Our analysis of the circumstances surrounding child deaths where chronic neglect is present leads us to conclude that particular interpretations are dangerous. These are those that:

- lead to an exclusive focus upon adult behaviours;
- lead to a failure to undertake a proper and thorough assessment of the capacity of the parents/carers/community to care for the child based upon *all* the evidence available including previous contact with the department and other service providers.;
- do not include a proper and rigorous assessment of the impact of neglect upon the child's immediate wellbeing and longer term developmental outcomes;
- minimise the importance of assessing the likelihood of the reoccurrences of neglect given the past history of the child's parents/carers/community;
- over emphasise small improvements in the care of the child rather than focusing on identifying sustained improvements over time;
- do not seek to document evidence of care rather than the absence of neglect in support of decisions to close the case;
- make assumptions about the strengths of parents/carers without making a proper assessment of both their strengths and weaknesses; and,
- do not include a broad definition of family as it relates to Indigenous community understandings of family.

#### **6.6 Child impact assessment**

Given the tendency to focus upon adult behaviours, it is imperative that any framework for implementing the Department's policy on neglect includes a child impact assessment in which the impact of neglect upon a child is assessed in relation to the child's current wellbeing and his or her future developmental outcomes. We note that, as part of the Department's reform agenda, there is an intention to adopt a Signs of Safety risk assessment approach. It is imperative that this approach includes a process for documenting the risks to children's wellbeing and developmental outcomes likely to ensue from particular acts of omission and commission over time.

## **6.7 Decision making-multidisciplinary practice and collaborative partnerships**

Given that there were notable gaps in the documenting of case and safety planning processes, it is difficult to make a firm judgement about the effectiveness of multidisciplinary and collaborative decision making with regard to risk assessment, case planning or indeed intervention and support strategies. Nevertheless, analysis of the documentation that does exist leads us to believe that much more needs to be done in terms of engaging other service providers, health professionals and child protection officers through collaborative partnerships in the processes of decision making and case planning. In particular, and in accordance with the promising practices identified by the Secretariat of the National Aboriginal and Torres Strait Islander Child Care, it would seem prudent for the Department to establish formal partnerships with Indigenous organisations – especially, but not only, in rural and remote locations – with regard to the assessment of risk to children and appropriate support and interventions for families/carers similar to those existing in Queensland and Victoria.

## **6.8 Acknowledgment of the nature of neglect and its implications for long term Departmental involvement in cases**

It is evident that there is a lack of emphasis upon the unique characteristics of neglect in comparison with other forms of abuse. As a consequence, the cumulative harmful effects of neglect upon children are minimised – as is the need for long-term interventions and support for families living with family violence, substance misuse and mental health problems. Many of the children were exposed to cumulative harm resulting from neglect that was directly associated with their parent's alcohol or other drug misuse, yet there is little evidence of any acknowledgment of this or the need to address these harmful patterns of substance misuse. In addition, there were many recorded instances of children being directly caught up in violent fights between their parents. While these incidents were often recorded as serious and prompted some intervention by the Department, there is no evidence in any of the cases of an assessment being made of the cumulative psychological and emotional harms that may be done to children who witness such violent episodes. Interventions that ameliorate chronic alcohol and other substance dependence and family violence are an essential part of preventing children suffering neglect and chronic neglect. It is important that the Department takes a long term view with regard to the delivery of programs aimed at addressing both these issues.

## **6.9 Early intervention**

Clearly, the young age at which these children were brought to the attention of the Department points to the critical importance of maternal, child health and early childhood services in the direct care of children and in providing support to families where neglect is of concern. There is no doubt that there is a need for an increased emphasis upon the importance of 'shared care' where families are clearly struggling to care for their children's wellbeing. 'Shared care' should be operationalised in the form of a formal partnership between families, statutory authorities, Indigenous child care agencies and communities to ensure that children's needs are met. For example, where parents are consistently unable to ensure a proper and adequate diet for their children alternative strategies need to be put in place to ensure the children are fed.

This would require a proper assessment of family strengths and weaknesses and an acknowledgement that requiring parent/carers to take on additional responsibilities when the underlying causes of their incapacity to care for the child have not been addressed is not a viable option.

## **6.10 Recommendations**

The analysis of the data provided to us by the CDRC and evidence drawn from the available literature lead us to make the following recommendations. As requested by the CDRC the recommendations are operationalised with regard to the Department's current reform agenda. Each recommendation is listed under the categories set out in reform agenda and where applicable the particular projects to which they have particular significance are indicated.

### ***Category 1. Field Service Delivery DCP Reform Implementation (Projects 5a, 6a 6b & 32a)***

1. That the implementation guidelines for the Signs of Safety risk assessment approach provide clear processes for assessing the additional risk of chronic neglect associated with:
  - a) intergenerational child abuse and neglect;
  - b) living in rural and remote communities;
  - c) the increased vulnerability of infants and toddlers;
  - d) the presence of chronic substance dependence; and,
  - e) the presence of family violence.
2. That the review of Service Delivery Policy and Field Worker Guidelines include the development of a clear and specific procedure for undertaking a:
  - a) formal and documented child impact assessment of the risks associated with cumulative harm in cases where neglect is indicated – including a rigorous assessment of their current wellbeing and development as well as any associated risks to their continuing development;
  - b) formal and documented assessments of the family/carer/community's capacity to care for the child which would include a proper and rigorous assessment of both the family/carer/community strengths and weaknesses; and,
  - c) evidence of sustained care for the child over time before cases are closed.
3. That, where neglect or chronic neglect is indicated, the implementation guidelines provide clear processes for ensuring that the child's immediate and extended family and community are actively engaged in the processes of risk assessment and case planning.
4. That the scope for the 'Interagency Early Intervention: At risk new born babies (Project 32a)' includes attention to the increased vulnerability to the harms associated with neglect and chronic neglect for infants and toddlers.

***Category 3. Aboriginal Engagement DCP Reform Implementation (Projects 2 & 19)***

5. That the newly constituted Aboriginal Reference Group include as part of its work plan:
  - a) an implementation framework for the development of partnerships between the Department and appropriate Indigenous agencies similar to those arrangements in place in Queensland and Victoria with regard to risk assessment and case planning;
  - b) an examination of the findings of this report and provide a response to it to the Department for inclusion in the direction the Department gives to the Family Support Services Strategic Framework and State Plan; and,
  - c) consider the utility and practicality of a formalised 'shared care' approach to family support for Aboriginal families which are clearly struggling to provide adequate care to their children. This would require consideration of how respite services, family support agencies and the Department can enter into formal and legally binding contracts with each other and families to ensure adequate care is provided to children where chronic neglect is indicated.

***Category 5. Whole of Government Partnerships DCP Reform Implementation (Projects 14 & 26)***

6. That the Department provide specific direction to the Family Support Services Strategic Framework and State Plan:
  - a) regarding the need for long term intervention strategies and programs aimed at addressing the intergenerational effects of abuse and neglect – particularly those that address alcohol and other substance dependence and family violence (Project 14);
  - b) regarding the development of a 'shared care' program similar to that which operates in the United Kingdom for families/carers who are obviously struggling to provide adequate care to their children – this will require respite services, family support agencies and the Department entering into formal and legally binding contracts with each other and families to ensure adequate care is provided to children where chronic neglect is indicated (Project 14); and,
  - c) regarding the need for an increase in the number of Aboriginal and Islander Child Care Agencies operating in Western Australia, particularly in rural and remote locations (Project 14).
7. That the Department develop policies and guidelines for developing leadership with regard to case planning and management through collaborative arrangements with other lead agencies (Project 26).

***Category 6. Corporate Support Systems DCP Reform Implementation (Projects 11 & 9)***

8. That the Department:

- a) establish a rigorous process for the full documentation of case management decisions and follow-up strategies (project 11);
- b) provide training and development to front line workers regarding the harms to children resulting from chronic neglect in particular those that are associated with alcohol and other substance misuse and the witnessing of family violence (project 9); and,
- c) demonstrate leadership in case planning and management through taking responsibility for case management and the facilitation of collaborative arrangements with other lead agencies.

## 7. References

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