Chapter 9: Fatal assault

> *"The killing of a child is a crime of considerable ease, both from the standpoint of committing the act and of subsequently escaping detection. The act is generally committed in the privacy of the home, in the absence of any witnesses"* (Myers, 1967 cited in Mouzos, 2000:133).

Thirteen children and young people died from a fatal assault in Queensland between 1 January 2004 and 30 June 2005, a rate of 1.4 deaths per 100,000 children. Fatal assaults accounted for 8.9% of child deaths from external causes during the reporting period.

Defining fatal assault

Child fatal assault is defined as the death of a child or young person from "acts of violence perpetrated upon him or her by another person" (Lawrence, 2004:838). A child focused definition of fatal assault differs substantially from some legal and criminological definitions. For example, child focused definitions tend to include a broader age range; birth to 17 years compared to birth to 14 years in some criminological definitions (Strang, 1996; Mouzos, 2000). More significantly, in child focused definitions, the perpetrator's intention is not relevant. The definition includes violence leading to the child's death even when the perpetrator may not have intended the outcome, as well as cases in which the perpetrator did intend to kill the child (Lawrence, 2004:838; NSW Child Death Review Team, 2002; NSW Child Death Review Team, 2003). As such, fatal assault includes cases where a child's death is the sequelae of fatal assault, even if the death occurred some time later.

Categorising fatal assault

Much of the contemporary literature on the fatal assault of children and young people in Australia has been generated by the New South Wales Child Death Review Team (see for example, Lawrence, 2004; Lawrence & Irvine, 2004). The 2002 report, *Fatal Assault of Children and Young People* together with *Fatal Assault and Neglect of Children and Young People* (2003) constitute a significant body of work on the deaths of children and young people from assault and neglect. The Commission has drawn from these reports to develop the categorisation of fatal assault in this chapter.

Fatal assault is a heterogenous class of acts (Mouzos, 2000:4). Although the child dies from violence in each case, the social context surrounding these incidents differs substantially. Theories for explaining the problem of child fatal assault mainly concentrate on the perpetrator (his/her relation to the victim, mental state and gender) as well as the social context of the incident (Lawrence, 2004:842, 845–846).

While there is no internationally or nationally accepted means of classifying the circumstances of child fatal assaults, all can be classed as either familial or non-familial. Other classifications are based on the scenario around the child's death. The New South Wales Child Death Review Team (2002; 2003) and Lawrence (2004:842–843) report that several major types of fatal assault are repeatedly found in research studies including:

- infanticide
- fatal child abuse
- domestic homicide
- psychiatric illness
- fatal sexual assault, and
- teen fatal assault.

Through its child death research, the Commission has also identified a form of fatal child abuse, fabricated or induced illness (FII) (formerly Munchausen syndrome by proxy), that also warrants attention.

While classification into types of assault is based on the scenario surrounding the death, these categories are not static and social problems frequently overlap (Lawrence, 2004:843). For example, deaths are classified as domestic homicide if family breakdown and/or conflict is the precipitating factor in the fatal incident. Although mental health problems or child abuse may coexist in the family, the child's death is seen to be triggered by the family breakdown (Lawrence, 2004:843; NSW Child Death Review Team, 2002:6). Similarly, child protection workers involved with parents affected by mental illness may classify incidents resulting from psychiatric disorders as child abuse.

Infanticide

Finkelhor (1997:23) defines infanticide as "the killing of a recently born child by a relative in situations where the relative does not want the child, and is ill-equipped to care for him/her".

Although the perpetrator can be either male or female, it appears that mothers more often commit infanticide. Studies suggest that a typical scenario concerns a teenage mother who is poor and single and the pregnancy unwanted (Wallace, cited in Finkelhor, 1997:24; Lawrence, 2004:844). In addition, the mother has often received very little or no prenatal care and has not given birth in a hospital. In cases of infanticide it is often difficult to establish a cause of death or whether the infant was even born alive (NSW Child Death Review Team, 2002:7).

Fatal child abuse

Fatal child abuse is a pattern of assault in which the child is either killed by a one-off assault or as a result of escalating physical violence over time (Lawrence, 2004:844). A study of homicide in England between 1989 and 1993 found that in more than half of child fatal assaults the child had experienced prior abuse by the perpetrator (Wilczynski, 1997 cited in Mouzos, 2000:138–139).

Fatal child abuse occurs predominantly in infants and very young children (aged birth to four years), who lack the power or resources to defend themselves, the typical "battered child" (Kempe et al., 1962 cited in Cohle & Byard, 2004:77). The perpetrator is usually a parent or caregiver. The death is most commonly caused by blunt force; children are punched, hit, kicked, shaken or thrown, resulting in injuries which include "bruising, factures, dislocations and ruptures, such as subdural haematomas and retinal haemorrhages" (Cohle & Byard, 2004:77; Wallace, 1986 cited in Lawrence, 2004:844). Deaths are also caused by suffocation, strangulation or intentional burns or scalds. Chole and Byard (2004:77) report that the precipitating event often involves disciplinary action.

A five-month-old infant was shaken and repeatedly hit and punched by her mother when she would not settle. The infant's injures included extensive brain damage, retinal haemorrhages, fractures to the arms and legs and broken ribs. She was left with virtually no cortical brain function, only primitive reflexes, and suffered blindness, hearing loss and degenerative disability.

The infant's injuries were initially reported as having been caused by a fall from a change table within a week before the hospital visit. She had a history of abuse, previously sustaining a broken rib and facial injuries.

The infant had an extremely poor prognosis with a life expectancy of less than three years. The child died about a month before her fourth birthday; her death was a direct result of the original injuries.

The parental relationship was characterised by domestic violence (perpetrated by the mother) and alcohol abuse.

Fabricated or induced illness

Fabricated or induced illness (FII), formerly known as Munchausen syndrome by proxy, is a covert, often lethal form of physical abuse in which a caregiver fabricates or induces illness in a child (Abdulhamid, 2004; Chadwick, 1996:29)[187]. The need of the perpetrator to view the child as sick leads to a combination of unnecessary medical treatment and excessive restrictions on the child's functioning and development, creating a pattern of child abuse which is both difficult to identify and treat (Masterson & Wilson, 1987:21). Victims of FII are usually young children[188] and perpetrators are almost always parents or caregivers.

According to the 2004 *Public Report to Cumbria Child Protection Committee Serious Case Review of events leading to the death of MD who was the victim of fabricated or induced illness (FII)*

187 The use of terminology to describe the fabrication or induction of illness in a child has been the subject of considerable debate between professionals. The differences of opinion have mainly centred around the lack of focus on the child victim and an inappropriate concentration on the perpetrator (Department of Health, 2001:5). Consequently, in order to keep the child's safety and welfare the primary impetus of professional activity, the Department of Health in the UK suggested that the expression Munchausen's syndrome by proxy be abandoned and recommended the use of the term FII. This new definition focuses on the harm to the child as opposed the perpetrator's characteristics or motivation (Michael Dickinson Report, 2004:8).

188 FII victims may also include elderly, disabled individuals.

(formerly known as Munchausen syndrome by proxy) (Michael Dickinson Report), FII is most commonly characterised by:

- a child presenting for medical assessment, usually persistent and often resulting in multiple medical procedures
- the perpetrator denying the cause of the child's illness, and
- acute symptoms and signs which cease when the child is separated from the perpetrator.

FII does not exist as a medico-legal entity and therefore is not classified as a mental illness[189].

> Video surveillance was installed in a hospital after a case of FII was suspected. The tapes showed the mother turning off the apnoea alarm attached to her child, placing a folded bib on her shoulder, clutching the infant to her chest and forcing her face into the bib. The mother then switched the alarm back on. Several minutes later the mother placed the now completely floppy infant back in the cot, where she gasped twice. Again the mother turned off the monitor, placed the bib on the infant's face, and leaned her upper body heavily over her daughter (Byard & Burnell, 1994:354)[190].

Domestic homicide

Domestic homicides are usually precipitated by a breakdown in, or termination of, the parents' relationship. These incidents are frequently associated with the wife leaving the relationship (and taking or leaving behind the children) or residence or contact proceedings (Johnson, 2002; Mouzos, 2000:143). Johnson (2002) reports that domestic homicides are always premeditated and usually follow months or years of dysfunctional behaviour by the perpetrator, including threats to harm themselves or other family members.

Domestic homicide is very often followed by suicide. An offender who kills his or her children is nearly ten times more likely to suicide than an offender who kills someone other then their own child (Carach & Grabosky, 1998 cited in Mouzos, 2000:143; Strang, 1996:4).

In the vast majority of murder-suicides where residency of, or access to the children is in dispute, the perpetrator is male and either the children's biological father or stepfather. Conversely, in murder-suicide cases where women are the perpetrators there is usually evidence of mental illness involving delusional thought processes (Johnson, 2002).

In Australia, between July 1989 and December 1993, 35% of children (aged 14 years or under) who were fatally assaulted died as a consequence of a family dispute (Strang, 1996:3).

> The parent's relationship had ended due to the father's increasing domestic violence, which at times placed the children at risk of serious harm. After his application for a shared care arrangement was refused, the father killed his children and himself in the family home.
>
> Although the father's motive remains unclear, a suicide note insinuated he was responding to the court decision and it appears that he was trying to prove ownership of the two young children.

Psychiatric illness

Fatal assaults in this category are precipitated by the psychiatric illness of a parent or caregiver. This may include mothers who kill their children while suffering severe postnatal depression or psychoses (NSW Child Death Review Team, 2003:5). Stroud's (1997 cited in NSW Child Death Review Team, 2002:7) review of mental illness and child homicide found that child killings precipitated by psychiatric illness are distributed across the age span and not concentrated in any particular age category. In Australia the perpetrator, in 14% of child fatal assaults between 1989 and 1993, appeared to have been suffering from psychiatric illness (Strang, 1996:3).

Fatal sexual assault

Fatal sexual assault or sexual homicide occurs when a victim dies during or after a sexual assault. Lethal assault in the context of a sexual attack is considered particularly violent.

189 See for example, R v LM [2004] QCA 192.

190 Although there was one case of alleged FII in the reporting period, a case study from the academic literature has been substituted to ensure that police investigations and court processes are not prejudiced.

> "The sudden and unprovoked nature of these attacks, the brutality of the offences, and the powerlessness and defencelessness of most of the victims, combine to make these incidents amongst the most disturbing of all homicides" (Wallace, 1986 cited in Mouzos, 2000:77).

The reported number of fatal sexual assaults in official statistics is likely to be an undercount due to the manner in which these incidents are investigated and reported (Ressler et al., 1998 cited in Mouzos, 2000:77). Conclusive evidence of a sexual assault is sometimes lacking. In cases where it is obvious that both a sexual assault and a homicide have taken place, the assault is often only reported as a homicide.

Wallace (1986 cited in Lawrence, 2004:845) reports that children are disproportionately victims of fatal sexual assaults: "almost half of the victims of all fatal sexual assaults were children 3–16 years of age".

In Australia between July 1989 and December 1993, 9% of the victims of a sexual assault were children under 14 years. In only two cases the perpetrator was a stranger (Strang, 1996:3–4).

Teen fatal assault

Adolescent homicides occur in older children, during the later teen years. Unlike infanticide, fatal child abuse and domestic homicides, the perpetrators of teen fatal assaults are rarely caregivers or family members (Finklehor, 1997). Rather, the circumstances and causes of adolescent homicide resemble that of adult homicides. In these incidents, confrontational violence occurs between friends, acquaintances, boyfriends and strangers (Lawrence, 2004:845; Cohle & Byard, 2004:77). The vast majority of adolescent homicides are carried out by male assailants (Lawrence, 2004:845).

Child fatal assault from a developmental perspective

The rates of child fatal assault are greatest during infancy and the later teen years, with two defined patterns of 'infantile' and 'adolescent' assault (Christoffel, 1990; McClain et al., 1993). The frequency and types of fatal assaults vary with age, which suggests a developmental pattern of assault (Finkelhor, 1997; NSW Child Death Review Team, 2002).

Fatal assaults of children and young people can be broken into three distinct age groups: young childhood, middle childhood and the teenage years. The age of the child and category of the assault also largely determines whether or not the fatal assault occurs within the family (Lawrence, 2004:843).

Infants and young children

Infants and very young children (four years and under) are at particular risk of lethal violence. They are small, vulnerable, totally dependent on a caregiver for survival and have no means of defending themselves. Children of this age can still be picked up and shaken or thrown and only a limited amount of force can cause serious injury (Finkelhor, 1997:22). Violence perpetrated on children in this age group is therefore more likely to be fatal (Lawrence, 2004:846).

It is internationally recognised that official statistics substantially undercount the number of fatal assaults of infants and young children. Finkelhor (1997:22) contends that fatal assaults of young children are frequently difficult to detect and document because their presentation often resembles deaths due to accidents and other causes. For example, it is difficult to distinguish infants and young children who are suffocated from those who die from sudden infant death syndrome (SIDS) or undetermined causes, as the findings at autopsy are entirely non-specific in both cases (Byard, 2004:502; Finkelhor, 1997:22). In Australia, for infants less than one year of age, the largest cause of death after natural causes is 'sudden death, cause unknown' (Category 798, Australian Bureau of Statistics) (Strang 1996:2). It is possible that a small proportion of these deaths may be deliberately caused (Lawrence, 2004:84)[191].

191 It is also often difficult to distinguish young children who are intentionally dropped, pushed or thrown from those who die from falls (Finkelhor, 1997:22). Chadwick et al., (cited in Cohle & Byard, 2004:83) contend that in cases of fatal abuse reported as due to a fall, if caregivers' histories were to be believed, the chance of dying from a fall of less then four feet was eight times greater than from a fall of between ten and forty-five feet. Moreover, in some cases of so-called accidental deaths, Finkelhor (1997:22) argues that there may be a "major component of wilful parental negligence that is difficult to establish".

Most research indicates that the greatest risk of fatal assault to young children is from family members, usually a parent, and that killings by people unknown to the child are relatively rare. In Australia, between 1989 and 1993, only 4% of fatal assaults of children aged 14 and under were committed by strangers (Strang, 1996:3).

Middle childhood

Between the ages of five and 12, the rates of fatal abuse decrease markedly. While children may face considerable violence in the home or at school during these years, it is usually not lethal (Finkelhor, 1997:26). Finkelhor (1997:26) describes middle childhood as "a period of transition". Children in this age group have outgrown the vulnerability of the very young: they are less dependent, and increasingly robust, making them better able to hide, avoid blunt force injuries and escape from aggressive parents. More force is also required for an injury to be lethal. Also, most children in middle childhood have not yet begun to engage in risk taking activities, and are therefore protected from some of the dangers that contribute to the high rates of homicide during the adolescent years.

During middle childhood most fatal assaults still occur within the family. The New South Wales Child Death Review Team's (2002:xii) study of fatal assault found that parental mental illness and family breakdown were major factors in middle childhood fatal assault.

Adolescence

Reflecting the child's expanding social sphere, teen homicide is the type of child fatal assault that bears closest resemblance to, and appears to be an extension of, the adult homicide problem. Teen homicide appears to be an extension of adult homicide. Like adult homicide, the perpetrators and victims of teen homicides are predominantly male (Finkelhor, 1997:19). In contrast to fatal assaults of young children and children in the middle years, most adolescent assaults are non-familial (Lawrence, 2004:843; Cohle & Byard, 2004:77). Despite the stereotype that teenagers are usually killed by other teenagers, Finklehor (1997:19) found that in almost two thirds of adolescent homicides the perpetrator was an adult. Although the assailants in teen homicides are usually 'youthful', they are primarily young adults not adolescents themselves.

Fatal neglect

While numerous studies have examined the deaths of children and young people from assault, there is a paucity of research on fatal neglect. Deaths of children from neglect are frequently difficult to detect or are not reported and classified as such. Consequently, there is a lack of information and research in this area (Lawrence & Irvine, 2004:2, 9).

Child death review teams charged with reviewing the circumstances of, and trends in child deaths often determine which cases constitute neglect, using police and coronial information as well as extensive records from health, education and human service agencies. The New South Wales Child Death Review Team has developed a screening procedure for coronial and non-coronial cases, to identify deaths caused by abuse, neglect or suspicious of abuse and neglect. The number of deaths reported by the team as due to fatal assault or neglect is greater than those recorded in other official statistics, such as Australian Bureau of Statistics (ABS) data.

The Commission is currently developing similar screening tools for identifying fatal child neglect in Queensland.

Identifying and reviewing deaths from, or suspicious of, assault and neglect requires full case file reviews of records from government agencies, including the Departments of Child Safety, Communities, Health, Housing, Police, Education, Disability Services, the Registry of Births Deaths and Marriages and the Office of the State Coroner.

Section 89ZG of the *Commission for Children and Young People and Child Guardian Act 2000* provides that a government entity may enter into an arrangement to provide the Commissioner with information reasonably needed to perform the Commission's child death research functions[192]. Without these agreements, it is only possible to discuss deaths resulting from acts of violence perpetrated upon a child by another person. As

192 The Commission hopes to develop agreements with these agencies in order to report on fatal neglect in 2005-06. Arrangements have recently been developed with the Registry of Births Deaths and Marriages, the Office of the State Coroner and the Department of Child Safety.

such, this chapter has not included a review of deaths from fatal neglect, or those which occur in circumstances suspicious of abuse and neglect.

Fatal assault trends and patterns, 2004–05

Between 1 January 2004 and 30 June 2005, 13 children died as a result of fatal assault, a rate of 1.4 deaths per 100,000 children aged from birth to 17 years. These children died in 10 separate incidents. Two incidents involved the deaths of siblings.

Table 9.1 presents the age group and gender of the children and young people who were fatally assaulted.

Table 9.1: Assault fatalities by age at death and gender

Age at death	Females *n*	Males *n*	Total *n*	Rate per 100,000
Under 1 year	0	4	4	8.3
1–4 years	2	1	3	*
5–9 years	0	0	0	*
10–14 years	1	0	1	*
15–17 years	2	3	5	3.1
Total	**5**	**8**	**13**	**1.4**
Rate per 100,000	**1.1**	**1.6**	**1.4**	

Data source: Queensland Child Death Register (2004–05)

** Rates calculated on numbers less than four are unreliable.*

Gender

Of the 13 children killed, eight (61.5%) were male and five (38.5%) were female. This is consistent with the findings of the New South Wales Child Death Review Team's reports *Fatal Assault of Children and Young People* (2002) and *Fatal Assault and Neglect of Children and Young People* (2003), where a higher incidence of fatal assault was reported for male children than female children.

In contrast to these findings, there is not much difference in the gender distribution of child homicide victims at a national level. Between 1989 and 1999, 51.6% of Australian child homicide victims were male and 48.4% were female (Mouzos, 2000:135). In Queensland between 1991 and 2003 (see chapter 2), there was only a slight variation in gender, with 49.1% of child fatal assault victims being male and 50.9% female.

The gender of fatal assault victims varied most in the under one year age group in which all four infant victims were male. This is inconsistent with national findings that the highest risk of homicide victimisation for females is under one year of age (with a rate of 2.6 deaths per 100,000 female infants between 1989 and 1999) (Mouzos, 2000:135).

Age

The children who died from fatal assaults ranged in age from three months to 17 years. The highest number of fatal assaults was found in children aged 15 to 17 years (five deaths) and those under one year (four deaths).

Australian and international research has consistently found that children under the age of one are at a relatively high risk of fatal assault. At a national level, the highest rate of child homicide in Australia is less than one year of age (Strang, 1996). International research has also found that the risk of homicide is greater in the first year of life than in any other equivalent life span (Mouzos, 2000:135).

During the reporting period, the same number of infants under one year and 17-year-olds died from fatal assault (four deaths each). In contrast, between 1991 and 2003 in Queensland, the number of fatal assaults of infants under one year was significantly greater than for any other age category, with 28 deaths (25.0%) compared to 11 deaths (9.8%) in both the one year and 16 year age groups.

From a developmental perspective, two patterns of fatal assault are evident: assaults of infants and very young children and of adolescent assaults. Seven children aged from birth to four years (53.8%) and five 13 to 17-year-olds (38.5%) were fatally assaulted. Only one victim was in middle childhood. This is consistent with national and international literature on developmental theories of child fatal assault.

Coronial findings

At the time of reporting, 12 of the 13 cases of fatal assault were open before the Coroner. Coronial proceedings had been finalised in one case. Autopsies had been conducted in 11 of the 13 cases. Two cases were pending autopsy test results.

Category of assault

Table 9.2 classifies the deaths according to the major categories of fatal assault in the research literature. The cause of death, the child's age and the perpetrator are also included.

Table 9.2: Category of assaults by perpetrator, age and cause of death

Category	Perpetrator	Age	Certified cause of death
Teen fatal assault	Acquaintance	17 years	Pending test results (*reportedly involved a bladed instrument)
Teen fatal assault	Acquaintance	17 years	Multiple stab wounds
Teen fatal assault	3 teenagers (aged 16,16 & 17)	17 years	Head injury (*reportedly involved blunt force injuries)
Teen fatal assault	3 teenagers (aged 16,16 & 17)	17 years	Head injury (*reportedly involved blunt force injuries)
Domestic homicide	Father/step-father	1 year	Carbon monoxide toxicity
Domestic homicide	Father/step-father	7 months	Carbon monoxide toxicity
Domestic homicide	Father	1 year	Undetermined (*reportedly drugged then suffocated)
Domestic homicide	Father	3 months	Undetermined (*reportedly drugged then suffocated)
Domestic homicide	Mother	9 months	Pending test results (*reportedly involved knife wound to the throat area)
Fatal child abuse	Mother	3 years	Lower respiratory tract inflammation and aspiration pneumonia due to neurovegetative state caused by a head injury in 2001
Fatal child abuse	Mother	8 months	Asphyxia due to smothering/ suffocation. Recurrent episodes of hypoxic ischaemic brain injury
Fatal sexual assault*	Unknown	16 years	Blunt object head injury
Other (unknown)**	Mother	11 years	Multiple stab wounds to chest

Data source: Queensland Child Death Register (2004–05)

** information used to classify death gleaned from other sources in addition to police and coronial information.*
*** details of circumstances insufficient to classify the death.*

Strang's (1996:2) study of homicide of Australian children under 15 years between 1989 and 1993 reported two common scenarios: family disputes (domestic homicides) and fatal child abuse.

During the 18 month reporting period, domestic homicides accounted for more than 60% of fatal assaults of children under 15 years. Fatal child abuse was the second most common category, accounting for 25.0% of fatal assaults of children under 15 years. Four of the five adolescents aged 15 to 17 years were killed in teen fatal assaults. Two adolescents were killed by other teenagers the same age or younger.

Method of assault

Table 9.3 shows the method of assault by age of the children and young people who died in the reporting period.

Table 9.3 Method of assault by age at death

Method of assault	Age (years)					
	Under 1	1–4	5–9	10–14	15–17	Total
Blunt force injury					3	4
Physical assault (no weapon)		1				
Stabbing	1			1	1	3
Suffocation	2	1				3
Carbon monoxide poisoning	1	1				2
Other/ unknown					1	1
Total	**4**	**3**	**0**	**1**	**5**	**13**

Data source: Queensland Child Death Register (2004–05)

As discussed previously, the force required to kill a small child is low compared to a teenage or an adult victim. Research suggests that weapons commonly classified as dangerous are rarely used in the fatal assault of infants and young children (Finkelhor 1997:22; Mouzos, 2000:135). Rather, children under the age of five years are most likely to be beaten to death, and the youngest victims are most likely to be suffocated, violently shaken or thrown (Mouzos, 2000:136).

During the 18 month reporting period, seven children under five died from fatal assault; three were suffocated, two died of carbon monoxide poisoning and one died as a consequence of being shaken and hit during infancy. Only one child under the age of five was killed with a weapon.

All teen fatal assaults involved weapons, including metal poles, a hammer and knives. Three adolescents were killed by blows with a blunt object, one was stabbed to death and another's death involved a bladed instrument. The only child who died during middle childhood was stabbed. These findings are consistent with Australian research findings that older children and teenagers (like adult men and women) are most likely to be killed with a knife or other sharp instrument (Mouzos, 2000:136).

Victim-offender relationship

Consistent with national and international findings, all fatal assaults of children under the age of 15 were committed by a parent or stepparent. Child deaths from parental abuse are unusual homicides because of the high proportion of women offenders, usually biological mothers (National Child Protection Clearinghouse, 2005). In the reporting period, mothers were responsible for four of eight fatal assaults by a parent.

Consistent with other research, all five of the fatal assaults of teenagers were non-familial. It appears that the perpetrator/s were known to the victims in most teen homicides.

Location

In Australia, 60.2% of homicides occur in homes (Mouzos, 2000:19, 135). During the reporting period, 10 of the 13 fatal assaults (76.9%) were committed in a residence. Six of those occurred in the victim's home (60.0%)[193]. Two assaults took place on a street/ road/highway or other open area such as parkland/ bushland. One child was killed in a hospital.

Multiple victims

The 13 children killed during the 18 month period died in 10 separate incidents. Four of these incidents (40.0%) involved more than one victim; two involved the deaths of siblings. A total of 17 people (13 children, four adults) died.

Strang (1996:2) reports that between July 1989 and December 1996 in Australia, 20% of homicides of children under 15 involved more than one victim (compared with 5% of all homicides which involved multiple victims). In almost all fatal assaults of children under the age of 15, the offender was the child's father.

During the 18 month reporting period, three homicides involving multiple victims involved

193 Two assaults occurred while on an access visit with their father. As these children lived between residences, these deaths have been classified as occurring at home.

children under 15 years. In two cases, the child's father or stepfather was the perpetrator. The other incident involved the child's mother. All three offenders suicided after the fatal assault.

In addition, there were three homicides associated with a single incident. However, one of the victims was over the age of 18 and has not been counted in this report. The other victims were over 15 years. The three victims were not related. This incident involved multiple offenders.

Aboriginal and Torres Strait Islander status

One of the 13 fatal assaults was of an Aboriginal child.

Geographic distribution (ARIA)

Twelve of the 13 children fatally assaulted resided in metropolitan areas, none were living in regional areas and only one child was living in remote Queensland. The rate of fatal assault in metropolitan areas was 2.9 deaths per 100,000 children aged from birth to 17 years. This is considerably higher than the rate of fatal assault in metropolitan areas reported in the 13 year period reviewed (1.3 deaths per 100,000 children aged birth to 17 years) (see chapter 2).

Socioeconomic status (SEIFA)

Six of the 13 children and young people fatally assaulted were living in low or very low socioeconomic areas. Four of those six were living in the lowest socioeconomic areas of Queensland. Five children were from high or very high socioeconomic areas and two were living in a moderate area.

Known to the Department of Child Safety

During the 18 month reporting period, seven of the 13 fatally assaulted children were known to the Department of Child Safety (DChS) or the former Department of Families. The department's involvement with four of seven children will be considered by the Child Death Case Review Committee (CDCRC)[194].

Research in the United States has found that fatal child abuse is more common in families marked by poverty and substance abuse (Levine et al., 1994 cited in Finkelhor, 1997:25). Studies have also found that between 24% and 45% of child abuse fatalities occur in families known to child protection services. Levine and colleagues (1994 cited in Finkelhor, 1997:25) report that in as many as one in eight deaths, the case was currently active.

Forthcoming research on fatal assault and neglect

The deaths of children who are known to child protection services are commonly seen as major events which trigger serious reviews of agency policy and procedures (Lawrence, 2004:837). In Queensland the CDCRC reviews the deaths of children who were known to the DChS within three years before their death. All child deaths from assault and neglect should also trigger serious reflection about social policy for children.

The Commission is planing an in-depth study on the fatal assault and neglect of children and young people in Queensland. This research will include analysis of the deaths of children who died from possible fatal assault or neglect.

The study will provide a state-wide profile of child fatal assault and neglect. The profile will include the characteristics of the children, families, living situations, socioeconomic status, the victim-offender relationship and precipitating factors to the fatal event. The aim of the project is to identify the circumstances that place children at increased risk of assault or neglect and support the development of targeted interventions.

While research has begun, the project cannot be completed until the Commission has agreements with relevant agencies to access information that will assist with the identification of all deaths from possible fatal assault and neglect.

194 Since 1 August 2004, DChS has been required to conduct a review of its involvement with a child if the child was known to the department within the three years prior to their death. The CDCRC is an independent committee responsible for considering the department's review. The committee is multi-disciplinary and is chaired by the Commissioner. As three of the fatal assaults occurred prior to 1 August 2004 they will not be reviewed by the CDCRC.