CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Submission to the Royal Commission into Domestic, Family and Sexual Violence

Government of South Australia

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Introduction

The Child Death and Serious Injury Review Committee (the Committee) contributes to the prevention of death and serious injury of South Australian children. The Committee is an independent, statutory body established under the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*[1]. It has reviewed the circumstances and causes of all child[2] deaths in South Australia since 2005.

Reviews are based on analysis of information about deaths and serious injury collected from government agencies including the Office of Births, Deaths and Marriages, the Department for Child Protection, and the South Australian Coroner's Court. The Committee reviews some deaths and serious injuries of children in more detail and might look for information from agencies such as the Department for Education, SA Health, non-government organisations and private practitioners if they have provided services to the child or their family.

The Committee's Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People (the Authority) provides a culturally safe space for the review of deaths, or serious injuries to, Aboriginal[3] infants, children and young people. The Authority seeks to do this in a culturally inclusive environment and respectful way to amplify the voices of Aboriginal children, and to create systemic change using a truth telling approach. A social and emotional wellbeing framework[4] is used by the Authority to review these deaths, coupled with professional Aboriginal child experiences and research. The framework is informed by cultural ways of knowing, being, and doing, and recognises the importance of culture and history as important factors that inform and guide understandings of health and mental wellbeing and intergeneration trauma for Aboriginal and Torres Strait Islander peoples. It encompasses expressions and experiences, connection to body and behaviours, mind and emotions, family and kinship, community, culture, Country and Ancestors, as well as the structural determinants/ factors of health.

The Committee makes recommendations to the Minister for Education, Training and Skills which are based on its reviews, the Authority's findings, systemic understandings, and statistical information. These recommendations propose improvements to legislation, policies, procedures or administrative issues that could prevent similar deaths or serious injuries. The Committee also monitors the implementation of their recommendations.

1 See: Children and Young People (Oversight and Advocacy Bodies) Act 2016 | South Australian Legislation
2 In this report, the terms 'child' or 'children' are used to describe infants, children and young people aged from 0-17 years.
3 The term 'Aboriginal' is used in this document to refer to anyone who identifies, or is identified by a parent or caregiver, as Aboriginal and/or Torres Strait Islander.
4 See: National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

The Committee's annual reports[5] summarise the Committee's reviews and recommendations to help prevent deaths and serious injuries to children and provide information on the deaths of children (from birth to 17 years inclusive) from many causes including illness and disease, transport crashes, suicide, and drowning.

The Child Death and Serious Injury Review Committee provides the following submission to the Royal Commission into Domestic, Family and Sexual Violence. Firstly, the Committee has undertaken a quantitative analysis of all children known to have died[6] from January 2005 to December 2024 and where the Committee identified that the children had experienced domestic and family violence. Secondly, the Committee has undertaken a qualitative analysis of the commonalities in the life events of ten children as recorded in service records about them and their families. While the details of each case considered in the qualitative analysis is not included in this submission to protect the confidentiality of the children and their families, conclusions from the analysis are provided. In the final section, the Committee raises common themes from the analysis presented under the interest areas of the Royal Commission, as outlined in their terms of reference.

Analysis of children's experience of domestic and family violence

The following section provides an analysis of qualitative and quantitative information about the reported experiences of children who resided in a context of domestic and family violence prior to their deaths. The term domestic violence is used to refer to 'any behaviour within an intimate relationship (including current or past marriages, domestic partnerships or dates) that causes physical, sexual or psychological harm'[7]. It can occur in a domestic setting, and also outside of a domestic setting. Family violence is used as a broader term than domestic violence, as it refers not only to violence between intimate partners but also to violence perpetrated by parents (and guardians) against children, between other family members and in family-like settings[8]. In this report the term 'domestic and family violence' is primarily used as inclusive of intimate partner violence and violence against children.

5 See: https://cdsirc.sa.gov.au/annual-reports/.
6 As at the date of extraction of the data. Excludes pending.
7 Commonwealth of Australia (Department of Social Services) 2022 National Plan to End Violence against Women and Children 2022-2032. https://www.dss.gov.au/system/files/resources/national-plan-end-violence-against-women-and-children-2022-2032.pdf
8 Ibid.

Quantitative analysis from the Committee's register of child deaths

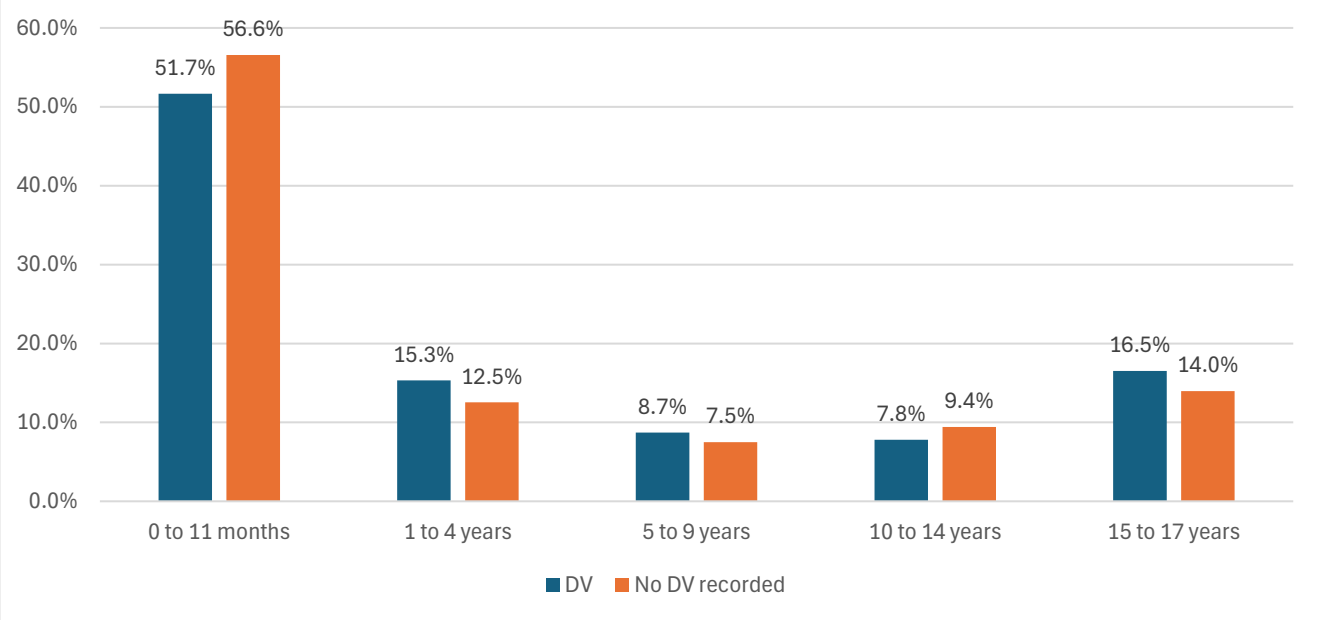
The Committee identified where a child had been exposed to domestic and family violence for all deaths reviewed from January 2005 to December 2024. Information was sourced from the Committee's child death register (the database). The majority of the records in the database that show exposure to domestic and family violence are sourced from information in child protection histories[9]. An additional text search of the database was undertaken for the words 'domestic violence' and 'DV'. The data was reviewed manually to confirm the presence of domestic violence.

Due to the nature of the sources of information obtained by the Committee, it is likely that the following analysis underestimates the prevalence of domestic and family violence experienced by children who have died.

Following is an analysis of 333 deaths of children where domestic and family violence was noted as having been present in their lives prior to death compared with 1,761 where there was no record of domestic and family violence in the database[10]. In the Committee's reviews, domestic and family violence usually involved the parents or caregivers of a child.

Figure 1 shows that there was a similar distribution by age group at the time of death for both the children known to have been exposed to domestic and family violence compared with those who had no records indicating this exposure.

Figure 1: Deaths of children exposed to domestic and family violence compared to those with no domestic and family violence recorded, by age group, 1 January 2005 to 31 December 2024

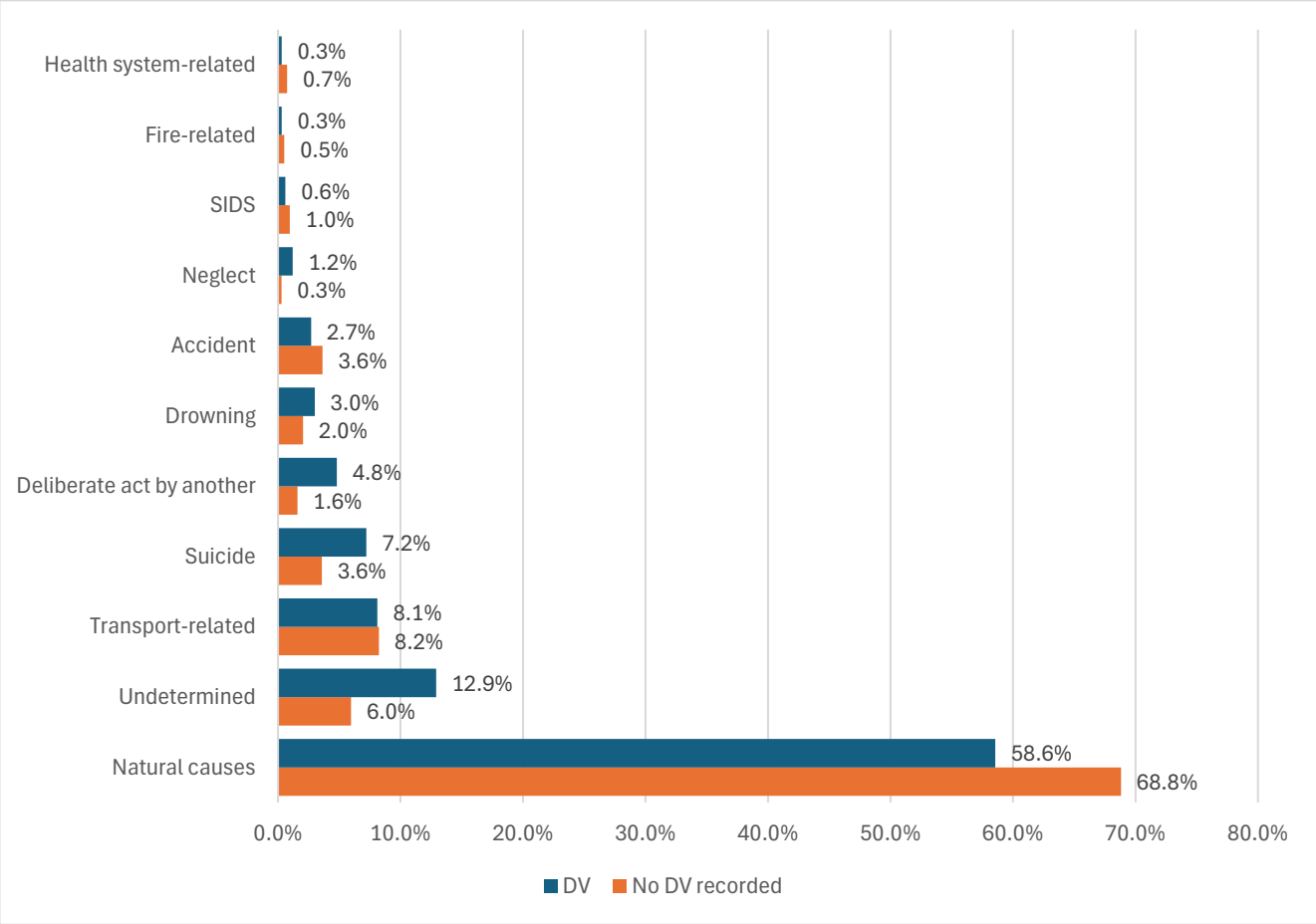


[9] Approximately 30% of the children recorded on the database had child protection histories.

[10] Information about domestic violence is not systematically collected across all cases on the database, therefore, cases with no domestic violence recorded may include some children who had experienced domestic or family violence during their lifetime.

Figure 2 shows that by category of death, higher proportions were recorded for 'undetermined', 'suicide' and 'deliberate act by another' where the child was known to have been exposed to domestic and family violence compared to the children where there was no record of exposure.

Figure 2: Deaths of children exposed to domestic and family violence compared to those with no domestic and family violence recorded, by category of death[11], 1 January 2005 to 31 December 2024



[11] Excludes pending cases.

Figure 3 shows a much higher proportion of the children who died who were exposed to domestic and family violence resided in the most disadvantaged areas (socio-demographic areas classified as SEIFA 1) compared to the children who died where there was no record of exposure.

Figure 3: Deaths of children exposed to domestic and family violence compared to those with no domestic and family violence recorded, by socio-economic disadvantage indexes (SEIFA), 1 January 2005 to 31 December 2024

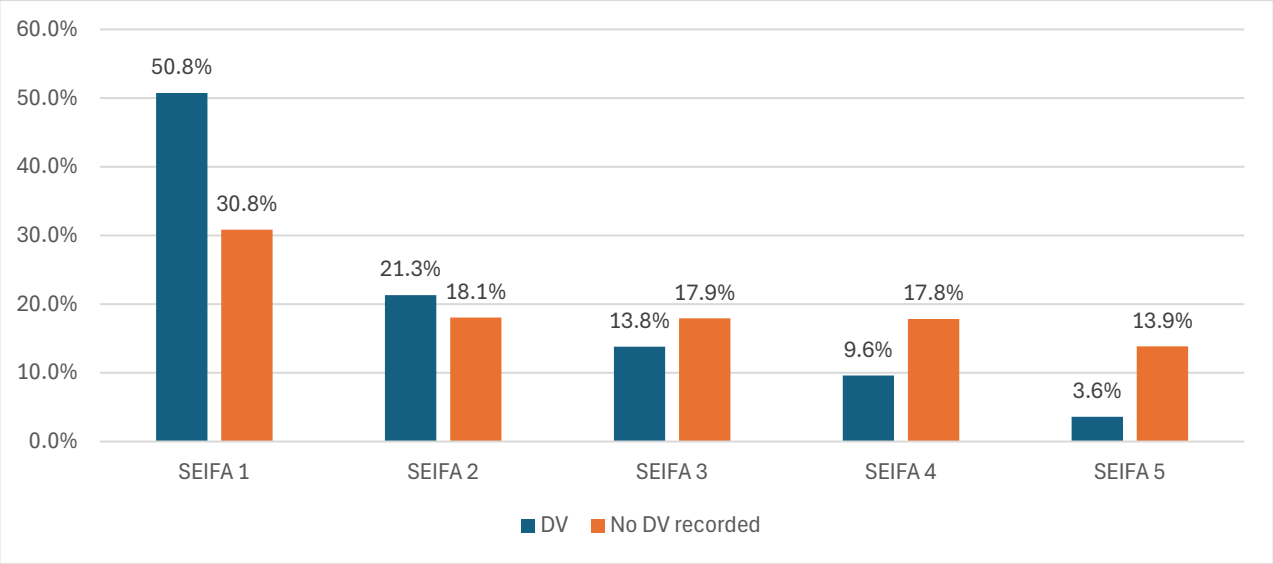


Figure 4 shows that for both groups, the highest proportions based on the location of the children's usual residences were recorded for both Northern and Southern Adelaide.

For the children who died who were exposed to domestic and family violence, it is noted that there were higher proportions recorded for several regional areas of South Australia.

Figure 4: Deaths of children exposed to domestic and family violence compared to those with no domestic and family violence recorded, by SA region of usual residence, 1 January 2005 to 31 December 2024

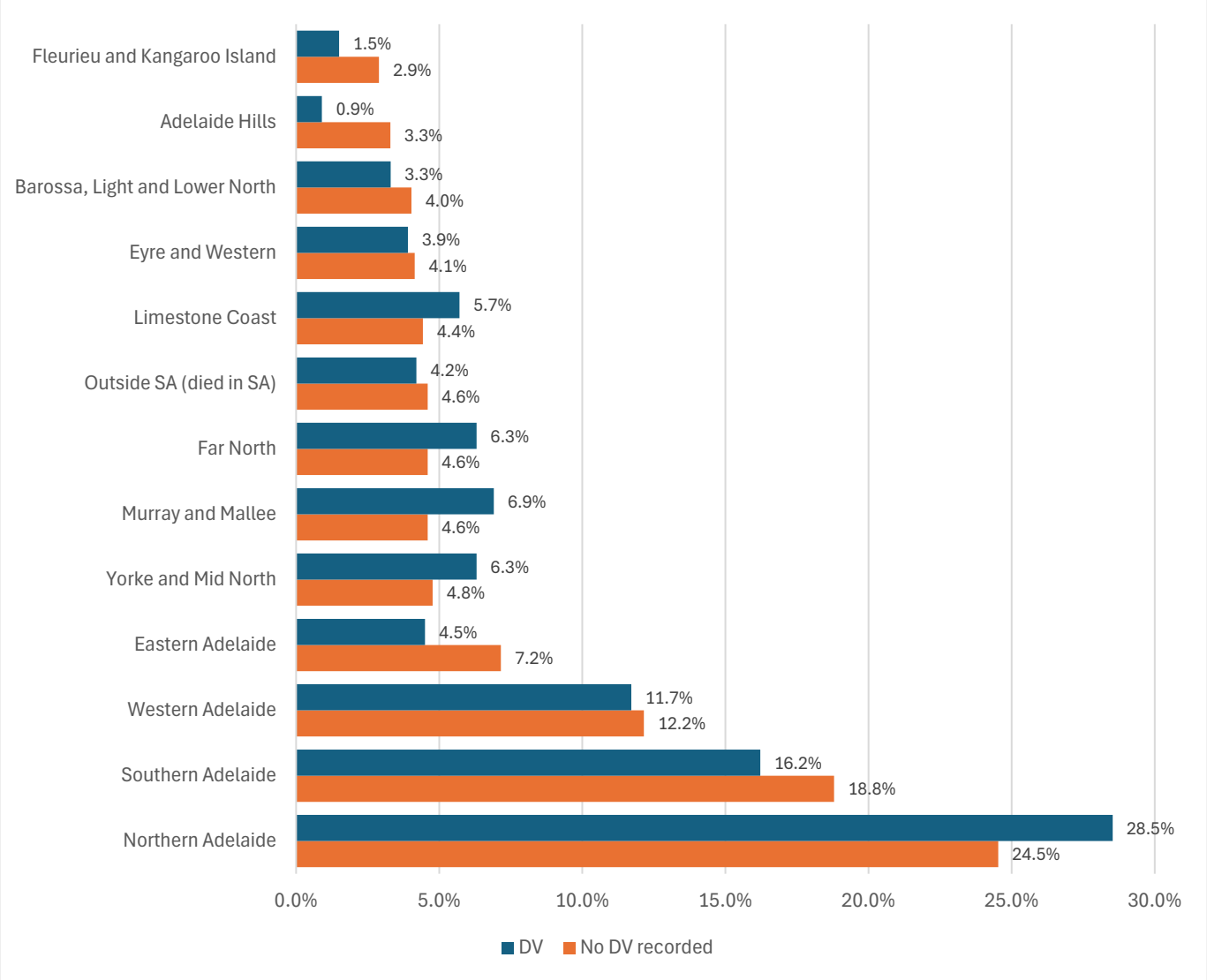
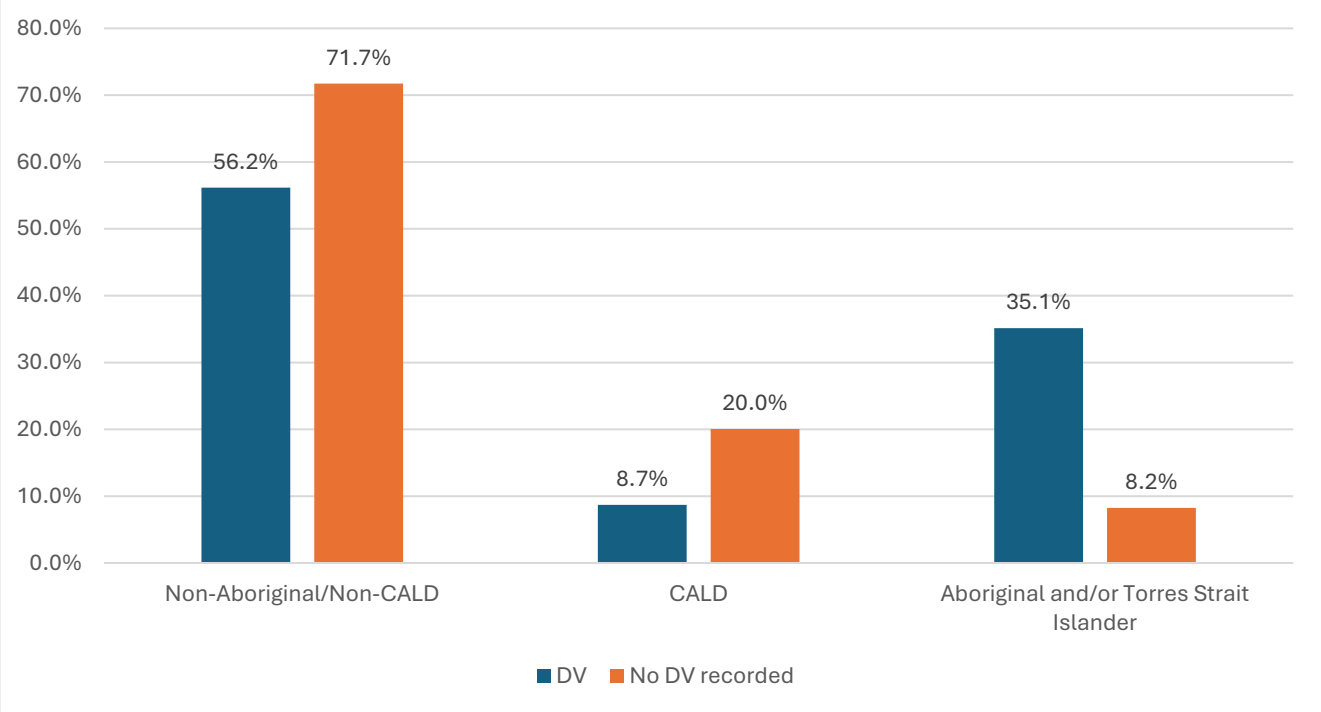


Figure 5 shows that over a third of the children who died where there was domestic and family violence exposure during their life were Aboriginal, and just under one in ten were culturally and linguistically diverse (CALD)[12].

Given that 4.5% of children aged 0 to 17 years in the South Australian community are Aboriginal, this shows an over-representation of Aboriginal children in both groups. Although there is a much higher proportion of children recorded as Aboriginal with a record of domestic and family violence exposure, this may be affected by the way the data in the database is collected.

Unfortunately, population figures are not available for CALD children aged 0 to 17 years, therefore, it is unknown whether the children who have died who were identified as CALD were over-represented in either group.

Figure 5: Deaths of children exposed to domestic and family violence compared to those with no domestic and family violence recorded, by ethnicity status, 1 January 2005 to 31 December 2024



[12] CALD includes all children who were either born in a predominantly non-English speaking country, or who had at least one parent born in a predominantly non-English speaking country.

Qualitative analysis of ten child deaths

The Committee's in-depth reviews of children who died from 2005 to 2024 have demonstrated that some children experienced or were exposed to ongoing and severe domestic and family violence. In this submission, a qualitative analysis of the circumstances of ten children examined their narratives and experiences of domestic and family violence in more detail. Of the ten children, four identified as Aboriginal and six as non-Aboriginal. While the details of each case considered in the qualitative analysis is not included in this submission to protect the confidentiality of the children and their families, conclusions from the analysis are provided. The findings highlight the complexity of children's lives and raises the need to provide effective intervention and support to prevent the consequences of cumulative harm.

It is difficult to directly attribute the death of a child to domestic and family violence, however, this analysis evidences the materiality to outcome of children's experience of domestic and family violence and the limitations of service systems which are responsive rather than proactive.

Understanding the vulnerabilities of these children

While the life stories of these respective children are unique, they all lived in a context of ongoing domestic and family violence where they witnessed violent interactions between the adults caring for them. The majority of these children also experienced physical and emotional abuse directed at them.

The analysis indicated that these children were highly vulnerable. For example:

- Being born prematurely, including in circumstances where the premature birth was due to the mother being assaulted during pregnancy
- Being born drug addicted
- Living with homelessness, abuse and chronic neglect
- Living with progressive illnesses/significant life-limiting health conditions
- Suffering from significant trauma-related mental health issues
- Experiencing ongoing feelings of anxiety and lack of safety.

Understanding the experiences of the parents/carers and the impact on parenting

The analysis indicated that the parents/carers of these children also experienced complex childhood trauma and other factors that contributed to a complex family environment for their children.

One of the most common factors that emerged from the analysis was that most of the children's parents had significant childhood histories of interaction with child protection services.

Other common factors for the parents/carers, predominantly women, of these children included:

- Abuse of drugs and/or alcohol
- Mental health issues
- Childhood histories of domestic and family violence
- Interaction with the justice system
- Ongoing unemployment.

Research has demonstrated that the parents' mental health, domestic violence, and use of drugs and alcohol has an effect on their own health and parenting as well as being associated with poorer outcomes for their children[13,14].

Furthermore, the analysis indicates that the burden of care fell predominantly to the mothers/female carers of the children further adding to the experience of trauma and precluding them from meeting the complex needs of the children.

The children's and parents' involvement with services

For Aboriginal and Torres Strait Islander families, connection to culture and receiving support from culturally responsive services is critically important. Information extracted from the records indicated that most of these families were in receipt of culturally responsive and informed services, however, the level of co-ordination of the services involved with these children and their families was not apparent. As shown in the quantitative analysis in Figure 4, there were higher proportions of deaths in children recorded for several regional areas of South Australia. It should be noted that in rural and remote locations, the dependency on having relationships with services is critical in preventing child deaths.

For several of the non-Aboriginal children, there were multiple services involved. In this analysis, the services ranged from universal services such as the Child and Family Health Service (CAFHS) to targeted services such as the Child and Adolescent Mental Health Service (CAMHS) and disability services. For some of these children, the predominant service involved was the child's school. There were a limited number of services that addressed the circumstances relating to domestic and family violence in these families and the impact on these children.

[13] ANROWS. *Inter-parental conflict, parenting, and child development in Australian Families: Fact Shee*t. https://aifs.gov.au/sites/default/files/2022-06/Parenting_factsheet1_Inter-parental-conflict-parenting-and-child-development-in-Australian-families.pdf

[14] Barrett, S et al. *Interventions to reduce parental substance use, domestic violence and mental health problems, and their impacts upon children's well-being: A systematic review of reviews and evidence mapping*. 2024 Trauma, Violence and Abuse. 25(1):393-412

Themes arising from the analysis

In this section, the Committee raises common themes from the analysis about interventions that aim to provide effective support to children and prevent the effects of cumulative harm to children experiencing domestic and family violence. The Committee's recommendations are presented under the interest areas outlined in the Royal Commission's Terms of Reference.

Early Intervention

The Committee raises the issues of domestic violence in pregnancy, developmental vulnerability and early intervention, vulnerability in complex lives, and visibility and accountability of perpetrators under the Royal Commission's interest area of early intervention.

Domestic and family violence in pregnancy

The Committee draws the Royal Commission's attention to the need to intervene effectively in pregnancy to prevent the impact of domestic and family violence on the newborn. The experience of domestic and family violence in pregnancy has been shown to be associated with poor neonatal outcomes including higher risk of congenital abnormalities[15], low birth weight[16] and preterm birth[17,18], small for gestational age[19], premature rupture of membranes[20], and severe neonatal morbidity[21].

Children in families with a refugee background have also been noted to have experienced domestic and family violence.

Additionally, there have been cases reviewed by the Committee and Authority where mothers are reluctant to seek antenatal care for fear of their unborn child being removed.

Findings and Recommendations

In the Committee's view, early identification and assertive intervention for domestic and family violence in high-risk pregnancies should be available through SA Health birthing services across the state in partnership with relevant service providers. Receiving services within a safe relationship with their midwife and warm referral to appropriate family support or domestic and family violence services are important processes to build trust with pregnant women experiencing violence. Consideration could be given to co-locating family support or domestic and family violence services with pregnancy and birthing services in community locations which are considered to be culturally safe for Aboriginal women. The Committee considers that family support and domestic and family

[15] Orr C, Kelty E, Fisher C, O'Donnell M, Glauert R, Preen D. *The lasting impact of family and domestic violence on neonatal health outcomes*. Birth 2023: 50: 578-586.
[16] Ibid.
[17] Ibid.
[18] Lockington EP, Sherrell HC, Crawford K, Rae K, Kumar S. *Intimate partner violence is a significant risk factor for adverse pregnancy outcomes*. Am J Obstet Gynaecol Glob Rep 2023;3: 100283.
[19] Ibid.
[20] Ibid.
[21] Ibid.

violence services should be adequately funded to provide this community outreach work as well as alternative housing for women at immediate risk. The committee considers also that available and appropriate services provided directly to perpetrators of violence must also be prioritised.

The Committee also raises the issue of child protection responses during pregnancy. When an unborn child of concern notification is made to child protection services, an early response to connect pregnant women to family support and/or domestic and family violence services is warranted even if the threshold for action by child protection services is not reached. When high risk families experiencing complexity come to the attention of SA Health birthing services or child protection services and there are numerous services involved, these services need to be well coordinated, create stronger partnerships, and be communicative.

Developmental vulnerability and early intervention

Bronfenbrenner's ecological-developmental model has been a long-standing way of representing how risk and protective factors interact to influence a child's risk of abuse and/or neglect. The child's individual characteristics and developmental stage are at the centre of the model, and domestic and family violence is a key risk factor within the family environment which makes up the next layer of the model. Neighbourhood and community settings and cultural beliefs and values form the more distant layers of the Bronfenbrenner model[22]. For Aboriginal children, the ecological-developmental model has been adapted to include 'strong culture' emphasising the importance for Aboriginal children of the connection to community, country and kin[23]. Strong child, strong environment, strong culture and strengths and challenges form the layers of the ecological model around the child. Culture is a life-giving and sustaining strength for Aboriginal children and a way of children understanding who they are and where they are from, and as such, is the basis for a child's successful participation in life[24]. Shonkoff et al have suggested that early childhood adversity in the form of toxic stress can be directly linked to poorer health outcomes, learning problems, and poor physical and mental wellbeing in adulthood[25].

Several of the deaths analysed here are of children whose parents also lived with domestic and family violence as a child. Recent research has shown that young people who had experienced violence between family members and been targeted with abuse were nine times more likely to use violence in the home[26].

[22] Australian Institute of Family Studies. *Risk and protective factors for child abuse and neglect*. May 2017 https://aifs.gov.au/resources/policy-and-practice-papers/risk-and-protective-factors-child-abuse-and-neglect

[23] Priest, N, Mackean, T, Davis, E, Briggs, and Waters, E. *Aboriginal perspectives of child health and wellbeing in an urban setting: Developing a conceptual framework*. 2012. Health Sociology Review. 21(2): 180-195.

[24] Ibid.

[25] Shonkoff, JP, Garner, AS and The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood Adoption, and Dependent Care, and Section on Developmental and Behavioural Pediatrics. 2012 *The lifelong effects of early childhood adversity and toxic stress*. Pediatrics 129(1) http://publications.aap.org/pediatrics/article-pdf/129/1/e232/1057314/peds_2011-2663.pdf

[26] Fitz-Gibbon, K, Meyer, S, Maher, J, and Roberts, S. *Adolescent family violence in Australia: A national study of prevalence, history of childhood victimisation and impacts*. Research report 15/2022 ANROWS. 2022

Findings and Recommendations

The Committee recommends that domestic and family violence services strengthen their focus on the early recognition of the impact of domestic and family violence on children and the need to ensure children receive an effective, developmentally informed intervention.

Underlying vulnerabilities in the complex lives of children

Both the qualitative and quantitative analyses show that children experience co-existing and ongoing disadvantage at the same time as domestic and family violence. In addition, research shows that adverse childhood events have been associated with poorer mental health and suicidality[27].

Attention to the social determinants of health[28, 29] in service planning may positively influence health and wellbeing outcomes for children experiencing prolonged periods of domestic and family violence with co-existing and ongoing disadvantage.

Social determinants of poor health and development outcomes include:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Findings and Recommendations

In the Committee's view, a public health response which embeds preventive action targeting broad social determinants into support services at the universal, secondary and tertiary service level should be used to position responses to domestic and family violence within services to families with vulnerable children[30].

[27] Sahle, BW, Reavley, NJ, Wenjing, L, Morgan, AJ, Bee Hui Yap, M, Reupert, A, Jorm, AF. *The association between adverse childhood experiences and common mental disorders and suicidality: an umbrella review of systematic reviews and meta-analyses*. European Child & Adolescent Psychiatry. https://doi.org/10.1007/s00787-021-01745-2

[28] World Health Organisation. 2023. *Social Determinants of Health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 Accessed 13 Oct 2023.

[29] Marmot, M. Fair Society, Healthy Lives. *The Marmot Review. Strategic review of Health Inequities in England post 2010*. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf. Accessed 13 Oct 2023.

[30] Higgins, D. *A public health approach to enhancing safe and supportive family environments for children*. Family Matters 2015 96: 39-52.

Visibility and accountability of perpetrators

The qualitative analysis of the children's circumstances and identified factors of domestic and family violence indicated the mothers/female carers were more visible and held accountable for the burden of care and safety of their children compared to the perpetrators.

Findings and Recommendations

In the Committee's view, working with perpetrators to hold them accountable for their use of violence is important to reduce the exposure of children to domestic and family violence. Ensuring timely and effective intervention to change harmful behaviour experienced by children has the potential not only to reduce exposure, but also to challenge the norms learned by children during childhood about the functioning of intimate relationships.

Response

The Committee raises the issues of cumulative harm, neglect of medical care, cultural responses to domestic and family violence, and developing systems to accurately identify the prevalence of domestic and family violence under the Royal Commission's interest area of response.

Cumulative harm focus

Most of the children who died in this analysis experienced domestic and family violence over many years of their lives, and in the context of associated stressors including parental drug and alcohol use, mental health problems and interaction with police and justice services. Cumulative harm describes the effect on a child of multiple long-term stressors. The effect of these stressors can be intergenerational, exponential, and severe due to the child's developmental vulnerability. Long term exposure to toxic stress associated with the environments these children have experienced has been shown to harm brain development[31].

Findings and Recommendations

In the Committee's view, the service system response to cumulative harm should be across-agency and include an effective response to domestic and family violence. The Committee has made the following recommendation to the health, education, child protection and community service sectors and draws this to the attention of the Royal Commission:

[31] Bromfield, L, Gillingham, P, Higgins, DJ. *Cumulative harm and chronic child maltreatment*. 2007. Developing Practice 19: Winter/Spring; 34-42

RECOMMENDATION: An education program and toolkit of resources should be developed and adapted to the needs of the health, education, child protection and community service workforce providing services to vulnerable children. This should include:

- ***recognition of the cumulative harm created by longstanding neglect and noting especially the following red flags[32]:***
  - ***the increased vulnerability of a child with complex care needs and intellectual disability***
  - ***the significance of repeated health conditions; for example, lice infestations, constipation and Percutaneous Endoscopic Gastrostomy (PEG) site infections***
  - ***an ongoing history of squalor in the child's living conditions***
  - ***a parent's history of foster care***
  - ***a parent's history of mental health problems***
  - ***signs that the family is "closing off", for example, declining requests for home visits.***
- ***the characteristics of successful responses[33] to cumulative harm, including:***
  - ***building a picture over time of the child's cumulative experience of neglect and harm***
  - ***building a complete picture of the child, the adults in their life, and the history of the family, including fathers***
  - ***information sharing as a basis for collaborative work practice with other service providers and guided by the Information Sharing Guidelines (ISG) and professional collaborative work practice models[34].***
  - ***remaining focused on the best interests of the child***
  - ***considering the importance of untreated or ongoing health conditions***
  - ***retaining professional curiosity and respectful uncertainty in practice***
  - ***prioritising engagement with the family, and escalating to assertive engagement in response to family closure***
  - ***keeping a focus on the need to improve outcomes for the child.***

[32] NSPCC. Neglect: learning from case reviews. *Summary of key issues and learning for improved practice around neglect*. December 2022. NSPCC.
[33] Ibid.
[34] Interprofessional education collaborative. *Core competencies for interprofessional collaborative practice: 2016 update*. 2016. Washington, DC: Interprofessional Education Collaborative,

Neglect of medical care

The deaths of several children in this analysis involved the issue of ongoing high care needs due to their health condition. The burden of care over many years fell on the mothers of the children in this analysis who were born with life-limiting conditions. Added to this they lived in circumstances of domestic and family violence.

Medical neglect occurs when children are harmed or placed at significant risk of harm by gaps in their medical care[35]. This is most likely to occur and to be recognised when families lack capability, commonly due to poverty, and when medical demands are high, such as with complex, severe, and chronic illness. Strategies used by services to support the children in this analysis included admissions to hospital for social reasons to assist with optimizing care and removing children to temporary specialist disability care.

Findings and Recommendations

The Committee has previously examined the issue of medical neglect in detail. The Committee would like to reiterate the importance of the development of an across-agency service response for the rapid identification and response to neglect of children's medical care.

In the Committee's view, domestic and family violence services should enhance their practice to ensure that responses to children experiencing violence are centred on the child's needs, particularly for those requiring high levels of care.

Cultural responses to domestic and family violence in Aboriginal families

The Committee's Aboriginal Authority has raised the importance of working with the Aboriginal community to provide culturally responsive services to Aboriginal children and families that are holistic and ensure that the family is connected to culture. Research has highlighted the risks of cultural disconnection for Aboriginal children placed away from their family homes. It reinforces the importance of service systems in actively preventing cultural disconnection, and providing proactive, strong support to help Aboriginal children reconnect with their culture, a journey that is ideally experienced within their family and community[36]. Several histories in this analysis identified examples of services that were more responsive to the needs of the child and family but usually with an episodic approach.

The Aboriginal definition of family violence includes acknowledgement of the spiritual and cultural perpetration of family violence by non-Aboriginal people against Aboriginal partners, children, young people and extended family members; abuse of Elders; and lateral violence within Aboriginal communities[37].

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[35] Boos SC, Fortin K, *Medical neglect*. Pediatric Annals, 2014;(11):e253-e259. https://doi.org/10.3928/00904481-20141022-08.
[36] Krakouer J. *Journeys of culturally connecting: Aboriginal young people's experiences of cultural connection in and beyond out-of-home care*. 2023. Child and Family Social Work: p822-832.
[37] SAFE+EQUAL. *Aboriginal community led responses - Aboriginal definition of family violence*. https://safeandequal.org.au/working-in-family-violence/service-responses/aboriginal-community-led-response/

Racism and lack of cultural safety and responsiveness have been noted by the Authority in their reviews of other child deaths, both in universal and more targeted care and support services. This has prevented effective support to Aboriginal families.

The Authority has identified consistent themes and questions about effective service provision through their review of the deaths of Aboriginal children.

Findings and Recommendations

The Authority draws the Royal Commission's attention to the following findings and questions about culturally responsive service provision.

Support systems, like the National Disability Insurance Scheme and general practice, are often complex and can be biased to supporting people who know the system best or have the loudest voice. How do services ensure access to support is equitable and culturally safe for Aboriginal families and communities?

The Authority has also reviewed several deaths involving children with high care needs, where multiple services were involved, and parents were overwhelmed due to their own earlier personal journey and trauma related to having to work with practices that have never been or are not culturally informed. In these circumstances, how do support services ensure service provision is culturally informed, coordinated (with a lead agency) and delivered in a culturally responsive way (e.g. busy services taking the time to listen to what is happening in a patient's life and recognising the cultural authority of grandparents, aunties and uncles in supporting overwhelmed parents)?

The Authority is interested in investigating the way that services report and record information about a child, to ensure the child's voice is at the centre of service delivery, and where case notes identify family strengths and obligations rather than starting with the risks and deficits in a child's life. It is also the Authority's experience that bias, judgement and racism are still present across many services, and the Authority is interested in investigating ways in which service delivery can improve for better outcomes.

Cultural responses to domestic and family violence in families with a multicultural background

There is also a need to ensure that multicultural families are provided with services informed by the experience of migrant families.

Findings and Recommendations

The Committee draws the Royal Commission's attention to its findings arising from reviews of the deaths of children whose family had a multicultural background. Capacity building within services focussed on strategies to assist effective communication and improve understanding of acceptable parenting practices in different migrant cultures were important factors in successful models of care. Such models of care should also include appreciation of the impact of trauma experienced by

families before they arrived in South Australia and at settlement. Trauma experienced prior to, and after migration to South Australia may contribute to lowered trust and increased difficulties in engagement with services.

Developing systems to accurately identify the prevalence of domestic and family violence

In the analysis of the qualitative and quantitative data, it was evident that there is a lack of readily available information that accurately highlights the prevalence of domestic and family violence and the number of children who were exposed.

Findings and Recommendations

To enable evidence-based planning and resourcing of domestic, family and sexual violence (DFSV) early intervention and response services, whole-population data on the experience of DFSV and contact with relevant services is required. We note the witness statement made to the Royal Commission from Thriving Families which referenced research from the BetterStart Health and Development Research group finding 1 in 30 children in one year are exposed to DFSV. However, this is likely to be an underestimate given the lack of SAPOL and other relevant justice data. The Committee recommends the SA Government invests in the use of data from relevant government and non-government services across South Australia to enable evidence to be produced regarding the number and characteristics of children, families, and communities who experience DFSV. This would need to include investment in service-level data collection, and the integration of key data sources including SAPOL, Courts, Youth Justice, Domestic and Family Violence services, child protection, family support, health and housing and homelessness services delivered by government and non-government agencies.

Coordination

Collaborative across-agency practice

The analysis of the family circumstances identified that most of the families had multiple services involved.

The Committee has made recommendations about the need for effective and coordinated collaborative practice across services to reduce complexity and increase the safety and wellbeing of children experiencing multiple disadvantages including where they are experiencing domestic and family violence.

Findings and Recommendations

In the Committee's view, effective collaborative across-agency practice should include assigning a lead agency to discuss concerns with all members of the services involved, undertaking an assessment of the child's immediate risk, compiling an accurate history, involving a social worker and/or Aboriginal cultural adviser, identifying barriers to accessing services, developing a Case Plan, managing interagency relationships, remaining engaged with the family and enacting escalation pathways when needed. Family support and domestic and family violence services should be funded so that they can increase their responsiveness to the high and complex needs of children.

Conclusion

In conclusion, it is submitted that the analysis of data collected by the Committee demonstrates the need to build a strong primary prevention approach within services to Aboriginal and non-Aboriginal children. That model has the best potential to improve the health and wellbeing of children and prevent intergenerational domestic and family violence.

I thank the South Australian Royal Commission into Domestic, Family and Sexual Violence for the opportunity to put forward the Committee's recommendations based on evidence collected.

Jane Abbey KC
Chair
Child Death and Serious Injury Review Committee

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