A Life Too Short

Child death by homicide in New Zealand: An examination of incidence and statutory child protection actions.

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Abstract

Using secondary analysis methodology - a statistical analysis of Police data - this study examines the annual incidence and patterns of child (0-14 years) death by homicide in New Zealand in the decade 1991-2000, and identifies the similarities and differences of these with an earlier New Zealand study and with international patterns.

The study then determines the number of victims of child homicide with whom the New Zealand child care and protection service had had significant contact during the years 1996-2000, this period being chosen because of the availability of comprehensive case records. The report describes the New Zealand child care and protection legislative scheme and delineates the phases of an investigation undertaken by the Department of Child Youth and Family Services, identifying the possible practice errors attendant with each phase. Using qualitative analysis of case reviews undertaken by the Department of Child Youth and Family Services, the study investigates when deaths have occurred: during intake and prior to investigation; during an investigation; or during an intervention; and identifies the incidence of practice error. The findings of the two parts of the study are integrated using a systems perspective that discusses the influences of family, professional, organisational and community systems on child homicide. The report concludes with the implications of this analysis for child care and protection policy, practice and research. The findings of the study are discussed together with the implications for child protection practice.
Definitions

*Child homicide* is the unlawful killing of a child 0 to 14 years. It is variously described as infanticide, death from maltreatment, manslaughter and murder.

*Filicide* is the term given to those child homicides perpetrated by the child’s parent or parents.
Acknowledgements

The deaths of 91 New Zealand children have provided the material for this thesis. Therefore, my first acknowledgement is to them. That they died so violently in this land of plenty is a tragedy of considerable proportions. I acknowledge also their families who have lived what no family should have to experience.

The idea that I should do a Master in Social Work came from Associate Professor Marie Connolly and she has continued to encourage the project as the thesis supervisor. I am sure she is right that after 40 years of practice in social work in New Zealand, it was high time I gained the qualification. I am grateful to Dr Connolly for her encouragement, support and wise counsel.

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Finally, I would like especially to thank Suzanne, who, when we retired in 2001, thought she knew what retirement was. She has generously supported this study nonetheless.
Part 1: The Study Framework
Chapter One

An Introduction to the Topic

Throughout the 1990s, the New Zealand public was confronted with stories of children who died in the most horrific and frighteningly violent circumstances. Publicity around these deaths was sometimes associated with examination and criticism of agency practices and perceived failings. While health, education and police professionals faced criticism, the most sustained and critical scrutiny was focussed on social workers employed by the Department of Child Youth and Family Services (CYFS) who are responsible for the child care and protection processes prescribed by the Children, Young Persons and their Families Act 1989 (The Act).

There is a lack of clarity, in the professions and in the community, about how many children die as the result of homicide before they reach 15 years of age. While there has been a relatively recent analysis of morbidity and death due to child abuse in New Zealand taken from medical records (Kotch, Chalmers, Fanslow, Marshall & Langley, 1993) and one attempt to understand patterns in deaths of children known to the child protection agency in New Zealand (Kinley & Doolan, 1997), there is no information available publicly about how many of these children were known to the CYFS social workers in any significant way. Nor has there been any recent analysis about how New Zealand compares in both respects with countries like Australia, the United Kingdom or the United States of America.
Therefore, the first aspect of the study is to gain an understanding about the nature of this ultimate form of violence towards children in New Zealand and to assess, where possible, how New Zealand aligns with international comparisons. A number of questions emerge when considering the issue of child homicide. At what age are children most vulnerable to homicide victimisation? How are they killed? Who killed them? What are the demographic risk factors that emerge from a study of data over time? Are there indicators of the child most at risk that might inform child protection practices in the future? In the first phase of this study, demographic data sources recorded by the New Zealand Police in cases of child homicide for the period 1991 to 2000 inclusive will be used to answer some of these questions.

The second phase of the study responds to the need for information about the coincidence of child homicide and statutory child care and protection actions. The study examines case files held by CYFS to explore the characteristics and experience of children who have been killed whilst known to the New Zealand statutory child protection agency. It is important to know how many of these children had contact with the child protection service of CYFS at, or about, the time of their deaths so that more can be known about how these cases were managed, and in particular at what part of the process children appeared to be most vulnerable. When children already known to CYFS are killed, their homicides result in an intense crisis for the agency and its workers. What went wrong? Could this homicide have been predicted? Are children placed at risk because of inadequate or faulty information gathering and assessment processes? Are the resolution and decision-making processes of the agency placing children in harms way? Do the interventions chosen protect children or leave them vulnerable to further harm? Are there professional or organisational
impediments to good practice? It is the task of the second phase of the study to explore these issues.

Research into these matters can help inform child protection policy and frame appropriate practice. If it is shown that a significant proportion of homicides of those known to CYFS occurred while a report of abuse was being investigated, issues arise about the speed of the response and how well social workers understood the heightened risk to children that child protection investigations can constitute. If it is shown that a significant proportion of such homicides occurred after assessment and after a decision about intervention had been made, serious issues about the safety of the decision-making approach must arise. Of particular interest is how homicide featured in relation to different intervention paths. If there is a nil or very low incidence of child death following a particular intervention, it may be inferred that the intervention approach has a greater capacity to deliver safer plans and outcomes. Alternatively, if the intervention is associated with levels of child homicide, this may raise questions about the intervention and its capacity to deliver safer plans and outcomes.

Child death by homicide when the child victim is involved in child protection actions is a relatively rare, and thus a momentous, occurrence in New Zealand. It needs to be considered within the context of the many thousands of care or protection actions carried out in any one year with non-fatal consequences. It is important therefore that a description of casework with child homicide victims known to the child protection agency is not interpreted as representative of agency practice, nor is it the intention of this study to suggest so. Rather, the study’s intent is to explore the circumstances
surrounding this small number of children so that we may learn from their experiences.

In summary, the study examines demographic data collected by Police relating to all child deaths by homicide in the decade 1991-2000. It identifies the proportion of those known to CYFS for the period 1996-2000. It analyses these latter cases to determine at what point of the CYFS process the children died and considers whether there is any point or points of heightened risk in the child protection process. It seeks to identify whether there was any pattern of practice error, and whether there were organisational or environmental impediments to good practice. The practice issues that arise from the study are discussed.

Aims of the study

These are to:

- Contribute to the national and international literature on child homicide and child protection practice;

- Build knowledge in New Zealand about the phenomenon of child death by homicide and its coincidence with child protection practice;

- Examine how the incidence and features of child homicide in New Zealand compare with literature about these matters in other countries;

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1 This period was chosen because of the availability of comprehensive records in CYF.
• Increase understanding about the New Zealand child most at risk of homicide victimisation; and

• Identify any policy and or practice improvements that might lead to enhanced child protection services in New Zealand.

Research questions

The primary research questions are:

1. What are the international similarities and differences with respect to child homicide?

2. Has the incidence of child death by homicide in New Zealand changed over time?

3. What are the characteristics of the child most at risk of homicide in New Zealand?

4. What proportion of child homicide victims were known to CYFS at the time of, or prior to their deaths?

5. At what stage of the New Zealand statutory child care and protection process did homicides occur and was any stage more risky in respect of homicide than others?
6. Is there any pattern in the incidence of practice error evident in case analysis that could inform improved approaches to child protection?

7. What influence do organisational or environmental issues have on child protection practice?

*Integrating the findings*

When children are killed, their families figure prominently. There will be a danger that the search for understanding can focus too narrowly and fail to appreciate that families are not islands unto themselves. Munford and Sanders (1999), for example, point to the importance of context in understanding families. Family does not exist in isolation but in the context of a variety of interactive and dynamic experiences and systems. Families are shaped through their cultural origins, the histories of their family, their social and economic experiences and their household composition. They are further moulded by religion, the community and political environment in which they live and policies and services of the state.

The study recognises that child welfare and protection involves interplay of: children’s family systems; the community and cultural systems in which children and families are located; and the professional and organisational systems designed to ensure children’s well-being and safety. Therefore, any examination of child homicide must seek an understanding of the influences of all these systems and their contribution to what is the ultimate failure of child care and protection law and policy.
The study adopts a systems perspective in order to better understand the phenomenon of child homicide, the complex interaction of family, community, professional, and organisational systems, and the policy, practice and research implications that result. Children are seen as anchored in a family system, which in turn responds to and influences its cultural and community context. Family and community systems are influenced by, and influence, the organisational and professional systems that support them. The dynamic interactions of the systems can be shown as follows:

*Figure 1.1: A systems perspective of influences affecting child homicide*

In essence, a systems analysis reinforces the notion of the environment as “a series of mediating layers” (Compton & Galaway, 1999, p.38), impacting on the way in which the situation is perceived and responded to. Within this complex set of interactions the need for intervention to be system changing as well as people helping has also been identified (Siporin, 1980). While important generally, it is particularly important when exploring issues of child homicide since system failure has so frequently featured as an issue in child death reports (Reder, Duncan & Gray, 1993; OCC, 2000).
According to White (1997, p.192), “… an examination of the whole professional context may show up how agencies contribute to unhelpful outcomes”.

**Thesis organisation**

The thesis is organised in three parts:

1. Part 1 sets the basis for the study by: establishing the reasons for the research and the key research questions; conducting an examination of international trends and patterns in child homicide and literature about these; and providing an outline of the New Zealand child care and protection approach. The aim is to anchor the study within an international context and within the context of New Zealand law and policy.

2. Part 2 reports on the methodologies chosen for the studies and on the studies themselves. Statistical data about child homicide in New Zealand for the most recent complete decade is analysed and discussed, with parallels drawn between national trends and patterns and those evident from the literature review. This helps us understand the global picture of child homicide and where New Zealand either conforms to or deviates from this. A small sub-sample of children included in the main statistical analysis was identified as having had prior contact with CYFS. Access to reviews that have been completed in relation to casework undertaken with these children and their families enabled the study to examine family and community influences in more depth, as well as any professional or organisational impacts on these cases. From this analysis we may formulate ideas about how the professional
response to children at risk might be strengthened, and how negative organisational impacts on professional endeavour might be minimised.

3. Part 3 integrates the quantitative and qualitative studies to reach a richer understanding of child homicide in New Zealand than was available from either of the methods separately, and examines the implications of the overall study for policy, practice and research.

What the study shows is that too many children in New Zealand have their lives cut short as a result of abuse or neglect. Research efforts to gain knowledge that might lessen the incidence of child homicide, is one small way of honouring the memory of children who have died in these circumstances.

The next chapter examines the research and literature about child homicide in Western countries, which will provide the broad context for reporting and understanding the New Zealand statistical data on child homicide.
Chapter Two
International Patterns of Child Homicide: A Review of the Literature

Introduction

A dearth of research in New Zealand creates significant gaps in our knowledge and understanding of the child homicide phenomenon. There have been few retrievable attempts to understand the size and shape of fatal violence towards children and to elicit which children are most at risk, and from whom. Most of what is known in New Zealand about child death by homicide is taken from international literature, with local writers providing some commentary on the implications of the literature for this country (Wilson, 1997; Ridley & Scott, 1999). There has been an analysis of morbidity and death due to child abuse in New Zealand (Kotch et al, 1993) and one attempt to understand patterns in child homicide of children known to the child protection agency in New Zealand (Kinley & Doolan, 1997).

Child homicide data

The statistics about child death by homicide present difficulties both with respect to interpretation and comparison. International literature records a history of under-identification and there are recognised counting issues and under-reporting (Schlosser, Pierpoint & Poertner, 1992; Strang, 1996; Wilczynski, 1997; Herman-Giddens, 2001; Krug, Dahlberg, Mercey, Zwi & Lozano, 2002). Studies have estimated, for example, that as many as 5% of children who have died from Sudden Infant Death Syndrome may have been misdiagnosed incidents of parental neglect or abuse (Bass, Kravath & Glass, 1986, cited in Pecora, Whittaker & Maluccio, 1992), and that as many as 20%
of children who have died in house fires may have died as a result of neglectful supervision (Mitchel, 1987, cited in Pecora et al, 1992). It seems likely that death from neglect is more likely to be under-reported (Pecora et al, 1992). Recent studies in North America have estimated that as many as 50 to 60 percent of deaths that had resulted from child abuse or neglect were not recorded as such, with neglect the most unrecorded cause of maltreatment fatalities (Crume, DiGuiseppi, Byers & Sirotnak, 2002, and Herman-Giddens, Brown, Verbiest, Carlson, Hooten et al., 1999, cited in National Clearing House on Child Abuse and Neglect Information, 2004).

There is evidence that under-reporting is only one aspect of the problem, in that there is class and race bias in who gets reported for child abuse, and this has implications for the proper identification of child homicide by abuse (Newberger & Bourne, 1985). One New Zealand study (Kotch et al, 1993) supports this in finding that there was an association between minority ethnic status of the victim and labelling of injury as child abuse. Attempts to rate countries relative to one another on their record of child maltreatment deaths are thought to suffer from flaws created by: under-identification; under-reporting and different standards in countries about sensitivity to child abuse; and the rigour of investigations (UNICEF, 2003). The UNICEF study, likely to be the most comprehensive attempt at international analysis of child homicide patterns, records that:

Inconsistencies of classification and a lack of common definitions and research methodologies means that little internationally comparable data exist and that the extent of child maltreatment is almost certainly under-represented by the statistics. (UNICEF, 2003, p. 2).

The issues affecting the reliability and accuracy of child mortality data generally have been identified as including: varying reporting requirements within or between
different administrations; differing definitions of neglect and abuse; variation in review or coronial processes; the amount of time (up to a year in some cases) to determine a link between the fatality and abuse or neglect; and the miscoding of death certificates (NCCAN, 2004).

Incidence of child homicide

In a recent attempt to understand the size and shape of global violence it was estimated that 57,000 homicides of children under the age of 15 occur annually (Krug et al, 2002). International rates of fatal abuse vary according to the income level of a country and regions of the world. Reported rates in low to middle income countries are two to three times higher than rates reported in high income countries and rates are highest in the African region and lowest in the European, Eastern Mediterranean and Western Pacific regions (Krug et al, 2002).

An analysis of child maltreatment deaths in rich nations found “that 3,500 children less than 15 years of age die from maltreatment (physical abuse and neglect) every year in the industrialised world” (UNICEF, 2003, p. 2). This study calculated child maltreatment mortality rates in OECD countries in 4 age bands (less than 1; 1-4; 5-9; 10-14) and then weighted these with a common set of weights reflecting a standard OECD population. It concluded that New Zealand had a child maltreatment death rate of 1.2 per 100,000 of the child population 1-14 years for the period 1994-1998. In descending order, from low rates of child homicide to high, New Zealand was placed 25th out of 27 countries, with only the USA and Mexico featuring higher child homicide rates. However, when figures were revised to include child deaths “... of
undetermined intent", New Zealand improved to 22\textsuperscript{nd} place. Both positions represented deterioration for New Zealand when compared with the period 1971-1975 when the basis for the rankings was established. Then, the New Zealand child maltreatment mortality rate was calculated at 0.9 per 100,000-child population, and New Zealand was in 9\textsuperscript{th} position on a league table of 23 OECD countries. Between the two periods, the New Zealand rate deteriorated in comparison with Belgium, Sweden, Switzerland, Canada, Austria, Australia, the United Kingdom, Finland, Poland and Japan, and improved only in relation to Portugal.

The United States has a higher incidence of child homicide than New Zealand. There were an estimated 1,400 such fatalities in 2002, a rate of 1.98 per 100,000 children in the general population (NCCAN, 2004) and in the analysis of maltreatment deaths in rich nations the following year it recorded a rate of 2.2 (UNICEF, 2003). The difference may be accounted for by the weighting methodology applied by the UNICEF study. Spain was the best performing country in the OECD, with a child homicide rate of 0.1 per 100,000 children in the general population, while its neighbour, Portugal, was the worst, with a rate between 0.4 identified homicides rising to 3.7 per 100,000 when deaths of “undetermined intent” are added (UNICEF, 2001).

The rate of child homicide does not appear to be increasing in OECD countries. Of the 23 OECD countries assessed both in 1971-1975 and during a 5 year span in the 1990s, fourteen countries recorded a fall in their child homicide rate, four countries maintained a stable rate and in five countries, including New Zealand, there was an

\footnote{“When no other cause or motive can be established, the death of a child is most likely to be the result of abuse or neglect that cannot be proved in a court of law” (UNICEF, 2003, p.7)}
increase, although with the exception of Portugal, the differences between the two periods are so small as to be of little statistical significance (UNICEF, 2003). Experts also contest whether such marginal increases are real or the result or improved detection and reporting practices and the impact of fatality review processes, which in the United States are demonstrating a capacity to improve the coordination of data collection among agencies (NCCAN, 2004). There was no increase in the official incidence of child killing in Australia, England or Wales in the periods cited in studies between 1984 and 1994, and increases in America were largely in the 15-17 year age group, largely, it would seem, because of the prevalence of gun crime in that country (Wilczynski, 1997).

Age of victims

Victims of child homicide are likely to be younger on average (2.8 years) than all children reported to child protection services (7.2 years) (Pecora et al, 1992). In virtually every country, infants under the age of 1 year have the highest homicide victimisation (UNICEF, 2003). Homicide rates in the 0-4 year age group are more than double those of 5-14 year olds (Krug et al, 2002). Children less than one have a risk level approximately 3 times that of children aged 1 to 4 years, and this latter group faces risk almost double that faced by 5-14 year olds (UNICEF, 2003). The United States data for 2002 recorded 41% of victims were less than one year, while children under 4 years accounted for 76% of the fatalities (NCCAN, 2004). Throughout the OECD countries as a whole, 24% of child homicides were of children less than one, and 55% were of children less than 5 years (UNICEF, 2003). In a 1984 study, the average age of child homicide victims was 3.3 years (American Humane Association, 1984, cited in Armitage & Reeves, 1992). All studies come to the same
conclusion – in general the risk of homicide victimisation in children declines with age at least until early adolescence.

*Gender of victims*

Unlike sexual abuse, physical abuse studies have not detected any significant victim gender influence (NCCAN, 1988, cited in Hansen, Conaway & Christopher, 1990), although studies show slightly more boys than girls are homicide victims (Greenland, 1987, cited in Armytage & Reeves, 1992; Pecora et al, 1992). Place and status in the family may be more significant than gender. Studies indicated that victims tended to be the youngest, or only, child in the household and sometimes had a physical defect or were otherwise perceived as different, although medical factors were not a distinguishing factor generally (Pecora et al, 1992).

*Cause of death*

Among the homicides attributed to child abuse, the most common cause of death was injury to the head, followed by injuries to the abdominal area (Krug et al, 2002; Kotch et al, 1993). US data relating to 708 victims from 25 states less than 18 years of age in 2000, records 54.5% of deaths attributable to physical injury and 34.9% to neglect (UNICEF, 2003). However, in 2002, more than 38% of child maltreatment fatalities in the whole of the US were attributed to neglect alone, 30% to physical abuse alone, and the remainder were attributed to multiple maltreatment or other maltreatment types (NCCAN, 2004).
Who are the people that kill children?

Child homicide is predominantly an intra-familial phenomenon (Stroud, 2000; D’Orban, 1979). Most families involved in fatal maltreatment were two-parent situations (Alfaro, 1987, and Thompson & Wilson, 1989, cited in Pecora et al, 1992). There is a growing awareness that different forms of violence in family situations can be occurring simultaneously. There is, for example, an increasing body of evidence that links spousal violence and violence towards children (Tomison, 2000). Where spousal abuse is occurring there is a heightened risk of child abuse occurring in that household.

There is one notable aspect of intra-familial child abuse that distinguishes it from other forms of violence, and that is in relation to perpetrator gender. Taking all violent behaviour together, men are predominantly perpetrators and women are predominantly victims (Krug et al, 2002). With respect to child abuse, however, women feature prominently (Howitt, 1992), and thus they figure also in filicide, although in Howitt’s analysis, still at a lesser rate overall than men. This was also true in an Australian study (New South Wales Child Protection Committee, 1995, cited in Wilczynski, 1997) but the reverse was found in an English study where child-killers were more likely to be women (Wilczynski, 1997). Fathers or de facto male partners were the majority of child homicide perpetrators (Alfaro, 1987, and Thompson & Wilson, 1989, cited in Pecora et al, 1992).

The perpetrators of intra-familial child physical abuse in Canada in 1998 were fathers (41.3%), mothers (36.9%) stepfathers (1.1%), stepmothers (3.4%), other relatives (4.9%) and foster/adoptive parents (0.4%) (UNICEF, 2003). In a pattern that has
remained consistent over time in the US, one or both parents were involved in 79% of child homicides in 2002, while 16% involved maltreatment by non-parent caregivers. The remaining 5% was unknown or the data missing (NCCAN, 2004). In the United Kingdom, filicide was estimated to constitute 71% of all child killings (Home Office, 1995, cited in Wilczynski, 1997). Male caregivers cause most deaths that arise from physical abuse, while mothers are more often held responsible for deaths associated with neglect (NCCAN, 2004).

There is no single profile of a likely perpetrator of child homicide. Early studies into child abuse proposed that perpetrators evidenced severe psychopathology (Spinetta & Rigler, 1972). However, Walters (1975) proposed a much broader typology of abuse causation, which included social and parental incompetence, situational factors and causation springing from a perpetrator's own abuse victimisation or mental illness. A later ecological model proposed that abusive parenting was best understood as the interplay between psychological disturbance in the adult, the presence of some characteristics in the children themselves that elicited an abusive response from their caregivers, problems in family functioning, social stressors and cultural contexts, the values of which made abuse more possible (Belsky, 1980). This is supported by evidence emerging later that fewer abusing caregivers demonstrated diagnosable psychotic, schizophrenic or sociopath conditions, with maltreatment incidents resulting from a functional relationship between a variety of parental traits, child characteristics and environmental influences and stressors affecting the family (Kelly, 1990). It is claimed that the actual empirical evidence supporting the view that abusive parenting may be transmitted intergenerationally is quite weak, as it tends to
emanate from case studies, from which it is difficult to generalise (Burgess & Youngblade, 1988).

Certain characteristics of homicide perpetrators continue to appear in studies: youthfulness; low educational attainment; poverty; depression; and the existence of multiple stressors (NCCAN, 2004). There are cautions, though, about over emphasising the importance of individual factors:

The truth is that every factor is embedded in an entire network of influences and each factor’s relation to parenting is, in part, a consequence of its relations with many other relevant influences (Vondra, 1990, p.151)

In an early study of filicide in England and Wales (D’Orban, 1979), 60% of the children under 1 year of age who were killed, were killed by their mothers and in 90% of the cases, courts recognised a psychiatric condition in dealing with the perpetrator. Perpetrators were found to be younger on average than those caregivers reported for non-fatal abuse, with the vast majority under 30, and a mean age of 26.7 years for homicide perpetrators (American Association for Protecting Children, 1988, cited in Pecora et al, 1992). Minority and poor families were over-represented (Nixon, Pearn, Wilkey & Petrie 1981, cited in Pecora et al, 1992) and most perpetrators did not mean to kill or want to see their children die, but death was, rather, the outcome of a series of unfortunate events (Mitchel, 1989, cited in Pecora et al, 1992). Another study (Wilczynski, 1997) identifies three characteristics of child killers – they have multiple problems, are predominantly negative in outlook and exhibit considerable deficits in personal and social competency.

Child homicide by strangers is not only less frequent but has different characteristics to intra-familial homicide – they are more likely to be killings of older children in
their teenage years, more likely to involve weapon use and more likely to involve a male as the perpetrator (Home Office, 1995, cited in Wilczynski, 1997).

**Child Homicide as a proportion of all homicides**

Little mention of the incidence of child homicide as a proportion of all homicides appears in the literature. This is an important issue as it raises the question of whether violence against children is linked to the incidence of violence in society as a whole.

Of the 520,000 estimated number of homicides occurring globally in 2000, 57,000 (11%) were attributed to children 0-14 years (Krug et al, 2002). Child deaths in OECD countries have been compared with adult homicide rates in those countries, with any patterns being only discernible at the extremes. The analysis shows that the same small group of countries that have very low rates of child homicide have very low rates of adult homicide, while the 3 nations with the highest child homicide rate – The US, Mexico and Portugal – also have significantly higher adult homicide mortality. The bulk of the assessed countries, all with relatively low rates of child maltreatment fatality, showed variable rates of adult homicide (UNICEF, 2003). In this analysis, the New Zealand homicide rate for children 0-14 between 1994 and 1998 was 1.3 per 100,000, and 2.5 per 100,000 for the 15 plus population. This calculates to 11 child and 71 adult homicides per year over the period. Child homicides constituted 13.5% of the total for the period.

**Prior involvement of child care and protection authorities**

There is a regular occurrence of agency involvement with child homicide victims and their families prior to the child’s death:
What disturbs many child welfare professionals and child advocates is that a substantial number of these families [in which fatalities have occurred] had been reported to or served by [Child Protection Services] at least once before the child’s death. (Pecora et al, 1992, p.111).

Given the links between child abuse and other family problems, one would expect a significant involvement of child care and protection authorities in cases where children have died of neglect or physical assault. Studies confirm this. Almost eighty percent (79.5%) of filicidal parents had been seen on a number of occasions prior to a child’s homicide by a variety of helping professionals (Block & Tilton, 1994; cited in Wilczynski, 1997). A lower proportion of 59% was cited for Australian cases (NSWCPC, 1995, cited in Wilczynski, 1997). An American study found that, of the children who died of abuse and neglect annually in that country, almost half were known to child protection agencies before their deaths because of their family situations and the risks these presented to them (Costin et al, 1996, cited in Stoesz, 2002). Earlier studies indicate that 25% of child homicides occur in families known to agencies providing social services (Armytage & Reeves, 1992). In both the English and Australian cases, the most common reason for agency contact was the mental health of a parent (Wilczynski, 1997). Definitional and counting issues might cloud the usefulness of these comparisons, as some reports relate to contacts with child protection agencies (US) while other include a range of agencies (England).

A New Zealand study shows that children who died as a result on non-accidental injury had multiple referrals to CYFS, with times varying between one month and three years from first to last referral. Of five cases studied, four had had two or more referrals and one had had five. However, only two had been referred because of concerns about possible physical abuse, accenting the need for thorough investigation.
of reports about very young children, where patterns of family violence may not be the presenting issue (Kinley & Doolan, 1997).

While there might not be precise data about how many children and their families were known to child welfare authorities prior to the child’s death, we do know something about the casework that occurred with the children who were known. This has been made possible by the casework reviews agencies have carried out following the death of a child.

The child death reviews
The death of Maria Colwell in the United Kingdom in 1973 led to the first major case inquiry involving child care and protection professionals, and it captivated the community (Parton, 1985). There have been many child death inquiries since then and there are texts analysing multiple cases in search of practice patterns that lead to failure.

An Australian study found systemic and practice failures in an analysis of the casework around 28 children in the care of the Victorian state authority who died between 1984 and 1989, of whom 10 died of inter-familial abuse (Armytage & Reeves, 1992). Practice failures resulted from: deficits in knowledge (about minimization of abuse, for example); deficits in process (such as the lack of adequate risk assessment, case planning and inter-disciplinary communication) and system deficits (such as a failure to coordinate services across agencies and inadequate supervision of front-line workers).
A comprehensive review of 35 child deaths in the United Kingdom between 1973 and 1989 introduced a range of new concepts in child protection work (Reder, Duncan and Gray, 1993) and these are discussed more fully in the next chapter, in the context of a discussion relating to care and protection systems. More generally, the review found that care/dependency relationships and conflicts about control featured regularly in the children’s case histories and that closed professional systems and the polarization of workers were factors in the growth of danger for children. Closure in the interaction between the professional and the family was the most significant indicator of potential danger to a child and taking little control in such situations was thought to be more dangerous than taking none at all.

A small New Zealand study relating to 12 children in the care of CPFS who died (5 from physical abuse) during 1994 and 1995, found that, like the Australian study, a range of practice and systemic issues were noted in the casework reviews (Kinley & Doolan, 1997). There were deficits in knowledge, consultation, investigation, assessment, planning, decision-making and recording. It was noted that workers suffered from a lack of role clarity in some instances. Systemic problems related to worker training and supervision, workload issues, inter-office case transfers and the cultural appropriateness of services.

The Office of the New Zealand Commissioner for Children has reported on the deaths of three children, in two separate incidents, and these reports give detailed insight into the workings of the New Zealand care and protection system. In the first of these (OCC, 2000) the Commissioner reports on the circumstances of the death of James Whakaruru. The report notes that James died during a period of intense Government
action addressing domestic violence, and child abuse in particular, but that he died because there were: inconsistent interpretations of a number of laws by professionals and officials; failures in inter-disciplinary and inter-agency communication; failure by professionals to act decisively in James’ best interests and to follow procedures; and failures at the community level to recognize and report James’s circumstances. Workload issues also featured, both in having the effect of raising the threshold of intervention in James’s case and for being at least partly responsible for the failure of professionals and agencies to work well together.

The report into the deaths of Saliel and Olympia Aplin (OCC, 2003) is remarkable in its similarity to the James Whakaruru report. These young girls were subjected to multiple violent attacks that were unreported but not unnoticed. There was comprehensive professional failure, attributable to a combination of abuse minimization occasioned by the familiarity of the workers with the family, poor professional knowledge and judgment, and broad systemic failure within the network of the police, social welfare and education services.

All analyses have common themes – professional error, organisational deficiency and the failure of agencies to work collaboratively and cooperatively with each other.

A profile of the child most at risk of homicide victimisation

The literature suggests that the child most likely to become a victim of homicide is young, most often less than one year of age, is slightly more likely to be male and from a minority ethnic group or a poor family. He may be the youngest or only child in a two-parent household in which the parents are younger than average and where
there are multiple stressors such as poverty, unemployment, interpersonal friction and social isolation. Either his father (or father substitute) or his mother, and sometimes both, will cause his death, with his father more likely to batter him, and his mother more likely to contribute to his death through neglect. There is some chance that he will have an existing history with a child care and protection service. On any measure, he will have had a life too short.

This review of the literature has established a framework for an analysis of the New Zealand data. Chapter 3 describes the child care and protection system in New Zealand.
Chapter Three

The New Zealand Child Care and Protection System

Following the examination of child homicide data and patterns gleaned from the literature, this chapter describes the child care and protection system in New Zealand pursuant to the Children, Young Persons and their Families Act 1989 and the context in which it operated during the decade of the 1990s, drawing on literature of relevance to the qualitative aspects of this study.

The Legal Scheme

New Zealand child care and protection law is contained within the provisions of the Children, Young Persons and their Families Act 1989 (The Act). Statutory powers are vested in the Chief Executive of CYFS, in social workers and Care and Protection coordinators appointed by the Chief Executive, and in police officers. Some statutory powers are vested in the Directors of Iwi Social Services, Cultural Social Services and Child and Family Support Services, all Not-For-Profit agencies. The fact that powers and discretions are vested in individuals is an important aspect of the legal scheme. The agency that employs these individuals may provide them with guidance in the exercise of their functions, should ensure they are trained and competent to exercise their powers and discretions, but cannot dictate how these are exercised in the final analysis. The powers vested in the Chief Executive are delegated to professional staff, and in these instances the Chief Executive must direct how those powers and authorities are to be exercised. The scheme contrasts with that of the United Kingdom, for example, where the Children Act (England and Wales) 1989 vests
statutory authority with Local Authorities, which in turn delegate their responsibilities to professional staff, so that corporate bodies, not individuals, are accountable for the proper exercise of powers and functions.

Other key aspects of the New Zealand legislative scheme are:

- **The voluntary reporting of child ill treatment or neglect:**

  Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally or sexually), ill-treated, abused, neglected or deprived may report the matter to a Social Worker or a member of the Police”.  

  This provision is buttressed by two important duties of the Chief Executive of CYFS. The first duty is to:

  Promote, by education and publicity, among members of the public (including children and young persons) and members of professional and occupational groups, awareness of child abuse, the unacceptability of child abuse, the ways in which child abuse may be prevented, the need to report cases of child abuse, and the ways in which child abuse may be reported”.

  The second duty is to:

  Develop and implement protocols for agencies (both governmental and non-governmental) and professional and occupational groups in relation to the reporting of child abuse and monitor the effectiveness of such protocols.

- **The duty of receiving and investigating reports of child ill treatment or neglect** lies with either a social worker appointed by the Chief Executive of CYFS or a member of the Police. The duty to investigate is elevated to a power by a provision that allows the non-investigation of a report. The statutory officials

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3 S. 15, CYP&F Act 1989  
4 S. 7(ba)(i), CYP&F Act 1989  
5 S. 7(ba)(ii), CYP&F Act 1989  
6 s. 17(1), CYP&F Act 1989  
7 s. 17(3), CYP&F Act 1989
have powers to take emergency action to protect children, to arrange medical examinations and to access information relevant to their investigations.

- The requirement that any person investigating a report of child ill treatment or neglect:

  ... shall, as soon as practical after the investigation has commenced, consult with a Care and Protection Resource Panel in relation to the investigation.\(^8\)

Panels are statutory bodies established by the Act to, inter alia,

... provide advice to Social Workers, Care and Protection Coordinators and members of the Police on the exercise or performance, by such persons, of the functions, powers, and duties conferred or imposed on them by or under Part 11 or Part 111 of this Act.\(^9\)

- The requirement that a family group conference is held in any circumstance where, after inquiry, a social worker or member of police forms a belief that any child or young person is in need of care or protection.\(^10\) The Act introduced the family group conference as the central process for decision making in statutory civil actions relating to the care and protection of children. In this process, extended families are encouraged to plan for safe outcomes for their children, with professionals providing them with the information they need to do so. Families are enabled to work within their own cultural and familial milieu, professionals are encouraged to support the family’s plan, and agencies are expected to give effect to it “... by the provision of such services and resources, and the taking of such action and steps as are necessary …” unless it is “…clearly impracticable or clearly inconsistent with the principles

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\(^8\) s. 17(1) CYP&F Act 1989
\(^9\) s. 429(a) CYP&F Act 1989
\(^10\) s. 18 (1) CYP&F Act 1989
Thus there is a strong presumption that the professionals and the agency that have the responsibility of preventing recurrence of abuse will follow the lead of the extended family in such matters.

*Child abuse or neglect reporting*

The New Zealand approach to the reporting of child ill treatment or neglect contrasts with mandatory reporting requirements in the US and most states of Australia, but is similar to the process followed in the United Kingdom. The New Zealand approach is to inform, encourage and persuade people to recognise the signs and symptoms of ill treatment and neglect in children and to move to protect them by reporting their concerns, ensuring legal protection for all who do so in good faith. Special attention is given to the education of members of professional and occupational groups – the groups commonly mandated to report in some administrations – through the development of protocols with CYFS that establish commitment to and procedures for child protection in the groups and agencies, provide information on signs and symptoms, and advise how to report concerns. There has been advocacy for the introduction of mandatory reporting in New Zealand, and this has been twice debated by Parliament. The first occasion was in 1989 during the passage of the principal Act. The second debate occurred in 1994 when an amendment proposing mandatory reporting was withdrawn by the Government following Select Committee advice that a public information and awareness approach, and a professional and occupational groups education and protocols approach, was likely to be more productive and a better use of scarce resources than mandatory reporting.

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11 s34, CYP&F Act 1989
The investigation of reports of child abuse or neglect

Child protection investigation is state policing activity. The fact that the powers that accompany it rest with two statutory roles – the CYFS social worker or a police officer – conveys the statute’s intention in this respect. No other persons are empowered to investigate reports of child ill treatment or neglect or to secure a child’s safety through emergency action. In effect, most reports of child ill treatment or neglect are investigated by CYFS social workers. Serious allegations of sexual or physical abuse, where perpetrator identification is likely to lead to a criminal justice response, are more likely to involve Police working jointly with a social worker to plan an investigation and collect evidence under the provisions of what is known as the CYFS/Police Serious Abuse Team (SAT) Protocol. This joint process is aimed at limiting the exposure of children to investigative activity. A common process avoids multiple interviewing of children and can satisfy the evidential requirements for both civil and criminal purposes. In cases where Police become aware of instances of child ill treatment or neglect in the course of their duties they report these to CYFS.

While the law conveys a duty to investigate reports it also allows a power not to investigate, which seems a curious provision. It seems likely that this is to provide for situations where the local knowledge of social workers and police renders an investigation unnecessary, such as when the report is likely to be frivolous or vexatious. However, the common law “duty of care” attached to child protection investigation, means that social workers and police need to be certain of their

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12 CYFS Care and Protection Handbook
13 B v Attorney General (2003) 22 FRNZ 1044. This judgement established that social workers and police officers have a duty of care while they are carrying out an investigation. Therefore, a decision not to investigate a report is a serious matter, for which there must be sound grounds.
grounds in exercising this power if they are to avoid the risk of litigation for a failure to investigate a report.

Care and Protection Resource panels have been established to ensure social workers and/or police may have ready access to them. There is at least one panel for every CYFS site office and Police district. Panels comprise:

... persons from occupations and organisations (including voluntary and statutory organisations, cultural and community groups, Government Departments and Government Agencies) that are concerned with the care and protection of children and young persons.  

The CYFS process of managing reports of child abuse or neglect

Most contacts with CYFS relating concerns about a child are made by telephone. CYFS site offices during the period of this study managed their own intake, usually by rostering care and protection social work teams for a period of intake “duty”. Intake decision-making is aided by a set of guidelines helping the intake worker focus on the vulnerability of the child in assessing the necessary speed of the response. An intake decision that a report requires attention launches a process of case allocation, investigation, and assessment and, in some cases, planned intervention where concerns about a child’s welfare remain following investigation of the report. Each of these stages is susceptible to practice error – an act or an omission by a social worker – that results in a less than ideal response to the report.

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14 s. 428 (3) CYP&F Act 1989
15 Since 2000, CYFS has maintained a national Call Centre through which all new calls to the Department are routed, and where intake has become a specialist function for a group of social workers trained in this function.
The social work service response by CYFS

The typical service response traverses the phases of Intake, Investigation and Assessment and (where necessary) Intervention. Risk with respect to professional error exists in each phase, and when this occurs, the child may be exposed to further risk of abuse or neglect.

The phases and their potential risks of professional error are set out on the following table:

Table 3.1: The phases of service response to notifications and risk of professional error

<table>
<thead>
<tr>
<th>Activity</th>
<th>Professional error</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong>: The report information is assessed in relation to whether this constitutes a ground for child protection (s.14) and whether the matter is serious enough to warrant a statutory investigation procedure. Where reports meet both tests, the vulnerability of the child is then assessed to determine the speed with which a social worker must respond to the report and sight the child. There are 4 response categories: Critical, where the response must be immediate; Very Urgent, where a response is required within 2 days (the day of the report plus one); Urgent and Low Urgent, where a response is required within 7 and 28 days respectively. Critical categorisation means that the child is vulnerable to imminent and serious harm and is without known protectors. Very Urgent categorisation means that the child is vulnerable to serious harm but is under interim protection (in hospital, for example).</td>
<td>Intake worker underestimates seriousness and does not accept report for investigation.</td>
</tr>
<tr>
<td></td>
<td>Response category allocated by intake social worker is too low in relation to intake facts.</td>
</tr>
<tr>
<td></td>
<td>Social worker underestimates Seriousness of the report and does not investigate.</td>
</tr>
<tr>
<td><strong>Investigation and Assessment</strong>: The case is allocated to a lead social worker and investigated in accordance with departmental policies. In critical and very urgent situations, the first social work response will be to sight the child and assess immediate safety. The social worker has the power to seek and take (with court permission) possession of the child under a Place of Safety Warrant where necessary. Departmental policy requires the development of an investigation plan, and in certain serious physical and sexual abuse reports, investigation plans must be developed in conjunction with</td>
<td>Child not sighted within time set by response criteria.</td>
</tr>
<tr>
<td></td>
<td>Child does not have identified protector after initial contact by social worker.</td>
</tr>
<tr>
<td></td>
<td>There is an inadequate, or no, investigation plan.</td>
</tr>
</tbody>
</table>
Police under the Serious Abuse Team (SAT) policy. Social workers are required by law to liaise with and receive advice from a statutory body in their geographical area, known as the Care and Protection Resource Panel (CPRP), a body made up of appropriate child experts and people with community and cultural expertise. The investigation phase is characterised by information gathering from family, extended family and friend networks, and from other agencies. Where a child and family are known to a number of agencies a professional case conference is recommended standard practice during this process.

**Assessment outcome:** The social worker analyses and reflects on the information gathered from a range of sources. The Department provides an instrument, known as the Risk Estimation System (RES) that assists social workers to organise their information and reach an assessment outcome. Assessment outcome choices are: **No Further Action** – the report either has no substance or is able to be resolved through less formal processes and the family is referred to a helping agency; **Family/Whanau Agreement** – the report is not substantiated to the degree that statutory intervention is necessary, but a time limited period of services by the Department is necessary in order to restore a situation and prevent deterioration; **Family Group Conference** – the social worker forms a belief that the child is in need of care or protection - there is a significant risk of harm and statutory intervention is necessary to prevent this. Where the social worker has taken emergency action during the course of an investigation, the matter must be presented to the Family Court within 5 days, and the Court will order that a family group conference is held\(^\text{16}\).

| SAT protocol not initiated in cases of alleged serious physical or sexual abuse and critical information is not accessed. |
| Social worker does not consult with CPRP and critical information is not accessed. |
| Professional case conference not held where indicated and critical information is not accessed. |
| There is a lack of decisive child protection action. |
| Information gathering is deficient and RES is not used in arriving at assessment outcome. |
| Assessment outcome is less than the minimum necessary to secure the safety and well-being of the child. |
| Insufficient or poorly organised information is presented to FGC or Court. |
| Child’s interim placement is not properly vetted. |
| The intervention chosen is inappropriate in relation to case requirements. |

\(^\text{16}\) In a small number of such cases, warrant action may be withdrawn after the investigation, in which cases social workers are required to report to the Commissioner for Children their reasons for not proceeding with the warrant action.
plans are subject to review, by social workers in the case of Family/Whanau Agreements; by Care and Protection Coordinators in the case of family group conference plans, and by the Family Court where an order directing the Department exists.

A social worker is not allocated to manage plan implementation.

Plans become inactive or changed without full review and re-assessment.

Reviews do not occur within expected timeframe

Caregiver support is inadequate

Research suggests that the investigation and assessment of a report of child abuse can be a time of heightened risk for the child or children concerned, with information gathering and analysis by social workers affected by a number of professional stumbling blocks, for example: overriding belief systems held by workers; the tendency to treat information in ways that prevent pattern perception; and when workers resist what they are seeing for fear of making a commitment to action (Reder et al, 1993). Similar notions are incorporated in accommodation syndrome theory, which sees workers disabled and rendered impotent in the face of persistent client intimidation and threat (Goddard, 1998).

Danger to children is further heightened when these are combined with organisational risks such as: repeated reorganisations and restructuring; worker isolation; role confusion; and such matters as the failure to cover for an absent worker or to have appropriate arrangements for client servicing in place at weekends or holiday periods (Reder et al, 1993).
A follow-up study expanding on this seminal work again emphasises the dangers of the assessment period:

One practice issue stood out above all others in this review and was repeated in case after case. It concerned problems with assessment. (Reder and Duncan, 1999, p.82).

The researchers identified problems of: disparity between assessment and action; assessments simply not being undertaken; real levels of concern not being identified; and assessment paralysis (Reder & Duncan, 1999).

The question of what level of intervention is appropriate to the circumstances of a case is a key issue in child protection work. Dingwell, Eekelaar, and Murray (1995) refer to “the rule of optimism” which interferes not only with appropriate assessment but whether or not an intervention is necessary. The concept extends to workers accepting massively lower standards of care, a desensitisation process with effects not too dissimilar to those of accommodation syndrome discussed above.

The New Zealand intervention options revolve around whether or not a social worker forms a belief that there is a need for care or protection. The formation of such a belief makes the referral of the case for a family group conference mandatory. In instances where workers do not form a belief that there is a need for care or protection (i.e. the care or protection concerns are thought not likely to involve the risk of significant harm) but there is a need for services, less formal interventions are made possible or workers may encourage families in the use of private law options to address the concerns. There appear to have been no studies of the effectiveness of informal or private law interventions as a means of resolving care or protection.

17 S.18, CYP&F Act 1989
concerns in New Zealand. Of the five deaths that resulted from non-accidental injury analysed by one New Zealand study, two occurred in the investigation phase, one while a child was subject to a Family/Whanau Agreement, and two happened after the agency had ceased involvement with the children and their families. None had experienced a family group conference (Kinley & Doolan, 1997).

There is some evidence that the family group conference is a safe process. In a UK study, Crow and Marsh (1997) found re-abuse rates for children who were involved in a family group conference were 6% compared to 16-25% for others (n=80 family group conferences). In the same study, social workers assessed that family group conference plans protected children better than they would have been under conventional processes in 67% of the cases and as well as they would have been in 33%. Significantly, no case was assessed as being worse than they would have been. Another study (Lupton & Stevens, 1997) reported that 78% of professionals thought FGC plans were successful after 18 months to two years. Worrall (2001) reported that children benefit from the scrutiny of family members in relation to their safety.

Family group conferences are means of building social and familial networks that support families provide safe environments for children. Social network intervention evaluations show promising and encouraging results, but controlled studies are made difficult by family mobility and dropout rates (MacDonald, 2002). In a meta-analysis of studies about what works in Family Support services, it was found that working with family and social networks contributed as much as 40% to the effectiveness of family support services (along with the quality of the relationship, 30%; client hopefulness 15%; and the nature of the helping technique 15%) (McKeown, 2000).
An analysis of 20 research projects initiated in the UK following the implementation of the Children Act 1989 concluded that children are better protected by strengthening their family and social network supports than by spasmodic, incident focussed interventions (DH, 1995).

Context for statutory child protection work during the 1990s

While law governs the child protection system, it is influenced by a number of other factors that impact on workers, institutions and communities.

- **The political context**

  The 1990s were times of severe economic restraint, and to a significant degree the “welfare state” was in the process of being dismantled. The shift from state responsibility to community and family responsibility for child welfare was occurring in the context of increased unemployment and poverty (Connolly, 2001) and these two issues “are important because they reflect the deteriorating economic circumstances of families, whanau and communities expected to make provision for the needs of their families” (Cheyne, O’Brien & Belgrave, 1997, p.202).

  Family empowerment ideology underpinning the Children Young Persons and their Families Act 1989 had a tendency to become redefined by the strong individual and family responsibility orientation of the economic reforms of the late 1980s and the social policy thrusts of reducing dependency of people on the state which dominated the 1990s (O’Brien, 2001). Under neo-liberal economic theory, the rhetoric of family responsibility could be readily translated into a reduction of resources from the state (Cheyne et al, 1997; Doolan & Nixon, 2003).
Services were stripped from a number of the core state and voluntary services that are key partners in the child protection system. Health visiting and neonatal home visiting services were severely curtailed. Special education and mental health services diminished or could be accessed only by payment, at a time when the financial resources available to social workers were also diminishing. A number of voluntary helping agencies lost traditional sources of funding (as donations dried up) and volunteer workforces (as women increasingly joined the paid workforce). Child care and protection workers struggled to marshal the services their clients required as partner agencies withdrew to their own core functions, and their own Department lost the capacity to purchase what had once been freely provided.

Key processes of the new law were affected: Health and Education members of Care and Protection Resource Panels began to withdraw as their time and energies were directed to the core outputs of their own departments, or when CYFS was unable to fund their attendance. Commitment to professional activity such as case conferences and attendance at family group conferences also suffered. These conditions persisted throughout the 1990s and resulted in the increasing isolation of child protection workers from their traditional networks.

- The organisational context
Organisational disruption was almost endemic in the state child welfare agency throughout the decade and the agency was also defining and redefining service access eligibility in line with the requirements of the Public Finance Act 1989 (O’Brien, 2001). Staff demoralisation, pressure on financial resources, organisational change, and rapid staff turnover that eroded the base of experienced staff, were constant elements of child care and protection services during the decade (Brown, 2001).

Bureaucratic annexation of the social work process occurred, largely as a result of the provisions of the Public Finance Act 1989. Social work processes were redefined as “Outputs” and attempts were made to describe and measure social work activity in order to report on performance as required under that Act (O’Brien, 2001).

Several high profile cases, usually following the death of a child with whom CYFS had had an involvement, catapulted CYFS into a hostile public spotlight, and media and associated political pressures all exacerbated levels of anxiety in an endeavour in which managing anxiety is a day-to-day challenge. Under such circumstances, the agency environment can fail to be an environment conducive to best professional performance but rather becomes a place that features the fear of making a mistake (Doolan & Nixon, 2003).

The Department failed to achieve the goal, set at the beginning of the decade, of having 90% of its social work staff qualified by means of a tertiary professional qualification in social work, and to have in place an internal
process whereby competence could be tested at regular intervals. By 2001, only 44% of front line staff reached the qualification standard (Brown, 2001) and the internal competency assessment process developed in the mid-1990s had collapsed.

A number of positive developments occurred nonetheless. Among them:

- Child abuse reporting protocols were signed with a wide range of groups and organisations;
- Renewed attempts were made to energise the inter-agency environment, with such outcomes as the SAT protocol with Police for the joint investigation of serious abuse and a set of arrangements with the National Collective of Independent Women’s Refuges to ensure that services for battered women and their children became more aligned;
- The position of Chief Social Worker was created within CYFS to develop quality control processes and to give visibility to social work, as a profession and as the principal skill set used by CYFS;
- A risk estimation system, customised to meet the needs of Caucasian, Maori and Pacific Nations peoples was developed (although usage by child care and protection workers remained a problem);
- A professional supervision policy was established within CYFS for the first time (although standards had not been achieved by the end of the decade);
A “Dangerous Situations” policy was formulated, and was followed later by a well developed Critical Incident Stress Debriefing programme;

Practice handbooks were updated and became available to practitioners on-line; and an electronic case management system, which made case information available to CYFS workers across the country, was developed and updated during the decade.

- *The professional context*

Reports to the Department alleging child maltreatment increased year by year. The Department was functioning under a resource squeeze. These factors concentrated practice, and the agency’s energy and developmental focus, on forensic child protection investigation services (Connolly, 2004). It can be argued that there was a consequent loss of focus on quality needs assessment and strengths-based practice. There developed a pattern of reactive and defensive practice. Local research noted that the focus of work had shifted to the management of short-term interventions (DCYFS, 2001). Practice:

... continues to be deficit-based and reliant on the health of the personalities within the child’s immediate family system. In this respect, little has changed to address the social and economic networks that have a significant impact on their lives (Connolly, 2001, p.42).

Because of the increasing specialization of social work within the state agency (partly a response to complex legislation but also an effect of the drive for output activity definition and description so that costs might be related to activity) social workers “...have ended up doing narrowly prescribed and often relentless statutory tasks, usually with the most difficult families...” (Connolly,
2001, p.42) and the vision that the statutory social worker would be part of a cultural and community network providing support for families and helping families work from their strengths struggled to materialize.

This was by no means an experience confined to New Zealand. In Western countries:

... contemporary social work has become increasingly fragmented, shaped through managerial approaches that emphasise the desegregation, separation and quantification of the social work task. [...] Compartmentalizing social work into discrete measurable activities has undermined holistic and integrated approaches to practice and weakened professional commitment to work collaboratively (Doolan & Nixon, 2003:16).

Social work had become subject to rationalisation and re-shaping in a managerial culture that seems to regard social work practice as either irrational or pre-rational (Hough, 1996) making it more difficult for social workers to assert the benefits of reflection and supervision over prescription and measurement.

*The concept of professional error*

In chapter 2, reference was made to the child death reviews, and some of the findings from these were discussed. An integral aspect of these case studies has been a focus on practitioner failure, generally within a context of overall systemic failure. The phenomenon of error in child protection practice is worthy of some more detailed attention. Understanding of the concept of professional error is not highly developed, largely it is claimed because of the relative recency of the profession and that “…the bulk of the history of professional child protection has been little more than current
affairs” (Howitt, 1992, p. 1). Howitt, whose primary thesis is about the harm families suffer in the child abuse process, develops an argument that the concept of error presupposes that there is the possibility of error-free process, but that in child protection work “normal” and “error” may be largely indistinguishable – “In other words, error is but an aberrant success” (Howitt, 1992, p.3). This conceptualisation aids an understanding of why child protection errors, seemingly evident to clients and media commentators, may be regarded as something entirely different by the involved professionals.

van der Laan (1994) argues that social workers make two basic types of error from which everything else flows. Using statistical error typology, he describes Type 1 error – the false positive – as social workers “intervening unjustly” and Type 2 error – the false negative – as social workers “unjustly not intervening”. Type 1 error is associated with paternalistic, socially controlling social work practice, while Type 2 error is a negligent evasion of professional responsibility. van der Laan points to a dynamic relationship between the two error types. Efforts to avoid Type 1 error increase the risk of Type 2 error occurring, with the reverse also holding true. For example, efforts to eliminate error relating to negligence or the failure to follow procedure or policy can stimulate the use of power, with the result that social workers intervene illegitimately. Damned for not intervening, social workers will also be damned for over-intervening when their actions appear to the public at large to lack prudence.

van der Laan’s analysis claims that media and public interest in social work is largely focussed on Type 1 error, and that unjust intervention is generally considered a more
serious error than negligence. This may not hold true in relation to public anxiety about social work activity occurring at the time of a child’s death. Then, the focus of attention is inevitably on Type 2 error – social workers are seen not have intervened enough and to have been negligent in discharging their duties. Thus, there is a public truth discourse about the quality of social work in such cases, which serves to push to the background any normative dialogue about domestic violence and child abuse.

Laking (2004) points out that “disastrous operator decisions” are not confined to social work:

Experienced surgeons remove the wrong limb from a patient. Pilots deliberately fly well below safe altitudes and into mountains in clear, still air. At Chernobyl, engineers disabled safety interlocks, leading to a catastrophic explosion in the reactor. In the last two decades, accident investigations in these high-risk activities have begun to ask “What was it about the personal characteristics of the decision-makers or about the situation they were in that might have motivated them to take such a course of action?” and “Why were they able to make such a mistake or to violate established procedures without being detected or warned or stopped? (Laking, 2004, p.1).

Social work is a more complex and less connected practice environment than the hospital, the aircraft or the nuclear plant. Most often, publicity about failure in child protection focuses on the practice of the social work professional. The key problem with these types of investigation of social work error is determining whether social worker’s actions, assessed against guidelines for ideal practice, led to the tragedy. Howitt (1992) argues that for an adequate understanding of the phenomenon, theories of error require an accounting for ideological, political and bureaucratic influences, the beliefs and professional practices of workers, and situational factors relating to the presenting issues in a case, as well as the dynamic and process-linked factors that are seen to result in failure. The possibility of a theory of non-error that “no real problem
exists in the child protection system, but there is a problem with a society that sees the system’s activities as problematic”, must also be considered (Howitt, 1992, p.129).

Despite the existence of theories of error and even non-error, it is doubtful that child care and protection practice error can be explained satisfactorily by any theory. Indeed, as Howitt (1992, p. 131) notes “… one has to doubt that all of them put together would account fully for any of the range of errors in child protection work”.

The risk of professional error is evident, but the likelihood of ongoing professional error may be related to the way organisations and society reacts to it.

To regard things that go wrong as anything other than integral to the work of organisations is to risk a pressure to sweep them under the carpet; in effect, not to learn from them. Regarding errors as part and parcel of professional involvement in child protection does not imply complacency. It means that the topic of errors can be given a continuously high profile rather than being whispered about in corridors or bars. Errors can be seen as providing vital stimulus to progress and improvement. They offer data upon which to build procedures which are not so dependent on stultifying rules (Howitt, 1992, p. 198).

Both van der Laan (1994) and Laking (2004) advance alternative approaches to error management.

van der Laan emphasises the need for organisations to reach an understanding of the communicative nature of social work activity and on that basis promote three criteria for quality in social work practice that allows an assessment of whether a worker acted “prudently”. These are that:
1. The relationship between the worker and the client offers the possibility of a smooth transition between the objective (factual), normative (appropriate) and subjective (authentic) aspects of the problem situation;

2. The communication between the worker and the client is dialogical in nature, so that both work as communication partners and contribute actively to the development of a mutual understanding of the problem situations and its potential resolution;

3. There is case-by-case assessment to obviate the risks of unjustly not intervening and intervening unjustly.

Social workers, by pursuing these three quality indicators of prudent care, can:

... prevent a good management of their own activities from becoming synonymous with managerialism and professional responsibility from developing into social disciplinary practices (van der Laan, 1994, p.11).

This approach, while offering some distinct advantages over the current investigative formula, pays little attention to systemic contributors to practice error. Laking (2004) views social work error through the lens of the Reason Human Error Model (Reason, 1990, cited in Laking, 2004) and reaches the conclusion that investigations into child death tragedies have something missing. They have a careful analysis of events preceding death, and they canvass the actions and responses of public employees, but they offer no convincing explanation for why these professionals took the decisions they did. He postulates that the reasons for this may lay in the risk to individuals such investigations present – there will be a tendency to self-protection, inhibited and defensive discussion and an understating of practice error because the stakes are high for staff and they may fear the consequences of full and frank error disclosure.
A fresh approach has to deal first with the issue of blame, and accountability by being found out and punished. Laking notes that there is a tendency for the notion of “blame-free error analysis” to be dismissed as diluting fundamental worker responsibility. However, he points out that personal accountability is an integral part of any high performance system, along with learning from experience (i.e. learning from mistakes):

Indeed, there is a good deal of evidence that in high performing organisations whose members take collective responsibility for performance and for each others performance, an open, non-defensive approach to discussion of error is a necessary part of organisational culture (Laking, 2004, p. 2).

In applying the Reason Model to the statutory social work environment, Laking proposes that the most effective response to the risk of error is not the imposition of rules and more strictly defined procedures, but rather strategic responses at the level of organisational systems and culture. Much of what social workers do, even in such law-driven occupations as child protection and child welfare, takes place in situations and settings where outcomes are uncertain and complex, where tightly defined performance measures are unlikely to be the key in shaping behaviour, and where the boundaries between rules and discretion may need to be blurred in promoting client interest and wellbeing. Laking proposes more use of error analysis at the corporate level in statutory social work organisations, with quality assurance audits and case reviews including observations on factors in the work environment that contribute to error. This strategic approach would be informed by an incident reporting system, where staff are encouraged to report “near misses” or risky departures from standard operating procedures made necessary by events or seen to be an acceptable level of risk in the circumstances. A discipline such as this inculcated in an organisation has
the dual benefits of enabling the analysis of the contributory factors to error in a less blame-ridden atmosphere and the development of a large and textured database on systemic factors relating to error. If the assumption that there is a link between social work error and risk to clients is true, a database of near-miss occurrences or deviant operations, deliberate or not, would lead to a better corporate understanding and appreciation of systemic contributors to risk.

**Conclusion**

Child care and protection practice has become more difficult in recent times. As knowledge expands and public awareness of abuse and neglect grows, statutory protection services are placed under huge pressures. Child protection failure, too often attributed to one or two workers, or the breakdowns in the inter-agency network, is rarely seen within a broader political, social and economic context.

A child care and protection system that is risk-averse and defensive is likely to result in increasing numbers of children moving into care, a system which itself is not risk-free for children (DHSS, 1985; Packman, Randall and Jacques, 1986; Berridge and Cleaver, 1987; Triseliotis, 1989). Managing ambiguity and educated risk-taking are key components of the art of child care and protection social work.

At the beginning of the decade, new child welfare law in New Zealand called for more flexible and innovative approaches to resolving problems within families, for which social workers needed to be given greater autonomy and authority to negotiate options and seek common ground with family networks. Ironically, by the end of the decade, services had become more restricted, conservative and procedure-bound as a
result of a complex interplay of political, organisational and professional pressures, something CYFS had come to realise by launching its “New Directions” strategy at the beginning of the next decade (DCYFS, 2001).

Having now established the framework for the study, Part Two reports on the homicide studies.
Part 2: The Child Homicide Studies


Chapter Four

Methodologies

In order to meet study aims, it was necessary to select research methods that would give a broad understanding of the size and shape of child homicide in New Zealand and at the same time enable more in-depth understanding of contributory factors, with particular reference to the workings of the New Zealand child care and protection system in cases where children in the notice of CYFS had died. While the first of these aims indicated a statistical analysis of reported data about child homicide, the second indicated an examination of particular cases, so that the phenomenon could be better understood in human, as opposed to statistical, terms. Case analysis also makes possible judgements about such things as, for example, the presence of practice error in case management and the impact of organisational and environmental factors on individual cases.

The qualitative/quantitative debate

The research community debates the relative merits of quantitative and qualitative method. Proponents of the former are likely to accentuate its scientific nature, the rigour of the discipline and its potential for replication. Supporters of the latter point to its flexibility, the in-depth nature of the inquiry it makes possible and its capacity to relate to the complexity of the human condition (Connolly, 2002). Methodology debate accents the “different philosophical assumptions about the nature of reality, epistemology, values, the rhetoric of research, and methodology” (Creswell, 1994, cited in Creswell, 2003, p.4). While the methods can sit uneasily together in relation
to their respective model characteristics, it is argued that social work is one of the fields of study that can be enriched by broadening methods of inquiry by using both approaches (Connolly, 2002). Current thinking is less about the differences between quantitative and qualitative approaches and more about how research endeavour and practice can locate itself somewhere on the continuum between the two (Newman & Benz, 1998, cited in Creswell, 2003). Thus, studies are more likely to use mixed method, with studies tending to be either more quantitative or qualitative in nature (Creswell, 2003).

Quantitative and qualitative analysis

Quantitative method is concerned with determination; reductionism; empirical observation and measurement; and theory verification. Thus the focus is on the collection and organisation of verifiable data that can be expressed numerically, and can be aggregated and disaggregated to convey meaning and aid understanding (Creswell, 2003). Researchers can create their own data sets, through experiments or instruments for data gathering such as surveys, but research may also be conducted on data sets already established. The analysis of data by a researcher who has not been involved in its collection is generally known as secondary analysis.

In contrast, qualitative analysis focuses on everyday life situations and seeks to formulate questions and answers on the basis of the patterns that emerge in the research investigation (Patton, 1987, cited in Caudle, 1994). The researcher does not attempt to manipulate these settings for study purposes but rather embarks on “an intense investigative process of contrasting, comparing, replicating, cataloguing and classifying what is under study” (Caudle, 1994, p.69). A more recent definition,
which recognises that the dichotomy of laboratory and field study no longer sufficiently differentiates quantitative and qualitative method, sees qualitative research as:

... a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self (Denzin & Lincoln, 2003, p.4).

The research traditions in qualitative research focus inquiry on: an individual’s experiences (Biography); the experiences of a number of individuals about a particular concept, or “phenomenon” (Phenomenology); the generation of a theory about people’s responses to a phenomenon (Grounded Theory); the interpretation of group experience (Ethnography); and the exploration of a bounded system or “case” (Case Study). Each tradition draws from different mixes of academic discipline, utilises distinct forms of data collection, and requires different approaches to data analysis and results in different narrative forms (Cresswell, 1997).

It was determined that what was required in this study was a mix of quantitative and qualitative method. It was important to understand the scope of the child homicide problem in New Zealand, and as such, quantitative method provides the means through which this could be considered. The qualitative study of the smaller number of case studies known to CYFS is interpreted and understood within this context. Hence a mixed method approach allows both broad and particular analysis, and also offers the potential for some cross validation of the findings emanating from each method. Further, as all the cases involved in the qualitative analysis are also included in the set of data analysed statistically, there is opportunity for determining the extent to which the sub-population descriptions differ from the main group, which may
suggest leads to which cases are more likely to have prior involvement with a child protection agency. The qualitative study involved a case study document analysis of child homicide cases that were known to CYFS.

*Case study document analysis*

Stake (2003) argues that case study is less a method than a choice of what is to be studied. Case study is increasingly recognised as an important form of research inquiry particularly resonating with social workers, for whom “the case” is the basic unit of their work (Gilgun, 1994). The method involves intensive multi-variate and multi-perspective investigation of a single case or a number of cases, from which analytic generalisation seeks to inform both practice and theory (Gilgun, 1994).

The use of documents in research inquiry lies somewhere between the practice of directly observing behaviour or activity, and gathering data from interviews (Murphy & Dingwall, 2003). As well as providing a picture of what has occurred, documents can provide insight into what people or organisations “would like to be thought to be doing” (Murphy & Dingwall, 2003, p.66). The examination of documents allows us to examine how things were in relation to how we think things should be. This concept will be readily understood by social workers, who typically regard critique of casework as wisdom after the event. Policy and practice guidelines are documented. Case activity is documented. The goodness of fit between these two sets of documents is a rich field of inquiry. What has happened can be assessed against what is expected, and what is expected begins to adjust over time to what has happened.
Study methodology

The study undertook a secondary analysis of:

- New Zealand Police statistics about child homicides identified during the decade 1991 to 2000.
- CYFS data and information relating to children who died from homicide who had involvement with CYFS in the period 1996-2000.

The homicide statistics

Police statistics on child homicides are public records, but do not constitute a publicly reported data set. The information is available from Police on request and can be regarded as a reasonably reliable data set (NZ Police, 2003). Issues of comparability and consistency of definition can confound the study of organisational statistics. “Statistics rest on definitions about what to count as an example of the phenomenon that they purport to measure” (Murphy & Dingwall, 2003, p.67). Thus, for this study, it was expected that the search for international comparisons would encounter definitional dispute and difference about what constituted abuse and homicide and that variances about these could confound the usefulness of comparative examples. Therefore understanding is sought in relation to the sorts of patterns that emerge from the data rather than any direct comparability, and there is a need for explicit caution in such research against direct representation. Researchers of documents and statistics have to work with the fact that recorded information is not produced for the use of researchers but is produced by people who have their own interpretation of events and whose recording is in fulfilment of an employment contractual obligation. Thus “all statistical data are both socially and organisationally constructed” (Murphy & Dingwall, 2003, p.70).
Hence, the Police information was the source of the quantitative analysis undertaken. Using the demographic characteristics collected by Police, the study was able to calculate rates of child homicide in the total population and relative to child sub-populations. It was also possible to quantify factors that enabled some comparison with findings of international studies of child homicide, for example: the ages at which children died; how they died; their ethnicity; and the perpetrator’s relationship to the children.

The case study data

Since 1994, CYFS has required a report to its national office of the death, under any circumstances, of a child with whom it is working or with whom it had recently (within the previous two years) had contact. The period 1996-2000 was chosen for this part of the study because of the reliability of the CYFS information about these children over that time, and the fact that for any child who died from non-accidental injury or neglect, CYFS has conducted an intensive review of its casework services. This creates a rich source of data about the social work process followed and social work practice with these children and their families (DCYFS, 2003).

Hence, the case review files held by the Chief Social Worker within CYFS were the data source for the second part of the study. The CYFS data made possible further quantitative analysis of a sub-sample of the primary data. Thus, it was possible to establish the numbers that had had contact with CYFS and other demographic

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18 Chapter 4, Care and Protection Handbook, Department of Child Youth and Family Services
characteristics about this group to determine whether there were any substantial variances between those involved with CYFS and those who were not.

Analysis of post-death case review documents disclosed a range of qualitative information about case management of children who had died. It was possible to determine:

- At what part of the social work process the children died;
- What interventions were involved;
- Whether there was a discernable connection between the use, or lack of use, of interventions and subsequent vulnerability to homicide.
- What practice error was identified
- What environmental matters affected case management

Once the cases meeting the study parameters were determined, a document analysis was undertaken of the files. The study did not access any original records. While not technically case study methodology, the document analysis of the case review files is informed by case study theory (Stake, 1995). The cases were studied for instrumental rather than intrinsic purposes. This means that the purpose of the analysis is to establish patterns or insights to aid general understanding, rather than to build knowledge about the details of the cases themselves. The cases do not comprise a sample that represents others – they are all the cases occurring in a particular span of time. The object is “particularisation” (about those cases studied) rather than “generalisation” (to all child protection cases) (Stake, 1995, p.8). There is interpretative, as opposed to assertive reasoning.
The Chief Social Worker from the Department of Child Youth and Family Services supervised access to departmental information contained in the review reports.

Culture and research

Research is regarded as cross-cultural if the researcher and those being researched have different ethnicities (Spoonley, 1999). In such research, special considerations are necessary to ensure the “cultural safety” of both. New Zealand research that involves Maori as research subjects needs to embody culturally sensitive approaches that respect the culture, values and beliefs of Maori. Ways that this can be achieved are through: the mentoring of researchers by knowledgeable Maori; researcher incorporation into the ongoing life and activity of the community being studied; shared decision-making about research design and data collection and interpretation; and seeking Maori guidance in determining the sorts of questions to be addressed (Smith, 1992, cited in Smith, 1999).

The study had no particular outcome intentions in respect of Maori and was not focussed on this population. There was no direct involvement with Maori that would have required engagement with cultural mentors and exploration of study method for cultural appropriateness. It was clear, though, that some of the children making up the study sample would be Maori and therefore the issue of what questions should be asked in relation to them and how findings emerging from the study might be interpreted, arose. It was important therefore to have cultural guidance in these matters. The Reverend Maurice Gray, Upoko ki Runaka Otautahi, provided this cultural guidance.
**Ethical Issues**

The study did not involve the disclosure of any identifying personal information relating to persons living or dead. The foci of the study are the incidence and features of child homicide on the basis of statistical data gathered by Police and the point in the statutory child protection process at which children died as a result homicide, including what implications might arise for social work practice as a result.

The Police statistics are publicly available information and the documents relating to case reviews were made available by the Chief Social Worker. There was no requirement for contact with any person or persons associated with the cases. As the study involved only departmental documents, there are no ethical issues relating to voluntary participation, informed consent or participant safety. The case files were accessed on site over a three-day period. No material from the files was copied or retained by the investigator.

The study proposal was submitted to the Canterbury University Human Ethics Committee. The chairperson of the University Human Ethics Committee advised that:

> ... since there are no "live participants" in the terms the Human Ethics Committee (HEC) is usually concerned with, the issue seems to be the privacy of all those on the file, whose information you will see while accessing the data you need for the project

and advised that the proposal should be forwarded directly to the Department of Child Youth and Family Services, which is the custodian of the non-public information needed for this study.

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19 Dr Alison Loveridge, Department of Sociology and Anthropology, University of Canterbury, N.Z. – Email communication 03 June 2003.
On examination, there appeared to be no privacy issues relating to the intended use of personal information about the children (the fact of their death, their age, their ethnicity and the cause of death). The Privacy Act 1993, in its Interpretation section, provides the following interpretations:

1. “Personal Information” means information about an identifiable individual, and includes information in any register of deaths kept under the Births and Deaths Registration Act 1951;

2. “Individual” means a natural person, other than a deceased natural person.

To confirm that there were no ethical issues in relation to research in respect of deceased persons, the New Zealand Health Council Ethical Guidelines were consulted. The guidelines refer only to health information about living persons and discussion on deceased persons seems to be limited to such matters as the retention of tissue and body parts for research purposes.

The study does include statistical information about perpetrators and the qualitative analysis involves, in some cases a consideration of children’s family situations, thus involving people not yet deceased. Two principles of the Privacy Act seemed relevant – principle 10 which limits the use of personal information and principle 11 which limits the disclosure of personal information. Both principles exclude from their limiting provisions, information that:
(i) Is to be used in a form in which the individual concerned is not identified; or

(ii) Is to be used for statistical or research purposes and will not be published in a form that could reasonably be expected to identify the individuals involved.\(^{20}\)

As the qualitative analysis involved cases that come within the ambit of proceedings under the Children, Young Persons and their Families Act 1989, that legislation was perused for any guidance about the use of information arising. The Act does restrict publication of reports of proceedings under the Act\(^{21}\) but this restriction does not apply to:

(a) Any report in any publication that –
   (i) Is of a bona fide professional or technical nature; and
   (ii) Is intended for circulation among members of the legal, medical, or teaching professions, officers of the Public Service, psychologists, counsellors carrying out duties under this Act or the Family Proceedings Act 1980, or social welfare workers:
(b) Statistical information relating to proceedings under this Act:
(c) The results of any bona fide research relating to proceedings under this Act.\(^{22}\)

A proposal was submitted to the Research Access Committee of the Department and approval for access to CYFS information was given.

**Ethical considerations in relation to deceased persons**

It became apparent in the course of the study, that while the key persons in this study - the children – were deceased, the analysis included persons who were not. This would

\(^{20}\) Principle 10(f) and Principle 11(h), Privacy Act 1993.

\(^{21}\) S.438.

\(^{22}\) S.438 (2).
see to be inevitable in social research about deceased persons and renders all the more questionable, the lack of development of a clear position about such research by the University Human Ethics Committee. In a sense it was surprising that the issue was not debated at the ethics committee level, even if this was merely to assert that there are no ethical issues. No guidelines existed relating to ethical considerations for quantitative and qualitative studies about persons who are deceased, and it appeared that the study generated these questions for the first time. This highlights the need for more explicit guidelines in these matters.

Limitations of the study

The study has limitations. The range of demographic data collected by Police limits the assumptions that can be made as to the factors contributing to a risk of homicide victimisation in children. The study needed to guard against attributing risk to any of the recorded data when so many other factors that studies indicate may contribute to risk were unrecorded.

It cannot be inferred that the incidence of practice error in the cases studied was a contributor to the child’s death, as this study does not include a matched sample of cases where death did not occur. While it is tempting to associate practice error with poor case outcomes, the temptation has to be resisted in fairness to the workers concerned until it can be demonstrated that such practice error does not occur in similar cases with positive outcomes. This would be a fruitful future research endeavour.
Similarly, any generalisation of the findings about the safety record of the phases of the statutory process and, in particular, the interventions chosen by social workers, will be limited, both by the small number of cases involved and by the absence of matched cases where death had not occurred.

**Conclusion**

The study contributes to the international and national bodies of knowledge about the incidence and features of child homicide in New Zealand and attempts to establish some comparisons with like countries. It is the first study to establish the proportion of New Zealand child homicide victims known to the statutory child care and protection agency at the time of or prior to their deaths. The study addresses a key question about the safety of the New Zealand child care and protection process. It uses a mix of quantitative and qualitative analysis to reach an understanding of this most difficult issue – the phenomenon of child death by maltreatment.

The next three chapters report and discuss the findings of the quantitative and qualitative child homicide studies. Firstly the New Zealand data on child homicide from 1991 – 2000 is reported in chapter 5, followed by a discussion of the findings in Chapter 6. Chapter 7 then reports and discusses the findings relating to those children who died between 1996 and 2000 who were known to CYFS.
Chapter Five

Quantitative Findings: Patterns of Child Homicide in New Zealand

1991-2000

What follows is a reporting of the findings of the analysis carried out on Police statistical data. This establishes the size and shape of the child homicide phenomenon in New Zealand.

New Zealand Child Homicide Data 1991-2000

A total of 91 children were killed in the decade and 101 perpetrators were involved. There appear to have been at least eight multiple homicide incidents, involving 20 children in total. The chief characteristics of the data (Appendix 1) are now discussed.

Age distribution:

Twenty-six percent of the child victims were under one year of age (n=24); 63% (n=57) were under the age of 5 years; and 82% (n=75) were under the age of 10 years. The remaining 18% (n=16) were 11 to 14 years of age. The average age was 4.5 years. However, Maori and non-Maori average ages differ, being 3.7 and 5.4 years respectively. The average age of children killed by strangers (n=5) was 11.8 years.
Gender

Fifty-three percent (n=48) of child victims were male and 46% (n=42) were female, and the gender of one child was unknown (unborn child).

Ethnicity

Fifty-two percent (n=47) of child victims were Maori; 39% (n=35) Caucasian; and the remaining 9% were Asian (n=4), Samoan (n=3) and Unknown (n=2).
The relationship with ethnic proportions in the total population\textsuperscript{23} are shown in the following table:

**Table 5.1: Proportion of deaths by ethnicity compared with ethnic proportions of total population 1991-2000.**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% Child homicides</th>
<th>% Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian\textsuperscript{24}</td>
<td>38.5</td>
<td>75.8</td>
</tr>
<tr>
<td>Maori</td>
<td>51.6</td>
<td>14.2</td>
</tr>
<tr>
<td>Asian</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Samoan</td>
<td>3.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Other Pacific Island</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>2.2</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Cause of death:**

Thirty-three percent (n=30) of child victims died of head injury; 14\% (n=13) from other body part injury; 19\% (n=17) from strangulation, asphyxiation or suffocation; 20\% (n=18) from stab wounds, a cut throat or bleeding to death; and the remaining 14\% from poisoning (n=5), drowning (n=3), neglect (n=2), gunshot wounds (n=2) and unknown (n=1). Death by battering accounted for 47\% of all cases, but 60\% of Maori (n=47) and 34\% non-Maori deaths (n=4). On the other hand, death by strangulation, asphyxiation or suffocation accounted for 19\% of all cases, but 27\% of non-Maori

\textsuperscript{23} Calculated by averaging the total and ethnic populations in census data for 1991, 1996 and 2001
\textsuperscript{24} Calculated as total population minus Asian, Maori and all Pacific Island sub-populations
(n=12) and 10% of Maori deaths (n=5). All four deaths of Asian children, and two of the three Samoan deaths, were attributed to battering.

There was a difference in the pattern of methods used by male and female perpetrators. Of those held solely accountable (24 women and 46 men) women used battering in 29% and men in 56% of cases, whereas suffocation, asphyxiation or strangulation occurred in 46% of cases involving women and only 9% involving men. Women and men used drowning, poisoning, stabbing or allowing a child to bleed to death in 25% and 35% of cases respectively.

Perpetrator gender:

Sixty-six percent (n=67) of the perpetrators were male and 34% (n=34) were female.
Relationship of offender(s) (n=101) to child victims:

Thirty-one percent (n=31) of the perpetrators were fathers; 24% (n=24) were mothers; 18% (n=18) were de facto partners; 9% (n=9) were other relatives; 9% were a boarder (n=1), neighbours (n=2), acquaintances (n=4) and caregivers (n=2) and the remaining 11% were strangers (n=6) or the relationship unknown (n=4). De facto partners were involved in 34% (n=16) of the deaths of Maori children and only 6% (n=2) of the deaths on Caucasian children.
**Perpetrators of Filicide:**

Fifty-seven percent (n=52) of all child homicides were filicide involving 55 parents, of which 54% (n=28) were committed by fathers, 40% (n=21) by mothers and 6% (n=3) by mother and father jointly.

![Fig 5.7: Perpetrators - Filicide](image)

**Perpetrators of non-filicide:**

There were 39 cases of non-filicide homicide involving 46 perpetrators, of which 78% (n=36) were committed by men and 20% (n=9) by women and one was unknown.

![Fig. 5.8: Perpetrators - Non-filicide](image)
Proportion of deaths that were filicide of children less than 1 year:

Sixty-three percent (n=15) of homicides of children under 1 were filicide, and 37% (n=9) were by someone other than parents. In relation to the filicide of less than 1 year olds, mothers were perpetrators in 7 cases, fathers in 7 and in one case parents acted jointly.

Child homicide as a proportion of all homicides:

Child homicide averaged 15.2% of all homicides over the decade. The range was from 5.7% in 2000 to 25% in 1999. During the decade, children averaged 23% of the total population.

Rates of child homicide in New Zealand

An average of 9.1 homicides occurred each year in the decade, but there was no pattern year by year. The number ranged from a low of 5 in both 1991 and 1996, to a
high of 13 in 1992 and 1997. The yearly average rate was 0.24 per 100,000 head of total population. The national statistics have remained relatively constant. Between 1978 and 1987 there where 77 child abuse fatalities at a rate of 0.23 per 100,000 head of total (all ages) population, and between 1981 and 1990 the rate was 0.25 per 100,000 (Kotch et al, 1993, p.234). This constancy is consistent with international studies. The earlier study found that of 77 child fatalities in the 10-year period 1978 to 1987, 19% (n=14) were Maori, the authors pointing out that this proportion was not very different from the proportion of all New Zealand children who were Maori – 13.2% in 1978 to 13% in 1987 (Kotch et al, p.239). This raised a question as to whether there had been changes within the rates quoted above relative to Maori and non-Maori populations between the two ten-year periods. It seemed more appropriate to express these as rates against the child population 0-14 than the whole population, given the changes occurring in population make-up, and the changes in the child population between Maori and non-Maori populations. The comparisons between the two periods are presented in the following tables:

<table>
<thead>
<tr>
<th>Period</th>
<th>Annual average resident population 0-14 years</th>
<th>Annual average homicide 0-14 years</th>
<th>Rate per year per 100,000 0-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978-1987</td>
<td>817,160</td>
<td>7.7</td>
<td>0.94</td>
</tr>
<tr>
<td>1991-2000</td>
<td>849,163</td>
<td>9.1</td>
<td>1.07</td>
</tr>
</tbody>
</table>

25 This study included 15 and 16 year olds, of whom there were 15 fatalities. These are not included.
26 An assumption has been made that the proportion of fatalities of children 0-14 (n=77 or 7.7 per year) that were Maori remained constant at 19% (n=14 or 1.4 per year).
27 The data for 1991-2000 is from Police records and is likely to be of a high quality. Data for 1978-1987 is taken from the findings of another study (Kotch et al, 1993) and was gleaned from Health records. The latter report did not give raw data, although it noted that the study included deaths that were clearly homicides but did not appear on Health records as deaths resulting from "Child battering and other maltreatment" (Health code E967). This raises the possibility that some of these "misdiaagnosed" deaths did not reach homicide status in the criminal justice arena. Thus the 1978-1987 health data may be more accurate than Police data for the same period.
Table 5.3: Changes in rates of child homicide 1978-1987 and 1991-2000 in Maori population 0-14 years

<table>
<thead>
<tr>
<th>Period</th>
<th>Annual average Maori Population 0-14 years</th>
<th>Annual average homicide 0-14 years</th>
<th>Rate per year per 100,000 0-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978-1987</td>
<td>133,375</td>
<td>1.4</td>
<td>1.05</td>
</tr>
<tr>
<td>1991-2000</td>
<td>196,406</td>
<td>4.7</td>
<td>2.40</td>
</tr>
</tbody>
</table>

Table 5.4: Changes in rates of child homicide 1978-1987 and 1991-2000 in non-Maori population 0-14 years

<table>
<thead>
<tr>
<th>Period</th>
<th>Annual average Non-Maori population 0-14 years</th>
<th>Annual average homicide 0-14 years</th>
<th>Rate per year per 100,000 0-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978-1987</td>
<td>683,785</td>
<td>6.3</td>
<td>0.92</td>
</tr>
<tr>
<td>1991-2000</td>
<td>652,746</td>
<td>4.4</td>
<td>0.67</td>
</tr>
</tbody>
</table>

The relationships between tables 2 and 3 can be summarised as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Maori rate per 100,000</th>
<th>Non-Maori rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978-1987</td>
<td>1.05</td>
<td>0.92</td>
</tr>
<tr>
<td>1991-2000</td>
<td>2.40</td>
<td>0.67</td>
</tr>
</tbody>
</table>

Statistical analysis involving contingency tables and the Chi-square test for disproportionality shows:

- The rate increase for the total child population from 0.94 in 1978-187 to 1.07 in 1991-2000 is not statistically significant (p<0.4)

- The difference between the Maori rate (1.05) and non-Maori rate (0.92) of homicide for 1978-1987 is not statistically significant (p<0.66)
• The difference between the Maori rate (2.40) and non-Maori rate (0.67) in the decade 1991-2000 is highly statistically significant (p< 0.0001)

• The increase in the Maori rate of child homicide between 1978-1987 (1.05) and 1991-2000 (2.40) is highly statistically significant (p< 0.0039)

• The decrease in the non-Maori rate of child homicide between the 1978-1987 (0.92) and 1991-2000 (0.67) is not statistically significant (p= 0.1091)

Thus, while the rate of child homicide relative to the whole New Zealand population has remained constant over time, there have been significant changes in the rates between the non-Maori and Maori populations that beg explanation. A slight fall in the rate of non-Maori child homicide victimisation is offset by a large increase in the victimisation rate for Maori. However, while Maori deaths were 52% of all deaths for the decade, there was a concentration in the earlier part of the decade. Maori deaths accounted for 59% of all deaths between 1991 and 1995, and 44% between 1996 and 2000.

Within the non-Maori population, Samoan and Asian sub-populations figured in the statistics. The Samoan 0-14 year old population during the decade averaged 39,408 giving a yearly average homicide rate of 0.76 per 100,000 Samoan 0-14 population. The children of the six other major Pacific Nations people – Cook Islands, Fijian, Niuean, Tokelauan, Tongan and Tuvaluan - whose combined New Zealand resident populations equals that of the Samoan people, appeared to have no homicide
victimisation in the decade.\textsuperscript{30} The Asian child 0-14 population averaged 43,196 during the decade, resulting in a yearly average homicide rate of 0.92 per 100,000 Asian 0-14 population.\textsuperscript{31}

The rate relationships between the various sub-populations is shown in the following table:

\textit{Table 5.5: Rates of child homicide per 100,000 population 0-14 years, by ethnic groups 1991-2000}

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Rate of child homicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>2.4</td>
</tr>
<tr>
<td>Asian</td>
<td>0.92</td>
</tr>
<tr>
<td>Samoan</td>
<td>0.76</td>
</tr>
<tr>
<td>Caucasian</td>
<td>0.67</td>
</tr>
<tr>
<td>Other Pacific</td>
<td>0</td>
</tr>
</tbody>
</table>

By ethnic group, child homicide victimisation was highest for the Maori population, followed by the Asian, Samoan and Caucasian populations in that order. There was no evident child homicide victimisation of New Zealand resident children whose families originated in The Cook Islands, Fiji, Tonga, Niue, Tokelau or Tuvalu.

\textit{In summary}

- On average, 9 children died as a result of homicide in New Zealand each year of the decade studied;

- Maori children were killed at more than 3 times the rate of non-Maori children;

\textsuperscript{30} 1995 data lists one victim as Polynesian, and this death has been included with non-Maori data but cannot be ascribed further. The child could have been Maori, Samoan, or any one of the other Pacific Island populations.

\textsuperscript{31} Population figures were taken from NZ Statistics website for 1991, 1996 and 2001 censuses, and averaged.
• 63% of child homicides were of children under 5 years of age and 82% were of children under 10;

• Male children were slightly more vulnerable to homicide than female children;

• Battering was the most frequently recorded cause of death, followed by knife wounds and suffocation, asphyxiation or strangulation;

• Birth parents (mothers and/or fathers) were responsible for the largest proportion (54%) of child homicides;

• 57% of child homicides were filicides, of which 54% were committed by fathers, 40% by mothers and 6% involved both parents;

• Child homicides comprised 15% of all homicides in the decade studied.

These findings are discussed in Chapter 6, making links wherever possible to the international findings set out in Chapter 2.
Chapter Six

Discussion: Patterns of Child Homicide in New Zealand 1991-2000

The statistical data represents the stark facts on child homicide in New Zealand. But how are we to interpret these? How does the size and shape of child homicide in New Zealand compare with that of other Western countries? What might we infer from the increasing rate of child homicide in this country, and in particular, the rate differences between Maori and non-Maori populations that have become plainly evident?

Reporting and recording issues

In matching Police records for the period 1996-2000 with those of CYFS, two homicide deaths were detected that do not appear in Police statistics. One of these is understandable – the child undoubtedly died from child abuse, but death occurred more than one year following the injuries sustained, during which time she remained in CYFS care. The other is more difficult to explain, given that a perpetrator was arrested, convicted and imprisoned for the murder of the child. In any event, it constitutes a recording error rate of 4.25% for the five-year period. Both instances give support to what is recounted in the literature: time delays can affect the identification of deaths as homicide and some homicides escape official statistical records entirely.

Only two deaths in the total sample of 91 were attributed to neglect. The neglect rate of 2.2% of all child homicides contrasts significantly with the rates of up to 38% recorded in the US. It is safe to assume that deaths from neglectful supervision, such as drowning, house fires and being run over in a household driveway, are not making
their way into the New Zealand statistics. Whether such deaths result in criminal prosecution of neglectful caregivers may have some bearing on their classification as homicide or accidental deaths, but such inquiry is outside the scope of this study. In the US, neglect homicides have increased in the total number identified since the inception of child mortality review processes. This discipline is in the process of development in New Zealand under the auspices of the Ministry of Health and a future study might map the influence of this process on maltreatment death statistics.

The matter of neglectful supervision deaths is probably the area where there is most definitional debate. Sympathy and concern for otherwise caring and responsible parents who have a lapse in concentration affecting their child’s safety or wellbeing renders it difficult to attribute death to child maltreatment through neglect. The New Zealand child mortality review system will need to grapple with the issue of definition and ensure that the definitions adopted enhance the nation’s ability to compare its performance with other countries, or at least explain variations.

**Incidence**

The national statistics show that on average nine children died as a result of homicide in New Zealand each year during the period 1991-2000, at a rate of 0.24 per 100,000 general population, or 1.07 per 100,000-child population 0-14 years. The repeated cautions in the literature about reporting and counting issues in relation to child homicide may render inter-country comparisons and relative positions questionable. The UNICEF (2003) study for the period 1994-1998, recorded a child maltreatment mortality rate for New Zealand of 1.20 per 100,000, while for the same period the
mortality rate calculated by this study is 1.02 per 100,000.\textsuperscript{32} Thus, either the Police statistics are incomplete in relation to data available to the UNICEF study and represent an undercount of actual child maltreatment mortality, or the disparity represents the difference between raw data used in this study and weighted data used by UNICEF. What can be said is that New Zealand has a reported child maltreatment mortality rate higher than that reported by most of the developed world, and that its position relative to other rich countries has deteriorated since the early 1970s. However, New Zealand also has a somewhat lower level of deaths classified as “of undetermined intent” than countries such as France, the US, Canada, Japan and the United Kingdom.

Despite its already parlous position, it is likely that the New Zealand figures significantly undercount deaths that arise from neglect. If these were included, the disparity between New Zealand and the US might be considerably narrowed. Whether this would worsen the New Zealand position with the rest of the world is difficult to determine, given the high level of generality of the UNICEF report data (for example, there is no breakdown of cause of death, by country, that would enable such an analysis) and the lack of any common homicide definition in the OECD.

The data represents worrying information about Maori. While the incidence of child homicide is decreasing in the non-Maori population, the increase in the rate of homicide of Maori children is well beyond the realm of chance variation. Some things must have been occurring in Maori households and communities that were not evident to the same degree in non-Maori households and communities. While no one violent,

\textsuperscript{32} Police records show that 44 child homicides occurred between 1994-1998. On an average 0-14 population figure of 857,804 for that period, the rate of homicide is 1.02 per 100,000.
homicidal attack on a child can be justified or defended, what may be unique to Maori, and more evident because of their sizeable population, are other factors associated with their colonisation: generations of dispossession, low economic achievement and abrupt urbanisation. The Maori child homicide rate of 1.05 per 100,000 of the 0-14 child population in 1978-1987, even then outstripping the rate for the non-Maori population, may be connected to this disruption. Within the space of a decade this rate had more than doubled, and is now more than three times that of the non-Maori population. This increase may, to some degree at least, reflect the effects of the New Zealand economic reforms of the 1980s and 1990s, which created an underclass that had a disproportionate negative affect on Maori (Cheyne et al, 1997). That there was a disproportionate effect is supported by an official report stating:

Changes in the economic climate over the past 15 years have had a major impact on the Maori population. This is shown in higher rates of unemployment and growing differences in income between Maori and non-Maori. (Statistics New Zealand, 1998a, cited in MSD, 2002, p.73).

Both the World Health analysis (Krug et al, 2002) and the UNICEF (2003) report indicate a connection between rates of child abuse and child maltreatment fatality and levels of poverty and disadvantage. In any comparison of the living standards and social wellbeing of Maori and Caucasian New Zealanders, Maori fare less well. About 20% of the total New Zealand population are on a scale of very restricted to somewhat restricted living standards. For the Caucasian population, that figure is 15% and for Maori it is 39% (MSD, 2002, p.49). Living standards are affected by: income and asset levels; home ownership; the size of the economic unit (one parent or two, for example); the number of children raised; stage of life; and educational levels. In all categories, Maori fare less well than their Caucasian counterparts (MSD, 2002). The 1996 census, for example, reported:
Those reporting Maori and Pacific status had above-average unemployment rates, a greater proportion of sole-parent families, larger average family size, lower market earnings and have a younger age structure (Statistics New Zealand, 1998a and Te Puni Kokiri, 2000 cited in Stevens and Waldegrave, 2001, p.98).

All of these conditions are associated with higher levels of poverty.

Cultural consultancy\(^{33}\) offered the following perspective:

The period of the 1990s has seen a major deterioration in the wellbeing of Maori families. Some contributory factors were:

- The introduction, through Maori gang structures of methamphetamine (the recreational drug popularly known as P) has caused, it could be argued, more significant destruction in the Maori than in the non-Maori community to date. Children are targeted as users and then distributors. It is likely that the rising rates of violent crime, suicide, homicide, prostitution and mental health disorder are linked to the insidious effects of this drug;

- The “community” in which most Maori now live is, in reality, a collection of strangers. There has been the loss of civil society for many urban Maori who once interacted with the social structure and collectivity of whanau, hapu, iwi;

- Maori older than 60 years now comprise less than 4% of Maori population.\(^{34}\) The kaumatua and kuia of today are increasingly in their 40s and 50s and without the life experience, mana and following such status once enjoyed. Thus, those who once modelled the values, customs and beliefs underpinning life, family, care of children and social behaviour are less and less visible to Maori families and in communities generally;

\(^{33}\) Comments noted in a personal communication with Rev Maurice Gray, Upoko, Te Runaka Otautahi (Kai Tahu) 12 August 2004.

\(^{34}\) New Zealand Statistics: Maori Ethnic Group, mean year ended 31 December, 2000.
There is less tribal leadership interest today in Maori social development than there was before the decade of the 1990s. Maori social problems have fallen in the gap between Government responsibility and iwi responsibility following the settlements in major tribes. Government activity has focussed largely on the policy level rather than on the delivery of frontline services, while Maori leadership has mobilised around the land claims and the establishment of iwi economic enterprise. The “corporatisation of Maori” is leading to the loss of the concept of manaakitanga.

It is beyond the scope of this study to undertake the sophisticated statistical analysis required to isolate the social and demographic characteristics that contribute to a heightened risk of child fatality as a result of maltreatment. That Maori figure so prominently on the lower ends of scales of social and economic wellbeing indices may provide some explanation of the high levels of Maori child homicide but it cannot totally account for the phenomenon. After all, while the incidence of poverty for Maori is far higher than for Caucasian, the structure of poverty across the whole population demonstrates that 71.9% of poor people in New Zealand are nevertheless Caucasian (Stephens & Waldegrave, 2001, p.98).

Because other explanations are not readily available, there may be a temptation to interpret this study data on the basis of the demographic characteristics collected by Police. There is a danger that in the absence of other demographic descriptors, one variable such as race might achieve ascendency as a risk factor in child homicide that is not justified. Had Police also collected demographic data on income levels, family composition, family criminality or housing situations, for example, other variables
that resulted in high levels of risk of homicide might have emerged. Pryor and Rogers (2001) have established seven domains of factors influencing the social, psychological and physical development of children: aspects of family social class and income; family environmental factors (such as violence, for example); parental mental states; family criminality; stressful life events; social supports from significant others; and neighbourhood characteristics. To understand which of these, or combinations of these, most contribute to the risk of child homicide requires the analysis of data that is simply not currently available. It is, perhaps, unrealistic to expect Police to collect this sort of information when children are killed. What could be useful, though, is routine enquiry and recording of this data as part of a comprehensive child mortality review process.

It should be noted, also, that the literature reports class and race bias in who gets reported for child abuse and the rate of Maori child homicide may, in part at least, be a manifestation of this. The earlier New Zealand study used as a comparator in this study concluded that:

The under-reporting of child abuse as a cause of death among children 0-16 years of age, and the probable bias toward labelling Maori and other non-European children as having been abused while giving the “benefit of the doubt” to European children, has significant policy implications (Kotch et al, 1993, p.24).

Whatever the explanation, it could be argued that current community services and responses are failing Maori children at a far greater rate than they fail children from other cultures. Maori leadership has called for a change of approach (Turia, 2004) and a renewed emphasis on whanau-building as a means of addressing such problems within Maori communities. Such work will involve:

- The linking of Maori to their hapu, iwi;
The provision of information and services to whanau that address addiction and violence;

Resiliency models of community building; and

Good worker training that enables workers to bridge the absence of whanau strengths until these have an opportunity to grow and develop.35

Proactive support for alternative solutions is clearly indicated by these findings.

Samoan and Asian child homicide rates exceed those of the Caucasian populations, but the actual numbers (n=3 and n=4 respectively) are too small to determine whether these are more than chance variations. Both rates are significantly below those of Maori. The rate of homicide of Pacific Island children resident in New Zealand is low if Samoan and all other Pacific nations are included together. The rate of 0.38 per 100,000 resident Pacific Island children 0-14 years is the lowest for the sub-national populations, a result that is probably counter-intuitive for the general New Zealand population.

The apparent number of multiple homicides (inferred from groupings of children killed by the same method by the same parent) raises questions. These would clearly have been cataclysmic family events, and may be associated with the occurrence of adult relationship break-up or contests between parents on questions of custody of and access to children following family dissolution. This is an area warranting further investigation.

35 Advice noted in a personal communication with Rev Maurice Gray, Upoko, Runaka Otautahi, 12 August 2004.
Age of victims

Almost two thirds of all child homicides were of children under 5 years of age, with those under 1 year having the highest rate of victimisation for any age year. Both these findings are consistent with the literature. It is clear that young children are most vulnerable, and that the risk of child homicide diminishes with age. The average age at death of 4.5 years is higher than other studies have shown (a range of 2.8 to 3.3 years) and this is largely the result of the somewhat higher average age at death for non-Maori children compared with Maori. The Maori average age is only marginally above international comparisons. That the average age of children killed by strangers is much higher than those killed by caregivers is supported by this study.

Sixty three per cent (n=57) of the child homicide victims were under the age of five years. The period between birth and first entry to school can be a time of isolation from professional helping sources, particularly if the child does not have a pre-school educational experience, or is not seen by a health professional, or is seen by a number of different health professionals who have no means on checking information with one another. The inquiry into the death of James Whakaruru (OCC, 2000) records that James had contact with at least 44 health professionals during his 4 years of life, sometimes as a result of what we now know to have been non-accidental injuries. However, rarely did the same professional see him more than a few times and there was no system for information sharing between them.

There is no effective way of monitoring the safety and well being of children under the age of 5 years apart from the vigilance of extended family, friends and neighbours and those educational and health professionals who may have some access to them.
Indeed, since the abolition of the Family Benefit in 1990, there is no national database that records children and family whereabouts. The known association between physical child abuse, poverty, poor housing and employment problems results in a degree of mobility in these families that prevents communities and local professionals from building up a picture of a child and its situation. Indeed there is some evidence that families in which abuse is occurring can avoid outside contacts through a phenomenon described as “closure”. Reder et al, (1993, p. 99) notes this phenomenon:

This was a striking phenomenon noted in over half of the thirty-five cases, in which the family attempted to tighten the boundary around them so that they reduced their contact with the external world and few people were able to meet or speak with them. For example, their curtains were always drawn, the children stopped playing outside and no longer attended school or nursery. The parents failed appointments with professionals, the children were not taken to scheduled visits to health clinics and social workers and health visitors could not obtain entry to the home when they called.

All of this suggests that child abuse reporting protocols with police, education and health professionals required in terms of s.7(2)(ba)(ii) of The Act may need strengthening, to educate professionals about avoidance and mobility issues with families in which abuse may be occurring and to emphasise the need to move determinedly when a physical threat to, or serious neglect of, a child under five years of age is suspected. One approach with the potential to save many lives and bring ongoing non-fatal abuse or neglect to notice would be a national database linking health professionals.

*Gender of victims*

The New Zealand pattern is consistent with the literature findings. Boys were only marginally more victimised than girls. Police recording does not include whether child victims were only children, or if not, their position in the family, so this study is
unable to draw any conclusions about these matters that appear in the literature. This is demographic data that may become available over time as the child mortality review process develops in this country.

Who are the people that kill children?

In all but five, or possibly six, of the ninety-one New Zealand cases that made up the 1991-2000 sample the perpetrator knew the child victim. This confirms the findings of studies that child homicide is predominantly an intra-familial phenomenon. The sample is not dissimilar from those in other studies in the high proportion of filicides. This study differs from an English study in that fathers committed the majority of filicides, a pattern consistent with that reported in Australia. Fathers and mothers are equally responsible for the homicide of children under 1 year, which differs from a study indicating much higher rates of women perpetrators with this age group. While the proportion of deaths attributed to de facto partners is relatively low overall, there is a marked difference between Maori and non-Maori children. De facto partners were involved in a third and one twentieth of the deaths respectively. However, it should be noted that de facto relationships may be more usual in Maori families. In traditional Maori society, marriage was automatically contracted when couples slept together (the word for marriage is moe, which means “to sleep”) and the marriage was governed and supported by strong marae etiquette, rather than legal contracts. As Maori moved away from their marae bases following World War II, they tended towards Western-style de facto relationships, many of which have proven to be unstable and transient.37

36 In four cases the relationship of the perpetrator to the child was unknown. In 3 of these cases, the child was under 3 years of age, making a stranger perpetrator less likely.
37 Comments noted in a personal communication with Rev Maurice Gray, Upoko ki Te Runaka Otautahi, 12 August 2004.
The Anglican Archbishop of Wellington who, in responding to the announcement of the death of a Maori child through abuse, gives support for this analysis:

This latest killing is an example of mobile and separated families living an isolated existence. The easy access to drugs and alcohol, combined with temporary and fragile adult partner relationships, has reduced stability in their households (Walters, 2000, p.20)

The data was limited, as one would expect, given its source. There was no information about:

- family income levels and employment;
- the extent to which violence had featured previously in the families;
- the mental health situations of perpetrators; and
- the age of perpetrators.

Thus key demographic concomitants with child homicide that feature in the international literature could not be tested in this sample. Further study would be required to determine whether filicide perpetrators are younger on average, poor, likely to have employment issues and possibly have a mental health problem, or that child homicide may be linked to other forms of violence in households.

Men committed the majority of the child homicides that were not filicide, a familiar international pattern.

*Cause of death*

The pattern of injuries causing death also conforms to other studies, with the largest group, comprising one third of cases, involving head injuries. This should be regarded
as a minimum figure as many records gave the cause of death in more general terms, such as “multiple physical injuries”, which in all probability included injury to the head. Death by battering accounted for almost half of the deaths.

All but two of the homicides involved forms of physical violence, as opposed to acts of omission or neglect. The perception that women are more likely to be passive perpetrators, or more likely to be involved with deaths resulting from neglect, is not supported by this study. However, they did exhibit a lower proportion of battering than men. Conversely, women employed suffocation, asphyxiation or strangulation at a much higher rate than men. A recent New Zealand study has found resistance to the notion that women can be sexual predators despite evidence to the contrary (Evans, 2004). This study challenges perceptions of women as nurturers less likely to be capable of violence towards their young.

Proportion of all homicides

Child homicides averaged 15% of all homicides over the decade. This is slightly higher than an apparent international average of 11%, but it is difficult to know whether there is any significance in the difference given the high level of generality of the international figures. Of interest to future research is whether there are significant average differences for Maori and non-Maori populations given the finding of this study. The Maori child homicide of 2.4 per 100,000 Maori child population equates to the child homicide rate of the US, which in turn has one of the highest general population homicide rates in the industrialised world. If the international pattern that high rates of child homicide reflect high rates of homicide in the general population
holds true, the high rate of homicide of Maori children should reflect a high rate of
homicide of Maori generally.

Prior involvement of child care and protection authorities

It is of interest that as many as 80% of child homicides in the period 1996-2000 were of children who were not known to CYFS. The New Zealand data contrasts strongly with that of American, Australian and English studies discussed earlier, which found proportions of cases with prior agency contact ranging from 25% to nearly 80%. However, some of this variation may be accounted for by counting issues in all four countries. This study confines the issue of contact to the statutory agency, CYFS, while in some overseas studies it appears a broader range of helping agencies has been included.

It is possible, though unlikely, that the New Zealand data represents a pattern of one-off violent episodes resulting in homicide, rather than homicide resulting from a pattern of abuse incidents with child victims. Only a comprehensive mortality review process could establish this definitively. In the event that these were not unpredictable episodes of violence in the main, the figures raise issues about how children undergoing or at risk of life-threatening attack are identified in families and communities and their situations made known to child protection authorities. It seems inconceivable that 38 deaths occurred over a five-year period as a result of unpredictable events. The increasing body of evidence that links spousal violence and violence towards children suggests that while the children and their families may not have had contact with CYFS, they may well have had contact with other professionals and agencies – police, women’s refuges, doctors, nurses, pre-school centres, and
schools for example. Thirteen of the children not known to CYFS in the 1996-2000 sample were of school age, and a further five were in the pre-school age group, but of course may not have been attending any facility. The figures suggest that child abuse reporting protocols in place with Police, schools, pre-schools, refuges and medical practitioners may need revisiting or revitalising. How, and how well, CYFS monitors the effectiveness of these protocols – a legislative requirement of the agency – may also be worthy of examination.

The child most at risk of homicide victimisation in New Zealand

The national data indicates that the child most at risk of death from maltreatment in New Zealand during the last decade was less than one year of age, male, and Maori. He was most likely to die from battering, sustaining head and other fatal bodily injuries inflicted by one of his parents. He was unlikely to have been known by CYFS prior to his death.

Conclusion

The quantitative aspect of this study has resulted in a portrait of child homicide in New Zealand in the most recent complete decade. It has established that while child homicide patterns in New Zealand are largely consistent with those described in other Western countries, New Zealand has not made the gains many other countries appear to have made in reducing this form of extreme violence towards children. It has raised worrying information about violence towards Maori children, which begs further inquiry and research.

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38 S.7(2)(ba)(ii) CYP&F Act 1989
These findings are useful, and lead us to discussion in Chapter 8 about the impact of family and community systems on child welfare, and child protection in particular. The quantitative analysis has, however, been unable to shed light on the functioning of the professional system, where this was working with children who subsequently died. Nor has it been able to illuminate whether there are issues in service management or design which impact of the capacity of the professional system to operate effectively. For these purposes, a qualitative study is necessary. The findings of a detailed analysis of the case records of 9 children involved with CYFS prior to their deaths between 1996 and 2000 are now reported in Chapter 7.
Chapter Seven

The Qualitative Findings: The Analysis of the Cases known to Child
Youth and Family 1996-2000

Having examined the size and shape of child homicide in a broad international and national context, the study now moves to a more detailed qualitative analysis of a small subset of the cases – those children who, at the time of their death, were known to CYFS. Because the children who died as a consequence of non-accidental injury constitute very small numbers (maximum 3 in any one year) a statistical analysis is neither useful nor appropriate. Alternatively, a qualitative case analysis has been used to illuminate the issues with respect to the child care and protection intervention processes. Qualitative analysis of written records provides access to a lode of information from which more subtle interpretations can be drawn (Liamputtong & Ezzy, 2005). This adds further richness to the information discerned from the statistical analysis.

While the quantitative analysis that has been used in the first part of this study has been useful in describing the phenomenon of child homicide in New Zealand, it has, by the very nature of the data recorded by Police, been focused on the family and to some extent, the community systems (the latter being related to reporting activity and stranger perpetrators in particular). The qualitative part of the study enables an analysis of the complex interplay of family, community, professional and organisational systems that can result in a tragic outcome for a child. In addition, this added dimension provides a means of informing professional and organisational systems about possible strategies to strengthen their responsiveness to children at risk.
There is a widespread public assumption that the children who die as a result of homicide will be known to CYFS, so that the low level of incidence of such prior contact disclosed by this study is somewhat counter-intuitive:

Table 7.1 - Homicides of children 14 years and under 1996-2000\textsuperscript{39} and numbers of these known by Department of Child Youth and Family Services prior to death.\textsuperscript{40}

<table>
<thead>
<tr>
<th>Year</th>
<th>All deaths</th>
<th>Known to CYF</th>
<th>% Known by CYFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>5\textsuperscript{41}</td>
<td>0</td>
<td>N.A.</td>
</tr>
<tr>
<td>1997</td>
<td>13\textsuperscript{42}</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>1998</td>
<td>8</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>1999</td>
<td>12</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>2000</td>
<td>9</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Totals</td>
<td>47\textsuperscript{43}</td>
<td>9</td>
<td>19.14</td>
</tr>
<tr>
<td>Average</td>
<td>9.4 per year</td>
<td>1.8 per year</td>
<td></td>
</tr>
</tbody>
</table>

It is difficult to gauge how an incidence of 1 in 5 in New Zealand lines up with experiences elsewhere, given the issues of counting and definitional imprecision and whether or not studies took a broad or narrow understanding of what constitutes a child protection agency. One source (Pecora et al, 1992) claims a substantial number of families in which these tragedies occur have been reported to or served by child protection services and there are estimates that as many as 80% of families will have come to notice. However, an Australian estimate of 1 in 4 families having prior contact with child protection authorities (Armytage & Reeves, 1992) gives some comfort that the finding of this study is not markedly abnormal.

\textsuperscript{40} DCYFS. (2003). Unpublished data.
\textsuperscript{41} One child was in the care of CYFS because of the injury that ultimately led to death. Prior to that injury, the child had had no contact with CYFS. This death was not included in Police statistics.
\textsuperscript{42} One death not recorded in Police statistics but recorded in DCYFS files
\textsuperscript{43} Includes two deaths not recorded in Police statistics
The sample

The number of reports CYFS received about each child, the reasons for each report and who made the report are set out on the following table:

**Table 7.2 – Number of reports; reasons for report(s); reporter and perpetrator details; and date of death – 9 children known to CYFS**

<table>
<thead>
<tr>
<th>Case</th>
<th>Report(s)</th>
<th>Reason for Report</th>
<th>Reporter</th>
<th>Perpetrator</th>
<th>Date of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>First: 29.11.96, Second: 11.03.97</td>
<td>Neglect, Neglect/welfare</td>
<td>Father, Court Worker</td>
<td>Father</td>
<td>09.09.97 aged 2 years 11 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>First: 24.02.97, Second: 14.08.97</td>
<td>Sexual abuse by father, Sexual abuse by father</td>
<td>Father’s ex partner, Rape Crisis worker</td>
<td>Father</td>
<td>10.09.97 aged 12 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>First: 13.08.97, Second: 19.08.97, Third: 25.08.97</td>
<td>Neglect, Physical abuse/neg., Neglect</td>
<td>Agency, Landlord, Grandmother</td>
<td>De facto father</td>
<td>09.02.98 aged 1 year 5 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>First: 08.09.97</td>
<td>Neglect</td>
<td>Agency</td>
<td>De facto father</td>
<td>08.06.98 aged 11 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>First: 13.08.98</td>
<td>Care Arrangements</td>
<td>Court</td>
<td>Father</td>
<td>16.12.98 aged 8 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>First: 19.07.96, Second: 23.01.97</td>
<td>Physical abuse, Care arrangements</td>
<td>Police, Court</td>
<td>De facto father</td>
<td>05.04.99 aged 4 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>First: 25.02.99</td>
<td>Neglect/welfare</td>
<td>School</td>
<td>Mother &amp; partner (F)</td>
<td>10.05.99 aged 6 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>First: 8.3.99, Second: 13.8.99</td>
<td>Physical abuse, Physical abuse</td>
<td>Hospital, Health Social Worker</td>
<td>Mother</td>
<td>20.08.99 aged 8 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>First: 17.12.99</td>
<td>Physical abuse/neg.</td>
<td>Agency</td>
<td>De facto father</td>
<td>12.01.00 aged 4 years</td>
</tr>
</tbody>
</table>
The sample description
The children were aged from 8 months to 12 years. Two were under one, and six of the nine children were under 5 years. Six were Maori and three Caucasian. Five were boys and four were girls. None of the children died as results of acts of omission, but rather all were killed by aggressive actions - five were battered, three stabbed and one was suffocated. These patterns in the small sample reflect those in the national statistics.

The majority of the ten perpetrators were men (n=7). Half were de facto parents, 3 were fathers; and 2 were mothers. Hence the children knew the perpetrators well in all cases. Five of the nine cases were filicide, 2 by mothers and 3 by fathers. The other four deaths occurred at the hands of the parent’s de facto partner, and in one other case a de facto male was jointly charged with the child’s mother for the homicide (hence the count of 10 perpetrators for 9 child deaths). Thus, in 5 out of 9 of these cases a de facto partner figured, a much higher level than the 18% involvement of de facto partners in the national sample. Case analysis shows that in none of these families did the child’s natural parents co-habit. In almost half of the cases (n=4) the child’s custodial parent had undergone a partnership change (in one case the resumption of a former relationship) in the recent months before the child’s death, and in three of these cases the new partner was the perpetrator. Of the remaining cases, two involved de facto relationships where the length of the arrangement was unable to be discerned from case data, and three cases involved sole parents. This finding might indicate that notifications alleging child abuse or neglect, where there has been a relatively recent partnership change or a partnership arrangement has ceased for the child’s custodial parent, should be responded to with some urgency.
The reports to CYFS

A total of 15 reports were received about the 9 children. One child had 3 reports to CYFS prior to death, four had two reports, and in four cases there was only the one report to CYFS before death occurred. The length of time between first report and death for the 9 children ranged from 26 days to 990 days. However, on average (excluding the extremes) the length of time was between five and six months.

The reports cited 19 causes of concern. Concerns about neglect, welfare and care arrangements dominated these, being cited in all but two of the cases. Physical abuse was cited in four of the nine cases. The dilemma for any child care and protection agency is how to rate the urgency of reports alleging neglect or expressing concerns about a child’s living environment, alongside those of outright physical abuse. There will be a tendency to respond first to the overtly physical episode, and rightly so. However, the fact that a number of these children were reported for concerns other than physical abuse but were clearly nevertheless at risk of physical harm, highlights the importance of focusing also on the dangers of unsuitable living or care environments, particularly for very young children. Over half of these children were the subjects of more than one report of concern about them and that the agency had contact with these families for 5 to 6 months on average. In no case was the agency able to read the signs that could have led to effective protective action on behalf of the children.

The majority of the reports were made by staff of professional or helping agencies (12 of the 15 reports), with the remainder made by family members. That so many of the reports about these children were made by professionals is some validation of CYFS
efforts to educate professionals about the signs and symptoms of abuse and of reporting pathways. However, the low level of family/friends input into moves to secure children’s wellbeing and safety is a concern, and the policy implications of this will be discussed in chapter 8.

The statutory social work process and the occurrence of homicide

The study established the key phases in the social work process in response to reports to CYFS of concerns about a child: intake; investigation and assessment; and intervention. None of the children died during the intake phase of the work. Three died during the investigation and assessment phase, and six died during the intervention phase:

Table 7.3: Incidence of child homicide in three social work process phases

<table>
<thead>
<tr>
<th>Social work process phase</th>
<th>Number of homicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intake</td>
<td>0</td>
</tr>
<tr>
<td>2. Investigation and assessment</td>
<td>3</td>
</tr>
<tr>
<td>3. Intervention</td>
<td></td>
</tr>
<tr>
<td>a. No further action required</td>
<td>1</td>
</tr>
<tr>
<td>b. Family/Whanau Agreement</td>
<td>2(^{44})</td>
</tr>
<tr>
<td>c. Guardianship Act</td>
<td>3</td>
</tr>
<tr>
<td>d. Family Group Conference Plan (or Court-ordered plan following a FGC)</td>
<td>0</td>
</tr>
</tbody>
</table>

In cases where homicide occurred during the investigation and assessment process the case reviews indicated that there was a tendency for investigations to drift without

\(^{44}\) A Family/Whanau Agreement was proposed in one case but the child died before it was implemented
reaching any substantive conclusion, and these may have been examples where taking little control was more dangerous than taking none at all (Reder et al, 1993). While services were provided, workers did not formalise their conclusions about the child protection concerns that formed the basis of the investigation. Common factors in these three cases were that there was: no recorded investigation plan; no formal risk assessment; and all demonstrated a lack of determined child protection action. In two of the cases there was no attempt to convene an inter-agency case conference when there was evidence that this was necessary, nor was there meaningful consultation with the Care and Protection Resource Panel.

Research suggests that the investigation of a report of child abuse is a time of heightened risk for the child or children concerned (Reder et al, 1993). This ought to be part of the lore of child protection work and worker awareness in this regard is critical. In the cases studied, the failure to act speedily and decisively left children in situations of avoidable risk. The failure to employ the Agency’s own risk assessment instrument is also of significant concern. The findings in relation to these 3 cases raise issues about the quality of child protection evidential training in the Agency, and about the quality of agency supervision practice.

The remaining deaths (n=6) occurred after intervention decisions had been made. Because there are a number of possible intervention decisions, it is useful to examine these in greater depth.

1. In one case, workers assessed that there was no need for ongoing services and the case was closed (no further action required). There was a cursory and
inadequate investigation that accepted assurances from family caregivers and school about safety and monitoring, which later proved to be unreliable. There was no attempt to verify information about family relationships that later proved to be erroneous and intended to deceive. There were two factors known to the investigating social worker that could have triggered a more in-depth investigation but did not. One was that the child had allegedly been conceived in rape and there was suggestion of mother rejection. The other was that the child appeared to be in an informal care-giving situation. Critical child protection processes were missed. The case was never referred to the Care and Protection Resource Panel, there was no formal risk assessment and there was no attempt to involve the wider family.

2. *In two cases, workers assessed that a Family/Whanau Agreement was an appropriate level of intervention.*

   a. In the first of these cases, an agency reported concerns of neglect and wider family members expressed concerns about the welfare of three children in the family. Two older children were taken into care but the infant who subsequently died was left at home. The social worker consulted with the Care and Protection Resource Panel, convened a professional’s case conference and held a family meeting at which a Family/Whanau Agreement was proposed and accepted. There was no formal risk assessment. The mother entered a new relationship, which was unknown to CYFS, and the child died within two weeks at the hands of the mother’s de facto partner. The last social work contact was four weeks
before the child’s death, but the review document did not clarify what
degree of contact was envisaged by the plan. The post-death case review
found that: the neglect issues were serious enough to warrant a family
group conference; early indications of domestic violence in the family
were never resolved in the investigation; and some indications that the
Family/Whanau Agreement was not working did not result in adjustments
to case direction.

b. In the second case, three notifications (one anonymous) to CYFS were
also about neglect and the failure to thrive of two young children. The
investigation was inconclusive and when the mother and children moved
to another part of the country the investigating social worker
recommended to the new district a Family/Whanau Agreement, but also
hinted at the possibility of a family group conference. The new district
social worker visited once, did not sight the children and this child died at
the hands of the mother’s de facto partner before any definitive action by
CYFS was underway. The subsequent case review determined that: the
notifications alleging major concerns should have triggered a critical
response; there was no written investigation plan; there was no formal risk
assessment; there was no engagement with the wider family; there was no
case conference held although a number of agencies were involved with
the family; the focus of the work was one-to-one with the mother; the
Care and Protection Resource Panel had not been consulted in relation to
the second and third notifications; and that overall the casework was
characterised by a lack of determined child protection focus. There were
some factors evident that should have raised worker anxiety about the welfare of these infants: The children were very young; their mother was in the process of relationship change; the mother was alleged to have talked of adopting out the child who died; and the mother moved to another district in the course of the investigation.

3. In three cases workers recommended or supported private law options under the Guardianship Act 1962, in preference to protection action under the public law provisions of the CYP&F Act 1989.

a. In the first of these cases, concerns about an infant’s living situation led to her being placed with her natural father (and his new partner) who indicated his intention to seek guardianship and custody under private law provisions. The father did not want ongoing social worker involvement and the case was closed when the father was granted interim custody and assurances were obtained from a health professional about regular monitoring of the situation. The child died at the hands of her father two weeks after case closure. The case review cited: a lack of decisive child protection social work; a failure to review and re-assess case direction for changing circumstances; there was no assessment of the father’s caregiving capacity; and there was an inadequate response in law to the child’s protection needs. Factors that could have led to a more determined intervention were: the young age of the child; the fact that the father was in a new relationship; the father’s resistance to social work assistance; the father reporting some management difficulties with the child; and the
father’s request for information about parenting courses and counselling. This was seen to be a case where all indicators pointed to the need for a family group conference.

b. In this case, the child was already subject to private law care provisions and the court asked a CYFS social worker to report on a parent application to resume custody.\textsuperscript{45} The child’s current custodial parent killed the child on the evening of the day the court agreed to a change of custody to the other parent and before the custody transfer was possible. While the social worker was seen to have acted professionally in this case, questions were raised about whether the information gathered by the social worker in reporting to the court was of sufficient concern to have warranted independent child protection action by the social worker, which the law permits. Such action would have transferred the matter to public law provisions and a family group conference would have occurred. Indications which might have led the social worker to such action were: the custodial parent’s history of mental health disorder; a comment from a health professional that the custodial parent’s condition was deteriorating; the perceived unreliability of the monitoring of the custodial parent’s mental health state by the child’s grandparents; and the inherent risks to the child of a sudden change of custody in these circumstances.

c. In this case, the de facto partner of a pre-school age child’s mother, who had previously been imprisoned for an assault on the same child, killed

\textsuperscript{45} A statutory duty pursuant to S.29 of the Guardianship Act, 1962
the child. At the time of the first assault, which led to the imprisonment of the perpetrator, social workers had encouraged the child’s grandmother to seek custody and guardianship under private law provision on their assessment that she had the strength to prevent further contact between her daughter and her imprisoned de facto partner. Social workers withdrew from the case, assessing the child was safe. The child died two years later. A national independent review criticised the lack of decisive child protection action following the first incident, assessing that there were more than sufficient grounds for a family group conference referral to have occurred and that CYFS was wrong to have ceased its involvement with this family when it did. It also criticised a number of other agencies and professionals for failure to share and consolidate information known to each of them. The correctional agency, for example, had ordered the man to live at the same address as the boy’s mother on his discharge from prison. The child had had more than 40 separate contacts with a variety of medical professionals in the space of two or three years, many of which were injury related. Factors that could have triggered a more decided public law response to this child’s situation were: the mother’s relationship with the perpetrator was interrupted by criminal justice proceedings against the perpetrator, not by her own decision; the perpetrator’s likely internment was effectively less than six months; the child’s future safety was reliant on the strength of a grandparent in the face of an abusive aggressive male; and CYFS’s own knowledge of this family network over a number of years.
Thus, six of the children known to CYFS died following an assessment outcome and a choice of other types of intervention or (in one case) a decision that no further action was required. This is a particularly worrying finding. In these six cases, agency professionals had investigated the matter and determined on a course of action that left a child vulnerable to ongoing abuse and ultimately death. In each of these cases, the agency failed to achieve a key outcome – the prevention of recurrence of abuse once it had intervened to ensure the safety of a child. The six cases involved children who arguably should have been referred for a family group conference. In at least two of the cases, there appeared to be grounds for Place of Safety warrant action,\textsuperscript{46} which would have also ensured the involvement of the Family Court.

While case review processes may always be discounted as wisdom after the event, it is important to note that the information reviewers accessed was information largely available to workers, or was information that would have been available if there had been a more diligent investigation.

In the case where no further action was determined as the appropriate response to the investigation, there were elements of worker accommodation to events, which would at least puzzle a non-professional and make them wonder about the child’s situation. This is a risk in the relentless activity of child protection work – that the unusual becomes commonplace and the bizarre is rendered normal. An effective antidote to this is regular clinical supervision that encourages reflection, re-interpretation and re-analysis of events.

\textsuperscript{46} S.39, CYP&F Act 1989
In two cases, workers decided to enter into a Family/Whanau Agreement as an appropriate response to what they had found. Both these cases centred about allegations of neglect and this may be significant. It is possible that neglect cases do not get the sort of decisive child protection response that may be needed in some situations. This raises questions about the role of, and need for, child protection responses within neglectful parenting situations. Monitoring a large sample of neglect cases past the point of assessment outcome to see what does happen with cases where significant neglect has been substantiated could be useful research activity.

The determination of three cases was by way of private family law options under the Guardianship Act, and in each case there was retrospective cause for concern about the choice of, or acquiescence to, this method of addressing evident care or protection issues. There might be more confidence in this course of action following a family group conference but it may present risks where information remains within a closed system because there has been no involvement of the wider family. In those circumstances, responsibility for controlling a potential abuser rests with the family member who has chosen, or been persuaded, to seek orders under the Guardianship Act 1962. Careful thought needs to be given to the use of private law options in matters of child protection. Statutory social workers need, perhaps, to eschew recourse to private family law when an abuse or neglect allegation is substantiated, even when, and possibly especially when, the matter is already before the Family Court as a result of a custody or access dispute between parents. Social workers have investigation powers and responsibilities independent of the involvement of the Family Court. Statutes are clearly delineated in their thinking about a child’s protection needs and private law options through the Family Court are not primarily
designed for responding to child protection requirements. Deference to the involvement of the Family Court and to such officials as Counsel for the Child may result in social workers not discharging their own duties professionally, an example of the effects of exaggerated hierarchy referred to by Reder et al (1993). Statutory social workers need to be confident in their role and responsibilities within the context of the Family Court, and in the specialist nature of the CYPF Act, which may offer a more suitable response to child protection need.

The cases illustrated a number of factors that warranted determined child protection action by social workers. These were:

- The child was very young and there was evidence of abuse injury;
- There was evidence of, or information possibly indicating, the mother’s rejection of the child;
- The reported concerns were about an informally arranged care situation;
- There was unresolved information about previous domestic violence in the child’s care-giving situation;
- Informal plans to secure the child’s safety were seen not to be working;
- The custodial parent or parents had a history of mental health instability which was not currently professionally monitored;
- There was a proposal to institute a custody change between the parents as a result of mental instability in the parent relinquishing custody;
- A child’s safety was reliant on its mother not resuming a relationship with the child’s abuser where she has not been the instigator of the separation;
• The child’s safety was reliant on the ability of a sole family caregiver to prevent perpetrator access to the child;
• There was an agency history of involvement with the family network about cases of neglect and/or abuse.

All of these will raise a red flag for an experienced child protection worker. As CYFS reports problems with frontline retention and inexperience, it must ensure that its supervisors at least are skilled and competent in these areas of practice and that supervision of inexperienced workers is occurring.

There were four aspects of the statutory process that were free of child death tragedy in the period.

1. *No child died during the intake process or prior to case allocation.* There has been much concern reported in the New Zealand news media, about the number of unallocated cases held by CYFS at any one time. Unallocated cases are created when the time for a recommended response to the report has expired and it has not been possible to allocate a worker to the case. The matter rests with an Intake supervisor who is required to allocate resources according to priority and must regularly assess unallocated cases against new intake to determine an appropriate response queue. This is a form of services rationing accepted, somewhat reluctantly, in the health arena but regarded as unacceptable by media in relation to child care and protection reports. While this is not to say that children on the unallocated list are not at risk, this study
provides some confidence in the CYFS management of unallocated cases, at least in as far as it is not resulting in cases of child homicide.

2. *No children died pending a statutory review of their cases.* While there is a statutory requirement for reviews of plans, and it is one of the processes on which CYFS’s performance is judged, the Agency has never performed highly in this area.\(^{47}\) Nonetheless, the poor management of this part of the statutory process does not appear to have constituted a risk in cases where homicide has occurred.

3. *No child died while under a CYP&F Act care or protection order of the Family Court.* This would indicate that, at least in relation to child homicide, children in care were at less risk than those for whom other options were chosen.

4. *No child died of non-accidental injury following the holding of a family group conference.* This is an interesting result. At least in the case of interventions relating to non-accidental injury, it would suggest that the family group conference has been effective in providing safer plans and outcomes. Given the family group conference has become a central feature of the New Zealand child protection response, from a practice perspective this finding is important and merits particular discussion.

\(^{47}\) Personal knowledge
The Family Group Conference

Significantly, the case reviews relating to several of the children who died lamented the failure to involve family more widely both in increasing the number of people with knowledge about the abuse being sustained by a child and increasing the number of potential protective agents within the child’s social and familial contexts.

In each case, reviews found there was sufficient evidence warranting a family group conference, but social workers chose not to intervene at all in one case and in the other five, intervened in ways that proved inadequate in relation to the child’s needs for protection and care. The New Zealand child care and protection system has checks and balances designed to highlight situations of risk for children. This study indicates that these were by-passed in a number of cases that ended in tragedy. The low level of use of the statutory provision for decision-making and planning resolution – the family group conference – is a worrying situation. Social workers chose to work informally or sought private law outcomes in preference to the specialist provisions of the CYP&F Act 1989. Family group conferences were not convened when there was ample evidence to suggest that they should have been.

This decision point is important. The referral for a family group conference pursuant to S.18 of the CYP&F Act triggers a number of things:

1. Another professional, a Care and Protection Coordinator becomes involved;
2. The Coordinator undertakes a family network search and engagement in preparation for a family group conference;
3. There is a mandatory requirement that the Coordinator consult with the local Care and Protection Resource panel, another chance for the panel to consider the case;

4. Where the Family Court is already involved, a Counsel for the Child will be appointed to work with social work and other professionals and ultimately to advise the court on the child’s best interests;

5. A family group conference is empowered to arrive at any decision, recommendation or plan (as is appropriate in the circumstances) to protect a child and to provide for its care;

6. Family group conference plans are monitored and reviewed.

When social workers choose not to invoke these provisions they deny, in effect, the child’s access to other professional expertise, to wider family involvement and support and to the protection of the court where this is necessary. Although the sample group of children in this study is small, the findings suggest that greater use of the family group conference may well have proved a safer path to follow for these children.

The family group conference process has become well known internationally, and is perceived as characterising the New Zealand approach to child care and protection. Because social workers are required by law to refer children considered to be in need of protection for a family group conference, there is a risk that any failure of the child protection system may be ascribed to the family group conference process. This research corrects any misconception that the family group conference has been a
contributing factor in the child’s lack of safety in situations of child homicide in New Zealand.

**Professional error**

Because professional error has been identified as an important component in child homicide situations, it was important to examine whether professional errors were evident in the management of these cases. The results are reported below:

Table 7.4: Incidence of professional error disclosed in 9 case reviews

<table>
<thead>
<tr>
<th>Activity</th>
<th>Professional error</th>
<th>Incidence</th>
</tr>
</thead>
</table>
| **Intake**       | • Intake social worker underestimates seriousness and does not accept report for investigation  
                  • Response category allocated by intake social worker is too low in relation to intake facts  
                  • Social worker underestimates seriousness and does not investigate | 0         |
| **Investigation**| • Child not sighted within time set by response criteria  
                  • Child does not have identified protector after initial contact by social worker  
                  • There is an inadequate, or no, investigation plan  
                  • SAT protocol not initiated in cases of alleged serious physical or sexual abuse and critical information is not accessed  
                  • Social worker does not consult with CPRP and critical information is not accessed  
                  • Professional case conference not held where indicated and critical information is not accessed  
                  • There is a lack of decisive child protection action | 2 1 6 2 4 5 5 |
| **Assessment outcome** | • Information gathering is deficient and RES is not used in arriving at assessment outcome  
                              • Assessment outcome is less than the minimum necessary to secure the safety and well being of the child  
                              • Insufficient or poorly organised information is presented to FGC or Court  
                              • Child’s interim placement is not properly vetted | 8 5 1 3 |
In a further three instances, an evident lack of knowledge about what constitutes a child protection risk contributed to a minimisation of the concerns. In these cases, there was evidence of mother rejection relating to the mothers’ reports of lack of feelings for a child conceived in rape in two cases and a mother’s communication to others that she was thinking about adopting out the child, in the third case. Adding these three errors to those above, a total of at least 58 professional errors were evident across the 9 cases, an average of 6 to 7 professional errors per case. One case exhibited 11 errors, another 10, and the range was 4-11 errors.

The number of professional errors evident in the analysis of cases is a sobering finding. In some cases, there seemed to be not only an absence of professional know-how but also of elementary common sense. Again this raises questions about the degree to which more senior and experienced supervisors were monitoring or overseeing practice. There was a deadly cocktail of practice error evident – a mix of poor preparation and planning for an investigation, a failure to consult and case conference, poor information gathering and risk assessment, and dangerous decision-making – not only about what intervention was necessary, but about how that decision was to be made.
It may be tempting to regard the presence of such practice errors as predictive of ultimate fatality and their elimination as preventative of further tragedies. However, it is difficult to assess the impact of practice error while research into practice risks within the context of non-fatal cases of severe child abuse remains underdeveloped. This study does highlight the need for greater knowledge about professional practice activity and its relationship to child abuse fatalities.

**Organisational risk**

The case reviews contained comments by reviewers of internal (CYFS) or external environmental factors that in their opinion impacted negatively on casework and case management. An analysis of these factors emerged as follows:

<table>
<thead>
<tr>
<th>Environmental factor</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td></td>
</tr>
<tr>
<td>· The management of after hours reports</td>
<td>1</td>
</tr>
<tr>
<td>· Inappropriate work allocation</td>
<td>1</td>
</tr>
<tr>
<td>· The management of case transfers</td>
<td>1</td>
</tr>
<tr>
<td>· Office staffing below strength due to vacancies/absences</td>
<td>2</td>
</tr>
<tr>
<td>· Office workload management issues</td>
<td>4</td>
</tr>
<tr>
<td>· Issues relating to role clarity between social workers and supervisors</td>
<td>1</td>
</tr>
<tr>
<td>· Inter-team communication</td>
<td>1</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
</tr>
<tr>
<td>· Inter-agency communication issues</td>
<td>2</td>
</tr>
<tr>
<td>· Geographical distances</td>
<td>1</td>
</tr>
<tr>
<td>· Care and Protection Resource Panel performance</td>
<td>1</td>
</tr>
</tbody>
</table>

Reviewers assessed a range of environmental factors that contributed to practice failure. Two reviews recorded no environmental issues, three recorded one, two recorded two, and one case recorded no less than 5 factors that were seen to inhibit effective casework.
This data emanating from the study must be regarded as indicative only. Case reviewers were not explicitly directed to identify and report on any environmental issues that may have impacted on the effective management of a case. That they did so in some cases is testimony to their prominence in particular cases, but a more purposeful inquiry would have undoubtedly unearthed many more issues. One case was particularly severely affected by at least five environmental concerns that were seen to inhibit effective professional response. The most pervasive of the concerns across cases (n=4) was that of workload management issues for that particular office.

It is interesting that in many international child death reports interagency collaboration and cooperation featured prominently as factors in the tragedies. In this study it was identified as a factor in only two of the cases. Again, it is important to note the limitations with respect to the gathering of this information. Nevertheless, further research would illuminate the issue.

In summary

Summarising the findings, 20% of child homicides were of children who were known to CYFS prior to their death, and on average, two children known to CYFS died each year. Professional and agency staff made the majority of the reports. Men were the predominant perpetrators in this sub-group, and de facto partners were perpetrators in 5 of the 9 cases. Five were cases of filicide and in 4 cases a de facto partner of one of the child’s parents was the sole perpetrator. More than half of the cases (n=5) had more than one report to CYFS before their deaths. Deaths generally occurred within 5 to 6 months of first report to CYFS. Concerns about neglect and care arrangements dominated the 15 reports made about the 9 children.
No deaths occurred during the intake and allocation process. The investigation and assessment process was a time of risk for 3 children, but the majority (n=6) of the children in the sample died following assessment and choice of an intervention path by a social worker. The interventions chosen fell short of public law care and protection provisions and failed to involve wider family in planning for safety and care. There were no homicides concurrent with social work intervention once a family group conference had been held or the child was subject to a Family Court order.

There were on average between 6 and 7 practice errors evident per case, with a range of 4 to 11 practice errors. Environmental factors impacted negatively on 7 of the 9 cases, and severely in one case.

Having now looked at both the broader issues relating to child homicide, and the more specific issues relating to the children that were known to CYFS, Chapter 8 will integrate the findings from the quantitative and qualitative components of this study. In the concluding chapter of the thesis we will examine the interactions of family, community, professional and organisational systems around the children who died and discuss the implications of the study for policy, practice and research in child welfare and child protection.
Part 3: Integrating the Findings
Chapter Eight

Discussion

The Implications for Policy, Practice and Research

Chapter 1 proposed a systems perspective as a useful method of analysing the various contributing factors to child homicide. Such an approach builds knowledge that can be applied to improve child care and protection practice and, additionally, enables identification of elements of systems that could be changed to improve outcomes for children. Supporting this systemic approach, this final chapter now integrates the study’s findings within a thematic conceptual framework of family, professional, organisational, and community influences. It is important that, in a search for interventions to reduce the incidence of child homicide, governments and agencies do not limit their focus to any one factor – an individual family member, the family itself, or a particular worker deemed responsible for the case. The complexity of these cases demands a broader analysis that includes also an examination of environmental factors and the contribution agencies themselves make to professional endeavour that results in a tragic outcome. Hence, an exploration of the interconnectedness of systemic factors provides the potential for richer insights into the nested reality of the child within the family, and within the supportive community. The chapter concludes with a discussion of the implications for policy, practice and research.

Family Influences

As the majority of child homicides are filicide, and most of the remainder occur within a child’s care-giving situation, family influences are a major factor in child deaths. There are indications in the literature that families in which serious child
abuse occurs display some common characteristics – youthfulness of parents; low educational attainment, relationship instability and spousal violence; and multiple stressors affecting adult functioning in the households. Minority and poor families are over-represented in child homicide statistics internationally, although cautions are also given about class and race biases evident when these statistics are analysed.

This study has been unable to confirm these characteristics in the New Zealand sample, other than the over representation of Maori as victims and perpetrators in the statistics. The concentration of Maori does lend some weight to the likely presence of elements such as poverty and multiple stressors affecting households – Maori people’s health, life expectancy, per capita income and employment status are all inferior to the Caucasian population (MSD, 2002) and they had suffered disproportionately in terms of increasing poverty as the result of the New Zealand economic reforms of the 1980s and 1990s (O’Brien, 2001).

Although many families displaying indicators of negative indices of wellbeing will be safe and nurturing environments for children (MSD, 2004), the presence of these indices in families that do abuse can guide the design of helping services, and also give important impetus and direction to social policy interventions that support families. There is enormous potential for things to go wrong when those things that mould families are also significant stressors in their lives.

While the numbers are small overall, it is noteworthy that, of the 15 reports of child welfare concerns made to CYFS in relation to the 9 homicide victims with whom it had had contact, only 3 were made by non-professionals, indicating a possible
reluctance of family to report concerns about child safety. Walters (2000) speculates that shame will prevent many Maori from disclosing such family problems as incest, violence and drug taking. The claim is that secrecy in families and secrecy of families has an influence in perpetuating family conditions that constitute a danger to very young children. However, this needs to be balanced against Departmental statistics that during the fiscal year 2000/01, family friends and neighbours made 40% of all notifications about child concerns to the Department, and other research that indicates family do, indeed, report (Worrall, 2001). However, neither of these sources throws any light on whether there are differences in reporting behaviour between Maori and non-Maori.

The common experience of family disruption and transition in the small case sample of children known to CYFS raises issues both with respect to inter- and extra- family support. The pattern of family instability evident in the sample, when viewed alongside the findings of studies which depict caregiver perpetrators of homicide as being young, not well educated, poor, prone to depression and likely to be facing multiple stressors in their lives, is likely to impact on the attachment and bonding of children to a significant degree.

Good outcomes [wellbeing, attachment and resilience] are achieved through positive parenting, a stable family life, strong family and kin relationships, community involvement and supportive social networks (Connolly, 2004, p.8).

The situation of unstable families may be exacerbated by the increasing isolation of families, particularly young Maori families, from traditional collective child-rearing arrangements. Intergenerational child-rearing responsibilities gave support to young

\[48\] CYFS unpublished information.
parents, but also provided alternative avenues for children to receive the love and nurturance necessary for their healthy development. Children rejected or poorly treated by their natural parents could find safe haven within the context of their whanau. While intergenerational caring still occurs in Maori households to a greater degree than it does in non-Maori households (MSD, 2004) many young Maori adults with child-rearing responsibilities may be alienated from the civil society of the whanau, hapu, iwi and without the compensatory effects of any alternative civil society of equivalent value.

The study notes that while the proportion of de facto partners who were perpetrators of child homicide in New Zealand was somewhat below that reported in other studies, in the smaller case sample they figured in over half the cases (n=5). This would appear to be at least partly related to the number of Maori in the sample, and may indicate that when these two factors coincide with a report of neglect and/or physical abuse of a child, a more determined examination of the stability of the child’s living environment needs to occur. Coupled with this, a more urgent approach to sharing information with wider family/whanau could strengthen protections around the child.

**Professional Influences**

The professional system did seem to fail in significant ways the small number of homicide victims with whom it was involved. There was significant incidence of error, with failures in process, in decisiveness and in knowledge. Better practice may have ameliorated some of the negative family impacts these children were enduring.
This study brings renewed emphasis to the child protection maxim that workers should never work alone. Throughout the cases analysed, there was a failure to: identify and engage wider family networks around the household experiencing problems; consult meaningfully with Care and Protection Resource Panels; convene inter-agency meetings or case conferences to extend the information necessary for good decision-making; and to engage in reflective dialogue with a competent supervisor. By choosing not to initiate a family group conference, it could be argued that social workers cut their clients off from lines of support and help within their kith and kin network. By failing to use the tools and supports made available as integral elements of a safe child protection system, they also cut themselves off from the systems designed to foster safe practice.

Statutory child care and protection social work is risky business. It is carried out in the most intimate and sensitive parts of family life. It is fraught with anxiety, uncertainty, misleading or incomplete information and secrecy. It challenges adult behaviour and adult concepts of child ownership, and evinces strong reactions and negative stances towards workers. Social workers need courage to persevere when faced with aggressive, passive or avoidant behaviour from caregivers responsible for children’s welfare. They need a solid understanding of such things as violence in intimate relationships, and the situations of women and their children in unstable and unpredictable domestic environments. They need awareness of the signs and symptoms of abusive relationships and behaviour and the manifestation of these in children. They need detailed knowledge and understanding of child protection and care law and the ability to steer clear and logical pathways through the legal options they have. They need to know how to investigate reports, gather information and
determine courses of action based on systematic and comprehensive analysis. They need to understand family and community systems and be able to engage these in helping families identify their strengths and determine how they might become strong in relation to protecting their most vulnerable members. That social workers involved with the families of children who died seemed to lack basic professional knowledge, worked narrowly within relatively closed systems that did not engage wider family perspectives and supports, and acted outside of established procedures, indicates a need for a rethink about the sorts of organisational supports they require.

Few of the critical components of effective child care or protection practice are deliverable through management prescription or edict. Rather, they represent elements of the “art” of the work. Management and reporting regimes focussed on counting and monitoring volumes and processes will not of themselves improve child care or protection outcomes. Indeed they may contribute towards organisational and professional climates that place undue performance pressures on front line workers in areas of little relevance to good child outcomes. Social workers in statutory practice need a solid social work education and extensive agency training in critical processes. They need the resources and the mandate to broaden the scope of their work. They need the confidence and the resources to work collaboratively and flexibly with families, communities, and partner agencies and professionals. They need to have regular access to competent and reflective supervision with supervisors who themselves are “experts” in this area. They need to work in stable organisations in which structure, work processes and resource management are aligned and directed to achieving good outcomes for children and families. These appear to be the investment requirements for safe and sound child welfare work.
Organisational influences

New Zealand social policy and social work literature relating to the 1990s incorporates discourse on the negative impact on professional systems of the economic and state restructuring reforms of Government (Cheyne et al, 1997; O’Brien, 2001; Connolly, 2001; Doolan & Nixon, 2003). Organisations also reacted to serious cases of professional error by imposing constraints on discretion and judgement and placing increasing reliance on procedural prescription (Connolly, 2004; Doolan & Nixon, 2003). There is evidence that, despite the family preservation philosophy underpinning New Zealand child welfare law, a combination of ideological, organisational and community factors steered professional focus towards residual, forensic models of practice (Connolly, 2004). This case sample study illustrated strongly, the residual nature of the services investment in the families concerned. In no case was there evidence of a whole-of-family perspective, of wide family involvement in identifying issues and planning solutions or of service provision that incorporated the building of a strong supportive relationship over time between the family and the responsible professional. Rather, there seemed to be a readiness to either close or divert cases quickly or to offer low levels of service, which later appeared to have been minimally implemented. The workers seemed poorly equipped for the task, through a mixture of busy-ness, poor knowledge and, by inference at least, inadequate reflective supervision about case direction and outcomes.

Although not demonstrated by this research, professional bureaucracies do seem to be in an unenviable position. Established to provide a service framework within which
front line endeavour may be supported and managed, they are also subject to the rules relating to public management and expenditure control. The imperatives of each sometimes compete. For example, responding to a front line request to reduce recording and reporting to enable more time to be spent with clients has to be balanced with the competing system demand for more detailed accounting of front-line activity against expenditure. This is not an uncommon dilemma for agency heads in the current state environment. In the cases sample, a number of workers reported work overload as a significant issue in the management of particular cases.

These matters impact on professional activity and ultimately affect outcomes for children and families. Case reviews regularly noted the organisational pressures under which staff laboured, even though there was no specific invitation to reviewers to enquire into such matters. Endemic restructuring, chronic resource shortages, burgeoning and unmanaged demand increases, and waiting lists all affected the outlook and energy of staff. These are distractions that affect professional behaviour and performance, and as such they contribute another ingredient to that recipe of risk to vulnerable children.

How organisations respond to professional error when it occurs will be an important element in how staff feel about their organisation. Disclosure of near misses and deviant operations will not readily occur where professional personnel fear blame and retribution as consequences. Promoting a sense of corporate responsibility and ownership of professional error (Laking, 2004) and rewarding disclosure as responsible professional behaviour could have the effect of changing the current
culture surrounding the investigation of case activity at the time of a child homicide occurrence.

**Community influences**

The relatively low levels of prior involvement of CYFS with children who are homicide victims raises the question of how communities support and monitor families for their safety and wellbeing. As discussed in Chapter 6, professionals will not, by and large, be in a position to monitor and report concerns about the children most vulnerable to homicide – those under 5 years of age. If children of all ages are to be protected from the risk of physical abuse, which may on occasion lead to their death, then community ownership of this matter seems essential. In chapter 2, reference was made to the possibility that the sorts of values held by communities can influence abusive behaviour within those communities (Belsky, 1980). It could be argued that two values that have currency in New Zealand that work against community ownership developing readily. One is the belief that physical disciplining of children is a parental right with which the state should not interfere; and the second relates to the notion that what happens in families is a family’s business and essentially a private matter.

Law\(^{49}\) that allows parents to use reasonable force in chastising their children tends to support these values. Challenges to: the reasonableness of this law; its allowance of a form of violence against children not permitted against adults; its contribution to the notion that children are chattels of their parents and not individuals with rights distinct from those who rear them; have yet to engender any change. The provision seems an

\(^{49}\) S.59, Crimes Act 1961.

This study confirms that very young children are being severely physically assaulted to the point of death. Nevertheless, non-fatal physical abuse of a child rarely results in a criminal prosecution in New Zealand. Between 1996 and 2000, CYFS investigations substantiated 8974 instances of the physical abuse of children while the same period saw only 1,616 convictions for violence towards children (Doolan, 2004). This represents something less than one conviction for every five episodes. Despite the wide range of organisations seeking repeal of the Section 59 provision (EPOCH, 2000) the Government has chosen a path to community education and awareness raising in preference to an outright ban at this point in time.

Nine countries have an outright ban on the use of corporal punishment and a further two have effectively rendered the practice illegal through decisions of their constitutional courts (EPOCH, 2000). Seven of these countries appear on the list of the 27 developed countries whose records on child maltreatment deaths were assessed by UNICEF (2003). All occupy positions significantly better than that of New Zealand, with six occupying positions in the top 12 countries overall. Shaping behaviour through public awareness programmes takes time. In ten years, probably a minimum time period for such change to become evident, a further 90 or more children may have had their lives cut short, with up to half of those dying as a result of body battering.
The belief that what happens in families is private and should not be interfered with is likely to affect decisions about whether or not to report child abuse to authorities. There can be no worse censure of one’s performance as a neighbour or friend than the accusation of “busy-body-ness” and most people will want to avoid that charge. There is evidence in a Danish study that families held back on expressing their concerns about a child (Rasmussen, 2002). In this study the majority of family members attending a family group conference related having had previous concerns about a child in their family network. Interestingly, it was the family group conference that provided a means by which they were able to reveal concerns they had previously kept to themselves.

Community attitudes and beliefs clearly have enormous potential to impact on children’s welfare.

**Implications for policy, practice and research**

The study highlighted a number of issues that beg a policy, practice or research response. In shedding light on some aspects of child homicide in New Zealand, the study also illuminated gaps in our knowledge.

**Implications for policy**

The study has noted and sought to understand, the hugely disparate homicide rate of Maori children. What is happening in some Maori families – increasing isolation and distancing from whanau, hapu, iwi support systems; drug and alcohol dependence; relationship instability; and poverty – is unlikely to be addressed by social policy that addresses the needs of the community as though it was a homogeneous entity. Maori
need is quantitatively, and may be qualitatively, different, and the difficulties they face in redressing social and economic disadvantage have proved remarkably resistant to bureaucratically designed helping services. The present New Zealand climate is somewhat unsympathetic to Government initiatives targeted to Maori. Yet Maori have proved largely impervious to social programmes currently in place and fresh innovative policies are required. Government attempts to address social and economic condition of Maori through a number of programmes and services using collective, rather than individual, intervention models are either in the design stage or have not yet been evaluated (apart from the Family Group Conference) (MSD, 2004). Statistics indicating a worsening situation for Maori in the area of child homicide suggest a greater need for Iwi and urban Maori involvement in the design and delivery of initiatives for their communities. How to develop civil society for young Maori in their urban environment, equivalent in its meaning and supportiveness to that once available through whanau, hapu, iwi associations, is a significant policy challenge.

Similarly worrying is the country’s present approach to the physical disciplining of children. The current policy choice allows the exercise of parental physical discipline as a defence against a charge of assault, but seeks to dissuade caregivers from the use of physical force by means of public education. Given the links between excessive physical force and death revealed in this study, the policy choice tolerates a level of child homicide during the years it will take for public attitudes and caregiver behaviour to change. An alternative policy approach might be for the Government to forge a new social consensus on this issue. In a sense it is an argument about rights. It may be possible to promote the notion of a social contract with the people of New Zealand whereby the majority who represent the least threat of physical violence to
their children agree to relinquish their “right” to chastise physically in order that the minority who are a risk are more easily identified and contained. In this way, the right of children to be free from gratuitous violence might be achieved.

This research has brought new focus on the vulnerability to physical abuse of children under the age of 5 years. Because pre-school enrolment is voluntary, it is likely that the professionals most likely to have contact with these children in the first 5 years of their life will be medical practitioners – those in general practice and those in hospital accident and emergency clinics. There is no present means by which medical practitioners can access patient records on a national basis, and thus no means of viewing current injuries in the light of past occurrences when parents choose different practitioners for different events. This study gives support to the notion of a national database linking health professionals providing services to children. This might be a more productive investment for Government in ensuring the safety of children than the Child Protection Registers used in the United Kingdom, for example. By being an integral part of medical service delivery, the former will contribute directly to safer practice, while the latter may only give the appearance of doing so, as it is not compulsory for medical personnel to consult the register in every case.

Child welfare organisations will remain under intense public scrutiny. This study suggests that the current approach to investigating child deaths, focussing on the actions or omissions of individuals, fails significantly on a number of counts. The process generally fails to satisfy the public or the media. It can be perceived as punitive by staff and result in defensive, risk averse practice. It largely ignores the organisational contexts within which workers operate, and does not give due weight to environmental and situational impacts on child protection work. The approach does
not foster an environment that enables free and frank disclosure of risky professional activity in order to promote child and worker safety, new learning and improved practice. The future may lie in developing error management capability in child welfare organisations of the sort that exists elsewhere where there is a high risk of operator error. The challenge for child welfare administrations will be to move from a systems of punitive accountability when mistakes occur to systems that reward disclosure of intentional or unintentional departure from accepted operating procedures and promote accountability based on taking responsibility and learning from mistakes.

Implications for practice

Neglect and care concerns about a child may not attract the level of professional response in New Zealand that this study suggests they require. This is seen to be a risk when child welfare agencies become fixed on the highly forensic and intervention focussed work of child protection. Although the physical and sexual abuse of children tends to receive priority attention in terms of child welfare response, it could be argued that chronically poor and neglectful living environments for children, with all the risk of cognitive and emotional retardation and reduction of life chances that these can entail, will have a more life-course persistent impact on them. The danger in according a lower response criterion to reports of neglect is evidenced by the fact that in this study, the majority of reports to CYFS about children who subsequently died related to their care needs. In a significant number of these cases also, the principal caregiver had undergone a relationship change, and the principal caregiver’s de facto partner killed over half of the children. Of the nine children known to CYFS, six were less than five years old and three were less than one year old. Case reviewers
determined that in four of the cases, intake workers assigned a response category to the notification that was less urgent than the content of the notification suggested.

A practice implication for the agency might be the desirability of according all reports about children less than five years of age a similar priority, regardless of the nature of the report itself. The very vulnerability of a child of this age and the known lack of specificity of many reports, suggests that a report about a child less than 5 years old should always be regarded as serious unless an initial investigation determines otherwise.

Children under 10 years of age require some particular focus as well. This study would indicate at least a very urgent response to any report of physical abuse, non-accidental injury or neglect relating to a child between the ages of 5 and 10 years, regardless of the nature of the report itself.

In the CYFS sample of 9 children, three died during the investigation and assessment process. Investigation or assessments were characterised by drift and a lack of decisiveness by workers. Sometimes, workers appeared to move into service provision without ever satisfactorily reaching a conclusion about the initial report about the child. The statutory agency might well consider placing some time boundaries around the investigation and assessment process, so that it becomes a time-limited process or one for which there is mandatory supervisory review at regular intervals. This might be especially important for children less than ten years of age. A time allowance of no more than 28 days before mandatory supervisory review would convey a sense of urgency and focus to workers and families alike.
The family group conference is the core of the New Zealand approach to child protection. However, this study indicates that either the gateway to this process is too closely guarded by the state agency’s social workers (possibly as a means of informal workload control or the perception that resources are not available to pursue cases through this route) or that there is simply poor decision-making at critical times with critical cases. A departmental estimate\(^{50}\) is that only 11% of those investigations that assess there is substance to the report and there is need for further action, proceed to a family group conference. This could mean that social workers and their supervisors are giving greater priority to, or have more confidence in, their own decision-making and planning skills than they have in the family group conference process. Alternatively, as Coordinator numbers have not increased since 1989,\(^{51}\) a form of gate keeping access to the family group conference as a means of managing workload may have been occurring.

Extended family participation in decision-making has been identified as a key factor in improving placement outcomes for children and their families (Doolan and Nixon, 2003). There is also some evidence that once family members become aware of safety issues for children they themselves move strongly to protect children from further abusive experiences (Worrall, 2001). In the light of these and other studies, it is perhaps surprising to see that social workers in New Zealand use the process so sparingly. Given the family group conference has the potential to offer increased protections for both children (in terms of harnessing the family and professional systems toward safe decision-making) and professionals (through broader monitoring  

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\(^{50}\) Personal communication from Neil Cleaver, National Manager, Coordinator Services, DCYFS, Wellington, NZ, January 2004.  
\(^{51}\) As above.
and review processes) one would have thought that referrals would be made more often. After all, it is a legitimate outcome of a family group conference that there is no need for care and protection for a particular child, but in such cases, it is not the social worker acting unilaterally who reaches this determination, but the statutory body convened to determine the case.

The statutory agency cannot require social workers to refer children and their families for a family group conference. To require a worker to believe that a child is in need of care or protection is clearly outside the provisions of the legal scheme. However, CYFS can make workers aware of the dangers of attempting to resolve care and protection concerns, especially with very young children, by means of informal or private law provisions. Where intervention is deemed necessary in cases where physical abuse, non-accidental injury or serious neglect has been reported in relation to children under 10 years, research findings from this study encourage the referral of children and their families to a family group conference, in preference to the use of Family/Whanau Agreements or the encouragement to families to initiate private law arrangements. The agency also needs to ensure that the pathway to the family group conference is not blocked by organisational barriers such as inadequate budgeting for convening conferences or insufficient resources to facilitate the realisation of plans.

In 1994, an amendment to The Act included two new duties for the Chief Executive of CYFS. The first of these is to promote by education and publicity in the community at large, an awareness of child abuse, its unacceptability and prevention, the need to report it and how to report. The CYFS “Breaking the Cycle” campaign in

52 S.7 (2)(ba)(i) and (ii)
the second half of the 1990s, resulted. This featured television, radio and print media advertising, as well as many local events focussing on the issue of child abuse. These local events were facilitated by CYFS Community Liaison Social Workers, a role established to enable the Chief Executive to discharge the duty locally. It is not possible to know whether these initiatives influenced the reduction in the proportion of Maori child homicides that occurred in the latter part of the decade. However, this research suggests that at least with the child homicide cases known to CYFS, there was a relatively low level of family members reports (n=3) in the 15 reports. This provides some support for a renewed focus on public education. The public awareness programme appears no longer to be funded and is certainly not evident in New Zealand media today. It may be timely therefore to revisit this issue, and once again reinforce the notion of family and community responsibility in terms of children’s safety.

The second new duty of the Chief Executive is to develop and implement protocols for agencies, governmental and non-governmental, and professional and occupational groups in relation to the reporting of child abuse, and to monitor the effectiveness of these. This study would also suggest a need to revisit the child abuse reporting protocols that have been developed, particularly with professional groups most likely to have contact with children less than five years of age. A revision of the protocols needs to centre on issues of child vulnerability; the co-incidence of various types of violence in families; the co-incidence of concerns about neglect and living environments with the physical abuse of children; and the characteristics and “closure” behaviours of families where violence is present. How, and how well, the department monitors protocols for their effectiveness may also be an issue. The rigour
with which the department monitors programmes that derive from the duties of the
Chief Executive may be as important to the integrity and effectiveness of the child
care and protection system as the supervisory monitoring of practice referred to
earlier.

Implications for research

Improving data collection is critical to future research on child homicide victims.
Child mortality review processes in the US have demonstrably improved the
coordination of data collection amongst agencies. In New Zealand it is difficult to find
information about child mortality risk and incidence. The developing Child Mortality
Review programme under the auspices of the Ministry of Health is a hopeful start.
Eventually, this programme should be able to determine the true level of deaths of
children that have resulted from maltreatment. In developing an understanding of the
risk factors that contribute to a higher likelihood of serious or fatal abuse, the
programme will need to establish a capacity for gathering data on a wider range of
socio-economic factors than are collected officially now. These include: family
income levels; family structure; housing adequacy; employment; household violence;
criminality; the age of perpetrators; and the mental health status of caregivers who
abuse. Research also needs to investigate issues relating to children with disability
and any association between disability and child homicide. Isolating critical
characteristics of caregivers who cause death through maltreatment is also important.
The literature, for example, records that such caregivers may be younger on average
than caregivers reported for non-fatal abuse. Studies could also help explore the
associations between poverty and multiple stressors in a family, and child homicide.
There is clearly much research potential with respect to the neglect of children. The literature suggests that neglect is the most under recorded cause of maltreatment fatality (Pecora et al, 1992). The US has devoted energy and resource to this area, and in 2002, more than 38% of maltreatment fatalities in the US were attributed to neglect alone. This compares to a figure of less than 2% (n=2) of deaths being attributed to neglect alone in Police statistics in this country. Neglect and care issues dominated reports about the 9 children with whom CYFS were working prior to their death, yet all died of violence. Although this study represented a very small sample, clearly, there is a need to better understand the connections between poor child rearing and care, and violence. Monitoring a large number of neglect cases over time could result in useful outcome data addressing these issues.

It was not possible to explore the coincidence of child homicide with private law custody and access disputes in this study. It nevertheless remains a difficult issue in practice and presents an important area for future research. One of the CYFS cases that did involve a custody struggle between the child’s natural parents indicated something of the vulnerability of younger children in these circumstances. The Police statistics contain what appear to be eight instances of multiple homicides by a caregiver, which may be linked to adult relationship breakdown and possibly private law proceedings. None of these 8 instances involved CYFS. Coincidence of homicide with private law proceedings may prove to be of more relevance than its coincidence with child care and protection actions.

The case studies of child homicide victims who had had involvement with CYFS indicate some particular avenues for further inquiry about agency practices, such as:
• The capacity of Family/Whanau Agreements and private law proceedings to address care and protection concerns in non-fatal abuse cases;

• An analysis of which cases are being referred to family group conferences and which are not, and determining how this critical decision point is affected by issues of worker belief and knowledge and agency resources and guidance;

• Determining whether practice errors in cases of fatality are present in matched cases that did not have a fatal outcome;

• Longer term outcome studies in large numbers of cases, particularly related to worker choices of intervention.

There has been limited attention to outcome research generally in the New Zealand child welfare system. This is of critical importance and needs to be addressed if we are to better understand the efficacy of practice interventions within child care and protection processes.

Finally, this study raises a research possibility in relation to the broader population – how child homicide is linked to other forms of domestic violence, and in particular, how child homicide rates are linked to adult homicide rates in the community. This later question may be of particular importance to Maori. If the finding (UNICEF, 2003) that countries with the highest levels of child homicide also have the highest levels of adult homicides holds true, then this phenomenon should be detectable in the Maori population in New Zealand, as the child homicide rate in this sub-population ranks amongst the highest in the Western world.
Conclusion

This study has shown that children were more vulnerable to death by maltreatment in New Zealand during the period 1991-2000 than they would have been in almost any other country of the developed world. Further, Maori children were almost three times more likely to become homicide victims than New Zealand’s non-Maori children. Someone responsible for their care killed most of the children who died. Community, professional and organisational systems were unable to respond in ways that could have prevented their deaths.

That ninety-one children had lives too short is a responsibility we all share.
References


## Appendix 1 - Child Homicides – 14 years and under\(^{53}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Victim age</th>
<th>Victim sex</th>
<th>Ethnicity</th>
<th>Death by</th>
<th>Relationship of offender</th>
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<td>2</td>
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<td>Maori</td>
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</tr>
<tr>
<td></td>
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<td>Head injury</td>
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<td>Suffocation</td>
<td>Mother</td>
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<td>11</td>
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<tr>
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<td>Stabbing</td>
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<td>Head/body injury</td>
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\(^{53}\) NZ Police (2003).
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<td>Caucasian</td>
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