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Trends in the fatal assault of children in NSW: 1996-2005 NSW Child Death Review Team

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Previous special reports published by the Child Death Review Team

- *Systemic issues arising from child deaths involving parental substance dependence* (Part C of the 1998–99 Child Death Review Team Annual Report)
- *Fatal Assault of Children and Young People (2002)*
- *Suicide and Risk Taking Deaths of Children and Young People (2003)*
- *Fatal Assault and Neglect of Children and Young People (2003)*
- *Sudden Unexpected Deaths in Infancy: the New South Wales Experience (2005)*

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Introduction

The purpose of the Child Death Review Team (the Team) is to help prevent or reduce the number of deaths in New South Wales of children and young people aged 0-17 years. One of the ways the Team does this is by monitoring and reporting on trends and patterns in the deaths of children and young people in New South Wales.

This report forms part of a larger exploratory study of trends in the deaths of children and young people aged 0-17 years in New South Wales in the ten year period 1996–2005 and the factors that might have influenced those trends. This is the first time the Team has provided information of this type. Previous reports of the Team have provided a description of the deaths that occurred in the reporting year, or a description of the deaths from a particular cause over a number of years.

Statistical standards appropriate for an exploratory investigation have been used. While the statistical significance of particular findings is noted in the report, the level of this significance should not be confused with the importance or relevance of the findings.

The Team prepared this report on deaths of children from assault before the remainder of the study so that the information would be available for consideration by the Special Commission of Inquiry into Child Protection Services in New South Wales.

Messages from this study

- **There was no evidence of an increase in the likelihood of the deaths of children from assault in recent years**

- **The deaths of children from assault are relatively rare**

The number of children who die from assault is small accounting for only 1.4 per cent of all the deaths of children over the ten year period 1996 to 2005.

- **Nearly 60 per cent of children come from families with a child who had been the subject of a report to Department of Community Services within three years prior to the death**

This means that, while the majority of families whose children die from assault come into contact with the child protection system, more than one assault death in three occurs in a family with no contact with that system.

- **The greatest difference in incident rates was found for age and Aboriginality**

We found that the risk of death by assault for children less than one year old is 16 times more likely than for those aged five years or older; for those children aged one year old death is six times more likely; and for those children aged two to four years old death is four times more likely.

The risk of death by assault for Aboriginal children is four times greater than that of non-Aboriginal children.

Description of child deaths resulting from assault

A death was included in this study if it concerned a child under 14 years and resulted from beating, burning, drowning, pushing, shaking, stabbing, shooting, poisoning, suffocating, strangling or other physical means. Two children in the 14-15 year age group are included in this study because unlike other fatal assaults for children 14 years and older, their deaths occurred in the context of a familial relationship (See Appendix 1: *Definition of child deaths resulting from assault*, for a more detailed discussion).

Over the period 1996 to 2005, 96 of the 6,879 children and young people whose deaths were registered in NSW, died in these circumstances (1.4%).

The overwhelming majority of the fatal injuries were known to be inflicted by parents, spouses or domestic partners or other family members (95.8%). The fatal injuries of the remaining children were inflicted by carers such as acquaintances or friends, or persons unknown to the children.

Toxicology undertaken to inform autopsy revealed evidence of drug ingestion in 11 of the 96 assault deaths. Benzodiazepines, which have strongly sedative properties, were found in toxicology for four of the children. Three, including two infants and a 2-4 year old, had traces of methadone. One, an infant, had measurable blood alcohol levels (0.040-0.059gm/100ml). Methamphetamines were found in the toxicology of one of the infants. Three had paracetamol in their blood which was not used in resuscitation efforts. Drugs that might have been present as a result of the treatment of the primary causes of death have not been included.

Demographic characteristics of the child and family

Demographic information about the deaths of the children is presented in Table 1.

Table 1 Demographic information for child deaths from assault			
		Number	Per cent
		96	100
Sex			
	Female	39	40.63
	Male	57	59.38
Age group			
	<1 year	33	34.38
	1 year	13	13.54
	2 to 4 years	26	27.08
	5 to 9 years	15	15.63
	10-13 years	7	7.29
	14-15 years	2	2.08
Aboriginal¹		12	12.5
Vulnerable²		54	56.25
Disabled		1	1.04
Outside NSW		1	1.04
Within NSW with known usual residence			
	Socioeconomic background ³		
	Low SES	38	40
	Middle SES	34	35.79
	High SES	23	24.21
	Remoteness ⁴		
	Major cities ⁵	43	45.26
	Inner regional ⁶	40	42.11
	Outer regional ⁷	10	10.53
	Remote and very remote ⁸	2	2.11

1 Further details on how this demographic characteristic has been measured and used in analysis is provided in the forthcoming report by the Team.

2 The definition of vulnerability used in this report is where a child, or a sibling, had been reported as at risk of harm to the Department of Community Services within the three years prior to their death. A risk of harm report may relate to the child's basic physical or psychological needs not being met; carers not arranging necessary medical care; physical or sexual abuse or ill-treatment; serious physical or psychological harm due to the presence of domestic violence in their household; or serious psychological harm from parent/caregivers behaviour toward the child.

3 For this report the ABS Index of Socioeconomic Disadvantage was used but reduced to three categories to facilitate reporting and interpretation. Children living in the bottom third of the ABS measure (those who are the most disadvantaged) are classed as Low SES, those in the middle third are classed as Middle SES, and those in the top third (those who are least disadvantaged) are classed as High SES. *Low*, *Middle* and *High* have to do with relative location within the distribution of socioeconomic disadvantage and do not necessarily describe socioeconomic disadvantage in an absolute sense.

4 The geographic remoteness categories are commonly used in statistical reporting, and usage here follows that of the ABS.

5 Major cities is a category in the ABS geographic remoteness categories. Examples include Sydney, Queanbeyan, and Newcastle. Examples of SLAs coded as primarily in major cities include Camden, Penrith, Mosman, Liverpool and Parramatta.

6 Inner regional is a category in the in the ABS geographic remoteness categories. Examples of SLAs coded as primarily in inner regional areas include Hawkesbury, Dubbo, Lake Macquarie, Maitland, Tamworth, Lismore, Albury, Wagga Wagga and Ballina.

7 Outer regional is a category in the ABS geographic remoteness categories. Examples of SLAs coded as primarily in outer regional areas include Gunnedah, Kempsey, Inverell, Cooma-Monaro, Parkes and Coonabarabran.

8 Remote and very remote are categories in the ABS geographic remoteness categories. Examples of SLAs coded as primarily in remote areas include Balranald, Warren, Walgett, Hay and Moree Plains (e.g. Collarenebri). Examples of SLAs coded as mostly very remote include Bourke, Lord Howe Island, Brewarrina and Cobar.

Of the 54 children identified as vulnerable, nine (17%) were Aboriginal and 33 (61%) were male.

Many of the children lived in families where there were ongoing issues associated with violence, crime, drug and alcohol abuse, and mental illness. The presence of domestic violence could be definitively determined in the families of 50 per cent of the children, other criminal behaviour in the families of 38.54 per cent, drug and alcohol abuse in the families of 37.50 per cent, and mental illness in the families of 33.33 per cent. One of the issues examined was evident in 31.25 per cent of the families; two issues in 16.68 per cent of the families; three issues in 21.88 per cent of the families; and in 7.29 per cent of the families, all issues were evident.

Relative likelihood of death for children with specific characteristics

Table 2 shows the incident rate ratios (IRR) within each demographic factor considered. IRR allow consideration of differences in the likelihood of dying from assault within each demographic factor (see Appendix 2: *Understanding the statistics used in this report* for more information about IRRs).

For this purpose, age groups have been further collapsed, with all those aged five years and above now grouped together. Remote and very remote areas have also been grouped with outer regional areas.

The statistically significant findings are for age group and Aboriginality (see Table 2).

- Infants are 16 times more likely to die from assault as 5-15 year olds, one year olds are nearly six times more likely, and two to four year olds are four times more likely to die from assault.
- Aboriginal children are four times more likely than non-Aboriginal children to die from assault.

The other findings here are that:

- children living in high SES areas are only 70 per cent as likely to die from assault as those living in other areas; and
- males are 38 per cent more likely to die from assault than are females.

Table 2 Incident rate ratios for demographic groups used in trend analysis

	Crude mortality rate per 100,000	IRR	Standard Error	LRT	p value
Compared with Females	0.57			2.25 (1)	0.134
Males	0.77	1.377	(0.463)		
Compared with Low SES	0.73			1.90 (2)	0.387
Middle SES	0.73	0.993	(0.234)		
High SES	0.53	0.723	(0.191)		
Compared with Major cities	0.62				
Inner regions	0.74	1.199	(0.263)	0.68 (2)	0.711
Outer regions/remote	0.67	1.089	(0.356)		
Compared with 5-15 year olds	0.24				
Infants	3.85	15.77***	(4.230)	104.85 (3)	0.000
1 year olds	1.40	5.726***	(2.025)		
2 to 4 year olds	0.99	4.068***	(1.151)		
Compared with Non Aboriginal	0.61			8.46 (1)	0.004
Aboriginal	2.37	3.910***	(1.208)		

+ p < 0.10 * p < 0.05 ** p < 0.01 *** p < 0.001

For assistance in interpreting these statistics see Appendix 2: *Understanding the statistics used in this report*

Overall trends in child deaths resulting from assault

The highest rate of death from assault was of 0.92 deaths per 100,000 in 2003. The lowest rate was of 0.35 deaths in 2002 (see Table 3).

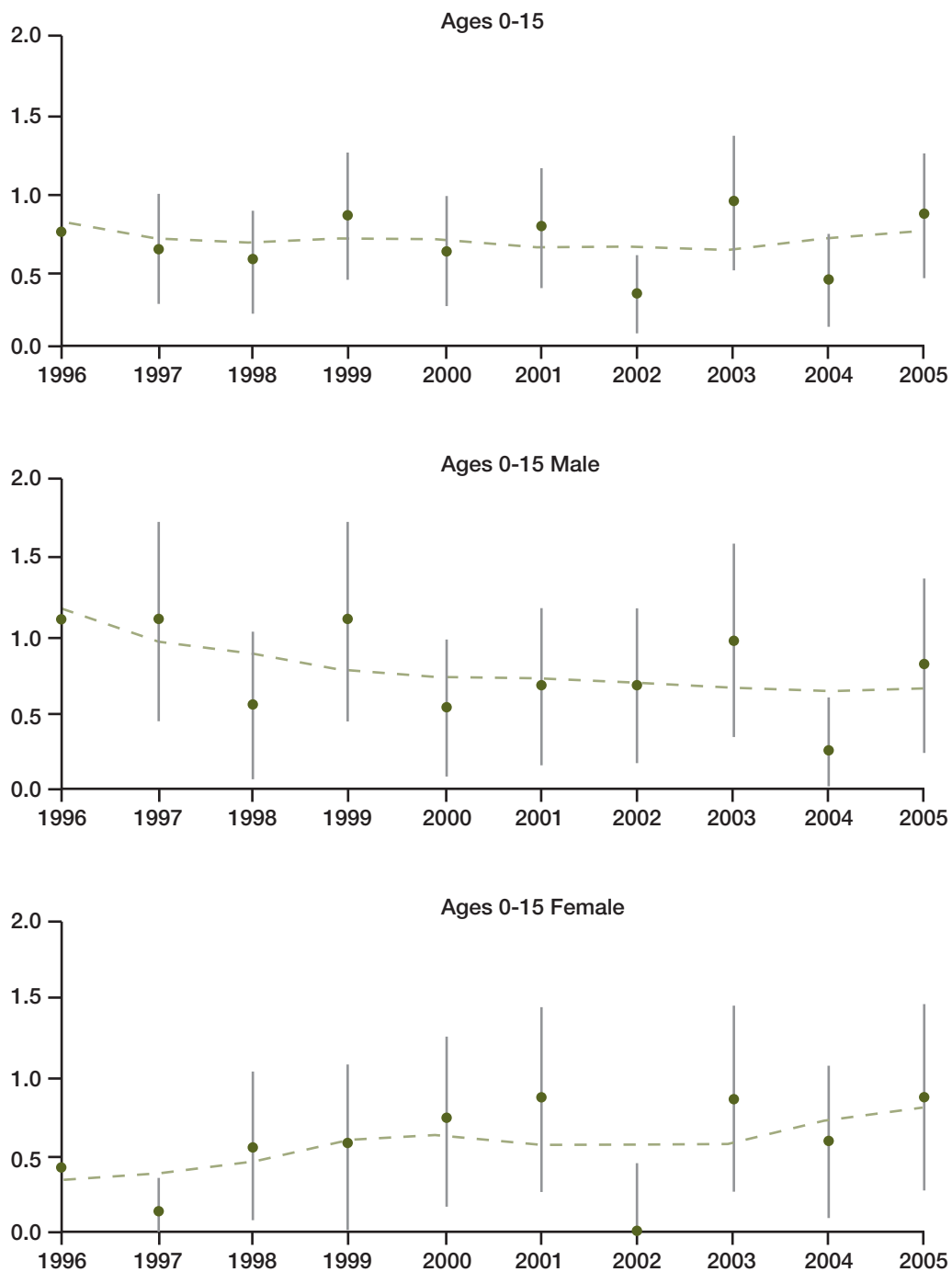
There is no discernible trend in deaths from assault over the ten-year period. Mortality rates between the first five-year (1996-2000) and the second five-year period (2001-2005) were also compared. There was no noticeable difference in mortality rates between them (see Figure 1).

Table 3 Crude and directly standardised mortality rates with confidence intervals, by sex and year

Year	Population	Number of Deaths	Crude Mortality Rate	Directly Standardised Mortality Rate	Lower Confidence Interval	Upper Confidence Interval
Persons						
1996	1397080	11	0.79	0.78	0.39	1.16
1997	1406408	9	0.64	0.63	0.29	0.98
1998	1411692	8	0.57	0.56	0.23	0.88
1999	1417819	12	0.85	0.84	0.44	1.24
2000	1425293	9	0.63	0.63	0.28	0.97
2001	1432236	11	0.77	0.77	0.39	1.15
2002	1430132	5	0.35	0.35	0.09	0.61
2003	1422930	13	0.91	0.92	0.5	1.34
2004	1421063	6	0.42	0.43	0.14	0.72
2005	1421373	12	0.84	0.85	0.44	1.25
Male						
1996	715721	8	1.12	1.1	0.46	1.74
1997	720549	8	1.11	1.1	0.46	1.74
1998	723362	4	0.55	0.55	0.1	1.01
1999	726521	8	1.1	1.09	0.46	1.73
2000	730697	4	0.55	0.54	0.1	0.99
2001	734319	5	0.68	0.68	0.18	1.19
2002	733522	5	0.68	0.68	0.18	1.18
2003	730517	7	0.96	0.97	0.37	1.57
2004	729627	2	0.27	0.28	0	0.6
2005	729959	6	0.82	0.82	0.27	1.37
Female						
1996	681359	3	0.44	0.43	0.02	0.84
1997	685859	1	0.15	0.14	0	0.38
1998	688330	4	0.58	0.57	0.1	1.03
1999	691298	4	0.58	0.58	0.1	1.05
2000	694596	5	0.72	0.72	0.19	1.25
2001	697917	6	0.86	0.87	0.28	1.45
2002	696610	0	0	0	0	0
2003	692413	6	0.87	0.87	0.28	1.45
2004	691436	4	0.58	0.59	0.1	1.07
2005	691414	6	0.87	0.87	0.29	1.46

Note: Rates have been standardised using the 2001 Australian census population age profile.

Figure 1 Directly standardised mortality rates from 1996 to 2005 with confidence intervals and smoothed trend line, for all deaths and by sex



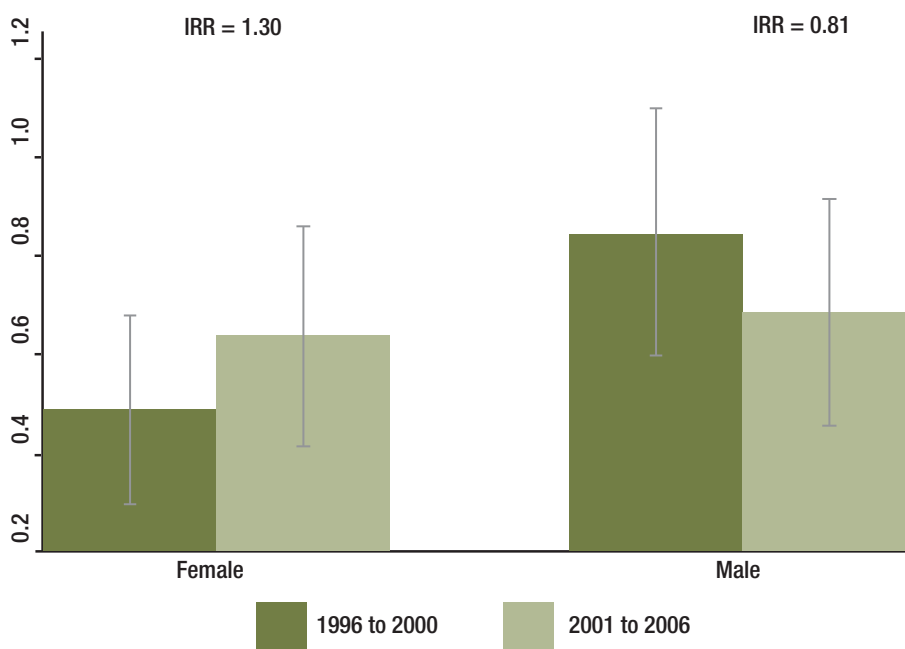
Rates have been standardised using the 2001 Australian population age profile

Demographic characteristics associated with trend

Further analysis was undertaken to determine if sex, relative socio-economic disadvantage or geographic remoteness were associated with differences in mortality rate due to assault when comparing the two five-year periods, 1996-2000 and 2001-2005. The numbers of Aboriginal deaths were too small to allow for analysis between the two periods.

As seen in Figure 2, for males, deaths from assault in 2001-2005 were approximately 80 per cent lower than in 1996-2000 (IRR = .812 CI: .479-1.375). For females, however, such deaths were 30 per cent higher (IRR = 1.303 CI: .766-2.216) (see Appendix 2: *Understanding the statistics used in this report*, for a discussion of confidence levels).

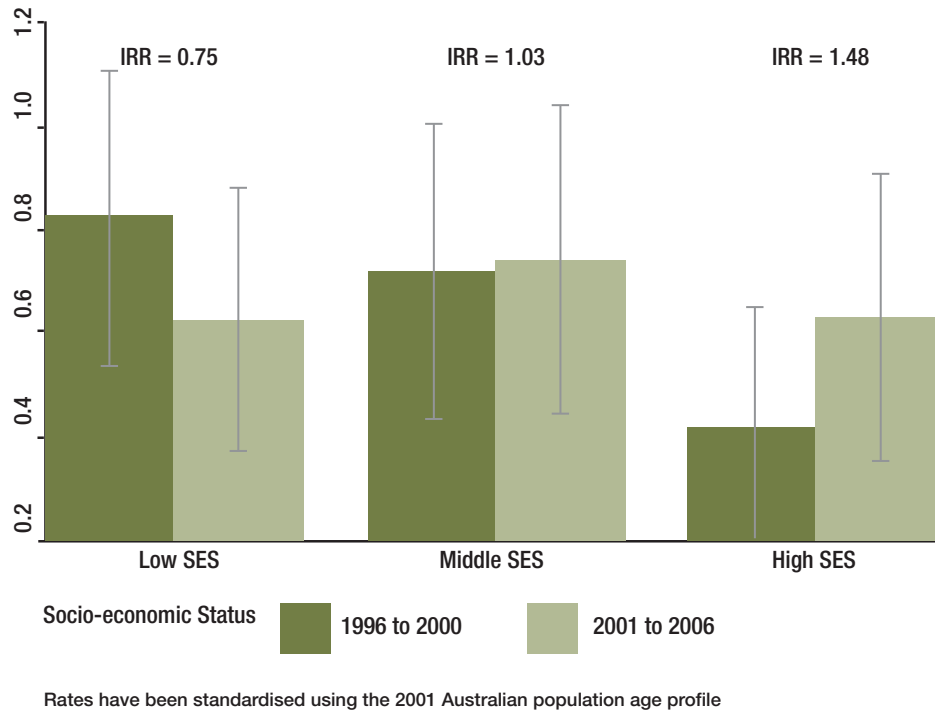
Figure 2 Directly standardised mortality rates for two periods, from 1996 to 2000 and 2001 to 2005, by sex



Rates have been standardised using the 2001 Australian population age profile

As seen in Figure 3, changes in deaths from assault between 1996-2000 and 2001-2005 appear to vary by socioeconomic group.

Figure 3 Directly standardised mortality rates for two periods, from 1996 to 2000 and 2001 to 2005, by socioeconomic status

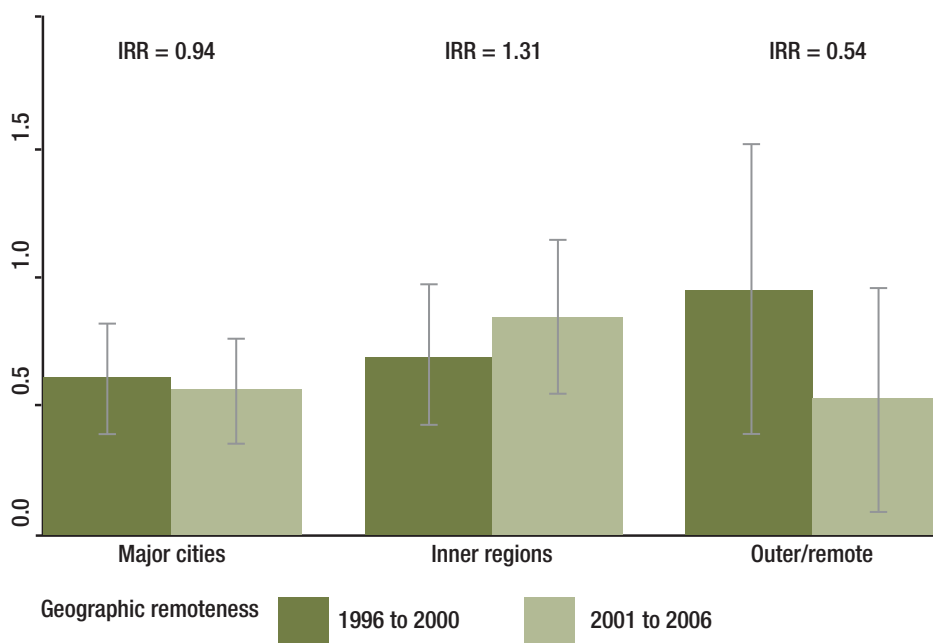


For those living in Low SES areas, the likelihood of death from assault has declined by 25 per cent (IRR = .753 CI: .438 – 1.292).

For those living in Middle SES areas, the likelihood of death from assault has remained almost constant (IRR = 1.030 CI: .586 – 1.811).

For those living in High SES areas, the likelihood of death from assault has increased by 48 per cent (IRR = 1.483 CI: .734 – 2.995).

Figure 4 Directly standardised mortality rates for two periods, from 1996 to 2000 and 2001 to 2005, by geographic remoteness



Rates have been standardised using the 2001 Australian population age profile

For those in major cities the likelihood of death from assault decreased by approximately six per cent between the two periods (IRR = .938 CI: .568 – 1.550).

For those in inner regional areas the likelihood of death from assault increased by approximately 30 per cent between the two periods (IRR = 1.307 CI: .729 – 2.345).

For those in outer regional and remote areas the likelihood of death from assault decreased by approximately 45 per cent between the two periods (IRR = .543 CI: .198 – 1.479). While the numbers may be small in this group the finding seems to indicate a change in these areas.

The influence of vulnerability on the change between the two periods could not be examined as the necessary data was not available to the Team at the time of reporting. Table 4 shows the number of deaths of vulnerable children by year, which is the best that can be considered under this circumstance.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Deaths of vulnerable children	7	3	2	6	7	6	2	12	1	8

The number of deaths of vulnerable children appears to vary by chance, and caution needs to be exercised in drawing any conclusion: the number of deaths is likely to swing up or down in what may be a random manner. A drop in numbers for any particular year need not indicate an improvement, just as an increase in numbers in any particular year need not indicate a worsening: rather they reflect the erratic nature of such deaths.

Conclusion

The deaths of children from assault are rare in NSW, accounting for only 1.4 per cent of all the deaths of children and young people aged 0-17 over the ten-year period 1996 to 2005.

The demographic factors most strongly associated with these deaths are age group and Aboriginal identity. The younger the child, the greater the risk of dying from assault: children under one year old are 16 times more likely to die from assault as five to 15 year olds. Aboriginal children are four times more likely to die from assault than non-Aboriginal children.

Examined overall, both across the ten years of the study period year by year and when compared into two five-year periods (1996-2000, 2001-2005), there is no discernable change in these fatalities.

There are some apparent differences between the two periods when further considering changes by demographic factors.

- For males, deaths from assault in 2001-2005 were approximately 20 per cent lower than those in 1996-2000, while for females they were 30 per cent higher.
- While deaths from assault appear to have declined by 25 per cent for those living in relatively low SES areas, they have remained constant for the middle group and they have increased by 48 per cent for relatively higher SES areas.
- While for those children living in inner regional areas the likelihood of death from assault increased by approximately 30 per cent, in outer regional areas and major cities the likelihood of death decreased (45% and 6% respectively).

These findings should inform further research activity. In turn, this helps with prevention efforts by increasing the knowledge base about factors that may influence trends in fatal assault of children.

Fifty-six per cent of the deaths of children by assault concerned children identified as vulnerable. Population figures are not available to the Team to calculate their mortality rates and how these compared with non-vulnerable children. The numbers of these deaths, however, appear to have swung erratically across the ten-year period. Where interventions are made to prevent these deaths, an extended follow-up time period is needed to test their effectiveness, as any apparent immediate improvement could be due simply to the erratic nature of these deaths.

Appendix 1: Definition of child deaths resulting from assault

The Child Death Review Team has undertaken two studies examining the deaths of children and young people due to assault, *Fatal Assault of Children and Young People* (2002) and *Fatal Assault and Neglect of Children and Young People* (2003). These studies reviewed the deaths of 100 children and young people aged 12 to 17 years in the period January 1996 to June 2002 that were registered in New South Wales.

From this work the Team has developed a research category to allow it to continue to monitor and report on these deaths. The category is made up of the following ICD-10AM⁹ cause of death codes under the sub chapter heading Assault: X85 to X99, Y00 to Y05, and Y07 to Y09 as the underlying cause of death or an associated cause. (The ICD-10AM code Y06 – neglect and abandonment is excluded). For these ICD-10AM death codes to be assigned the International Statistical Classification of Diseases and Related Health Problems 10th revision, requires the injuries inflicted by another person to have occurred with the intent to injure or kill. In addition the Child Death Review Team includes a small number of deaths where the intent cannot be established but the circumstances are highly suggestive of intent. In this study there were two deaths of this type. For this reason, the number of deaths resulting from assault reported here will not be consistent with other state or national data.

The Team's previous research identified a need to distinguish different kinds of fatal assault: those occurring in the context of familial relationships and those occurring in non-familial contexts, the latter predominately concerning teenage altercations. Deaths which result from teenage violence appear to have a distinctive risk profile and a perspective other than child abuse is required. Familial assaults can be further distinguished into deaths occurring in particular contexts such as family breakdown, mental illness.

Appendix 2: Understanding the statistics used in this report

The *Commission for Children and Young People Act 1998* requires the Team to monitor trends and patterns in the deaths of children and young people in New South Wales. The purpose of the monitoring is to help identify problems, and the populations affected by them and their location with the ultimate aim of undertaking better prevention.

Monitoring trends is a multi-stage process. It starts with identifying issues and the populations affected using exploratory techniques. Increasingly rigorous methods are then applied to better identify and specify the dimensions of the problem and the populations at risk.

The Team has maintained the New South Wales Child Death Register from 1996. Over the ensuing period the Team has developed an extensive data holding covering the children and young people whose deaths are registered in New South Wales. Thus it is now possible to begin exploring whether there have been trends in these deaths and the factors that might have influenced those trends.

This report is the first time the Team has provided information of this type. A fuller explanation of the methods used in it is provided in the Child Death Review Team *Trends in Child Deaths in NSW: 1996-2005* report (forthcoming).

This report is primarily aimed at determining differences in the likelihood of dying from assault across a ten year period using standards appropriate for an exploratory investigation: differences by time period and differences in time period by demographic factors.

9 International Classification of Diseases Australian Modification

A challenge when undertaking surveillance of mortality for children and young people, particularly at the level of particular causes of death, is that death can and should be a rare event. Rare events pose particular problems for statistical analysis, and many consider such events beyond the scope of current statistical techniques.

With small numbers of deaths there is a risk that problems will be identified that are later found not to exist. There is also a risk that problems will not be identified when they do exist, or differences in the risk of a problem for particular groups will not be identified when it does.

The Team's obligation is to examine trends to try and prevent deaths of children therefore it needs to acknowledge the statistical challenge of small numbers but not abandon its effort to monitor deaths and their distribution. As a result the statistical analysis in this report aims to identify possible issues, not exclude their possibility by requiring standards that are more appropriate to later stages of the surveillance process.

Consequently the confidence level for all analysis has been set at 90 per cent, rather than the more common 95 per cent. Where a finding has statistical significance at a confidence level of 90 per cent or above, that is indicated with the results, as per the note to Table 2: that is, at the 90, 95, 99 and 99.9 per cent levels.

The error estimates used are calculated in the most appropriate ways for the actual data being analysed and are all statistically robust estimates (i.e. calculated using Huber-White Sandwich estimation)¹⁰.

To describe differences in the likelihood of dying from assault across a ten year period, incident rate ratios (IRR) are calculated. IRRs are estimates of the ratios of the mortality rates adjusted for age (the IRRs for the age groups are ratios for age specific rates). As all but two deaths from assault during the period applied to those aged 0-14 years these IRRs are calculated specifically for those in that age range. A ratio has a numerator and a denominator, where the denominator provides the baseline for the comparison.

Where the mortality rates are the same, the IRR will equal 1. Where a mortality rate is less than that of the comparison group, the IRR will be less than 1, being the proportion of the comparison group mortality rate. Where a mortality rate is greater than that of the comparison group, the IRR will be greater than 1. An IRR of 2 means that the mortality rate is twice as large as that of the comparison group – or 100 per cent larger.

IRRs have been calculated using count regression procedures appropriate for data characterised with small and rare counts, including inflated zeros.

IRRs are subject to errors in calculation and their susceptibility to error is summarised in the standard error, as presented in Table 2, or in the confidence interval which is sometimes presented in the text.

The statistic labelled LRT (likelihood ratio test) and its p value, indicates whether there is a statistically significant difference between a model including a demographic characteristic in comparison with a model with no demographic characteristics at all (intercept only). It provides a sense of whether the demographic factor adds anything statistically to our capacity to understand those deaths, compared with knowing nothing about that demographic characteristic.

10 See Berry J. G. Harrison, JE., 2005. A guide to statistical methods for injury surveillance. *Injury Technical Paper Series No 5.* (AIHW cat. No. INJCAT 72). Adelaide: AIHW.
 Hilbe, J. M. 2007. Negative binomial regression. New York: Cambridge University Press
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 Cameron, A. C. and P. K. Trivedi. 1998. Regression analysis of count data, New York: Cambridge University Press.

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