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# Deaths of Children in Out-of-Home-Care: What do Inquest Reports Reveal About the Framing of Child Protection Practice?

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## ABSTRACT

In Western Australia (WA), a coronial inquest into the death of a child who had been in care is mandatory. An inquest is a public hearing, a fact-finding process to determine the cause of the death, prevent future deaths from occurring in similar circumstances and to comment on the public health implications. With these functions in mind, an analysis of the inquest reports regarding the deaths of children aged 13–18 years who were in care was undertaken. The aims were to make visible the representations and frames that describe child protection practice in relation to these children who were in out of home care, the complex problems faced by their families and the care and support provided to them by the child welfare system. We identified three frames: blame featuring individual responsibility and parental deficits, disengagement and service delivery failure as a missed opportunity. We conclude that what is needed in coronial inquests is a fuller representation of broader systemic issues that are inevitably consequential for child and family well-being. Highlighting social and structural inequalities, trauma, discrimination and racism could arguably maximise the potential for coronial findings to reflect the need for supportive practice and a more preventative approach.

## 1 | Introduction

All jurisdictions in Australia have review processes of deaths of children who have had an involvement with child protection services, whether they die of natural causes or otherwise. In Western Australia (WA) there are two mechanisms that investigate the death of a child in care, the Coroner's Court and the Child Death Review conducted by the Ombudsman. For the most part, child death inquiries conducted by the Ombudsman focus on an aggregate of child deaths and such inquiries and reviews have already been the subject of much research (Preston-Shoot 2018; Sheehan 2016). Using one Australian jurisdiction, Western Australia, as a case study, this paper explores how child protection interventions were framed in coroners' reports. The trigger for studying how children, families and child protection practice

were represented and framed in inquest reports was a story in the local daily paper, *The West Australian*, of an inquest finding into the death of Child RM who was 17 years old at the time of her death by suicide, had been in care for most of her life and had 57 placements while in care. The story was covered on the front page and a two page spread with comments from the Minister for Aboriginal Affairs, the Minister for Child Protection and the Premier of the State (Hennessy, 28th August 2020: 1, 10 and 11). With the headline 'Lost Children' the story referenced the coroner's report: 'This year *The West* revealed the case of Girl RM, a 17-year-old who took her own life in 2017 after experiencing homelessness and abuse while she was meant to be under department care' (Hennessy, 10 September 2020: 10). There were 38 inquests conducted in WA over the decade, 2014–2023 of children who had been in care, and 11 of these were inquest findings into the deaths of children aged

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13–18 years of age. Generally, these children had been in care for a relatively long period of time, some for up to 15 years, thus using these publicly available reports provided greater scope to meet the aims of this study to make visible the representations and framing of child protection interventions and the support provided to the families once the children entered care. As Kedell (2017) observes, what is reported about what the child protection workers did and said they did open a window to understanding the complex problems associated with the risk of harm to a child and thus provides the potential for influencing policy and prevention of future deaths.

Although this case study focusses on just one state of Australia, Western Australia, the findings have broader relevance. Cashmore and Wulczyn (2024: 2) observe that while international research and national research are important, there is strong value in a local focus. They argue: ‘place does matter and the Australian context has its own unique mix of cultural diversity and geographic distribution of the population as well as differences in policy context, community resources and service provision.’ While a more expansive analysis can have broad relevance and applicability, nationally and internationally, there are potentially important lessons that can be gleaned from more local interrogation of available data. Indeed, Vincent (2014) following his study comparing child death reviews in Australia, New Zealand, United States, Canada, England and Wales, warns that generalising across geographical, historical and professional contexts can itself be dangerous.

It has been noted that there can be long-term and fatal consequences for children who had some child protection exposure and were placed in out-of-home care, and in the 15–19 age group, these deaths were found to be due to external causes such as motor vehicle accidents and suicide (Fraser et al. 2014; Segal et al. 2021; Russell et al. 2021). A preliminary reading of the 38 reports confirmed the relevance of these observations for those children in the 13–18 year age group and was the rationale for focusing on this age group. The research approach by Bacchi (2009) that the way problems are constructed and framed affects what can be thought about and acted upon guided the crafting of the questions and the interpretation of the inquest reports. The guiding questions were:

1. What personal and social characteristics of the child and family were referenced in the inquest reports?
2. What was said about the care, supervision and treatment that the children and families received from child protection caseworkers?

The following provides (i) a rationale for the focus on inquests, (ii) an overview of contemporary child protection with practice components that highlight social wellbeing, family support and relationships and (iii) an explanation of the concept “framing”.

## 2 | Conceptual Context

### 2.1 | Why Study Inquests?

Coronial inquests are public proceedings, conducted in an open court, usually about a single death and their reports are publicly available (Coroner’s Court of WA 2022). A Coronial Inquest (i) uses

an inquisitorial approach as distinct from an adversarial one, as a fact-finding mission about the cause of death, (ii) might make recommendations to prevent such deaths from occurring in the future, (iii) comments on any matter connected with the death, including public health, safety or the administration of justice, (iv) and is a means of public accountability (Coroner’s Court of WA 2018, 2020; Humphreys et al. 2014). These reports can add much to building knowledge and social welfare scholarship as they pay attention to the wider context including commenting on the actions of public institutions such as health, education, police and justice (Kirton-Darling 2023; Mackay and McCahon 2019; Mok 2014; Newhouse et al. 2020; Walsh et al. 2022). The potential for these reports to draw attention to preventative and public health outcomes is highlighted by Mok (2014, 323):

Every death represented the “tip of an iceberg of injuries”, so when patterns of injury surfaced, this was indicative of a collective public health problem. Accordingly, a broad-based multi-disciplinary strategy not only has the potential to forestall deaths, but to alleviate health and safety risks more generally. An effective preventive strategy requires an understanding of the way an entire system operates.

Allison and Cunneen (2022) also emphasise this potential in relation to Indigenous populations.

Coroners are empowered to consider a wide range of matters in investigating a death. They are “uniquely positioned to [deal] with the totality” of circumstances surrounding a death, as one participant suggested, with capacity to “broaden out that idea of manner and cause of death to encapsulate something like history or the culture of a particular geographic area where something occurred, or the culture of the organisation in which the death occurred”. This enables coroners to investigate an issue of particular significance to First Nations families... that is racism.

(p. 253)

Additionally, Gibbs (2009), Sim (2015) and Walsh et al. (2022) state that as publicly available documents containing social and personal details of particular groups, coronial reports allow for a compelling story to be told, bringing a descriptive insight into child protection work. Davies et al. (2023) argue that in order to fulfil the preventative feature of coronial inquiries, coroners need to be able to have access to and understand the interplay between broader structural factors and child safety and family well-being and practice that embody features of parental inclusion and relationships based on their needs and wants.

### 2.2 | Social Wellbeing, Family Support and Child Protection Practice

Broadly what is presented here refers to practice components at the statutory end of the spectrum of child and family welfare service delivery and it is about the deaths of children who were

already in care. Munford and Sanders (2016) state that key to achieving positive outcomes for children and their families is building an understanding of their experience, establishing trust based and respectful relationships and supporting these children to be the centre of decisions that affect their transitions within or out of the care system. Braithwaite (2021: 68) suggests that 'it is fundamental for workers to know what it is like to walk in the shoes of the other'. Similarly, Munford and Sanders (2016) drawing on the experiences of young people who experienced statutory services state that engagement is a two-way process. Furrer et al. (2023) analysed in-depth interviews with youth in foster care about their experiences in planning meetings and they found that engagement is more likely to lead to a subjective experience of needs satisfaction if they occur within structured and predictable conditions in their encounters with welfare workers, and if their preferences are given genuine support. Higgins and Hunt (2024: 12) in a review of 52 papers suggest that the complex interplay between various child related factors, parent or family characteristics and contextual factors provide the key to developing prevention efforts and they highlight the need to address 'housing instability, income loss and hardship or disadvantage'. A number of studies have also underscored the relationship between parenting struggles and child maltreatment (Bilson et al. 2013, 2017; Bywaters et al. 2016; Cassells et al. 2020). Using the Australian Temperament Project with a cohort of 2443 individuals and their parents, Doidge et al. (2017) found that poverty and economic disadvantage were strong predictors for child maltreatment, and prevention is possible if childhood economic disadvantage is addressed. Similarly, the Commissioner for Children and Young People, WA (2018) and Krumer-Nevo (2016) suggest that to know and work in collaboration with those in poverty and prevent 'collateral harm' requires an understanding of how its' tangible and material features affect these families and their parenting on a daily basis. Another key systemic issue identified widely is racism. As Krakouer (2023: 109) states

rather than being supported with material resources, Indigenous parents tend to be blamed for their "dysfunction" by CP systems. Solutions to child maltreatment cases focus on correcting individual "parental pathology"—such as parents obtaining housing or undertaking parenting courses—while structural inequality is generally overlooked.

In summary, the key drivers that affect the lives of children and their families are poverty, material deprivation and inequality, and the mediator to work towards family and social wellbeing needs is for vulnerable families to experience trustworthy and supportive relationships with service providers. This understanding of child protection practice influenced the interpretation of the texts and how the frames were identified and constructed as representing the definition and cause of the problem and its' solutions.

### 2.3 | Framing

How an issue is framed has important consequences. Featherstone (2016) and other framing theorists referenced

here state that we think in frames. The purpose of exploring and naming what is represented as frames is to further highlight how inquest reports as public documents tell the story of the complex social problems facing these families and what was said about what child protection practitioners did. Lakoff (2004: p.73), a linguist and framing theorist, defines frames as 'mental structures that shape the way we see the world;' and that 'all of our knowledge makes use of frames...All thinking and talking involves "framing". ...one cannot avoid framing'. It is argued, therefore, that how an issue is framed is 'crucial to public reasoning and, by extension, action' (Gilliam and Bales 2001: 4). Paying attention to how interventions were framed links problem definition, causal interpretation as well as solutions, and a common understanding of what vulnerable families need to safely care for their children (Bacchi 2012; Kingdon 2003; Such 2023). Featherstone (2016) links framing and story-telling and makes the case for telling stories about the problem of child abuse, she says:

According to framing theorists, our minds use stories to understand the world, and we think in frames. These are a quick way for us to understand the world based on existing preconceptions about it. ...it will need to be taken on and owned by opinion formers and influential advocates in coalition with families who are offered the opportunity to tell their stories, and to be recognised and understood.

(pp. 149 & 152)

### 3 | Methodology

Coronial inquest reports into the deaths of 11 children aged 13–18 years who were in care at the time of their deaths constituted the empirical basis of the case study. Coroner's inquest reports are available on the website <https://www.coronerscourt.wa.gov.au/>. They are anonymised, listed by year of inquest with the initials of the child's name, and include a suppression order that prevents naming the child. The reports range in length from 12 pages to 54 pages (most were longer than 30 pages) with considerable detail describing the statutory Department's involvement with the child, and descriptions and evidence about the police, medical and hospital, mental health interventions, post mortem results and sometimes statements from family members. The reports are mainly descriptive, and include the coroner's comments and conclusions.

The rationale for documentary analysis is made by Dalglish et al. (2020: 1425) who assert 'Documents exist not as stand-alone objects of study but must be understood in the social web of meaning within which they are produced and consumed'. All 38 reports of inquests conducted over 10 years from 2014 to 2023 were subject to an initial scanning and analysis. The rationale for the decision to focus on just the reports of 11 children in the age-group 13–18 years was that these children were older, had been in care longer and logically their reports would have more data from which to draw inferences and themes about the care they received. The analysis was designed to identify what the inquest reports included about the care provided to the child and the support given to the families.

A literature review laid the groundwork on which to interpret the texts. The search terms for the literature review were ‘frames’, ‘framing’, ‘death of a child’ AND ‘out-of-home care’ AND ‘Coronial inquests’, ‘coroner’s reports’ AND ‘social’ AND ‘child welfare’, ‘out-of-home-care’ AND ‘preventative models of care’ and ‘relational’ AND ‘supportive casework’ AND ‘child protection’. The literature, including research reports in professional and academic journals and reports conducted for government, provided the scaffolding for the initial development of codes and categories that described child protection practice. The analysis of the inquest reports took a qualitative approach. Bowen’s (2009) description of qualitative content analysis fits with how these inquest reports were analysed, as a ‘form of pattern recognition within the data, with emerging themes becoming categories for analysis’ (p. 32). Carpenter et al. (2021: 529) in their thematic analysis of coronial inquests and Indigenous suicides made a point that such analysis concurs with the understanding that ‘a key theme does not necessarily depend on a quantifiable measure but on whether it captures something significant in relation to the overall research questions.’ The analysis was interpretive and deductive, the categories having emerged from the literature about child protection practice (Altheide and Schneider 2013). The themes were then interpreted to create the frames. The decision to conduct a qualitative analysis of the text to identify the frames and focus on child protection practice was prompted by the presence in the text of certain phrases and terms. These included ‘missed opportunity’, ‘self-select’, ‘with the benefit of hindsight’, family support’, ‘engagement’ and ‘it would have been good practice’. These terms and phrases were analysed in relation to their proximity to what was reported in the inquest reports about the care, treatment and support provided to the children and families, the decisions about child placement and the child protection workers’ relationship with the child and family and what was reported about the cause of death.

### 3.1 | Ethical Considerations

All data utilised are available in the public domain, and the study did not involve active participation of human subjects. This paper refers to the names of the children and family by initials as they were in the coroners’ reports. In acknowledgment of the sensitivities for families of any commentary about their child, care was taken not to make any comments that might be hurtful. The senior executives whose evidence is examined were identified by their names in the reports, but for the purposes of this paper and to maximise anonymity, reference to any senior executive made by the coroner is referred to as ‘the senior executive’.

## 4 | Findings

Table 1 presents a profile of children aged 13–18 years as a segue to the key focus of this study, which is about the representation of child protection interventions. Six of the 11 children were Aboriginal, and at 54% of the total, this figure is consistent with the over-representation of children in state care, as has been frequently reported (SNAICC 2020). Five of the teenagers, of whom two were Aboriginal, had complex medical needs, developmental and physical disabilities. In relation to Child CNR, who had a rheumatic heart condition, the coroner concluded that the high incidence of rheumatic fever in Aboriginal communities

was probably related to social circumstances and overcrowding, and that lowering the incidence and preventing future deaths lay with changing the social conditions. In relation to the three children, Child MKP, Child TP and Child JBA, whose deaths were put down to natural causes, there were no references to social co-morbidities, and it was the severity of their disabilities that seemed to have triggered them entering care. The focus of the inquest reports was on their medical needs, implying the inevitability of their deaths. A deeper analysis is required of this group of children with disabilities, as Walsh et al. (2022) note; a finding that the death was from natural causes does not mean that the death was inevitable.

As Table One identifies, the parental issues at the point of entry into care for Child E, Child JDC, RM, Child JM and Child C were unstable housing, mental health problems, domestic violence and drug and alcohol use. There were short periods when these teenagers returned to their birth parents, although not as a result of a plan for reunification by the Department. Additional supports to the families had not been provided and their lives and living conditions had not stabilised sufficiently for permanent reunification. At the time of their deaths, three adolescents who had been in care for most of their lives had no fixed address. This was put down to the problem of them repeatedly leaving their placements and returning to their birth parents.

### 4.1 | What Are the Frames?

The qualitative analysis and the literature review enabled three broad frames to be identified, and this section describes those frames and the issues that populated them. Given the complex, multi-layered and interactive nature of child protection practice and the problems faced by vulnerable children and their families, there is considerable overlap between the three frames that were identified. The frames were (i) blame: featuring individual responsibility and parental deficits, (ii) disengagement and (iii) service delivery failure as a missed opportunity.

#### 4.1.1 | Blame: Individual Responsibility and Parental Deficits

The blame frame featuring individual responsibility and parental deficits constructed causation and the context in which the children entered care as arising from individual pathologies. Citing the children’s in utero exposure to toxic substances resulting in neurological damage could be interpreted as blaming the mother. Despite the dominating presence of drug and alcohol abuse, domestic violence, mental illness and unstable living conditions, there was no evidence that work with the families was done to ameliorate these problems. Interventions directed at issues to do with poverty or the need for tangible material resources or financial help were similarly not apparent in the reports.

Three of the adolescents (Child E, Child RM and Child J) died from suicide. Child J had previously threatened to stab himself, and was described as having disengaged from mental health services. The coroner concluded that it was the break-up of his first relationship with a girlfriend that triggered the suicide.

**TABLE 1** | Profile children aged 13–18.

Name	Age	Date of death	Date of inquest	Time in care	Aboriginal 54%	Drug and alcohol			Mental illness	Family violence	Homeless	Medical/ disability	Cause of death
						Y	Y	Y					
Child E	15	15/11/2010	17/10/2014	11 years	Y	Y	Y	Y	Y	Y	Y		By suicide
MKP	15	26/11/2011	18/06/2015	10 years								Y	Natural causes, Seizure disorder
Child TP	15	9/12/2011	04/05/2016	13 years								Y	Natural causes, Seizure disorder
Child JBA	17	26/05/2015	28/11/2016	11 years							Y	Y	Natural causes, seizures
Child JDC	18	22/05/2012	20/11/2017	7 years	Y	Y	Y	Y	Y	Y			Injuries from car crash; serious infection
ChildHLS	15	14/03/2013	26/04/2018	2 years	Y	Y	Y	Y	Y	Y	Y		Misadventure- Traumatic amputation of left foot-attacked by crocodile
Child CNR	16	26/03/2014	09/05/2019	12 months	Y							Y	Heart failure due to rheumatic heart disease
Child RM	17	16/04/2017	16/07/2020	15 years	Y	Y	Y	Y	Y	Y			By suicide
Child JM	16	01/04/2017	30/12/2020	3 years		Y	Y						Injuries-collision following high speed chase in a stolen car
Child J	16	25/04/2017	15/12/2021	14 years	Y	Y	Y	Y	Y	Y			By suicide
Child C	15	27/11/2020	24/01/2023	6 years		Y				Y			Struck her head on the road and died from head injury

Child RM had a history of alcohol abuse and was the victim of assault, with allegations of historical sexual abuse, emotional and physical harm including from older males whom she chose as partners. She was admitted to a secure, therapeutic trauma-informed facility on four occasions where the length of stay is time limited. On the last admission when she was discharged from the facility, she was referred to a centre for young people at risk of homelessness and had no other community-based transition services to support her. With respect to her suicide the coroner commented that ‘the reason she decided to take her life is unfathomable...impulsive act of taking her life was in some way connected to the complex developmental trauma she had clearly experienced’. Child RM had 57 placements.

In relation to Child E, the coroner concluded that he

...suffered an early infancy of neglect, deprived of appropriate responsive care during crucial times for the development of his frontal executive brain function...Unfortunately, in his impulsivity, Child E... made a wrong decision...and chose to end his life.

(Coroner’s Court of Western Australia. Record of Investigation into Death, Ref. 31/14: p. 23)

The three young people who took their own lives were described as having ‘selected a highly lethal means of suicide’, had an ‘inability to engage’ and for whom ‘little could be done’. Similarly, Child J’s inquest report gave a history of self-harm and a diagnosis of clinical depression, ‘having attachment issues’ and ‘individual vulnerabilities’ (Coroner’s Court of Western Australia 2021. Record of Investigation into death of Child J: 22 and 42). Notably he had 34 living arrangements and 30 caseworkers in his 14 years in care. With reference to Child E’s suicide the report described him as ‘being unable to control his impulse’ and was ‘...neurologically ill equipped to manage daily life stresses and demands...suffered executive system difficulties’ (Coroner’s Court of Western Australia, Record of Investigation into Death, Ref. 31/14: p. 21, 23).

Multiple placements which included residential care, kinship care and foster care were a feature with the children in this age group and again the breakdown of these arrangements were attributed to individual responsibility. Like Child RM and Child J, Child JM who died in a car collision following a high-speed chase by police was also reported to have had numerous placements and Child C was said to have been placed into the care of a number of foster and family carers. In Child J’s case, the coroner noted that his mental state and ability to forge supportive relationships were likely to have been adversely affected by the ‘large number of placements and case managers he had over the years...mirrored the lack of consistency of care in his personal life’ and that the failure to reunite him with first his mother, then later his father, compounded his early trauma (Coroner’s Court of WA, Record of Investigation into the death of Child J. 2021: 50). In the case of Child HLS for whom the report stated that more could have been done to engage him in learning and consistent with the blame frame, the coroner referenced parental deficit: ‘Due to the toxic effects of alcohol when he was in his mother’s womb, HLS was born with a disability that made it much harder for him to grow and learn and regulate

his behaviour’ (Coroner’s Court of Western Australia, Record of Investigation into Death of HLS Ref 30/17: p. 42).

Child E had died from suicide and the report described his mother as having ‘had a childhood and an adult life marred by homelessness, drunkenness and abuse which would have provided her with few role models for appropriate parenting’ (Coroner’s Court of Western Australia 2014, Ref No 31/14: 3). There was commentary from the coroner about the need for culturally appropriate placement decisions and two reports made reference to transgenerational trauma as an endemic feature in the Aboriginal population. However, for the most part blame and attribution of responsibility to the individual without reference to context or broader structures emerged as an important frame overlapping with the next frame discussed below.

#### 4.1.2 | Disengagement

The blame frame featuring individual responsibility and parental deficits described above existed alongside a trajectory of references to a lack of engagement of the child with child protection workers, with the child being held responsible. The number of placements and caseworkers that these children had, as listed earlier, provides a potent perspective on the frame that highlights individual responsibility and can also be seen as a pathway to representing the problem as a lack of engagement. Child JDC had been in care since she was 10 years old and, for the most part, was described as unwilling to engage with the services offered by the department. Child JDC had been drinking when she drove her uncle’s car and died as a result of injuries from the car crash, her treatment for the injuries complicated by the previously undiagnosed diabetes. The coroner’s comment below needs to be noted in the context of the responsibility of the State to the child’s health and well-being (Coroner’s Court of Western Australia 2017a, Record of Investigation into the death of Child JDC: 11):

From my perspective, the evidence before me raises two major areas of concern in relation to the deceased’s treatment, care and supervision. The first is how the deceased was able to have diabetes without it being diagnosed while she was in the care of the Department.

In response to this statement by the coroner, the senior executive’s response strongly reflected the disengagement frame with features of the first frame encompassing blame, and inarguably the responsibility of the child: ‘The Department can offer them support services and care and hope that they make good choices from what we offer’ (p. 11). During her teen years Child RM’s health was poor, she was needing a liver transplant, she was drinking excessively and was the subject of numerous physical and sexual assaults and she had formed a sexual relationship with a much older male. She was frequently lost to contact by caseworkers. The inquest report, stated that she ‘self-selected’, ‘had poor decision-making skills and... self-selected unapproved placements’, ‘absconding and self-selecting her living arrangements’ and ‘making poor choices which placed her at risk’ (Coroner’s Court of Western Australia. WACOR 14, 2020: 5, 18, 17).

### 4.1.3 | Service Delivery Failure as a Missed Opportunity

The gaps in practice highlighted by the coroner were predominantly around providing support to the families and children, working to enable the children to have a safe and close relationship with their birth families and for child protection workers to have a 'deep rapport' with the child. The term *missed opportunity*, to explain these gaps, described what the children did as 'self-selecting', 'choosing' and 'poor decision-making skills'. These descriptors had the effect of not making visible how the child protection decisions were made and precluded closer scrutiny of practices and how they were experienced by the child and family. Child J died as a result of suicide and the coroner noted that he 'appeared happiest when living with family, but this was unfortunately not always possible' (Coroner's Court of WA, 2020, WACOR 14: 10).

In the case of Child RM, not supporting the mother when she was making efforts to stabilise her lifestyle was described as a *missed opportunity*:

With the benefit of hindsight, Mr. Senior Executive acknowledged that the Department should have done more to support Child RM's mother to sustain and strengthen the positive lifestyle changes she was making.

...with the benefit of hindsight, Mr. Senior Executive also queried whether the Department had done enough to regularly engage with Child RM and develop a deep rapport with her. Mr. Senior Executive also noted that although the Department is committed to "cultural input" into every child placement decision, it hadn't nailed this concept yet.

The senior executive noted that since 2012, the Department has placed far more emphasis on family support and that the introduction of the Intensive Family Support Service was in response to the fact that: 'not enough was being done in that space' (Western Australia Coroner's Court (2020) WACOR 14, para 30, 31, 32, 33).

## 5 | Discussion

The descriptions of the reasons and causes of the deaths were narrow and the silences were about systemic issues and the broader context of the lives of the children, their families and communities. Just two inquest reports (Child CNR, Child J) among the 11 drew attention to the wider historical and structural inequities, as well as the effects of colonisation, racism and poor social conditions. In the case of Child CNR, the coroner commented:

That rheumatic fever even exists in Western Australia is a matter of concern, adding to concerns about the well-publicised poor social conditions of a high

proportion of Indigenous Western Australians living in remote areas'.

(Coroner's Court of Western Australia, Record of Investigation into Death of CNR, 2017b: 15)

At the inquest for Child J, Dr. Boulton, a now retired Senior Regional Paediatrician was called as a witness. He described trauma as 'contributing to the complete disruption of the social fabric of their society...a bitter fruit...and the result of the complete disruption of the social fabric of their society in little more than 100 years ago in the Kimberley'. The report stated that:

Dr. Boulton's comments about the issues with children in out-of-home care are supported by the recently released Family Matters Report 2021, which highlights the ongoing impact of poverty, homelessness, intergenerational trauma and social exclusion on Aboriginal and Torres Strait Islander families, resulting in 21,523 Aboriginal and Torres Strait Islander children being in out-of-home care at 30 June 2020. Each year that number is increasing, despite various commitments from governments, suggesting the responses so far have been inadequate. (Coroner's Court of Western Australia 2021 Record of Investigation into Death of Child J: 51)

Most of the inquest reports referenced trauma and intergenerational trauma. However, for policy and practice to foreground trauma-informed care as more than just a concept requires knowledge, skills and strategies that incorporate relationships and engagement as a tool for healing and promoting family and social well-being (Levenson 2020). More recent scholarship on trauma informed care in child protection work strikes a cautionary note, that trauma informed care can become an individual centric approach, pathologise reactions to systemic injustice and not adequately capture how systemic oppression can shape trauma experiences (Leotti and Wahab 2024).

The blame frame with individual responsibility and parental deficits at its core bring to mind Morris et al. (2018: 370) description of practice being about managing individual risk detached from socio-economic conditions such that 'Poverty is the wallpaper of practice: too big to tackle and too familiar to notice'. In relation to Aboriginal children and families this focus did not broaden out the circumstances to include systemic issues such as racism and inequality and so precluding them from more detailed examination by the coroner, particularly the negative impact on their mental health, leading to high rates of premature deaths (Allison and Cunneen 2022; Crosby 2021; Truong and Moore 2023). Carpenter et al. (2021) in their analysis of coronial inquests and indigenous suicide point out that Indigenous Australians are more than twice as likely to commit suicide than non-indigenous Australians. Westerman and Sheridan (2020) suggest that cultural resilience is a moderator of suicide risk, together with a whole of community approach.

Framing the failure in service delivery to fully engage with both the children and their families as a *missed opportunity*

was pervasive, arguably inoculating caseworkers against blame and regret and minimising the true effect on the families and children. The term *missed opportunity* as a response is a simple, fast answer which comes across as a plausible explanation, an act of omission masking the potential for more critical reflection. Questions that would have opened the way to more tangible and deeper conceptualisation of practice according to Thompson (2013) are: 'Did the worker do what was professionally required of them? Did they carry out their duties to an adequate standard or did they fail to do something that was necessary in line with their professional role?' An analysis of why the opportunities were missed, how they were missed and under what circumstances an opportunity might have been recognised to initiate intervention might have given the coroners sufficient context to explore systemic deficiencies and to contextualise the reasoning and decision-making processes in complex situations, beyond just the immediate circumstances of the death. These were the silences about individual worker factors, at the micro-level to do with reasoning skills, judgement and values, as well as structural, policy and psycho-social environment such as access to supervision. An inclusion of these factors could have drawn attention to the complexity of child protection practice. Additionally, for the coroner to frame recommendations reflecting public health and preventative measures data and evidence about the intersection of poverty, social exclusion, parenting difficulties and the effect coming under the gaze of statutory agencies have on help seeking by vulnerable families were needed.

The following data are strong indicators of the need to bring a wide angle lens and systemic framing to child protection practice and foreground the need for early intervention and broad based support: (i) the Report of the Productivity Commission (2020) shows a very low spending on family support services at 5.6% of the total child protection budget, (ii) SNAICC (2020), the National Voice for Aboriginal and Torres Strait Islander children in their Family Matters Report states that at 17.8 times the rate, Western Australia had the highest over-representation of Aboriginal and Torres Strait Islander children in care, 'while also investing the least per capita in intensive family support and investing comparatively little in other family support services' (Lewis et al. 2019: 64) and (iii) the Bankwest Curtin Economics Centre, Early Years Report showed that severe poverty among children under 5 years of age is higher in WA than any other Australian State, a rising trend in WA compared to a decline in the national rate (Cassells et al. 2020). To extend the scope of coronial reports, in addition to data, frames need to include descriptive insights about families struggling with poverty, chronic and tangible material needs and for this to occur Such (2023) suggests frames that also demonstrate authenticity, inclusiveness and trust.

## 6 | Limitations and Implications for Research

A limitation in this study is that the analysis was restricted to what the reports contained about the work of child protection practitioners and these were inarguably interpretations made by the coroners. The next step would be to interview the coroners to understand the decisions made by them as to what constitutes evidence and to understand the comments and

recommendations made by them. In addition to textual analysis regarding child protection practice, there is scope for similar analysis across disciplines to look for common themes and what can be learned to make services and practice more responsive and reduce harm. To maximise the coroners' role in prevention and public health requires an analysis of the work of other agencies, such as mental health, medical, education and justice agencies and there may be a benefit to considering the influence of macro participation of the political, economic, philosophic and geographical landscape. Additionally, an analysis of the other age groups of children and those with severe disabilities and complex medical conditions is needed. There is a strong case for child protection workers to utilise multiple frames to highlight the role of nuanced decision making and human judgement, organisational culture and resources available to the organisation so that well-being and broad-based supportive interventions dominate. Gillingham and Whittaker (2023: 19) suggest using insights from research and theory 'to understand both the psychological aspect of individual decision makers and the influence of the decision environment'. The methodology for such an inquiry would be field studies and in-depth interviews. While this study focused on framing of practice, another logical step would be to further research media coverage and how the problem and its solutions are framed in the public domain and in response to inquest reports.

## 7 | Conclusion

The inquest reports discussed here, for the most part, did not contain the full context of the children's lives and of what was needed to be done to promote and ensure access to health and social well-being and not just the prevention of deaths. Inquests have wide evidence gathering powers, their conclusions are public, and they can have an impact on social and public health policy, legislation and public discourse. Inquests offer child protection services the opportunity to frame for the benefit of the coroner the multiple layers of complex stressors in practice and to capture the broader social and structural disadvantage and trauma that affect the lives of children and families. Importantly, inquests provide an opportunity to shape policies and practice that assert the primacy of early intervention and prevention within helpful, trust-based and supportive models of care.

### Author Contributions

**Celine Harrison:** conceptualization, methodology, investigation, writing – original draft. **Maria Harries:** conceptualization, validation, writing – review and editing. **Mark Liddiard:** conceptualization, validation, writing – review and editing.

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## Conflicts of Interest

The authors declare no conflicts of interest.

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