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Revisiting cumulative harm: Reflecting on new research insights, legislative developments and coronial evidence as a road map for next steps

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Abstract

In 2018, I penned an analysis of national and international approaches to cumulative harm in a child protection context, published in *Children Australia*, that identified an evolution acknowledging the impact of all harm to children as detrimental. Through analysis of the available policies informing child protection in Australia, it was clear there was a shift towards a more holistic understanding of harm and the impacts of long-term maltreatment. However, a nationwide, collaborative level of consistent practice that placed cumulative harm and reoccurring maltreatment on an equal footing with episodic maltreatment, particularly in relation to notification and reporting, had not yet been achieved. This begs the question, what has occurred to address this need, this gap, and promote the acknowledgement of cumulative harm since 2018? In this paper, I revisit this important topic, reviewing recent scholarly works, legislative developments across Australian jurisdictions and evidence from a decade of coronial inquests into child deaths that provide powerful messages of guidance on responding to cumulative harm.

Keywords:

abuse, coronial inquests, cumulative harm, legislation, neglect.

Background

Over the last decade, there has emerged an overwhelming body of research that provides evidence for what researchers and practitioners know instinctively to be true, that multiple experiences of childhood maltreatment are alarmingly more frequent than singular, episodic events (Bromfield et al., 2007; Bromfield & Higgins, 2005; Edwards et al., 2003; Felitti et al., 1998; Higgins, 2004; Higgins & McCabe, 2001). Empirical research, and our experience on the gruelling front line of child welfare and social care service delivery, supports the notion that an accumulation of risk and harm in childhood is far more predictive and far more valuable in informing practice than viewing these adversities and violations in isolation (Appleyard et al., 2005;

MacKenzie et al., 2011a, 2011b). Cumulative harm, coined by Australian researchers Bromfield, Gillingham and Higgins (2007), is a label that has been attributed to

> *the effects of patterns of circumstances and events in a child's life, which diminish the child's sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or 'layers' of neglect* (Miller, 2007: p. 1).

Despite the strength of the research and practice dialogue supporting the importance of recognising the accumulation of adversity in legislation, policy and practice, this perspective has had a fraught history of infiltrating both the investigation of, and responses to, childhood maltreatment.

Cumulative harm to date

In 2018, I penned an analysis of national and international approaches to cumulative harm in a child protection context, published in *Children Australia*, that identified a global evolution acknowledging the impact of all harm to children as detrimental (Bryce, 2018). Through analysis of the available policies informing child protection in Australia, it was clear there had been a shift towards a more holistic understanding of harm and the impacts of long-term maltreatment. However, a nationwide, collaborative level of consistent practice that placed cumulative harm and reoccurring maltreatment on an equal footing with episodic maltreatment, particularly in relation to notification and reporting, had not yet been achieved.

Those who had written on the topic at the time all emphasised that the vital importance that research findings and clinical knowledge about chronic maltreatment and its legacy of cumulative harm, 'find a central place in our legislative frameworks, our practice guidelines, our data collection processes, and our intervention models' (Bryce, 2018). Since cumulative harm's 'inception' in 2007 (Bromfield et al., 2007), implementation in practice frameworks (Bromfield & Miller, 2012), and further interrogation (Broadley, 2014; Bryce, 2018), there remains consensus about cumulative harm's value. There is clear agreement that policy and procedure must reflect the equally pervasive and damaging nature of cumulative harm on the development and functioning of the individual and allow for intervention in matters of ongoing maltreatment, regardless of whether the child is exhibiting indicators of harm at the time the maltreatment is identified.

Recent scholarly works

So, what has occurred to address this need, this gap, and promote the acknowledgement of the cumulative adversity since 2018? In keeping with the 'slow burn' pattern that proceeded developments pre-2018, there has been a smattering of scholarly endeavours since 2018 seeking to advocate for, and continue to build momentum around, the specific issue of accumulation. It is important to note that there is some diversity in how cumulative harm is recognised in the literature. Australian publications adhere most closely to the label of 'cumulative harm'; however, this concept has found a home more broadly in research that explores repeated maltreatment experiences or repetitious involvement with statutory child protection services. There remains only a small cohort of researchers exploring the phenomenon of cumulative harm, risk or adversity in its own right. Interestingly, a Google Scholar search yields an alarming number of articles utilising the term 'cumulative harm' in relation to salmon farming, international water law and pollution!

In 2019, Australian researcher Rosemary Sheehan conducted a systematic literature review examining how the construct of cumulative harm is understood and operationalised within current Australian child protection legislation, policy and practice and situated this within an international context (Sheehan, 2019a). The review revealed that although the construct of cumulative harm has been increasingly incorporated into child protection practice and legislation, service delivery remains largely episodic and crisis-driven. Sheehan's review also identified that despite agreement that prevention and early intervention are preferred responses to reducing the cumulative impact of adverse childhood experiences, there has been minimal research on what constitutes an effective service delivery or tertiary response to cumulative harm. Sheehan highlighted the ambiguous, insidious and often invisible nature of cumulative harm cases, which often fail to reach thresholds for intervention. Sheehan's findings mirrored closely my own analysis in my 2018 paper (Bryce, 2018).

I have also written, and co-written, a number of additional papers on cumulative harm, largely concerned with the theoretical understanding of the concept (Bryce & Collier, 2022), application of cumulative harm evaluation in various settings, including intensive family support services (Bryce et al., 2024; Collier & Bryce, 2021) and higher education and vocational decision making (Bryce et al., 2023a, 2023b). However, two of my recent works addressed important developments in understanding the accumulation of adversity and its impact. The first explored the specific impact of cumulative harm in the context of the COVID 19 pandemic (Bryce, 2020).

This article called attention to the 'escalation' that would likely occur as we emerged from COVID-19 isolation measures and the impact of this time that would become apparent. For helping professionals, addressing the accumulation of adversity, disadvantage, exposure to domestic and family violence and chronic maltreatment would be a priority in responding to the impacts of the COVID-19 context, post pandemic. Entering into this unchartered territory of service delivery would require an acknowledgment of the way that risk and harm accumulate and an integration of this knowledge into all direct and indirect practice after the pandemic. I stressed that adopting a collaborative, multisystem approach to meeting the complex needs of vulnerable families, addressing oppression and disempowerment through a lens of systemic marginalisation and mitigating the augmentation of stressors due to the pandemic and the related measures of social distancing restrictions, would be proactive means of harm reduction.

I hypothesised that, post pandemic, there would be no service delivery that would not involve responding to accumulated risk and cumulative harm in some form, and that would be COVID-19's legacy in our profession. However, perhaps we as practitioners would achieve a more accurate appreciation for the mechanisms of accumulation, and our practice would be better informed for having understood maltreatment, equipped with this new knowdge.

The second article (Bryce et al., 2023c) explored the retrospective lived experiences of adults who endured cumulative harm in their childhood. This research identified the contributors, characteristics and commonalities of the lived experiences of cumulative harm and catalysed a paradigm shift that positioned accumulation as a distinct harm type. This work also clarified the qualities that embody cumulative harm: persistent dysfunction, dysregulation, disadvantage and disconnection.

The Australian Childhood Maltreatment Study (ACMS; Haslam et al., 2023) was the first nationally representative study of the prevalence of child maltreatment in Australia. This study found that one in four children have experienced three to five types of abuse (physical, sexual, emotional, neglect and exposure to domestic family violence). The ACMS also drew attention to the prevalence of emotional abuse and that it is in fact particularly harmful and much more damaging than previously understood (Haslam et al., 2023). Young Australians aged 16–24 years were more likely to report experiencing emotional abuse (34.6% *v* 30.9%) and exposure to domestic violence (43.8% *v* 39.6%). ACMS researchers recommended an 'emotional revolution' – a paradigm shift that refocuses our attention on the pervasiveness and dominance of emotional abuse (Mathews, 2023). We have long considered neglect to be the greatest contributor to cumulative harm, but perhaps it is more nuanced than this. This new research, from the ACMS, tells us that it is in fact the emotional impact of neglect, the emotional abuse, that causes the most significant cumulative harm**.**

Research findings from the United States of America have called attention to the importance of recognising risk and harm in a 'dose' relationship (Hamby et al., 2021), reflecting findings from the seminal Adverse Childhood Experiences study (Edwards et al., 2003; Felitti et al., 1998). Hamby et al. (2021) highlighted that, by the end of childhood, most people are exposed to trauma and adversity, and that the *cumulative dose*, in the form of the number of adversities of any type , is strongly associated with leading causes of death and morbidity. Hamby et al. (2021) also drew our attention to the expanding scope of what constitutes cumulative harm, with recognition of the contribution that experiences outside the family – including peer victimisation, community violence and racism – can make to *trauma dose*. Hamby argued the need to further expand this scope of understanding to include the traumatic impact of historical trauma and systemic marginalisation within the cumulative trauma framework (Hamby et al., 2020), potentially propelling doses even higher for many people, particularly those impacted by colonisation.

Developments in legislation and policy

Australia wide, it appears there have been some additional developments across legislation and policy that are worth noting. In Victoria, two inquiries, completed in 2018, follow the publication of my article in *Children Australia*, and highlight the role of cumulative harm in suicide, and the heightened risk for children with complex medical needs and/or disability. The Systemic Inquiry into Cumulative Harm and Suicide in Child Deaths (Commission for Children and Young People, 2018a) examined the deaths by suicide of 26 children and revealed a pattern of missed opportunities to address significant and persistent harm from an early age (Commission for Children and Young People, 2018a). It found 91% of cases were closed at the early stage of intake or investigation, and that 33% of these children's deaths occurred within eight weeks of the final child protection report being closed. Across the deaths examined, each child came to the attention of child protective services an average of seven times, with a range of 2–25 notifications (Commission for Children and Young People, 2018a). The Systemic Inquiry into Vulnerable Children and Young People with Complex Medical Needs and/or Disability examined 72 child death inquiries between 2013 and 2017 and acknowledged the additional cumulative risks posed by disability (Commission for Children and Young People, 2018b).

In NSW, it is heartening to observe cumulative harm featured in Education Legislation, via the NSW Department of Education (2024) resource Child Protection: Responding To and Reporting Students at Risk of Harm, advising educators and school leaders to contact the Child Wellbeing Unit when:

> *there is an observable pattern of cumulative harm that does not meet the threshold of significant harm* (p. 7).

Additionally, NSW Health has also adopted this language in their guidance on information exchange provisions under chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW Government, 2024). This highlights that these information exchange provisions aid in identifying cumulative harm resultant from a combination of factors and/or over time. Such information exchange can occur whether or not the child or young person is known to community services and whether or not the child or young person consents to the information exchange. I even uncovered a link to an informative animation created for the NSW Ministry of Health. There has been clear dissemination of this important issue across multidisciplinary fields, which is a positive development. Concerningly, cumulative harm does not feature specifically in the NSW *Children and Young Persons (Care and Protection) Act 1998* (NSW Government, 1998), despite this being a recommendation of the Special Commission of Inquiry into Child Protection Services in (Wood, 2008: section 6.2c).

Tasmanian legislation, *Children, Young Persons and their Families Act 1997* (Tasmanian Government, 1997), which, at the time of my 2018 article did not expressly consider the effects of cumulative patterns of harm on a child's safety and development, in 2024 provides for best interests of the child to be determined as follows:

> *Without limiting the matters that may be taken into account in determining the best interests of a child, the following matters are to be taken into account for that purpose: (o) any persuasive reports of the child being harmed or at risk of harm and the cumulative effects of such harm or risk* (Section 10e).

In 2021, Coroner Olivia McTaggart made public her findings into the deaths of seven Tasmanian children in north and north-west Tasmania from 2014 to 2018. She reported that 'poor decision making by Tasmania's child protection system resulted in lost opportunities to protect the lives of seven children' (McTaggart, 2015: p. 7). The key systematic barriers revealed by Ms McTaggart were: inadequate information collected to inform sound risk assessments; unacceptably lengthy delays in risk assessments; a propensity to prematurely close cases under the assumptions that agencies were continuing to work closely and effectively with the family; a lack of attention to the issues and assessment of

cumulative harm; deficiencies in safety planning; and, poor internal communications with colleagues, including of the oversight of case-related decision making.

In South Australia, a full review of the *Children and Young People (Safety) Act 2017* (South Australian Department for Child Protection, 2017) was conducted in 2023, the final report of which made numerous mentions of their intentions to detect and act on cumulative harm (South Australian Department for Child Protection, 2023). However minimal information is available as to what was implemented to action these intentions following this report. Cumulative harm does feature in the current iteration of the *Act* (2017).

The Northern Territory has made little progress in the implementation of cumulative-harm-specific practices at a legislative level, with nil mentions noted in the *Care and Protection of Children Act 2007* (Northern Territory Government, 2007). It does find a home in the Professional reporters guide: Reporting child harm or exploitation (Territory Families, 2020), specifically advising that 'patterns of parental behaviour, with the child exposed to persistent negative experiences or circumstances, may be indicative of cumulative harm' (Territory Families, 2020: p. 16).

There remains no specific mention of cumulative harm, nor its importance in principle and practice, in the Western Australian *Children and Community Services Act 2004* (Western Australian Government, 2004) or the *Children and Community Services Amendment Act 2021* (Western Australian Government, 2021). Cumulative harm does appear in the Western Australian Government Policy on Neglect Western Australian Department of Communities, 2021}), that was reviewed and republished in line with recommendations of the Ombudsman Western Australia in 2021. As with many of the legislative documents that fail to specifically refer to cumulative harm, there is often a broad caveat that may be considered to suffice, referring to harm being caused by a series or combination of acts, omissions or circumstances. However, it is this ambiguity that has been clearly identified as a key barrier to an effective response to accumulative adversity in vulnerable children and families.

Queensland's Child Protection Department has provided additional clarity in their practice manual (Queensland Department of Families, Seniors, Disability Services and Child Safety, 2024), under the section devoted to 'Assessing the information and deciding the outcome', to ensure the assessment of harm considers the effect of cumulative harm on the child. The manual highlights that:

> *previous reports to Child Safety may not have been recorded as a notification, or previous investigation and assessments may not have been substantiated for harm to the child, but the cumulative effect of experiencing the abusive action or inaction over time may have led to significant harm being suffered now* (no page).

Specifically, the manual requires practitioners to consider the vulnerability of the child and the pattern of behaviour by the person responsible or allegedly responsible for the risk of harm. In particular, the manual asks practitioners to consider the type of abuse, and the frequency, chronicity, and duration of the abuse; and importantly, the child's (cumulative) experience of harm they have suffered, now and in the past.

In Queensland, The Child Death Review Board (CDRB) conducts systemic reviews following the death of a child connected to the child protection system under Part 3A of the *Family and Child Commission Act 2014* (Queensland Government, 2014). In their most recently published Annual Report (Queensland Family & Child Commission, 2023), references to cumulative harm were littered throughout the document, totalling no fewer than 25 mentions. Interestingly, the report also makes mention of the recommendations of the 2021–2022 report (Queensland Family & Child Commission, 2022) that the Queensland Department of Children, Youth Justice and Multicultural Affairs (now the Queensland Department of Families, Seniors, Disability Services and Child Safety) strengthen intake processes to make sure staff are able to give proper consideration to indicators of cumulative harm, particularly when frequent child concern reports are recorded (Recommendation 2) and develop additional guidance for assessing cumulative harm (Recommendation 3). In response, the Queensland Government, in 2022–2023, increased mandatory and non-mandatory cumulative harm training for staff and incorporated visual depictions of child protection histories into its newly developed IT system, 'Unify', that aims to illustrate and make more visible cumulative impacts of harm on children, young people and their families. According to the Queensland Government, Unify will generate a prompt if a third (or more) intake event has been generated for a child or young person within 12 months. This functionality seeks to prompt practitioners to consider the impacts of cumulative harm on the child (Queensland Family & Child Commission, 2023). Identification and 'threshold' issues have historically impeded attempts to identify and address cumulative harm at the intake stage of a child protection matter if successful. Therefore, this mechanism will likely have promising influence on how Queensland Child Protection manages the identification response to cumulative harm. The available literature did not reveal such initiatives in other states, which is not to say these do not exist, and future research would benefit from further review of other similar innovations.

Despite repeated calls for child protection systems to account for, and respond to, cumulative harm (of all harm types), many inquiries have found evidence that cumulative harm is neither being appropriately and consistently considered nor assessed (Child Protection Systems Royal Commission, 2016; Queensland Child Protection Commission of Inquiry, 2013; Royal Commission into the Protection and Detention of Children in the Northern Territory, 2017; Wood, 2008).

Evidence from coronial inquests – Is prioritising cumulative harm still important?

Literature since 2007 highlights the traces of cumulative harm observed in practice dialogue at a grassroots level; however, perhaps some of the strongest advocacy for the importance of recognising and redressing cumulative harm comes from coronial inquests into the deaths of children.

As I lamented in my 2018 paper, more than a decade of coronial investigations provides convincing evidence for the need for a means of assessing and recording the accumulation of risk and harm. According to Sheehan (2016), the theme of cumulative harm going unrecognised or mismanaged in organisations supporting the safety of children frequently appears in child death reviews.

According to Bentley (2014), the Child Death Case Review Committee investigating the contributing factors in the death of an 8-year-old child in Queensland, Australia, made the following recommendations:

> *the Department provide training to all staff of the region in relation to assessment and consideration of cumulative harm during intake and investigation and assessment processes* (p. 20).

In 2021, nearly a decade later, the Australian Capital Territory's Government Response to the Coroner's Report into the death of Bradyn Dillon (Minister for Families and Community Services, 2021) argued that:

> *a case analysis allows child protection practitioners to think about long-term cumulative harm, rather than a single incident of immediate risk, and ensures the voice of the child is at the front and centre of decision-making* (p. 14).

The report went on to stipulate that a renewed focus on 'strengthening the understanding and application of risk assessment, including cumulative harm' was imperative in preventing the deaths of children in the future.

A systematic review of publicly available coroner reports investigating deaths of children known to child protective services produced between 2010 and 2023 that refer to cumulative harm in their findings uncovered 30 specific coronial inquests from various Australian states and territories (see Appendix I). Databases storing the coroner reports for each state and territory were searched for mention of the terms 'cumulative', 'accumulation' and 'chronic' in relation to harm or risk of harm. Relevant reports were saved in Portable Document Format (pdf) format in separate folders for each state or territory, then analysed using thematic analysis to interpret data. The findings of these inquests detail the catastrophic impacts of cumulative harm and risk, and the significant contribution accumulation made to the death of children, many of which were known to child welfare agencies and services. Seventeen of these inquests were conducted between 2019 and 2023.

A systematic content and thematic analysis of these 30 coronial reports identified diverse causes and manner of death, providing further justification for improved measures of assessing and responding to the multiplicity, chronicity and complexity of child maltreatment and adversity. The causes of death ranged from filicide, suffocation, suicide, head injuries, medical neglect resulting in sepsis and haemorrhaging, blunt force injuries to body and head, drownings, high-level risk-taking behaviours leading to motor vehicle accidents and physical assaults. In each coronial report, it is noted that an accumulation of adverse experiences that were sustained over an extended period contributed to the ultimate fatality of the child (Bentley, 2014, 2020; Buckley, 2015; Cavanagh, 2010; Hunter, 2021; Johns, 2015; McTaggart, 2015; Minister for Families and Community Services, 2021; Ryan, 2015; Vicker, 2014). The adversities reported in each case (documented in Appendix II) demonstrate the multiplicity of maltreatment types and volume of exposure to adversity that each child endured prior to their death, also providing convincing evidence for the presence of cumulative harm in each case.

Although this list of coronial inquests is by no means exhaustive (with difficulties encountered regarding accessing and systematically searching some coronial databases), in each instance, the events that preceded the death of each child were characterised by a common theme: repeated exposure to adversity, maltreatment and neglect that resulted in an accumulation of risks and harms. The adverse childhood experiences that each child endured included multiple episodes of physical abuse, exposure to domestic and family violence, exposure to community violence, severe emotional harm caused by care neglect, supervisory neglect, medical neglect and emotional neglect. This was often reported to be in combination with exposure to parental mental ill-health, substance misuse, criminality, parental incarceration and, for several of the children, sexual abuse. The impacts of these adverse experiences for the majority of these children are extensive, including multiple placement breakdowns in the statutory care system, insecure attachments leading to further vulnerabilities, unsuccessful attempts at reunification, parental separation and divorce, high-level risk-taking behaviours, suicidal ideation and attempts, self-harm and drug misuse, behavioural impulsivity, hyper-arousal, isolation, sexual predation and school disengagement. This cumulative harm exposure diminishes any resilience a child has and increases the child's predisposition to mental health concerns, further reducing capacity to psychologically cope with the frequency duration, and severity of adversity as it manifests ongoingly (Bromfield & Higgins, 2005).

Can we 'write over the tape'?

So how do we address repeated childhood adversities and traumas? The evidence from research and practice, particularly those powerful coronial findings that seem to house most of the current discourse advocating for recognition of cumulative harm, clearly tells us we need informed practitioners, suitably nuanced assessment tools and systems that identify risk and respond early with preventative measures. However, emerging research on positive childhood experiences and poly-strengths suggests another oddly simple method, that individual, family and community strengths may also contribute to outcomes in the same dose-like manner as adverse experiences (Bethell et al., 2019; Han et al., 2023; Kocatürk & Çiçek, 2023). Combatting cumulative adverse experiences with cumulative positive experiences, for those of us old enough to understand the reference, is a little like writing over a tape.

Positive childhood experiences can be defined as:

> *… favourable experiences between birth to age 18 characterized by internal and external perceived safety, security, and support; and positive and predictable qualities of life* (Narayan et al., 2018: p. 20).

These experiences include internal (e.g. positive sense of self) and familial (e.g. safe caregiver) resources and experiences, as well as positive relationships and experiences with peers, teachers and other adults. These assets and resources promote competent development and buffer children against the negative consequences of adversity (Han et al., 2023). As with maltreatment and adversity, these positive relationships and experiences rarely occur in isolation and, instead, tend to accumulate across multiple levels with cumulative benefits on positive adjustment and

adaptation (Evans et al., 2013; Masten et al., 2021; Narayan et al., 2021). In fact, recent research (Bethell et al., 2019) exploring positive childhood experiences (PCEs)in adult populations found that they have a dose–response association with adult depression, poor mental health and adult-reported social and emotional support after adjustment for adverse childhood experiences (ACEs). Bethell et al. (2019) argued, therefore, that assessing and proactively promoting PCEs may reduce adult mental ill-health and relational problems, even in the concurrent presence of ACEs.

Conclusion

In summary, we have continued to make progress in our approach to cumulative harm in the lives of children and families. Research has clarified the qualities and characteristics of the lived experiences of cumulative harm. Legislation and policy have reinforced the priorities for responding at a statutory level, through information sharing, knowledge and skill, and the embedding of the awareness of accumulation at every level of our interventions, particularly intake and assessment. Emerging research has revealed that we can begin to override those repeated messages of harm with positivity, growth and relationship. Through coronial inquiries and child death reviews, we have learned from tragedy, and those whose job it is to make sense of the worst outcomes and provide us with critical learnings have clearly built cumulative harm into the discourse. Future research would benefit from a focus on exploring how current legal parameters actively hinder recognition and action with regard to cumulative harm, revising the work of Sheehan (2019a, 2019b) and Broadley (2014). Additionally, further research is required to examine how the concept of multiple exposures to different types of harm were analysed in the ACMS, and its consistent association with health (mental ill-health and health-risk behaviours). Equally, additional layers of cumulative experiences, such as intergenerational trauma, require deeper interrogation.

It is unsettling, to say the least, that the most powerful messages of guidance on responding to cumulative adversity come from child death reviews and coronial inquests … but we must make the most of this knowledge and be motivated and impassioned by the heartbreaking origins of these recommendations.

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Appendix I

Thirty specific coronial inquests from various Australian states and territories coded by mention of cumulative harm

Note: grey shading indicates inquests between 2019 and 2023

Code (State, Report project number)	Reference	Mentions of cumulative harm	Extract regarding cumulative harm
ACT-1	Coroners Court of the Australian Capital Territory. (2021). *Inquest into the death of Bradyn Stuart Dillon.*	Cumulative – 111 Accumulation – 0 Chronic – 0	*It is patently clear to me* [coroner]*, that PG* [Child Safety Officer-CSO] *did not have any proper understanding of what cumulative harm was at the time she gave her evidence*
NSW-1	Coroners Court of New South Wales. (2022). *Inquest into the death of CS.*	Cumulative – 7 Accumulation – 0 Chronic – 0	*did not consider the children's experiences in the care of their family and did not recognise the risk of cumulative harm to CS and DS*
NSW-2	Coroners Court of New South Wales. (2019). *Inquest into the death of Emily.*	Cumulative – 1 Accumulation – 0 Chronic – 0	*failed to adequately recognise the series of serious cumulative risk factors Emily presented with in her last year of life*
NSW-3	Coroners Court of New South Wales. (2018). *Inquest into the death of J.*	Cumulative – 1 –	*This would have indicated an increased level of risk, and would heighten concerns 'for the level of cumulative harm experienced by the children'*
NSW-4	Coroners Court of New South Wales. (2016). *Inquest into the death of M.*	Cumulative – 1 Accumulat(ion) – 2 Chronic	
NSW-5	Coroners Court of New South Wales. (2023). *Inquest into the death of SG.*	Cumulative – 4 Accumulate – Chronic –	*The cumulative effect of this should have had some bearing on the latter reports. There were a number of missed opportunities to ensure that received assistance.* (51)
NSW-6	Coroners Court of New South Wales. (2021). *Inquest into the death of Z.*		*It is likely that the extent of the neglect experienced by Z and his siblings was not fully understood. There was no evidence that the history, frequency of reports, duration of the children's experience of neglect, likelihood that the children would continue to be at harm or their developmental stage were considered*
NSW-7	Coroners Court of New South Wales. (2021). *Inquest into the deaths of John, Jack and Jennifer Edwards.*		
NSW-8	Coroners Court of New South Wales. (2021). *Inquest into the death of SN.*		
NT-1	Coroners Court of Northern Territory. (2010). *Inquest into the death of Deborah Leanne Melville-Lothian.*		
NT2	Coroners Court of Northern Territory. (2020). *Inquest into the deaths of Master W, Miss B and Master JK.*	Cumulative – 0 Accumulate – 0 Chronic – 1	*There were multiple notifications received in relation to the welfare of the children*
QLD-1	Coroners Court of Queensland. (2010). *Inquest into the death of a 2 year old child.*		
QLD-2	Coroners Court of Queensland. (2015). *Inquest into the death of a 13 year old girl (P).*		
QLD-3	Coroners Court of Queensland. (2014). *Inquest into the death of a child, Faith.*		
QLD-4	Coroners Court of Queensland. (2015). *Inquest into the deaths of JE and JJ.*		
QLD-5	Coroners Court of Queensland. (2020). *Non-Inquest findings into the death of T & P.*	Cumulative – 1 Accumulate – Chronic –	*the Panel considered the children had experienced precursors of cumulative harm and neglect, including previous concerns regarding inadequate supervision*
QLD-6	Coroners Court of Queensland. (2020). *Non-Inquest findings into the death of CJ, a 14 year old boy.*	Cumulative – 3 Accumulate – 2 Chronic –	*a pattern of cumulative harm or trauma that required comprehensive and holistic intervention, likely due to the accumulation of issues*
QLD-7	Coroners Court of Queensland. (2021). *Non-Inquest findings into the death of T, an eight-week-old infant.*	Cumulative – 1 Accumulate – 1 Chronic	*A full and deliberate analysis was needed* [unfortunately it was not provided] *to make sense of multiple concerns and contacts with this family and the impact of cumulative harm on the children. Undue weight was given to previous assessment outcomes …*

SA-1	Coroners Court of South Australia. (2022). *Finding of Inquest into the deaths of Amber Rose Rigney and Korey Lee Mitchell.*	Cumulative – 4 Accumulate – 2 Chronic – 0	*known previous history of the child's care, or to the lack of such history, or with the likely cumulative effect on the child of that history to date. It is difficult to imagine how any meaningful risk assessment in relation to children could ignore previous history*
SA-2	Coroners Court of South Australia. (2023). *Inquest into the death of Zhane Andrew Keith Chilcott.*	Cumulative – 1 Accumulate – 0 Chronic – 0	*This inquest has identified many specific failings in the provision to Zhane of state care. In my opinion, the cumulative effect of all those failings was to increase his risk of suicide*
TAS-1	Coroners Court of Tasmania. (2010). *Investigation into death without inquest of Baby R.*		
TAS-2	Coroners Court of Tasmania. (2015). *Record of Investigation into Death (with inquest) of Jasmine Rose Pearce.*		
TAS-3	Coroners Court of Tasmania. (2018). *Findings, Comments and Recommendations of Coroner Olivia McTaggart following the holding of an inquest under the Coroners Act 1995 into the death of:* *Rhiannon Pearl Vanessa Pitchford.*		
VIC-1	Coroners Court of Victoria. (2022). *Finding into death without inquest – Child C.*	Cumulative – 10 Accumulate – 0 Chronic – 0	*I find that Child C's passing was clearly preventable, with the principal cause being a lack of parental supervision. There was also a failure by Child Protection to adequately assess and appreciate the significant risk associated with Child C's exposure to neglect and cumulative harm and a failure to escalate Child C's case to the investigation phase at an earlier stage of its involvement with him*
VIC-2	Coroners Court of Victoria. (2020). *Finding into death without inquest – HB.*	Cumulative – 3 Accumulate – 0 Chronic – 1	*paid too little heed to the family's protective history which revealed poor past engagement with services and the potential for cumulative harm and/or chronic neglect*
VIC-3	Coroners Court of Victoria. (2020). *Finding into death without inquest – Baby S.*	Cumulative – 4 Accumulate – 0 Chronic – 0	*However, despite these practice guidelines, it is apparent in this case that Child Protection lacked assertive engagement with other professionals, who could have assisted them in their analysis and contributed to balanced and well considered decision making concerning cumulative risk to Baby S*
VIC-4	Coroners Court of Victoria. (2022). Finding into death without inquest – Master S.	Cumulative – 5 Accumulate – 1 Chronic –1	*specifically asked whether there should have been a cumulative harm review. Master S's life lacked stability and connection to a parental figure, and he experienced cumulative harm as a result of numerous factors*
VIC-5	Coroners Court of Victoria. (2020). *Finding into death without inquest – Zakiya Crystal Lisa Thomas.*	Cumulative – 0 Accumulate – 1 Chronic – 1	*Axiomatically family violence has a serious impact on the health and wellbeing of children and young people the long-term impacts of which may not always be apparent in the short term. The North and West Children's Resource Program noted that the impacts "on children who live with family violence may be acute and chronic, immediate and accumulative, direct and indirect, seen and unseen*
WA-1	Coroners Court of Western Australia. (2017). *Record of Investigation into death of Child JM.*	Cumulative – 4 Accumulate – 0 Chronic – 0	*There is now a greater focus upon the impact of potential cumulative harm. Mr Mace explained that now, in a situation arising in circumstances similar to Child JM, the Department of Communities would require the assessor to look at the history and to consider the cumulative impact of harm. This assessment would consider any history of association with another person who may be seen to be a negative influence upon the child being assessed*

Appendix II

Adversities reported in each case

Report	DFV	Substance abuse	Neglect	Emotional Abuse	Physical Abuse	Mental Health issues	Sexual Abuse	Incarceration/involvement with justice system	Insecure Housing	Frequent School Absence
ACT-1	✓	✓ (parent)	✓	✓	✓			✓ (parent)		
NSW-1	✓	✓ (parent)	✓	✓	✓	✓ (parent)				
NSW-2					✓	✓ (child)				
NSW-3	✓		✓				✓	✓ (parent)	✓	
NSW-4		✓ (child)			✓	✓ (child)		✓ (child)		✓
NSW-5	✓		✓		✓	✓ (parent and child)	✓			
NSW-6		✓ (parent)	✓		✓					
NSW-7	✓	✓		✓	✓			✓ (parent)		
NSW-8						✓ (parent)				
NT-1	✓	✓	✓	✓	✓		✓	✓ (parent)	✓	✓
NT-2	✓	✓	✓	✓	✓	✓	✓	✓ (child)		✓
QLD-1	✓	✓ (parent)	✓	✓	✓					
QLD-2	✓		✓	✓	✓	✓ (child)	✓	✓ (child)		✓
QLD-3	✓		✓	✓	✓					✓
QLD-4		✓ (child)	✓	✓				✓ (child)		✓
QLD-5	✓	✓ (parent)	✓	✓	✓					✓
QLD-6	✓	✓ (parent)	✓	✓	✓	✓ (parent)	✓	✓ (child)		✓
QLD-7	✓	✓ (parent)	✓						✓	✓ (older siblings)
SA-1			✓	✓		✓ (child)				
SA-2	✓	✓ (parent and child)				✓ (child)		✓ (parent and child)		
TAS-1	✓	✓ (parent)	✓			✓ (parent)			✓	
TAS-2	✓	✓ (parent)	✓			✓ (parent)			✓	
TAS-3	✓	✓ (parent)	✓	✓ (sibling)	✓ (sibling)					✓ (sibling)
VIC-1		✓ (parent)	✓	✓						✓ (sibling)
VIC -2		✓ (parent)	✓	✓	✓					✓
VIC-3	✓	✓ (parent)	✓		✓	(parent)			✓	
VIC-4	✓	✓ (parent and child)		✓	✓	✓ (parent and child)		✓ (child)		✓
VIC-5	✓	✓ (parent and child)	✓		✓	✓ (child)	✓			✓
WA-1	✓	✓ (parent)	✓			✓ (child)		✓ (parent and child)		✓