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Media Release

Independent watchdog releases report on child deaths

In 2006-07, the Child Death Case Review Committee (CDCRC) reviewed the deaths of 62 children known to the child protection system.

In 42 cases, the child was under the age of four at the time of death.

While 69.3% of the 62 reviews considered involved children in the care of one or both of their biological parents at the time of deaths.

CDCRC Chair Elizabeth Fraser said the risk to the 0 to four age group is increased by their inability to protect themselves.

"Overall, the report findings highlight the need for timely, tailored responses to address the risks in families in contact with the child protection system", Ms Fraser said.

Ms Fraser said the statistics also highlight the importance of improving community-based services for families.

"I'll continue to advocate to government on the importance of effective early intervention support for these families," she said.

The CDCRC is the independent body in Queensland which reviews the deaths of children who have had contact with the Department of Child Safety in the three years before they died.

The report notes that children known to the department are a high risk group, and are three times more likely to die of external causes than all children.

"It's vital that timely intervention and effective support structures are put in place to help families reduce risk as much as possible," Ms Fraser said.

External causes of death included non-accidental trauma, such as fatal assault (7 deaths) and suspected suicide (4); and accidental deaths, including transport incidents (7), drowning (3) and other non intentional deaths (2).

Because of the timeframes around the review process, 36 of the 62 reviews considered were about children who died in 2005-06. Under the Commission's Act, the department has six months to review each death, and the CDCRC has three months to assess the review.

In 2006-07, 57 children known to the department died, compared with 52 the previous financial year.

However, the overall the rate at which children known to the department died dropped from 73.4 per 100,000 in 2005-06 to 66.2 per 100,000 in 2006-07.

"Overall, this is an encouraging sign," Ms Fraser said.

The CDCRC aims to help the department improve the way it conducts reviews into child deaths to identify areas where practice can be improved.

While the Committee noted improvement in the quality of reviews in 2006-07, areas identified for practice improvement included:

- interagency collaboration
- unborn child notifications
- children with disabilities, and
- record keeping.

"The committee is encouraged by the department's response to its recommendations and its concerns about the deaths of children aged 0 to four," she said.

"I expect the department's 'One Chance at Childhood' initiative to further improve outcomes for young children by having experts provide advice on decisions affecting those aged 0 to four."

Committee members extended their condolences to the families, carers and friends of all those children who died and were subject to review in this year's report.

"I commend this report to those in the sector, as it demonstrates the government's commitment to accountability, transparency and ongoing improvements to our child protection system," Ms Fraser said.

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