

Child Death Case review Committee

Media Release

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CDCRC report makes system more accountable

The Child Death Case Review Committee has today released its second Annual Report on the deaths of children and young people known to the child protection system.

[A child is considered to be 'known' to the Department of Child Safety (DChS) if they had contact with the department in the three years before their deaths.]

The 2005-06 CDCRC Annual Report covers the first full year in which the deaths of children and young people known to the department have been reviewed by the independent external committee.

The report provides an essential accountability mechanism in the child protection system and aims to enhance child protection in Queensland.

The purpose of the analysis and reporting of this information is to help government and the community better support children most at risk.

A total of 51 children and young people known to DChS died in the 12 months to 30 June 2006. Of these, the CDCRC reviewed 40 cases in detail. Ten deaths were due to fatal assaults or suicide, however, none of these occurred while the child was in foster care.

18 children died from illness or disease and 12 died from accidental causes, including eight in transport accidents and four drownings.

Committee Chair, Elizabeth Fraser, said although caution needs to be exercised when interpreting the data due to the relatively small number of deaths, the figures show children DChS deals with are the most vulnerable and at-risk group in the state.

The report revealed children known to the child protection system were more likely to be fatally assaulted than those in the general population, with 9.9 deaths per 100,000 from fatal assault to June 30 2006, compared with 0.9 deaths per 100,000 in the general population.

In addition, children and young people known to the department were more likely to suicide with 6.6 deaths per 100,000 in the child protection population compared with 1.5 deaths per 100,000 of all Queensland children aged 1-17 years.

"The high death rates among these children can be partly explained by the high levels of substance abuse and family violence to which they are exposed," the Commissioner said.

"The CDCRC report shows a combination of these factors was evident in 52% of the deaths of children known to the department during this period."

The CDCRC is chaired by the Commissioner for Children and Young People and Child Guardian and is made up of eight members, including the Police Commissioner, Qld Health paediatric and psychiatric experts and Indigenous representatives.

Under the system of review, DChS has six months to review the death of a child who is known to the department and the CDCRC has three months to examine the review.

Commissioner, Elizabeth Fraser, said a significant number of the cases reviewed in 2005-06 involved cases which occurred before or at the start of the child safety system reform process.

The department has already moved to address some of the systemic issues identified, including problems with:

- record-keeping
- the quality of risk assessments
- standards of professional practice (including non-compliance with departmental legislation and policy), and
- the management of new or inexperienced staff.

‘Where problems have been identified, I have been impressed by the department’s willingness to take positive steps to deal with them,’ the Commissioner said.

“At the end of the reporting period the CDCRC was satisfied that appropriate steps were being taken by the department to implement the 172 recommendations made in that period.”

In the coming year, the CDCRC will continue to monitor the implementation of its recommendations and the steps taken by the department to address the issues raised.

On behalf of the CDCRC the Commissioner expressed her condolences to the families, carers and friends of the children and young people whose cases have come before the CDCRC.

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