



commission for  
children and young people  
and child guardian

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## **Media Release**

### **Overall child deaths down, but suicide stats remain concerning**

For the second year running, suicide has been identified as the leading external (non-natural) cause of death for children between 10-14 years.

The issue is recorded in the Commission for Children and Young People and Child Guardian's Annual Report on the Deaths of Children and Young People in Queensland in 2005-06, released today.

Commissioner, Elizabeth Fraser, said although the numbers involved are not large, the continuing trend is concerning.

As a result, the Commission has initiated a research project into this issue, which over the next 12 months is expected to generate improved data gathering and findings about prevention and early intervention strategies.

"One of the key problems in combating this problem is having it recognised as an issue in the first place," Ms Fraser said.

"We know that 17% of all deaths in this age group were due to suicide, but official figures on youth suicide are under-reported at both commonwealth and state level because of way deaths are recorded."

The Commission's report indicates many children's suicides are reported as accidental deaths by the Australian Bureau of Statistics and the registry of Births Deaths and Marriages is restricted from recording the word 'suicide' as a cause of death by its Act.

In addition, the Australian Bureau of Statistics doesn't report on suicide figures for children under 15 years-of-age.

"Until official reporting systems can more effectively track the numbers of children and young people dying by their own hand, community action and government funding are unlikely to match the need for them," the Commissioner said.

In addition, the Commission has made a recommendation that the Department of Child Safety (DChS) review the deaths of children who have had siblings known to the department, even if the child who died had no direct contact with the child protection

system – the department currently only has the power to review the deaths of children known to the department.

“These cases often involve a younger sibling who has been born after DChS involvement with a family has ceased,” Ms Fraser said.

“Newborns appear to be at increased risk in such environments, and I believe DChS could learn more about the risk factors if it did reviews of these child deaths.”

In 2005–06 the Commission identified four deaths where there was no contact between the dead child and the department, but the child’s sibling/s had been the subject of departmental involvement.

“I’m concerned potential lessons from these cases could be lost, as they’re not reviewed by the independent Child Death Case Review Committee,” the Commissioner said.

The Child Death Case Review Committee (CDCRC) only reviews the deaths of all children known to the department in the three years before their deaths. (A child is considered to be ‘known’ to DChS if they have had contact with the department in the previous three years.)

She said the Commission’s ability to identify such cases depends on the information available to police during investigations into a death. As there hasn’t been a focus on a sibling’s contact with the department to date, the real number of children involved could be higher than four.

Identifying key risk factors is critical in developing effective family support strategies.

The Commission’s report, *Deaths of Children and Young People Queensland 2005-06* analyses and provides information on the factors contributing to child and youth mortality in this state.

It presents findings on 426 deaths of children and young people, and includes six recommendations on improving the integrity and reliability of the data on those deaths.

This is a drop from 481 deaths last financial year.

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