Chapter 4:

Chapter 4: Child deaths in 2004–05

Deaths of children known to the Department of Child Safety

During the period from 1 July 2004 to 30 June 2005, the deaths of 482 children were registered in Queensland with the Registry of Birth, Deaths and Marriages.

The Department of Child Safety's (the Department's) legislative obligation for conducting child death case reviews commenced on 1 August 2004. As such, the Department is only required to conduct reviews in relation to deaths that occurred after this date[14]. From 1 August 2004 to 30 June 2005, 33 children who died in Queensland were known to the Department either at the time of, or within the three years before, their death.

During the reporting period, the Department completed 14 original reviews, involving a total of 15 child deaths. The CDCRC reviewed eight of the 14 original reviews. The review processes for both the Department and the CDCRC are described in chapter three of this report.

Table 4.1 provides a demographic profile of the 33 deaths of children known to the Department. Cases marked with an asterisk (*) refer to the nine children whose child death case reviews were reviewed by the CDCRC (two of these children died in the same incident and were the subject of a joint review).

Table 4.1 Deaths of children known to Department

Subject child	Age bracket	Gender	Indigenous status	Region	Cause of death
SC1	Under 1 yr	Female	Not Indigenous	Metropolitan	Acquired disease/illness
SC2*	1–4 yrs	Female	Aboriginal	Regional	Acquired disease/illness
SC3*	15–17 yrs	Male	Not Indigenous	Regional	Acquired disease/illness
SC4	Under 1 yr	Male	Aboriginal	Remote	Not yet determined
SC5*	5–9 yrs	Male	Not Indigenous	Regional	Acquired disease/illness
SC6*	15–17 yrs	Female	Not Indigenous	Regional	External causes
SC7	Under 1 yr	Male	Torres Strait Islander	Regional	Acquired disease/illness
SC8*	Under 1 yr	Male	Not Indigenous	Regional	Sudden Infant Death Syndrome (SIDS)
SC9*	1–4 yrs	Female	Aboriginal	Remote	External causes
SC10*	1–4 yrs	Male	Aboriginal	Remote	External causes
SC11	1–4 yrs	Female	Not Indigenous	Remote	Acquired disease/illness
SC12*	10–14 yrs	Male	Not Indigenous	Regional	External causes
SC13*	Under 1 yr	Female	Not Indigenous	Regional	Acquired disease/illness
SC14	Under 1 yr	Male	Aboriginal	Regional	Acquired disease/illness
SC15	5–9 yrs	Female	Not Indigenous	Regional	Acquired disease/illness
SC16	15–17 yrs	Male	Not Indigenous	Interstate	External causes
SC17	15–17 yrs	Male	Not Indigenous	Remote	External causes
SC18	1–4 yrs	Female	Aboriginal	Remote	Acquired disease/illness
SC19	Under 1 yr	Male	Unknown	Regional	Non-accidental trauma
SC20	1–4 yrs	Male	Not Indigenous	Regional	Non-accidental trauma
SC21	10–14 yrs	Male	Not Indigenous	Regional	External causes
SC22	15–17 yrs	Male	Unknown	Metropolitan	Acquired disease/illness
SC23	1–4 yrs	Male	Unknown	Metropolitan	Acquired disease/illness
SC24	5–9 yrs	Male	Aboriginal	Regional	Acquired disease/illness
SC25	1–4 yrs	Female	Aboriginal	Remote	Acquired disease/illness
SC26	1–4 yrs	Male	Not Indigenous	Remote	External causes
SC27	15–17 yrs	Female	Not Indigenous	Regional	Acquired disease/illness
SC28	Under 1 yr	Male	Aboriginal	Metropolitan	Not yet determined
SC29	5–9 yrs	Male	Not Indigenous	Remote	Acquired disease/illness
SC30	1–4 yrs	Female	Not Indigenous	Remote	Acquired disease/illness
SC31	5–9 yrs	Male	Not Indigenous	Metropolitan	Not yet determined
SC32	1–4 yrs	Female	Aboriginal	Remote	External causes
SC33	10–14 yrs	Male	Aboriginal	Remote	External causes

14 *Child Safety Legislation Amendment Act 2004 No. 13* (Qld) s 16.

Age and gender

Of the 33 children who died, over half (57 per cent) were aged between birth and four years. More males than females died (64 per cent and 36 per cent respectively).

Table 4.2 Age and gender of children

	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Female	2	7	1	0	2	12
Male	6	4	4	3	4	21
Total	**8**	**11**	**5**	**3**	**6**	**33**

Aboriginal and Torres Strait Islander status

Twelve Aboriginal or Torres Strait Islander children died during this reporting period, accounting for 36 per cent of deaths of children known to the Department.

Geographical distribution

The large majority of the children who died resided in regional or remote areas (82 per cent).

Table 4.3 Areas where children resided

Area	Number of children
Metropolitan*	5
Regional**	15
Remote***	12
Interstate	1

** The metropolitan area refers to Brisbane city and surrounding suburbs.*
*** The regional area refers to inner and outer regional locations in Queensland.*
**** The remote area refers to rural and minor towns in Queensland.*

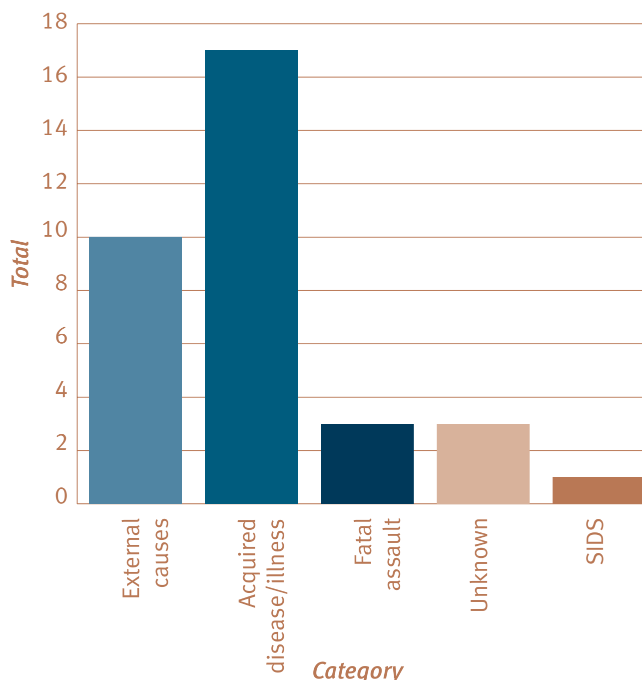
Categories of death

The Commission's Child Death Register categorises cause of death according to the World Health Organisation's *International Classification of Diseases and Related Health Problems (ICD)* 10th revision.

In the reporting period 'acquired disease/illness' was the main cause of death of children known to the Department. This category includes deaths resulting from significant disabilities and/or long-term illnesses.

External causes accounted for 10 deaths of children known to the Department and included car accidents, drowning and house fires.

Figure 4.1 Categories of death of children



Child death case reviews

This section provides an overview of the original reviews undertaken by the Department and externally reviewed by the CDCRC during the reporting period.

It also provides a description of the key characteristics of the children and families who were the subject of the reviews, including an outline of the nature of the Department's contact with these children and families.

Completed reviews

From 1 August 2004 to 30 June 2005 the Department completed 14 original reviews involving 15 children who died.

The CDCRC reviewed eight of the Department's original review reports concerning nine children.

Compliance with legislative timeframes

The Department

Once the Department has been notified of a child's death it must, as soon as practicable, complete a review of its involvement with the child. A copy of the original review report and relevant documents must be provided to the CDCRC within six months[15].

As set out in Table 4.4, the Department completed seven of its 14 original reviews within its six month statutory timeframe, with two provided to the CDCRC five days early. Of those that were provided outside the timeframe, the delay varied from one month to two and a half months. Four original review reports were outstanding as at 30 June 2005.

15 Section 246D of the CP Act.

Table 4.4 Due dates and dates of receipt of original review reports

Original review report	Due date	Date received
Report 1	09/02/2005	09/02/2005
Report 2	08/03/2005	27/05/2005
Report 3	13/03/2005	31/03/2005
Report 4	21/03/2005	18/04/2005
Report 5	25/02/2005	29/03/2005
Report 6	27/02/2005	27/02/2005
Report 7	21/04/2005	20/06/2005
Report 8	05/04/2005	03/06/2005
Report 9	18/04/2005	18/04/2005
Report 10	13/04/2005	13/04/2005
Report 11	15/04/2005	Outstanding as at 30/06/2005
Report 12	02/05/2005	03/05/2005
Report 13	21/05/2005	Outstanding as at 30/06/2005
Report 14	20/05/2005	Outstanding as at 30/06/2005
Report 15	17/05/2005	17/05/2005
Report 16	08/06/2005	03/06/2005
Report 17	08/06/2005	03/06/2005
Report 18	25/06/2005	Outstanding as at 30/06/2005

The Department advises the CDCRC of any revised due dates and provides preliminary reports when it is unable to meet the statutory timeframe for completing the review. However, these preliminary reports provide only limited information including a brief outline of the facts, the terms of reference and the review status.

The CDCRC

The CDCRC is required to give a copy of its review reports to the Department within three months after receiving the Department's original review report[16].

The CDCRC complied with its three month statutory timeframe for each of its eight reviews completed in 2004–05. Two reports were provided to the Department on the due date. One report was provided six weeks early and the remaining five reports were provided between five days and three weeks early.

Child and family characteristics

The following child and family characteristics were identified in the eight reviews completed by the CDCRC during the reporting period.

Age and gender

Five of the nine children were aged under four years, one was aged five to nine years and three were aged 15 to 17 years. Five children were male and four were female.

16 Section 89U of the CCYPCG Act.

Table 4.5 Age and gender of children

	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Female	1	2	0	0	1	4
Male	1	1	1	0	2	5
Total	**2**	**3**	**1**	**0**	**3**	**9**

Aboriginal and Torres Strait Islander status

Three of the nine children who died were of Aboriginal or Torres Strait Islander origin.

Care arrangements at the time of death

Table 4.6 represents the care arrangements in place at the time of the nine deaths. Five of the children were placed in alternative care at the time of their death.

Table 4.6 Care arrangements at the time of death

Two parent families		Single parent families		Alternative care			Total
Biological Parents	Grandparent and biological parents	Biological mother	Biological father	Extended family/ friends	Foster family	Hospital	
1	0	3	0	2	3	0	9

Parental characteristics

Consideration needs to be given to external factors when assessing the risk of harm to a child. Parental issues such as substance abuse, family violence, transience, mental illness, child protection history and intellectual disability impact on the parent's capacity to provide adequate care and protection to their child. Table 4.7 summarises the presence of these characteristics in the families of the eight children.

Table 4.7 Overview of parental characteristics

Parental characteristics	Cases where characteristic identified
Family violence	4 (50%)
Substance abuse	3 (37.5%)
Mental illness	2 (25%)
Corrective services history	2 (25%)
Transience	1 (12.5%)
Intellectual disability	0

Parental substance abuse and family violence were identified in the majority of families. A transient lifestyle was noted in one of the cases and parental mental illness was identified in two cases. In most cases where specific parental characteristics were evident, families presented with more than one of the characteristics described above (83 per cent). The most commonly combined parental characteristics were substance abuse and family violence, substance abuse and mental illness, and family violence and corrective services history.

Nature of contact with the Department

When the Department receives information about a child or young person an 'intake' is recorded. If the information leads the Department to reasonably believe that a child has suffered harm or is at risk of suffering harm, a 'child protection notification' (CPN) is recorded. If the level of harm is considered to be significant the Department will carry out an 'initial assessment' to determine the protective needs of the child. If the level of harm is not considered to be significant the Department will provide 'protective advice' to the notifier but will not make any contact with the family involved[17].

Table 4.8 shows the child protection status at the time of the child's death and the child's and their family's history of involvement with the Department.

Overall, five of the nine children were subject to current departmental intervention when they died, two were not subject to current intervention, and in the other two cases the level of intervention at the time of the child's death cannot be established due to the Department's poor recordkeeping.

17 The nature and extent of these responses is currently the subject of significant reform as a result of the CMC inquiry.

Table 4.8 Child protection status and history of departmental involvement

Subject child	Age bracket	Gender	Indigenous status	Area	Cause of death	Child protection status at time of death	History of previous departmental involvement
SC2	1–4 years	Female	Aboriginal	Regional	Acquired disease/ illness	SC was under a Child Protection Order (CPO) since 2001 (extended in 2003) and was placed with departmental carers.	One Child Protection Notification (CPN) in relation to SC resulted in substantiated physical harm in 2001 and two CPNs regarding the SC's siblings in 2003–04 were unsubstantiated.
SC3	15–17 years	Male	Not Indigenous	Regional	Acquired disease/ illness	SC was not subject to any departmental orders or departmental intervention.	SC and his siblings were the subject of nine CPNs and three intakes in 1992–03. Two of these CPNs resulted in alternative placement of SC and his siblings, three resulted in substantiated harm or risk of harm, one was responded to by protective advice and three were not completed. A protective supervision order was granted in 1994 and released in 1998.
SC5	5–9 years	Male	Not Indigenous	Regional	Acquired disease/ illness	SC was under a short-term CPO since 2003 (extended in 2004) and was residing with foster carers.	SC was subject of two CPNs from 2002–04. At the time of death the Initial Assessment (IA) following the CPN recorded in 2004 had not been completed and no outcome had been recorded in the Department's database.
SC6	15–17 years	Female	Not Indigenous	Regional	External causes	SC was not subject to any departmental orders or departmental intervention.	SC was the subject of a CPN in 2004 which was responded to with protective advice.
SC8	Under 1 year	Male	Not Indigenous	Regional	Sudden Infant Death Syndrome (SIDS)	SC and his family were involved in Intensive Family Support (IFS) with a 28 day approval for placement of SC with parental consent.	SC and his siblings were subject to one CPN in 2004 which resulted in substantiated risk of harm. A Temporary Assessment Order (TAO) was made followed by a Court Assessment Order (CAO). When the CAO expired, an IFS case was opened.

Table 4.8 Child protection status and history of departmental involvement *continued*

Subject child	Age bracket	Gender	Indigenous status	Area	Cause of death	Child protection status at time of death	History of previous departmental involvement
SC9	1–4 years	Female	Aboriginal	Remote	External causes	SC was assigned an Early Intervention and Prevention Worker (EIPW).	SC and her siblings were the subject of nine CPNs and two intakes in 1995-2004. Three CPNs were substantiated, three were substantiated at risk, two were unsubstantiated and one was recorded with no outcome. Four CPNs resulted in a referral to an EIPW.
SC10	1–4 years	Male	Aboriginal	Remote	External causes	SC was assigned an EIPW.	SC and his siblings were subject to nine CPNs and two intakes in 1995–2004. Three CPNs were substantiated, three were substantiated at risk, two were unsubstantiated and one was recorded with no outcome. Four CPNs resulted in a referral to an EIPW.
SC12	15–17 years	Male	Not Indigenous	Regional	External causes	Unclear whether IFS intervention was provided to SC's family due to poor record keeping.	SC and his siblings were subject to two CPNs in 2003–04. The first CPN was unsubstantiated and the second was substantiated.
SC13	Under 1 year	Female	Not Indigenous	Regional	Acquired disease/ illness	Unclear whether IFS intervention remained open to SC's family due to poor record keeping.	SC and her siblings were subject to one CPN in 2004 which resulted in a substantiated risk. As a result, an IFS case was opened.