

Chapter 3

Overview of reviews considered by the CDCRC in 2006–07

Key messages

- In 2006–07 the CDCRC considered 61 child death case reviews in relation to 62 distinct children.
- Disease and morbid conditions were the cause of death in 23 cases (37.0%) of the cases considered. Infant deaths due to SIDS or undetermined causes accounted for 7 deaths (11.3%).
- Fifty percent of the cases considered related to children who died as a result of external causes, with 13 of those being the result of non-accidental trauma (9 fatal assaults and 4 suspected suicides).
- Of the 62 children whose cases were reviewed, 67.7% were aged between birth and four years at the time of their death.
- Overall, 85.3% of the child death case reviews considered in 2006–07 involved children or young people who either were in the child protection system or died within six months of being known to the department.
- Twenty-two of the 62 children were the subject of an open Investigation and Assessment at the time of their death, and all but one concerned a child aged between birth and four years.

The first part of this chapter provides an overview of the CDCRC's activities in 2006–07. The second provides key demographic and case-specific information in relation to the children and young people whose cases were the subject of review.

CDCRC activities in 2006–07

The department has six months to complete a review about its involvement with a child or young person and provide a report to the CDCRC. The CDCRC, in turn, has three months to consider the review and provide a report to the department about its findings and recommendations.

In 2006–07 the CDCRC considered 61 reviews prepared by the department in relation to 62 distinct children. As at 30 June 2007, the CDCRC had finalised and

provided reports to the department for 50 of the 61 reviews it had considered.⁹ Because of the time frames associated with the review process, 59.0% (36) of the reviews considered were about deaths of children that occurred in 2005–06, while 41.0% (26) related to deaths that occurred in 2006–07.

The CDCRC review process involves the following four steps:

1. Meeting to consider the department’s review, including making findings and formulating recommendations
2. Preparing a report to the department based on the CDCRC’s consideration of a review
3. Finalisation of a review (that is, delivering a report to the department), and
4. Monitoring the implementation of recommendations.

Child death case reviews considered in 2006–07

This section provides a quantitative and qualitative analysis of the 61 case reviews (concerning 62 children and young people) that were considered by the CDCRC in 2006–07. For consistency, this information is presented in a similar format to Chapter 2 (which relates to the 57 children and young people who actually died in 2006–07). However, given the nature of the case review process, this chapter contains additional data and details about the status and extent of child protection service delivery at the time of the 62 deaths.

Cause of death

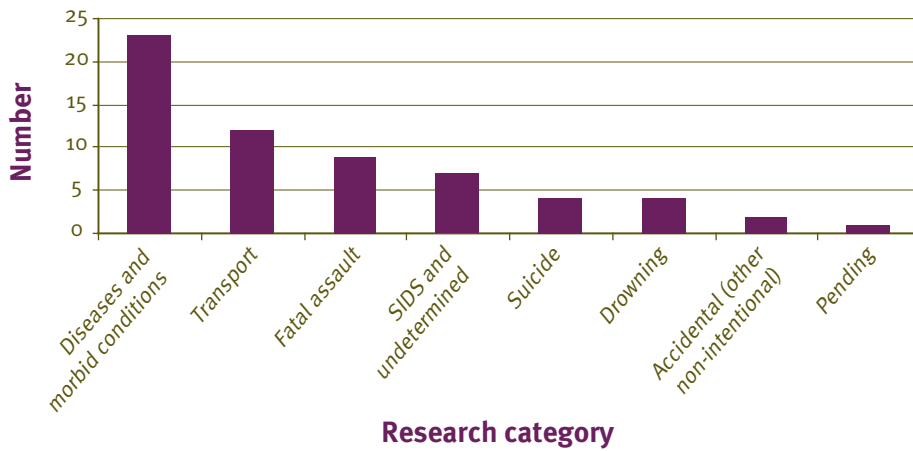
Figure 3.1 shows the cause of death for the 62 children.

Diseases and/or morbid conditions were the cause of death in 23 (37.0%) of the cases considered by the CDCRC in 2006–07. Infant deaths due to SIDS and/or undetermined causes accounted for 7 deaths (11.3%), and the cause of death for one child was unknown (pending test results).

External causes accounted for 50.0% (31 deaths) of the cases considered and included transport incidents (12 deaths), drowning (4 deaths) and accidental (other non-intentional) (2 deaths). Non-accidental trauma accounted for the remaining 13 deaths; of these, 9 were fatal assault and 4 were suspected suicide.

⁹ Of the 61 reviews considered, the CDCRC finalised (i.e. delivered reports to the department) in respect of 50 cases as at 30 June 2007. Reports in relation to 11 of the reviews considered by the CDCRC were being drafted as at 30 June 2007 and were not due to be delivered to the department, in accordance with the three-month statutory time frame, until after 30 June 2007. This report discusses the 61 reviews (in relation to 62 children) considered by the CDCRC as the CDCRC had deliberated on the matter and formulated its recommendations in the 2006–07 reporting period.

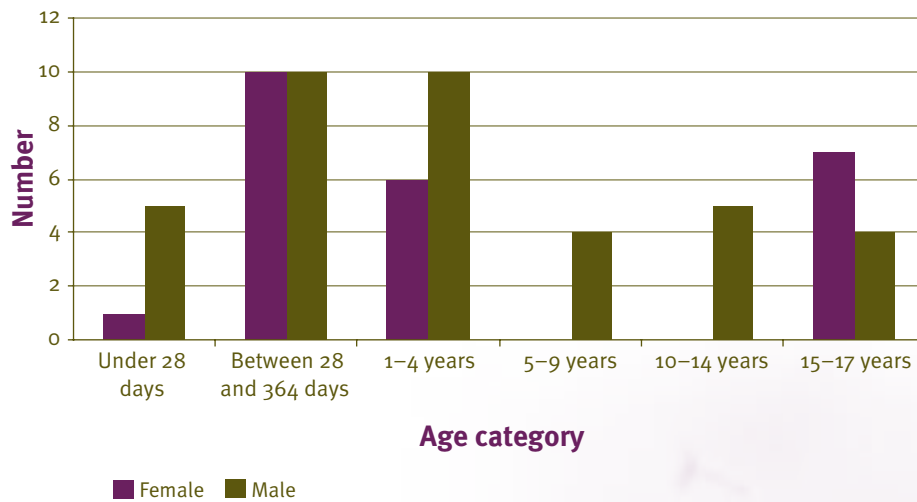
Figure 3.1 Child death reviews considered in 2006–07: cause of death



Age and gender

More males than females died (61.3% and 38.7% respectively). Figure 3.2 shows the distribution of deaths across the age brackets.

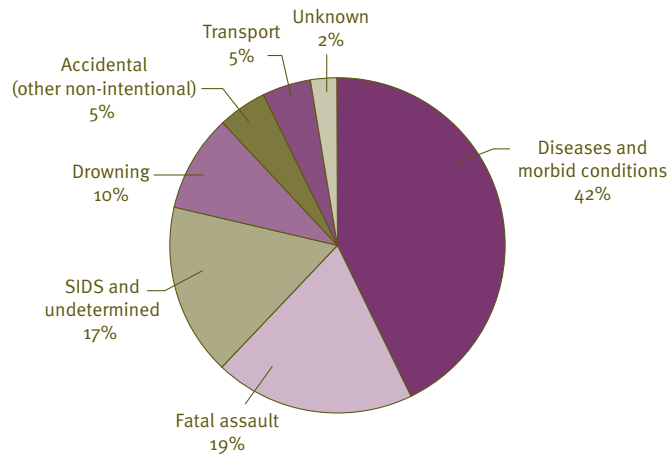
Figure 3.2 Child death case reviews considered in 2006–07: age and gender



As Figure 3.2 highlights, of the 62 children and young people whose cases were reviewed, 67.7% were aged between birth and 4 years at the time of death.

Figure 3.3 shows the cause of death for children aged between birth and 4 years.

Figure 3.3 Cause of death for children aged between birth and 4 years



Aboriginal and Torres Strait Islander status

Twenty of the child death reviews considered by the CDCRC in 2006–07 involved Aboriginal and/or Torres Strait Islander children, accounting for 32.2% of cases considered (18 Aboriginal, 1 Torres Strait and 1 both Aboriginal and Torres Strait Islander).

Geographical distribution (ARIA+)

The child death reviews considered involved 24 children who resided in major cities of Australia and 13 children who resided in inner regional areas (42.1% and 22.8% respectively). Sixteen of the children resided in outer regional areas (25.8%), while 8 children resided in remote or very remote areas (11.2%).

Table 3.1 Child death reviews considered in 2006–07: areas where children resided

Area	Number of children
Major Cities of Australia	24
Inner Regional Australia	13
Outer Regional Australia	16
Remote Australia	3
Very Remote Australia	4
Unknown ¹⁰	2

Living arrangements at time of death

Table 3.2 shows the children and young people’s living arrangements at the time of their death. The majority (69.3%) were in the care of both or one of their biological parents. Nine of the children were in out-of-home care placements made or sanctioned by the department.

¹⁰ Source: Queensland Child Death Register. In some circumstances, region was ‘unknown’ at the time of publication, pending update of the register (to enable geocoding by the Office of Economic and Statistical Research).

Table 3.2 Child death reviews considered in 2006–07: living arrangements at the time of death

Two-parent families	Single-parent families		Other living arrangements				Total
	Biological mother	Biological father	Extended family/friends	Foster care	Hospital	Other approved placement ¹¹	
25	16	2	9 ¹²	3 ¹³	6 ¹⁴	1	62

Family characteristics

Family characteristics such as substance abuse, violence, high mobility of lifestyle (transience), mental illness, corrective services history and intellectual disability affect the quality of care and protection. Table 3.3 summarises the presence of parental characteristics in the families of the 62 children.

Table 3.3 Child death reviews considered in 2006–07: family characteristics identified

Parental characteristics	Cases where characteristics identified
Family violence	29
Substance abuse	28
Mental illness	7
Corrective services history	5
Transience	3
Intellectual disability	1

In 42 (67.7%) of the cases considered, one or more of the above family characteristics were identified as present. The coexistence of parental substance abuse and violence was identified in the majority of these 42 cases. A transient lifestyle was noted in 3 cases and parental mental illness was identified in 7 cases.

Child protection status at time of death

Figure 3.4 shows the length of time between the child or young person's contact with the department and their death. Thirty-eight of the 62 children and young people (that is, 61.2%) were subject to some form of departmental intervention or involvement at the time of their death. A further 12.9% and 11.2% died within three and six months respectively of case closure.

¹¹ Approved placement under s. 82 of the *Child Protection Act 1999*.

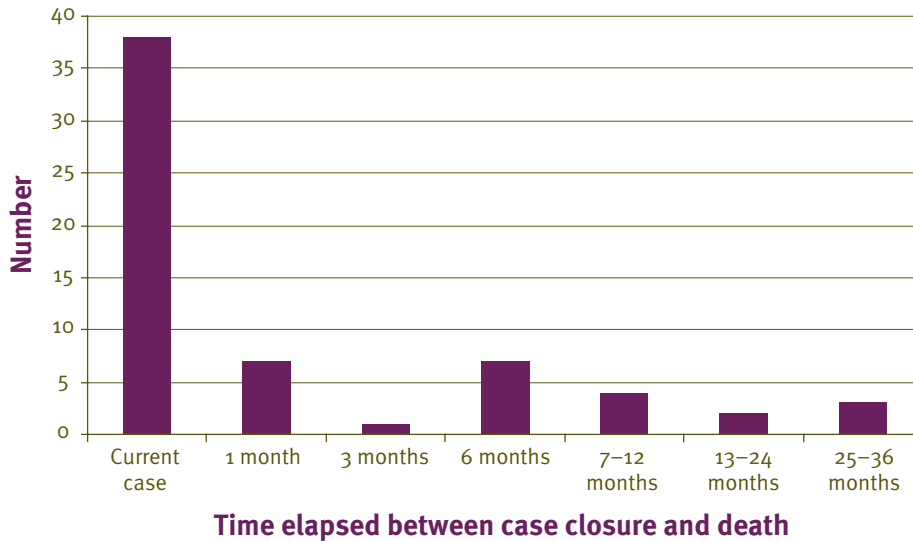
¹² Of the 9 children placed with extended family/friends, 2 died from diseases and morbid conditions, 1 drowned, 3 suicided, 1 was fatally assaulted and 1 died in a transport incident. The cause of death in 1 case is currently unknown.

¹³ Of the 3 children and young people who were in foster care, 2 died from disease/illness and 1 died in a transport incident.

¹⁴ These children were inpatients at hospitals at the time of their death. Health service delivery was not identified as a concern in these cases.

Overall, 85.3% of the child death reviews considered by the CDCRC in 2006–07 involved children or young people who either were a current client or died within six months of being known to the department.

Figure 3.4 Child death reviews considered in 2006–07: length of time between contact with the department and the child or young person’s death



Nature of contact with the department

When the department receives information about a child or young person a variety of responses are available, ranging from providing information and advice to moving a child to a safe place. Therefore, there is scope for the extent of the department’s involvement to vary significantly in each child death case reviewed by the CDCRC.

Table 3.4 shows the nature of the department’s contact/intervention with the child or young person in the 38 cases that were open/current at the time of the child’s death.

Table 3.4: Child death case reviews considered in 2006–07: nature of child’s contact with the department at time of death

Nature of departmental contact	Number of cases
Suicide Risk Alert	2
Child Protection Notification	2
Investigation and Assessment	22
Intervention with Parental Agreement	2
Temporary Assessment Order	1
Child Protection Order	9

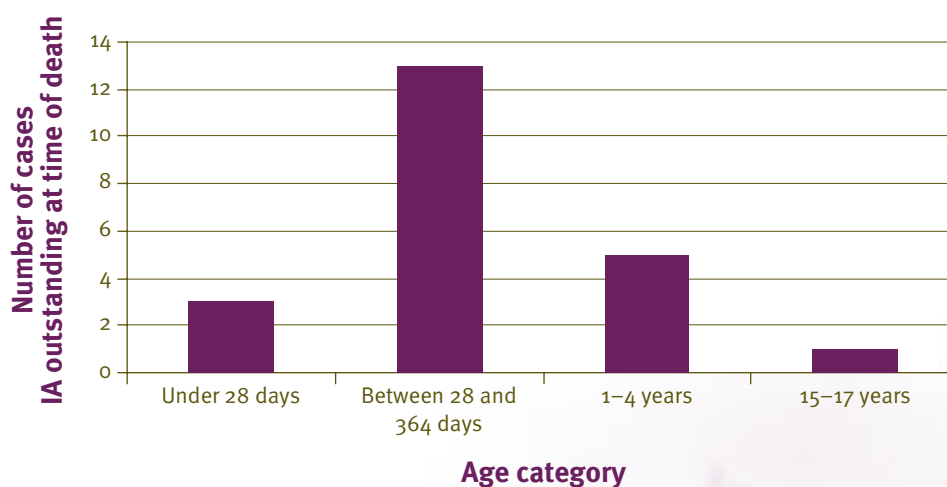
Overall, 22 of the 62 children were the subject of an open Investigation and Assessment (IA) into their safety and needs at the time of their death, with the status of the IAs being:

- unallocated
- allocated but yet to be commenced
- commenced (and in progress at the time of the child’s death), or
- progressed, but not final.

As Figure 3.5 shows, the most significant feature of the cases that were the subject of an open IA at the time of the child’s death was the child’s age. All but one of the 22 cases involved a child aged less than 4 years.

The length of time that the IAs were open varied from 1 day to 470 days, with the average being 97 days. According to the department’s Child Safety Practice Manual, the maximum period of time an IA can be open is two months from the date the notification was received.

Figure 3.5 Number of cases of Investigation and Assessment open at time of death, by age category



Note: Age categories have been excluded if no IAs for that age category were open at the time of death.

The CDCRC is very concerned about the high number of cases considered in the reporting period where the child was the subject of an open IA at the time of their death. Even more worrying is the finding that the majority of these cases involved children whose vulnerability was amplified by their young age.

During the year the CDCRC provided its data about children aged 0–4 years to the department in support of its *One Chance at Childhood* initiative, which is expected to strengthen the service delivery response at three key intervention points for children aged 0–4 years: assessment of Child Protection Notifications, conduct of Investigation and Assessments, and reunification decisions.

The following two case studies highlight the CDCRC's concerns.

Case study¹⁵

The subject child (SC) died within weeks of birth.

The department's involvement with SC and his family commenced by way of a Child Protection Notification (CPN) recorded the day after SC's birth. The CPN concerned allegations of SC's mother having no antenatal care, a history of drug-induced psychosis and presenting to hospital four days before the delivery of SC, threatening suicide after an argument with her partner. The CPN was assigned a 10-day response time frame, because of the persistent and escalating risk of harm to SC and the multiple risk factors that were identified at the time of notification.

The department recorded a further five Records of Enquiry involving concerns for SC's safety, based on the escalating drug use and erratic behaviour of the mother and the removal of a previously-identified protective factor in the form of SC's hospital in-patient status. In spite of these concerns, the nature of the enquiries was not deemed to meet the threshold for either a Child Concern Report (CCR) or a CPN and was assigned a Record of Enquiry status.

Further information concerning risks to SC and their sibling was provided through referral of SC's sibling to the Suspected Child Abuse and Neglect (SCAN) Team, with the case reviewed on three occasions.

At the time of SC's death, no IA had been commenced.

Case study¹⁶

SC died aged 2 years. SC and multiple older siblings lived a highly transient lifestyle characterised by ongoing and escalating domestic violence. In the 21 months leading up to the SC's death, the department recorded one CCR and nine CPNs with an IA response in relation to SC and/or siblings.

Of the nine IAs, four were completed at the time of SC's death and five were uncompleted, with three of these remaining unallocated nearly eight months after SC's death.

An analysis of the concerns and risk factors identified in relation to each CPN revealed a consistent and escalating pattern of domestic violence between the parents, involving physical harm to SC and siblings, together with substance abuse, unaddressed mental health problems and limited parenting and protective capacity of the mother, who was the primary caregiver.

¹⁵ Case Review 22/2006.

¹⁶ Case Review 29/2006.

In spite of the substantiation of harm and risk of harm to SC, in relation to each of the IAs completed, no formal casework was undertaken with the family; nor was the extent of the family's child protection history ever formally assessed in terms of its cumulative and escalating pattern of harm.

The department's review correctly identified a number of grave deficiencies in departmental practice regarding the SC and family. For example, it identified that, by failing to undertake IAs relating to the five outstanding CPNs recorded in 2005, the department had not complied with section 14 of the Child Protection Act 1999.

The CDCRC agreed with the review findings in this respect and reiterated the relevance that the extensive child protection history of the family ought to have had in relation to the response priority assigned to these IAs.