

Executive summary

Key statistics for 2006–07

Of the 57 children and young people known to the child protection system who died in Queensland in 2006–07, the causes of death were:

Cause of death	Number
Diseases and morbid conditions	22
Non-accidental trauma	11 (fatal assault – 7; suspected suicide – 4)
SIDS and/or undetermined < 1 year old	4
Transport	7
Drowning	3
Accidental	2
Undetermined > 1 year old	1
Unknown/pending	7

Overall, children known to the child protection system died at a rate of 66.2 per 100,000, while for all children in Queensland the rate of death was 44.1 per 100,000. The rate of death due to diseases and morbid conditions was slightly lower than that in the general population. The rates of death due to causes other than diseases and morbid conditions exceeded the comparable rates in the general population. One explanation is the complex contextual factors associated with children and young people known to the Department of Child Safety. Of the contextual factors, parental substance abuse and family violence were the most common; in most cases (67.7%), a combination of unfavourable characteristics was present.

Scope exists to enhance prevention and intervention service delivery to other children and young people known to the department, particularly those at risk of death due to non-accidental trauma, including suicide. This finding is consistent with the CDCRC's 2005–06 annual report.

Sixteen Aboriginal and/or Torres Strait Islander children and young people known to the child protection system died during the reporting period, accounting for 28.0% of the 57 deaths.

Concerns identified by the CDCRC about child protection service delivery by the Department of Child Safety

In 2006–07 the CDCRC considered 61 child death reviews involving 62 distinct children and young people. 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.

Of those cases considered, 38 involved ongoing service delivery of some form by the department at the time of the child or young person's 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

The CDCRC is concerned that, of the 22 children and young people who died while the subject of an open Investigation and Assessment, 21 were in the 0–4 age range. The department has recently announced the 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, including Investigation and Assessment.

The CDCRC is also concerned about recurring issues in service delivery evident in the case reviews completed during the year, including:

- approaches to risk assessments that adversely affect their quality
- scope for greater interagency collaboration
- inadequate responses to unborn child notifications
- the extent to which the individual needs of children and young people with disabilities are met
- risks created by inadequate record-keeping, and
- contextual factors that affect service delivery within particular Child Safety Service Centres.

The CDCRC will continue to monitor these issues and work with the department wherever possible to help strengthen services in these areas.

Observations by the CDCRC about the quality of the Department of Child Safety’s internal child death reviews

In general, the positive aspects of the department’s internal reviews in 2006–07 were:

- compliance with statutory requirements significantly improved in comparison with the previous reporting period; in this period, 97.0% of time frames were met
- an Indigenous person was appointed or engaged in the review process in every Indigenous child death review
- the terms of reference used in 92.0% of the reviews were considered case specific and provided an appropriate scope and focus for the review

- in all reviews, the department’s dissemination of the internal review findings was in accordance with the department’s Child Death Case Review Policy and Procedures
- the department used a review/investigation plan which was considered to be of particular value to the reviews and the review process
- all information, in every review, was obtained by the department in a lawful, ethical and culturally sensitive manner.

The areas where the CDCRC noted scope for strengthened performance by the department’s internal reviews during the reporting period were:

- not adequately addressing substantive cultural issues in the conduct of reviews (despite the appointment of cultural consultants in all relevant cases)
- limiting the extent of reviews to a particular time frame, and not considering the entire period of the department’s involvement/history
- not obtaining all necessary information, or not obtaining all necessary information in a timely manner, from external agencies that are willing to cooperate (as opposed to those agencies less inclined to engage with reviews)
- not supplying all relevant departmental information to the review, or not identifying all relevant departmental persons to be interviewed, in a timely manner
- not adequately identifying deficiencies or gaps in service delivery to the child and its family by all entities
- not commencing reviews in a timely manner (sometimes due to resource issues created by peaks in review activity), which raises the risk of recollection-based evidence and information not being fully beneficial to the review, and
- not adequately considering the application and adequacy of the relevant legislation, policies and procedures that applied or should have applied to the child and its family.

The year ahead

The CDCRC's work in the next reporting period will include focus on the following areas.

Building capacity through system-level data

In 2007–08 the CDCRC intends to continue identifying opportunities to compile, analyse and report on the system-level data generated by its child death case reviews. This will serve the dual purposes of providing early alerts of any concerning trends evident from child death case reviews, and building system capacity to monitor and respond.

The CDCRC will also begin feeding data into linked initiatives, such as the Child Guardian Key Outcome Indicators, which will bring together and analyse system-level data about the safety and wellbeing of children and young people captured by a range of service providers within the child protection system and the Commission for Children and Young People and Child Guardian.

New members

In appointing members of the CDCRC, the Premier looks to include people with investigative or analytical skills and also to reflect the diversity of professional services that children and young people in the child protection system may receive, including pediatrics and child health, mental health and child protection services.

Under the *Commission for Children and Young People and Child Guardian Act 2000*, members of the CDCRC are appointed by the Premier for a maximum of three years. The current members were appointed in November 2004 and their terms are therefore due to expire in November 2007, meaning that in the year ahead new members will be appointed.