

# Child Death Case Review Committee

## Annual Report 2006–07

Reviews of child deaths known to the  
Queensland child protection system







31 October 2007

The Honourable Anna Bligh MP  
Premier  
Parliament House  
George Street  
Brisbane Qld 4000

Dear Premier

I submit the annual report for the Child Death Case Review Committee (the CDCRC) for the 2006–07 financial year.

The CDCRC plays a key role in improving the safety and wellbeing of all children and young people who come into contact with the Queensland child protection system. It does this by making recommendations to improve the quality of the Department of Child Safety's internal child death reviews and the quality of its frontline child protection services.

The CDCRC's work is also critical in building government and community confidence in the ability of the child protection system to respond quickly and transparently when a child known to it dies.

This report is made pursuant to section 89ZA(1) of the *Commission for Children and Young People and Child Guardian Act 2000*. It outlines the CDCRC's role, key activities and performance for 2006–07, including information and data about the delivery of child protection services by the Department of Child Safety to the children and young people who sadly died during the year, and the capacity of the department to review these deaths.

I draw your attention to section 89ZA(3) of the *Commission for Children and Young People and Child Guardian Act 2000*, which requires you to table this report in the Parliament within 14 days of receipt.

Yours sincerely

A handwritten signature in blue ink that reads "Elizabeth Fraser". The signature is fluid and cursive, with the first letter 'E' being particularly large and stylized.

**Elizabeth Fraser**  
Chairperson  
Child Death Case Review Committee

# Contents

<b>Message from the Chairperson</b>	<b>iv</b>
<b>Executive summary</b>	<b>vi</b>
Key statistics for 2006–07	vi
Concerns identified by the CDCRC about child protection service delivery by the Department of Child Safety	vi
Observations by the CDCRC about the quality of the Department of Child Safety’s internal child death reviews	vii
The year ahead	ix
<b>Chapter 1: Child death reviews in Queensland</b>	<b>1</b>
The response when a child dies in Queensland	1
<b>Chapter 2: Overview of child deaths in 2006–07</b>	<b>2</b>
Key messages	2
Cause of death	3
Rates of death of children known to the department	4
Age and gender	7
Aboriginal and Torres Strait Islander status	7
Geographical distribution (ARIA+)	7
<b>Chapter 3: Overview of reviews considered by the CDCRC in 2006–07</b>	<b>8</b>
Key messages	8
CDCRC activities in 2006–07	8
Child death case reviews considered in 2006–07	9
Cause of death	9
Age and gender	10
Aboriginal and Torres Strait Islander status	11
Geographical distribution (ARIA+)	11
Living arrangements at time of death	11
Family characteristics	12
Child protection status at time of death	12
Nature of contact with the department	13

<b>Chapter 4: Outcomes of reviews conducted by the CDCRC in 2006–07</b>	<b>17</b>
Key messages	17
Assessment against review criteria	17
Response to issues identified by the CDCRC in the 2005–06 reporting period	17
Quality of the department’s internal reviews in 2006–07	18
Improved compliance with the six-month statutory time frame	19
Reduction in the number of desktop reviews	19
Cultural input into reviews	19
Timeliness of reviews and information gathering	24
Cultural input to internal reviews	26
Accountability	28
<b>Chapter 5: Systemic issues</b>	<b>30</b>
Key messages	30
System-level reporting	30
Potential systemic issues identified in 2006–07	31
Risk assessment	32
Unborn child notifications	37
Interagency collaboration	40
Children and young people with disabilities	47
Record-keeping	50
Contextual issues affecting service delivery	52
<b>Chapter 6: The year ahead</b>	<b>54</b>
New members	54
Building capacity through system-level data	54
<b>Appendices</b>	<b>56</b>
Appendix 1: CDCRC members during 2006–07	56
Appendix 2: Review criteria	61
Appendix 3: Abbreviations and dictionary	63
Appendix 4: Detail about the Queensland child death review process and other jurisdictions	65

## Message from the Chairperson

During the 2006–07 reporting period, 444 children and young people died in Queensland. Of these, 57 (12.8%) were known to the Department of Child Safety (the department), which represents six more than in the prior 2005–06 reporting period. However, overall a decrease occurred in the rate at which children and young people known to the department died in 2006–07, when compared with 2005–06.

At the outset, I would like to offer my condolences, and those of the Child Death Case Review Committee (CDCRC) members, to the families, carers and friends of those children and young people.

This is the third annual report of the CDCRC, the independent body charged with responsibility for reviewing the deaths of children and young people known to the child protection system. The CDCRC's investment of effort over the past three years has added significant value to Queensland's child protection system, both by helping the department to build its capacity to undertake internal reviews, and by identifying areas for improvement in frontline practice.

I was pleased to note further progress by the department in the past year in relation to its capacity to conduct internal child death reviews. The department submitted 97.0% of its internal review reports to the CDCRC within the six-month legislated time frame, which represents a 34.0% increase on the previous reporting period. There has also been a noticeable increase in the quality of the department's internal reviews. Each internal review is assessed against the CDCRC's gazetted review criteria, a checklist of best-practice requirements for reviews that creates a high level of focus and consistency across the CDCRC's work.

This report contains detailed findings of both the positive and the negative aspects of the department's reviews that the CDCRC considered during the year. Where scope has been identified for improvements, the CDCRC has generally been pleased with the department's responsiveness and I look forward to its capacity to conduct internal child death reviews maturing in the coming years.

During the year the CDCRC initiated a project to improve its collection of system-level data in relation to both child protection issues and the quality of the department's internal reviews. This project has enhanced the ability of the CDCRC to identify and bring to the department's attention emerging trends and patterns in service delivery that may become systemic problems if not addressed.

My early concerns relate largely to children in the 0–4 age range – in particular, to circumstances where their deaths occur while they are subject to an open child protection 'Investigation and Assessment'. During the year the CDCRC considered reviews in relation to the deaths of 62 distinct children (some of whom actually died in the 2005–06 reporting period). Of the 62 deaths reviewed, 22 involved open Investigation and Assessments, and all but one concerned a child aged 0–4.

It is my hope that the ongoing compilation and analysis of review data will assist in drawing together any concerns about individual threads of the service delivery system that the CDCRC has commented on in the past three years. This should position and support the department to respond to multiple individual recommendations as themes in service delivery by dedicated projects, should it choose to do so, rather than as isolated or ad hoc responses. For example, the CDCRC's data about children aged 0–4 years have been provided 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. Given the CDCRC's findings, the initiative is both vital and timely.

I am pleased to report that the CDCRC was able to meet its three-month statutory time frame in relation to each of the 62 reviews it considered. This is the third year that all time frames have been met and this is due, in no small part, to the strong commitment and hard work of my colleagues on the CDCRC and the Secretariat that supports it.

Overall, there remains a high return on the investment made by the CDCRC and the department in conducting comprehensive child death reviews. Most importantly it demonstrates the government's and community's respect for, and commitment to, upholding each child's rights and fostering accountability, transparency and learning. I expect this return to be strengthened when the system-level analysis of CDCRC data is fully established and, in particular, when it begins to feed 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.

On behalf of the CDCRC I commend consideration of the report to key stakeholders.



**Elizabeth Fraser**  
Chairperson  
Child Death Case Review Committee