

# Child Death Case Review Committee

## Summary Report 2006–07

Reviews of child deaths known to the  
Queensland child protection system



# Overview

## Child Death Case Review Committee Annual Report 2006–07

The Child Death Case Review Committee's (CDCRC's) 2006–07 Annual Report is the third published by the committee. The CDCRC is an independent external body established in August 2004 to help improve the accountability of the Department of Child Safety's (the department's) child death reviews.

The CDCRC plays a key role in improving the safety and wellbeing of children and young people who come into contact with Queensland's child protection system. Over the past three years, the CDCRC's reviews have contributed to a better child protection system in this state by helping the department build its capacity to carry out internal reviews of child deaths, and by influencing improvements in frontline practice.

### Role of the Child Death Case Review Committee

Since 1 August 2004, the department has been required to review its involvement in each case where a child dies, where the child was known to the department in the three years before their death.

The department has six months from the time it learns about a child's death to provide a report to the CDCRC about its involvement with the child.

The CDCRC then considers the report and makes recommendations about:

- improving policies impacting on services to children in the child protection system
- improving relationships between the department and other agencies involved with children and families, and
- whether disciplinary action should be taken against any departmental staff.

The CDCRC is a multi-disciplinary committee of between five and seven members who have expertise in fields like paediatrics and child health, forensic pathology, investigations and child protection.

The Commissioner for Children and Young People and Child Guardian chairs the CDCRC and the Assistant Commissioner is a member.

### Overview of child deaths in 2006–07

#### *All child deaths compared with the child protection population*

- In the 12 months between 1 July 2006 and 30 June 2007, 444 children and young people died in Queensland.
- Of these, 57, or 12.8%, were known to the department at the time of, or in the three years before their deaths – an increase of six deaths from 2005–06.
- Overall there was a **decrease in the rate** at which child and young people known to the department died in 2006–07, compared with 2005–06.
- In 2006–07, children **known to the child protection system** died at a rate of 66.2 per 100,000 compared with 73.4 for 2005–06.
- For **all children** in Queensland, the rate of death was 44.1 per 100,000 in 2006–07 compared with 43.8 per 100,000 in 2005–06.

#### *Child protection population*

- Diseases and/or morbid conditions accounted for 22 (or 38.5%) of the deaths.
- Twenty-three (40.3%) of the children and young people died from external causes, 11 as a result of non-accidental trauma (seven fatal assaults and four suspected suicides).
- The cause of death for seven children and young people is currently pending, and the cause of one death was 'undetermined'.

- Children and young people known to the child protection system died of **external causes and non-accidental trauma at a rate three times higher** than for all children (26.7 per 100,000 compared with 8.8 per 100,000). This may be partly explained by complex contextual factors associated with these children, such as parental substance abuse and family violence. In most cases, (67.7%) a combination of these characteristics was present.
- Most of the children known to the department who died (72%) were aged between birth and four years.

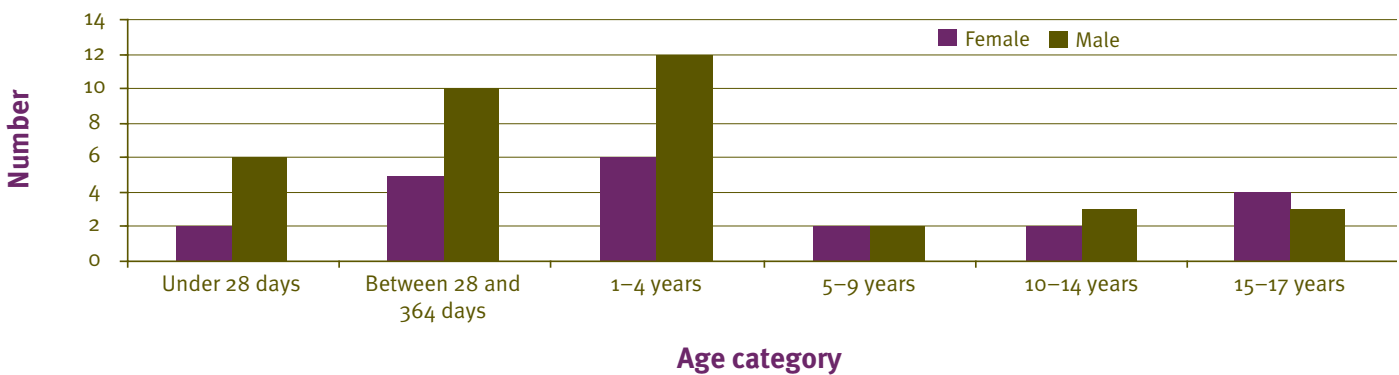
**Table 1 Deaths of children known to the department by age, compared with all children, 2006–07**

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total	Rates per 100,000 known to child protection system	Rates per 100,000 for all children
Diseases and morbid conditions	8	8	3	1	2	22	25.6	31.6
SIDS and undetermined	4	0	0	0	0	4	4.6	1.3
<b>CCYPCG research categories</b>								
Transport	1	3	1	1	1	7	8.1	3.9
Fatal assault	3	3	0	0	1	7	8.1	1.0
Suicide	0	0	0	3	1	4	4.6	1.4
Drowning	0	3	0	0	0	3	*	1.7
Accidental (other non-intentional)	1	1	0	0	0	2	*	0.8
<b>Total for research categories</b>	<b>5</b>	<b>10</b>	<b>1</b>	<b>4</b>	<b>3</b>	<b>23</b>	<b>26.7</b>	<b>8.8</b>
Undetermined ≥ 1 year	0	0	0	0	1	1	*	*
Pending	6	0	0	0	1	7	8.1	2.1
<b>Total</b>	<b>23</b>	<b>18</b>	<b>4</b>	<b>5</b>	<b>7</b>	<b>57</b>	<b>66.2</b>	<b>44.1</b>

Source: Queensland Child Death Register.

\* Numbers less than 4 are too low to be calculated as a rate. However, these numbers have been included in the totals to provide the most accurate overall rate.

**Figure 1 Age and gender of children known to the department who died in 2006–07**



- Sixteen (28%) of the children known to the department who died in 2006–07 were Aboriginal and/or Torres Strait Islander.
- The majority (69.3%) were in the care of one or both biological parents at the time of their death.

### Child death case reviews considered in 2006–07

In 2006–07, the CDCRC considered 61 child death reviews involving 62 different children. Due to timeframes around the review process, 59% (36) of the reviews considered were about deaths in 2005–06, while 41% (26) of the deaths occurred in 2006–07.

## Cause of death

- Disease and morbid conditions were the most common causes of death, resulting in 23 (37%) of the cases considered.
- Infant deaths due to SIDS or undetermined causes accounted for seven deaths (11.3%).
- Fifty percent of cases (31) considered related to children who died from external causes, with 13 the result of non-accidental trauma (nine fatal assaults and four suspected suicides).

## Key issues raised about child protection services

Overall, 85.3% of the child death reviews considered in 2006–07 involved children or young people who were current clients of the department, or died within six months of their last contact with it.

**Figure 2 Child death reviews considered in 2006–07: length of time between contact with the department and the child or young person's death**



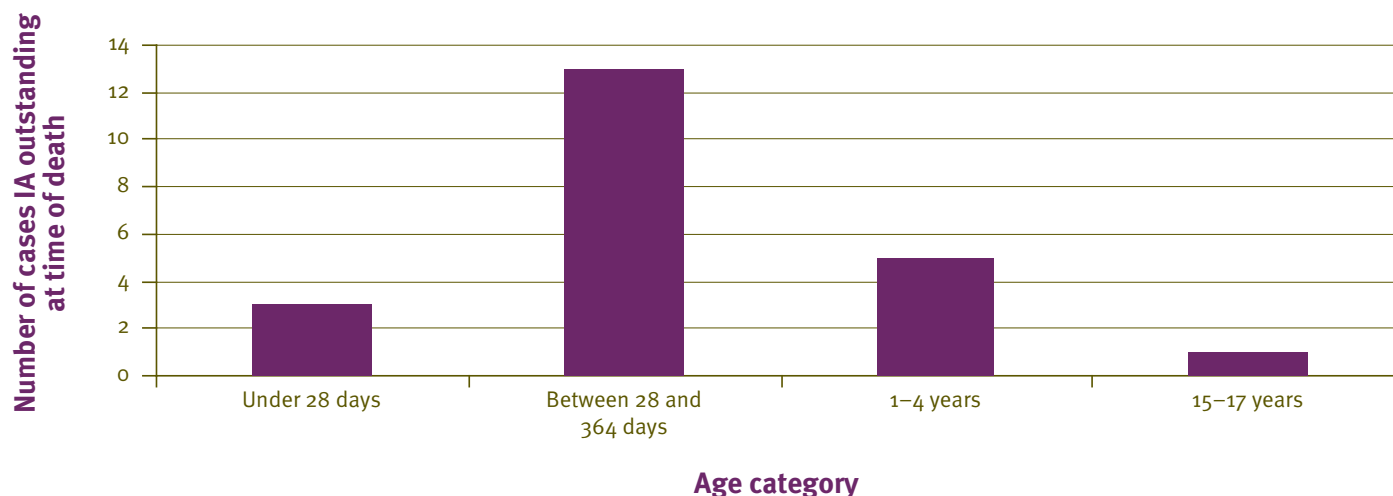
Of the cases considered, 38 children were receiving services of some kind from the department at the time of their deaths.

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

Twenty-two children and young people died while the subject of an open Investigation and Assessment, and all but one death involved children between birth and four years.

The department's recently-announced *One Chance at Childhood* initiative is expected to strengthen services for children aged 0–4 years at three key intervention points, including if they are the subject of an Investigation and Assessment.

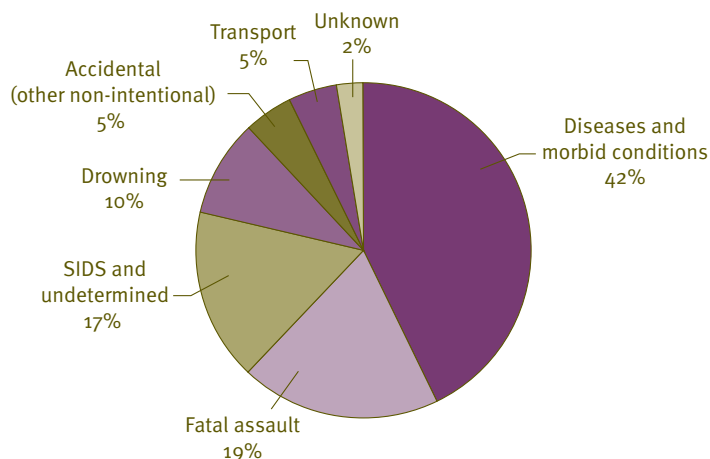
Figure 3 Number of cases of Investigation and Assessment open at time of death, by age category



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

Of the 62 children whose cases were reviewed, 67% were aged between birth and four years at the time they died.

Figure 4 Child death reviews considered in 2006–07: cause of death for children aged between birth and 4 years



### Possible systemic issues identified in 2006–07

When considering child death reviews, a systemic issue is one identified by the CDCRC through reviews of systems, policies or practices, that affects or may affect, more than one child to the detriment of their rights, interests or wellbeing.

Overall, the CDCRC’s report highlights the department’s significant progress in implementing reforms in key areas of practice. But there is evidence that historical service delivery issues are still impacting on outcomes for children and young people.

The CDCRC is concerned about recurring service delivery issues identified 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 needs of children and young people with a disability are met
- risks created by inadequate record-keeping, and
- factors affecting services delivered by particular Child Safety Service Centres.

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

## The year ahead

In 2007–08 the CDCRC will continue to compile, analyse and report on the data generated by its child death case reviews. This will provide early warning of any concerning trends arising from child death case reviews, and build the system's capacity to monitor and respond to issues. This should also help the department respond to individual recommendations on service delivery through dedicated projects, rather than with multiple isolated or ad hoc responses.

For example, the CDCRC's data on children aged 0–4 years have been provided to the department to support its *One Chance at Childhood* initiative. This is expected to strengthen responses 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 department's initiative is both vital and timely.

The CDCRC will also identify opportunities to share system-level data from child death case reviews with other relevant stakeholders by promoting the findings of its reviews in a range of forums. Although the department is the lead agency for child protection, the CDCRC acknowledges that it is not the only agency responsible for delivering services to those in the child protection system. Many child death case review findings have implications for the practice of other agencies in the sector.

Overall, there are high returns on the investment by the CDCRC and the department in conducting comprehensive child death reviews. This will be further strengthened when system-level analysis of CDCRC data is fully established, and will contribute to initiatives such as the *Child Guardian Key Outcome Indicators*. This initiative will bring together and analyse systemic data on the safety and wellbeing of children and young people captured by the Commission and a range of other service providers in the child protection system.

The qualitative and quantitative information captured through CDCRC reviews will be used to report against each of the following *Key Outcome Indicators*:

- Effective Assessment
- Appropriate service delivery for children and young people who do not enter out-of-home care but require further intervention
- Safe and stable out-of-home-care
- Individual needs are listened to, understood and met
- Best education possible
- Best health possible, and
- Special needs of Aboriginal, Torres Strait Islander and culturally and linguistically diverse children and young people are met.

A full copy of the Child Death Case Review Committee Annual Report 2006–07 is available on the Commission's website at [www.ccypcg.qld.gov.au](http://www.ccypcg.qld.gov.au)