Child Death Case Review Committee
Summary Report 2007–08

Reviews of child deaths known to the Queensland child protection system

Overview

Child Death Case Review Committee Annual Report 2007–08

The Child Death Case Review Committee Annual Report 2007–08 (the report) is the fourth annual report published by the independent Child Death Case Review Committee (CDCRC).

The CDCRC plays a contributory role in improving the safety and wellbeing of children and young people who come into contact with the Queensland child protection system by ensuring the quality and accountability of the Department of Child Safety's (the department's) child death reviews and driving areas of improvement in frontline practice.

Role of the Child Death Case Review Committee

Since 1 August 2004, the department has been required to conduct a review of its involvement in each case where a child dies, where that child was known to the department in the three years before their death. The department has six months from the time it learns about the child's death to provide the CDCRC with a report about its involvement with the child.

The CDCRC is then required to consider the department's report and, if necessary, make recommendations about:

- improving policies which impact 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 in relation to their involvement with a child.

Overview of child deaths in 2007–08

All child deaths compared with the child protection population

- In the 12-month period 1 July 2007 to 30 June 2008, 457 children and young people died in Queensland.
- Of these, 63 (13.8%) were known to the department, either at the time of, or within the three years prior to their deaths.
- For all children in Queensland, the rate of death was 45.4 per 100,000 in 2007–08 and 44.1 per 100,000 in 2006–07.
- Children known to the child protection system died at a rate of 69.2 per 100,000 in 2007–08 and 66.2 in 2006–07.

Child protection population

- Diseases and/or morbid conditions accounted for 20 of the 63 deaths (31.7%).
- Thirty-two (51%) of the children and young people died from external causes, 16 as a result of non-accidental trauma (9 fatal assaults and 7 suspected suicides).
- 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 that for all children (35.2 per 100,000 compared with 11.2 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 77% of the reviews undertaken by the CDCRC, one or more of these characteristics was present.
- The rate of death from diseases and morbid conditions was lower for children known to the department (22.0 per 100,000, compared with 28.9 per 100,000).

Table 1 Deaths of children known to the department, compared with all deaths, 2007–08

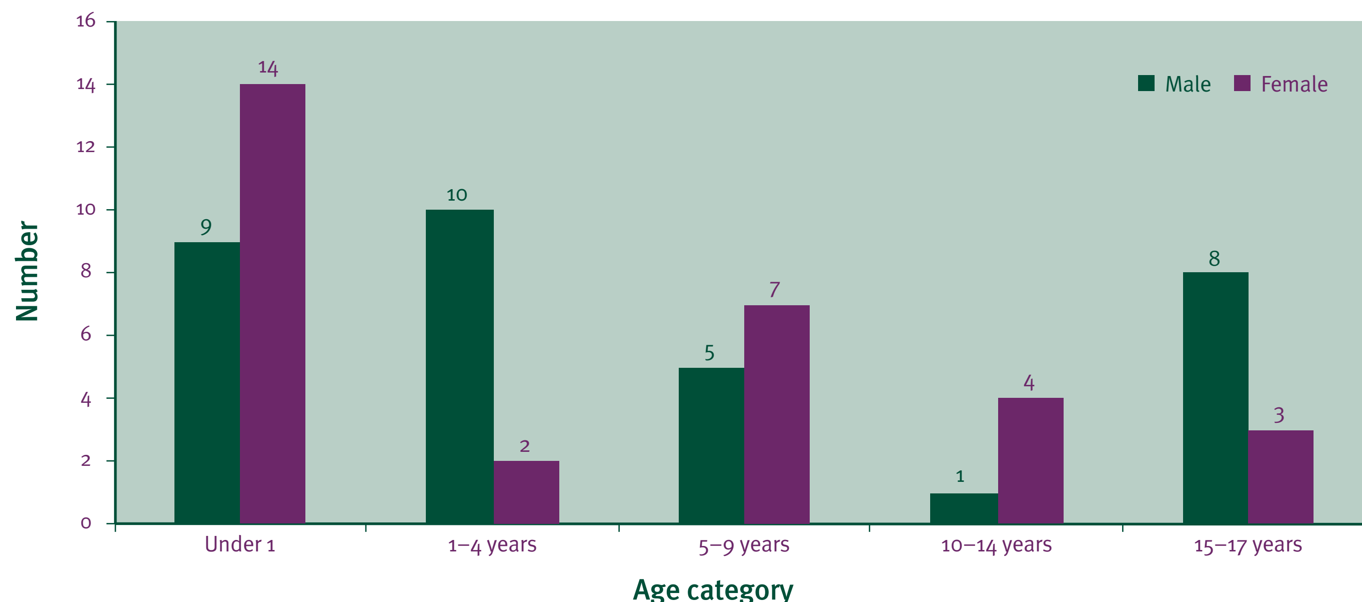
Portfolio category	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total	Rates per 100,000 known to Child Protection (CP) system, 2007–08	Rates per 100,000 for all children, 2007–08	Rates per 100,000 known to CP system, 2006–07
Diseases and morbid conditions	7	4	8	0	1	20	22	28.9	25.6
SIDS and undetermined	1	0	0	0	0	1	1.1	1.7	4.6
CCYPCG research categories									
Transport	0	3	2	1	2	8	8.8	5.0	8.1
Fatal assault	4	3	0	2	0	9	9.9	1.1	8.1
Suicide	0	0	0	0	7	7	7.7	2.2	4.6
Drowning	0	0	2	0	0	2	2.2	1.4	*
Accidental (other non-intentional)	1	1	0	1	0	3	3.3	1.0	*
Fire	0	1	2	0	0	3	3.3	0.5	0
Total for research categories	**5**	**8**	**6**	**4**	**9**	**32**	**35.2**	**11.2**	**26.7**
Undetermined $\geq$ 1 year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	*
Pending	8	0	0	1	1	10	11	3.7	8.1
Total	**21**	**12**	**14**	**5**	**11**	**63**	**69.2**	**45.4**	**66.2**

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.

- Fifty-six percent of the children known to the department who died were aged between birth and four years.
- More males than females died (55% and 45% respectively).

Figure 1 Age and gender of children known to the department who died in 2007–08



Overview of child death case reviews considered in 2007–08

In 2007–08, the CDCRC considered 62 child death reviews involving 64 children. Two of the reviews considered two children in the same review.

Cause of death

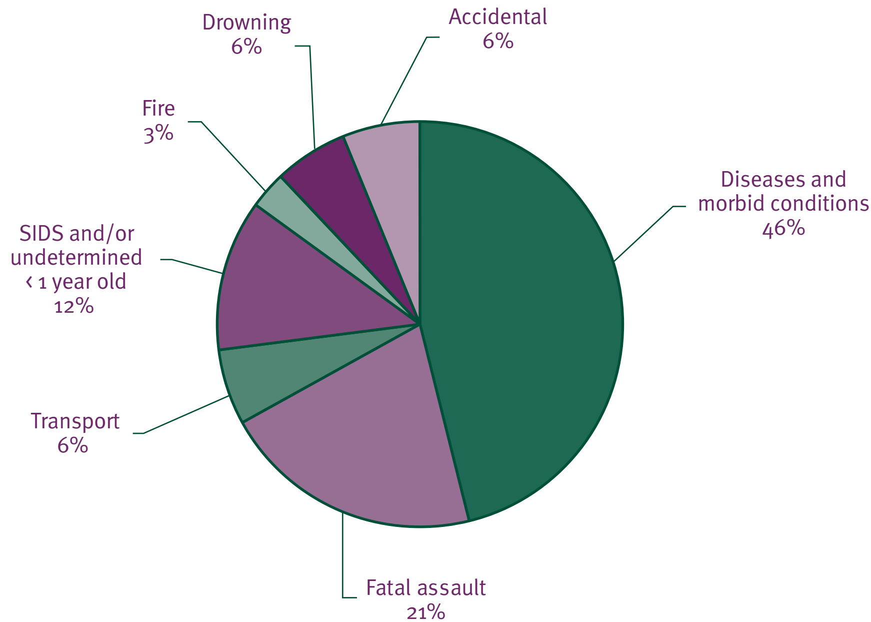
- Disease and morbid conditions were the cause of death in 28 (44%) of the cases considered by the CDCRC in 2007–08. The cause of death for one child was unknown, with test results pending.

- In 2007–08, 47% of the cases considered related to children who died as a result of external causes, with 16 of those being the result of non-accidental trauma (8 fatal assaults and 8 suspected suicides).

Key issues about child protection service delivery

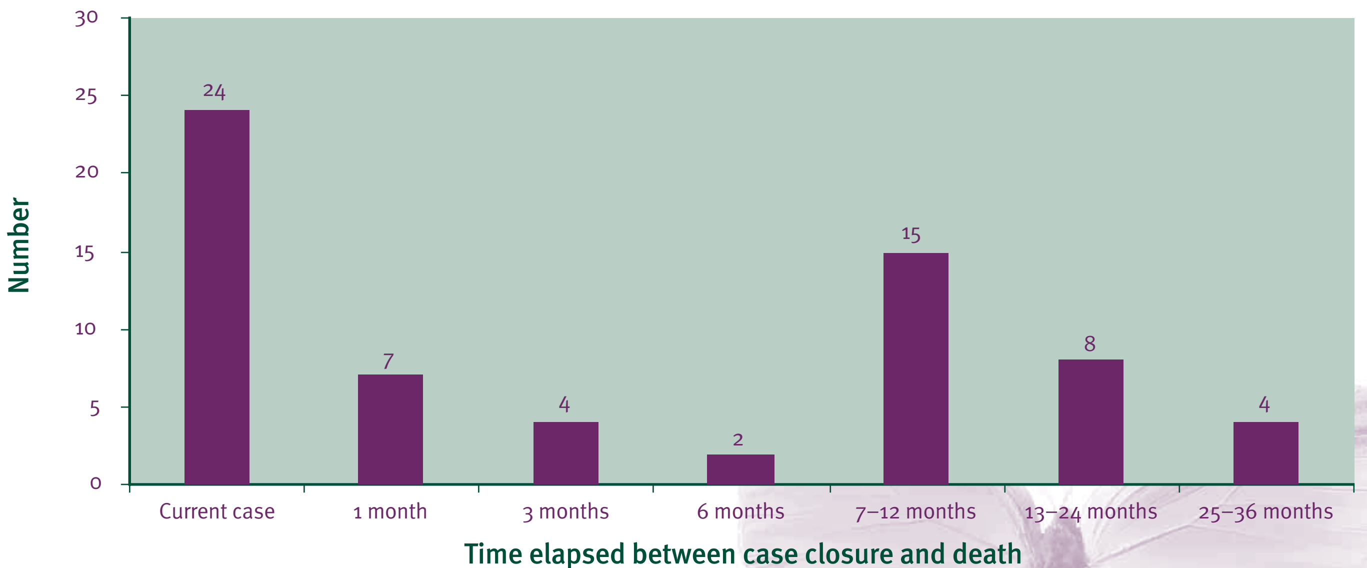
- Of the 64 children whose cases were reviewed, 34 (53%) were aged between birth and four years at the time of their death.
- This high figure reflects the extreme vulnerability of this age group and confirms the CDCRC's position that young age is a critical risk factor in the investigation and assessment of the safety of children and young people.

Figure 2 Children considered in 2007–08: cause of death for 34 children aged between birth and 4 years



Overall, 58% of the child death reviews considered by the CDCRC in 2007–08 involved children or young people who were a current client or who died within six months of being known to the department.

Figure 3 Child death reviews considered in 2007–08: length of time between contact with the department and the child or young person's death



During 2007–08, 24 of the 64 children and young people (37.5%) were subject to some form of departmental intervention or involvement at the time of their death and 17% and 3% died within three and six months respectively of case closure.

Figure 4 Child death case reviews considered in 2007–08: nature of child's contact with the department at time of death

Nature of departmental contact	Number of cases
Open Investigation and Assessment	14
Intervention with Parental Agreement	4
Temporary Assessment Order	1
Child Protection Order	3
Protective Supervision Order	1
Court Assessment Order	1

Fourteen of these children were the subject of an open Investigation and Assessment (IA) into their safety and protective needs at the time of their death. The time frame for how long the IAs were open varied from 1 day to 620 days, with the average being 88 days.

Family and parental issues – such as substance abuse, domestic and family violence (DFV), high mobility of lifestyle (transience), mental illness, corrective services history and intellectual and/or physical disability – impact on the quality of care and protection provided to children.

Figure 5 Child death reviews considered in 2007–08: family characteristics identified

Family characteristics	Cases where characteristics identified
Domestic and family violence	41
Substance abuse	35
Mental illness	9
Corrective services history	19
Transience	7
Intellectual disability	2

In 48 (77%) of the cases considered, one or more of the above family characteristics were identified as present. Of note was the high prevalence of DFV, which occurred in 41 cases (66%), and the coexistence of DFV as a risk factor with substance abuse, as found in 31 of the 35 cases (89%) involving substance abuse.

The CDCRC data and findings from child death reviews (involving the presence of DFV) are important considerations in the development of service enhancements across the whole-of-government and non-government sectors to address DFV, including early intervention.

Deaths of children and young people resulting from suicide

In 2007–08, the CDCRC noted that 12.7% of deaths reviewed in the reporting period were recorded as suspected suicide.

Of the 8 children whose deaths were due to suspected suicide, 6 deaths or 75% of cases involved an accessible recorded history of previously reported suicide attempts or ideation, high risk behavior and/or self harm. For 7 of these cases (88%) the department did not conduct an investigation in response to the notified concerns at the point of its only or most recent contact, having determined that the information did not meet the threshold for the recording of a Child Protection Notification (CPN).

The CDCRC acknowledges the complex challenges associated with responding to the needs of high-risk adolescents and identifies greater proactive collaboration with mental health and other support services is essential for the child protection system to be able to provide an appropriate response in such instances in the future.

The CDCRC has identified a number of factors relevant to improving service delivery to this subgroup of the child protection population, including:

- availability of support services, including prevention, early intervention, residential and intensive therapeutic services

- expertise of authorised officers in assessing the reciprocal relationship between previous or ongoing abuse or neglect and high-risk behaviour, and
- timely statutory involvement by the department when children and young people are considered to be the statutory responsibility of other agencies, in circumstances in which they are in receipt of services by the Queensland Police Service (QPS) or Youth Justice Services.

In 2008–09, the CDCRC will continue to support, wherever possible, the Commission's childhood and adolescent suicide analysis project, which will examine the key elements of the risk and socio-demographic profile of this cohort. This project has an emphasis on prevention and early intervention pathways and will make recommendations for service improvement and responsiveness.

Possible systemic issues identified in 2007–08

Within the context of child death reviews, systemic issues represent the aggregated output of the work of the CDCRC and its key outcomes by identifying in one or more reviews of systems, policies or practices, those areas of service delivery which have the greatest proven and potential impact on the welfare and best interests of children and young people. The interrelationship of these issues is evidence of the holistic nature of child protection, which exists across a continuum of broad human service delivery.

In 2007–08, the CDCRC identified scope for continuous improvement by the department and its child protection partners in the following key areas of practice, including:

- case planning
- timeliness of assessments
- internal communication
- after-hours service delivery, and
- staff training.

The CDCRC considers that each of the above areas has broad and cumulative implications for the quality of statutory and coordinated service delivery to children and young people. The CDCRC has identified these issues as systemic on the basis of their potential to generate better outcomes for children if effectively actioned. Accordingly, the CDCRC will continue to monitor these issues and work with the department where appropriate to strengthen service in these areas.

Longitudinal Analysis 2004–08

After four years of operation, the CDCRC has analysed the trends and patterns that have emerged and/or remained consistent concerning children whose deaths have been considered by the CDCRC. These include:

- children known to the child protection system continue to be over-represented in all external causes of death
- a consistently high death rate for children aged birth to four years, underscoring the extreme vulnerability of children in this age group
- domestic and family violence as a family characteristic has been consistently present in the majority of child death reviews, highlighting the importance of the prevention work being undertaken in this area, and
- almost all of the deaths that occurred in foster care were due to natural causes and none of these deaths were due to non-accidental trauma. This observation lends weight to the quality of Queensland's foster care system in meeting the safety and protective needs of children who are considered to be in need of out-of-home protection.

The year ahead

To date, the child death review process has been viewed as an operational and strategic tool in the reform of the child protection system, a role in which it has helped to enhance accountability and driven important areas of change.

In 2008–09, the CDCRC will focus its strategic direction at a broader, system-wide level that builds on gains made to date and draws discrete service delivery issues into a coordinated system-level approach.

It is anticipated that the industry expertise of the CDCRC and the planned redefinition of its review criteria will help to facilitate a dual, balanced focus between the individual circumstances and events relating to the child and the application of these individual cases to their context within the broader system.

The full version of the *Child Death Case Review Committee Annual Report 2007-08* can be accessed online through the Commission's website at **www.ccypcg.qld.gov.au**

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