



Message from the Chairperson

During the 2007–08 reporting period, 457 children and young people died in Queensland. Of these, 63 were known to the Department of Child Safety (the department).

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 fourth 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 in the three years before their deaths. The process fosters transparency of the practices of both the department and its child protection partners, and enables a coordinated, systemic analysis of any service delivery issues which may be affecting child protection outcomes.

The CDCRC's public value and credibility are largely derived from the multidisciplinary professional expertise and independence of its members. The expertise of the members assists the CDCRC to fulfil its mandate to apply a child-focused consideration to individual reviews and recommendations for reform.

The reviews provide an opportunity to reflect in detail on the history of each child's involvement with the department and whether there are any lessons to be learnt or issues to be addressed. Under the provisions of the *Commission for Children and Young People and Child Guardian Act 2000* (the CCYPCG Act), the requirement to review the deaths of any of these children does not necessarily signal malfeasance. As the data demonstrate, the children die from a multitude of circumstances, many of which involve existing morbid conditions and tragic accidents. However, each death triggers scrutiny by the CDCRC to ensure that there is strong accountability of the child safety system for its actions.

In 2007–08, the CDCRC reviewed the service history of eight children and young people who lost their lives as a result of suspected suicide and identified their limited access to mental health services, support and statutory intervention. Given the acknowledged challenges in delivering effective interventions to this cohort of young people, the CDCRC has made recommendations at both a strategic (interagency) level and an operational (frontline practice) level to promote a greater understanding of the risk profile and support needs of these children and young people.

The CDCRC has also identified scope for continuous improvement by the department and its child protection partners in a number of key areas of practice. These include case planning, timeliness of assessments, internal communication, after-hours service delivery and staff training, each of which the CDCRC considers has broad and cumulative outcomes for the quality of statutory and coordinated service delivery to children and young people. The CDCRC has identified these as systemic issues on the basis of their potential to generate better outcomes for children if effectively actioned.

This report also contains a four-year data analysis, which highlights that no children or young people died from non-accidental trauma (fatal assault or suicide) while living with foster carers. The fact that most of the children whose causes of death were due to non-accidental trauma were living with their parents or relatives highlights the complexity of risks that need to be considered in determining appropriate critical support and intervention for these children and young people.

This year marked an important milestone for the CDCRC with the appointment of new members in November 2007, after completion of the three-year term of appointment of the inaugural members.

I would like to take this opportunity to sincerely thank the members of the outgoing CDCRC for their invaluable contribution in establishing the child death review process and for their commitment to improving service delivery to Queensland's most vulnerable children. I would also like to welcome the current members, who have brought a diverse wealth of relevant experience to the child death review process, and I thank them too for their contribution this year.

I am pleased to report that the CDCRC was again able to meet its three-month statutory time frame in relation to each of the 62 reviews it considered during the reporting period. The 62 reviews related to the deaths of 64 children. Two of the Department's original reviews combined the deaths of two children.

This is the fourth year that all time frames have been met and this is due, in no small part, to the dedication of my colleagues on the CDCRC and the Secretariat that supports it.

In conclusion, I would also like to thank the department and its staff for the support they have given to the process.

Elizabeth Fraser
Chairperson
Child Death Case Review Committee





Executive summary

Key statistics for 2007–08

Of the 63 children and young people known to the child protection system who died in Queensland during 2007–08, the causes of death were:

Cause of death	2006–07	2007–08
Diseases and morbid conditions	22	20
Non-accidental trauma	11	16
Fatal assault	(7)	(9)
Suspected suicide	(4)	(7)
SIDS and/or undetermined < 1 year old	4	1
Transport	7	8
Drowning	3	2
Accidental	2	3
Fire	0	3
Undetermined ≥ 1 year old	1	0
Unknown/pending	7	10
Total	57	63

Overall, in 2007–08, children known to the child protection system died at a rate of 69.2 per 100,000. The rate for all children in Queensland was 45.4 per 100,000.

The rate of death due to diseases and morbid conditions was 22.0 per 100,000, which was 6.9% less than that in the general population. The rate of death due to causes other than diseases and morbid conditions was 47.2 per 100,000, which was 30.7% higher than that for 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 domestic and family violence were the most common and, in most cases (77%), one or more unfavourable characteristics were present.

Child protection service delivery by the Department of Child Safety

In 2007–08 the CDCRC considered 62 child death reviews involving 64 children and young people.¹ Of the child death reviews considered by the CDCRC, 56% involved children or young people who were a current client or who died within six months of being known to the department.

Of those cases considered, 24 (37.5%) involved ongoing service delivery of some form by the department at the time of the child or young person's death. The nature of the contact is set out in the following table.

¹ Two of the department's original reviews combined the deaths of two children.

Nature of departmental contact	2006–07	2007–08
Investigation and Assessment	22	14
Intervention with Parental Agreement	2	3
Temporary Assessment Order	1	1
Child Protection Order	9	4
Court Assessment Order	0	1
Protective Supervision Order	0	1
Total	34	24

Fourteen of the 64 children whose deaths were reviewed were the subject of an open Investigation and Assessment (IA) at the time of their death. The most common feature of these cases was the child’s age (12 cases involved a child aged less than 4 years of age). These figures are consistent with those identified in the previous reporting period and underscore the vulnerability of very young children and the importance of the Investigation and Assessment phase of contact.²


The CDCRC noted that, of the 8 cases considered in which the child or young person died as a result of suspected suicide, no investigation took place for 7 of these children at the point of their most recent notification to the department, even though 6 children had a recorded history of suicide attempts, suicide ideation or other high-risk behaviour that was accessible to the department through the process of interagency information exchange.³

The CDCRC also identified a number of recurring issues in service delivery evident in the case reviews completed during the year, related to:

- the quality of case planning and case management
- timeliness of responses to five and ten-day Response Priority Timeframe Child Protection Notifications

2 In the Department of Child Safety’s response to a draft copy of this report, it stated that this paragraph incorrectly concludes that children who had an open investigation at the time of their death were more vulnerable because the investigation was not completed. The department also stated that this paragraph further implies that the lack of a complete investigation by the department may have contributed to the child’s death. The department also stated that it should be noted that the cause of death in 8 of the 14 cases was natural causes – that is, significant disabilities or terminal illnesses where the child died in hospital – and that in many of these cases the department acted appropriately in not interviewing parents and sighting a child who was terminally ill or in hospital, or not expected to live as a result of an accident. For example, in one case the department began an investigation as a result of the incident that resulted in the child’s death. That is, it was the incident that brought the child to the department’s attention. The department began an investigation, during which the child died.

3 In its response, the Department of Child Safety stated that this paragraph implies that the department did not undertake a risk assessment for 7 of the 8 children referred to the department when it was required to do so. The department claimed that this is incorrect. It stated that in all 7 cases the children did not reach the legislative threshold for recording a notification and that it is only once the legislative threshold has been reached that the department has the legislated mandate to begin an Investigation and Assessment. The department further stated that, where the concerns received do not meet the legislative threshold (recorded as either general inquiries or Child Concern Reports), the department does not have the statutory authority to begin an investigation. The department also claimed that the statement that there was a recorded history of suicide attempts for 6 of these children is incorrect. The department stated that it was not aware of these details at the time, as these were not the primary concerns brought to its attention. However, the CDCRC noted that this information was held by other agencies and available to the department had an appropriate request for information been made. The department also stated that suicide prevention is a shared responsibility across government and non-government sectors and that the department only has a mandate to intervene when it has been assessed that a child has been harmed or is at significant risk of harm and does not have a parent able or willing to protect them.

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- compliance with the requirements for internal case transfers and information exchange, and its impact on continuity of assessments and case management
 - limitations in access to after-hours services during periods of office closure, resulting in delayed assessments and fragmented case management, and
 - gaps in critical areas of practice, related to a lack of attendance by departmental officers at Child Safety Officer training.⁴

The CDCRC has advised the department of its assessment in these areas and noted the department's responses to enhance performance. The CDCRC will continue to monitor progress on these issues where appropriate in future reviews.

Observations by the CDCRC about the quality of the Department of Child Safety's original child death reviews

In general, the positive aspects of the department's original reviews in 2007–08 were:

- all but one of the 62 reviews (98.4%) were provided to the CDCRC within the six-month statutory time frame
- there was evidence that the original review had considered the possible need for the conduct of specific officers to be referred for disciplinary/performance management action, and
- there was evidence of some improvement in the timeliness of requests made to external agencies for information regarding that agency's involvement with the child.

The areas where the CDCRC noted scope for strengthened performance by the department in completing its original reviews related to:

- original reviews adopting a holistic and complete analysis of the relevant child's circumstances, encompassing the broader family context and/or the full period of departmental history, to the extent of its relevance to service delivery
- review findings and recommendations addressing systemic issues and facilitating opportunities for continuous improvement
- fully exploring considerations of cultural diversity for children who identify as being of a cultural heritage other than Aboriginal or Torres Strait Islander, and
- original reviews being started in a timely manner and providing the maximum opportunity for all relevant information to be gathered.

The CDCRC will continue to engage with the department to explore ways in which these issues can be addressed, particularly with regard to the quality of findings and recommendations, which are the key deliverables associated with the child death review process.

⁴ In its response, the department stated that there is no evidence to suggest a link between attendance at training and the death of any of the children on which it reported.