

Speech

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Briefing on the Deaths of Children and Young People Annual Report 2007-08 and Child Death Case Review Committee Annual Report 2007-08

Date: 20 November 2008
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Cnr Charlotte and Albert Streets

Acknowledgements

Ladies and gentlemen, I would like to begin this morning by acknowledging the traditional owners of the land on which we stand.

I also wish to offer my condolences and those of the Child Death Case Review Committee to the families, carers and friends of the children and young people who died during the year.

Welcome, good morning and thank you for your interest in the work of the Commission and the Child Death Case Review Committee.

These are the fourth annual child death reports that have been produced during my tenure as Commissioner and Chairperson of the Child Death Case Review Committee.

As I have a number of stakeholders in the one room today, I would like to take this opportunity to speak more broadly than just in relation to deaths data from the past year. I would also like to touch upon the quality of the investment and the current and potential returns on the investment in Queensland's child death review and research activities. Specifically:

- the investment to date from across government
- some early outcomes from the investment, including progress that many people in this room have made a contribution to
- areas requiring more effort and further investment based on the findings from the annual reports, and
- I would like to discuss how we can move forward, together, to maximise the potential to prevent child deaths.

There have been many lessons learnt during the past four years. Chief among them is that the detailed review of, and research into, child deaths is an incredibly challenging field, particularly where those deaths may have been prevented:

- the subject matter is often disturbing
- frustrations tend to arise when clear warnings are not heeded or individual vulnerabilities not catered for, and
- outcomes of the intellect and energy applied to preventing deaths can also be more difficult to measure than we may think. The required changes may occur in excruciatingly small increments, particularly where small numbers or many risk factors are involved, and they may also traverse significant periods of time. Sometimes generations.

In some established areas, we are in the business of moving mountains, and this can take lifetimes.

Having said that, it is exceedingly easy to remain positive and focussed on the task at hand – that being, delivering on the opportunity to prevent child deaths.

One of the key reasons why the energy levels, drive and motivation within the Commission towards preventing child deaths remain so high is directly related to the investment made by those agencies here today.

Clearly, the desire to save young lives is paramount. But what those of us gathered here today, or within the broader community, may not be aware of is that something special is happening within government at the moment.

An institutional stumbling block for many great initiatives has been cleared, an historical and sometimes invisible barrier of passivity has been skirted, and an area of prior criticism and detraction of the public sector has been overcome.

In a word, what is happening in the child death area is...

collaboration. True collaboration. Collaboration across multiple agencies for a common purpose – that is, building a high quality evidence base about trends and patterns in child deaths. This evidence base is a vital plank – it joins the fact of a death with the intellect and wisdom to prevent future tragedies.

What is truly heartening is that this collaboration has happened within a legislative framework that enables, rather than compels, government agencies to work together. No one has been dragged to the table. Agencies and individuals have applied time, energy and precious resources because it is the right thing to do. Because an opportunity to do more has been presented, and because of a genuine belief and commitment that we **can** do more to prevent child deaths.

Simply by not playing our cards too closely to our chest, we recognise that we can better identify and target the risk factors present in preventable child deaths.

Therefore, before moving into the content of this year's child death reports, I would like to pause to offer my sincere thanks for the cooperation, trust and support shown for the Commission during the year in maintaining and building upon its child death register and conducting child death research and reviews:

- thank you to the Department of Justice and Attorney-General (Registry of Births, Deaths and Marriages)
- thank you to the Office of the State Coroner
- thank you to the Queensland Police Service
- thank you to Queensland Health

- thank you to the Department of Education, Training and the Arts
- thank you to the Department of Child Safety
- thank you to the Department of Communities
- thank you to the Department of Housing
- thank you to the Department of Industrial Relations (Division of Workplace Health and Safety), and
- thank you to the Child Death Case Review Committee.

Some of you here today may be surprised to learn that information and data provided by each of these agencies and entities has contributed to the Commission's child death register and research this year.

Those agencies and entities who have contributed may not be aware of it, but you represent a success story within government and are part of something special.

The detailed review process that is activated when a child known to the child protection system dies, represents a further coming together of key agencies and people in pursuit of the common cause of preventing future deaths, among a highly vulnerable group of children. Additional work and effort is applied to this challenging endeavour by the:

- Queensland Police Service
- Office of the State Coroner
- Department of Justice and Attorney-General (Registry of Births, Deaths and Marriages)
- Department of Child Safety, and
- Child Death Case Review Committee and its Secretariat.

Individual brilliance, expertise and energy of specialists from within government and non-government agencies are also called upon to support these detailed reviews processes, for example:

- The Queensland Health and Department of Communities' Child Safety Directors have, at different times, assisted the Department of Child Safety's internal child

death oversight committee – thank you Corelle (Davies) and Helen (Warneke) for your contribution

- Equally, the Child Death Case Review Committee, which I chair, has been assisted by the experience and support of:
 - the Queensland Police Child Safety Director, Detective Superintendent Peter Crawford, and his proxy, Detective Inspector Cameron Harsley
 - Acting CEO of the Health Quality and Complaints Commission, Geoff Murphy
 - Annette Murphy, a registered nurse and child protection expert
 - Leading human services and social work academics, Jennifer Felton and Dr Yvonne Darlington
 - Gwen Schrieber, an expert in Aboriginal health
 - Isobel Stephen, who has some 17 years experience in issues relating to Torres Strait Islander women and children
 - my Assistant Commissioner, Barry Salmon, and
 - the Committee's very capable Secretariat staff, who assisted the Committee to meet its tight three-month statutory timeframe for reviews, which has remained unblemished these past four years.

Thank you to all the agencies and individuals who have contributed to the child death register, research and review work this year, including my talented analysts, who have worked tirelessly in maintaining the register and preparing the annual report.

Your contribution is significant and with it comes a clear responsibility for the Commission to make good on the promise of coordinating action to prevent child deaths.

I would also like to take this opportunity to sincerely thank the members of the outgoing Child Death Case Review Committee for their invaluable contribution in establishing the child death review process in 2004 and for their commitment to

improving service delivery to Queensland's most vulnerable children up until November 2007.

Through the combined efforts of all concerned, Queensland has moved to the national lead in the quality of its evidence base about child deaths.

While the Commission's child death register highlights that the majority of deaths of children in Queensland are due to natural causes, there remains a significant number of deaths resulting from external, non-natural, causes each year that may be preventable. It is this group that the Commission will continue to focus on.

What remains now is for the Commission to package the evidence in ways to allow it to be easily converted into practical ideas and solutions for preventing deaths.

I would like to share two examples with you in areas where progress is already evident, namely:

- the development of SIDS resources within the health services sector, and
- low-speed driveway runovers.

Firstly, SIDS resources: The Commission's inaugural annual report on its analysis of the child death register, which was released in November 2005, recommended that Queensland Health develop and implement statewide action regarding the quality of information provided to parents about safe sleeping practices. This included developing culturally appropriate materials that convey consistent messages to parents, particularly those in high risk circumstances.

The Commission's analysis of the child death register identified that messages about safe sleeping practices may not have been communicated consistently, and that health service professionals were well placed to educate, promote and influence safe sleeping practices.

Queensland Health subsequently developed and published a number of high quality resources for health practitioners, parents and Indigenous communities highlighting risk factors and safe sleeping practices.

In this case, the Commission, through its child death review work, was able to highlight the issue for Queensland Health.

Queensland Health, along with SIDS and Kids, are to be commended for the development of the resources. However, none of this would have occurred without the evidence collected from many agencies that enabled the issue to be highlighted – these agencies were the Queensland Police Service, the Registry of Births, Deaths and Marriages, the Office of the State Coroner and Queensland Health.

The second example relates to a recommendation I made – also in the inaugural annual report – that the Premier request the Parliamentary Travelsafe Committee to investigate and report on ways to reduce fatalities and injuries to children from low-speed driveway run-overs in Queensland.

The recommendation arose following the Commission's analysis of the child death register. This analysis highlighted Queensland's rate of deaths from low-speed driveway run-overs as exceeding the national average. The issue was complicated by the occurrence of these deaths on private property.

The Parliamentary Travelsafe Committee commenced its investigation in March 2007 and conducted a public hearing in April of the same year. The Parliamentary Travelsafe Committee made seven recommendations, all of which were supported by the relevant agencies, including Queensland Transport, Department of Public Works, Queensland Injury Prevention Council and the Motor Accident Insurance Commission.

In this small way, I wish to highlight that your investment – your time, your energy, your faith in the Commission – is paying off.

It's my hope that future releases of the child death annual reports and research findings are more than a summary or an account of another project completed, or another year's worth of information and data.

Telling the tale is obviously important, but more is required – I would like days such as today to represent the coming together of action-oriented government and non-government organisations. Those who have a stake or interest in service delivery or the development of policy, program and prevention initiatives, that can influence the prevalence of risk factors and the rate of child deaths.

I view the Commission's role and responsibility as vital in providing evidence, in the manner and form required by stakeholders, to inform debate, discussion and, most importantly, action about preventing child deaths.

I will discuss my vision and plan in further detail shortly. However, I would like to mention that, to keep pace with the amount of information and data the Commission is analysing, and to do justice to the extent of multi-agency collaboration, the Commission is developing a new information management system, dedicated to the child death register, research and review functions.

The first release of this information management system occurred, without fuss, during this year.

A further, more advanced release will occur in the next six months. This will enable the analysis and reporting on data to reach a degree of sophistication not previously seen in Australia.

This brings me to the point of sharing with you some of the key findings from the Commission's analysis of its child death register and the findings of the Child Death Case Review Committee for the 07/08 financial year.

While it is heartening to discuss what seems to be working, we cannot underestimate the work that lies ahead and where more effort might be applied. The areas highlighted in this year's annual reports include deaths resulting from:

- transport incidents
- drowning
- fatal assault, and
- suicide.

Transport incidents were the leading external cause of death for all age categories of children and young people over 1 year of age.

Of particular concern is that 24 young people aged 15-17 years died as a result of a transport incident. These deaths accounted for almost half of all children and young people who died in a transport incident.

Underpinning the high number of deaths resulting from a transport incident is that 37% of children and young people in a motor vehicle accident were not wearing seatbelts and 50% of children fatally injured in motorcycle incidents were not wearing helmets.

This finding highlights the need to promote the use of seatbelts and protective equipment to reduce the extent of injuries in the event of a crash.

We now move on to drowning. Lack of adequate supervision remains a pervasive feature of drowning fatalities. It remains the key preventative action available to reduce the risk of drowning. In many cases, young children were left unsupervised for extended periods.

80% of private pool drownings involved fences with defects, such that they were not compliant with the relevant statutory standard. This finding highlights the point that pool fences must not only be compliant with the relevant standards when erected, but also be maintained in order to remain compliant.

We now look at fatal assault. In all 11 cases where a child or young person died as a result of a fatal assault, the perpetrator was a family member. Eight of the 11 deaths occurred in the family home and 9 of the 11 children were known to the Department of Child Safety.

The children known to the Department of Child Safety were the subjects of low level notifications that did not reach the threshold for statutory intervention.

These findings highlight the need for secondary supports for struggling families, such as outreach support services, maternal or child health nurses and better access to quality and affordable childcare.

The findings also highlight the fact that child protection cannot be viewed as a government problem alone – the reasons a child comes to the knowledge of the child protection system are irrevocably linked to their parents and the community around the child.

It should be noted that since the child death review processes commenced in 2004, no child in foster care in Queensland has died as a result of non-accidental trauma, such as fatal assault.

Finally, we look at suicide. While there were no 10-14 year old suicides this year, the rate of 15-17 year old suicides doubled from previous years.

The majority of these young people stated or implied their intent to someone prior to their death.

It highlights to all of us that we must always take threats of suicide seriously. I will be promoting this message during the coming year.

The *Child Death Case Review Committee Annual Report* identifies that 75% of the suicide deaths reviewed by the Committee involved young people who had limited access to mental health services, support and statutory intervention.

Given the challenges in delivering effective interventions to this cohort of young people, the Committee 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 young people.

This year the Committee has identified five key systemic issues requiring further consideration and action by the Department of Child Safety. These are:

- the quality of case planning and case management
- timeliness of responses to 5 and 10 day response priority timeframe child protection notifications
- compliance with requirements for internal case transfers and information exchange, and its impact on continuity of assessments and case management
- limitations of after hours services and service delivery during periods of office closure, resulting in delayed assessments and fragmented case management, and
- attendance by departmental officers at mandatory child safety officer training

The child death annual reports clearly contain significantly more detail about the full range of deaths that have occurred during 07/08 and deserve your detailed consideration.

While I haven't specifically highlighted the fact in the slides, one statistic I intend to monitor closely in the years ahead is the evident reduction in the past 12 months of the deaths of Aboriginal and Torres Strait Islander children and young people due to disease and morbid conditions.

There has been a drastic reduction in the rate – it has approximately halved – and while it is too early to be significant of a trend, it's an area of government and non-government service delivery that has involved much blood, sweat and tears and warrants careful analysis and communication.

Now that both the Commission's and the Child Death Case Review Committee's key relationships and information management capabilities are reaching a level of maturity – which will expand the scope and ease of analysis and reporting on child deaths – the next investment to be made will be to engage, educate and promote the full spectrum of findings.

Many different parts of the Queensland government and community can play a part in preventing child deaths, including mums and dads, the government and non-government human services sector, sporting clubs and schools. Everyone can be involved – it's all a question of “who?” and “how?”

In my dual role as Commissioner and Chairperson of the Committee, I'm in a unique position to communicate and coordinate the required action.

In the year ahead I plan to complete work on a Child Death Prevention Strategy. The strategy will be used to coordinate communication and action, based on the evidence contained in the child death register.

Under the strategy, the Commission will encourage all relevant stakeholders to be involved, by providing opportunities to:

- **Access** information about child deaths and how to prevent them. As part of the Child Death Prevention Strategy, the Commission intends to raise the profile of the Child Death Register, making data more accessible to stakeholders through Issues Reports and Bulletins. These will be published in addition to the annual report.
- The Commission will **build** research partnerships that extend current understandings about ways to address risk factors in preventable child deaths. To support these research partnerships, the Commission will develop criteria and processes for the appointment of genuine researchers under the Commission's

Act, allowing access to specific data that the Commission holds in order to undertake research that will help reduce the likelihood of child deaths, and

- The Commission will also work to **change** attitudes, behaviours, environments and laws to make things safer for children, either through formal recommendations under the Commission's Act, advocating for change informally, or supporting stakeholders to perform their existing prevention activities by providing regular advice on contemporary trends and issues in child deaths.

In a nutshell, to be successful, the strategy must get the required data and trend information, to the right stakeholders, to enable a considered and timely response to existing and emerging issues.

As I have already discussed, many of you here today have played a vital role in the birth and growth of the Commission's child death review and research functions. These established relationships will be vital to the success of the strategy.

There are also some of you that are beginning new relationships with the Commission – organisations such as the Queensland Injury Prevention Council and the Australian Institute for Suicide Research and Prevention.

These new collaborations, particularly within the non-government and academic sectors, will be critical to the success of the strategy.

I will be working hard over the next 12 months with all stakeholders to ensure that you are a part of the future direction.

In closing, I would again like to thank you for attending this presentation. I am encouraged by the number of stakeholders who have made the effort to be here today. I know many of you are active in your different fields and are making great progress to keep our children and young people safe and I look forward to working with you more closely in the year ahead.