Chapter 9 — Child death prevention activities

This chapter details the child death prevention activities beyond those to do with maintaining and reporting on the Child Death Register, that the QFCC has undertaken in 2018–19.

The QFCC continues to concentrate its efforts on maintaining the accuracy and comprehensiveness of information in the Child Death Register, meeting the legislated requirement to report annually and sharing data with researchers and the community. Collecting, analysing and publishing information on the causes of child deaths is an important step in preventing child deaths and serious injuries.

This year the QFCC’s prevention activities included:

- seven community education fact sheets and resources
- the Seconds Count driveway and car park safety campaign
- sharing information with the Department of Education to support suicide postvention in affected schools
- briefing senior government officers on youth suicide data
- contributing to the development of the Queensland Suicide Prevention Plan
- delivering research forums in Brisbane and Cairns themed on improving youth mental health
- providing tailored child death data to 24 stakeholders
- making three submissions in relation to: Queensland Open Doors to Renting Reform; review of the permanent ban on miniature motorbikes; and the safety standard for corded internal window coverings, and
- projects to improve the QFCC Child Death Register database, including migrating legacy records for 2004–2012 into the register and progressing an upgrade to the database system.
Maintaining the child death register

The QFCC maintains the Queensland Child Death Register under Part 3 of the *Family and Child Commission Act 2014*. Information from the register is analysed and an annual report on the deaths of all children in Queensland is produced. This assists to improve understanding of risk factors and supports new policies and practices to reduce child deaths.

The register contains data for some 7000 child deaths registered since 1 January 2004. It provides a valuable evidence base that is used to:

- develop safety and injury prevention activities
- monitor the effectiveness of prevention activities, and
- provide detailed child death data to researchers and government agencies.

Child death prevention publications

In December 2018, the *Annual Report: Deaths of Children and young people Queensland 2017–18* was tabled in Parliament. This was the 14th annual report to be produced on child deaths in Queensland. The authorised electronic version of the annual report can be accessed on the Queensland Parliament website and the 2017–18 report webpage.

The QFCC also produced and made available on the QFCC website a number of fact sheets and resources during 2018–19, including:

- [Child deaths in Queensland 2017–18](#)
- [Aboriginal and Torres Strait Islander child mortality 2017–18](#)
- [Children known to the child protection system 2017–18](#)
- [Youth suicide in Queensland, and](#)
- [14-year tables: Analysis of deaths of children and young people, Queensland, 2004–05 to 2017–18](#).

The QFCC coordinated and published the *Australian and New Zealand child death statistics 2016* on behalf of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG).


Activities to improve collection of child death information

During 2018–19, the QFCC completed the migration of legacy child death records from 2004–2012 into the current child death database, allowing for improvement to the timeliness and accuracy of analysis and data provision to government and researchers. The QFCC is also progressing an upgrade to the database system which houses the register.

For the purpose of child death prevention and to maintain the Child Death Register, the QFCC has written to relevant government departments on 45 occasions. These included:

- 37 letters to the Department of Education, which included two letters seeking information and 35 Suspected Suicide Notifications to support suicide postvention in Queensland state schools
- three letters to the Department of Child Safety, Youth and Women to seek information
- two letters to the Queensland Health to seek information
- one letter to Queensland Police Service to seek information
- one letter to Workplace Health and Safety Queensland to seek information, and
- one letter to the Department of Housing and Public Works to seek information.
The QFCC continued to collaborate on a working group with agencies including the Coroners Court of Queensland, the Queensland Police Service and the Queensland Paediatric Quality Council to improve data collection and processes relating to sudden unexpected death in infancy (SUDI).

**Supporting youth suicide prevention efforts**

The QFCC continued to monitor and support prevention of suicide deaths of children and young people. In 2018–19, this included:

- sharing information with the Department of Education to support suicide postvention in affected schools
- providing briefings and data updates to senior government officers
- a presentation on youth suicide at the ‘Keep Queenslanders Healthy’ cluster group
- promoting mental wellbeing tips through QFCC social media channels
- contributing to the development of the Queensland Suicide Prevention Plan, and
- participating in the Deputy Premier’s Social and Emotional Wellbeing Community Roundtable, convened to address suicide among Aboriginal and Torres Strait Islander peoples.

Two of the three QFCC Research in the Round forums held in the year addressed the theme *Improving youth mental health*. One forum was held in Brisbane in March 2019 and one in Cairns in June 2019.

**Seconds Count campaign on driveway and car park safety**

The QFCC’s 2018 *Seconds Count* campaign was launched to raise awareness of child safety risks from low-speed vehicle run-over accidents that typically occur in the family driveway, and public car parks.

The QFCC, in collaboration with Kidsafe Queensland, developed the evidence base for this joint community safety campaign which was sponsored by the Department of Transport and Main Roads (TMR) and promoted through TMR’s *StreetSmarts* (formerly *JoinTheDrive*) social media channels.

A fact sheet on driveway and car park safety, titled *Don’t go if you don’t know*, augmented the campaign.

**Policy submissions**

During 2018–19, the QFCC used information in the Queensland Child Death Register to provide advice and recommendations in three submissions:

- The Queensland Government’s consultation *Open Doors to Renting Reform* – the QFCC supported changes that would allow tenants to fix furniture and televisions to the walls or make other changes for safety reasons, unless there are reasonable grounds to refuse (such as the presence of asbestos or heritage-listing status).
- The Australian Competition and Consumer Commission’s (ACCC) review of a permanent ban on miniature motorbikes with unsafe design features – the QFCC was supportive of Option 2, which was to revoke the permanent ban and introduce a requirement for instructions, warnings and a speed limiting device.
- The ACCC’s review of the safety standard for corded internal window coverings – the QFCC was supportive of Option 2, which was to make a new safety standard to include the following: changes to warning labels; options for alternative safety devices; restrictions of cord lengths; and minimum requirements for cleats and durability of safety devices.
Research summaries

The QFCC provides short Research Summaries of contemporary research findings which are designed to make research more accessible to policy makers and practitioners. A key element of the Research Summaries is identifying the implications of the findings for policy and practice. In 2018–19, three of the Research Summaries produced were relevant to child death prevention:

- Bendall, S 2019, 'What is trauma-informed care and how should it be practiced in youth mental health settings?', QFCC.
- McDermott, B 2019, 'Embracing Complexity: why youth mental health problems require more than youth mental health interventions', QFCC.

Researcher access to child death data

A key strategy to support child death and injury prevention is to make data held in the register available for research, public education, policy development and program design. Access to the comprehensive dataset is available at no cost to genuine researchers.\(^{80}\) Stakeholders wishing to access the register to support their research, policy or program initiatives can email their request to child_death_prevention@qfcc.qld.gov.au.

In 2018–19, the QFCC responded to 24 requests for access to the child death register. Table 9.1 gives an overview of the type of data provided in 2018–19 and the purpose for which it was used.

Table 9.1: Purpose of data request by type of data requested 2018–19

<table>
<thead>
<tr>
<th>Type of data requested</th>
<th>Purpose of data request</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Research</td>
<td>Public education and reporting</td>
</tr>
<tr>
<td>Accidental</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>All deaths</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>All non-natural causes</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diseases and morbid conditions</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Drowning</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Interstate residents</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sudden unexpected deaths in infancy (SUDI)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Data source: QFCC Register of child death data requests (2018–19)

Projects provided with child death information include the following:

- SUDI data provided to the Queensland Paediatric Quality Council (QPQC) to support the Infant Mortality Sub-Committee (IMSC) on its project, Analysis of Infant Deaths 2015–16
- data on child drowning provided to the Queensland Building and Construction Commission to support its quality assurance of fatal immersion incidents 2017–19
- data on child drowning provided on a regular basis to the Royal Life Saving Society – Australia to support its National Drowning Report and research program
- data on fatal child injuries as a result of falling furniture or televisions was provided to Kidsafe Queensland for public education and reporting purposes

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\(^{80}\) Under section 28 of the FCC Act, the QFCC is able to provide child death information for genuine research, defined as research relating to childhood mortality or morbidity with a view to increasing knowledge of incidence, causes and risk factors relating to same. Genuine research includes policy and program initiatives to reduce child death or injury.
• youth suicide data provided to the Department of Education and the Department of Aboriginal and Torres Strait Islander Partnerships to support the Social and Emotional Wellbeing Community Meetings in 2019
• a hospital-based clinical audit on paediatric deaths
• a Children’s Health Queensland research and prevention campaign to reduce paediatric trauma
• a Children’s Health Queensland project standardising best-practice care for children and their families receiving end-of-life care, and
• a PhD research project in relation to Aboriginal youth suicides in the Toowoomba, Darling Downs and Southwest Queensland regions.

Research findings supported through child death data

Data provided from QFCC’s Child Death Register has supported research in a number of fields of child death and injury prevention, leading to the following published findings:

Drowning-related research

• Royal Life Saving – Australia 2018, Royal Life Saving national drowning report 2018.
• Royal Life Saving – Australia 2018, Trends in child drowning over the last 25 years.
• Royal Life Saving – Australia. 2018, A 10 year national study of overseas born drowning deaths.

Homicide-related research


SUDI-related research

Suicide-related research


Systems reviews relating to child deaths

During 2018–19, the Attorney-General and Minister for Justice asked the QFCC to undertake three whole-of-system reviews and to provide reports on the findings.81 The three reviews all relate to systems and services in relation to child deaths. These reviews are underway.

Child Death Review Board

In 2017, the QFCC released the report, *A systems review of individual agency findings following the death of a child*, which recommended that the government consider a revised external and independent model for reviewing the deaths of children known to the child protection system. Subsequently, the QFCC worked with the Department of Justice and Attorney-General, in consultation with nominated agencies, to identify a new model. The government has announced that the QFCC will host a new and independent Child Death Review Board from mid-2020, pending passage of the Bill through Parliament.

Participation in state and national advisory groups

QFCC officers participated on a number of advisory bodies, including:

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG)
- Consumer Product Injury Research Advisory Group
- Queensland Government Births and Deaths Working Group
- Queensland Paediatric Quality Council Steering Committee
- Road Safety Research Network
- Shifting Minds Strategic Leadership Group
- Sudden Unexpected Deaths in Infancy (SUDI) Multiagency Working Group
- Suicide Prevention Plan Cross-agency Working Group
- Water Safety Roundtable.

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81 The Attorney-General and Minister for Justice requests were made under section 22 of the Family and Child Commission Act.