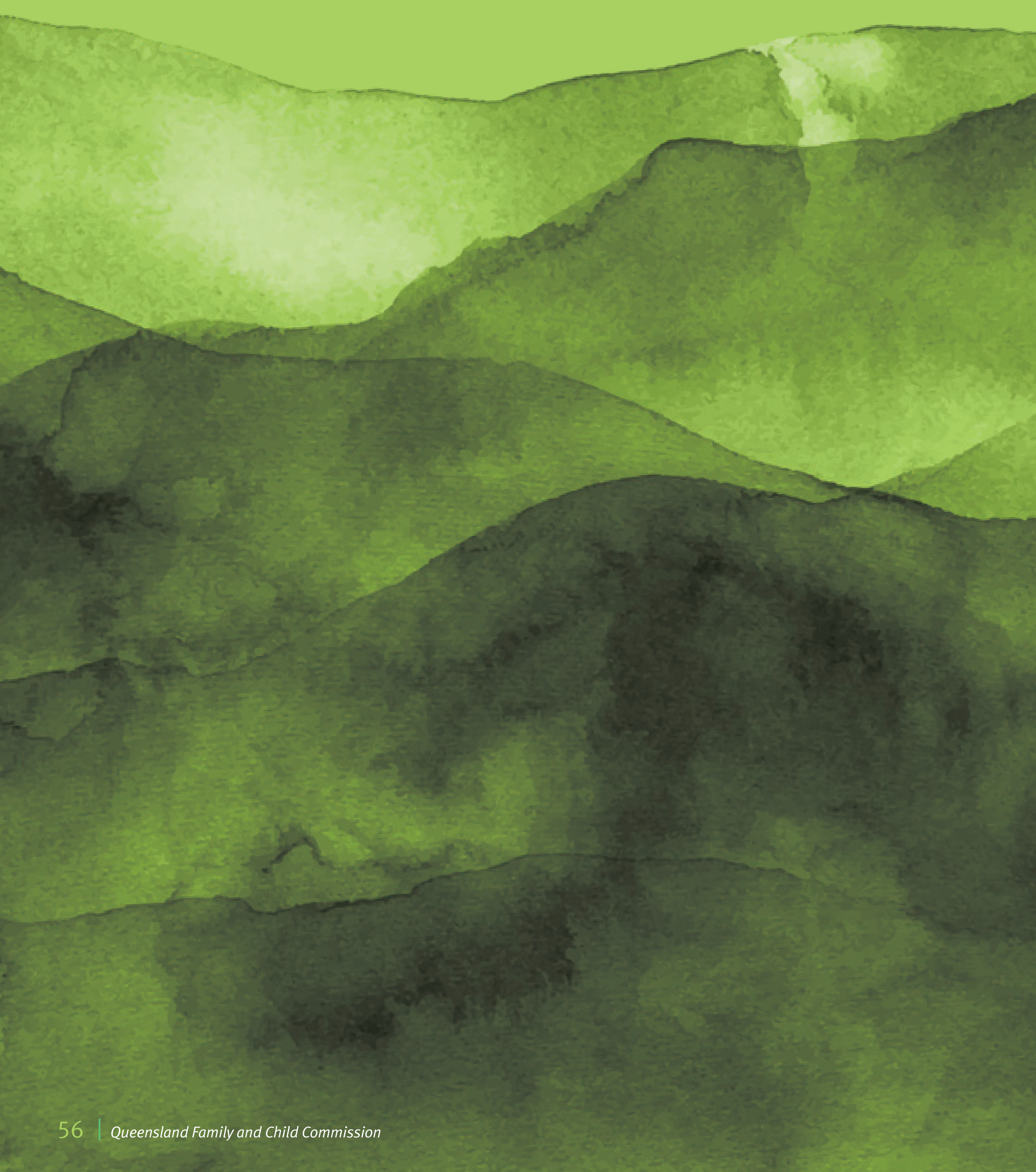
8 Child death prevention activities



Maintaining the Child Death Register

The QFCC maintains the Queensland Child Death Register in accordance with Part 3 of the *Family and Child Commission Act 2014*, under which it is required to produce an annual report on the deaths of all children in Queensland.

The Register was established in 2004 and currently contains over 7,700 records that have been classified by the cause of death, demographic and incident characteristics. It allows the QFCC to extract information from its 17 years of recorded data, highlighting risk factors and trends to inform research, support policy improvement and community safety initiatives to help reduce the likelihood of child deaths.

Redesign of the Child Death Register

The QFCC has undertaken a two-year development project to replace the Child Death Register database system.

The redesigned system, Coda, was successfully implemented on 12 March 2021. The new application sits on a cloud-based platform and has modernised the Register by capturing quality information in a more structured way. Manual processes have been automated, making reporting easier and enabling better auditing, and enhancing the way sensitive information is captured.

Stakeholder engagement with other child death jurisdictions, system users and genuine researchers was used to understand what improvements were needed. The redesign incorporated an in-depth review of the way the Register information is collected and used. Redundant or rarely used fields were removed, while other fields were added or amended to improve sequencing or address emerging issues.

The introduction of Coda has resulted in improvements including:

- ability to immediately record child death data in Coda as it is received—no longer a need to wait for formal death registration through the Registry of Births, Deaths and Marriages
- enhanced accessibility and intuitive design for ease of navigation
- increased efficiency through automation, system processing speed and refinement of content/structure of information
- geographical remoteness and socio-economic status indicators updated to latest Census data
- improved case search and display functionality and speed in return of search results
- centralisation of case records with their supporting documentation
- incorporation of task workflow into the system
- refinements to the decision making around Aboriginal and Torres Strait Islander status where source records are inconsistent
- enhanced recording of multiple fatality events (child and/or adult)
- secure portal for cause of death coding undertaken remotely by ABS mortality coders
- ICD-10 coding linked to the latest online version of the classification
- structured placement of suicide fields aligned with the suicide classification model
- improved access and efficiency in extracting the data through the report building tool.

An important element of the project was migrating the full set of child death records into Coda. Migration of field data was, for the most part, achieved on a one-to-one basis. However, only partial migration was possible in some complex areas where substantial changes were made to improve the data structure. The QFCC will continue to undertake data audits, data cleansing and populating new fields, as well as progressing other system enhancements, in the coming year.

Publications

Annual report

In March 2021 the *Annual Report: Deaths of Children and young people Queensland 2019–20* was tabled in Parliament. This was the 16th annual report to be produced on child deaths in Queensland. The electronic version of the annual report can be accessed on the **Queensland Parliament website** (authorised version) and the **2019–20 report webpage**.

The QFCC also published the ***Australian and New Zealand child death statistics 2018***, prepared on behalf of the members of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). This report, along with factsheets and 16-year data tables, are available on the report webpage.

16-year trend review

The ***Counting lives, changing patterns: Findings from the Queensland Child Death Register 2004–2019*** report was tabled in the Queensland Parliament on 13 May 2021. The QFCC reviewed the 16 years of child death data held in its Child Death Register, with a focus on those causes of death considered to be most preventable by modifying behavioural or environmental factors.

The report provides a high-level overview of broad trends and patterns in child mortality in Queensland. By analysing all deaths occurring during the 16-year period, the QFCC was able to identify patterns and conduct complex statistical analysis to generate new insights into risk and protective factors.

The report can be used to inform policy and program development to improve safety for children and young people. Several areas requiring further research have been identified, which the QFCC intends to act on in collaboration with stakeholders.

Systems reviews relating to child deaths

In 2020–21, the QFCC delivered system review reports to the Honourable Attorney-General and Minister for Justice and Minister for Women and Minister for Domestic and Family Violence. The review reports followed the deaths and serious neglect of several children and made recommendations to improve the child protection system.

The QFCC consulted with multiple agencies to inform the review findings.

The reviews identified gaps in system responses intended to keep vulnerable children safe and help their parents to protect and care for them. The QFCC continues to work with the Minister and government agencies to implement the necessary changes to protect vulnerable children.

Publicly available systems reviews by the QFCC can be found at **System reviews | Queensland Family & Child Commission (qfcc.qld.gov.au)**.

Child Death Review Board

On 1 July 2020, the *Child Death Review Legislation Amendment Act 2020* commenced, implementing a new child death review model in Queensland. The introduction of the new model followed a recommendation made by the QFCC in its report: *A systems review of individual agency findings following the death of a child*.

The new model included the establishment of the independent Child Death Review Board (CDRB). The CDRB conducts systemic reviews following the death of a child, connected to the child protection system, to identify opportunities to improve the child protection system and prevent future deaths. It does not investigate the deaths of individual children.

In addition to establishing the CDRB, under the new model more agencies are required to review service responses following the death or serious physical injury of a child known to the child protection system.

More information on the CDRB functions, procedures and reports can be found at **Home – Child Death Review Board – Queensland Government (cdrb.qld.gov.au)**

Supporting youth suicide and SUDI prevention efforts

The QFCC continued to monitor and support prevention of suicide deaths of children and young people. This included sharing information with the Department of Education to support suicide postvention in affected schools and promoting mental wellbeing tips through QFCC social media channels.

SUDI prevention was also an area of focus and in the last year the QFCC contributed by:

- providing SUDI data for several initiatives including reviews of infant product safety standards
- supporting activities led by the Queensland Paediatric Quality Council
- participation in the SUDI multiagency advisory meeting pilot.

The CDRB, in its first year of operation, has also engaged with researchers in the areas of suicide and SUDI prevention to inform improvements to system responses for highly vulnerable children and families.

SUDI multiagency advisory meeting pilot

Following advocacy from the QPQC and QFCC, the Office of the State Coroner has initiated a 9-month pilot of a Multiagency advisory meeting for recent SUDI deaths. The advisory meeting is to provide advice and recommendations to the investigating Coroner in relation to SUDI deaths reports under the *Coroners Act 2003* regarding:

- the identification of contributory factors
- further investigation or enquiries that may assist to establish a cause of death and/or identify and better understand risk factors arising from the circumstances of the child's death
- the identification of any gaps or potential opportunities for improvement by government, non-government and private sector agencies involved with the child's family or the child's care prior to the death
- possible recommendations to prevent future infant deaths happening in similar circumstances
- appropriate support pathways for the child's family.

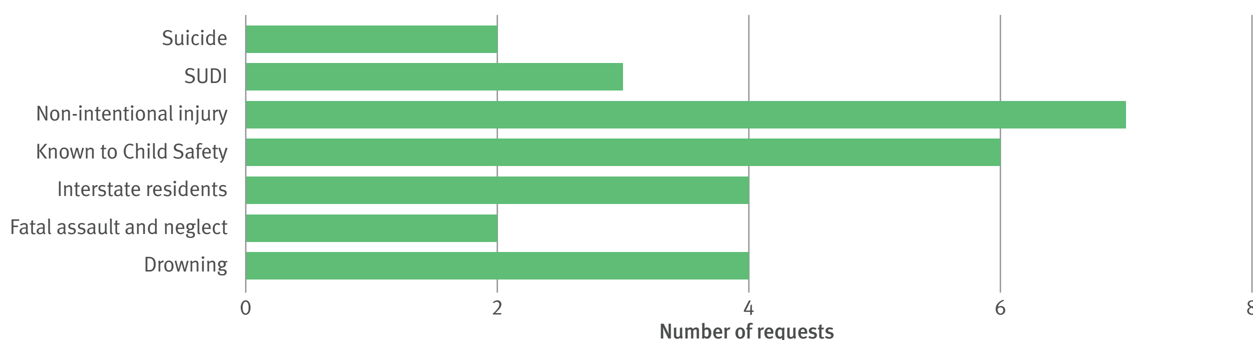
The meeting is chaired by the QPQC Chair and attended by the State Coroner and representatives from the Queensland Police Service, Forensic and Scientific Services, Queensland Ambulance Service, Queensland Health, Department of Children, Youth Justice and Multicultural Affairs and the QFCC.

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. Data from the comprehensive dataset is available at no cost to genuine researchers.[55] Applications to obtain data can be made by emailing **child_death_prevention@qfcc.qld.gov.au**.

In 2020–21, the QFCC responded to 28 requests for Child Death Register data. Figure 8.1 gives an overview of the types of data provided. The purposes the data was used for included: public education and reporting (50%); policy and program development (18%); research (18%); and safety standards (14%).

Figure 8.1: Type of data requested (number), 2020–21



Projects provided with child death information

- Non-intentional injury data was provided to:
  - Kidsafe to inform a Victorian coronial inquest into a child fatality as a result of entrapment in a car window
  - the Office of Fair Trading to inform product safety standards and assist with product specific child death investigations
  - Queensland Injury Surveillance Unit to understand the incidence of deaths linked to the choking game or choking experimentation in Queensland.
- Drowning data was provided to:
  - Mackay Regional Council to support a Pool Fencing Safety Campaign to promote compliant pool fencing
  - Royal Life Saving Society Australia on a regular basis to support its National Drowning Report and research program
  - Queensland Building and Construction Commission to support a summer pool safety awareness campaign.
- Fatal assault and neglect data was provided to the University of New England to support PhD research around deaths of children known to the Family Court and Federal Circuit Court.
- SUDI data was provided to the QPQC Infant Mortality Sub-Committee, for its comprehensive analysis of the issues associated with infant deaths. The research paper, ***Infant Reflux and Inclined Sleep: Why is this a SUDI risk?*** was published in September 2020. The project is also informing development of the Queensland clinical guideline for infant safe sleeping.
- Child death data on place of death location type was provided to the University of Queensland School of Medicine to support PhD research on staff wellbeing in Paediatric Intensive Care Units.
- Child death data for children known to Child Safety provided to the CDRB included:
  - updated cause of death and case specific information to support the review processes
  - SUDI case data and geographical remoteness data for research projects.

55 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.

Participation in state and national advisory groups

Whilst the COVID-19 global pandemic has disrupted face to face stakeholder and community engagement during 2020–21, engagement has continued via online platforms. QFCC officers participated in the following advisory bodies during 2020–21:

- Australian and New Zealand Child Death Review and Prevention Group
- Consumer Product Injury Research Advisory Group
- Interim Queensland Government Suicide Prevention Network
- SUDI multiagency advisory meeting
- QPQC Infant Mortality Sub-Committee
- QPQC Steering Committee
- Queensland Government Births and Deaths Working Group
- Road Safety Research Network.

Focus areas for 2021–22

Child death prevention strategy

The QFCC is developing a strategy to guide its child death prevention activities over the next 5 years. It is intended to provide an approach to using data captured in the Child Death Register to prioritise prevention initiatives in response to patterns and trends in child deaths in Queensland. It will focus on areas where interventions are possible, effective, and able to be implemented through practice and policy change and community education messaging.

Child Death Register enhancement

The QFCC will continue to work with developers to further enhance and refine the Child Death Register. This commitment to ongoing improvement will see the Register continue to evolve with technology and business needs, including further enhancement of the reporting tool.

In addition to enhancements within the system, a comprehensive data dictionary will be developed to establish consistent definitions of fields, data items and procedures. The dictionary will be a valuable reference for communication between system developers and end users, as well as supporting future enhancements through the clarification of business processes and requirements.

Information sharing

Information sharing between partner agencies is a critical element of maintaining an accurate and holistic suite of data in the Child Death Register. The QFCC will continue to collaborate with partner agencies to ensure the information sharing agreements continue to be fit for purpose and are meeting the needs of individual agencies.