



Annual Report

Deaths of children and young people Queensland

2020–21

Queensland
Family & Child
Commission



About this report

This report has been prepared under section 29 of the *Family and Child Commission Act 2014*. It describes information on the deaths of children and young people in Queensland registered in the period 1 July 2020 to 30 June 2021.

The Queensland Family and Child Commission (QFCC) is a statutory authority of the Queensland Government. Established in 2014, the QFCC provides oversight of the family and child support system, with an aim to bring children's rights to life. Through awareness, advocacy and accountability, we seek to give practical effect to the rights of all children and young people in Queensland.

Accessibility

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds.



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Contact for enquiries

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Queensland
Family & Child
Commission

28 October 2021

The Honourable Shannon Fentiman MP
Attorney-General and Minister for Justice,
Minister for Women and Minister for the Prevention of Domestic and Family Violence
1 William Street
BRISBANE QLD 4000

Dear Attorney-General

In accordance with section 29(1) of the *Family and Child Commission Act 2014*, I provide to you the Queensland Family and Child Commission's annual report analysing the deaths of Queensland children and young people.

The report analyses the deaths of all children and young people in Queensland registered in the period 1 July 2020 to 30 June 2021, with a particular focus on external (non-natural) causes.

I draw your attention to section 29(7) of the *Family and Child Commission Act 2014* which requires you to table this report in the Parliament within 14 sitting days.

Yours sincerely

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission

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Acknowledgements

The Queensland Family and Child Commission (QFCC) acknowledges the Turrbal and Yugara peoples as the Traditional Custodians across the land on which the QFCC meets and works. We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to their Elders past, present and emerging.

The QFCC acknowledges the special rights of children which are recorded in the *United Nations Convention on the Rights of the Child* (UNCRC), guided by its four principles: the right of all children to survival and development; respect of the best interests of the child as a primary consideration in all decisions relating to children; the right of all children to express their views freely on all matters affecting them; and the right of all children to enjoy all rights of the CRC without discrimination of any kind.

The QFCC thanks the government and non-government agencies and individuals who contributed data and their expertise to the report. In particular, we express appreciation to the Registry of Births, Deaths and Marriages; the Coroners Court of Queensland; Queensland Police Service; Queensland Health; Department of Children, Youth Justice and Multicultural Affairs; the Australian Bureau of Statistics (ABS); Queensland Paediatric Quality Council; Queensland Ambulance Service; Queensland Treasury; and the Royal Life Saving Society of Australia. The Victorian Department of Justice and Regulation is also acknowledged as administrator of the National Coronial Information System.

The QFCC would also like to acknowledge the contribution of data from other Australian and New Zealand agencies and committees which perform similar child death review functions. This data has been compiled for an inter-jurisdictional overview representing further steps towards developing a nationally comparable child death review dataset. The overview is available online at <https://www.qfcc.qld.gov.au> on the child death reports webpage.

The QFCC would like to acknowledge the considerable efforts of those involved in the redesigned Child Death Register, Coda, including the development and testing teams and the QFCC Child Death Prevention team.

We also acknowledge and appreciate the work of staff from the QFCC who contributed to data analysis, research and drafting processes.

This report may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline

Phone: 13 11 14

Beyond Blue

Phone: 1300 22 4636

Kids Helpline (for 5–25 year olds)

Phone: 1800 55 1800



Foreword

Each year, one of the most important duties of the Queensland Family and Child Commission (QFCC) is to maintain a register of child deaths in Queensland. We analyse the data behind the tragedies and report on trends and patterns over time. Our information is used in policies, programs and public education campaigns to reduce deaths and to help keep our children safe.

We never allow ourselves to forget that the death of a child or young person, in any circumstances, is devastating for the family, friends and communities who are touched by the loss.

This is the seventh year of operation for the QFCC and the seventeenth year of reporting on the deaths of children and young people in Queensland. It has been a challenging one, as governments and communities have worked to minimise the negative impact of the COVID-19 pandemic. We have adapted our approaches so we could continue to make a difference to the safety and wellbeing of children.

In 2021, we implemented a redesigned register (Coda). This was significant, because Coda doesn't just provide improvements to the quality and quantity of the data we capture, it also enhances our reporting capabilities. We can now provide more specialised analysis of the data held in the system.

This year alone, we recorded information relating to 398 children whose deaths were registered between 1 July 2020 and 30 June 2021. While the majority of these deaths (67 per cent) were from natural causes, 86 children and young people died from what we call 'external causes' that the government and community can do something about.

In examining this information, we consider the risk factors that may play a part in specific causes of death. We also use it to contribute to initiatives designed to deal with these risk factors. The initiatives can range from developing targeted prevention messages through to providing evidence to support policy, practice and legislation.


In most areas of child mortality, the statistics seem to be moving in the right direction, but there are two trends that I am particularly concerned about. The first is motor vehicle crashes. Of the children and young people who died this year, 19 lost their lives in this way. This is the highest annual figure since 2014–15.

The number of motor vehicle crash fatalities fell considerably between 2004 and 2016, but we've seen concerning increases since 2016, particularly in 15–17 year-olds. In fact, over the past five years, almost 40% of all motor vehicle deaths featured drivers aged 18 years and under, travelling with passengers of a similar age.

The second relates to suicide, to which we have lost 30 young people this year, continuing an increasing trend. Sadly, this trend has been noted in other jurisdictions as well. Mental health and suicide prevention is high on the government's agenda. I am encouraged by this, and the QFCC works hard to keep parliamentarians and government officers up to date with relevant data.

In partnership with our youth advocates—the young people who serve on the QFCC's Youth Advisory Council—we have also been highlighting the importance of mental wellbeing for young people and developing strategies to connect them with the supports they need.¹

¹ The Youth Advisory Council (YAC) champions the voices of children and young people to provide youth perspectives and leadership to the QFCC. The YAC meets regularly to provide advice to the Commissioners on what is important to children and young people in Queensland.

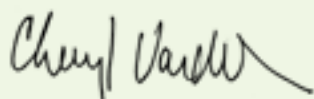


Earlier this year, the *Counting lives, changing patterns: Findings from the Queensland Child Death Register 2004–2019* report was tabled in Queensland Parliament. It analysed 16 years of data held in the Queensland Child Death Register, focusing on the deaths that can be prevented if we modify behavioural and environmental factors. I hope the findings of this groundbreaking report will be used in future research, policies and programs. Most of all, I hope it will save the lives of children and young people.

The Child Death Review Board began operating this year, and I was honoured to chair it. Its work complements the QFCC's child death prevention activities. While the QFCC reviews the circumstances of child deaths on an annual basis, the Child Death Review Board examines them at a systems level. Both approaches are critical to understanding the risk factors we need to be aware of and the preventative measures we need to take.

As this is my last annual report as the Principal Commissioner of the QFCC, I want to acknowledge the dedication demonstrated by those who work on the register of child deaths. It is not an easy task. The team members are committed to professionally gathering and analysing information, to understanding and communicating it, and to making a real difference to the lives of children.

It has been a privilege to lead these people and this work. It is difficult to think of anything more worthwhile than keeping children safe.



Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission