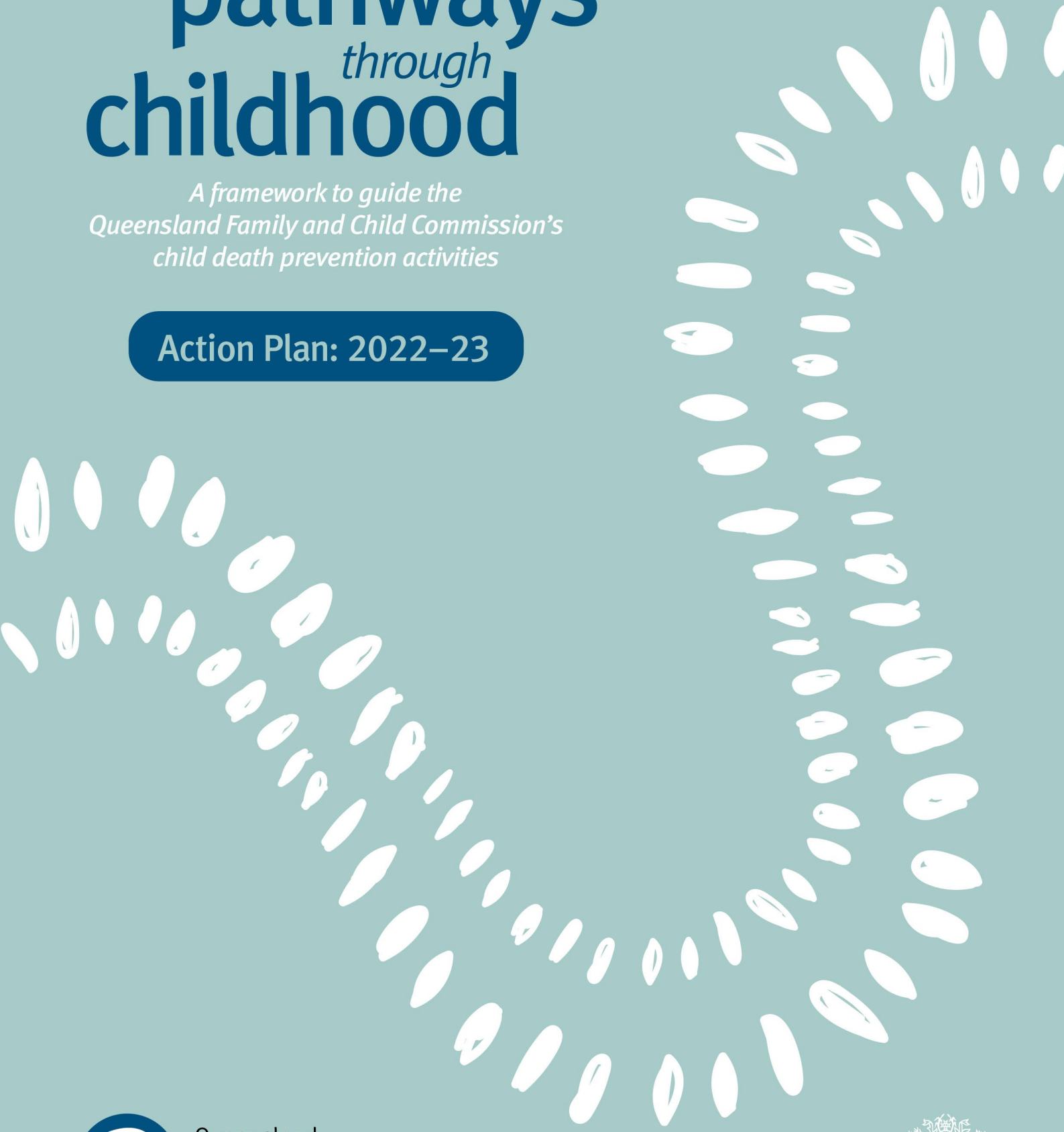
Safer pathways through childhood 2022–2027

A framework to guide the Queensland Family and Child Commission's child death prevention activities

Action Plan: 2022–23



Queensland Family & Child Commission

Queensland Government

Action Plan: 2022–23

A message from the Commissioners

The Queensland Family and Child Commission's *Safer pathways through childhood* framework (the Safer pathways framework) sets the direction of our child death prevention functions over the next five years. It formalises the work we already undertake, outlining our priorities to help us work towards achieving health equity for Queensland children.

We are pleased to launch the *Safer pathways through childhood action plan: 2022–23*. This document details the actions we will take over the coming year to address the focus areas established under the framework.

During this first year of the Safer pathways framework, our focus is on delivering projects using our existing dataset. These projects will analyse this data in different ways, to generate new and insightful findings to support child death prevention initiatives.

We will also further develop our capacity to undertake more complex projects in the years ahead, by developing partnerships with stakeholders and broadening the scope of data we collect.

Over the next year, we look forward to working with stakeholders, old and new, to start delivering on the focus areas the QFCC has set for its child death prevention work. Together, we can make a real difference in the lives of Queensland children and families.

Natalie Lewis
Commissioner
Queensland **Family and Child** Commission

Luke Twyford
Principal Commissioner
Queensland **Family and Child** Commission

The Safer pathways framework

The Safer pathways framework focuses on achieving health equity. All children, no matter where they live or who they are, should have the same opportunities to lead a full life and to reach their potential. Yet some groups of children are more at risk of premature mortality than others, due to a range of systemic factors.

Children more likely to experience health inequity and premature mortality are considered priority populations under the framework. These include children known to statutory systems (such as the child protection and youth justice systems), First Nations children, children with disability, children living in remote or low socio-economic areas, and children under 5 years of age.

The QFCC uses a socio-ecological model to frame its child death prevention work. It acknowledges that reducing child deaths requires more than just individual behaviour change. Prevention efforts must influence factors in a child's family and community, as well as the constraints imposed by the structural and historical contexts in which they exist.

Impact areas

There are four main ways in which our work under the Safer pathways framework helps prevent child deaths (our impact areas):

1. **Data quality:** We produce high quality data and contribute to improvements in related datasets.
2. **Expertise:** We value specialist knowledge and collaborate with expert stakeholders and the community.
3. **Research into action:** We seek opportunities to use our data and expertise to reduce child deaths.
4. **Continuous improvement:** We monitor data to identify emerging trends, system improvements and effective prevention initiatives.

We achieve these impacts in the context of **collaborative partnerships**.

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Focus areas

The Safer pathways framework sets out the focus areas for the QFCC's child death prevention work over the next five years. Our work will aim to contribute to the evidence base about:

- the impact of ***family-level adversity***
- the origins and impact of ***risk-taking*** by both children and parents
- guidelines for ***supervision*** across age groups and circumstances
- ***help-seeking behaviours and access to services*** by young people and families
- opportunities to reduce risk through ***environmental design, product safety and regulation***
- accuracy of data for ***First Nations children***
- the ***impacts of COVID-19*** on children and families
- ***youth suicide*** prevention
- death certification for ***sudden unexpected death in infancy*** (SUDI), and
- deaths from ***preventable natural causes***.

First year actions

Our actions for 2022–23 target several focus areas across multiple impact areas.

There are several types of prevention activities we will undertake.

- Rapid reviews are short publications usually able to be prepared using existing QFCC data.
- Deep dives are more complex projects, undertaken in partnership with others, often involving co-design or additional data. Deep dives may extend over more than one action plan period.
- Awareness-raising and advocacy activities will promote key prevention messages.
- Initiating actions position QFCC to undertake projects under future action plans.

Rapid reviews

Preventable childhood mortality

The complete range of conditions causing death that are considered preventable or potentially avoidable is a topic of continuing international debate. To effectively measure the impact of our child death prevention activities over time, it is necessary to measure the rate of preventable deaths.

We will review existing standards designed to measure potentially avoidable deaths and consider how applicable they are to child mortality specifically. This is intended to inform future work, in collaboration with experts, about which causes of child death the QFCC considers preventable.

Paediatric sepsis

In line with our focus on preventable mortality, we will partner with experts to specifically consider child deaths from sepsis. Sepsis stems from infection and is a leading cause of childhood morbidity and mortality in Australia.[1] It can be difficult to detect in children, and certain population groups are at higher risk.

This project will help us better understand the incidence of deaths from paediatric sepsis and factors that may place some children at higher risk of infection and adverse outcomes.

Swimming pool drownings

Children under five years of age are most at risk of drowning, with private swimming pools a key water hazard. Queensland has strong pool fencing laws to help prevent young children entering pool areas unsupervised. Despite this, the average number of young children drowning in swimming pools has increased since 2013.[2]

This year, we will look closely at contributing factors in these events, including whether there are opportunities to strengthen the enforcement of pool fencing legislation.

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[1] Children's Health Queensland Hospital and Health Service (2019) Queensland Paediatric Guideline: Sepsis – Recognition and emergency management in children. Accessed 13 June 2022.

[2] Based on 5-year rolling average numbers. Queensland Family and Child Commission (2022) Annual Report: Deaths of children and young people, Queensland, 2020–21. Accessed 11 July 2022.

Children known to the child protection system

Children known to statutory systems are generally more likely to have experienced family-level adversity and health inequity, placing them at greater risk of premature mortality. In Queensland, children known to the child protection system die from external causes of death at a rate 4.2 times the general child population.[3]

In 2022–23 we will undertake further analysis of the deaths of children known to the child protection system in Queensland over time.

Deep dives

Preventing suicide in First Nations communities

First Nations children die by suicide at three times the rate of non-Indigenous children. This heightened vulnerability to suicide is linked with historical and continued structural inequality, stemming from the legacy of colonisation, forced removal of children, erosion of cultural traditions, language and family structure, and intergenerational trauma. Connection to culture is a critical protective factor against suicide.

This year, we will begin work to identify Queensland Indigenous communities with low rates of youth suicide and work with these communities to identify the protective factors that are helping to keep their young people safe.

Initiating actions

Defining family-level adversity

The QFCC aims to understand the effects of adverse experiences on child health and wellbeing, including the risk of premature death. To do this, we need a clear understanding of the kinds of experiences that comprise family-level adversity, how these can be measured, and the supporting data available. We will initiate this work in 2022–23. This will require collaboration with experts in the field. It will also likely involve requesting additional data from stakeholders under our legislation and building our capacity to incorporate this information into the Queensland Child Death Register.[4]

Data linkages

Aligning with our commitment to collaborative partnerships, we will explore how we can work with other government agencies to better understand child deaths, including through using linked datasets. Areas of interest include:

- prior emergency department presentations
- prior hospital admissions
- historical ambulance responses for a child or their family
- antenatal and birth factors relevant to infant deaths.

By linking this data with information from the Queensland Child Death Register, the QFCC and its partners can make a significant contribution to the research evidence on child mortality and potential prevention mechanisms.

Improved identification of First Nations children

Measuring improvements in rates of death for First Nations children requires us to be able to reliably identify those children in the data we hold. Unfortunately, First Nations status is sometimes incomplete or is inconsistently reported. This can result in an underestimate of the disparities in mortality rates between Indigenous and non-Indigenous children.

This year we will establish new processes to manage inconsistent information about whether a child and their family identified as Aboriginal or Torres Strait Islander. This will ensure more accurate reporting of rates of death for First Nations children, and a more complete understanding of progress towards Closing the Gap targets.

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[3] Queensland Family and Child Commission (2020) **Counting Lives, Changing Patterns: Findings from the Queensland Child Death Register, 2004–2019**. Accessed 11 July 2022.

[4] Under **s. 27 of the *Family and Child Commission Act 2014***, the Principal Commissioner of the QFCC has the power to request any information they consider necessary to perform the QFCC's child death functions from any public entity. The public entity must comply with this request unless exceptional circumstances apply.

National dataset on child deaths

As a member the Australian and New Zealand Child Death Review and Prevention Group, we will contribute to efforts to build a national child death dataset.

This will assist in establishing national rates of SUDI and suicide, which are categories of death currently under-reported at a national level. This initiative will also facilitate more reliable comparisons of child mortality across jurisdictions.

Awareness raising and advocacy

Youth mental health

Youth mental health is a priority for the QFCC and the QFCC Youth Advisory Council. This aligns with the Safer pathways framework's focus areas. Data about the mental health of children and young people who have died will be used to support advocacy initiatives wherever possible.

We will also work to improve our understanding of who young people turn to when experiencing mental health issues, barriers to accessing formal supports, and gaps that exist in the available data about this, including by:

- surveying community members and frontline workers in the child protection and family support sector about the availability and accessibility of youth mental health services across Queensland
- increasing young people's understanding of how to access mental health services, and
- partnering with key stakeholders to lead a youth mental health round table.

Building our social media presence

Social media is a critical tool for distributing messages to families about how to reduce the risk of childhood injury and death. We will be looking at ways to better engage families with child death prevention messages and to link with existing awareness-raising events (for example, World Suicide Prevention Day).

Fulfilling our legislative obligations

In 2022–23 the QFCC will continue the child death prevention work we already undertake, including:

- maintaining a register of all child deaths in Queensland
- analysing and reporting on data in the Child Death Register in our **Annual Report: Deaths of children and young people, Queensland** to contribute to the evidence base on child deaths
- responding to stakeholders' requests for information and advice to support their prevention initiatives
- providing feedback on policies and programs, and
- releasing data to researchers who meet the criteria outlined in our legislation.[5]

To make a request for child death information, email **child_death_prevention@qfcc.qld.gov.au**

[5] Under **s. 28 of the QFCC's Act**, the Principal Commissioner may release data from the Child Death Register to a person they are satisfied is conducting genuine research to help reduce the likelihood of child deaths.

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Action	Category of death	Priority population	Focus area	Impact area
Rapid reviews				
Preventable childhood mortality • Defining preventable causes of death for children	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality
Paediatric sepsis • Identifying the incidence of deaths from sepsis • Understanding risk factors for sepsis	Natural causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Collaborative partnerships
Swimming pools drownings • Regional analysis of swimming pool drownings • Specific focus on pool fencing and supervision	Drowning	Children under 5	• Environmental hazards, product safety and regulation • Supervision	• Research into action
Children known to the child protection system • Trends and patterns in the deaths of children known to the child protection system compared with all deaths in Queensland	All causes	Children known to statutory systems	• Building capacity and monitoring trends • Family-level adversity	• Research into action • Continuous improvement
Deep dives				
Preventing suicide in First Nations communities • Identifying strengths and protective factors of communities with low youth suicide rates	Suicide	First Nations children	• Help-seeking and access to services • Building capacity and monitoring trends	• Data quality • Foster expertise • Collaborative partnerships

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Action	Category of death	Priority population	Focus area	Impact area
Initiating actions				
Family-level adversity • Defining, measuring and gathering data to build an evidence base on family-level adversity and child mortality	All causes	All priority population groups	• Family-level adversity • Building capacity and monitoring trends	• Data quality • Collaborative partnerships
Data linkages • Linking administrative datasets to build the evidence base on precipitating factors to child deaths	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Foster expertise • Collaborative partnerships
Improved identification of First Nations children • Establishing business rules to support decisions about recording a child's First Nations status in the Child Death Register when the status is inconsistent	All causes	First Nations children	• Building capacity and monitoring trends	• Data quality • Continuous improvement • Collaborative partnerships
National child death dataset • Contributing to a national minimum child death dataset to facilitate inter-jurisdictional comparisons	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Collaborative partnerships
Awareness raising and advocacy				
Youth mental health • Contributing to broader advocacy initiatives • Identifying and addressing barriers to understanding how young people connect with mental health supports (formal and informal)	All causes	All priority population groups	• Help-seeking and access to services • Building capacity and monitoring trends	• Data quality • Foster expertise • Collaborative partnerships
Social media • Identifying ways to promote child death prevention messages through social media	All causes	All priority population groups	• All focus areas	• Research into action
Fulfilling legislative obligations • Recording, analysing and reporting on data in the Queensland Child Death Register • Providing feedback on policies and programs • Continuing to support stakeholder needs for child death data and information	All causes	All priority population groups	• All focus areas	• Data quality • Foster expertise • Collaborative partnerships