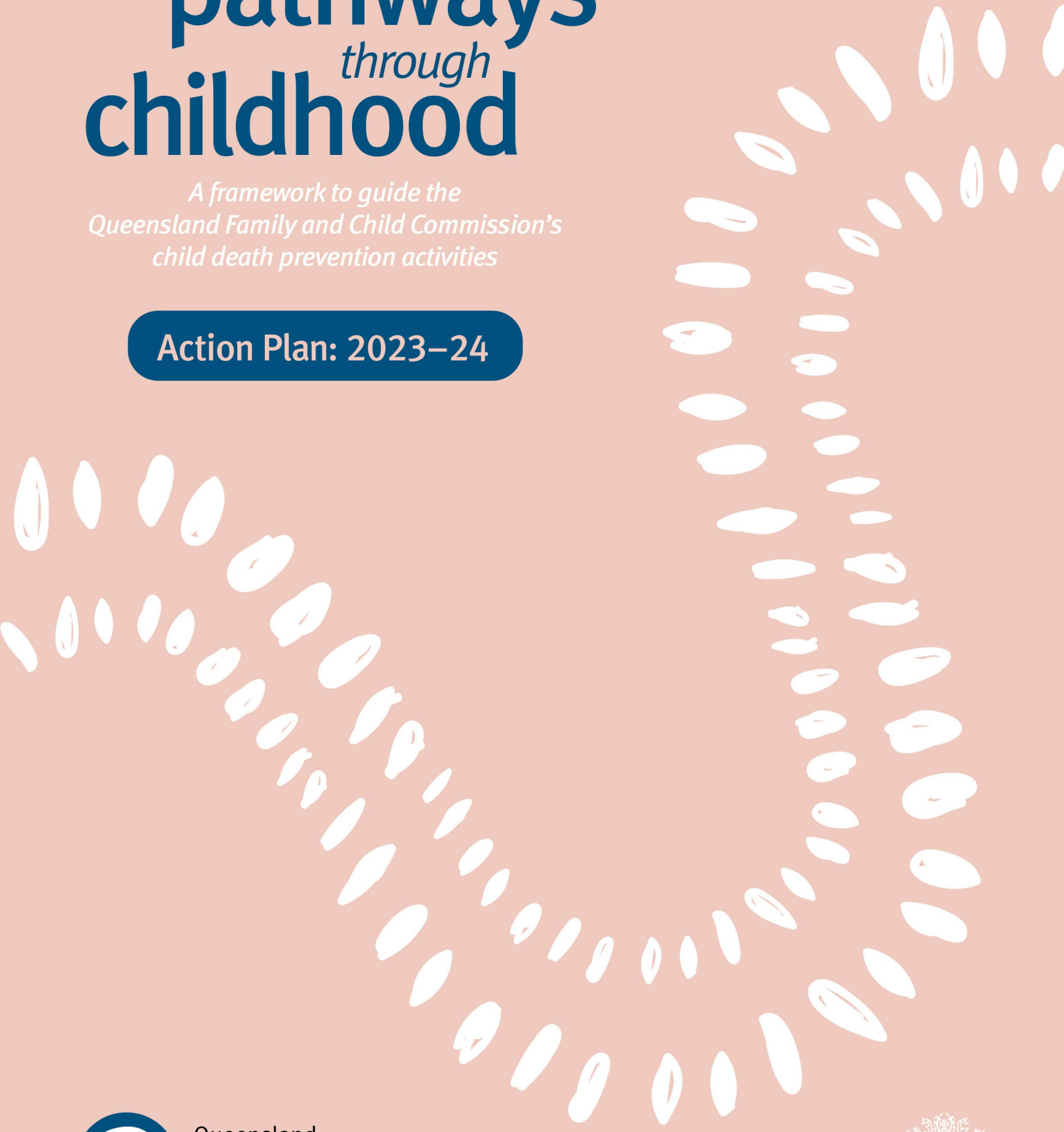
Safer pathways through childhood 2022–2027

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

Action Plan: 2023–24



Queensland Family & Child Commission

Queensland Government

A message from the Commissioner

In 2022, the Queensland Family and Child Commission released the ***Safer pathways through childhood*** framework (the Safer pathways framework), setting the direction of our child death prevention functions through to 2027.

We believe that 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. We take a social justice approach to our child death prevention work that is focused on achieving health equity. The Safer pathways framework is informed by a socio-ecological model that recognises the historical, cultural, social and economic circumstances that can create barriers to some groups of children experiencing optimal health outcomes.

In the first year of the Safer pathways framework, we undertook a range of projects aimed at both generating new findings in relation to child mortality in Queensland and increasing our capacity to undertake more complex work in the future. This included a regional analysis of drowning and near-drowning incidents in backyard swimming pools identifying critical compliance issues with pool fencing regulations. In partnership with Children's Health Queensland, we commenced ground-breaking research to identify the true incidence of paediatric sepsis deaths, laying the foundations for future work to define preventable childhood mortality. We brokered agreements to increase the range of child death data available to the QFCC and commenced work to better conceptualise adversity among children who die in Queensland.

Over the next year, we will continue to progress some of these in-depth projects and commence a range of new activities. Emerging areas of interest in 2023–24 include the definition of supervisory neglect, the use of restraints in fatal transport incidents and risk factors for sudden unexpected death in infancy over time. We will continue to work closely with stakeholders to deliver on these focus areas.

Together, we can make a real difference in the lives of children and families.

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

The Safer pathways framework

The socio-ecological model upon which the Safer Pathways framework is based 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 context in which they exist.

Priority populations

The Safer pathways framework has prioritised activities aimed at producing findings to help identify ways to reduce health inequity among certain groups: children known 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 focus on these groups is evident throughout the projects outlined in this year's action plan.

Impact areas

There are four main ways our work under Safer pathways makes an impact on reducing child deaths:

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**.

Focus areas

Our work under the Safer pathways framework aims to contribute to the evidence-base about:

- disadvantage, adversity and social vulnerability
- risk-taking (by both children and parents)
- appropriate supervision across childhood
- help-seeking behaviour and access to services
- reducing risk through design, product safety and regulation
- improving data about First Nations children
- impacts of COVID-19

- youth suicide prevention
- incidence and risk factors for sudden unexpected death in infancy (SUDI)
- preventable mortality.

Learnings from 2022–23

The ***Safer pathways through childhood: Action plan 2022–23*** set out an ambitious array of child death prevention activities for the year. Our achievements under last year's plan will be reported in the QFCC's ***Annual Report: Deaths of children and young people, Queensland 2022–23***.

Our first year working under the Safer pathways framework highlighted several factors we have considered in developing the 2023–24 action plan:

- There is incredible benefit in partnering with experts and other key stakeholders. Developing these arrangements takes time, although the outcomes achieved outweigh any delays to the project.
- Data linkage is complex. Even once data is received, there may be significant work to incorporate it into existing datasets. The process of data cleansing is time consuming but vital to ensure quality outputs.
- Conceptual thinking also takes time, and projects tackling new or under-explored issues may carry across more than one action plan.
- There are extensive linkages between projects, which can mean we must re-order or reframe our intended projects based on the outcomes of previous ones.
- Exploratory studies can take us in exciting new directions. While this may deviate from the outcome we originally intended, this work is where we are likely to uncover innovative findings to help reduce and prevent child deaths.

As a result of these considerations, our second-year actions are fewer in number, allowing us to continue producing high quality outcomes across a range of topics.

Second year actions

Fulfilling our legislative obligations

In 2023–24 we will continue to fulfill our legislative child death prevention functions, 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
- releasing data to researchers who meet the criteria outlined in our legislation.[1]

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

Continuing projects

During 2022–23 we undertook a number of 'discovery pieces'—broader conceptual work to help us better define and understand an issue. Some of these became in-depth projects that will continue into 2023–24.

Paediatric sepsis

Last year the QFCC partnered with clinical experts from the Queensland Paediatric Sepsis Program (QPSP) at Children's Health Queensland with the objective of determining the true incidence of paediatric sepsis deaths in Queensland. Sepsis stems from infection and is a leading cause of preventable childhood morbidity and mortality in Australia.[2]

This project developed a novel methodology for identifying paediatric sepsis deaths from mortality data, recognising that in addition to deaths officially certified as due to sepsis, many additional deaths are recorded as involving infection and organ dysfunction—the key components of sepsis—but are not explicitly recorded as sepsis deaths.

[1] 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.
[2] Children's Health Queensland Hospital and Health Service. ***Queensland Paediatric Guideline: Sepsis—Recognition and emergency management in children***. Published February 21, 2023. **https://www.childrens.health.qld.gov.au/guideline-sepsis-recognition-and-emergency-management-in-children/** Accessed June 15, 2023.

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This year, we will continue to work with our partners at QPSP to analyse rates of paediatric sepsis mortality over time and the socio-demographic and clinical factors associated with sepsis deaths that occur within hospital as well as those that occur suddenly at home or in the community. This analysis will also consider important differences between population sub-groups, including First Nations and other culturally and linguistically diverse children, children living in regional and remote and socio-economically disadvantaged areas, and children with underlying medical complexity.

This body of research will lead to quality improvement in the documentation of sepsis and the underlying infective organism in death records and in the recognition and management of sepsis and potential sepsis in children.

Measuring adversity

The 2022–23 Safer pathways action plan included a focus on better understanding the effects of adversity on child health and wellbeing. This was intended as a long-term multi-stage project that would help us identify what to measure, how to measure it and the sources of available data.

Last year we reviewed the existing research in this area. This identified that the concept we sought to measure was far broader than initially thought. As a result, we have reframed this project as one which will seek to develop a measure of adversity and social vulnerability among children who die in Queensland. This measure will encapsulate adverse childhood experiences (such as abuse and neglect, parental substance use or domestic and family violence), experiences of social exclusion and vulnerability (such as financial hardship, social isolation, parental unemployment, access to services, physical/mental health and disability, education) and other social determinants of health. It will also have a particular focus on ensuring that indicators of adversity are reflective of the experiences and needs of First Nations children and families.

During 2023–24, we will continue to progress this work by identifying the indicators of adversity for which we are able to obtain information from administrative datasets and working with expert stakeholders to develop a model for using this to identify associations between adversity and child mortality.

Data linkage

Last year we sought to explore how we could better work with other government agencies to access other administrative datasets and include relevant information in the Queensland Child Death Register.

As reported in our *Annual Report*, we reached a significant milestone in entering into an arrangement with Queensland Health to link the Child Death Register with data from Queensland Health's Master Linkage File, which comprises a range of health datasets, including:

- Perinatal Data Collection
- Queensland Hospital Admitted Patient Data Collection
- Emergency Data Collection
- Congenital Abnormalities Linked File.

We will continue our data linkage work in 2023–24, exploring new partnerships that can help support other projects such as the 'Measuring adversity' or 'Supervisory neglect' pieces.

Preventable childhood mortality

Determining the range of conditions causing death considered to be preventable was an intended deliverable under last year's action plan. However, with sepsis known to be a leading cause of preventable paediatric deaths, it was necessary to establish methods for reliably identifying sepsis and other infections prior to embarking upon this broader project.

This year, we will use the findings of the paediatric sepsis project to inform our understanding of preventable childhood mortality. We will review existing standards designed to measure potentially avoidable deaths and consider whether these are applicable to child mortality specifically. We will work closely with expert stakeholders both in Queensland and other jurisdictions in undertaking this work.

Discovery pieces for 2023–24

Redefining assault and neglect

The Safer pathways framework identified the need to better define adequate supervision across a range of circumstances and accounting for the changing developmental needs of children as they age. This includes supervisory requirements in and around water (such as bathtubs, swimming pools, dams and natural bodies of water), riding off-road motorcycles and ATVs for recreational purposes, and playing in and around the home. To commence this broader piece of work, we must first determine the point at which inadequate supervision becomes supervisory neglect. This has triggered us to consider our definitions for fatal assault and neglect more broadly.

This is a complex area with clear intersections with criminal law, child protection and paediatric health.

During 2023–24, the QFCC will work with an expert advisory group to identify appropriate definitions, classifications and screening criteria. This will allow the QFCC to more confidently identify different types of assault and neglect, to gather relevant information about them, and to consider how these should be reported.

Defined scope projects

In addition to the continuing projects and more conceptual discovery pieces, we also intend to complete a range of projects with a more defined scope.

Sudden unexpected death in infancy (SUDI)

The Queensland SUDI Study, finalised in 2020, used data from the Queensland Child Death Register to examine risk factors for sudden infant death between 2010 and 2014.[3] It made a significant contribution to our understanding of SUDI in Queensland, identified a need to prioritise targeted, multimodal prevention efforts for families experiencing multiple adversity, with a focus on reducing smoking, increasing breastfeeding and improving the safety of surface sharing.

With many more years of additional of data now held within the Register, it is timely to consider using linked data from Queensland Health to consider changes in trends and patterns in SUDI in Queensland over a longer period of time. This will include examining the prevalence of major SUDI risk factors, including:

- pre-term birth and low birthweight
- maternal smoking during pregnancy
- antenatal care utilisation
- alcohol and substance use during pregnancy
- sleep position and location
- surface sharing in the context of other known risk factors.

Child car restraints

The QFCC's stakeholders have identified a need to examine the use of car restraints for children involved in fatal transport incidents. Preliminary consultation has identified that information about the type of restraints, where they are positioned within the vehicle and how they are used may not always be consistently collected and/or reported. The QFCC will work with relevant stakeholders to identify potential sources of this information, highlight any data gaps and analyse available data to produce critical safety messages for parents about the use of child restraints in vehicles.

[3] Shipstone, R, Young, J, Kearney, L, Thompson, JMD. Prevalence of risk factors for sudden infant death among Indigenous and non-Indigenous people in Australia. *Acta Paediatr*. 2020;12:2614-2626. doi: 10.1111/apa.15274
Shipstone, R, Young, J, Kearney, L, Thompson, JMD. Applying a social exclusion framework to explore the relationship between sudden unexpected deaths in infancy (SUDI) and social vulnerability. *Front. Public Health.* doi: 10.3389/fpubh.2020.563573

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Action	Category of death	Priority population	Focus area	Impact area
Continuing projects				
Paediatric sepsis • Investigate patterns within sub-groups of paediatric sepsis deaths	Natural causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Collaborative partnerships
Measuring adversity • Develop a model for measuring adversity among children who die in Queensland using indicators of adversity and social vulnerability	All causes	All priority population groups	• Building capacity and monitoring trends • Family-level adversity	• Data quality • Fostering expertise • Continuous improvement • Collaborative partnerships
Data linkage • 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
Discovery pieces				
Preventable childhood mortality • Defining preventable causes of death for children	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Fostering expertise • Collaborative partnerships
Redefining assault and neglect • Seek expert advice to help define and identify cases of supervisory neglect	Assault and neglect	All priority population groups	• Building capacity and monitoring trends • Supervision	• Data quality • Fostering expertise • Collaborative partnerships
Defined scope projects				
Sudden unexpected death in infancy • Identify trends and patterns in SUDI risk factors over time	SUDI	Children under 5	• Building capacity and monitoring trends • Environmental hazards, product safety • Family-level adversity	• Continuous improvement • Research into action
Child car restraints • Identify trends and patterns in car restraint use and highlight potential data gaps	Transport	All priority population groups	• Environmental hazards, product safety, regulation	• Data quality • Research into action • Continuous improvement