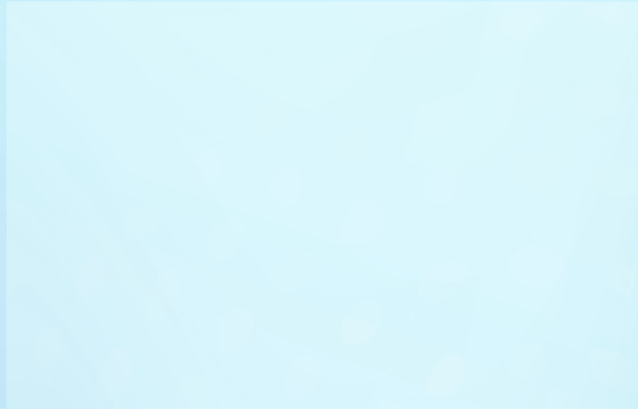
9 Child death prevention activities



Maintaining the Child Death Register

The QFCC maintains Queensland's 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 Child Death Register was established in 2004 and currently contains over 8,500 records that have been classified by cause of death, demographic and incident characteristics. It allows the QFCC to extract information from its 19 years of recorded data, highlighting risk factors and trends that can inform research, support policy improvement and community safety initiatives to help reduce the likelihood of child deaths.

Publications

In December 2022 the *Annual Report: Deaths of children and young people Queensland 2021–22* was tabled in Parliament. This was the 18th 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).[82]

Resources associated with the annual report, including the 18-year summary tables, Appendices B to G, and fact sheets, can be found at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

The QFCC also published the ***Australian child death statistics 2020* report**, prepared on behalf of the members of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). This report can be found at **www.qfcc.qld.gov.au/sector/child-death/child-death-statistics-anz**

Australian and New Zealand child death review conference and meeting

The QFCC hosted the 2023 ANZCDR&PG conference on 23 May. This online conference was a professional development opportunity for the specialist teams in each jurisdiction responsible for child death reviews and registers. The conference included a range of speakers on three themes.

Session 1's theme was *Data linkage and knowledge sharing to deepen our understanding of child deaths*. The session showcased projects where agencies have shared knowledge, information and linked data to support case analyses and improve understanding of the causes and risk factors in child deaths.

Session 2's theme was *Classification of sudden infant deaths*, and explored how classification algorithms can help to better identify unsafe sleep factors and suffocation in infants, the importance of understanding airway protection in safer sleep messaging, followed by insights on product safety issues for safer infant sleep.

The theme of session 3 was *Issues for the future of analysis and reporting*. It provided essential information to support decision-makers planning the transition from the ICD-10 and the implementation of classification system ICD-11 with a focus on those changes, implementation plans being developed here in Australia and some specific changes currently under discussion with the international community and WHO on SUDI. It also identified impacts of the revised population estimates from the 2021 Census, particularly for First Nations populations.

Session recordings can be found here **www.qfcc.qld.gov.au/events/2023/ANZCDRPG-Conference**

On 25 May 2023, representatives from child death review teams from each state and territory across Australia met in the QFCC Boardroom (and virtually) to share experiences, practices, barriers and priorities in relation to child death review and prevention. One of the key focus areas for the group is the development of a national dataset to strengthen child death and injury prevention and research to inform practice and policy. The group also discussed the varying impacts of COVID-19.

82 **www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/Online-Tabled-Papers**

Safer pathways through childhood framework

In 2022 the QFCC launched ***Safer pathways through childhood***.[83] The framework, designed to maximise the impact of the QFCC's legislated child death prevention functions, provides a roadmap for the QFCC's child death prevention activities over the next 5 years (2022–27). This framework takes a social justice approach to child death and injury prevention that focuses on achieving health equity. In addition to fulfilling our legislative obligations the QFCC will, in consultation with stakeholders, identify specific prevention activities to address priority areas each year. Work progressed under the 2022–23 action plan are summarized below.

Swimming pool drownings

In November 2022, the QFCC released an information paper analysing all drownings and non-fatal immersions occurring in back yard swimming pools since 2011. Key findings of this study are detailed in **Chapter 4 – Drowning**.

Family level adversity

While the QFCC has collected data on a range of indicators, such as, mental health, domestic and family violence and alcohol and substance use since 2013, further work is required to expand and refine this dataset. This piece of work aims to establish a clearer understanding of the impact of a range of adversities, experiences and vulnerabilities on a child's wellbeing and potential links to premature mortality. By collecting information about the experiences and circumstances of children who have died, it provides a deeper understanding of where prevention and early intervention efforts, including systemic and social change, are best targeted.

Preventable childhood mortality

The child death prevention work of the QFCC has been focused to date on external causes of mortality and sudden unexpected deaths in infancy (SUDI). However, 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. The QFCC is currently reviewing Australian and International frameworks and standards for reporting. This review will form a foundation for work to be done with experts in the health sector to identify a comprehensive framework and ICD-10 code list of causes of child death considered preventable.

Paediatric sepsis

The paediatric sepsis project is a partnership project being undertaken in collaboration with the Queensland Paediatric Sepsis Program (QPSP) at Children's Health Queensland.[84] The overarching aim of this study is to identify and describe the incidence of deaths due to sepsis in children aged less than 18 years in Queensland (who have left hospital after birth), using multiple cause of death data from the Queensland Child Death Register, linked with administrative health datasets. This project is further explored in **Chapter 2**.

The *Safer pathways through childhood framework*, 2022–23 Action Plan and Swimming pool immersions of young children in Queensland 2011–2021 can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

83 www.qfcc.qld.gov.au/safer-pathways-through-childhood

84 www.childrens.health.qld.gov.au/wp-content/uploads/PDF/QPSP-Sustainability-plan.pdf

QFCC submissions

During 2022–23, the QFCC used information in the Queensland Child Death Register to provide advice and recommendations in relation to the following consultations:[85]

- Australian Competition and Consumer Commission (ACCC) review into the safety of infant inclined products. The QFCC supported proposals for a mandatory standard focusing on all infant sleep products and a permanent ban on the supply of inclined sleep products with an incline greater than 7 degrees.
- ACCC's product safety priorities for 2023–24. The QFCC raised three issues: reducing risk of heat stress injury in vehicles, infant swaddle suits and misuse of aerosol deodorants.

Supporting youth suicide prevention

The QFCC continued to monitor and support prevention of suicide deaths of children and young people. This included a crucial information sharing process with the Department of Education to inform student wellbeing policy development and support suicide postvention in affected schools. The QFCC contributed to suicide prevention by:

- increasing awareness across government of trends and spikes in suicide numbers
- reporting on situational circumstances and risk factors affecting young people
- providing suicide data to government agencies to support development of mental health and wellbeing initiatives.

Researcher access to child death data

A key strategy to support child death and injury prevention is to make data held in the Child Death Register available for research, public education, policy development and program design. Data from the comprehensive dataset is available at no cost to genuine researchers.[86] Applications to obtain data can be made by emailing **child_death_prevention@qfcc.qld.gov.au**

In 2022–23, the QFCC responded to 20 external requests for Child Death Register data. Data provided to genuine researchers may be either aggregated or presented as confidential unit records. Table 9.1 gives an overview of the key projects and agencies for which data was provided.

85 QFCC submissions can be found at **www.qfcc.qld.gov.au/sector/policy-submissions**

86 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.

Table 9.1: Child death data requests by agency and purpose, 2022–23

Type of data	Requesting agency	Purpose
All deaths	Queensland Child Death Review Board	Provide background on frequency of sibling deaths to inform consideration of system responses to multiple child deaths in a family
Aboriginal and Torres Strait Islander deaths	Queensland Government Statistician's Office	Presentation to ANZCDR&PG on the impact of census changes for Aboriginal and Torres Strait Islander populations
Children known to the child protection system	Queensland Child Death Review Board	Provide child death and coronial information required to undertake case reviews
	ABC Tasmania	Inform a media story about the perceived failings of child protection systems nationwide
Diseases and morbid conditions	Queensland Health	Investigation of the incidence of, and factors associated with, child deaths due to sepsis in Queensland (collaborative project with QFCC)
Drowning	Gold Coast City Council	Inform a review of pool fence compliance measures
	Royal Life Saving Society Australia	Inform the National Drowning Report and drowning prevention research and advocacy
Interstate residents	Children and Young People Death Review Committee ACT	Australian Capital Territory reporting on deaths of residents in other jurisdictions
	Child Death Review and Prevention Committee NT	Northern Territory reporting on deaths of residents in other jurisdictions
	Child Death and Serious Injury Review Committee SA	South Australian reporting on deaths of residents in other jurisdictions
	Consultative Council on Obstetric and Paediatric Mortality and Morbidity VIC	Victorian reporting on deaths of residents in other jurisdictions
Non-intentional injury and SUDI	Australian Competition and Consumer Commission	Inform content refresh of Keeping Baby Safe public awareness campaign and Your First Steps website
Sudden unexpected death in infancy (SUDI)	Australian Competition and Consumer Commission	Inform review of policy options to reduce the risk of death and injury associated with infant sleep products
	Queensland Paediatric Quality Council	Analysis to comprehensively identify the issues associated with infant deaths and make recommendations for future investigation
Suicide	Queensland Government Statistician's Office	Undertaking research to identify First Nations communities with comparatively lower rates of suicide (collaborative project with QFCC)
Transport	Queensland Health	Inform media article on ride-on mower injuries and safety
	Queensland Department of Transport and Main Roads	Support public education and guidance for parents and carers on the need for and appropriate use of child restraints in vehicles

Notes: Not all requests are shown.

Participation in state and national advisory groups

QFCC officers participated in the following advisory bodies during 2022–23:

- Australian and New Zealand Child Death Review and Prevention Group
- Australian National Child Death Data Collection Working Group
- Consumer Product Injury Research Advisory Group
- Queensland Government Suicide Prevention Network
- Suicide Prevention Oversight Group
- QPQC Infant Mortality Sub-Committee
- QPQC Steering Committee
- Queensland Government Births and Deaths Working Group
- Road Safety Research Network.