Chapter 9 - Child death prevention activities

Details the prevention activities undertaken by the Commission for Children and Young People and Child Guardian (CCYPCG) in 2013–14 and updates the progress of previous recommendations.

**Key achievements in 2013–14**

- Provided tailored child death data to 50 external stakeholders to inform their work in preventing child deaths and injuries.
- Published four trends and issues papers focusing on current child death and injury prevention issues impacting on the safety and wellbeing of vulnerable children and young people.
- Prepared five evidence-based submissions to inform the development of child death or injury prevention initiatives.
- Led and supported external stakeholder child death and injury prevention initiatives.
Child death prevention activities: 2013–14

Under sections 143 and 145 of the *Commission for Children and Young People and Child Guardian Act 2000* (the CCYPCG Act, repealed 1 July 2014), the CCYPCG was required to maintain a register of all child deaths in Queensland; analyse the information contained in the register; and conduct research to identify trends and patterns to help reduce the likelihood of child deaths. Section 144 of the Act also allowed for the use of information from the Queensland Child Death Register by persons conducting research to help reduce the likelihood of child deaths. It is these sections of the former CCYPCG Act that are relevant to this reporting period.

In 2014–15, the Queensland Family and Child Commission (QFCC) will also be required to produce an annual report on child deaths in Queensland under section 29 of the *Family and Child Commission Act 2014*. Further, the QFCC, like the former CCYPCG, must maintain a register of information relating to child deaths in Queensland (section 25) and classify and analyse information contained in the register as well as conduct research (section 26). Under section 28 of the *Family and Child Commission Act 2014*, information contained in register will continue to be accessible to persons conducting research to help reduce the likelihood of child deaths.

In 2013–14, the CCYPCG took the opportunity to share its data and analyses to inform the development of child death and injury prevention initiatives. A range of stakeholders (both Government and non-government) are responsible for the development and/or implementation of various prevention strategies, programs, policies and/or research initiatives, and the CCYPCG aimed to provide a solid and contemporary evidence base to support such activities.

A summary of these activities undertaken during 2013–14 is detailed below.

**Trends and Issues Papers**

The CCYPCG Trends and Issues Papers address topical child death and injury prevention issues. The papers are intended to increase awareness of the issues to ensure Government and non-government key stakeholders, researchers and the broader community are better informed about the factors that can affect the vulnerability of children and young people, and be better placed to drive prevention and intervention efforts to reduce child deaths. Four Trends and Issues Papers were released during 2013–14:

- **Notifiable and vaccine-preventable diseases in Queensland** – this paper advocated for parents and caregivers to make informed decisions about vaccinating their children.
- **Low speed vehicle run-overs** – this paper advocated for strategies that build layers of protection by changing driver behaviour, environmental design and vehicle safety technologies.
- **Swimming pool safety** – advocated for strategies that build layers of protection through active supervision, maintenance and compliant use of fencing and gates, and water safety awareness training.
- **Prevalence of youth suicide in Queensland** – this paper highlighted trends in youth suicides in Queensland.

To promote the papers to all areas of the community, the CCYPCG released media statements and distributed the papers to a broad stakeholder group. The release of the papers generated significant interest from a number of groups, including local and national media coverage. As illustrated in Table 9.1 the papers published during the reporting period were downloaded 11,960 times in total during the reporting period. Further, papers from the previous 2011–12 and 2012–13 reporting periods continued to generate public interest with an additional 10,477 downloads from the former CCYPCG website in 2013–14.
Table 9.1: Trends and Issues Paper by number of public downloads, 2013–14

<table>
<thead>
<tr>
<th>Title of Trends and Issues Paper</th>
<th>Released</th>
<th>Downloads in 2013–14</th>
<th>Total downloads since release</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child deaths – suicide intent</td>
<td>November 2011</td>
<td>404</td>
<td>1433</td>
</tr>
<tr>
<td>Child deaths – fatal assault and neglect</td>
<td>January 2012</td>
<td>644</td>
<td>1823</td>
</tr>
<tr>
<td>Child deaths – bicycle safety</td>
<td>February 2012</td>
<td>78</td>
<td>244</td>
</tr>
<tr>
<td>Child deaths – driving in flood waters</td>
<td>February 2012</td>
<td>100</td>
<td>444</td>
</tr>
<tr>
<td>Child deaths – cyber bullying as a risk factor for youth suicide</td>
<td>March 2012</td>
<td>4920</td>
<td>10627</td>
</tr>
<tr>
<td>Child deaths – sudden cardiac deaths</td>
<td>March 2012</td>
<td>88</td>
<td>295</td>
</tr>
<tr>
<td>Child deaths – bathtub drowning prevention</td>
<td>May 2012</td>
<td>305</td>
<td>1225</td>
</tr>
<tr>
<td>Child deaths – quad bike deaths in Queensland</td>
<td>August 2012</td>
<td>1051</td>
<td>1828</td>
</tr>
<tr>
<td>Child deaths – rural drowning</td>
<td>August 2012</td>
<td>314</td>
<td>684</td>
</tr>
<tr>
<td>Child deaths – overrepresentation of Aboriginal and Torres Strait Islander youth who suicide</td>
<td>December 2012</td>
<td>473</td>
<td>1587</td>
</tr>
<tr>
<td>Child deaths – supervision of children under five around water hazards</td>
<td>December 2012</td>
<td>467</td>
<td>757</td>
</tr>
<tr>
<td>Child deaths – under-reporting of youth suicide</td>
<td>February 2013</td>
<td>1079</td>
<td>2940</td>
</tr>
<tr>
<td>Child deaths – supervision of children under five around transport hazards</td>
<td>March 2013</td>
<td>204</td>
<td>910</td>
</tr>
<tr>
<td>Child deaths – risk of death in off-road transport incidents</td>
<td>May 2013</td>
<td>350</td>
<td>926</td>
</tr>
<tr>
<td>Child deaths – notifiable and vaccine-preventable diseases</td>
<td>August 2013</td>
<td>3444</td>
<td>3444</td>
</tr>
<tr>
<td>Child deaths – low speed vehicle run-overs</td>
<td>December 2013</td>
<td>715</td>
<td>715</td>
</tr>
<tr>
<td>Child deaths – swimming pool safety</td>
<td>December 2013</td>
<td>1099</td>
<td>1099</td>
</tr>
<tr>
<td>Child deaths – prevalence of youth suicide in Queensland</td>
<td>January 2014</td>
<td>6702</td>
<td>6702</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>22437</strong></td>
<td><strong>37683</strong></td>
</tr>
</tbody>
</table>


Data requests

Now in its tenth year of operation, the Queensland Child Death Register is a highly authoritative, comprehensive and contemporary data source for monitoring and reporting on the incidence of child death in Queensland. It is also increasingly being accessed to support research into ways child deaths may be prevented.

The child death review process developed and undertaken by the CCYPCG is valuable over and above traditional statistical reporting, given its ability to investigate beyond causes of death to examine social and situational risk factors as gathered from the analysis of autopsies, coronial, child protection and police files, as well as other relevant data sources. This makes it far more contemporary than other child death data sets and is a function that will continue under the auspices of the QFCC.

As the new custodian of this unique child mortality dataset, the QFCC recognises the value of this strong evidence base in developing prevention initiatives and encourages access to the register by stakeholders to inform their work in preventing child death and injury.

The Child Death Register may be accessed at no cost to organisations or individuals conducting genuine research. Stakeholders wishing to access the register to support their research, policy or program initiatives can email their request to child.death@qfcc.qld.gov.au.

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61. ‘Genuine research’ is 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/program initiatives to reduce child death or injury.
During 2013–14, the CCYPCG received 50 requests for access to the Child Death Register from external stakeholders. Requests included:

- data regarding drowning deaths for provision to the Queensland Injury Surveillance Unit and Department of Housing and Public Works to inform the administration of swimming pool fencing legislation and a related immersion notification program, and to the Royal Life Saving Society – Australia to inform its National Drowning Report and related drowning prevention activities
- information and data regarding transport fatalities to support research initiatives conducted by Kidsafe QLD; the University of the Sunshine Coast Accident Research (USCAR); and the Queensland Injury Surveillance Unit
- complex summaries of circumstances of slow suffocation deaths to inform safe sleeping and safe infant handling research undertaken by the University of the Sunshine Coast
- suicide data to assist in research and development of programs for the Australian Institute of Suicide Research and Prevention (AISRAP); Office of the State Coroner; the Queensland Mental Health Commission; and the University of Queensland Centre for Clinical Research, and
- accidental death data including product safety surveillance data for the Australian Competition and Consumer Commission and the Centre for Accident Research and Road Safety – Queensland (CARRS-Q).

Table 9.2 provides an overview of the type of data requested in 2013–14 and the purpose for which it was used.

<table>
<thead>
<tr>
<th>Type of data requested</th>
<th>Purpose of data request</th>
<th>Research</th>
<th>Public education/reporting</th>
<th>Policy/program development</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowning</td>
<td></td>
<td>3</td>
<td>11</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Accidental</td>
<td></td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Diseases and morbid conditions</td>
<td></td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>All external causes</td>
<td></td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>All deaths</td>
<td></td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Interstate residents</td>
<td></td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>17</td>
<td>28</td>
<td>5</td>
<td>50</td>
</tr>
</tbody>
</table>

Data source: Commission for Children and Young People and Child Guardian, Queensland (2013–14)

The CCYPCG’s data was used to conduct new peer reviewed research or as an authoritative source for official statistics in several areas, such as:

- child suicide\footnote{Soole, R., Kölves, K., & De Leo, D. (2014). ‘Factors related to childhood suicides: Analysis of the Queensland Child Death Register’. Crisis (in print).}
It was also used in presentations at several national and international forums and conferences, including:

- the National Suicide Prevention Conference\textsuperscript{70}
- Australian College of Midwives Conference,\textsuperscript{71} and
- World Conference on Drowning Prevention.\textsuperscript{72,73}

In order to measure the usefulness of the CCYPCG’s death data, including the purposes for which it is used and the efficacy of data request procedures, the CCYPCG sought feedback from all recipients of child death data.

Throughout the reporting year, the CCYPCG consistently received positive feedback from stakeholders granted access to the Queensland Child Death Register. In particular, stakeholders indicated the data was both timely and useful in advancing child death prevention initiatives. A number of agencies also commented on the quality of the information and the service provided.

> “I would like to thank the Commission for its timely help and information. The availability of child death data is a fantastic and unique service offered in Queensland.”
> James Cook University

> “We appreciate the in-depth quality of the data provided, as this is the only data that can be related to hospital trauma data to give an accurate picture of the kinds of severe trauma that affect Queensland children.”
> Queensland Children’s Medical Research Institute, University of Queensland

In 2014–15, the QFCC will continue to promote data from the Child Death Register to recognised stakeholders and genuine researchers as an evidence base to inform prevention initiatives.


Policy submissions

As well as contributing to policy and legislation amendments, the CCYPCG engaged with a number of policy and program initiatives to advocate for the best interests of Queensland children. During 2013–14, the CCYPCG completed five policy submissions based on evidence from the Queensland Child Death Register. The submissions are summarised as follows:

• a submission to the Queensland Parliament Transport, Housing and Local Government Committee Inquiry into Cycling Issues outlined specific considerations for young cyclists, including helmet use, improved road safety education and cycle path infrastructure to reduce cycling related fatalities
• a submission to the Department of Infrastructure and Transport in response to its Driveway Safety Design Guidelines Discussion Paper, supporting the introduction of guidelines to design driveways that are safer for young children and reduce deaths and injury from low speed vehicle run-overs
• a submission to the Coronal Council of Victoria regarding its proposed amendments to coronial legislation and practice to increase the standardised reporting of suicide as a benchmark for national changes to coronial practice with a particular focus on reducing the under-reporting of youth suicide
• a submission to the Department of Justice and Attorney-General regarding its review of the Births, Deaths and Marriages Registration Act 2003, supporting current and proposed strategies aimed to increase the birth and death registrations of Aboriginal and Torres Strait Islanders in Queensland as well as the benefits of transitioning to electronic registration processes, and
• a submission to the National Children's Commissioner regarding intentional self-harm and suicidal behaviour in children, in which critical issues were outlined on the reporting of youth suicide, emerging risk factors and trends, and which recommended engagement and strategic planning with peak bodies in the sector to identify opportunities for mutual advocacy and collaboration.

Committees

The CCYPCG participated as a member of various committees in this reporting period, including the:

• Australian and New Zealand Child Death Review and Prevention Group
• Queensland Council for Injury Prevention
• Queensland Advisory Group on Suicide
• National Committee for the Standardised Reporting of Suicide
• CARRS-Q Road Safety Researchers Network
• Child Restraint Safety Campaign Committee
• Queensland Births and Deaths Working Group
• Consumer Product Injury Research Advisory Group, and
• Australasian Mortality Data Interest Group.

Australian and New Zealand Child Death Review and Prevention Group

All states and territories within Australia, as well as New Zealand, have child death review mechanisms in various forms and stages of development. In recognition of the need to develop nationally comparable data and promote prevention messages across jurisdictions, agencies with child death review functions have convened the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG).

Established in 2005, the aim of this group is to identify and share information about trends and issues in infant, child and youth mortality, and work collaboratively towards national and international reporting.

The group is committed to working collaboratively to maximise the potential for the breadth of knowledge held in each jurisdiction to contribute to national consistency in reporting, particularly in relation to risk factor information and the promotion of consistent prevention messages.

74. See also Chapter 10, National child death statistics.
In March 2014, Victoria hosted the ANZCDR&PG’s annual meeting, with the theme of building minimum national death datasets, including reviewing the outcomes of a pilot study using swimming pool drowning data. The meeting provided an opportunity to learn about emerging issues and improvements in practice in other child death review jurisdictions. It also provided a forum to promote the redeveloped Queensland Child Death Register (Egis) and the associated review of CCYP CG’s child death data model.

Queensland Advisory Group on Suicide

The Queensland Advisory Group on Suicide (QAGS) was established in 2012 with its primary aim to utilise available data and the technical expertise of key stakeholders to monitor and identify suicide trends and opportunities for systemic reform.

QAGS’ purpose is to:

- facilitate earlier access to suicide data for strategic analysis and review
- consider the results of death reviews which are known or suspected to be due to suicide
- identify systemic issues that may have prevented such deaths, and
- inform a coordinated cross sectoral and whole of government response to achieve improvements in suicide prevention and suicide risk reduction.

Key achievements of QAGS in 2013–14 include:

- validating media reports to ensure communities and government and non-government agencies have an accurate understanding of suicide trends and characteristics in Queensland, and
- reviewing data collections, methodologies and current applications to identify opportunities to improve the utility of suicide data reporting and meet the evolving needs of suicide prevention stakeholders.

Conferences

CCYP CG presented at the World Suicide Prevention Day Forum held in September 2013. The forum’s theme was Stigma: A major barrier to suicide prevention. CCYP CG’s presentation on Social media’s role in creating a stigma duality of youth suicide explored evidence-based research links of stigma influencing youth suicide and explored strategies for practitioners to reduce stigma in the community. The presentation examined the specific role of social media of creating an unprecedented influence on suicide risk factors, such as contagion.

External advice and information sharing

The CCYP CG has historically actively supported initiatives and strategies that build awareness of the prevalence of child death and injury in Queensland and more widely across Australia. The CCYP CG played an important role to assist government and non-government stakeholders, as well as the broader community, in their efforts to reduce child deaths and injuries. One way the CCYP CG undertook this was the provision of advice and information.

In 2013–14, the CCYP CG was afforded opportunities to provide advice to other Queensland government agencies developing new strategic plans and operational services for vulnerable children and young people (i.e. the Queensland Mental Health and Drug Strategic Plan) or undergoing a review (i.e. the Child and Youth Mental Health Service Adaptive Response Care Redesign Project). Additionally, CCYP CG’s expertise in child death and injury in Queensland has helped to inform research priorities for the academic sector and identify emerging trends in the data to inform other data custodians (e.g. reporting an emerging increased trend of suicides of children under 15 years to Queensland coroners).

The CCYP CG also regularly engaged with other child death review bodies in other jurisdictions to discuss data methodology and analysis, and to provide comparative statistics and advice regarding child death prevention policies and legislation. This work has generated an evidence base that is of value not only in Queensland but across Australian and New Zealand jurisdictions.
Provision of professional training

During 2013–14, the CCYPCG provided professional development training regarding youth suicide risk factors and prevention to social work staff at the Department of Human Services as well as the National Coordinators from StandBy Response Service. These professional development sessions provided opportunities to share information, strategies and resources held by CCYPCG to inform frontline service provision for vulnerable children and young people.

Media releases

CCYPCG continued to promote safety messages to the broader community through the release of media statements. During the reporting period, four media statements were released. These releases resulted in state-wide and national print, television and radio coverage about important child death prevention issues.

Research collaborations and grants

During 2013–14, CCYPCG continued to support and progress research activities and initiatives with a number of stakeholders, including:

- progressing an ARC Linkage Grant with the Australian Institute of Suicide Research and Prevention (AISRAP) focusing on risk factors associated with suicide in Queensland children under 15 years
- supporting a University of the Sunshine Coast trial of a safe sleep enabler, known as a Pépi-Pod, for vulnerable infants in high risk shared sleep environments, and
- participating on a cross-government and industry research project for the collaborative development of injury surveillance data capture of product-related injuries and deaths.

Examples of CCYPCG’s role in providing expert advice regarding child death and injury prevention research has included:

- the development of a survey relating to baby sling carriers for the Queensland University of Technology, and
- supporting research activities through the provision of expert advice and peer review of several research manuscripts.

Recommendations

In accordance with the functions specified under section 145 of the Commission for Children and Young People and Child Guardian Act 2000, the CCYPCG was able to make recommendations arising from its analysis of the Queensland Child Death Register about improvements to laws, policies and practices aimed at reducing or preventing child deaths. In 2013–14, the CCYPCG did not make any formal recommendations in the annual report, however, the CCYPCG responded to various issues through active participation in responding to policy issues and the provision of data to stakeholders.

Table 9.3 below lists the outstanding recommendation made as a result of previous findings.

Table 9.3: Implementation of previous CCYPCG recommendations, 2004–2007

<table>
<thead>
<tr>
<th>Agency</th>
<th>Recommendation</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland Government</td>
<td>Explore and report on options and strategies to assist the rural sector to identify and address risks to children and young people posed by rural hazards. <strong>Reason:</strong> The Commission is concerned about the deaths and injuries to children and young people from quad bikes(^{75}), dams and other rural hazards, and believes that risk factors can be reduced or eliminated.</td>
<td>Partially implemented</td>
</tr>
</tbody>
</table>

Amendments to the *Rural Plant Code of Practice 2004* were undertaken by Workplace Health and Safety Queensland in 2011–12. A national review of the Workplace Health and Safety Codes of Practice and guidance, including managing risks of plant in rural workplaces, was completed during 2012–13.

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\(^{75}\) In line with the recommendations of a Victorian coronial inquest into deaths as a result of four-wheel motorcycle incidents, the Commission has adopted the term ‘quad bike’ to describe these vehicles, rather than ‘all-terrain vehicles’ as used previously. This inquest identified that the description of these vehicles as all-terrain was a ‘serious overstatement of their capabilities’ which can create an ‘impression of invincibility’ for riders.