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 2014 – 30 June 2015.

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We value the views of our readers and invite you to give us feedback on this report.

Document details

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<tr>
<th>Security Classification</th>
<th>PUBLIC</th>
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<td>Date of review of security classification</td>
<td>15 October 2015</td>
</tr>
<tr>
<td>Authority</td>
<td>QFCC</td>
</tr>
<tr>
<td>Author</td>
<td>QFCC</td>
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<tr>
<td>Documentation status</td>
<td>Final Version</td>
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Contact for enquiries

All enquiries regarding this document should be directed in the first instance to the Commission’s Strategic Research, Evaluation and Reporting Program, PO Box 15217, Brisbane City East QLD 4002 or by email to child.death@qfcc.qld.gov.au

Acknowledgements

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ISSN: 1833-9522 (print); 1833-9530 (online)

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Information security

This document has been security classified using the Queensland Government Information Security Classification (QGISCF) as PUBLIC and will be managed according to the requirements of the QGISCF.
30 October 2015

The Honourable Annastacia Palaszczuk MP
Premier of Queensland and Minister for the Arts
Executive Building
100 George Street
BRISBANE QLD 4000

Dear Premier

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 2014 – 30 June 2015, 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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Appendix 6.1: Suicide classification model

Appendix 7.1: Fatal assault and neglect screening criteria

Appendix 10.1: Methodology for Australian and New Zealand child death statistics
Acknowledgements

The Queensland Family and Child Commission (QFCC) acknowledges the unique and diverse cultures of Aboriginal and Torres Strait Islander people and notes that, throughout this document, the term Aboriginal and Torres Strait Islander has been used to collectively describe two distinct groups of people. The QFCC respects the beliefs of the Aboriginal and Torres Strait Islander peoples and advises that there is information regarding Aboriginal and Torres Strait Islander deceased people in this report.

The QFCC would like to thank the Queensland state government departments and non-government organisations that contributed data and provided advice for this report. Particular appreciation is expressed to officers from the Registry of Births, Deaths and Marriages; the Office of the State Coroner; the Queensland Police Service; the Queensland Ambulance Service; Queensland Health; the Department of Communities, Child Safety and Disability Services; the Australian Bureau of Statistics; and Queensland Treasury.

The QFCC would also like to acknowledge the contribution of data from other Australian and New Zealand agencies and committees who perform similar child death review functions. For the seventh year in a row, this annual report has utilised this data to compile an interjurisdictional overview representing further steps towards developing a nationally comparable child death review dataset.

The QFCC would like to acknowledge the former Commission for Children and Young People and Child Guardian for undertaking the work of child death research in Queensland from 2004 to 2014, and the substantial effort involved in developing the comprehensive database for child death data that exists today. The contribution of officers from the QFCC’s Strategic Research, Evaluation and Reporting Program who maintained the Queensland Child Death Register, analysed the data and prepared the report is also acknowledged and appreciated.
Foreword

On behalf of the Queensland Family and Child Commission (QFCC), I would like to extend my sincere condolences to the families and friends of the 445 children and young people whose deaths were registered in 2014–15.

This is Queensland’s 11th annual report analysing the deaths of children and young people in this state, focusing on the circumstances and risk factors surrounding external (non-natural) causes of death. This report aims to provide evidence for supporting and focusing child death prevention efforts using the only dataset of all deaths of children and young people in Queensland.

The QFCC’s Queensland Child Death Register now holds data in relation to 5413 children and young people whose deaths have been registered in Queensland since 1 January 2004.

Beyond medical causes of child deaths, deaths from preventable causes are relatively rare. But sometimes, despite our best efforts, a set of circumstances and factors will lead to a child’s death that we can’t predict or prevent. Families, community members and professionals have to contend with such tragic outcomes.

What we can do is have processes to review, to research and to raise community awareness. In some circumstances we need to forensically investigate the circumstances that may have led to a child’s death. Coroners, pathologists, those responsible for reviewing child protection and domestic violence cases, and specialist researchers have key roles in this regard. We need to learn from these reviews, we need to look to other jurisdictions and countries to see what programs prove effective in preventing deaths, we need to be vigilant in identifying emerging risks.

This is where it is important to collect and collate information and conduct research to identify the risks and trends, and to inform prevention programs and policies.

Over time, safeguards have been put in place to modify and regulate building, product and transport safety codes. Historically, we have examples of design or legislation, which have contributed to reducing deaths and serious injury. The list is long, but child-proof packaging on medicines and poisons, safety switches, smoke alarms, and design of nursery furniture, fridges, stoves and toys are all examples. In transport, we have seen the value of seatbelt and child restraint requirements, random breath testing and reduced speed limits near schools and in residential areas. Pool fencing legislation and compliance requirements have been in place and strengthened in recent decades, and even though private pool ownership has gone up over this time, the number of pool drownings of young children has gone down.

As to child deaths from diseases and medical conditions, most of these occur in the first weeks and months of life, caused by perinatal conditions or congenital abnormalities. Medical science and health care have made great inroads here, but tiny children remain vulnerable. It is essential that antenatal care is accessed during pregnancy and that medical advice to reduce risks to unborn children is followed.

Infant mortality for Aboriginal and Torres Strait Islanders is around twice that of non-Indigenous children. For both Aboriginal and Torres Strait Islander and non-Indigenous children, deaths due to perinatal conditions or congenital abnormalities are big contributors to the number of deaths from diseases and medical conditions. So again, I would emphasise the vital role of antenatal care during pregnancy and following medical advice—these things can make a difference.

Closing the gap in outcomes for Aboriginal and Torres Strait Islander people must remain as a priority for government at all levels.

What are the most important messages that need to be reinforced based on the areas of highest risk and known best protections? In my view, these are:

- Access antenatal care and follow medical advice during pregnancy.
- Use child restraints and seatbelts. Don’t drink and drive. Don’t drive through flood waters.
- Don’t walk away from infants in the bath or shower. Don’t rely on siblings to supervise.
• Maintain compliant pool fencing and be diligent about closing gates. Learn resuscitation.
• Provide appropriate supervision for young children especially near pools, dams or creeks—they can wander off very quickly and some children can be adept at circumventing obstacles.
• On rural properties or acreage, teach children about dangers and strongly reinforce 'no go' areas. Provide a safe play area and consider barriers where hazards are nearby.
• Be especially vigilant of nearby hazards in the first months in a new property.
• Provide young people with the space to develop but be alert to signs of distress or instability.
• Seek help if family violence is occurring.
• If you are aware of a family in trouble, see what you can do to help or direct them to services.

Every death in this report is a heavy loss for families, friends and communities. Every death from a preventable cause leaves regret, heartache and grief. It is hoped that by collecting, collating and sharing information on child deaths, awareness of possible risks can be heightened and child death prevention activities can be better formulated and targeted. This year's report again demonstrates the need for continued efforts to reduce child deaths.

I have informed relevant stakeholders of pertinent findings from this report to advocate for strengthened efforts to prevent the deaths of children and young people, where possible.

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission
Executive summary

Purpose and establishment

The Queensland Family and Child Commission (QFCC) was established on 1 July 2014 as part of the Queensland Government’s far-reaching reforms around child protection. As a statutory body, the QFCC is charged with the responsibility to provide independent advice and expert oversight to ensure that government and non-government agencies are delivering best practice services for families and children across Queensland. The QFCC also promotes and advocates the role of families and communities to protect and care for Queensland’s children and young people, so that more children can stay at home safely.

Prior to the establishment of the QFCC on 1 July 2014, the Commission for Children and Young People and Child Guardian (CCYPCG) was responsible for maintaining the Queensland Child Death Register and conducting research into child deaths. The CCYPCG ceased operations on 30 June 2014 and accordingly, the Queensland Child Death Register and other functions relating to child deaths were transferred to the QFCC.

This report represents the 11th annual report to be produced on child deaths in Queensland. Under Part 3 of the Family and Child Commission Act, the QFCC has responsibility for the child death register and production of an annual report, specifically to:

- maintain a register of the deaths of all children and young people in Queensland
- classify deaths and analyse and identify patterns or trends from the data
- conduct research alone or in cooperation with other entities
- identify areas for further research by QFCC or other entities
- make recommendations arising from the register and conducting research about laws, policies, practices and services.

This report highlights the key trends and issues relevant to the deaths of children and young people aged 0–17 years registered in Queensland in 2014–15. This report is complemented by comprehensive data tables, which can be accessed on the QFCC’s website to provide a more detailed account of Queensland child death statistics. The methodology for data analysis is explained in Appendix 1.1 of this report.

Access to comprehensive child death data is available at no cost to organisations or individuals conducting genuine research. Stakeholders wishing to access the Queensland Child Death Register to support their research, policy or program initiatives should email their request to child.death@qfcc.qld.gov.au.
**Child deaths in Queensland, findings in 2014–15 and trends since 2004**

Deaths of children are relatively rare beyond the vulnerable first weeks and months of life. The QFCC notes that due to relatively small numbers involved in the following information, caution should be exercised in interpreting year-to-year changes, as these may not be indicative of particular trends. However, many patterns of mortality in population sub-groups (such as age groups, sex and Indigenous status) are repeated each year for particular causes of death, reflecting consistent risk and vulnerability profiles.

In the 12-month period from 1 July 2014 to 30 June 2015, the deaths of 445 children were registered in Queensland, a rate of 40.2 deaths per 100,000 children and young people aged 0–17 years.

The table over the page broadly outlines the causes of death by age group for the 445 registered deaths.

The table below shows the number and rate of child deaths in Queensland each reporting period since 2004–05. Over the 11-year period of data collection, there have been some year-to-year fluctuations in child death rates; however, there has been a general reduction in recent years.

<table>
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<tr>
<th>Year</th>
<th>Number of deaths</th>
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<td>2005–06</td>
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<td>446</td>
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<tr>
<td>2014–15</td>
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</tr>
</tbody>
</table>


**Leading causes of child deaths**

- Deaths from diseases and morbid conditions (natural causes) accounted for the majority of deaths of children and young people registered in 2014–15 (69.4 per cent), occurring at a rate of 27.9 deaths per 100,000 aged 0–17 years.
- External or non-natural causes of death (transport, drowning, other non-intentional injury, suicide and fatal assault and neglect) accounted for 20.2 per cent of child deaths, and occurred at a rate of 8.1 deaths per 100,000 aged 0–17 years.
- Suicide accounted for 6.3 per cent of deaths of children and young people and was the leading external cause of death, occurring at a rate of 2.5 deaths per 100,000 children and young people (28 deaths).
- Over the 11 reporting periods in the Queensland Child Death Register, the leading external causes of death have generally been transport, suicide or drowning. Transport has been the leading external cause for the previous 10 periods; however, in 2014–15, with the low number of transport deaths in this year, suicide is for the first time the leading external cause of death for 0–17 year olds.
## Cause of death by age category, 2014–15

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Under 1 year n</th>
<th>1–4 years n</th>
<th>5–9 years n</th>
<th>10–14 years n</th>
<th>15–17 years n</th>
<th>Total n</th>
<th>Rate per 100,000</th>
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<td>245</td>
<td>20</td>
<td>16</td>
<td>11</td>
<td>17</td>
<td>309</td>
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<td>Explained diseases and morbid conditions</td>
<td>239</td>
<td>20</td>
<td>16</td>
<td>11</td>
<td>17</td>
<td>303</td>
<td>27.4</td>
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<td>0</td>
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<td>0.5</td>
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<td>0</td>
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<td>1</td>
<td>2</td>
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<td>29.0</td>
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</table>

Data source: Queensland Child Death Register (2014–15)

* Rates have not been calculated for numbers less than four.

1. Rates are calculated per 100,000 children aged 0–17 years in Queensland.
2. Rates for age categories are calculated per 100,000 children in each age category.
3. Although deaths that only occur within a certain age category (SIDS, suicide) are generally expressed as a rate per 100,000 children within that age category (e.g. infants under 1 year or young people aged 10–17 years), all rates have been calculated per 100,000 children aged 0–17 years in Queensland to enable comparison across all causes of death. Age-specific death rates are discussed in the chapters relating to each cause of death.
By age and sex

- In 2014–15, for the 0–17 years age group the mortality rate for males was slightly higher than for females, with a rate of 41.6 deaths per 100,000 males compared to 38.4 deaths per 100,000 females.
- Diseases and morbid conditions were the most frequent cause of death of infants under 1 year of age, accounting for 86.0 per cent of the deaths in this age category (245 deaths).
- The leading cause of death for children aged 1–4 years was diseases and morbid conditions (20 deaths), followed by drowning (10 deaths).
- Children aged 5–9 years died most frequently of diseases and morbid conditions (16 deaths). Drowning and fatal assault and neglect were the equal second leading cause of death (five deaths each).
- Diseases and morbid conditions were the leading cause of death for children aged 10–14 years (11 deaths). The leading external cause of death for 10–14 year-olds was suicide (four deaths).
- Suicide was the leading cause of death for young people aged 15–17 years (24 deaths) followed by diseases and morbid conditions (17 deaths). The number of 15–17 year-olds who died from transport incidents (nine deaths) is the lowest recorded since the commencement of the child death register in 2004.

Aboriginal and Torres Strait Islander children

- Aboriginal and Torres Strait Islander children accounted for 16.4 per cent of deaths and died at 2.3 times the rate of non-Indigenous children in Queensland in 2014–15.
- Deaths of Indigenous infants from diseases and morbid conditions make up the largest proportion of all deaths of Indigenous children and young people (49.3 per cent of the 73 deaths from all causes).
- Over the last 11 years, the Indigenous mortality rates from diseases and morbid conditions have generally been 1.5–2 times the rates for non-Indigenous children.
- There were six suicide deaths of Aboriginal and Torres Strait Islander young people. The rate of suicide among Aboriginal and Torres Strait Islander young people was more than three times that of their non-Indigenous peers.
- Aboriginal and Torres Strait Islander infants are over-represented in sudden unexpected deaths in infancy (SUDI). During 2014–15, they died suddenly and unexpectedly at 3.9 times the rate of non-Indigenous infants.

Children known to the child protection system in the 12 months prior to their death

- In 2014–15 children known to the child protection system died at a rate of 53.7 deaths per 100,000, compared with 40.2 deaths per 100,000 for all Queensland children.
- Fifteen young people who died as a result of suicide were known to the child protection system.
- Three of the 14 children who died due to fatal assault or neglect were known to the child protection system.1

Diseases and morbid conditions

- In 2014–15, the deaths of 309 children and young people were the result of diseases and morbid conditions, a rate of 27.9 deaths per 100,000 children and young people aged 0–17 years in Queensland. Both the number and rate of deaths from diseases and morbid conditions in 2014–15 are the lowest recorded over the 11 years since 2004.
- The most common causes of death as a result of diseases and morbid conditions were certain conditions originating in the perinatal period (13.1 deaths per 100,000 children aged 0–17 years), with the majority occurring as a result of complications of pregnancy, labour and delivery. This was followed by deaths due to congenital malformations, deformations and chromosomal abnormalities (8.3 deaths per 100,000).
- Deaths of children from diseases and morbid conditions are most likely to occur in the first weeks and months of life, with infants accounting for 79.3 per cent of deaths from diseases and morbid conditions in 2014–15. The infant mortality rate in relation to diseases and morbid conditions (using live births as the denominator) is 3.9 deaths per 1000 live births.
- Infant deaths from the two leading causes—conditions originating in the perinatal period and congenital malformations, deformations and chromosomal abnormalities (220 deaths combined)—make up the largest

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1 While all three cases were in line with the definition, in two cases there were no child protection histories prior to the incidents that resulted in the deaths.
proportion of all deaths of children and young people (71.2 per cent of all 309 deaths from diseases and morbid conditions and 49.4 per cent of the 445 deaths from all causes).

**Transport-related deaths**
- In 2014–15, 25 children and young people died in transport incidents, a rate of 2.3 deaths per 100,000 children aged 0–17 years. This is the lowest annual number of transport-related fatalities since reporting commenced in 2004.

**Drowning**
- Children aged 1–4 years made up the largest group of drowning deaths (10 deaths), a pattern that has been found in all previous reporting periods, and an indication of the particular vulnerability of this age group.
- Of the children aged 1–4 years, five children drowned in private pools and five drowned in rural water hazards such as farm dams.
- Pool fencing standards were introduced in 1991 and have been incrementally strengthened over time. The number of drowning deaths of young children has fluctuated from year to year; however, numbers before the introduction of pool fencing requirements were generally higher than those seen since the introduction of standards, and especially in the last decade. For example, the average annual number of children under 5 drowned in private pools for the three-year period 1983–1985, was 11.3 deaths compared to an average of 3.3 drowned annually in 2012–2014.
- Swimming pool fencing and diligence in keeping pool gates closed, appropriate supervision of young children in bathtubs or where pools and water hazards are in the vicinity, and establishing safe play areas on rural properties and acreage where hazards are nearby are recommended approaches to reducing the risk of drowning for young children.

**Suicide**
- There were 28 suicide of young people during 2014–15. This year’s total of 28 is the highest number of suicide deaths recorded over the 11 years since 2004, with numbers in other recording periods ranging from 15 to 23.
- Contributing to the 11-year high in suicide deaths were the deaths of 14 females, which was higher than in any other reporting period since the register started in 2004. The 14 male suicides were within the range from 17 as the highest annual number (in 2013–14) and nine as the lowest (in 2005–06 and 2008–09).
- Male suicides for young people usually outnumber female suicides, and over the most recent three-year period, the suicide rate for males was 1.6 times that for females.

**Fatal assault and neglect**
- Fourteen children and young people died as a result of fatal assault and neglect in Queensland in 2014–15, the highest number recorded since reporting began in 2004. This number is due, in part, to a single incident involving multiple fatalities.
- Nine children were victims of domestic homicide. Four deaths were identified as fatal child abuse. The remaining deaths were due to neonaticide.

**Sudden unexpected deaths in infancy (SUDI)**
- There were 39 cases of sudden unexpected death in infancy (SUDI) in 2014–15: a rate of 61.4 deaths per 100,000 infants (aged under 1 year). The number and rate of SUDI deaths have fluctuated over the last 11 reporting periods; however, the 2014–15 rate is the lowest recorded since reporting began in 2004, while the 39 deaths is close to the lowest number (36 deaths were recorded in 2007–08).
- Six deaths were attributed to sudden infant death syndrome (SIDS) and undetermined causes (of the 12 SUDIs with an official cause of death). Official causes of death were still pending for 27 deaths.
- Six of the sudden and unexpected infant deaths were found, following post-mortem examination, to have an explained cause of death. All six children died as a result of infant illnesses unrecognised prior to their deaths.
• Predominantly, deaths from sudden unexpected deaths in infancy are recorded as ‘cause pending’ until the outcomes of coroner’s investigations or post-mortem examinations are concluded. Looking to the period 2012–13, where only two of the 48 deaths remained pending, over half of the deaths (27 or 56.3 per cent) were attributed to SIDS, seven were due to unrecognised infant illnesses, five each were sleep accidents and cause undetermined, and two were due to fatal assault.

Queensland Child Death Register access and data requests

The QFCC, through its strategy of providing access to data from the Queensland Child Death Register, supported a range of researchers and stakeholders during the reporting period in the development and implementation of programs, policies and initiatives or research programs that require a solid and contemporary evidence base. The overarching aim of this strategy is to promote the information collected in the Queensland Child Death Register to stakeholders (at both the state and national levels), identify opportunities to engage with stakeholders and share the child death dataset and key findings to inform ongoing prevention efforts.

During 2014–15, the QFCC received 18 requests for access to the Queensland Child Death Register from external stakeholders. The table over the page indicates the types and purposes for which data was provided to external researchers and stakeholders. Examples of the projects provided with information include the following:

• A University of the Sunshine Coast study examining sudden unexpected deaths in infancy (SUDI) death records in order to identify ways to better engage vulnerable, marginalised, difficult-to-engage groups to provide risk-reduction education.
• A review of circumstances and events surrounding deaths of infants by the Queensland Paediatric Quality Council Infant Mortality Subcommittee, in an effort to comprehensively identify the factors associated with infant deaths and appropriate interventions.
• A national study by the Royal Prince Alfred Hospital (NSW) is examining underlying medical causes of death by obtaining detailed information on unexpected early neonatal deaths (i.e. within the first seven days of life).
• The Royal Life Saving Society of Australia publishes the National Drowning Report and provides related drowning prevention activities and information.
• A Department of Education and Training review of suicide postvention practices in state schools.

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<tr>
<th>Purpose of data request by type of data requested, 2014–15</th>
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<tbody>
<tr>
<td>Type of data requested</td>
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<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Diseases and morbid conditions</td>
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<tr>
<td>SUDI</td>
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<tr>
<td>Drowning</td>
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<tr>
<td>Transport</td>
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<tr>
<td>Suicide</td>
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<tr>
<td>All deaths</td>
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<td>Total</td>
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Committees
The QFCC participated in various committees in this reporting period, including the:

- Australian and New Zealand Child Death Review and Prevention Group
- Queensland Perinatal and Infant Mortality Taskforce
- Queensland Births and Deaths Working Group
- Queensland Council for Injury Prevention Executive Committee Meeting
- CARRS-Q Road Safety Researchers Network.

Report structure
The report structure is divided into seven parts as follows:

Part I—Introduction and overview
Part II—Deaths from diseases and morbid conditions
Part III—Non-intentional injury-related deaths
  - Transport
  - Drowning
  - Other non-intentional injury-related deaths
Part IV—Intentional injury-related deaths
  - Suicide
  - Fatal assault and neglect
Part V—Sudden unexpected deaths in infancy
Part VI—Child death prevention activities
Part VII—Australian and New Zealand child death statistics
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