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 2017 to 30 June 2018.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding the annual report, you can contact Translating and Interpreting Service National on 13 14 50 (local call charge if calling within Australia; higher rates apply from mobile phones and payphones) to arrange for an interpreter to effectively explain the report to you.

Electronic copies of this and other reports are available on our website at www.qfcc.qld.gov.au

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

Contact for enquiries
For enquiries or further information about this annual report (including to receive a hard copy of it) please contact us at:

Queensland Family and Child Commission
Level 22, 53 Albert Street
PO Box 15217, Brisbane City East QLD 4002
Email child_death_prevention@qfcc.qld.gov.au
www.qfcc.qld.gov.au

Acknowledgements
This Annual Report: Deaths of children and young people, Queensland, 2017–18 was developed and updated by the Queensland Family and Child Commission.


Copyright


ISSN: 1833-9522 (Print)
1833-9530 (Online)

Licence

This annual report is licensed by the State of Queensland (Queensland Family and Child Commission) under a Creative Commons Attribution (CCBY) 4.0 International licence. You are free to copy, communicate and adapt this annual report, as long as you attribute the work to the State of Queensland (Queensland Family and Child Commission). To view a copy of this licence visit http://creativecommons.org/licenses/by/4.0/.

For permissions beyond the scope of this licence, please contact the Commission’s Family and Child Research Program, PO Box 15217, Brisbane City East QLD 4002 or by email to child_death_prevention@qfcc.qld.gov.au.
31 October 2018

The Honourable Yvette D’Ath MP
Attorney-General and Minister for Justice
Leader of the House
1 William Street
BRISBANE QLD 4000

Dear Attorney-General

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 2017 to 30 June 2018, 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
# Contents

Acknowledgements ........................................................................................................ iv

Foreword ......................................................................................................................... 1

Executive summary ......................................................................................................... 3

Child deaths in Queensland, findings in 2017–18 and trends since 2004 ....................... 3

Queensland Child Death Register access and data requests ........................................ 9

Report structure ............................................................................................................. 10

Chapter 1 — Child deaths in Queensland .................................................................. 11

Key findings .................................................................................................................... 11

Child deaths in Queensland 2015–18 ........................................................................... 12

Child deaths in Queensland: Findings 2017–18 .......................................................... 13

Children reported missing ............................................................................................ 20

Chapter 2 — Deaths from diseases and morbid conditions .......................................... 21

Key findings .................................................................................................................... 21

Deaths from diseases and morbid conditions 2015–18 ................................................... 22

Deaths from diseases and morbid conditions: Findings 2017–18 .............................. 24

Major causes ................................................................................................................ 27

Chapter 3 — Transport-related deaths ........................................................................ 31

Key findings .................................................................................................................... 31

Transport-related deaths 2015–18 ................................................................................ 32

Transport-related deaths: Findings 2017–18 ................................................................. 33

Transport-related characteristics .................................................................................. 34

Risk factors ................................................................................................................... 36

Quad bike safety ............................................................................................................ 37

Chapter 4 — Drowning ................................................................................................. 38

Key findings .................................................................................................................... 38

Drowning 2015–18 ....................................................................................................... 39

Drowning: Findings 2017–18 ...................................................................................... 40

Risk factors ................................................................................................................... 40

Chapter 5 — Other non-intentional injury-related deaths ............................................. 45

Key findings .................................................................................................................... 45

Other non-intentional injury-related deaths 2015–18 ..................................................... 46

Other non-intentional injury-related deaths: Findings 2017–18 ................................. 47

Chapter 6 — Suicide ..................................................................................................... 49

Key findings .................................................................................................................... 49

Suicide 2015–18 .......................................................................................................... 50

Defining and classifying suicide .................................................................................... 51

Suicide: Findings 2017–18 ........................................................................................... 51
## Annual Report Deaths of children and young people Queensland 2017–18

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumstances of death</td>
<td>52</td>
</tr>
<tr>
<td>Precipitating incidents and stressful life events</td>
<td>54</td>
</tr>
<tr>
<td>Mental Health Coach Program in Queensland schools</td>
<td>56</td>
</tr>
<tr>
<td>Recent research on youth suicide</td>
<td>57</td>
</tr>
<tr>
<td><strong>Chapter 7 — Fatal assault and neglect</strong></td>
<td>59</td>
</tr>
<tr>
<td>Key findings</td>
<td>59</td>
</tr>
<tr>
<td>Fatal assault and neglect 2015–18</td>
<td>60</td>
</tr>
<tr>
<td>Defining fatal assault and neglect</td>
<td>61</td>
</tr>
<tr>
<td>Fatal assault and neglect: Findings 2017–18</td>
<td>61</td>
</tr>
<tr>
<td>Sentencing for criminal offences arising from the death of a child</td>
<td>62</td>
</tr>
<tr>
<td><strong>Chapter 8 — Sudden unexpected deaths in infancy</strong></td>
<td>64</td>
</tr>
<tr>
<td>Key findings</td>
<td>64</td>
</tr>
<tr>
<td>Sudden unexpected deaths in infancy 2015–18</td>
<td>65</td>
</tr>
<tr>
<td>The classification of sudden unexpected deaths in infancy</td>
<td>66</td>
</tr>
<tr>
<td>Sudden unexpected deaths in infancy: Findings 2017–18</td>
<td>66</td>
</tr>
<tr>
<td>Cause of death 2016–17</td>
<td>68</td>
</tr>
<tr>
<td>Risk factors for SUDI deaths</td>
<td>69</td>
</tr>
<tr>
<td>Shared sleeping with other risk factors</td>
<td>70</td>
</tr>
<tr>
<td>Expert panel review of SUDI cases</td>
<td>70</td>
</tr>
<tr>
<td><strong>Chapter 9 — Child death prevention activities</strong></td>
<td>72</td>
</tr>
<tr>
<td>Activities to improve collection of child death information</td>
<td>73</td>
</tr>
<tr>
<td>Child death prevention resources</td>
<td>73</td>
</tr>
<tr>
<td>Seconds Count Campaign</td>
<td>74</td>
</tr>
<tr>
<td>Research in the Round</td>
<td>74</td>
</tr>
<tr>
<td>Researcher access to child death data</td>
<td>74</td>
</tr>
<tr>
<td>Research findings supported through child death data</td>
<td>75</td>
</tr>
<tr>
<td>Policy submissions</td>
<td>76</td>
</tr>
<tr>
<td>Advisory bodies</td>
<td>76</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td>78</td>
</tr>
<tr>
<td>Appendix 1 — Methodology</td>
<td>78</td>
</tr>
<tr>
<td>Appendix 2 — Abbreviations and definitions</td>
<td>86</td>
</tr>
<tr>
<td>Appendix 3 — Cause of death by ICD-10 Mortality Coding Classification</td>
<td>92</td>
</tr>
<tr>
<td>Appendix 4 — Notifiable diseases</td>
<td>94</td>
</tr>
<tr>
<td>Appendix 5 — Inclusions within the other non-intentional injury category</td>
<td>96</td>
</tr>
<tr>
<td>Appendix 6 — Suicide classification model</td>
<td>97</td>
</tr>
<tr>
<td>Appendix 7 — Fatal assault and neglect screening criteria</td>
<td>99</td>
</tr>
</tbody>
</table>
Acknowledgements

The Queensland Family and Child Commission (QFCC) acknowledges the unique and diverse cultures of Aboriginal and Torres Strait Islander peoples and notes, 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 there is information regarding Aboriginal and Torres Strait Islander deceased people in this report.

The QFCC would like to thank the government departments and non-government organisations who 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; Queensland Health; the Department of Child Safety, Youth and Women (DCSYW); the Australian Bureau of Statistics (ABS); and Queensland Treasury. The Victorian Department of Justice and Regulation is also acknowledged as administrators of the National Coronial Information System.

The QFCC would like to acknowledge the researchers contributing to child death prevention research, including the following agencies and individuals whose research is referenced in this report:

- Royal Life Saving Australia
- Queensland Paediatric Quality Council, Infant Mortality Sub-Committee
- Queensland Sentencing Advisory Council
- Associate Professor James Scott
- Dr Samantha Batchelor
- Ms Leda Barnett.

The QFCC would also like to acknowledge the contribution of data from other Australian and New Zealand agencies and committees which perform similar child death review functions. This data has been compiled for an inter-jurisdictional overview representing further steps towards developing a nationally comparable child death review dataset. The overview is available online at https://www.qfcc.qld.gov.au/ on the child death reports and data page.

The contribution of officers from the QFCC’s Family and Child Research team 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, I would like to extend my sincere condolences to the families, carers and friends of children and young people who have passed away. It is my hope that this report will contribute to an understanding of child deaths and how to prevent them.

The death of a child under any circumstances is a tragedy. The main focus of this report is on the circumstances and risk factors surrounding the deaths of the children and young people who lost their lives due to external causes of death, including transport incidents, drowning, suicide and non-accidental trauma. These provide the greatest opportunities to prevent future deaths.

The Family and Child Commission Act 2014 requires the QFCC to maintain a register of information relating to child deaths in Queensland, and to classify, analyse and report on trends and patterns in child deaths each year. The register maintained by the QFCC contains information about the deaths of all children and young people in Queensland since 1 January 2004.

This report, the 14th in the series, found there were 385 child deaths in 2017–18, a rate of 33.8 per 100 000 children aged 0–17 years. Overall, the rate of deaths of children and young people has been in decline since reporting commenced in 2004, primarily due to a reduction in the number of natural cause deaths from diseases and morbid conditions, and to a lesser extent from decreases in transport fatalities. This year represents the lowest recorded number and annual rate since reporting commenced in 2004–05.

Themes we note this year include:

- Aboriginal and/or Torres Strait Islander children were consistently over-represented in child deaths, with the mortality rate of Indigenous children twice the rate for non-Indigenous children.
- Mortality rates of children known to the child protection system are several times higher than the mortality rate of all Queensland children for external causes of death, including for drowning, other non-intentional injury, suicide, fatal assault and sudden unexpected infant deaths.
- Twenty-four young people suicided. Suicide represented more than half of all deaths due to external causes for 10–17 year olds.
- The vulnerability of very young children to accidental death: in backyard swimming pools, driveways and carparks, and for infants in unsafe sleep environments.

Again this year, not one child drowned in a private swimming pool where the pool gate was properly latched and the fencing compliant. The regulation of pool fencing is truly a life-saver, and emphasises that we need to be vigilant every day about maintaining the fence, keeping climbable items away and, most importantly, keeping the gate securely closed.

Young children aged 1–4 years continue to be vulnerable to pedestrian deaths, particularly low-speed vehicle run-overs. These incidents tend to occur in non-traffic areas such as driveways or garages, and the vehicle is usually being operated by a family member. The rate of low-speed vehicle run-over deaths has remained relatively stable since reporting commenced in 2004–05. Any person moving a vehicle should make sure they know where young children are and check around the vehicle. As has been shown for safety around pools, fenced play areas and self-closing gates and doors (to driveways and garages) provide vital physical barriers to keep children out of harm’s way.
A significant number of agencies are using QFCC’s data as an evidence base for policy and program development and to inform campaigns aimed at preventing child deaths. During the year we responded to 27 requests for tailored child death data from external stakeholders. Our data has been used for a large number of purposes including informing suicide research, supporting the drowning research studies conducted by the Royal Life Saving Society of Australia, research into sudden unexpected deaths in infancy, as well as supporting a number of other research and prevention activities being conducted across Australia.

The QFCC is also legislated to make recommendations relating to laws, policies, practices and services to help reduce the likelihood of future deaths. In 2017–18 we used information on child fatalities in quad bike incidents to inform submissions to the Australian Competition and Consumer Commission’s review of national standards for quad bikes and side-by-side vehicles.

We hope by collecting and sharing information on child deaths we can raise awareness of possible risks and better inform prevention activities. I look forward to working with stakeholders to further advance these endeavours in the year ahead. As Principal Commissioner of the QFCC I am committed to working with you to make sure all Queensland children, young people and their families are more than safe.

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission