

Queensland
Family & Child
Commission

ANNUAL REPORT

Deaths of children
and young people
Queensland

2015 – 16

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 2015 to 30 June 2016.



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Acknowledgements

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Annual Report: Deaths of children and young people, Queensland, 2015 – 16

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31 October 2016

Queensland
Family & Child
Commission

The Honourable Anastacia 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 between 1 July 2015 to 30 June 2016, 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

A handwritten signature in black ink that reads 'Cheryl Vardon'.

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission

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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 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; the Queensland Ambulance Service; Queensland Health; the Department of Communities, Child Safety and Disability Services (DCCSDS); 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 also like to acknowledge the contribution of data from other Australian and New Zealand agencies and committees who 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 in supplementary information and can be accessed online at www.qfcc.qld.gov.au.

The contribution of officers from the QFCC's Operations Program who maintained the Queensland Child Death Register, analysed the data and prepared the report is also acknowledged and appreciated.

Foreword

The QFCC's legislative mandate to register, analyse and report on trends and patterns in child deaths contributes to Australia's commitment as a signatory to the United Nations Convention on the Rights of the Child (UNCRC). In particular, Article 24 of UNCRC requires that, among other things, parties shall implement measures designed to achieve the highest attainable standard of health, including taking measures that diminish infant and child mortality.

Underpinning these formal reasons for reviewing child deaths rests the very human elements of not wanting young lives to end prematurely and the desire to dignify those who do die with a determined search for the contributing factors. In this way we strive to give meaning to the personal heartbreak of lives lost too soon by finding ways to prevent future tragedy.

On behalf of the QFCC, I would like to extend my sincere condolences to the families, carers and friends of the 390 children and young people whose deaths we registered in 2015 – 16.

This report, the twelfth in the series, analyses the deaths of these children and young people by focusing on the circumstances and risk factors surrounding external (non-natural) causes of death and sudden unexpected deaths in infancy (SUDI).

The QFCC now holds data and information in relation to 5843 children and young people whose deaths have been registered in Queensland since 1 January 2004. We use this evidence base to:

- provide tailored data to stakeholders in support of their prevention efforts
- partner in research and systemic reviews where areas of concern are identified
- proactively publish and promote trend information and prevention messages to stakeholders and the community
- provide evidence-based submissions to help inform the development of policy and legislation
- prepare and publish this report each year.

The child death review work undertaken by the QFCC demonstrates a desire to deeply, thoroughly and systematically reflect upon the risks that exist in children's lives with a view to preventing them from manifesting or, preferably, eliminating them altogether. Child death reviews are effective in this way over and above the work traditionally performed by statistical bodies because they probe beyond a compilation of death certificate data and routinely involve detailed consideration of autopsies, coronial findings, child protection, health and police information.

Our data is also contemporary. This annual report is compiled and made available for public release within four months of the reporting period closing. Responses to requests for tailored child death data are generally provided within 72 hours.

During the year we noted:

- An overall 12% decrease in child deaths, driven by reductions across natural cause infant deaths and the non-natural causes of transport, suicide, drowning and fatal assault/neglect.
- A 30% decrease in the deaths of Aboriginal and Torres Strait Islander children (compared to the 12% reduction for all children).
- For the first time in a reporting period no deaths were registered involving defective pool fencing, which suggests the introduction of strengthened pool fencing laws and registration of private pools is working as a prevention mechanism.
- Favourable Parliamentary consideration of proposed changes to strengthen smoke alarms laws. The QFCC supported the initiative in a submission analysing 32 child deaths in house fires over a 12-year period.
- As with previous years, the deaths of children known to the child protection system occurred at a higher rate than the general population. This is explained, to a large extent, by the significant disadvantage, abuse and neglect these children experience prior to coming to the attention of the child protection system.

During the year we also responded to 31 requests for tailored child death data from 31 stakeholders. This included responses for the *National Drowning Report*, a study on SUDI, regional data on suicide deaths, and for research in relation to pedestrian and bicycle-related deaths.

I anticipate the public value added by the QFCC's work in reviewing, analysing and reporting on child deaths will continue to grow through our ongoing promotion of awareness about risk factors associated with child deaths.

An increasing number of agencies and organisations are also now accessing and utilising this high quality and contemporary evidence base in policy and program development and the formulation of strategies and campaigns aimed at preventing child deaths.

I look forward to working with stakeholders to further advance these endeavours in the year ahead. As Principal Commissioner of the Queensland Family and Child Commission 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