

Commonwealth Treasury consultation – Improving the effectiveness of the consumer product safety system Submission

9 December 2019

Queensland Family and Child Commission

PO Box 15217

Brisbane City East QLD 4002

qfcc.qld.gov.au

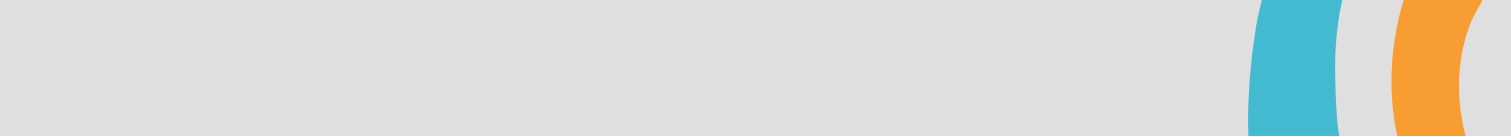
Submission contact

Manager Child Death Prevention

Email: child_death_prevention@qfcc.qld.gov.au

Phone: 07 3900 6030

Reference: TF19/708



Submission summary

The Queensland Family and Child Commission (QFCC) welcomes the opportunity to make a submission to the Commonwealth Treasury in relation to the need for an improved product safety system, including the introduction of a General Safety Provision (GSP).

The QFCC was established on 1 July 2014 with a role to promote and advocate the safety and wellbeing of children and young people, particularly those who are vulnerable. As part of this, the QFCC has a statutory responsibility to maintain the Queensland Child Death Register (CDR), which contains information relating to the deaths of all children and young people in Queensland since 1 January 2004, and report annually on trends and risk factors. The QFCC also has functions to reduce the likelihood of child deaths including making recommendations, arising from keeping the CDR and conducting research about laws, policies, practices and services.

In response to the Commonwealth Treasury's consultation questions on improving the effectiveness of the product safety framework, the QFCC supports:

- Option 6: A new safety duty with a higher safety threshold - requiring traders to ensure products placed on the market are safe by adhering to prescriptive requirements (modelled on the UK GSP). The QFCC considers that this option has the highest likelihood of significantly reducing the frequency and severity of serious injuries and deaths, by ensuring that only safe products are made available to the market.

Data for prevention activities

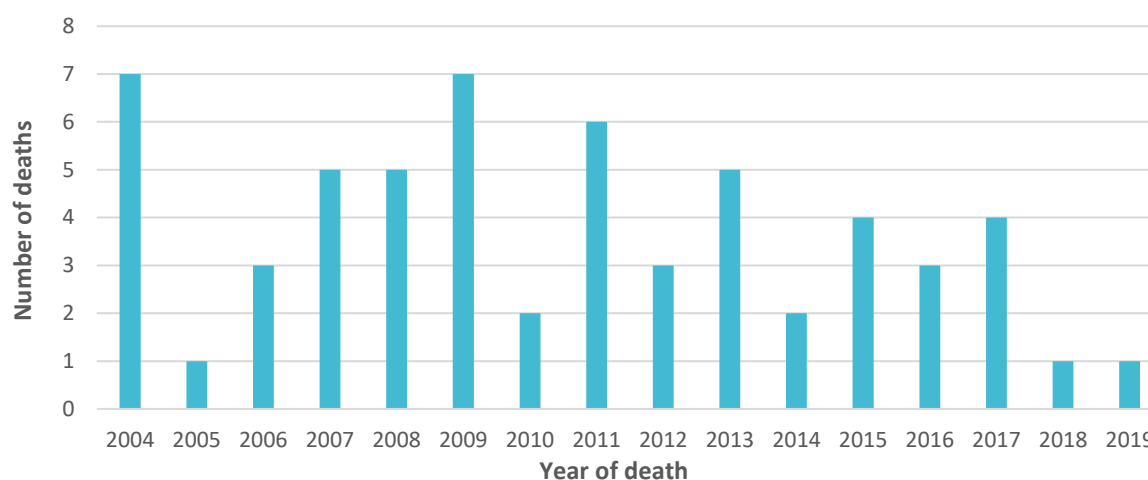
The QFCC collects, analyses and publishes information about child deaths to help prevent future deaths and serious injuries. We work with researchers and other agencies to raise community awareness and develop prevention programs and policies, by identifying risk factors, trends and emerging safety hazards. The QFCC can provide detailed child death data to researchers and organisations, at no cost – please email child_death_prevention@qfcc.qld.gov.au

Data from the Queensland Child Death Register

Unintentional product-related deaths of children and young people, January 2004 – October 2019

The Queensland Child Death Register contains information relating to 59 children and young people who died in Queensland between January 2004 and October 2019 as a result of unintentional product-related injuries.¹ There has been an average of 3 deaths per year, across the 15-year period to date (see Figure 1).

Figure 1: Unintentional product-related deaths by year of death, Queensland, Jan 2004 – Oct 2019^p (n = 59)

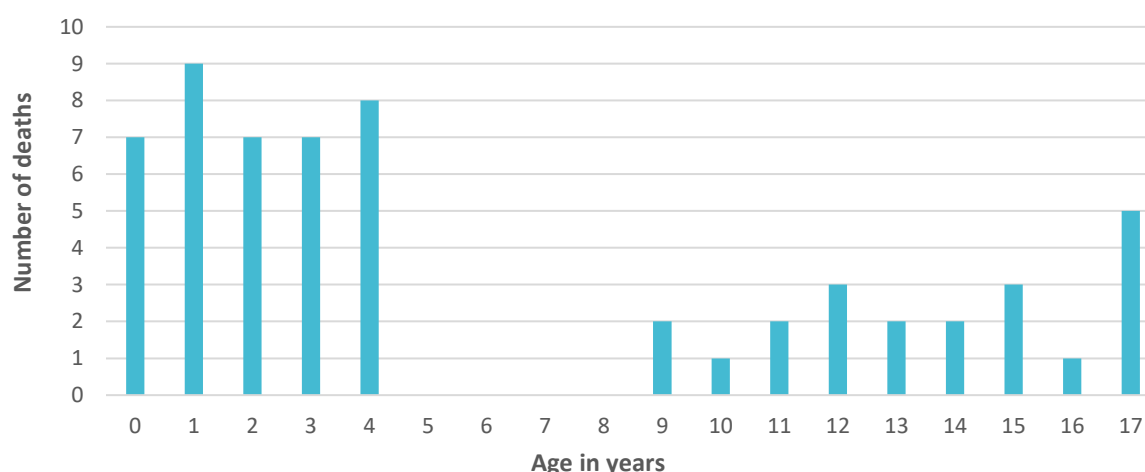


Data source: Child Death Register (2004-2019)

p Data for the 2019 period is provisional.

As indicated in Figure 2, children under the age of 5 were over-represented in unintentional product-related deaths (38 deaths, 64%), highlighting that children in this age group are particularly vulnerable to unintentional injury.

Figure 2: Unintentional product-related deaths by single year of age, Queensland, Jan 2004 – Oct 2019^p (n = 59)



Data source: Child Death Register (2004-2019)

p Data for the 2019 period is provisional.

¹ Deaths were included in this analysis where a product (through its use or misuse) was causatively linked with the death, but where the use of the product was not intended to cause death (ie excludes suicide or fatal assault and neglect).

Given the over-representation of young children in unintentional product-related mortality data, it is important to note that whilst adult supervision is an effective strategy in injury prevention, maintaining continuous active supervision of young children is not realistic. Young children may be more susceptible to product-related injuries due to their developmental abilities, physical size and exploring items that are not intended for use by young children. As such, the QFCC advocates that injury prevention strategies build layers of protection, including but not limited to, creating awareness of hazards, restricting access to hazards and consideration of alternative designs for products known to be associated with unintentional injury.

Whilst this list is not exhaustive, common household products featured most frequently in the data, with the highest number of deaths associated with cigarette/barbecue lighters, aerosol cans/gas cannisters and quad bikes. Details of product types, age groups, mechanism of injury and number of deaths are outlined in Table 1 below.

Table 1: Unintentional product-related deaths, January 2004 – October 2019^p

Product Type	Age groups recorded	Injury and mechanism details	Number of deaths
Bean bag	Under 1 year	Asphyxia – fall from sleep surface resulting in wedging between beanbag and other surface.	1
Button battery	1–4 years	Caustic injury - ingested button battery from unknown source.	1
Caustic substance	1–4 years 10–14 years	Caustic injury - ingestion of caustic substances requiring (unsuccessful) surgical intervention.	2
Cigarette/barbecue lighter	1–4 years 15–17 years	Burns and/or smoke inhalation - unintentional house fires subsequent to young children experimenting with fire, predominantly young children.	11
Cot mattress	Under 1 year	Asphyxia - wedged between mattress and side of cot as a result of incorrect sized mattresses being used in cots.	2
Falling furniture/television	1–4 years	Asphyxia/crushing - struck/crushed when climbing/exploring.	5
Infant bath aid	Under 1 year	Drowning - immersion while left unattended in bath.	1
Infant sling	Under 1 year	Asphyxia - mechanism unable to be determined.	2
Aerosol can or gas cylinder (butane/propane)	10–14 years 15–17 years	Poisoning - intentional inhalation of volatile substances (deodorant or other gas cannisters) by young people.	11
Magnetic toy	1–4 years	Bowel perforation - ingestion of multiple magnetic balls (toy).	1
Portable cot/change table	Under 1 year	Asphyxia - strangulation by strap of change table attachment to portable cot.	1
Portable pool	1–4 years	Drowning - immersion following children being left unsupervised in proximity to unfenced portable pool.	3
Pram	Under 1 year	Asphyxia - strangulation by strap on pram while sleeping unrestrained.	1
Quad bike	1–4 years 5–9 years 10–14 years 15–17 years	Asphyxia/striking/crushing injury - overturn/entrapment, overturn/striking, collision or thrown/fallen incidents.	12
Toy box	1–4 years	Asphyxia - confinement/entrapment in toy box	2
Window covering (blind) cord	1–4 years	Asphyxia – strangulation on loose blind cords.	3
Total			59

Data source: Child Death Register (2004-2019)

^p Data for the 2019 period is provisional.

Sudden unexpected deaths in infancy in unsafe sleep environments, 2004–05 to 2018–19

Sudden Unexpected Death in Infancy (SUDI) is a category of deaths where an infant dies suddenly, usually during sleep, and with no immediately obvious cause. Classifying deaths in this way assists in the identification of possible risk factors for, and associations with, sudden infant death and, most significantly, those factors which may be preventable or amenable to change.

In the period 2004–05 to 2018–19 there were 437 SUDI deaths in Queensland where the cause of death was either:

- Sudden Infant Death Syndrome (SIDS) – 294 (67%)
- undetermined causes – 120 (28%)
- cause of death pending – 23 (5%).

Sudden Infant Death Syndrome (SIDS) and undetermined causes are both considered to be ‘unexplained causes’, in that coronial investigations were not able to find a definitive cause.

SUDIs make up a significant group of all child deaths (0–17 years). Comparative numbers of SUDIs and leading external causes of death across the 15 years in Queensland include:

- 437 infant SUDI deaths from SIDS, undetermined causes and cause pending (29.1 per year on average)
- 500 transport-related deaths (33.3 per year)
- 318 suicide deaths (21.2 per year)
- 218 drowning deaths (14.5 per year).

Table 2 provides data on deaths during sleep events, attributed to SIDS and undetermined causes or where a cause of death is yet to be determined; where the sleep environment may have contributed to an increased risk of death. Specifically, where the infant sleep surface or the bedding or items within the sleep environment did not meet safe sleep guidelines disseminated by Red Nose.²

Of the infant deaths during sleep:

- 68% of the infant deaths had one or more unsafe elements present (297 of 437)
- 36% (157) were in infant beds (cot, bassinet, port-a-cot, cradle), of which 64% (101) had one or more unsafe elements present
- 52% (227) were in adult beds, of which 76% (172) had one or more unsafe elements present
- additionally, 80% of the infant deaths in adult beds involved bed-sharing.

² Red Nose. *Safe sleeping – sleep baby safely and reduce the risk of sudden unexpected death in infancy.*

https://rednose.org.au/section/safe-sleeping?qclid=EAAlaQobChMIk9SH8JeY5gIVkA4rCh0vwgWxEAAAYASAAEgJb1PD_BwE

Table 2: Sleep surface and presence of unsafe sleep environment for SIDS, undetermined cause and cause pending deaths (2004–05 to 2018–19)

Sleep surface	Did not meet Red Nose safe sleep guidelines ^a							All deaths
	Mattress ^b	Bedding ^c	Pillow	Sheepskin	Bumpers	Soft toys	Total	
Cot	6	38	24	5	8	18	61	97
Bassinet	3	12	2	3	1	1	18	30
Port-a-cot	11	14	6	2	0	5	21	25
Cradle	0	1	0	0	0	0	1	5
Pram/stroller	N/A	2	2	0	0	0	3	3
Other infant sleep surface NEC ^d	N/A	3	0	0	0	0	0	5
Adult bed ^e	N/A	144	79	5	0	2	172	227
Other sleep surface ^f	N/A	12	10	0	0	0	16	34
Held by carer	N/A	0	1	0	0	0	1	7
Not stated	N/A	0	1	0	0	0	1	4
All deaths ^g	20	226	125	15	9	26	297	437

Data Source: Child Death Register (2004-2019)

- More than one unsafe factor may be present for each infant's sleep environment, therefore the sum of the counts may be greater than the total.
- Mattress suitability related to deaths where the mattress was the incorrect size or where other items (such as pillows, blankets or clothing) were used as a substitute mattress.
- Inappropriate bedding includes where the bedding identified in the sleep environment fell outside the safe sleep guidelines (bulky bedding e.g. adult doona).
- Other infant sleep surface, not elsewhere classified (NEC) includes: baby capsules/restraints, snuggle beds/baby cocoons, children's fold-out couch and cot mattresses on the floor.
- Adult bed includes bed, mattress on floor and other adult sleep surface (not elsewhere classified).
- Other sleep surface includes: couch/lounge, cardboard box, baby baths, playmats, swing/rocker, suitcases and the floor.
- Other factors in the sleep environment not shown in the table:
 - bed-sharing – of the 227 infants who were sleeping on an adult bed, 181 infants (80%) were sharing the sleep surface with another person/s (including parents/caregivers and/or siblings)
 - anti-roll pillow or sleep-positioner – 7 infants were sleeping with the aid of an anti-roll pillow or sleep-positioner wedge³
 - amber beads – 2 infants were wearing an amber necklace/bracelet/anklet at the time of the death incident.⁴

³ Red Nose. *Is it safe to use products designed to keep baby in a particular position during sleep?*

<https://rednose.org.au/article/is-it-safe-to-use-products-designed-to-keep-baby-in-a-particular-position>

⁴ Red Nose. *Is it ok for babies to wear a necklace or beads.* <https://rednose.org.au/article/is-it-ok-for-babies-to-wear-a-necklace-or-beads>

Response to consultation questions

Question 1

Do you agree with the key problems identified in the existing product safety system? Please provide any examples or evidence to explain your views.

The QFCC agrees with the key problems outlined in relation to the existing product safety system. The following examples highlight the current difficulties faced without the provision of a horizontal directive (General Safety Provision) applying to all consumer products:

- **Unsafe products are in the market and the system is slow to respond – button batteries**
The safety issues and system responses in relation to products containing button batteries illustrate the problems with the current system. The dangers of button batteries have been known for many years⁵ and well before the two child deaths in Australia. Many serious injuries from children ingesting batteries are also noted in the Australian Competition and Consumer Commission *Button Battery Safety Issues Paper* (2019). An industry code was introduced three years after the first child death, but its voluntary nature means products with unsecure battery compartments continue to be readily available in retail stores and online. Consideration is currently being given to mandating the industry code, but it may take some time before any potential changes lead to unsafe products being removed from the market.
- **Consumers assume products in the market are safe for children – infant sleep products**
Sudden infant deaths during sleep make up a significant group of all child deaths, with an average of 29 deaths per year in Queensland alone. It is a complex issue, and in many cases a definitive cause of death cannot be identified. However, QFCC data indicates in two thirds of cases one or more elements considered to increase the risk of infant death from suffocation were present. For this reason, it is essential that infant products (particularly sleep products) meet safe sleep guidelines. Examples of products currently available in the market which do meet the guidelines include cot bumpers, sleep positioners and cot hammocks. New or expecting parents may not be aware of safe sleep guidelines when purchasing products for their infant, and many would expect that infant products would not be available for purchase unless they were safe. Further, there may be confusion for parents around products not intended for sleep, that may be unsafe when an infant is not directly supervised e.g. bouncinettes and inclined chairs.
- **Unsafe misuse of products – intentional inhalation of deodorants by young people**
Misuse of products through intentional inhalation of volatile substances (e.g. deodorants) to induce a 'high' (also known as 'chroming') has resulted in 11 deaths in Queensland in the last 15 years. Many of these deaths involved a single deodorant brand. Under the current product safety system there is no incentive or imperative for manufacturers to redesign products in ways which could minimise potential misuse.

⁵ Barker, R 2018 'Button batteries kill. Here's how we can prevent needless child deaths from battery ingestion' *The Conversation* <https://theconversation.com/button-batteries-kill-heres-how-we-can-prevent-needless-child-deaths-from-battery-ingestion-101187>

Question 2

Do you agree with the policy objectives outlined in this RIS? What are your reasons?

The QFCC agrees with the policy objectives. While many manufacturers and retailers act responsibly, the current system is slow to respond to issues and there is insufficient onus on manufacturers and retailers to provide safe products.

Question 3

What impact will the proposed options have on product safety, risks to consumers, access to products as well as business practices and costs? Please provide details.

It is hoped that with changes outlined within Option 6 (a new safety duty with a higher safety threshold), traders would have greater clarity for ensuring only safe products are available to the market, including infant and nursery products that meet safe sleep guidelines. The QFCC child death data indicates that children aged under 5 are most at risk for unintentional product-related death.

Further, products with the highest representation in mortality data (cigarette lighters, quad bikes and aerosol cans) were more likely to have caused injury or death as a result of misuse of those products. It is envisaged that Option 6 would place greater onus on manufacturers to produce products which are safe to use but are also designed to minimise the risk that products are misused.

Question 4

What is your preferred reform option, or combination of options? What are your reasons?

In response to the Commonwealth Treasury's consultation questions on improving the effectiveness of the product safety framework, the QFCC supports:

- Option 6: A new safety duty with a higher safety threshold - requiring traders to ensure products placed on the market are safe by adhering to prescriptive requirements (modelled on the United Kingdom GSP). The QFCC considers that this option has the highest likelihood of significantly reducing the frequency and severity of serious injuries and deaths, by ensuring that only safe products are made available to the market.
- As noted in the Treasury consultation paper, Option 6 also has the advantage it would be consistent with international best practice and would align with safety systems in the European Union, UK, Singapore, Malaysia and Canada.

Options 1 to 5 are not supported as they do not make the necessary changes to improve the safety of products.