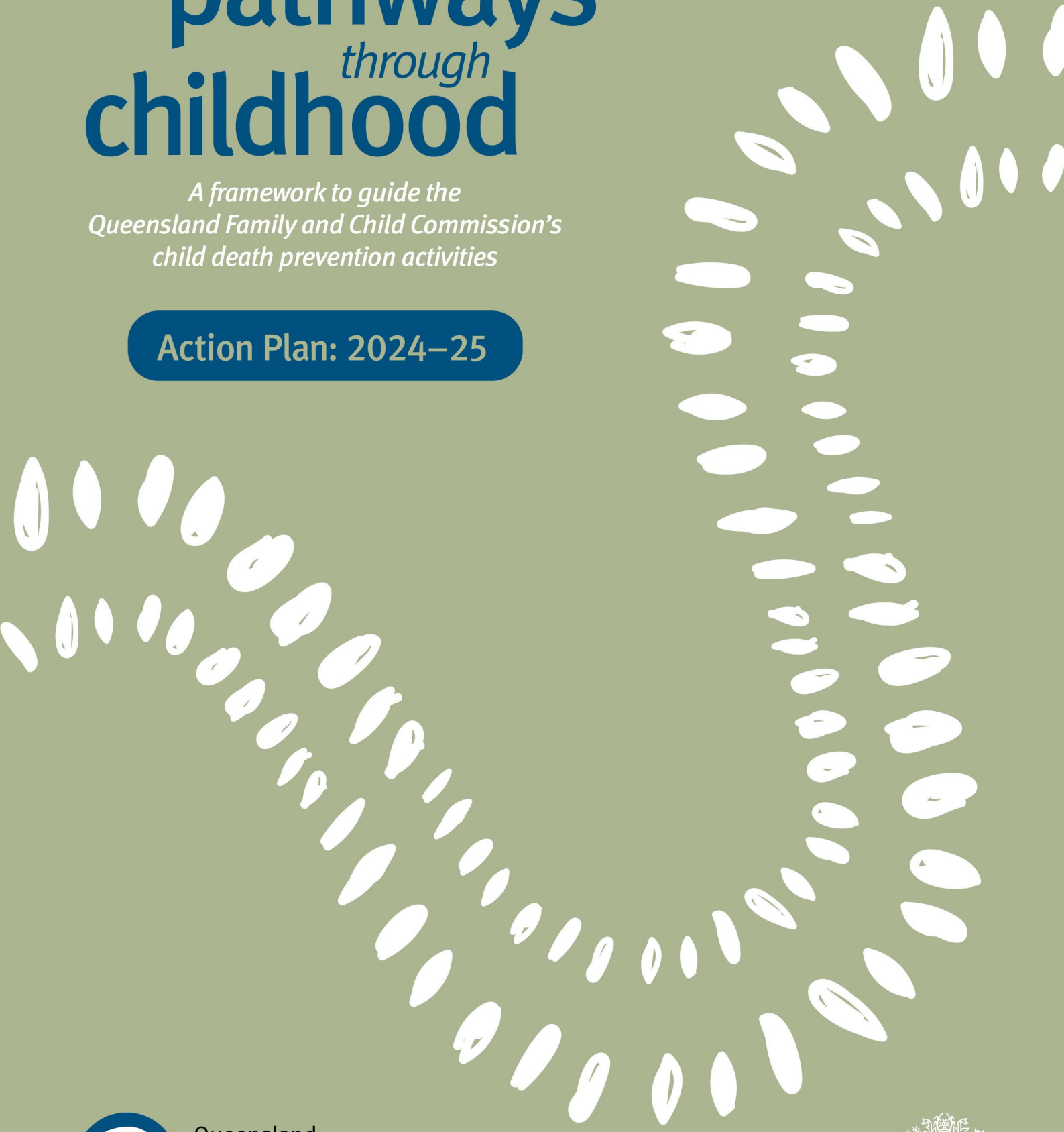
Safer pathways through childhood 2022–2027

A framework to guide the Queensland Family and Child Commission's child death prevention activities

Action Plan: 2024–25



Queensland Family & Child Commission

Queensland Government

A message from the Principal Commissioner

The Queensland Family and Child Commission's ***Safer pathways through childhood*** framework (the Safer pathways framework), sets the direction of our child death prevention functions through to 2027.

All children, irrespective of who they are, the family into which they were born and the community in which they live, should have the same opportunities to reach their full potential, including access to quality healthcare, education, and other social services. The socio-ecological model that informs our child death prevention work allows us to understand the complex interplay of individual, interpersonal (family and peers), community and societal factors that put children at risk of death from preventable causes. Prevention efforts must therefore influence factors in a child's social networks and local community, as well as the policies, systems, and institutions that impact on children's safety, education, health, and wellbeing.

In the first two years of the Safer pathways framework, we have undertaken a range of initiatives aimed at generating new findings in relation to preventable child deaths in Queensland and increasing our capacity to undertake more complex work in the future. This has included:

- a regional analysis of drowning and near-drowning incidents in backyard swimming pools identifying critical compliance issues with pool fencing regulations
- ground-breaking research (undertaken in partnership with Children's Health Queensland) to identify the true incidence of paediatric sepsis deaths in both hospital and community settings in Queensland
- an analysis of the use of child restraints in fatal transport incidents
- surveying community members and frontline workers in the child protection and family support sector about the availability and accessibility of youth mental health services across Queensland
- brokering agreements to increase child health data in the Queensland Child Death Register
- contributing to efforts to build a national child death dataset to assist in establishing national rates of child death, including Sudden Unexpected Deaths in Infancy (SUDI) and suicide, which are currently under-reported at a national level
- commencing work to consider our definitions and screening criteria for fatal assault and neglect, to allow the QFCC to more confidently identify deaths in suspicious circumstances and to determine the point at which inadequate supervision becomes supervisory neglect
- commencing work to better conceptualise preventability and adversity among children who die in Queensland
- hosting two child death review and prevention conferences bringing together global experts to deepen our understanding of risk factors around child death and strengthen prevention strategies
- using social media as a critical tool to distribute messages to families about how to reduce the risk of childhood injury and death.

This year we will continue to progress some of these projects and commence a range of new activities. Emerging areas of interest in 2023–24 include unregistered child deaths, trends in childhood suicide over time and the classification of Sudden Unexpected Deaths in infancy (SUDI).

We recognise the incredible benefit in a partnership approach to child death prevention and will continue to work closely with stakeholders to deliver on these focus areas. Together, we can make a real difference in the lives of children and families.

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

The Safer pathways framework

Priority populations

The Safer pathways framework has prioritised activities aimed at producing findings to help identify ways to reduce health inequity among certain groups: children known to statutory systems such as the child protection and youth justice systems, First Nations children, children with disability, children living in remote or low socio-economic areas, and children under 5 years of age. The focus on these groups is evident throughout the projects outlined in each action plan.

Impact areas

There are four main ways our work under Safer pathways makes an impact on reducing child deaths:

1. **Data quality:** We produce high quality data and contribute to improvements in related datasets.
2. **Expertise:** We value specialist knowledge and collaborate with expert stakeholders and the community.
3. **Research into action:** We seek opportunities to use our data and expertise to reduce child deaths.
4. **Continuous improvement:** We monitor data to identify emerging trends, system improvements and effective prevention initiatives.

We achieve these impacts in the context of **collaborative partnerships**.

Focus areas

Our work under the Safer pathways framework aims to contribute to the evidence-base about:

- disadvantage, adversity and social vulnerability
- risk-taking (by both children and parents)
- appropriate supervision across childhood
- help-seeking behaviour and access to services
- reducing risk through design, product safety and regulation
- improving data about First Nations children
- impacts of COVID-19
- youth suicide prevention
- incidence and risk factors for sudden unexpected death in infancy (SUDI)
- preventable mortality.

Third year actions

Continuing projects

Redefining assault and neglect

The need to determine the point at which inadequate supervision becomes neglect such that a child's death should be classified as a maltreatment fatality, prompted us to consider our definitions for fatal assault and neglect more broadly.

There is strong evidence to suggest that the number of children who die from maltreatment-related causes is underestimated in official data.[1][2] We are concerned that, consistent with this international research, some child deaths due to abuse and neglect may be under-captured in the Child Death Register and consequently under-reported in our annual reports and other child death research.

In working towards improved definitions and screening criteria for fatal assault and neglect, in 2023–24, we made enhancements to the Child Death Register, to better capture autopsy findings of unexplained injuries. We also commenced using the TEN-4-FACESp mnemonic, a validated screening tool to assist in distinguishing accidental injury from abuse in young children.[3]

This year, we will bring together an expert working group to develop a comprehensive classification system, with clearly delineated criteria, to identify all child deaths where maltreatment is the most probable cause, as well as those that occur in suspicious

[1]Covington, T, and M Petit. 'Prevention of Child Maltreatment Fatalities'. In *The Children's Bureau: Shaping a Century of Child Welfare Practices, Programs and Policies*, edited by K Briar-Lawson, M McCarthy, and N.S Dickinson, 141–65, 2013.
[2] Australian Institute of Family Studies. 'Child Deaths from Abuse and Neglect', October 2017. https://aifs.gov.au/resources/policy-and-practice-papers/child-deaths-abuse-and-neglect.
[3] Pierce, Mary Clyde, Kim Kaczor, Douglas J. Lorenz, Gina Bertocci, Amanda K. Fingarson, Kathi Makoroff, Rachel P. Berger, et al. 'Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics'. *JAMA Network Open 4*, no. 4 (14 April 2021). https://doi.org/10.1001/jamanetworkopen.2021.5832.

circumstances. A broader, child-centred research classification will better facilitate the identification of factors common to multiple deaths, as well as opportunities for early intervention and prevention.

Sudden unexpected death in infancy (SUDI)

In 2023–24, we planned to use linked perinatal data to consider changes in trends and patterns in SUDI in Queensland. As the Child Death Register does not yet incorporate perinatal data, this project has been reconceptualised.

SUDI shall remain a key focus of our child death prevention work in 2024–25. We will apply an evidence-based classification system to classify recent cases of SUDI according to the likelihood of suffocation. These categories are not intended to, and do not replace official cause-of-death determinations. Rather, they will allow us to better monitor the role of dangerous sleep environments and sleep accidents in SUDI. They also create a valuable tool to identify gaps in investigation and inform risk minimisation strategies.

Preventable mortality

In our first Action Plan, we scoped work to comprehensively determine the range of conditions causing deaths considered to be preventable. This has involved reviewing the international literature and existing standards designed to measure potentially preventable deaths, to determine whether these were sufficiently comprehensive and appropriate for childhood mortality specifically. While injury-related child deaths are commonly considered a major cause of preventable child death,[4] identifying preventable natural causes of death is substantially more complex. This is in part because deaths are typically reported by a single underlying cause. In children with disability, for example, this means the cause of death is often attributed to their disability (i.e. congenital anomalies). This can obscure the contribution of important causes, such as influenza and pneumonia, which in children without disability are frequently considered preventable. Determining how to report on the contribution of both the congenital anomalies and the infection and the extent to which either may be considered preventable is challenging.

There may also be value in categorising deaths to align with the focus of prevention initiatives. Prevention of child deaths from conditions present at birth focuses on primordial and primary prevention including antenatal and perinatal screening, early diagnosis and intervention while the prevention of causes acquired after birth (such as SUDI, injury and infection), focuses more on secondary and tertiary prevention, through environmental change, support for families, and the importance of infant and child health and social care providers in communities.

Conceptual thinking tackling new or under-explored issues takes time and it is important to consult with key stakeholders in these deliberations. In 2024–25 we will engage with clinical advisors with expertise in paediatrics, child mortality review and coding to provide advice regarding alternative and/or complementary approaches to the classification and reporting of child deaths, particularly those due to diseases and morbid conditions (natural cause deaths).

Child car restraints

In late 2023, we commenced a review of the use of car restraints for children aged 0–12 who died while passengers in motor vehicle incidents. This analysis is well underway and, encouragingly, preliminary data shows a reduction in fatalities and a corresponding increase in the use of restraints over time. However, socioeconomic, geographic and racial disparities are evident. The final analysis will consider the type of restraint, how it was used, and the child's seating position within the vehicle. Over the coming year, we will work with stakeholders to highlight data gaps and increase understanding about the factors that impact safe use of child restraints in vehicles.

Data linkage

Data linkage is a valuable way to enhance data in the Child Death Register, increasing its utility for informing child death prevention research and policy development. Our work to identify and report on all cases of paediatric sepsis in Queensland has highlighted the value of health data linkage in understanding causes and contributing factors to child deaths. Linked

[4] Australian Government (Department of Health and Aged Care). 'National Strategy for Injury Prevention', 15 September 2024. https://www.health.gov.au/our-work/national-strategy-for-injury-prevention.

hospital admission and emergency presentation data resulted in a near 32 per cent increase in the number of sepsis deaths identified and highlighted the under recording of sepsis on death certificates, leading to practice improvement recommendations in this area.

In 2023–24 we linked the Queensland Child Death Register with Queensland Health's Master Linkage File, to enable additional data to be collected on each child from different service settings such as antenatal and birthing services, hospital admissions and emergency department presentations. We will continue our data linkage work in 2024–25, exploring new partnerships that can help increase understanding of preventable child deaths. This will include:

- Queensland Ambulance Service data for unexpected deaths occurring in the community, including prior ambulance callouts for children who have died by suicide and for households in which an injury-related or unexplained child death has occurred.
- Exploring opportunities to access Education Queensland data for children attending state schools who died by suicide.

Discovery pieces for 2024–25

Unregistered child deaths

Article 7 of the United Nations Convention on the Rights of the Child notes that a child has a right to have their birth registered immediately after birth, and by extension, a child also has the right to have their death registered immediately after death. We have identified an apparent increasing trend in child deaths that remain unregistered for more than 60 days, a period more than four times the statutory timeframe for death registration. Aboriginal and Torres Strait Islander children appear over-represented in this cohort. This issue compromises the collection of accurate data on child deaths at both a state and national level. Data has been requested from the Registry of Births Deaths and Marriages and Queensland Health to quantify the under registration of child deaths and will be used to better understand the causes of this delay.

Defined scope projects

Youth suicide information paper

We remain concerned about the gradual, but statistically significant rise in youth suicide rates over time. In 2024–25, we will produce a descriptive analysis of trends and risk factors for youth suicide in Queensland in the 20-year period between 2004 and 2023. This will include a regional analysis tailored to Primary Health Network (PHN) regions, to respond to interest from PHNs for regional data, and to identify opportunities to adjust models of care.

This project aligns with ***Every Life: The Queensland Suicide Prevention Plan***, specifically addressing action item 49 to '*consolidate existing data on issues affecting children and young people to identify trends and risk factors and provide timely access to that data to all relevant agencies'*.

Research translation – paediatric sepsis

In late 2022, we partnered with the Queensland Paediatric Sepsis Program (QPSP) (Children's Health Queensland) to undertake Australia's first population-based study to determine the true incidence of child deaths from sepsis.

The ***Queensland Paediatric Sepsis Mortality Study***, identified practice improvements and made recommendations to improve the identification treatment and prevention of childhood sepsis including:

- identifying sepsis and the responsible pathogen on the cause of death certificate
- embedding sepsis red flags into infection *HealthPathways* of Queensland Primary Health Networks
- safety netting for children to highlight signs of deterioration
- improved clinical history gathering during coronial investigations of infection-related deaths
- undertaking culturally safe media campaigns to increase caregiver and community awareness of sepsis symptoms.

Leading government agencies have responded positively to the study and support the practice improvements. Research findings and recommendations do not, by themselves, lead to widespread implementation and positive impacts on health. Rather, findings and recommendations must be translated into practice and policy. Research translation involves researchers and policy makers working together to implement the findings into policy and practice.

In 2023–24 we provided $33,000 research translation funding and a commitment of in-kind support to the QPSP to assist with recommendation implementation. This grant will support the development of localised workflow, education packages and implementation plans, within the 16 Queensland Hospital and Health Services to upskill clinicians on death certification processes if sepsis is a known cause or contributor to death.

In 2024–25 we will coordinate and contribute to the development of novel investigative practices within the Coroners Court of Queensland. We will also contribute to the development of improved death certification practices within Queensland hospitals. The benefit of these collaborative initiatives is expected to be better identification of sepsis in children, including improved death records.

Fulfilling our legislative obligations

In addition to the specific prevention projects outlined in this action plan, in 2024–25 we will continue to fulfil our child death prevention functions under Part 3 of the *Family and Child Commission Act 2014*, including:

- maintaining a register of all child deaths in Queensland
- analysing and reporting on data in the Child Death Register in our **Annual Report: Deaths of children and young people, Queensland**
- responding to stakeholders' request for information and advice to support their prevention initiatives
- providing feedback on policies and programs
- releasing data to child death prevention researchers.

We will also be hosting the chid death review and prevention conference for a third year, as well as contributing towards a national child death data collection.

The QFCC would welcome contacts from researchers and agencies interested in partnering on child death prevention initiatives. To discuss opportunities for collaboration or to make a request for child death information, email **child_death_prevention@qfcc.qld.gov.au**

Child Death Review Board

In addition to our broader child death prevention functions, the QFCC provides secretariat support to the Child Death Review Board (CDRB). The CDRB is an independent board established to carry out system reviews following the deaths of children connected to the child protection system. These reviews identify opportunities to improve the child protection system and prevent future deaths. The CDRB uses agency information, research and data to make system-wide findings and recommendations for systemic improvements to help prevent deaths that may have been avoidable. Information about the CDRB, its reports and research publications is available at: **https://www.cdrb.qld.gov.au/**.

Action Plan: 2024–25

Action	Category of death	Priority population	Focus area	Impact area
Continuing projects				
Redefining assault and neglect • Seek expert advice to identify deaths due to, or suspicious of, assault and neglect, including supervisory neglect	Assault and neglect	All priority population groups	• Building capacity and monitoring trends • Supervision	• Data quality • Fostering expertise • Collaborative partnerships
Sudden unexpected death in infancy • Classify SUDI according to the likelihood of suffocation	SUDI	Children under 5 years	• Building capacity and monitoring trends • Environmental hazards, product safety, regulation	• Continuous improvement • Data quality • Research into action
Preventable childhood mortality • Defining preventable causes of death for children	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Fostering expertise • Continuous improvement • Collaborative partnerships
Child car restraints • Identify trends and patterns in car restraint use and highlight potential data gaps	Transport	All priority population groups	• Building capacity and monitoring trends • Environmental hazards, product safety, regulation	• Data quality • Research into action • Continuous improvement
Data linkage • Link administrative datasets to build the evidence base on precipitating factors to child deaths	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Fostering expertise • Collaborative partnerships
Discovery pieces				
Unregistered child deaths	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Continuous improvements

Action Plan: 2024–25

Action	Category of death	Priority population	Focus area	Impact area
Defined scope projects				
Youth suicide information paper • Identifying trends and risk factors for youth suicide over 20 years	Suicide	All priority population groups (except children under 5)	• Building capacity and monitoring trends • Family level adversity	• Research into action
Research translation – paediatric sepsis • Translating the findings and recommendations of the sepsis study into practice	Natural cause deaths	All priority population groups	• Building capacity and monitoring trends	• Collaborative partnerships • Continuous improvement • Data quality