Annual Report

Deaths of children and young people Queensland 2023–24

Queensland
Family & Child
Commission

Queensland
Government

9 Child death prevention activities

Maintaining the Child Death Register

The QFCC maintains Queensland's Child Death Register in accordance with Part 3 of the *Family and Child Commission Act 2014*, under which it is required to produce an annual report on the deaths of all children in Queensland.

The Child Death Register was established in 2004 and currently contains over 9,000 records that have been classified by cause of death, demographic and incident characteristics. It allows the QFCC to extract information from its 20 years of recorded data, highlighting risk factors and trends that can inform research, support policy improvement and community safety initiatives to help reduce the likelihood of child deaths.

Publications

In March 2024, the *Annual Report: Deaths of children and young people Queensland 2022–23* was tabled in Parliament. This was the 19th annual report to be produced on child deaths in Queensland. The electronic version of the annual report can be accessed on the Queensland Parliament website (authorised version).[90]

Resources associated with the annual report, including the 19-year summary tables, **Appendices B to G**, and fact sheets, can be found at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

The QFCC also published the report ***Australian child death statistics 2021***, prepared on behalf of the members of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). The report is available at **www.qfcc.qld.gov.au/sector/child-death/child-death-statistics-anz**

Australian and New Zealand child death review conference and meeting

On 14 May 2024, the QFCC hosted the ANZCDR&PG conference for the second year. This online conference was a professional development opportunity for the specialist teams in each jurisdiction responsible for child death reviews and registers. The conference attracted over 150 participants from across Australia and New Zealand from child protection, injury prevention, health, coronial and research sectors.

The conference featured subject matter experts from both Australia and internationally presenting on a range of captivating topics:

- Dr Joan Luby MD from the Washington University School of Medicine presented on the Preschool Predictors of Early Adolescent Suicidality.
- Dr Emily Hielscher from the University of Queensland presented a session around the Australia Youth Self-Harm Atlas: Spatial modelling and mapping of self-harm prevalence to inform youth suicide prevention strategies.
- Dr Paula Lister from the Queensland Paediatric Sepsis Program and Dr Rebecca Shipstone from the QFCC shared their research findings and recommendations from the Paediatric Sepsis Mortality Study.
- Dr Sharon Anne McAuley and Jodie Osborne from the Queensland Paediatric Quality Council shared their findings from reviews of serious paediatric clinical incident reports in Queensland.
- Dr Joanna Garstang from the National Health Service in the United Kingdom presented on the use of genome testing in child death review and prevention.
- Converge Internation ran an interactive session on vicarious trauma in the workplace for the participants.
- Colleagues from New Zealand, Kiri Matiatos (Family Violence Mortality Review) and Dr Gabrielle McDonald from Otago University presented on New Zealand's response to survivors of family violence homicide and the machinery of child death prevention, best practice for recommendations to be implemented respectively.

Session recordings can be found here: **https://www.qfcc.qld.gov.au/events/2024/ANZCDRPG-Conference**

90 **www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/Online-Tabled-Papers**

On 21 May 2024, representatives from child death review teams from each state and territory across Australia met for the annual meeting of the ANZCDR&PG, to share experiences, practices, barriers and priorities in relation to child death review and prevention. The group discussed a range of emerging issues including peer homicide, asthma deaths, suicide risk factors, malnutrition and neglect. One of the key focus areas for the group is the development of a national dataset to strengthen child death and injury prevention and research to inform practice and policy.

QFCC submissions

Two significant outcomes have been achieved in the last year in areas of QFCC's advocacy on product safety.

The Australian Competition and Consumer Commission (ACCC) established new national safety and information standards for infant sleep products. These standards cover both sleep and inclined non-sleep products, aiming to reduce the risks of death and injury to infants. The QFCC has been involved in collaborative advocacy efforts and has, over the past 4 years, made 2 relevant submissions to the ACCC during their inquiry stage and provided child death data on 3 occasions.

A new mandatory information standard to increase awareness of the dangers of toppling furniture has also been introduced by the ACCC. Under the standard, furniture suppliers will be required to provide safety warnings to consumers about the dangers of toppling furniture hazards. The QFCC has previously advocated for the introduction of safety and information standards to the ACCC and, in relation to rental reforms in Queensland, for renters to be able to install safety features such as those used to anchor furniture to prevent toppling.

Supporting youth suicide prevention

The QFCC continued to monitor and support prevention of suicide deaths of children and young people. This included a crucial information sharing process with the Department of Education to inform student wellbeing policy development and support suicide postvention in affected schools. The QFCC contributed to suicide prevention by:

- increasing awareness across government of trends in suicide numbers
- reporting on situational circumstances and risk factors affecting young people
- providing suicide data to government agencies to support development of mental health and wellbeing initiatives, including through the Queensland Government implementation plan for *Shifting minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023–2028* (*Shifting minds*), which is led by the Queensland Mental Health Commission.

Researcher access to child death data

A key strategy to support child death and injury prevention is to make data held in the Child Death Register available for research, public education, policy development and program design. Data from the comprehensive dataset is available at no cost to genuine researchers.[91] Applications to obtain data can be made by emailing **child_death_prevention@qfcc.qld.gov.au**

In 2023–24, the QFCC responded to 25 external requests for Child Death Register data. Data provided to genuine researchers may be either aggregated or presented as confidential unit records. Table 9.1 gives an overview of the key projects and agencies for which data was provided.

91 Under section 28 of the FCC Act, the QFCC is able to provide child death information for genuine research, defined as research relating to childhood mortality or morbidity with a view to increasing knowledge of incidence, causes and risk factors relating to same. Genuine research includes policy and program initiatives to reduce child death or injury.

Table 9.1: Child death data requests by agency and purpose, 2024–25

Type of data	Requesting agency	Purpose
All deaths	Department of Education	Background for consideration of funding additional supports to pregnant or parenting students in state school communities
	Queensland Civil and Administrative Tribunal	Notice to Produce information on deaths of children where the child had spent time in a watchhouse
	Request for information (RTI)	Respond to RTI seeking information on deaths of children where the child had spent time in a watchhouse
Children known to the child protection system	Coroners Court of Queensland	Confirm child protection status in relation to coronial case investigation
	Queensland Child Death Review Board	Provide child death and coronial information required to undertake case reviews
Diseases and morbid conditions	Centre for Children's Health Research	Scope opportunities to share data between the Child Death Register and the Paediatric Diabetes Registry
	Children and Young People Death Review Committee ACT	Report on the prevalence of deaths attributed to respiratory diseases and influenza across the states and territories
	Children's Health Queensland	Investigation of the incidence of, and factors associated with, child deaths due to sepsis in Queensland (collaborative project with QFCC)
Drowning	Royal Life Saving Society Australia	Inform the National Drowning Report and drowning prevention research and advocacy
Fatal assault and neglect	Queensland Police Service (QPS)	Comparison of QFCC data and QPS statistics to ensure all relevant incidents have been captured
	Courier Mail	Filicide data as background for media article
Interstate residents	Children and Young People Death Review Committee ACT	Australian Capital Territory reporting on deaths of residents in other jurisdictions
	Child Death Review and Prevention Committee NT	Northern Territory reporting on deaths of residents in other jurisdictions
	Child Death and Serious Injury Review Committee SA	South Australian reporting on deaths of residents in other jurisdictions

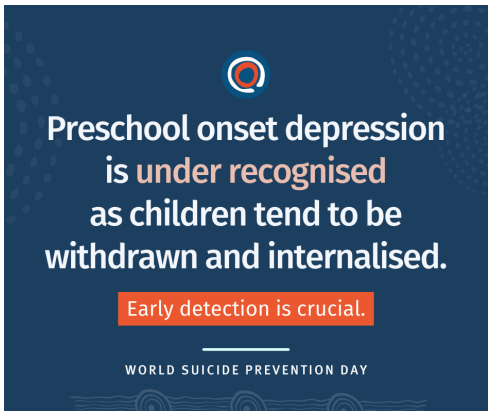
Table 9.1: Child death data requests by agency and purpose, 2024–25 *(continued)*

Type of data	Requesting agency	Purpose
Non-intentional injury	Queensland Injury Surveillance Unit	Inform coronial investigation into caustic ingestion injuries and consideration of regulating dangerous household products
	Queensland Injury Surveillance Unit	Identify potential hazards in infant sleep devices to inform consideration of the Australian cot and portacot standard
	Queensland Injury Surveillance Unit	Identify potential hazards in child and infant clothing to inform discussion on industry best practice guides
Suicide	Department of Child Safety, Seniors and Disability Services	Confirming details of suicide deaths of children who were known to the child protection system
	The Guardian	Enquiring if there is evidence of a suicide cluster in a region
Transport	ABC Sunshine Coast	Low speed run over data as background for media article

Notes: Not all requests are shown.

Prevention messaging

The QFCC uses its social media channels to raise awareness of child safety hazards and prevention messages. During 2023–24 the QFCC promoted prevention messaging via social media across a range of topics including: road safety, sepsis awareness, access to mental health services, suicide prevention, button battery safety, and water safety.



Participation in state and national advisory groups

QFCC officers participated in the following advisory bodies during 2023–24:

- Australian and New Zealand Child Death Review and Prevention Group
- Australian National Child Death Data Collection Working Group
- Consumer Product Injury Research Advisory Group
- Queensland Government Suicide Prevention Network
- Suicide Prevention Oversight Group
- Queensland Paediatric Quality Council (QPQC) Infant Mortality Sub-Committee
- QPQC Steering Committee
- QPQC genetic working group
- Queensland Government Births and Deaths Working Group
- Road Safety Research Network.

Safer pathways through childhood: Actions in 2023–24

The ***Safer pathways through childhood framework*** provides a roadmap for the QFCC's child death prevention activities over the period 2022–27. Each year the QFCC publishes its action plan of specific prevention activities to address priority areas in the coming year. The Safer pathways through childhood framework, annual action plans, and published reports, ***Swimming pool immersions of young children*** and ***Queensland paediatric sepsis mortality study***, can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

Progress on activities during 2023–24 is summarised in the Action plan for 2024–25. This includes the following new and continuing projects: redefining fatal assault and neglect, preventable childhood mortality, child car seat restraints, and data linkage.

Queensland paediatric sepsis mortality study

In February 2024, the QFCC released the **Queensland paediatric sepsis mortality study** (the study). Completed in partnership with the Queensland Paediatric Sepsis Program (QPSP), the study is an Australian first, and possibly the first of its kind globally. Its aim was to identify every sepsis-related child death that occurred in Queensland between 2004 and 2021 in hospitals, at home or in the community to better understand the true incidence of childhood sepsis and to find opportunities to better identify, treat and prevent it.

The study found that children from disadvantaged socio-economic backgrounds, those living in remote and very remote areas, and First Nations children were overrepresented in the deaths. Several recommendations for practice improvements were made 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 media campaign to increase caregiver and community awareness of sepsis symptoms.

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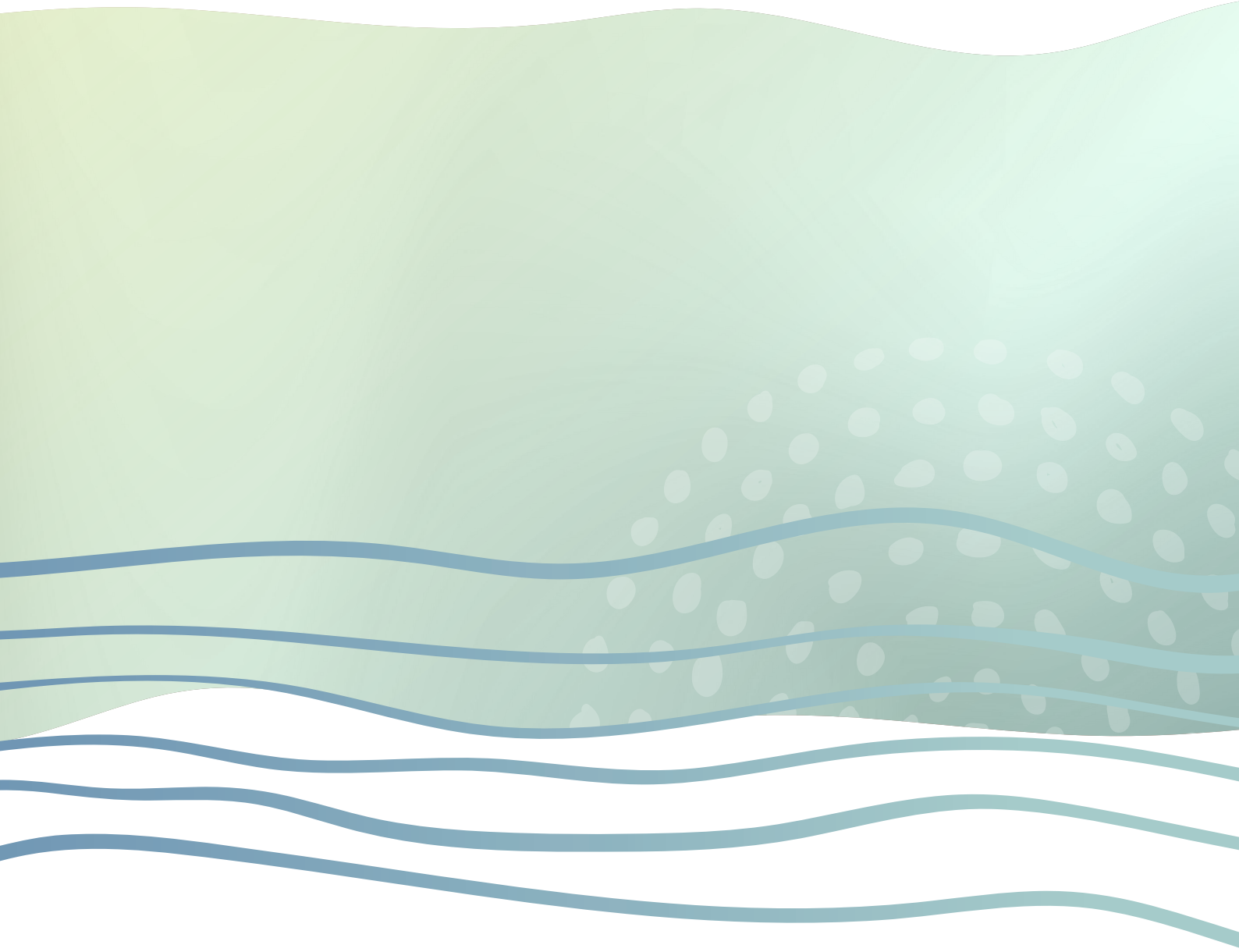
Safer pathways through childhood: Actions in 2023–24 *(continued)*

Lead government agencies have responded positively to these recommendations, and an implementation plan has been developed specifying the high-level actions, coordinating agency, and resourcing required to implement change.

The QFCC is working collaboratively with the QPSP, the Queensland Paediatric Quality Council (QPQC), coroners, forensic pathologists, and coronial nurses to develop a child and family health questionnaire to be used to gather more detailed clinical history in suspected infection-related child deaths, including underlying medical conditions, vaccination history, and touchpoints with health services in the lead up to death. This will be trialled by coronial nurses during 2024–25.

In a further action, the QPSP is developing 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. The benefit of this initiative is expected to be better identification of sepsis in children, including improved death records.



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