

Executive summary

Background

The Commission for Children and Young People and Child Guardian is an independent statutory body charged with the responsibility for protecting and promoting the rights, interests and wellbeing of Queensland children and young people under the age of 18.

The Commission's child death review function began on 1 August 2004. Under Part 4A – Child Deaths – of the *Commission for Children and Young People and Child Guardian Act 2000*, the Commission is responsible for:

- maintaining a register of the deaths of all children and young people in Queensland
- reviewing the causes and patterns of deaths of children and young people
- conducting broad research in relation to child deaths
- making recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child deaths, and
- preparing an annual report to Parliament and the public regarding child deaths.

This is the Commission's inaugural annual report analysing the deaths of Queensland children and young people registered in the 18 month period from 1 January 2004 to 30 June 2005.

The report is structured as follows:

Chapter 1 provides an historical overview of child death reviews. It describes the history behind the establishment of the Commission's child death review functions together with a detailed description of the child death review functions in other Australian states and internationally. This chapter highlights the value of child death review teams which systematically collate data about the causes and circumstances of child deaths in an effort to identify and remove risk factors for deaths that may have been preventable.

Chapter 2 provides an overview of trends and patterns of the deaths of Queensland children and young people for the 13 year period from 1 January 1991 to 30 December 2003. It contains a summary of all causes of death of children from birth to 17 years as well as a detailed analysis of external causes of death and sudden infant death syndrome. The analysis in this chapter is a secondary data analysis based on the registered cause of death and International Classification of Diseases (ICD) coding only.

Chapter 3 outlines the processes used by the Commission to maintain the child death register as well as the methodology for analysing the data in the register for this report.

Chapters 4 provides a summary of the causes of deaths of Queensland children aged from birth to 17 years registered in the 18 month period from 1 January 2004 to 30 June 2005.

Chapters 5 to 10 provide detailed literature reviews and analyses of the following external causes of death of Queensland children and young people in the 18 month period examined: transport, drowning, suicide, accidental, fatal assault and fire. A summary of the key findings from each chapter is presented below.

Chapter 11 contains an extensive literature review on Sudden Unexpected Deaths in Infancy (SUDIs) and the risk factors associated with sudden infant death syndrome and sleeping practices of infants. All SUDIs that occurred during the reporting period are examined in this chapter.

Child deaths in Queensland January 2004 – June 2005

Overview

In the 18 month period from 1 January 2004 to 30 June 2005, the deaths of 693 children were registered in Queensland. Of those, 409 were male (59.0%) and 284 were female (41.0%).

- Infants under one accounted for 432 deaths; more than half (70.8%) of those deaths occurred within the first 28 days of life.

- Children aged one to four years had the second highest number of deaths (93 deaths); transport accidents were the leading cause of death, followed by drowning.
- Children aged five to nine years accounted for 45 deaths, mostly from natural causes.
- Children aged 10 to 14 years accounted for 48 deaths; suicide was the leading cause of death for children in this age group.
- Adolescents aged 15 to 17 years accounted for 75 deaths; 34 of those deaths were the result of transport accidents.

Transport

- Transport accidents was the leading external cause of death (70 deaths) and the most common cause of death for both adolescents aged 15 to 17 years (60.7%) and toddlers aged one to four years (41.7%).
- The greatest number of transport fatalities occurred in motor vehicles (40 deaths) followed by pedestrian deaths (14 deaths).
- Eight pedestrian deaths were low speed (driveway) run-overs involving children under the age of four years.
- Four of the transport fatalities involved all terrain vehicles (ATVs) ridden by very young children, including two children aged four years.
- The Commission has undertaken a review of the literature and made recommendations in relation to low speed run-overs of toddlers and the risks to children associated with ATVs.

Drowning

- Twenty children and young people drowned.
- Drowning accounted for the second highest number of external deaths of children aged one to four years, after transport fatalities.
- The majority of drowning related incidents occurred in domestic swimming pools.
- After swimming pools the most common place for drowning was dams and other rural hazards (such as culverts and water troughs).
- In most cases the child fell or wandered into the water.
- Lack of supervision and/or adequate fencing was a factor in most drowning fatalities.

- The Commission has undertaken a review of the literature and made a recommendation about the risks to children posed by dams and other rural water hazards.

Suicide

- Nineteen children and young people were suspected of committing suicide.
- Suicide accounted for the highest number of external deaths of children aged 10 to 14 years and the second highest, after transport fatalities, for children aged 15 to 17 years.
- Aboriginal and Torres Strait Islander children and young people accounted for 31.6% of all suicides.
- The young age of children taking their own lives is of particular concern.
- The Commission intends to liaise with key agencies in 2005–06 regarding current strategies to prevent childhood suicide.

Accidental

- Nineteen children and young people died in an accident.
- Accidental deaths accounted for 13.0% of all external deaths of children and young people in Queensland.
- Children aged one to four years and young people aged 15 to 17 years each accounted for 31.6% of accidental deaths.
- Causes of accidental death included falls, poisoning, strangulation, suffocation and choking and being struck by a falling object.

Fatal assault

- Thirteen children and young people died as a result of fatal assault.
- Fatal assault accounted for 8.9% of deaths from external causes.
- The incidence of fatal assault was highest among infants and very young children and adolescents.
- Domestic homicides and teen fatal assaults were the two most common categories of assault.
- Children and young people with a history of child protection concerns were over-represented in fatal assaults.
- The Commission is planning to undertake an in-depth study of fatal assault and neglect of children and young people in Queensland.

Fire

- Five children and young people died in four residential house fires.
- Fire deaths represented 3.4% of all external deaths.
- All children who died were aged between one and four years.
- Four of the five children were of Aboriginal and/or Torres Strait Islander origin.
- At least three of the homes were not fitted with smoke alarms.
- The absence of smoke alarms highlights the importance of Department of Emergency Services, Queensland Fire and Rescue Service initiatives to increase community awareness about fire safety.

Sudden unexpected deaths in infancy

- Sudden and unexpected deaths in infancy (SUDI) is defined as deaths of infants under one year of age, with no immediately obvious cause.
- SUDIs accounted for 63 deaths of infants in the 18 month period.
- The cause of death for 21 cases of SUDI was certified as sudden infant death syndrome (SIDS) and five were certified as undetermined.
- In 21 of the 49 cases of SUDI (excluding those later found to be due to natural causes) the infant was sharing a sleeping surface with another person at the time of death.
- Aboriginal and Torres Strait Islander infants were significantly over-represented in SUDIs, dying at a rate five times greater than non-Indigenous infants.
- The Commission has undertaken an extensive review of the literature and made recommendations about the risk factors for SIDS and the sleeping practices of infants.

Summary of recommendations

Chapter 5: Transport: low speed (driveway) run-over deaths and injuries of children

The Commission recommends that the Premier request that the Parliamentary Travelsafe Committee investigate and report on ways to reduce fatalities and injuries to children from low speed driveway run-overs in Queensland.

Reason: *Queensland reportedly has a significantly higher rate of low speed run-overs than the rest of Australia. A lead agency needs to take responsibility for initiatives to prevent these fatalities on private properties. A detailed investigation and analysis of the most appropriate strategies for preventing these fatalities in Queensland is also required.*

Chapter 5: Transport: deaths and injuries caused all terrain vehicles and Chapter 6: Drowning: deaths and injuries caused by dams and other rural hazards

The Commission recommends that the Queensland Government notes the research findings about the risks to children and young people posed by all terrain vehicles (ATVs), dams and other rural hazards as well as the Commission's intention to engage with key agencies to:

- encourage agencies to explore options and strategies to assist the rural sector identify and address the risks to children and young people posed by rural hazards, and
- report, in 2005–06, on the strategies identified and outcomes achieved.

Reason: *The Commission is concerned about the deaths and injuries to children and young people from ATVs, dams and other rural hazards and believes risk factors can be reduced or eliminated.*

Chapter 11: Sudden unexpected deaths in infancy

The Commission recommends that Queensland Health develop and implement a State wide policy, to be followed by all relevant staff including midwives and health workers, in relation to information provided to new and expectant parents about safe sleeping practices (such as the UNICEF UK Baby Friendly Initiative).

Reason: Health professionals are in a strong position to educate, promote and influence safe sleeping practices to parents.

Following the development of the above policy, it is also recommended that Queensland Health:

- develop a training package in relation to the policy, and
- develop culturally appropriate materials and communication strategies that convey consistent and appropriate messages about safe sleeping messages to all new and expectant parents, particularly those at high risk.

Reason: To ensure consistent messages are being communicated by Queensland Health staff, particularly to parents of high risk infants.

Future directions

In 2005–06 the Commission will work on its second annual report on the trends and patterns of the deaths of Queensland’s children and young people and will monitor the implementation of this year’s recommendations. In addition, the Commission will begin research into those causes of child deaths that it has identified as key areas needing further investigation, including fatal assault and neglect of children, childhood suicide and the risks associated with ATVs, dams and other rural hazards.

Implementation of recommendations

In 2005–06, the Commission will monitor the implementation of the recommendations in this report in accordance with the *Commission for Children and Young People and Child Guardian Act*. The Commission will ask all relevant agencies to provide progress reports on the extent to which recommendations have been implemented, as well as strategies and timeframes for continued implementation and reasons for any alternative action or non-implementation.

Liaison with stakeholders

The Commission acknowledges the need to engage with a range of stakeholders and to remain abreast of emerging research, policies and procedures focused on preventing deaths and injuries of children and young people and Queenslanders generally. This year the Commission has established key contacts within government and non-government agencies and recognises the importance of ongoing information exchange.

In 2004–05 the Commission identified a wide-range of Queensland based initiatives that aim to improve the lives of children and young people. In the year ahead the Commission will work collaboratively with the agencies responsible for these initiatives.