

8 Deaths

Key messages

Mortality rates for children and young people are generally declining, although the mortality rate for 15–17 year olds is showing an increasing trend. Mortality rates for children aged 1–4 years old increased in the 2006–2008 period.

Mortality rates for Aboriginal and Torres Strait Islander children and young people are much higher than in the general population and the number of Indigenous deaths is probably higher than the available data indicate.

External causes of death (such as transport incidents, drowning, suicide and assault) are a major cause of death, particularly among 15–17 year olds. More than two-thirds of deaths in this age group were due to external causes.

Drowning is still a major cause of death among children under 5 years of age. Eight 1–4 year olds died from drowning in 2008. A swimming pool safety review is currently being undertaken by the Queensland Government to improve safety for all children.

Improvements

Mortality rates are continuing to decline for neonatal and post-neonatal infants. However, sudden infant death syndrome (SIDS) is still a leading cause of death for infants in their first year of life. Resources identifying safe sleeping practices and risk factors for SIDS have recently been developed and delivered to parents and health professionals in a bid to further reduce the mortality rates.

Areas of concern

Although mortality rates for children and young people are generally declining, the mortality rate for 15–17 year olds continues to increase. Deaths among young people in this age group are largely due to transport incidents and suicides, and as such are potentially preventable.

The rate of deaths due to transport incidents increased in 2006–2008. This was the leading cause of death for children and young people aged 10–14 years and 15–17 years, and was the second leading cause for 1–4 year olds and 5–9 year olds. One-quarter of all deaths of 1–17 year olds were due to transport incidents. Recent changes to licensing laws for young drivers are aimed at reducing the high incidence of transport-related deaths among young people.

The infant mortality rate for Indigenous babies in Queensland is almost twice the state rate. In addition, Aboriginal and Torres Strait Islander young people are over-represented in suicide deaths, with the Indigenous suicide rate almost seven times the non-Indigenous rate for the most recent period.

The Commission's Child Death Review functions

Since 1 August 2004 the Commission has been required, under Part 4A – Child deaths – of the *Commission for Children and Young People and Child Guardian Act 2000*, to:

- maintain a register of the deaths of all children and young people in Queensland (starting from 1 January 2001)
- review the causes and patterns of deaths of children and young people
- conduct broad research in relation to child deaths
- make recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child death, and
- prepare an annual report to Parliament and the public regarding child deaths.

Detailed analyses of the deaths of all Queensland children and young people since 1 January 2004 are contained in the Commission's *Child Death Annual Report* series.

The Commission's fifth annual report analysing deaths in the period 2008–09 is scheduled for release in November 2009.

Methodology and data limitations

The number of deaths of children and young people in Queensland each year is relatively small. As a result, year-to-year variations in numbers can cause large changes in mortality rates, which means that these rates are not necessarily a good indication of changing trends. For this reason, mortality rates reported in this chapter are rolling averages – that is, they are based on annual rates averaged over three years. For example, mortality rates for 2006–2008 are average rates from the years 2006, 2007 and 2008.

Data regarding the number of live births in Queensland in 2008 had not been released at the time of publication of this report. As a result, all infant mortality rates (including neonatal, post-neonatal and SIDS deaths) are reported up to and including 2007. Deaths of children over the age of 1 are reported up to and including 2008.

Information on cause of death included in this report is obtained from two main sources. Analyses of longer-term trends are based on the Australian Bureau of Statistics (ABS) Deaths Collection, as provided by the Office of Economic and Statistical Research (OESR). Information on deaths from 2004 onwards is based on the Queensland Child Death Register maintained by the Commission.

The Commission's child death data differ in some significant respects from the ABS Deaths Collection data. Although both collections use the International Classification of Diseases, tenth revision (ICD-10) to classify cause of death, differences can be found in the classification of cause of death because of differences in the amount of information available to each agency at the time of reporting. For example, the Commission specifically requests updated cause of death from the Registry of Births, Deaths and Marriages, which incorporates any subsequently obtained information from autopsy certificates or coronial findings. However, updates on cause of death may not be available to agencies such as the ABS and the OESR if the update occurred after the date of data transfer.

The Commission also recognises that ICD-10 carries inherent limitations. The classification is used to group conditions, diseases, external causes and health-related problems into homogeneous groups to assist with statistical collection and analysis of health information. In the process of grouping and classifying using ICD-10, various specificities in cause or circumstances of death that are of research interest are missed. To help overcome the limitations of ICD-10, the Commission also classifies deaths according to their circumstances, based on the information contained in the Police Report of Death to a Coroner.

These "research categories" classify deaths as being the result of transport incidents, drowning, fire, other non-intentional injury-related deaths,²¹ suicide or fatal assault. Discrepancies may exist between these categorisations and those reflected by ICD-10 coding alone. To avoid confusion, the Commission reports according to research category where one exists. Deaths due to natural causes (that is, diseases and morbid conditions) are reported by ICD-10 chapter level.

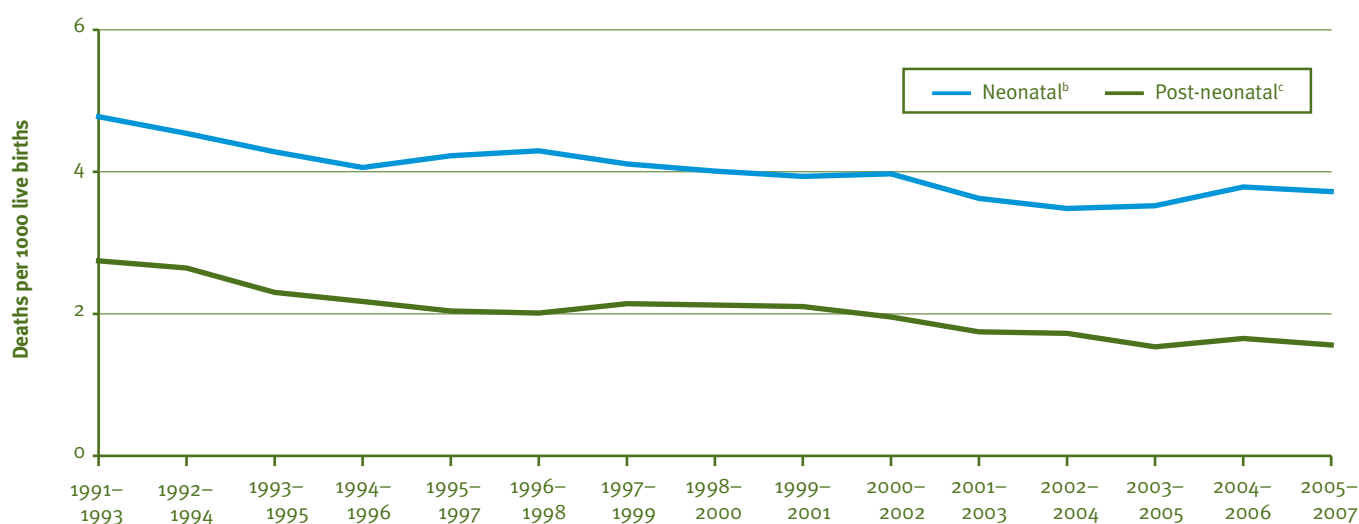
Further, in the case of youth suicide, ICD-10 coding practice requires a high standard of proof for a suicide to be coded as such. In the absence of a clear statement of intent before the child's death, or in cases where coroners do not specify that the death was self-inflicted, deaths are coded as accidents when they would ordinarily be categorised as suicides in clinical or research situations. The Commission therefore endeavours to reduce the likelihood of suicides being undercounted by classifying all cases where police have indicated that the death is a suspected suicide in the research category "suicide".

Trends in deaths of children and young people from 1991 to 2008

Neonatal and post-neonatal mortality

The rate of death under 4 weeks of age (neonatal deaths) of Queensland babies has decreased in the last 15 years, from 4.8 deaths per 1000 live births per year in 1991–1993 to 3.7 in 2005–2007 (Figure 8.1). Post-neonatal mortality (between 4 weeks and under 1 year of age) has also decreased, from 2.8 deaths per 1000 live births in 1991–1993 to 1.6 in 2005–2007.

Figure 8.1 Neonatal and post-neonatal mortality rate,^a Queensland, 1991–1993 to 2005–2007



Note: Years stated refers to three-year rolling averages at year's end.

a. Per 1000 live births.

b. Under 4 weeks of age.

c. Between 4 weeks and under one year of age.

Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Births, Australia, 2007*, cat. no. 3301.0

²¹ This category includes falls; strangulation, suffocation and choking; poisoning; exposure to electrical current; and "other".

Infant mortality

The infant mortality rate (the rate of death within the first year of life) has been generally declining in Queensland (Figure 8.2), falling from 7.5 deaths per 1000 live births in 1991–1993 to 5.3 deaths per 1000 in 2005–2007.

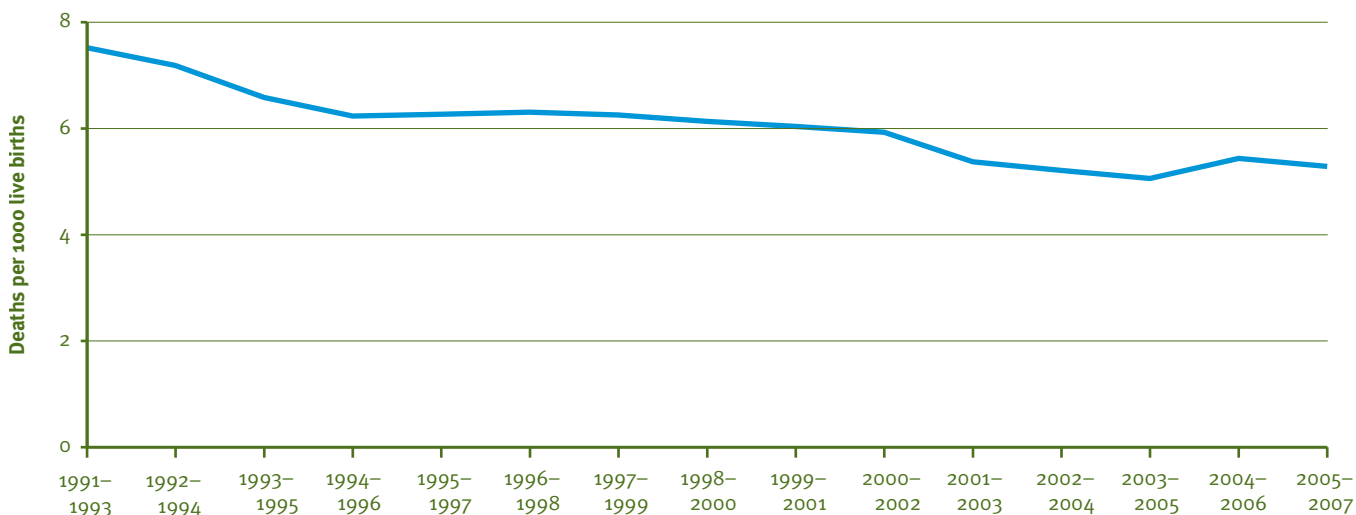
Mortality trends for 1–17 year olds

Mortality rates for children and young people have generally decreased in the last 17 years (Figure 8.3). Of those aged 1–17 years, mortality rates were highest for 15–17 year olds

(35.4 deaths per 100,000 per year in 2006–2008) and 1–4 year olds (28.6 per 100,000), compared with children aged 5–9 years (11.2 per 100,000) and 10–14 years (10.3 per 100,000).

Of concern, mortality rates for 15–17 year olds in Queensland have been increasing for the past three reporting periods (that is, since 2003–2005). The high incidence of transport incidents and suicides in this age group has contributed to the high rates of mortality.

Figure 8.2 Infant mortality rate,^a Queensland, 1991–1993 to 2005–2007

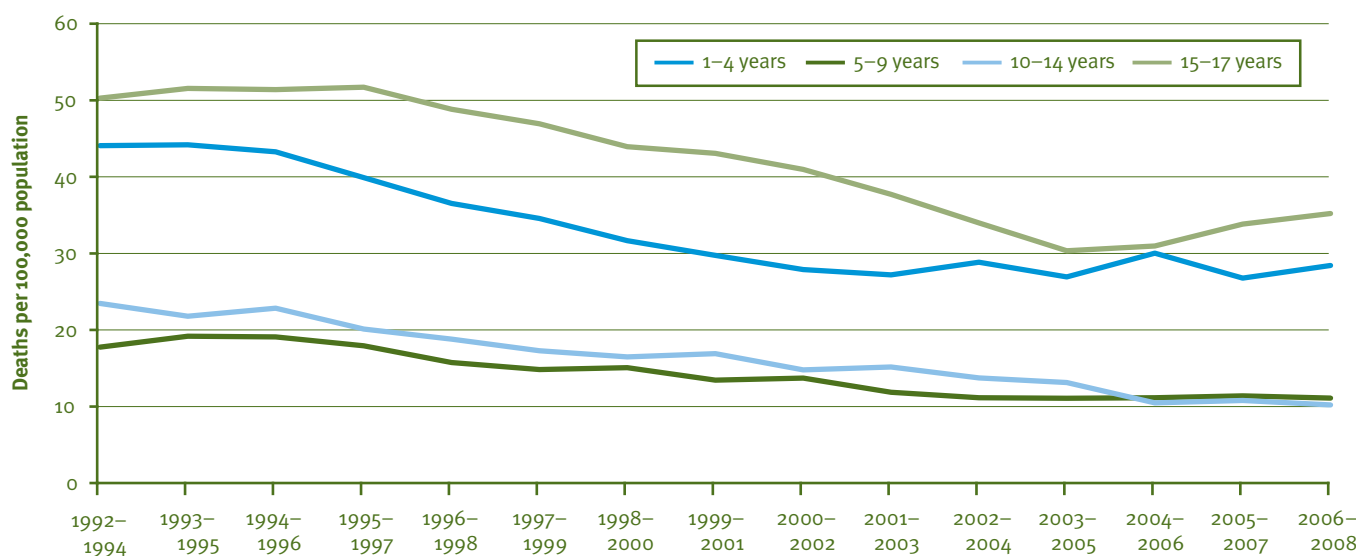


Note: Years stated refer to three-year rolling averages at year's end.

a. Deaths in the first year of life per 1000 live births.

Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Births, Australia, 2007*, cat. no. 3301.0

Figure 8.3 Mortality rate^a by age, Queensland, 1992–1994 to 2006–2008



Note: Years stated refer to three-year rolling averages at year's end.

a. Deaths per 100,000 population in age group.

Source: OESR, *Deaths Collection* (for deaths in the years to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex, Australia*, cat. no. 3201.0

Mortality – Aboriginal and Torres Strait Islander children and young people

Information on Indigenous status on birth and death registrations was introduced in Queensland in 1996. Although the identification of the deaths of Aboriginal and Torres Strait Islander people has improved considerably in recent years, it is not known how many Indigenous deaths are not identified. Therefore, the number of deaths registered as Aboriginal or Torres Strait Islander in a given year is expected to be an undercount of the actual number of Indigenous deaths. Between 2002 and 2006, coverage of Indigenous deaths in Queensland was estimated by the ABS to be only 51% (Australian Bureau of Statistics, 2007e). However, a Census Data Enhancement Indigenous Mortality Quality Study, which linked Census records with death registration data, revealed that the rate of coverage could be up to 87% in Queensland, although the report also noted that coverage for deaths of young Indigenous people was likely to be significantly lower (Australian Bureau of Statistics, 2008h).

Between 1996 and 2003, the deaths of 3902 children and young people were registered in Queensland. The data provided to the Commission identify only 7.2% ($n = 281$) of these children as Indigenous (Queensland Child Death Register). This figure represents significant under-reporting of Indigenous child mortality. In contrast, between 2006 and 2008, 11.9% ($n = 173$) of the 1459 child deaths registered in Queensland were identified as Indigenous. Although this figure is also likely to be an undercount of the total number of Indigenous child deaths occurring in the period, it demonstrates a progressive improvement in the recording of Indigenous status in official sources.

Because of the problems surrounding Indigenous identification, it is difficult to conduct trend analyses over time using data on Indigenous births and deaths. Although estimates and projections do exist, producing trends that can be reliably compared with the general population is problematic. Because of this limitation, key statistics on Indigenous mortality from other data sources have been included in this section.

The Queensland infant mortality rate for Indigenous infants is around twice the rate for all infants, with 9.7 Indigenous infants dying per 1000 live births in 2005–2007, compared with a Queensland rate of 5.3 infant deaths. Although still of serious concern, the gap between Indigenous and non-Indigenous infant mortality appears to be closing somewhat.

A Queensland Health analysis of perinatal deaths highlighted risk factors for Indigenous perinatal mortality (Queensland Health – Health Information Centre, 2004). Low birthweight caused by factors such as pre-term birth and intra-uterine growth retardation is a major determinant of perinatal deaths. The risk factors for low birthweight and pre-term births – cigarette smoking, genito-urinary tract infections, poor nutrition and psychosocial stress related to economic disadvantage – are consistently shown to be more prevalent in Indigenous mothers.

In general, Indigenous children of all age groups experienced higher rates of mortality than other Australian children, dying at a rate 2–3 times that of non-Indigenous children (Australian Institute of Health and Welfare, 2005; Australian Bureau of Statistics, 2007e).

Leading causes of death, 2006–2008

Table 8.1 shows the leading causes of death for each age group between 2006 and 2008.

The leading causes of death for infants in the neonatal period (the first 4 weeks of life) were certain conditions originating in the perinatal period²² ($n = 391$, 65.1% of deaths within the age group) and congenital malformations, deformations and chromosomal abnormalities²³ ($n = 188$, 30.3%).

For post-neonatal infants (aged between 4 weeks and under 1 year), the leading causes of death were SIDS and undetermined causes ($n = 59$, 20.7%) and conditions originating in the perinatal period ($n = 56$, 19.7%).

Young children aged 1–4 years died most frequently from drowning ($n = 32$, 17.4%), transport incidents ($n = 24$, 13.0%) and congenital malformations, deformations and chromosomal abnormalities ($n = 21$, 11.4%).

Children aged 5–9 years most often died from neoplasms ($n = 22$, 23.7%) and transport incidents ($n = 18$, 19.4%).

The leading causes of death for children aged 10–14 years were transport incidents ($n = 27$, 29.3%) and neoplasms ($n = 15$, 16.3%), while 15–17 year olds died most often from transport incidents ($n = 69$, 37.3%) and suicide ($n = 46$, 24.9%).

SIDS and undetermined causes of death

In this section, the information available relates to registered infant deaths (aged under 1 year) classified as SIDS (ICD-10 code R95) or of undetermined causes (other sudden deaths – cause unknown, ICD-10 codes R96–R99).

Queensland deaths from SIDS and undetermined causes comprise a significant proportion of infant deaths. When deaths due to perinatal-related conditions and congenital malformations are excluded from infant deaths, 30.2% of deaths occurring between 2006 and 2008 were classified as either SIDS or cause undetermined.

Figure 8.4 shows the steady decline of SIDS deaths, decreasing from 1.2 deaths per 1000 live births in 1991–1993 to 0.3 deaths in 2005–2007. Recorded deaths from SIDS made up 6.9% of all infant deaths in 2005–2007 in Queensland.

A number of factors may have contributed to the decrease, including improved access to preventative health care, increased public awareness of SIDS risk factors, and increased use of autopsies in suspected SIDS cases, leading to identification of non-SIDS causes (Commission for Children and Young People and Child Guardian, 2008a).

The classification of infant deaths as being due to undetermined causes since 1996 reflects ambiguities in definitions of SIDS. Detailed death scene examinations for apparent SIDS deaths were introduced in December 2003

22 Conditions that originate in the perinatal period (pregnancy and the first 28 days after birth) include causes that relate to pregnancy, foetal growth, labour and delivery.

23 Congenital malformations are conditions present at birth and are either hereditary or originate from pregnancy. They include deformities and chromosomal abnormalities.

by the Queensland Police Service to improve information available for investigation by coroners.

The Commission's *Child Deaths Annual Reports* reveal that Indigenous infants are over-represented in deaths from SIDS and undetermined causes, with mortality rates significantly

higher than for non-Indigenous infants. In 2007–08, Aboriginal and Torres Strait Islander infants died from SIDS or undetermined causes at nearly four times the rate of non-Indigenous infants (Commission for Children and Young People and Child Guardian, 2008a).

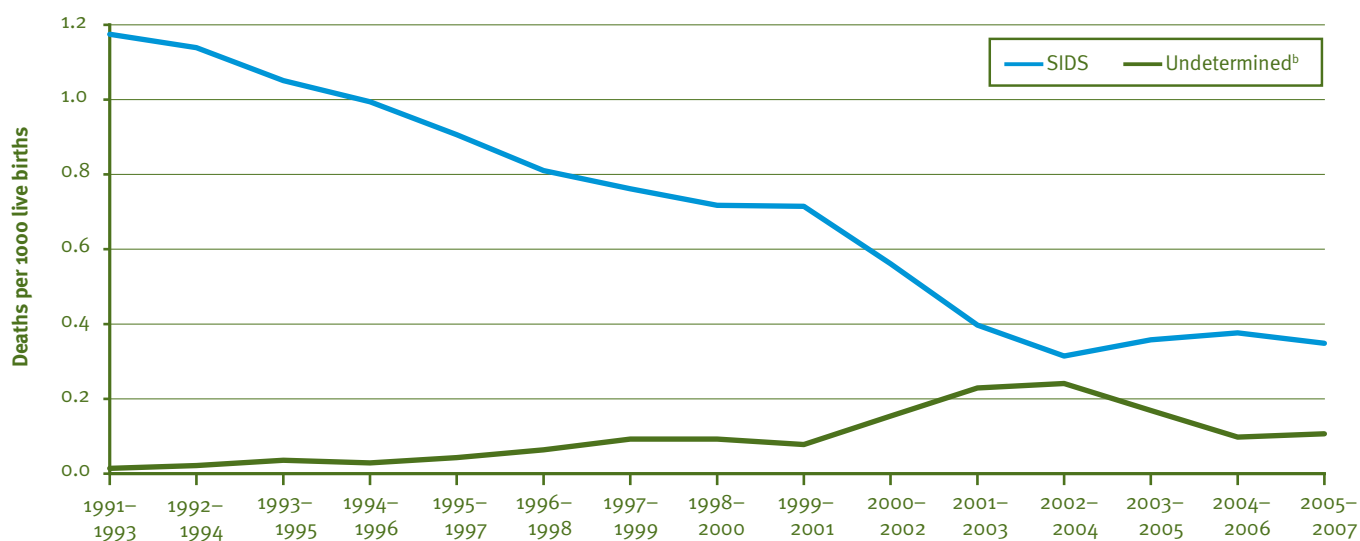
Table 8.1 Leading causes of death by age, Queensland, 2006–2008

Rank	Under 4 weeks	Between 4 weeks and 1 year	1–4 years	5–9 years	10–14 years	15–17 years
1	Certain conditions originating in the perinatal period (n = 391)	SIDS and undetermined (n = 59)	Drowning (n = 32)	Neoplasms (n = 22)	Transport (n = 27)	Transport (n = 69)
2	Congenital malformations, deformations and chromosomal abnormalities (n = 188)	Congenital malformations, deformations and chromosomal abnormalities (n = 56)	Transport (n = 24)	Transport (n = 18)	Neoplasms (n = 15)	Suicide (n = 46)
3	SIDS and undetermined (n = 9)	Certain conditions originating in the perinatal period (n = 45)	Congenital malformations, deformations and chromosomal abnormalities (n = 21)	Congenital malformations, deformations and chromosomal abnormalities (n = 12)	Suicide (n = 9)	Neoplasms (n = 17)
4	Diseases of the nervous system (n = 5)	Diseases of the nervous system (n = 19)	Diseases of the nervous system (n = 19)	Diseases of the nervous system (n = 11)	Diseases of the nervous system (n = 8)	Diseases of the nervous system (n = 10)
5	Neoplasms (n = 4) Fatal assault (n = 4)	Diseases of the respiratory system (n = 13)	Neoplasms (n = 16)	Drowning (n = 7)	Congenital malformations, deformations and chromosomal abnormalities (n = 7)	Other non-intentional injury-related deaths ^a (n = 7)

a. This category includes falls; non-intentional strangulations, suffocation and choking; poisoning; electrocution and other non-intentional injury-related deaths.

Source: CCYPCG, *Queensland Child Death Register*

Figure 8.4 SIDS infant mortality rate,^a Queensland, 1991–1993 to 2005–2007



Note: Years stated refer to three-year rolling averages at year's end.

a. SIDS-related deaths in the first year of life per 1000 live births.

b. Infant deaths, cause undetermined (ICD-10 codes R96–R99).

Source: OESR, *Deaths Collection* (for deaths in the years to 2003); CCYPCG; *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Births, Australia, 2007*, cat. no. 3301.0

The reports identified a number of risk factors for SIDS:

- infant factors – prematurity and low birthweight; twins or triplets; neonatal health problems; male gender; and recent history of viral respiratory infections and/or gastrointestinal illness
- parental factors – cigarette smoking; alcohol and drug abuse; young maternal age; single marital status; high number of births and short inter-pregnancy intervals; and poor or delayed prenatal care
- environmental risk factors – social disadvantage and poverty; sleeping on soft surfaces and loose bedding; stomach or side sleeping position; winter months; over-wrapping/overheating; and some forms of shared sleeping.

The reports also identified concerns in relation to unsafe sleeping practices such as smoking parents who share a sleep surface with their infant, or leaving young infants unattended on adult beds.

Between 1 July 2007 and 30 June 2008, the risk associated with unsafe sleeping practices was particularly highlighted, with over one-half (55.2%) of infants who died from SIDS and undetermined causes sharing a sleeping surface at the time of death (Commission for Children and Young People and Child Guardian, 2008a).

In 2005, the Commission recommended 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. In response, a research team from the Royal Children's Hospital and Health Service District developed a suite of parent and health professional resources (Queensland Health, 2008b; Young et al., 2008). The resources were launched in November 2008 for distribution throughout the state, and include bedside teaching tools designed to facilitate health professional and parent understanding of the importance of supine sleep and to support infant care practices that will reduce the risk of sudden and unexpected infant death. An electronic e-learning program based on the Safe Sleeping Education program is currently being developed.

Two projects have expressly targeted the needs of Aboriginal and Torres Strait Islander families:

- the *Keeping Bubba Safe* resources for health services, which include a flip chart, pamphlet and poster, and
- *Baby Help* – an infant illness assessment tool based on the original Baby Check tool, which has been adapted for use by Indigenous Health Workers and parents.

External causes of death

Deaths from external causes include deaths from non-intentional injury, such as drowning, fire and road transport incidents, as well as deaths from suicide and fatal assault. As with most other causes, deaths of 0–17 year olds caused by external factors have continued to decline, dropping from 17.3 per 100,000 per year in 1992–1994 to 9.7 in 2006–2008. A total of 2176 children died from external causes between 1992 and 2008, accounting for 23.8% of all causes.

In the period 2006–2008, deaths of 1–17 year olds due to external causes accounted for:

- 45.1% of deaths of 1–4 year olds
- 33.3% of deaths of 5–9 year olds
- 46.7% of deaths of 10–14 year olds, and
- 70.6% of deaths of 15–17 year olds.

Transport incidents accounted for almost half (47.9%) of all externally caused deaths among 1–17 year olds (24.9% of all 1–17 year old deaths). Drowning of young children was also a significant risk, causing 38.6% of all externally caused deaths of 1–4 year olds (17.4% of all deaths of 1–4 year olds).

There were more deaths of males than females across all age groups in the 18 years from 1991 to 2008, particularly deaths due to external causes. The disparity was most marked in deaths of 15–17 year olds, where there were about twice as many male deaths due to external causes as there were deaths among females (30 and 17 respectively in 2008). These were predominantly from transport accidents and suicide.

The Commission is working with key stakeholders to develop an evidence-based coordinated approach to child injury prevention in country Queensland through the *Keeping Country Kids Safe* (KCKS) initiative.

Drowning

There has been a general decrease in the rate of drowning deaths of 0–17 year olds over the past 17 years, with rates dropping from 2.3 per 100,000 in 1992–1994 to 1.5 per 100,000 in 2006–2008 (Figure 8.5).

In the last 17 years the number of drowning deaths of children aged under 5 has fluctuated between 4 and 20 per year. In 2008 there were 8 drowning deaths of children under 5, which was the same as 2007, but down from 16 in 2006.

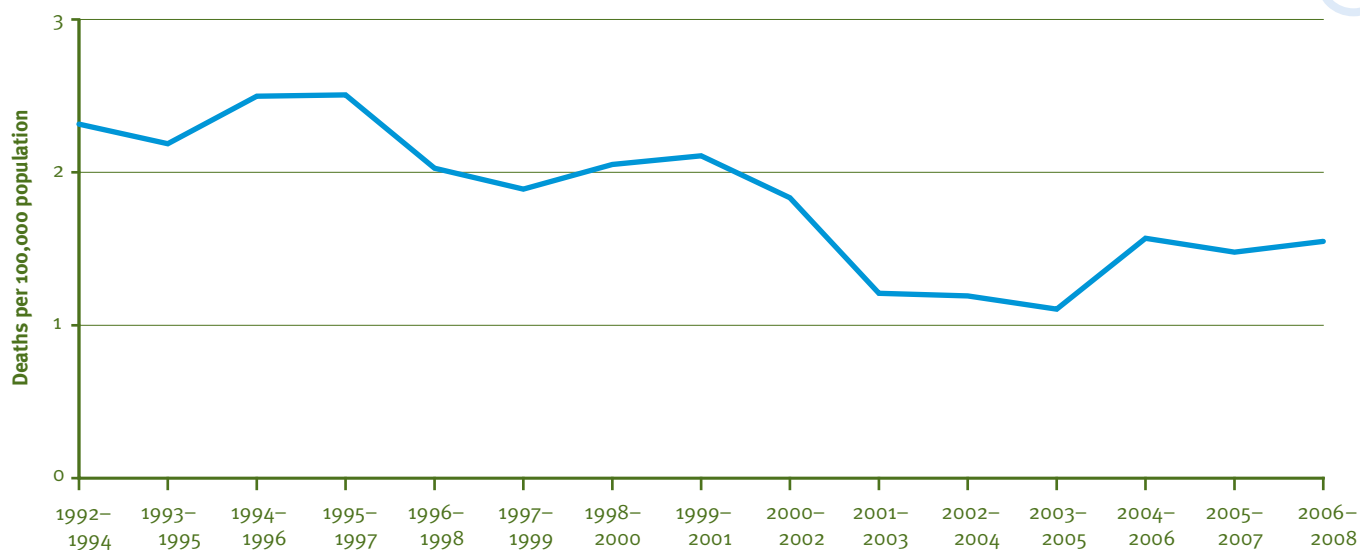
Of the 15 drowning deaths of 0–17 year olds in 2008, 8 drownings were in swimming pools and three-quarters of these were children aged 1–4 years. The majority (71.4%) of the 7 non-pool drownings occurred in rural dams, highlighting the importance of creating safe play areas with childproof fencing on rural properties.

Uniform pool fencing legislation was introduced in Queensland in February 1992 and has been shown to be effective in reducing pool drownings of young children (Cunningham et al., 2002). In the five years before the introduction of the legislation, around 13 children aged under 5 drowned each year, compared with an annual average of 3 drowning deaths between 2002 and 2007. This is despite the rapid increase in the number of domestic pools, with it being estimated that the number of swimming pools and outdoor spas more than doubled between 1991 and 2002 (Department of Local Government and Planning, 2003).

The Queensland Government is conducting a pool safety review, which proposes to make changes including:

- broadening pool laws to include all swimming pools in Queensland and not just outdoor pools on residential land
- implementing regular swimming pool inspections
- making pool safety standards uniform.

Figure 8.5 Drowning mortality rate,^a 0–17 year olds, Queensland, 1992–1994 to 2006–2008



Note: Years stated refer to three-year rolling averages at year's end.

a. Deaths per 100,000 population aged 0–17 years.

Source: OESR, *Deaths Collection* (for deaths in the years to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex, Australia*, cat. no. 3201.0

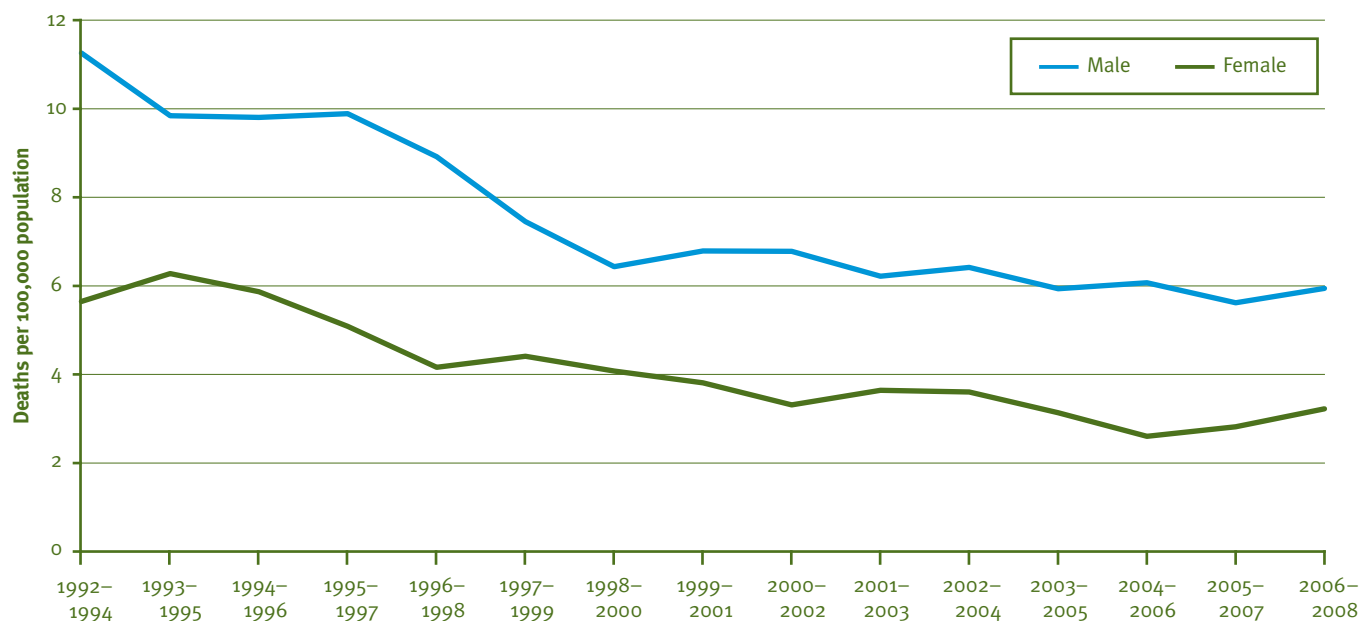
Transport

Deaths of children and young people caused by transport incidents have generally decreased, but they rose in the period 2006–2008 (Figure 8.6). Transport incidents were the leading cause of death among 10–14 year olds and 15–17 year olds, and the second leading cause among 1–4 year olds and 5–9 year olds.

Based on the ABS Unit Record Deaths File and the Commission's Queensland Child Death Register, in the period 1992–2008:

- about twice as many males as females died because of transport-related incidents (66.3% were males and 33.7% females)
- motorcycle and bicycle deaths were predominantly males (92.6% and 79.3% respectively).

Figure 8.6 Transport mortality rate^a by sex, 0–17 year olds, Queensland, 1992–1994 to 2006–2008



Note: Years stated refer to three-year rolling averages at year's end.

a. Deaths per 100,000 population aged 0–17 years.

Source: OESR, *Deaths Collection* (for deaths in the years to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex, Australia*, cat. no. 3201.0

In response to the high incidence of transport-related deaths of young people, the Queensland Government has recently amended the young driver licensing laws in Queensland. As of 1 July 2007, additional requirements for learner drivers under the age of 25 apply:

- learner licences may be obtained from the age of 16, and must be held for a minimum of 12 months
- L plates must be displayed while driving, and
- learners must gain 100 hours of supervised on-road driving, including 10 hours of night driving.

Once learners have successfully completed the practical assessment, they enter the provisional licence stage, which has been split into two phases. The P1 phase is a minimum of 12 months, during which a licence holder may drive unsupervised under the following conditions:

- red P plates must be displayed
- only one passenger under the age of 21 may be carried between the hours of 11pm and 5am (excluding immediate family members)
- mobile phones may not be used in any way by the driver, or on loudspeaker by the passengers, and
- vehicles driven must not be high powered (8-cylinder or turbocharged engines are not permitted, and there are additional restrictions regarding engine capacity, power and modifications).

Suicide

The male suicide mortality rate has been greater than the female rate for the entire period²⁴ between 1992 and 2008, the differences between the genders often being twofold or greater.

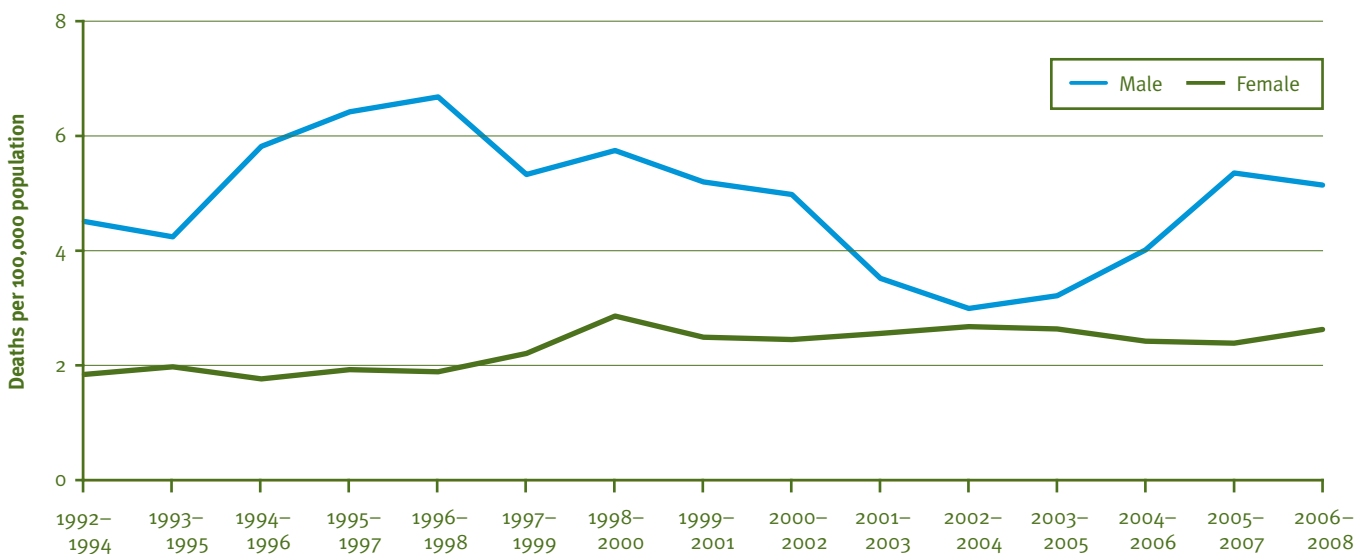
In this period, suicides only occurred in children and young people between 10 and 17 years of age, with 15–17 years being the most common age bracket for young people to take their own life (11.5 per 100,000 population for males in 2006–2008, 5.8 per 100,000 population for females). For the period 2006–2008, the suicide mortality rate for all children and young people aged 0–17 years was 2.4 deaths per 100,000 population for males and 1.2 deaths per 100,000 population for females.

As there were no suicide deaths of children under 10 years of age, Figure 8.7 outlines the suicide mortality trends for 10–17 year olds over the period 1992–2008. Rates for females have remained relatively stable over time, but have been gradually increasing. In contrast, suicides of males aged 10–17 years peaked in the period 1996–1998 and declined steadily for some time thereafter. However, rates have been increasing from the 2002–2004 period onwards, although it is unclear if these increases are the result of increases in suicidal behaviour, or an improved identification of suicides by the Commission (Commission for Children and Young People and Child Guardian, 2008a).

As reported in the Commission’s *Child Deaths Annual Report 2007–08*, 5 of the 21 suicides in 2007–08 were identified as Aboriginal or Torres Strait Islander (Commission for Children and Young People and Child Guardian, 2008a). The rate of suicide among Indigenous children and young people aged 10–17 years was almost seven times greater than for non-Indigenous children (17.0 and 2.5 per 100,000 respectively).

The Commission’s Child Death Review Team has released a discussion paper *Reducing Youth Suicide in Queensland* which reviewed the lives and deaths of 65 children and young people who suicide in Queensland between 2004 and 2007. This paper will guide the development of youth suicide prevention strategies with relevant stakeholders.

Figure 8.7 Suicide mortality rate^a by sex, 10–17 year olds, Queensland, 1992–1994 to 2006–2008



Note: Years stated refer to three-year rolling averages at year’s end.

a. Deaths per 100,000 population aged 10–17 years.

Source: OESR, *Deaths Collection* (for deaths in the years to 2003); CCYPCG, *Queensland Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex, Australia*, cat. no. 3201.0

²⁴ The exception being 2003, when only 5 male suicides were registered, in comparison with 7 female suicides.