

Australasian Mortality Data Interest Group
Understanding Mortality Data 2011 Workshop:
Commissioner's Welcome

I would like to begin by acknowledging the traditional custodians of the land upon which this seminar is being held, and pay my respects to elders past and present.

Welcome everyone to the Australasian Mortality Data Interest Group *Understanding Mortality Data 2011 Workshop*.

The Commission is very pleased to be able to host this event.

I extend a particular welcome to those who have travelled from interstate and overseas in order to attend.

Both myself and my staff will do all we can to make your attendance here comfortable.

The Workshop will feature a diverse range of speakers who are leaders in their fields over the next two days.

It will be an opportunity for us all to learn more about some of the important new work that is being done in the field of mortality data research.

The broad theme set by the Australasian Mortality Data Interest Group for this Workshop – “Mortality Research Supporting Policy and Practice” – is one which closely reflects the Commission’s own goals in child death prevention.

The subthemes for the Workshop – which include advancing mortality data collection, enhancing child death review processes, and forging constructive partnerships amongst mortality data professionals – also align closely with the Commission’s ongoing work in relation to child mortality in Queensland.

I would like to talk briefly today about some of the ways in which the Commission is working to further knowledge and partner others to do work in these areas.

As the Commissioner for Children and Young People in Queensland, my mandate is to promote and protect the rights, interests and wellbeing of all children under 18 years of age in the state.

Improving the safety and wellbeing of Queensland children is of particular importance to me – it is my agency’s mission and drives the focus of work the Commission undertakes.

Since 2004, the Commission has implemented its responsibility to establish and maintain the Queensland Child Death Register, containing details of all deaths of children and young people under 18 years in Queensland.

As of 2011, the Register holds the records of in excess of 3,500 fatalities.

Updating and reporting on the Register forms the main component of the Commission’s Child Death Review function.

Being able to access a comprehensive and contemporary data set of this nature is of vital importance to the research and reporting of risk factors and enabling the development of strategies for preventing child mortality.

The child death data we gather is extensive, combining information from a number of sources including the Registry of Births Deaths

and Marriages, the Office of the State Coroner, and the Queensland Police Service.

Our data is also very current: we generally receive notification of coronial deaths within 72 hours of them occurring, allowing us to update our Register on a regular basis.

I am committed to ensuring the mortality data we capture translates into effective initiatives in child welfare policy and practice.

Currently, we do this in four main ways:

1) the Commission reports annually to the State Parliament on the deaths of children and young people in Queensland, within four months of the end of the financial year being reported on;

2) we use the evidence base to inform our advocacy on policy and legislative considerations;

3) we make our data available, promptly and without fuss, to recognised stakeholders, and

4) we also conduct in depth research of our own.

I would like to mention a few examples of how we achieve this in practice:

1) our Annual Report – we have now published seven consecutive annual reports, containing detailed analyses of all Queensland child deaths and highlighting trends, issues and recommendations for action.

For example, in 2009-10 the leading external cause of death for Queensland children in under 4 years was drowning.

Both drowning and transport-related deaths were the leading external causes for children age 5 – 9 years.

Transport-related deaths were also the leading cause for 10 – 14 years olds in 2009-10.

And the most common external cause of death for young people aged 15 – 17 was suicide.

Translating what the data tells us into effective child death and injury prevention practice is crucial.

2) Policy and Legislative advocacy - because of the data we have we were able to take advantage of the opportunity to influence consideration of government in the area of pool drowning deaths of children, in particular through contributing to the Queensland Government Swimming Pool Safety Improvement Strategy.

The Commission has also recently used its Child Death Register data to advocate to the Queensland Government Joint Select Committee on Cyber Safety.

Focusing on the problem of child and youth suicide, the Commission was able to point in its submission to data highlighting the significance of contagion issues in suicide deaths.

Our evidence supported the need for relevant stakeholders to develop procedures to manage on-line behaviour in the wake of the suicide of a child, and to educate adults around the need to review and moderate the on-line behaviours of children and young people in such circumstances.

During 2009-10, we made a total of 9 advocacy submissions related to child death and injury prevention, most of which are published on our website.

3) Supporting recognised stakeholders – the Australasian Mortality Data Interest Group has identified the need for up-to-date, high quality statistics as a major priority in mortality data research.

The Commission is committed, as the central collator of mortality data for children and young people in Queensland, to providing a detailed, contemporary data base that stakeholders can access for research purposes.

The legislation allows for recognised stakeholders to make use of the Commission's Child Death Register data so as to reduce the likelihood of future deaths.

Our unique compilation of child mortality data has, since 2004, informed a myriad of research strategies and policy initiatives aimed at preventing deaths in children and young people.

In the past financial year, the Commission responded to 42 requests for tailored child death data:

11 requests related to research,

14 requests related to public education or reporting, and

17 requests related to Policy or Program Development.

Response timeframes are generally between one and five working days although we always appreciate more notice where possible.

The Commission is committed to supporting high-level collaborative research in child mortality, through constructive partnerships with organisations and professionals in the field. This includes the many talented people gathered here today.

4) Commission research – The Commission also conducts its own research and is currently investigating three major areas of child mortality: youth suicide; child safety in rural and remote communities; and fatal child maltreatment.

Through evidence held in the Child Death Register, the Commission has been able to systematically identify, risks including sometimes identifying new risks, that impact upon the

lives of children and young people, and to take a role in researching and reporting on these risk factors and ways of preventing deaths in the future.

The three investigations I mentioned will be completed during this financial year, so keep an eye on the Commission's website.

The child death review data that is now being routinely collected, both in Queensland and in other jurisdictions around Australia, represents a substantial contemporary evidence base for researchers and public policy makers, and provides a unique opportunity for collaboration between child mortality data professionals.

By participating in important forums such as the Australasian Mortality Data Interest Group's *Understanding Mortality Data 2011* Workshop, I hope that further opportunities will arise for the Commission to support mortality data professionals from Queensland and elsewhere.

In closing, I take the opportunity again to acknowledge the positive work that AMDIG and its stakeholders continue to undertake in

identifying and reducing potential harms in the lives of people - especially children and young people.

There are, of course, many more challenges to be faced, and in welcoming you all to the Workshop I look forward over the next two days to hearing more about some of the important work that is being done to meet these challenges.