

# **Speech notes**

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## **Child Death Annual Report 2008-09 Briefing**

**Date:** 26 November 2008  
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While overall, there has been an evident decline in the mortality rate of Queensland children in the past decade, 2626 is the number of Queensland children and young people who have died since 1 January 2004, following the establishment of the Commission's statutory child death register. This initiative symbolises Queensland's action to improve the safety and wellbeing of its children and young people.

565... 565 is the number of those deaths since 1 January 2004 that were due to non-natural causes, that is, transport fatalities, drowning, suicide, fatal assault, fire and accidental causes.

565 is therefore number of potentially preventable deaths of children and young people that have occurred in the past five years.

565 reasons why the Commission's function to maintain the child death register, and review, analyse and report on child deaths is so important – and why the Commission strives to help prevent childhood injuries and fatalities.

565 reasons why I have invited you all here today – to share the Commission's findings and ask that we align our efforts in the year ahead and work together to help prevent child deaths.

Good morning ladies and gentlemen. Thank you for your attendance this morning and your interest in the child death review work of the Commission and how this work might, either on its own, or in collaboration with you, help prevent child deaths.

I would like to begin by acknowledging the traditional custodians of the land upon which this briefing is being held.

I would also like to acknowledge the attendance of the members of the Child Death Case Review Committee, which plays an important role in reviewing the quality of service delivery to children known to the child protection system who die. As Commissioner and Child Guardian I chair the CDCRC and the Commission provides it secretariat support. The CDCRC has recently released its annual report, which is available on its website.

In addition to deriving learnings for the service delivery system, the CDCRC's reviews contribute to the broader work the Commission undertakes each year in reviewing, registering, analysing and reporting on trends and patterns in child deaths. Queensland now has a significant evidence base on which to better understand the risk factors relevant to all child deaths and,

wherever possible, continue the quest to further reduce child mortality rates.

This work is driven by a number of factors. Firstly, Article 24 of the United Nations Convention on the Rights of the Child (UNCROC) requires that, among other things, parties to the convention shall fully implement measures designed to achieve the highest attainable standard of health, including taking measures to diminish infant and child mortality. Australia is a signatory to UNCROC and the commitment to Article 24 is (in part) embedded in the child death functions of the Commission for Children and Young People and Child Guardian Act 2000.

Underpinning these formal reasons for conducting child death review also rests the human elements of not wanting young lives to end prematurely, and the desire to dignify those that do with a determined search for the contributing factors as a means of preventing further deaths in similar circumstances.

In that respect, the legitimacy of the Commission's child death work is not only derived from legal and well-founded bureaucratic mandates, but is also compelled by a broad-based community expectation and deeply entrenched moral imperative, to act to protect young lives by identifying and addressing risks.

The child death review work undertaken by the Commission is substantively valuable to the government and community. It evidences a commitment to international, national and state obligations. Also, at a more fundamental level, it clearly demonstrates a desire on the part of the government to deeply, thoroughly and systemically reflect upon the risks that exist in children's lives, with a view to preventing them from manifesting.

Child death review processes are effective in this way, over and above the work traditionally performed by Commonwealth statistical bodies, because they probe beyond a compilation of death certificate data and routinely involve consideration of autopsies, coronial files, child protection and police information. This reporting is also contemporary. For example, you will note that the 2008–09 child death dataset became publicly available only 135 days after the close of the financial year upon which it is reporting.

As in all our work, we should be guided by evidence of what works for children, families and communities. Within a child death review context, the evidence tells us what the risks were and, importantly, provides an opportunity for future deaths to be prevented. A key point you will hear me make today, and thereafter, is that the Commission now possesses a unique, highly credible and very detailed data set on child deaths. It is

available to any recognised stakeholder for use in advancing child death or injury prevention initiatives. All you need to do is ask.

With five years of data, the Commission's capacity to identify and report on trends, patterns and, importantly, risk factors is now well established. As such, the Commission is well placed to provide detailed, authoritative, timely and evidence based advice in the manner and form required by stakeholders, to ignite debate, discussion and, most importantly, action about preventing child deaths.

This brings me to the point of sharing with you some of the key findings from the Commission's analysis of its child death register over the past five years, with a focus on some key statistics and prevention messages.

In the period 1 January 2004 to 30 June 2009, 254 children and young people died as a result of transport incidents in Queensland.

On average, young people aged 15–17 years account for 50% of all transport incidents. The majority of fatalities involved motor vehicles.

Thirteen and a half percent, that is 34, of the 254 fatalities involved motorcycles or quad bikes, and just over half occurred off-road.

In 2008–09 there were 6 motorcycle fatalities (4 involving children aged 15–17 years and 2 involving children aged 10–14 years). Of particular concern, is that only 3 of the young people were known to be wearing helmets.

While licensing laws have been introduced which restrict young people under 18 years from riding motorcycles on public roads, most of the motorcycle fatalities occurred off-road where these laws do not apply, commonly in rural settings.

Safe riding practices for off-road motorcyclists, including the wearing of helmets and protective clothing and observing manufacturer recommendations about age, size and power specifications, are key prevention messages the Commission intends to promote in the year ahead.

In 2008–09 I launched the Keeping Country Kids Safe initiative, a project that aims to develop a comprehensive injury prevention strategy tailored to the needs of rural communities.

Our research found that children in country areas are 2.4 times more likely to die as a result of non-intentional injury than those in the city.

Children in the country also face a number of risks unique to their environment, which is often a blend of the home and workplace. These risks include drowning in dams or quad bike accidents, and injury or trauma from a number of hazards not present in urban settings. The Commission is committed to continuing to work with the rural sector to identify ways to prevent these child deaths and injuries occurring.

One of the major aims of the Keeping Country Kids Safe initiative is to strike a balance between minimising risks and keeping the things that make country life fun for children.

A key challenge will be changing the common attitude in the community that these fatalities are “tragic accidents” and promoting the belief that they are indeed preventable.

Turning now to drowning.

Since 1 January 2004, the Commission has reported that 87 Queensland children and young people have drowned. Seventy-five percent were under the age of 5. The statistics are

concerning and signal that much more needs to be done to prevent these deaths.

- 47% drowned in pools, and
- 53% drowned in non-pool locations, such as dams.

Lack of adequate supervision remains a pervasive feature of drowning fatalities for children under the age of 5. It remains the key preventative action available to reduce the risk of drowning when hazards are nearby.

The 2008-09 report once again highlights the importance of supervision. Of the 14 drownings of children under the age of 5, 6 occurred when the child had been left alone or had not been seen for up to five minutes. While in the other 8 cases, four of the children had not been seen for between 5 and 30 minutes; and another four had not been seen for over 30 minutes.

To prevent toddler drowning a key message we must be promoting is the importance of actively supervising young children around water hazards.

I acknowledge we cannot possibly watch our children 24 hours a day, particularly at home. But there is a need to remain vigilant if water hazards are present.

Significantly, 39% of private pool drownings during the year involved fences with defects, such that they were not compliant with the relevant standard. This finding highlights the point that pool fences must not only be compliant with the relevant standards when erected, but also be maintained in order to remain compliant.

I was pleased with the role the Commission was able to play in the government's review of pool fencing legislation during the year. Arguably, some approaches could have extended further, but on the whole it will deliver a stronger regulatory regime and I look forward to monitoring the outcomes. The contribution of Hannah's Foundation in helping initiate the review was notable and I would like to acknowledge Ms Katherine Plint from Hannah's Foundation who is here today.

Since 2004 I have consistently reported on, and expressed my concern about, the number and young age of children and young people taking their own lives.

Ninety Queensland children and young people took their own lives in the period 1 January 2004 to 30 June 2009. The fact that 90 deaths have occurred by a young person's own hand is incomprehensible - and the impact - immeasurable.

This year's report identifies a high number of contagion-related suicides and in doing so highlights the far-reaching impact suicide can have on children and young people. This reinforces the need for co-ordinated postvention responses to occur after the suicide or attempted suicide of a young person to access and manage the potential for contagion suicide among youth.

Consistent with previous years, this year's report shows that one-third of the 15 children who took their own life stated or implied their intent to someone prior to their death.

This reinforces the importance of taking all threats of suicide seriously.

Our work tells us that families and professionals sometimes see threats as manipulative or attention seeking – this is a dangerous view. When a child or young person threatens suicide, this means that they believe that there is something seriously wrong with their lives, and it is vital that this is not ignored.

Many of you here today would be aware of the Reducing Youth Suicide Project, which is currently being progressed by the Commission. Thank you to all those agencies who have contributed records and data to the project, the assistance provided by sharing this information has been invaluable.

I am pleased to report that the response to the Discussion Paper since it was released on 31 August this year has been overwhelming. To date, more than 10,000 copies of the Discussion Paper have been downloaded from the Commission's website and hundreds of submissions have already been received from a range of stakeholders.

This level of response signals that the issue of youth suicide is a key priority area for action, not only for the Commission but for the community as a whole.

42 Queensland children and young people were fatally assaulted between 1 January 2004 and 30 June 2009. The majority of fatal assaults were perpetrated by the child or young person's parent or step-parent.

More than half of all fatal assaults involved children under the age of 5 – the age at which we know children are most vulnerable.

In 26, or 62% of fatal assaults, the child or young person was known to the child protection system, either at the time of, or in the three years prior to, their deaths.

While these findings highlight that contact with child protection services is an important factor for consideration in guiding our research and prevention efforts, protecting children cannot be viewed as a government problem alone. The reasons a child comes to the knowledge of the child protection system are irrevocably linked to their parents and the community around the child. Effective child protection services require whole of community and service system support.

I genuinely believe that it is preferable for all children in circumstances placing them at risk of assault to come to the attention of the child protection system, which then provides an opportunity for assessment based upon the risk factors at play. Research into these risk factors is critical in building upon the understanding of how they should be assessed and the most appropriate service response.

Members of the community should be encouraged to continue reporting any concerns about the safety of children. The challenge therein lies in effectively identifying clear risk factors or warning signs that can be attributed to an increased risk of assault, and using this information to ensure that appropriate supports are put in place.

Child deaths from assault and also neglect are sentinel events that should trigger serious reflection. In recognition of this, the Commission is undertaking an in-depth study examining the fatal assault and neglect of children and young people in Queensland. The aim of the project will be to identify the circumstances that place children at increased risk of fatal assault or neglect, to support the development of targeted interventions.

I appreciate that the content of today's briefing, and the figures I have presented, are not "good new stories". However, it is the most meaningful and useful way that, as a community and government, and as family and friends, we can apply ourselves to preventing needless tragedies from recurring.

In recent decades a lot of very positive work has already been undertaken to make a difference to children and young people's lives through actioning modifiable risk factors. Many of you in the room today have played a leading hand in this work.

Within the context of risks that may arise through the delivery of child protection services, much work has been undertaken to extend the accountability and transparency of decision making to enable learnings to be derived to feed service system improvements. This has the potential for positive impacts both

within a statutory child protection context and more broadly in family support in high risk settings.

Within the context of environmental and mechanical risks and accidental causes of death, pool fencing legislation is one example where progress continues to be made. Noting in particular the work of Professor John Pearn and Associate Professor Jim Nixon – who undertook a seminal piece of research in the 1970's that began a movement toward legislated pool fencing requirements in Queensland. High standards for infant car restraints and other consumer products, compulsory helmets for cyclists, and tailored licensing laws for young drivers, are other examples of how credible investigations, research, data and, of course, perseverance, have translated into effective prevention efforts.

The work undertaken in establishing mechanisms for monitoring injury also require recognition. It is well know that initiatives such as the Queensland Injury Surveillance Unit were established on a shoe-string, but have continued to deliver a high return on investment. In the year ahead I am keen to further explore the similarities and differences between the Commission's child death register and injury surveillance datasets. I believe we did this effectively in the Keeping Country Kids Safe project, and for the first time this year have incorporated data from the Centre for

Pre-hospital Research in the annual report, to provide a better context and understanding to some causes of death, for example, drowning. By reporting on Ambulance callouts to non-fatal as well as fatal immersion incidents, I hope to present the full extent of the issue.

In responding to the current challenges, we have never before been so well placed to identify risk and determine what needs to be done.

While the Commission is responsible for reviewing, analysing and reporting on child deaths. Many different parts of the Queensland government and community have a part to play in preventing child deaths. I am pleased to report that an increasing number of agencies and organisations are now accessing and utilising the Commission's data in evidence based policy development and the formulation of strategies and campaigns aimed at preventing child deaths.

In releasing the child death annual report last year I commented that the outcomes of the intellect and energy applied to preventing death and injury can be more difficult to measure than we think. The required changes may occur in excruciatingly small increments, particularly where small numbers or many risk factors are involved and they may also traverse significant

periods of time. Sometimes consuming careers and sometimes spanning generations. These comments hold true today.

To those of you in the business of moving mountains, I salute you and encourage you to consider how the Commission might help.

Today I have identified 565 individual reasons for persisting. 565 reasons, which combined, represent an opportunity to confirm our priorities, fill any gaps in our understanding of risk factors and energise our ongoing efforts to prevent injuries to and fatalities of our children and young people.

Together we can make a difference.

I thank you for your attendance today.

In closing, I offer my condolences, and I am sure those of everyone present, to the families and friends of the children and young people whose lives ended too soon during the year.

Thank you.