Safer pathways *through* childhood

2022–2027

A framework to guide the Queensland Family and Child Commission's child death prevention activities

Queensland
Family & Child
Commission

Queensland
Government

The Queensland Family and Child Commission acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

About the Queensland Family and Child Commission (QFCC) and this document

The QFCC is a statutory body of the Queensland Government. Its purpose is to influence change that improves the safety and wellbeing of Queensland's children and their families. Under the *Family and Child Commission Act 2014*, the QFCC has been charged by government to review and improve the systems that protect and safeguard Queensland's children.

Interpreter

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding this report, you can contact Translating and Interpreting Service National on 13 14 50 to arrange for an interpreter to effectively explain it to you. Local call charges apply if calling within Australia; higher rates apply from mobile phones and payphones.

Contact for enquiries

Queensland Family and Child Commission
Level 8, 63 George Street
PO Box 15217, Brisbane City East QLD 4002

Email: info@qfcc.qld.gov.au
Website: www.qfcc.qld.gov.au

Attribution and licence

Content from this document should be attributed as:
The State of Queensland (Queensland Family and Child Commission) *Safer pathways through childhood: A framework to guide the Queensland Family and Child Commission's child death prevention activities, 2022–2027.*

Contents

Message from the Commissioners

The Queensland Family and Child Commission (QFCC) promotes the safety, wellbeing and best interests of children and young people.

Our functions include maintaining the Queensland Child Death Register, which holds information about every child who has died in Queensland since 2004. We analyse this information to build understanding that helps reduce the likelihood of future deaths.

The death of any child is a terrible tragedy. It is an indescribable loss to family and friends, and has long-term impacts reaching into the wider community. As Commissioners, it is our duty to ensure that we use every opportunity to influence work across the state to reduce risk and help prevent the deaths of Queensland children.

The *Safer pathways through childhood* framework formalises the child death prevention work we already undertake, and outlines our priorities for the future. It sets the direction of the QFCC's child death prevention activities for the next 5 years.

We are focused on promoting health equity by considering the factors that lead to some children experiencing a greater risk of premature death than others.

This framework explains the work we will undertake to address the following 4 key impact areas:

1. Improving data quality

We will continue to build our capacity to contribute to the knowledge base on child mortality, by improving data capture and quality. This includes expanding the breadth of data we collect, and linking to datasets held by other stakeholders.

2. Fostering expertise

We value the specialist knowledge we hold and will further develop our relationships with stakeholders at all levels to ensure this data reaches those who can put it to best use. Importantly, we will seek the experiences of children, young people and families wherever possible to guide our activities and seek their views on issues impacting them. An important part of this will be collaborating and co-designing with First Nations peoples.

3. Turning research into action

We will seek practical ways to use our data and knowledge to reduce child mortality, including by focusing our efforts on highlighting the effects of inequity on children and families. We will support initiatives that promote health equity and target the prevention of child deaths among priority populations, such as First Nations children, those known to the child protection and youth justice systems, children with disability, those who live in rural, remote or low socio-economic areas, and those under the age of 5. We will also advocate for changes to legislation, policy and practice to address inequities that place some children at higher risk.

4. Continuously improving

We will continue to actively monitor trends and patterns in child mortality and respond to emerging trends and prevention initiatives.

We are accountable to parliament and the public for our achievements under the *Safer pathways through childhood* framework and will report on its implementation and outcomes.

We are committed to using the data and expertise held by the QFCC to work with stakeholders to learn from children's deaths. In this way, we can improve the safety and wellbeing of all Queensland children.

Natalie Lewis
Commissioner
Queensland **Family and Child** Commission

Luke Twyford
Principal Commissioner
Queensland **Family and Child** Commission

Our role in preventing child deaths

We hold critical information about all child deaths in Queensland. We use this information to understand how deaths may be prevented in the future.

Our legislation and core business

Under Part 3 of the *Family and Child Commission Act 2014*, the QFCC must maintain a register of, and report annually on, all child deaths in Queensland.

The Queensland Child Death Register contains information about all children who have died in Queensland since 1 January 2004. We collect information from a range of agencies to support our child death prevention functions.

We classify and analyse this information to identify trends and patterns in child mortality. We then share our data and findings to promote prevention messages and to inform legislation, policy and practice change to prevent future deaths. By monitoring changes in data over time, we can assess the impact of these changes.

We also conduct research (alone or in collaboration with others); provide access to child death data for people conducting genuine research;* and make recommendations about improvements to laws, policies and practices, where this may assist in preventing future deaths.

The QFCC undertakes many other functions to improve the safety and wellbeing of Queensland children. For example, we provide oversight of the child and family support system in Queensland. As part of this, we have conducted multiple system reviews stemming from child deaths and made recommendations to improve the child protection system that have resulted in positive changes.†

We also provide case review and secretariat support to the Queensland Child Death Review Board, which carries out independent system reviews of service delivery for those children known to the child protection system who have died. We evaluate the effectiveness of policies and practices, promote and advocate for children's safety and wellbeing, and provide community education about systems and services to support families.

Bringing children's rights to life

All the QFCC's work, including the *Safer pathways through childhood* framework, is focused on upholding the rights of the child. This framework has been developed with reference to the 4 principles of the *United Nations Convention on the Rights of the Child*, namely:

- the right of all children to survival and development
- the best interest of the child as a primary consideration in all decisions relating to children
- the right for children to express their views freely on matters affecting them
- the right to enjoy all child rights without discrimination.[1]

The prevention activities we will conduct under this framework represent an opportunity for systems, services, communities, parents and carers to better uphold these rights and create safer environments for Queensland children.

---

* Under s. 28 of the *Family and Child Commission Act 2014*, a genuine researcher is a person with an approved application under the *Public Health Act 2005*, a member of a quality assurance committee under the *Hospital and Health Boards Act 2011*, or another person the Principal Commissioner considers is conducting genuine research.

† These include the *When a Child is Missing* report; the *Recommendation 28 Supplementary Review*; the *Review of the Blue Card and Foster Care System*; *Review into the Death of a Child Known to Child Safety* and the *Keeping School-Aged Children with Disability Safe*. These reports are available on the **QFCC website**.

Conceptual model and underlying principles

This framework outlines the QFCC's approach to its legislated child death prevention activities for the period from 2022 to 2027.

Our mission

The *Safer pathways through childhood* framework (Safer pathways framework) provides a roadmap for our child death prevention activities over the next 5 years. It details how we will use our data and expertise on child deaths to uphold all children's rights to a full life and health equity. We will consider factors at the individual, interpersonal, social, structural and historical levels to better support initiatives to reduce child mortality.

Each year, in consultation with stakeholders, we will identify specific prevention activities to address these priorities under an action plan.

Our model

In our work to prevent child deaths, we have adopted a social justice approach that focuses on achieving health equity.

Health is defined as a state of complete physical, mental and social wellbeing.[2] This aligns with Aboriginal and Torres Strait Islander holistic concepts of health, which include physical, social, emotional, cultural and spiritual wellbeing for individuals and communities.[3]

Childhood is a critical time for development and learning – establishing the building blocks of future health and wellbeing. During this time, children are vulnerable, and their right to safety and to live free from harm must be protected.[4]

All children, no matter where they live or who they are, should have the same opportunities to lead a full life and reach their potential. This cannot occur if health inequities persist.

Health inequities can be defined as systematic differences in health status arising from the social conditions in which people are born, grow, and live, that could be avoided by reasonable means.[5,6] These inequities have significant social and economic costs to individuals, communities, and societies. Importantly, they can be addressed through changes to government regulation, public policy and service delivery.*

Any measurable aspect of health that varies across individuals or according to socially relevant groupings (such as differences in mortality rates between males and females) can be called a 'health difference'. Sometimes, this is also referred to as 'health inequality'. When these differences are preventable and unnecessary, they are inequities.

Childhood mortality rates are key indicators of health inequity. They measure progress towards equity in children's health, development and wellbeing.

Achieving **health equity** involves striving for the highest possible standard of health for all children, including by protecting their rights to be free from discrimination, to have an adequate standard of living, and to be provided with appropriate services. Equity is achieved by improving the health and wellbeing of those most disadvantaged.

The cumulative impact of life experiences and environmental/social factors for some population groups can tip the scales towards health inequity. Figure 1 (on page 5) shows a simple way of conceptualising this.

Reducing the impact of some of these factors (through improved services or social attitudes or funding for evidence-based programs and services) will reduce children's chances of experiencing health inequity.

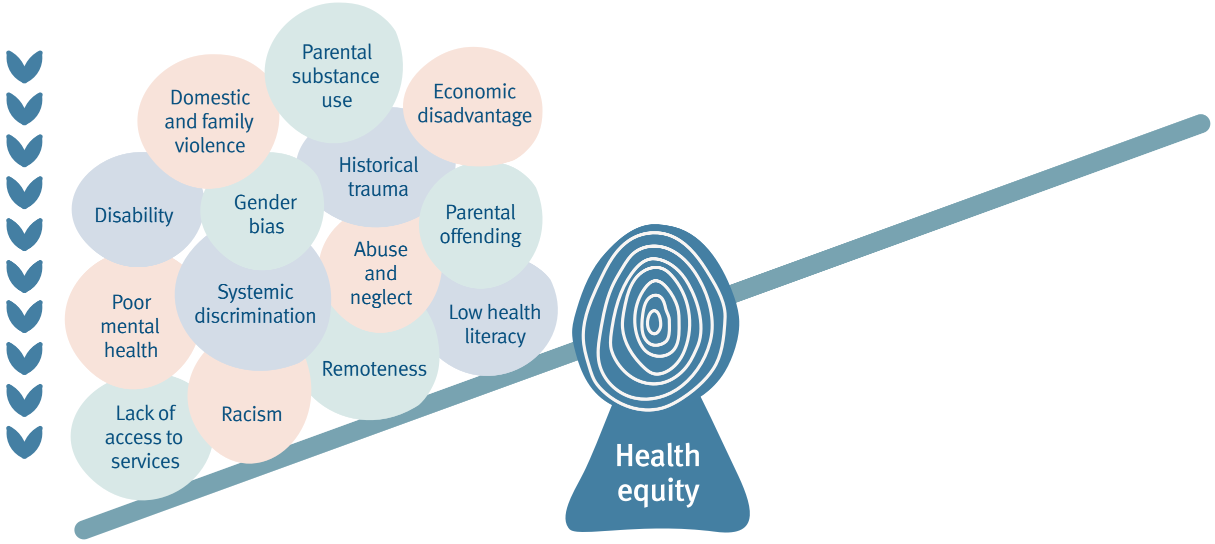
Social and structural† barriers create disadvantage for certain families and communities. This contributes to and compounds a child's experience of adversity and may limit access to appropriate services to address any individual risk factors.

---

* See, for example, Queensland Health's *Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework* which identifies eliminating discrimination, increasing access to health services, influencing the social determinants of health, delivering culturally safe services and partnership with First Nations peoples and communities as key actions to achieve First Nations health equity.

† We use the term 'structural' when we are referring to institutional and systemic practices.

Figure 1 *A model of health inequity*



Some population groups are more likely to experience these barriers than others. Our social institutions create structural inequalities that provide advantages for some while producing disadvantage for others. Factors such as race, ethnicity, culture, gender, employment, socio-economic status, disability and geography affect individuals' experience of systems designed to promote health and wellbeing, resulting in poorer outcomes for some social groups.

Not all children whose lives and deaths are captured in the Queensland Child Death Register will have experienced health inequity. Not all health differences, including rates of mortality, are the result of structural inequality or social disadvantage. However, existing research and the QFCC's own data indicate that many are affected in some way. Understanding the impact of health inequity, particularly among priority populations, is the central tenet of the Safer pathways framework.

In our work on preventing child deaths, we use a 'socio-ecological' model. This is a model that recognises child health outcomes are influenced by historical, cultural, social and economic circumstances, which in turn shape individual behaviours and choices. A complex interplay of factors influences child health, safety and wellbeing. Any attempts to understand and modify risk factors and individual health choices, without considering the social and physical environment in which these choices are made, are unlikely to be effective.

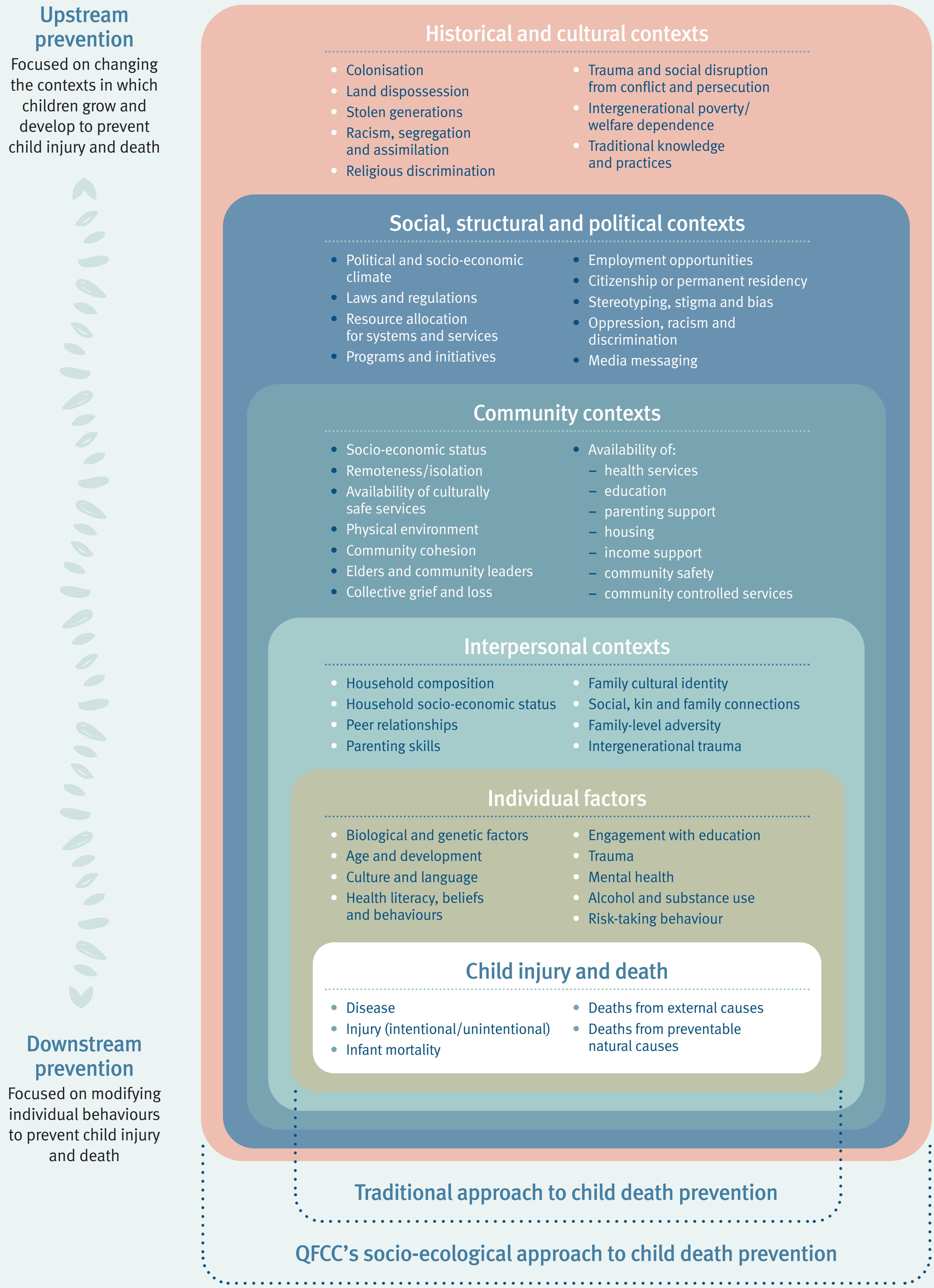
Figure 2 (on page 6) outlines some of the critical factors that combine to affect a child's chances of experiencing optimal health and wellbeing.

Importantly, socio-ecological approaches closely align with Aboriginal and Torres Strait Islander concepts of health. The health of First Nations peoples cannot be isolated from their political, social, economic, cultural and historical contexts, including the ongoing impacts of colonisation and disconnection from culture and country.[7]

In taking a socio-ecological approach to child death prevention, we intend to contribute to the evidence base about how factors at different levels impact on childhood mortality.

We will work with stakeholders to develop responses that include action at all levels of this model. As well as 'downstream' prevention aimed at modifying individual behaviours, we will also look to target 'upstream' factors such as the effects of socio-economic disadvantage, remoteness, the availability and appropriateness of services, and the experience of discrimination.

Figure 2 *A socio-ecological model for child death prevention*



Upstream prevention

Focused on changing the contexts in which children grow and develop to prevent child injury and death

Downstream prevention

Focused on modifying individual behaviours to prevent child injury and death

Historical and cultural contexts

- Colonisation
- Land dispossession
- Stolen generations
- Racism, segregation and assimilation
- Religious discrimination
- Trauma and social disruption from conflict and persecution
- Intergenerational poverty/welfare dependence
- Traditional knowledge and practices

Social, structural and political contexts

- Political and socio-economic climate
- Laws and regulations
- Resource allocation for systems and services
- Programs and initiatives
- Employment opportunities
- Citizenship or permanent residency
- Stereotyping, stigma and bias
- Oppression, racism and discrimination
- Media messaging

Community contexts

- Socio-economic status
- Remoteness/isolation
- Availability of culturally safe services
- Physical environment
- Community cohesion
- Elders and community leaders
- Collective grief and loss
- Availability of:
  - health services
  - education
  - parenting support
  - housing
  - income support
  - community safety
  - community controlled services

Interpersonal contexts

- Household composition
- Household socio-economic status
- Peer relationships
- Parenting skills
- Family cultural identity
- Social, kin and family connections
- Family-level adversity
- Intergenerational trauma

Individual factors

- Biological and genetic factors
- Age and development
- Culture and language
- Health literacy, beliefs and behaviours
- Engagement with education
- Trauma
- Mental health
- Alcohol and substance use
- Risk-taking behaviour

Child injury and death

- Disease
- Injury (intentional/unintentional)
- Infant mortality
- Deaths from external causes
- Deaths from preventable natural causes

Traditional approach to child death prevention

QFCC's socio-ecological approach to child death prevention

Our principles

The Safer pathways framework aims to uphold the following principles:

1

Promoting equity

We will take action to reduce the health inequities reflected in the disproportionate rates of child death among priority population groups.

3

Listening to the voices of children

We will centre our research and activities on the experiences of children and families. This includes collaborating with children, young people and families.

2

Using the evidence base

We will draw on data and research to identify priority areas on which to focus. These areas should reflect the causes of death that contribute most to child mortality in Queensland; risk factors common to multiple causes of death; and causes or risk factors most readily modifiable through changes to regulations, environment, policy or behaviour.

4

Upholding cultural integrity

We will uphold the principles of Aboriginal and Torres Strait Islander data sovereignty* by actively collaborating with First Nations peoples when undertaking research and developing prevention activities. This includes adhering to the Guidelines Framework† for working with Aboriginal and Torres Strait Islander Peoples and communities when conducting research.

5

Fostering collaboration

We will value the expertise of others and proactively seek opportunities to collaborate.

---

* ‘Indigenous data sovereignty is the right of Indigenous peoples to govern the collection, ownership and application of data about Indigenous communities, peoples, lands and resources’.[12]

† The Guidelines Framework comprises the National Health and Medical Research Council’s **Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities** and the Australian Institute of Aboriginal and Torres Strait Islander Studies’ **Code of Ethics for Aboriginal and Torres Strait Islander Research**.

Parameters

The Safer pathways framework is largely concerned with causes of child death that are most readily prevented by modifying socio-cultural, environmental or behavioural risk factors or by improving access to timely and effective services. These include deaths occurring as a result of:

- transport incidents
- drowning
- other non-intentional injury (such as falls, burns or poisoning)
- suicide
- fatal assault or neglect
- sudden unexpected deaths in infancy*
- potentially avoidable deaths from conditions amenable to public health interventions and early disease management (such as infections and vaccine-preventable conditions).

Sadly, not all causes of child death are preventable. Each year, many are due to natural causes such as genetic conditions, congenital abnormalities or medical conditions that are not usually considered avoidable. Here, the QFCC may have a role in advocating for improved policy and treatment practices and increased research investment.

The Safer pathways framework is not intended to govern the business of other agencies or organisations; nor is it intended to represent a coordinated state-wide strategy for preventing death or injury.

It does not replace the data collection, analysis and monitoring activities we undertake in keeping the Child Death Register. Rather, it uses these existing processes, alongside advice from a range of experts, to contribute to the development of evidence-based solutions to reduce preventable child deaths.

Collaborative partnerships

All of our work is supported by collaborative stakeholder relationships. The QFCC values the expertise of others and proactively seeks to work with stakeholders undertaking related initiatives.

A great many experts across Queensland are actively working to reduce risks to children, within their various areas of interest. We recognise that they are often best placed to deliver prevention initiatives, and we will draw on their expertise to help inform our child death prevention activities.

We will work with stakeholders by sharing data, providing support, undertaking joint projects, and consulting when we identify the prevention activities we will undertake each year.

The QFCC values the expertise of others and proactively seeks to work with stakeholders undertaking related initiatives.

---

* Sudden unexpected death in infancy is a research classification rather than a cause of death. It groups together the deaths of infants who would otherwise be expected to thrive, yet die suddenly. Deaths falling into this category are those of infants under one year of age, sudden in nature and unexpected, where there is no immediately obvious cause, and the infant had no known condition likely to cause death. There is significant evidence to indicate that modifications to an infant's sleep environment can help prevent these deaths.

Our impact areas

We have identified 4 areas in which we can have the greatest impact in reducing risk and preventing child deaths. These impact areas form the basis for the prevention activities we will undertake.

Figure 3 *Safer pathways through childhood framework – impact areas*

Data quality

We produce high quality data and contribute to improvements in related datasets

We work with others to improve the quality of child death data, and we uphold the principles of data sovereignty.

We continuously improve the Queensland Child Death Register and work with others to build links to other datasets.

We work to improve our understanding of risk factors for child death by collaborating with other experts in the field.

Expertise

We value specialist knowledge and collaborate with expert stakeholders and the community

We raise awareness of the QFCC and how its Child Death Register can inform child death prevention initiatives.

We support staff professional development and encourage interest in acquiring specialist skills.

We build stakeholder relationships to share information and learn from other experts.

We value community expertise. We incorporate the experiences of children and families and the cultural knowledge of First Nations communities into our work.

Research into action

We seek opportunities to use our data and expertise to reduce child deaths

We analyse our data and use expert research to identify trends and patterns in child deaths.

We promote our findings and prevention messages widely to maximise positive outcomes for children and families.

We use our findings to achieve improvements to services and systems to reduce and prevent child deaths.

We highlight the impact of health inequity on population groups experiencing higher rates of child death.

Continuous improvement

We monitor data to identify emerging trends, system improvements and effective prevention initiatives

We identify trends and patterns in child mortality over time and help to monitor the impact of prevention initiatives.

Our work is responsive to emerging trends, and addresses issues of concern.

We make formal recommendations to government where system improvement is needed and monitor the effect of these recommendations.

We are accountable for our work under the Safer pathways framework and report publicly on its outcomes.

Priority populations and focus areas

Not all children face the same risk of death in childhood as others. In Queensland, particular groups of children do not have the same health, wellbeing and developmental outcomes as their more socially advantaged peers.[8]

Queensland children likely to be affected by health inequity include children known to statutory systems (such as child protection and youth justice), First Nations children, children with disability, and children living in remote or socio-economically disadvantaged areas.

The inequity many children and families from these groups experience leads to disparities in their health and wellbeing. These children are considered priority populations under the Safer pathways framework. Many children belong to more than one priority population group. For example, First Nations children are more likely to live in remote areas.[9] This can compound the experience of health inequity for these children.

There are 2 groups whose experiences will be prioritised in all work conducted under the Safer pathways framework.

First Nations children

The structural inequalities experienced by First Nations families are profound. They stem from the legacy of colonisation and forced removals of children, and have resulted in the loss of cultural traditions, language, and family structure, producing intergenerational trauma.

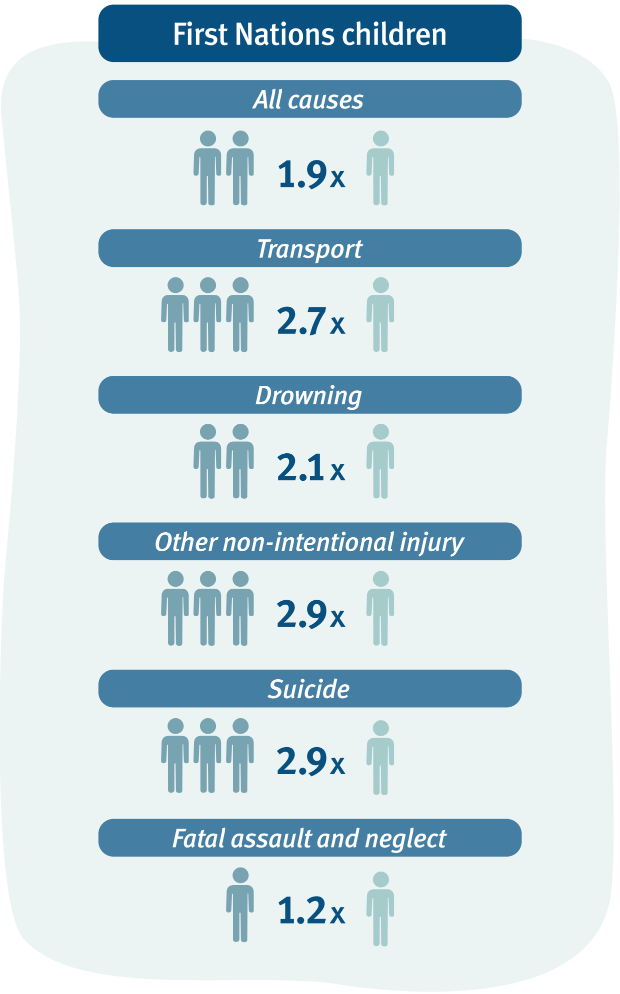
Historical and continued marginalisation have contributed to higher rates of social risk factors, including those relevant to childhood injury and death.

First Nations children are over-represented in child mortality statistics, dying at 1.9 times the rate of non-Indigenous children.[10] This over-representation is amplified in some categories of death. For example, First Nations children and young people die by suicide and non-intentional injury at 2.9 times the rate of their non-Indigenous peers.[10][*] In addition, Aboriginal and Torres Strait Islander infants die suddenly and unexpectedly at 3 times the rate of non-Indigenous infants.[11][†]

The QFCC is committed to highlighting the underlying causes of this over-representation and using its position to advocate for improved systems and services.

In implementing the Safer pathways framework, we will work closely with First Nations stakeholders. This is vital to ensuring we target the issues of greatest importance to community, that we do so in a respectful and culturally appropriate manner, and that our data adequately contextualises health inequity for First Nations children and recognises the strengths and diversity of Aboriginal and Torres Strait Islander communities.[12]

Figure 4 *Over-representation of First Nations children*[‡]



---

[*] These figures represent average rates for the 5-year period from 2015 to 2019.

[†] For the 3-year period from 2018 to 2021.

[‡] Average over the 5-year period 2015 to 2019.[10]

Children known to statutory systems

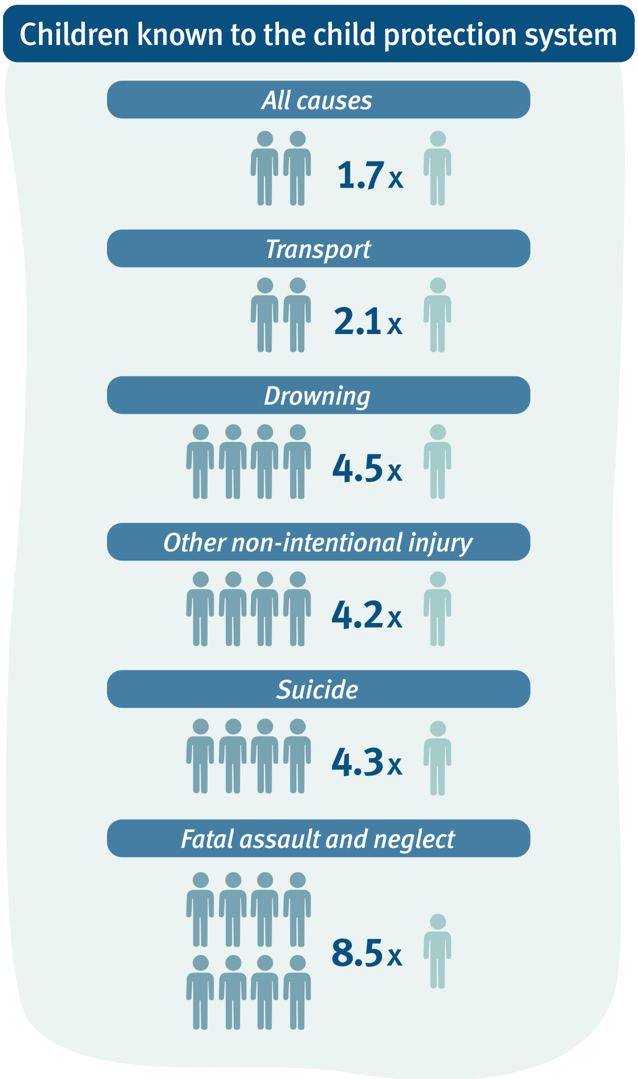
Children who are known to statutory systems are likely to have experienced adversity or belong to social groups subject to structural inequalities. It is often the nature of these experiences that has brought them into contact with these systems to begin with.

These children are at increased risk of premature death. QFCC data indicates that overall, children known to the child protection system die at 1.7 times the rate of all Queensland children.[10*] When examining external causes only – that is, those deaths typically considered avoidable – this level of over-representation rises to more than 4 times the mortality rate for all Queensland children. Children known to the child protection system die by suicide at 4.3 times the rate of all Queensland children, of fatal assault and neglect at 8.5 times the rate, and of drowning at 4.5 times the rate.[10†]

The Queensland Child Death Review Board reviews the deaths of children known to the child protection system and identifies system improvements. By focusing on factors contributing to health inequity for these children, the QFCC contributes to the knowledge base of the Child Death Review Board as it undertakes this important work.

The QFCC will lead work to better understand the experiences of children involved with the youth justice system prior to their death. While there is significant overlap with the population of children known to the child protection system, factors influencing the behaviours that lead to contact with the youth justice system are worthy of further investigation.

Figure 5 *Over-representation of children known to the child protection system*[‡]



---

* For the 5-year period from 2015 to 2019.

† For the 5-year period from 2015 to 2019.

‡ Average over the 5-year period 2015 to 2019.[10]

Other priority populations

Children with **disability** are at greater risk of adverse experiences. For example, children with disability have been found to be 3.5 times more likely to experience violence than other children. This may compound existing health problems and increase their risk of premature death.[13]

In Queensland, almost 40 per cent of children aged 0–14 years live outside of major cities, with two-thirds of First Nations children living in regional and remote areas.[14] Australians living in **rural and remote areas** have shorter life expectancy, higher levels of disease and injury, and poorer access to and use of health services than people living in metropolitan areas.[15] The poorer outcomes experienced by families in rural and remote areas may be due to multiple factors, including social isolation, disadvantage related to reduced education and employment opportunities, and limited access to health and social services.[15]

There is considerable evidence that **lower socio-economic status** during childhood is associated with a greater risk of experiencing premature death.[10,16] Of the 10 most disadvantaged local government areas in Australia, 7 are located in Queensland,[17] providing further reason for us to focus on children living in socio-economically disadvantaged areas.

In addition, children **under 5 years of age**, while not necessarily at increased risk of adversity, also represent a priority population. This is due to their complete reliance on parents, carers, and the other adults in their lives for their care, protection and survival.

In the prevention activities we undertake, we will highlight where children from rural and remote and low socio-economic areas, children with a disability and children under 5 are disproportionately affected.

Focus areas

We have identified several focus areas that have strong links to social disadvantage and health inequity. They include specific causes of child mortality, risk factors that contribute to deaths from several different causes, and underlying factors linked to broader social issues.

Figure 6 (on page 16) provides a visual representation of the focus areas the Safer pathways framework will address over the next 5 years.

Family-level adversity

One of our key priorities is to establish a clearer understanding of the impact of a child's interpersonal context, including family-level adversity. This is the most readily measurable component of health inequity.

Family-level adversity refers to a range of events that can cause trauma to a child, such as abuse and neglect or growing up in a family engaged in criminal behaviour, misusing alcohol and substances, experiencing mental illness or domestic and family violence.* The cumulative impact of these experiences has been linked with chronic stress and long-term adverse outcomes.[13,18,19]

Exposure to adversity in childhood is a growing public health concern globally. Recent research has found that those children with 4 or more adverse experiences who have died were more than 22 times more likely to have died from avoidable and non-natural causes (such as injury, abuse or suicide) than of conditions that are not typically considered preventable.[13]

Since 2013, the QFCC has collected data on a range of indicators (mental health, domestic and family violence, alcohol and substance use, and others) about children who have died. This data indicates that over a third of

Disadvantage and inequity in priority populations

In acknowledging the higher rates of death and the disadvantaged social circumstances experienced by many families from priority populations, we stress that this does not imply that social groups experiencing disadvantage are to blame. In all efforts to highlight the social and economic determinants contributing to health inequity, we have recognised the strength of communities' health assets – the collective resources that individuals and communities have at their disposal, such as knowledge, skills, networks, extended family and cultural identity – which reduce negative health outcomes and promote health and wellbeing.

---

* The QFCC's concept of 'family-level adversity' is grounded in research relating to the impact of adverse childhood experiences (ACEs). There are 10 ACEs that have been demonstrated to have a cumulative impact on outcomes in later life. These are included in a broader list of stressful life events defined as 'family-level adversity' by the QFCC.

deaths have at least one of these factors present for either the child or their family.* Further work is required to expand and refine this dataset. This includes working with stakeholders to build our capacity to collect and analyse information about adverse experiences present in the lives of children who have died.

This will support work to create a more comprehensive understanding of the relationship between family-level adversity and an increased risk of death during childhood.

The information collected through child death review and prevention processes provides a unique opportunity to understand the association between adverse experiences and childhood mortality. Such information may illuminate risk factors that can be addressed by health, social, criminal justice and other agencies through prevention and response measures.[13]

> No normal 12-year-old
> is stealing cars
> if everything is okay
> at home.
>
> ***Aimee***
> *QFCC Youth Advocate*

Risk-taking

Risk-taking behaviour is linked to many external causes of death among children, particularly those aged between 10 and 17.[10,11] Examples of risk-taking behaviours include alcohol and substance misuse, youth offending, risky driving behaviours, risk-taking around water hazards, and peer-to-peer violence.

Behavioural problems, including risk-taking behaviour, have also been identified as an indicator of suicide risk.† In addition, there is value in monitoring emerging trends associated with the increased exposure to, and impact of, technology and social media.

Risk-taking may also be evident in the behaviour of parents, with consequences for the safety of their children – particularly younger children who are dependent on them for their care and survival. This could include leaving young children unsupervised in unsafe situations, engaging in substance use and criminal activity around their children, or sharing a sleep surface with their infant in the context of known risk factors.

The QFCC aims to understand how risk-taking presents across these scenarios. Doing so will require efforts to better define the concept of risk-taking and improve data collection. This includes recognising that taking risks is an important feature of healthy adolescent development. We must distinguish between what is safe, acceptable and ethical, and what is unsafe and unacceptable.

> Taking risks is part of healthy
> adolescent development.
> We must distinguish
> between normal levels
> of risk-taking and unsafe,
> unacceptable risk-taking
> behaviour.

---

* Data relating to these characteristics has only been collected since 2013, and is only available for deaths reported to a coroner (primarily deaths from external or unexplained causes). Of the deaths from external and unexplained causes recorded between 2013 and 2019, 37 per cent had at least one of these characteristics noted, relating either to the child or their family.[10]

† In the opinion of the QFCC Youth Advocates, risk-taking in this context does not include self-harm and suicidal behaviour. They see these as help-seeking behaviours. QFCC's Youth Advocates are members of its Youth Advisory Council, which provides youth perspectives, leadership and advice to the Commissioners on what is important to children and young people in Queensland.

Supervision

Supervision plays a critical role in preventing child deaths, particularly of children under 12 years of age.

Providing guidance for parents about appropriate supervision is challenging, as children's needs change rapidly with their developing capabilities, and risks vary by circumstance. Supervision is further complicated by the experience of social disadvantage, with families faced with a range of competing priorities over and above the regular challenges of parenting.

We plan to work towards a clearer model of supervision for children up to 12 years of age. We will seek to understand the experiences of families from a range of backgrounds, particularly First Nations and culturally and linguistically diverse families, where roles and responsibilities may be shared with many members of a family group.

Help-seeking and access to services

We aim to identify ways to improve government and non-government systems and services to reduce the level of health inequity experienced by families. We are interested in reviewing the circumstances in which families have sought the assistance of services prior to a child death, particularly those where timely, appropriate supports were not available or accessed.

Examples of where this may be relevant include help-seeking by young people experiencing suicidal ideation,* parents seeking medical help for their child prior to a death from preventable natural causes, parents engaging with antenatal care (a factor known to protect against sudden infant death), and families seeking help prior to a death from assault or neglect. We will identify factors that may discourage or prevent help-seeking, particularly among priority populations, and whether available services are culturally safe.† As a result of our consultation with the QFCC's Youth Advocates, we will also focus on barriers to help-seeking by young people. We will examine ways in which services may reach out to families, rather than relying on them seeking help.

> **Self-harm is help-seeking, not risk-taking.**
>
> *Grace*
> *QFCC Youth Advocate*

Environmental hazards, product safety and regulation

Some of the most effective ways of addressing safety hazards are through regulation, design and safety standards. This is because they are less reliant on individual behaviour change than many other approaches.

We will consider the role of regulatory and design mechanisms, such as:

- pool fencing requirements
- young driver licensing
- improved infrastructure to provide safer routes for children to walk and cycle (active travel)
- product safety standards
- workplace health and safety laws.

Building capacity and monitoring trends

We have identified a range of issues on which further work is needed to define and record certain information relating to child deaths. We will prioritise data improvements relating to the following areas.

Identifying First Nations children

Accurately identifying First Nations peoples within administrative datasets has been an ongoing challenge in Australia, with a variety of factors producing an undercount of the number of Aboriginal and Torres Strait Islander people affected by particular social conditions.[20] The QFCC receives information from numerous sources, which can mean we are given conflicting information about whether a child and their family identified as Aboriginal and/or Torres Strait Islander. The QFCC will ensure that the process for identifying the status to use for reporting is as robust and culturally appropriate as possible. Improving the identification of First Nations children within the Child Death Register will facilitate a better understanding of the impacts of a variety of issues on health and wellbeing.

---

* Suicidal ideation is contemplation or preoccupation with death or suicide, ranging from fleeting thoughts to well-thought-out plans for suicide.[27]

† Cultural safety for Aboriginal and Torres Strait Islander peoples, as defined by the Department of Children, Youth Justice and Multicultural Affairs, refers to 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.'[Williams, cited in 28]

Impacts of COVID-19

The COVID-19 pandemic has had a dramatic impact on the lives of children and families across the globe, including by 'slowing and in some cases reversing the gains in child health and survival achieved over the past two decades'.[21] We need to be aware of the indirect effects of the pandemic and the steps governments have taken to manage it. These may include:

- mental health impacts arising from the pandemic and disruptions to social connections
- the effects of disruptions to education
- reduced access to face-to-face health and wellbeing services and/or a lack of accessibility to digital replacement services
- increased family and financial stress
- reduced opportunity for family, friends and services to monitor children's welfare and report concerns
- differences in families' ability to access vaccinations, testing and personal protective equipment
- potential for vaccine injury and long COVID.

These are emerging areas of risk and require us to build capacity to identify, record and report on their impacts on child deaths over time.

Youth suicide

The QFCC has identified a statistically significant increase in the rate of suicide among young people aged 15–17 years since 2004.[10] Suicide disproportionately affects young people known to statutory systems and First Nations young people. There is an urgent need to better understand and record factors that may be influencing the increase in youth suicide, such as adverse childhood experiences and health inequity.

We also intend to build our capacity to identify and record *suicide contagion* (where the suicide of one person influences the suicide of another) and suicide clusters (where suicides occur close together in time and space).[22]

Sudden unexpected death in infancy

Extensive research conducted on sudden unexpected death in infancy (SUDI) has established that, in contemporary western society, it is a phenomenon predominantly experienced by socially disadvantaged families. Families known to the child protection system, First Nations families, and families living in low socio-economic areas are all disproportionately represented in SUDI statistics.

There is a clear need to identify ways to address the barriers these families face that prevent them adopting safer sleep recommendations. This should be considered in the context of rising costs of living and housing affordability, which can result in homelessness and overcrowding.

Formulating safer infant sleep recommendations is dependent on the accuracy of data collected about SUDI and the way in which it is analysed. There are growing calls within Australia and internationally to improve the consistency and accuracy of infant death certification, and of the specific causes that should be grouped together when analysing SUDI deaths.

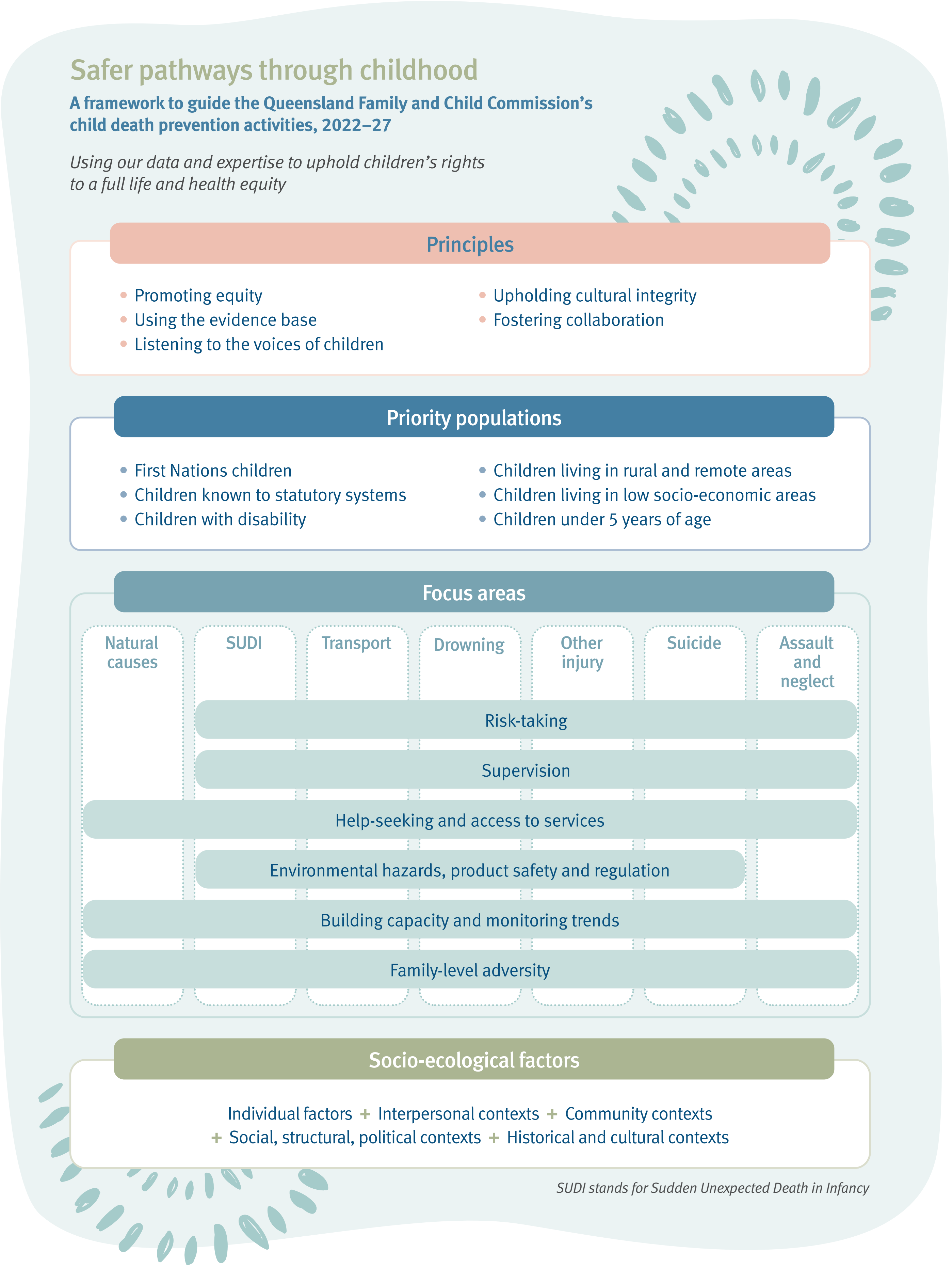
The QFCC is well-placed to partner with experts in ongoing work in relation to SUDI.

Deaths from preventable natural causes

Social disadvantage is strongly associated with deaths from natural causes, particularly among the youngest age groups, and we will expand the data we hold about indicators of social disadvantage.

There is value in building our capacity to address those most readily preventable. This includes deaths as a result of infections and other conditions not expected to cause death.

Figure 6 *Safer pathways through childhood framework – a visual representation*



Safer pathways through childhood

A framework to guide the Queensland Family and Child Commission's child death prevention activities, 2022–27

Using our data and expertise to uphold children's rights to a full life and health equity

Principles

- Promoting equity
- Using the evidence base
- Listening to the voices of children
- Upholding cultural integrity
- Fostering collaboration

Priority populations

- First Nations children
- Children known to statutory systems
- Children with disability
- Children living in rural and remote areas
- Children living in low socio-economic areas
- Children under 5 years of age

Focus areas

Socio-ecological factors

Individual factors + Interpersonal contexts + Community contexts + Social, structural, political contexts + Historical and cultural contexts

SUDI stands for Sudden Unexpected Death in Infancy

Methodology for developing the Safer pathways framework

In developing this framework, we used the extensive data available through the Child Death Register, developed an evaluation methodology, consulted with stakeholders, and considered relevant state and national strategies.

Our child death data

The child death review process helps us to identify patterns in child deaths and reflect on what can be learned from the death of a child. In 2020, we conducted a review of trends and patterns in child mortality since the Child Death Register began operation in 2004 (the **Counting lives, changing patterns** report). This provided critical findings about changes that have occurred over time. These findings helped generate issues for the Safer pathways framework.

Over the 16-year period under review (2004–2019), there was a statistically significant decrease in the annual rate of child deaths in Queensland, dropping an average of 3 per cent per year. Nonetheless, Queensland children still died at a rate of 33.1 per 100,000 children aged 0–17 years (2017–2019).[10]* Many of these deaths were from preventable causes, described under the following major groupings.

Infant mortality

Infant mortality rates are a measure of a population's overall health. They provide an indication of the social, environmental and economic circumstances into which a child is born (including factors such as maternal health) as well as the effectiveness, availability and accessibility of healthcare systems.[23] While infant mortality has declined since 2004, First Nations infants remain over-represented in the figures. In the 5-year period ending 2018, First Nations infants died at a rate of 6.5 per 1,000 live births, compared with 3.8 per 1,000 for non-Indigenous infants.[10]

Rates of unexplained infant deaths, which include sudden infant death syndrome (SIDS) and undetermined causes, also changed over time. The rate of SIDS deaths between 2011 and 2019 decreased by 17.4 per cent per year on average.[10] This is statistically significant. Unexplained infant deaths are, in the main, considered preventable and are largely associated with the social determinants of health, as they occur more often in low socio-economic areas.†

Transport fatalities

Deaths in transport incidents have decreased dramatically over time, with the annual rate falling by an average of 7.9 per cent per year, from 4.7 per 100,000 (2004–2008) to 1.7 per 100,000 (2015–2019).[10] However, they remain one of the leading external causes of death, particularly for older children, with risk-taking a key theme.

From the age of 10, risk-taking behaviours begin to increase, at a time when children have reduced supervision and increased access to a broader range of environments.[24] As children approach adulthood (15–17 years), they begin to undertake adult activities such as driving and employment. They may also use alcohol and drugs. These factors can increase their exposure to risk, particularly in the context of transport incidents.[24]

---

* The QFCC's most recent annual report identifies that the average rate between 2019 and 2021 was 32.9 deaths per 100,000 children aged 0–17 years.[11]

† The QFCC's review identified that deaths from unexplained causes (primarily infant deaths) were 2.4 times higher in very low socio-economic areas.

Drowning

Between 2004 and 2019, drowning deaths decreased slightly. However, children under 5 years of age remain most at risk.

Supervision is vital to drowning prevention. In 82.8 per cent of drownings of children under 5 years during the 16-year period, the child was not actively supervised.[10] Pool fencing forms another line of defence against drowning. However, 32 per cent of pool drownings of children under 5 (2004–2019) occurred in pools without any identifiable defects. In some of these cases, pool gates had been deliberately propped open or children left in the pool area unsupervised.[10]

Other non-intentional injury

This category groups together non-intentional deaths that occur too infrequently to be analysed separately, such as falls, being struck by falling objects, threats to breathing, fire and explosions, electrocution, exposure to excessive heat, and poisoning.

It is difficult to discern clear patterns, given the many different causes of death included, but prevention measures often include product safety and regulation. Examples include smoke alarm requirements for residential properties, child-resistant packaging for items such as button batteries, and product safety standards.

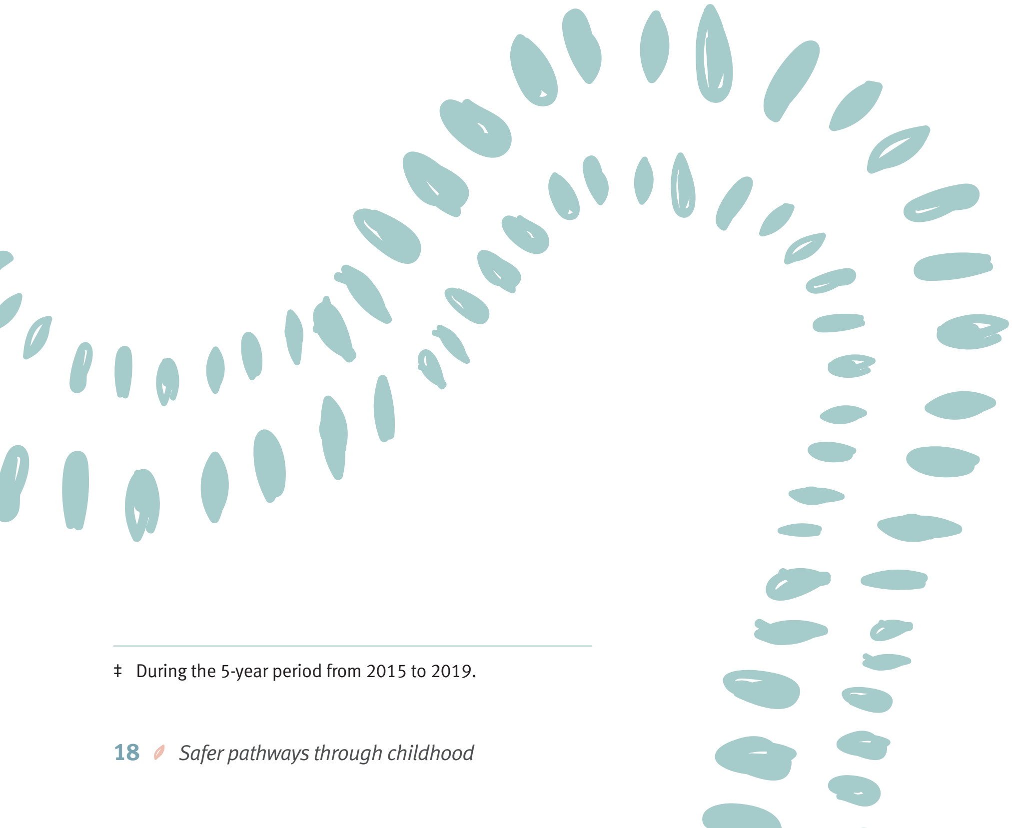
Suicide

Across the 16-year period reviewed by the QFCC, suicide was the only cause of death to have increased over time.

This increase was primarily concentrated in the 15 to 17-year age group. Suicides in this age group increased significantly, from 7.4 per 100,000 children in 2004–2008 to 10.3 per 100,000 in 2015–2019.[10] First Nations children and those known to child protection are also consistently over-represented in suicide statistics. While Aboriginal and Torres Strait Islander children made up approximately 8 per cent of the child population in Queensland, they accounted for more than 25 per cent of suicides between 2004 and 2019, dying at 2.9 times the rate of non-Indigenous children.[10‡]

Fatal assault and neglect

While child deaths from assault and neglect are relatively rare, more than 80 per cent of these deaths happen within families, with the alleged perpetrator being a parent, carer or other family member.[10] A small proportion (less than 20 per cent) of deaths from assault and neglect are perpetrated by people outside the child's family. These may involve older children and can include peer-to-peer violence, intimate partner violence, or assault by a stranger or acquaintance.



---

‡ During the 5-year period from 2015 to 2019.

Evaluating the options

Drawing on the findings of the *Counting lives, changing patterns* report, we identified those issues that most contributed to deaths within each of these major groupings. We also identified a number of overarching priorities that cross multiple causes and categories, as well as some emerging areas of interest, such as the impacts of COVID-19.

To help determine which of these should be the QFCC's focus over the next 5 years, we considered the following elements:

Mortality rate

We prioritised areas of focus that stand to reduce the greatest number of child deaths over those affecting fewer children, although exceptions apply.

Priority populations

We prioritised areas relating to causes or risk factors that disproportionately impact on particular cohorts of children, in order to address inequity leading to their over-representation in child deaths.

Opportunity for prevention

We prioritised areas in which there is a clear opportunity for data and expertise to prevent child deaths by contributing to the evidence base or advocating for changes to laws, policies, practices or behaviours.

Existing initiatives

Where a saturation of prevention initiatives targeting a priority area exists, we considered there was less need for our involvement, unless we identified a clear research or policy gap.

Impact

We considered whether each area of focus could feasibly be addressed within the functions, powers and resourcing of the QFCC. Where this was not possible, we explored the possibility of collaborating with stakeholders.

Child rights and health equity

We considered each focus area's impact on child rights. Each priority area represents an opportunity for systems, services, communities, parents and carers to better uphold the rights of children and create healthier and safer environments for them to achieve health equity.

Consultation

The Safer Pathways Working Group

A working group made up of experts in child death prevention, oversight, evaluation, policy, advocacy, youth engagement, media, and the child protection and youth justice systems convened to evaluate each of the potential focus areas using our evaluation methodology. This process helped to identify the areas of focus we have included in the framework.

Youth Advocates

To ensure these prevention priority areas appropriately reflected concerns held by children and young people, the QFCC also consulted with members of its Youth Advisory Council (Youth Advocates). Children and young people are often excluded from policy processes, despite the unique and valuable contributions they can make.

They endorsed the focus on health equity, acknowledging that there are lots of factors outside of young people's control that may increase their risk of death or injury.

Youth Advocates provided useful feedback on the need to recognise the diversity of children's living situations; the impact of non-physical domestic and family violence; and the ongoing effects of parental separation and divorce – particularly the impact of Family Court proceedings and ongoing conflict between parents.

The Youth Advocates also provided feedback about risk-taking. They wanted to make sure we understood that the presence of risk factors did not automatically mean a young person was engaging in risk-taking, and they felt strongly that self-harm and suicide attempts constituted help-seeking rather than risk-taking behaviour.

Help-seeking was an important topic for the Youth Advocates, particularly in relation to help-seeking by young parents, barriers to accessing mental health supports, and inconsistent/inadequate service responses to self-harm and suicide attempts.

They were eager to see young people directly engaged in prevention activities. Even though child death prevention is a sensitive topic, the Youth Advocates felt strongly that where young people are able to give informed consent, their participation in projects under the Safer pathways framework is vital.

External stakeholders

We sought feedback from a broad range of government and non-government stakeholders. These included:

- stakeholders involved with collecting and recording data about child deaths
- other government agencies with responsibilities relating to children, or matters affecting them under this framework
- researchers and academic institutions conducting research into relevant topics
- other bodies responsible for reviewing deaths
- agencies concerned with the health and wellbeing of First Nations people.

Our stakeholders were supportive of our health equity approach to child death prevention, in particular, our use of a socio-ecological model to underpin this work. They agreed with the focus areas we have identified and provided feedback.

Our consultation with external stakeholders has assisted in identifying a number of prevention activities and partnerships the QFCC will progress during its first year of implementing the Safer pathways framework.

Related strategies and plans

The QFCC's Safer pathways framework fits within a network of state and federal strategies and plans that are concerned with the prevention of death or injury from particular causes, the reduction of health inequity, and the provision of improved services to children and families.

These include (but are not limited to):

- the *National Injury Prevention Strategy 2020–2030*
- the *National Children's Mental Health and Wellbeing Strategy*
- the *National Action Plan for the Health of Children and Young People: 2020–2030*
- *Safe and Supported: The national framework for protecting Australia's children*
- *Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework*
- *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037*
- *Every life: The Queensland Suicide Prevention Plan 2019–29*
- the *Australian Water Safety Strategy 2030: Towards a nation free from drowning*
- the Queensland *Road Safety Education Blueprint*.

Next steps

A 5-year plan

Figure 6 (on page 16) sets out the focus areas we will address over the next 5 years and identifies which of the major causes of death will be covered by these topics.

In implementing this framework we will continue to collaborate with a broad range of stakeholders to identify and co-design specific projects to target the focus areas.

This will ensure that prevention activities:

- represent the needs of children, families and communities, particularly those who are most vulnerable
- are undertaken in collaboration with relevant experts
- are better able to influence programs and services delivered to children and families.

Action plans

We will release action plans to support the implementation of the Safer pathways framework. Each of these action plans will be developed in collaboration with key stakeholders and will provide details about the specific prevention activities for each period.

The *Safer pathways through childhood* action plans will be available on the **QFCC website**.

Measuring the impact of our child death prevention activities

The QFCC is accountable to parliament and the public for our contributions to child death prevention initiatives. We must monitor and evaluate the impact and outcome of the prevention activities conducted under the Safer pathways framework.

To understand how best to do this, it is important to understand how health promotion activities operate. Some prevention activities act at a systemic level to target the underlying social conditions linked to factors (environmental, social, economic and behavioural) that increase the risk of disease and injury.* Other prevention activities aim to decrease risk factors and promote healthy behaviours in susceptible populations, thereby reducing death, injury and illness. These are termed 'primary' prevention strategies. They occur 'upstream' at the community level and also focus on legislation and healthy public policy and programs to target the underlying social conditions that contribute to disease and injury. In doing so, they aim to create conditions that support safe, healthy choices at the family and individual level.

Primary prevention engages many sectors, partners, and settings to tackle the causes of child health inequity. Much of the work the QFCC is undertaking with the Safer pathways framework targets these upstream factors and aims to influence primary prevention efforts.

Measuring and demonstrating the progress of primary prevention is challenging, due to its complex and long-term nature.[25] We acknowledge that it may take many years of sustained prevention efforts across multiple settings before the activities under this framework create quantifiable reductions in mortality rates.

In addition, the many factors that influence child mortality (many of which are beyond any one agency's control) make it difficult to demonstrate a causal link between any prevention initiative and a reduction in mortality. For example, reductions in rates of sudden infant death within First Nations families will require increased access to culturally safe antenatal and maternity care on country; reductions in maternal smoking during pregnancy; and increased housing accessibility and affordability to reduce overcrowding, which contributes to unsafe shared sleep environments.[26]

Similarly, reducing youth suicide may require improvements in the affordability, availability and accessibility of mental health services for pre-teen and teenage children.

Most of the child death prevention activities we undertake involve research and advocacy. The QFCC does not have a service delivery role; rather we exert our influence by advocating for changes to services, programs, policy and legislation.

---

* Known within the research literature as *primordial prevention*.

Some of the actions we will undertake over the next 5 years are intended to build our capacity to monitor and report on the drivers that contribute to disparities in preventable childhood mortality. Such activities, while integral to developing a more nuanced understanding of child deaths and the interventions that may be required to reduce them, will not directly impact on mortality rates.

Despite these challenges, each prevention activity outlined in our action plans will include a focus on monitoring impacts, outcomes and measures of success. This may include:

- making formal recommendations and monitoring the implementation of these
- conducting post-implementation reviews of the success of the changes made
- developing partnerships with agencies and organisations with service delivery responsibilities
- creating linkages to other datasets to improve our data
- surveying our stakeholders to determine how our findings have been applied in practice
- measuring community awareness where applicable.

We will report publicly on the impacts and outcomes of the prevention activities conducted under the Safer pathways framework in our annual report on child deaths, available on the QFCC website.

Acknowledgements

The QFCC thanks the government and non-government agencies and individuals who contributed data and expertise to the development of this framework. In particular, we wish to thank the Youth Advocates who gave their time to contribute their perspectives.

The QFCC acknowledges that the contents of this document may cause distress to some people. If you need help or support, please contact any of these services:

Lifeline
Phone: **13 11 14**

Beyond Blue
Phone: **1300 22 4636**

Kids Helpline
(for 5–25-year-olds)
Phone: **1800 55 1800**

References

1. Unicef (2019). ‘Four principles of the Convention on the Rights of the Child’, *United Nations Convention on the Rights of the Child*. Accessed 25 May 2022. https://www.unicef.org/armenia/en/stories/four-principles-convention-rights-child
2. World Health Organization. *Constitution (1948)*. Accessed 16 May 2022. https://www.who.int/about/governance/constitution
3. Queensland Health (2021) *Making Tracks Together: Queensland’s Aboriginal and Torres Strait Islander Health Equity Framework*. Accessed 16 May 2022. https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1121383/health-equity-framework.pdf
4. Australian Institute of Health and Welfare (2020) *Australia’s children*. Accessed 17 May 2022. https://www.aihw.gov.au/getmedia/6af928d6-692e-4449-b915-cf2ca946982f/aihw-cws-69-print-report.pdf.aspx?inline=true
5. Commission on Social Determinants of Health (2008) *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. Accessed 22 March 2022. https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf
6. Arcaya MC, Arcaya AL & Subramanian SV (2015) ‘Inequalities in health: Definitions, concepts, and theories’, *Global Health Action* 8. Accessed 17 May 2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4481045/
7. Baba JT, Brolan CE & Hill P S (2014) ‘Aboriginal medical services cure more than illness: A qualitative study of how Indigenous services address the health impacts of discrimination in Brisbane communities’, *International Journal for Equity in Health* **13**, 56–66.
8. Centre for Community Child Health (2012) *A Snapshot of Early Childhood Development in Australia 2012: Australian Early Development Index National Report*. (Australian Early Development Census). Accessed 24 May 2022. https://www.aedc.gov.au/resources/detail/national-report-2012
9. Australian Bureau of Statistics (2018) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*. Accessed 16 May 2022. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release
10. Queensland Family and Child Commission (2020) *Counting lives, changing patterns: findings from the Queensland Child Death Register 2004–2019*. Accessed 19 May 2021. https://www.qfcc.qld.gov.au/sites/default/files/2022-06/QFCC%2016%20Year%20Review_0.pdf
11. Queensland Family and Child Commission (2021) *Annual Report: Deaths of children and young people, Queensland, 2020–21*. Accessed 3 March 2022. https://www.qfcc.qld.gov.au/sites/default/files/2022-06/QFCC_Deaths_children_young_people_Qld_2020%E2%80%9321_Accessible.PDF
12. Bodkin-Andrews G, Walter M, Lee V, Kukutai, T & Lovett, R (2019) ‘Delivering Indigenous data sovereignty’, in *National Indigenous Research Conference* (Australian Institute of Aboriginal and Torres Strait Islander Studies). Accessed 24 May 2022. https://aiatsis.gov.au/publication/116530
13. Grey HR, Ford K, Bellis MA, Lowey H & Wood S (2019) ‘Associations between childhood deaths and adverse childhood experiences: An audit of data from a child death overview panel’, *Child Abuse & Neglect* **90**, 22–31.
14. Australian Bureau of Statistics (2018) ‘Estimated resident Aboriginal and Torres Strait Islander and non-Indigenous population, states and territories, Remoteness Areas – 30 June 2016’, *Estimates of Aboriginal and Torres Strait Islander Australians*. Accessed 17 May 2022. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release#data-download
15. Australian Institute of Health and Welfare (2020) ‘Rural and remote health’, *Australian Institute of Health and Welfare*. Accessed 16 May 2022. https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health

16. Kim D & Saada A (2013) 'The social determinants of infant mortality and birth outcomes in Western developed nations: A cross-country systematic review', *International Journal of Environmental Research and Public Health* **10**, 2296–z2355.

17. Australian Bureau of Statistics (2018) 'Census uncovers Australia's most advantaged and disadvantaged areas' [media release], *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016*. Accessed 17 May 2022. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2016~Media%20Release~Census%20shows%20our%20most%20advantaged%20&%20disadvantaged%20areas%20(Media%20Release)~25

18. Joining Forces for Children (n.d.) 'What are adverse childhood experiences?' *Joining Forces for children*. Accessed 25 March 2021. https://www.joiningforcesforchildren.org/what-are-aces/

19. Center for Disease Control (2019) 'Adverse childhood experiences (ACEs): Preventing early trauma to improve adult health', *Vital Signs*. Accessed 17 February 2022. https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

20. Thompson SC, Woods JA & Katzenellenbogen JM (2012) 'The quality of Indigenous identification in administrative health data in Australia: Insights from studies using data linkage', *BMC Medical Informatics and Decision Making* **12**, 133–146.

21. Ghebreyesus TA & Russell C (2022) 'Opportunities in crisis for optimising child health and development', *The Lancet* **399**, 1830 –1844.

22. Kolves K & Koo YW, Australian Institute of Suicide Research and Prevention (2019) Re*view of suicide clusters and evidence-based prevention strategies for school-aged children*, NSW Ombudsman. Accessed 17 May 2022. https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0020/133715/Review-of-Suicide-clusters-and-evidence-based-prevention-strategies-for-school-aged-children.pdf

23. Australian Institute of Health and Welfare (2018) 'Infant mortality', *Children's Headline Indicators*. Accessed 3 March 2022. https://www.aihw.gov.au/reports/children-youth/childrens-headline-indicators/contents/2-infant-mortality

24. Pointer S, Australian Institute of Health and Welfare (2014) *Hospitalised Injury in Children and Young People 2011–12*. Accessed 2 March 2022. https://www.aihw.gov.au/getmedia/0bf3dcfe-f3b6-4857-9116-f28bfc2649c8/17903.pdf.aspx?inline=true#:~:text=Just%20over%20130%2C000%20children%20and,for%20the%20older%20age%20group

25. Clendon J, Munns A & McMurray A (2019) *Community health and wellness: Principles of primary health care*, Elsevier.

26. Shipstone RA, Young J, Kearney L & Thompson JMD (2020) 'Prevalence of risk factors for sudden infant death among Indigenous and non-Indigenous people in Australia', *Acta Paediatrica* **109**, 1–13.

27. Headspace (2009) *MythBuster: Suicidal Ideation*. Accessed 24 May 2022. https://headspace.org.au/assets/download-cards/suicidal-ideation-mythbusterv2.pdf

28. Department of Children Youth Justice and Multicultural Affairs (2021) 'Cultural safety', *Child Safety Practice Manual*. Accessed 23 May 2022. https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/working-with-aboriginal-and-torres-strait-islander/seeing-and-understanding/cultural-safety

Queensland
Family & Child
Commission

Queensland
Government