Appendices

Appendix A — Summary tables on child deaths in Queensland

Table A.1: Summary of deaths of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All deaths						
Deaths of children 0–17 years	419	385	386	378	398	32.9[a]
Cause of death						
Natural causes	**325**	**289**	**267**	**258**	**266**	**22.4[a]**
External causes	**73**	**72**	**92**	**77**	**86**	**7.2[a]**
Transport	14	24	22	21	31	1.9
Drowning	19	10	16	13	10	1.2
Other non-intentional injury-related death	15	14	8	9	12	1.0
Suicide	20	24	37	21	30	2.3
Fatal assault and neglect	5	0	9	13	3	0.5
Unexplained causes	**20**	**24**	**27**	**34**	**17**	**2.1**
SIDS and undetermined causes	20	24	24	19	17	1.8
Cause of death pending	1	**0**	0	9	**29**	**0.7**
Sudden Unexpected Deaths in Infancy (SUDI)						
Sudden unexpected infant deaths	30	33	26	35	34	0.5[a,b]
Sex[c]						
Female	190	163	162	163	185	30.4
Male	229	221	224	214	213	36.9
Age category						
Under 1 year	268	242	220	246	239	3.8[a,b]
1–4 years	53	41	50	42	41	17.8
5–9 years	27	21	27	17	19	6.6
10–14 years	35	31	32	28	31	9.6
15–17 years	36	50	57	45	68	27.5
Aboriginal and Torres Strait Islander status						
Indigenous	63	73	65	66	71	69.6[a]
Non-Indigenous	356	312	321	312	327	29.6[a]
Known to the child protection system						
Known to Child Safety	58	48	58	53	53	61.2

Data source: Queensland Child Death Register (Aug-2021)

a 3-year average rate.

b Rate per 1,000 live births for SUDI and age under 1 year.

c Excludes deaths of children whose sex was indeterminate.

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting SUDI and age under 1 year which are per 1,000 live births.*
3. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Aboriginal and Torres Strait Islander children

Table A.2: Summary of deaths of Aboriginal and Torres Strait Islander children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
Aboriginal and Torres Strait Islander deaths						
Total	**63**	**73**	**65**	**66**	**71**	**69.6**[a]
Cause of death						
Natural causes	**49**	**48**	**40**	**40**	**41**	**45.5**
External causes	**12**	**19**	**19**	**19**	**16**	**17.7**
Transport	4	7	3	4	3	4.4
Drowning	3	2	3	1	4	2.7
Other non-intentional injury-related death	1	5	2	4	4	3.3
Suicide	3	5	10	7	4	6.1
Fatal assault and neglect	1	0	1	3	1	1.3
Unexplained causes	**2**	**6**	**6**	**6**	**3**	**4.8**
SIDS and undetermined causes	2	6	6	6	3	4.8
Cause of death pending	**0**	**0**	**0**	**1**	**11**	**2.5**
Sudden Unexpected Deaths in Infancy (SUDI)						
Sudden unexpected infant deaths	4	10	5	9	11	1.2[b]
Age category						
Under 1 year	39	46	37	45	48	6.5[a,b]
1–4 years	5	8	9	6	8	33.0
5–9 years	8	5	4	1	1	13.9
10–14 years	4	4	6	4	4	16.8
15–17 years	7	10	9	10	10	61.8

Data source: Queensland Child Death Register (Aug-2021)

a 3-year average rate.

b Rate per 1,000 live births for SUDI and age under 1 year.

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Aboriginal and Torres Strait Islander status recorded in the Register is based on source documents. An audit was undertaken of decisions where the status in sources was inconsistent and in some cases the status was changed. As a result, there may be minor differences from previously reported mortality data by Indigenous status. Further information on the decision process can be found in Appendix B – Methodology.*
3. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for SUDI and age under 1 year which are per 1,000 live births.*
4. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*

Children known to Child Safety

Table A.3: Summary of deaths of children known to Child Safety in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
Deaths of children known to Child Safety						
Total	**58**	**48**	**58**	**53**	**53**	**61.2**
Cause of death						
Natural causes	**26**	**25**	**22**	**15**	**17**	**23.8**
External causes	**27**	**18**	**30**	**27**	**22**	**28.1**
Transport	2	5	2	5	5	4.3
Drowning	10	5	5	2	5	6.1
Other non-intentional injury-related death	2	6	2	2	6	4.1
Suicide	8	2	14	8	4	8.2
Fatal assault and neglect	5	0	7	10	2	5.4
Unexplained causes	**4**	**5**	**6**	**9**	**5**	**6.6**
SIDS and undetermined causes	4	5	6	9	5	6.6
Cause of death pending	**1**	**0**	**0**	**2**	**9**	**2.7**
Sudden Unexpected Deaths in Infancy (SUDI)						
Sudden unexpected infant deaths	7	10	8	9	13	*
Age category						
Under 1 year	15	20	18	18	24	*
1–4 years	18	11	12	16	9	*
5–9 years	9	5	5	2	5	*
10–14 years	6	3	8	7	8	*
15–17 years	10	9	15	10	7	*

Data source: Queensland Child Death Register (Aug-2021)

* *Rate not calculated as no denominator data are available.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *The number of children known to the child protection system represents the number of children, whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death.*
3. *Five-year average rates of death for children known to Child Safety use as a denominator the 5-year average number of children aged 0–17 years who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*
4. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*

Natural causes

Table A.4: Summary of deaths from natural causes of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All natural cause deaths						
Diseases and morbid conditions	325	289	267	258	266	24.1
Category						
Perinatal conditions	153	133	130	131	126	11.6
Congenital anomalies	88	70	61	81	73	6.4
Neoplasms	29	21	25	17	24	2.0
Infections[a]	19	28	10	9	5	1.2
Other disease or morbid conditions NEC	36	37	41	20	38	3.0
Sex[b]						
Female	152	125	116	109	125	22.1
Male	173	163	151	148	141	26.0
Age category						
Under 1 year	243	215	196	209	200	3.4[c]
1–4 years	30	23	27	16	18	8.9
5–9 years	19	14	14	9	12	4.1
10–14 years	17	22	17	14	13	5.1
15–17 years	16	15	13	10	23	8.3
Aboriginal and Torres Strait Islander status						
Indigenous	49	48	40	40	41	45.5
Non-Indigenous	276	241	227	218	225	22.2
Geographical area of usual residence (ARIA+)						
Remote	21	8	6	11	3	29.5
Regional	108	108	81	86	93	24.1
Metropolitan	188	161	171	155	167	23.0
Socio-economic status of usual residence (SEIFA)						
Low to very low	164	138	117	104	114	28.1
Moderate	52	50	50	61	51	22.7
High to very high	101	89	91	87	98	19.6
Known to the child protection system						
Known to Child Safety	26	25	22	15	17	23.8

Data source: Queensland Child Death Register (Aug-2021)

a 'Infections' is a hybrid category composed of ICD-10 Chapter I, Certain infectious and parasitic diseases; ICD-10 Chapter VI, Diseases of the nervous system, codes G00–G09 only; ICD-10 Chapter X, Diseases of the respiratory system, codes J00–J22 only.

b Excludes the deaths of 1 infant of indeterminate sex in 2017–18 and 2019–20 each.

c Rate per 1,000 live births for age under 1 year.

1. Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death

2. Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting for age under 1 year which is per 1,000 live births.

3. ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.

4. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.

Transport

Table A.5: Summary of transport-related deaths of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All transport deaths						
Transport	14	24	22	21	31	1.9
Incident type						
Motor vehicle	4	15	12	12	19	1.1
Pedestrian	5	7	7	6	4	1.1
Low-speed vehicle run-over	*3*	*5*	*3*	*2*	*3*	*0.3*
Motorcycle	2	0	2	1	5	0.2
Quad bike	0	1	0	1	2	0.1
Watercraft	1	1	0	0	0	*
Bicycle	1	0	1	1	1	0.1
Other	1	0	0	0	0	*
Sex						
Female	3	7	9	7	14	1.4
Male	11	17	13	14	17	2.4
Age category						
Under 1 year	1	1	0	0	1	*
1–4 years	4	7	5	2	5	1.8
5–9 years	2	3	6	3	4	1.1
10–14 years	2	3	4	5	5	1.2
15–17 years	5	10	7	11	16	5.3
Aboriginal and Torres Strait Islander status						
Indigenous	4	7	3	4	3	4.4
Non-Indigenous	10	17	19	17	28	1.7
Geographical area of usual residence (ARIA+)						
Remote	4	4	1	1	4	8.4
Regional	5	13	13	14	17	3.1
Metropolitan	5	7	8	5	9	0.9
Socio-economic status of usual residence (SEIFA)						
Low to very low	7	16	12	11	22	3.0
Moderate	6	2	4	4	7	2.0
High to very high	1	6	6	5	1	0.8
Known to the child protection system						
Known to Child Safety	2	5	2	5	5	4.3

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Low-speed vehicle run-over is a subset of the 'pedestrian' category; hence, summing categories will exceed the total.*
3. *Quad bike includes all-terrain vehicles (ATV) and side-by-side vehicles (SSV) (also known as utility task vehicles (UTV)).*
4. *The 'other' incident type category can include deaths involving aircraft, horse riding and specialised industrial vehicles.*
5. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland.*
6. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
7. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Drowning

Table A.6: Summary of drowning deaths of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All drowning deaths						
Drowning	19	10	16	13	10	1.2
Incident type						
Pool	7	6	8	6	2	0.5
Private pool	7	6	6	5	2	0.4
Public pool	0	0	2	1	0	*
Non-pool drownings	12	4	8	7	8	0.7
Bath	5	2	2	0	3	0.2
Beach or ocean	1	0	1	1	0	*
Dynamic waterway	1	1	3	2	1	0.1
Rural water hazard	1	1	0	3	3	0.1
Static inland waterway	2	0	2	0	1	0.1
Other	2	0	0	1	0	*
Sex						
Female	11	3	2	8	6	1.1
Male	8	7	14	5	4	1.3
Age category						
Under 1 year	3	1	2	0	2	2.6
1–4 years	11	7	6	9	5	3.0
5–9 years	4	2	4	2	1	0.8
10–14 years	0	0	1	0	1	*
15–17 years	1	0	3	2	1	0.8
Aboriginal and Torres Strait Islander status						
Indigenous	3	2	3	1	4	2.7
Non-Indigenous	16	8	13	12	6	1.0
Geographical area of usual residence (ARIA+)						
Remote	2	1	1	2	0	3.6
Regional	9	4	6	6	8	1.7
Metropolitan	7	5	4	5	2	0.6
Socio-economic status of usual residence (SEIFA)						
Low to very low	11	5	7	9	8	1.8
Moderate	5	2	1	1	1	0.9
High to very high	2	3	3	3	1	0.5
Known to the child protection system						
Known to Child Safety	10	5	5	2	5	6.1

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports.*
2. *'Other' non-pool water hazards include objects containing water and flood-related incidents.*
3. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rate for age under 1 year which is per 100,000 live births.*
4. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
5. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Other non-intentional injury

Table A.7: Summary of other non-intentional injury-related deaths of children in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All other non-intentional injury deaths						
Other non-intentional injury	15	14	8	9	12	1.0
Incident type						
Accidental poisoning	1	4	3	0	1	0.2
Deaths from fire	1	3	0	1	0	0.1
Exposure to inanimate mechanical forces	3	2	2	3	1	0.2
Threats to breathing	6	3	1	2	7	0.3
Other incidents	4	2	2	3	3	0.2
Sex						
Female	3	3	4	2	6	0.6
Male	12	11	4	7	6	1.3
Age category						
Under 1 year	2	1	0	0	3	1.9
1–4 years	3	4	3	3	4	1.3
5–9 years	0	1	1	2	1	0.3
10–14 years	8	2	2	1	1	0.9
15–17 years	2	6	2	3	3	1.7
Aboriginal and Torres Strait Islander status						
Indigenous	1	5	2	4	4	3.3
Non-Indigenous	14	9	6	5	8	0.8
Geographical area of usual residence (ARIA+)						
Remote	1	1	0	1	2	3.0
Regional	7	10	3	4	2	1.3
Metropolitan	7	3	4	3	8	0.7
Socio-economic status of usual residence (SEIFA)						
Low to very low	6	10	5	7	6	1.5
Moderate	4	1	0	1	2	0.7
High to very high	5	3	2	0	4	0.6
Known to the child protection system						
Known to Child Safety	2	6	2	2	6	4.1

Data source: Queensland Child Death Register (Aug-2021)

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rate for age under 1 year which is per 100,000 live births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Suicide

Table A.8: Summary of suicide deaths of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000[3]
All suicide deaths						
Suicide	20	24	37	21	30	2.3
Sex						
Female	6	14	18	6	12	4.5
Male	14	10	19	15	18	5.8
Age category						
10–17 years	20	23	37	21	30	5.1
5–9 years	0	1	0	0	0	*
10–14 years	8	4	8	6	6	2.0
15–17 years	12	19	29	15	24	10.6
Aboriginal and Torres Strait Islander status						
Indigenous	3	5	10	7	4	14.1
Non-Indigenous	17	19	27	14	26	4.4
Geographical area of usual residence (ARIA+)						
Remote	0	2	4	3	1	15.3
Regional	7	7	11	9	13	5.2
Metropolitan	13	15	21	9	16	4.7
Socio-economic status of usual residence (SEIFA)						
Low to very low	8	13	16	11	16	6.7
Moderate	3	3	7	2	3	3.5
High to very high	9	8	13	8	11	4.5
Known to the child protection system						
Known to Child Safety	8	2	14	8	4	8.2

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland.*
3. *Overall suicide rates are calculated per 100,000 children aged 0–17 years in Queensland. All other rates, except known to the child protection population, are calculated per 100,000 children aged 10–17 years in Queensland.*
4. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
5. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*
6. *Data relating to method of death are available to genuine researchers by request.*

Fatal assault and neglect

Table A.9: Summary of deaths from assault and neglect of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All fatal assault and neglect deaths						
Fatal assault and neglect	5	0	9	13	3	0.5
Sex						
Female	2	0	4	6	2	0.5
Male	3	0	5	7	1	0.5
Age category						
Under 1 year	1	0	2	4	0	2.3
1–4 years	3	0	4	5	2	1.1
5–9 years	1	0	2	1	0	0.2
10–14 years	0	0	0	0	0	0.0
15–17 years	0	0	1	3	1	0.5
Aboriginal and Torres Strait Islander status						
Indigenous	1	0	1	3	1	1.3
Non-Indigenous	4	0	8	10	2	0.4
Geographic area of usual residence (ARIA+)						
Remote	0	0	0	0	0	0.0
Regional	0	0	6	3	1	0.5
Metropolitan	5	0	3	10	2	0.5
Socio-economic status of usual residence (SEIFA)						
Low to very low	2	0	8	5	1	0.7
Moderate	2	0	0	3	2	0.6
High to very high	1	0	1	5	0	0.3
Known to the child protection system						
Known to Child Safety	5	0	7	10	2	5.4
Category of fatal assault and neglect						
Intra-familial	5	0	7	10	2	0.4
Neonaticide	0	0	0	0	0	0.0
Domestic homicide	2	0	5	3	0	0.2
Fatal child abuse	2	0	1	3	1	0.1
Fatal neglect	1	0	0	3	0	0.1
Other intra-familial assault NEC	0	0	1	1	1	*
Extra-familial	0	0	2	3	1	0.1
Intimate partner homicide	0	0	1	0	0	*
Peer homicide	0	0	0	2	1	*
Stranger homicide	0	0	0	0	0	0.0
Acquaintance homicide	0	0	1	1	0	*

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rate for age under 1 year which is per 100,000 live births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Unexplained causes

Table A.10: Summary of deaths from unexplained causes of children and young people in Queensland, 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All deaths from unexplained causes						
Unexplained causes	20	24	27	34	17	2.1
Cause of death						
Sudden Infant Death Syndrome (SIDS)	8	16	14	20	7	21.1
Undetermined cause (infants)	9	8	6	9	8	13.0
Undetermined cause (1–17 years)	3	0	7	5	2	0.3
Sex						
Female	13	11	9	21	5	2.1
Male	7	13	18	13	12	2.1
Age category						
Under 1 year	17	24	20	29	15	34.0
1–4 years	2	0	5	3	1	0.9
5–17 years	1	0	2	2	1	0.1
Aboriginal and Torres Strait Islander status						
Indigenous	2	6	6	6	3	4.8
Non-Indigenous	18	18	21	28	14	1.9
Geographic area of usual residence (ARIA+)						
Remote	0	0	2	0	0	*
Regional	8	11	10	10	6	2.3
Metropolitan	11	12	15	22	11	1.9
Socio-economic status of usual residence (SEIFA)						
Low to very low	9	12	18	20	9	3.0
Moderate	6	6	5	7	3	2.3
High to very high	4	5	4	5	5	1.0
Known to the child protection system						
Known to Child Safety	4	5	6	9	5	6.6

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for SIDS, Undetermined causes (<1 year) and age under 1 year which are per 100,000 live births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to Child Safety, through either being subject to a child concern report, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

Sudden Unexpected Deaths in Infancy

Table A.11: Summary of SUDI infant deaths in Queensland 2016–21

	2016–17	2017–18	2018–19	2019–20	2020–21	5 year average
	n	*n*	*n*	*n*	*n*	Rate per 100,000
All Sudden Unexpected Deaths in Infancy (SUDI)						
SUDI (infants)	30	33	26	35	34	0.5
Cause of death						
Explained causes	13	9	6	3	4	0.1
Unrecognised infant illness	10	9	6	2	1	0.1
Sleep accident	2	0	0	0	3	0.0
Fatal assault	1	0	0	1	0	*
Unexplained causes	17	24	20	29	15	0.3
SIDS	8	16	14	20	7	0.2
Undetermined	9	8	6	9	8	0.1
Cause of death pending	0	0	0	3	15	0.1
Sex						
Female	17	13	9	21	17	0.5
Male	13	20	17	14	17	0.5
Aboriginal and Torres Strait Islander status						
Indigenous	4	10	5	9	11	1.2
Non-Indigenous	26	23	21	26	23	0.4
Geographic area of usual residence (ARIA+)						
Remote	0	0	1	0	1	*
Regional	14	17	9	11	15	*
Metropolitan	15	15	16	22	18	*
Socio-economic status of usual residence (SEIFA)						
Low to very low	17	16	18	20	21	*
Moderate	6	8	3	8	6	*
High to very high	6	8	5	5	7	*
Known to the child protection system						
Known to Child Safety	7	10	8	9	13	*

Data source: Queensland Child Death Register (Aug-2021)

* *Rates have not been calculated for numbers less than four or where denominator data are not available.*

1. *Data presented are current in the Queensland Child Death Register as at August 2021 and thus may differ from previously published reports. Tables with data from 2004 are available online at* http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death
2. *Rates are averaged over 5 years and calculated per 1,000 births (in the sex/Indigenous status) in Queensland.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period, who were known to Child Safety Services within the 1-year period prior to their death.*

Appendix B — Methodology

This appendix provides an overview of the methodology employed in the production of the *Annual Report: Deaths of children and young people, Queensland, 2020–21*. It also explains the process of maintaining the Queensland Child Death Register and the methods used for the analysis of trends and patterns in the data.

Queensland Child Death Register

Under Part 3 (sections 25–29) of the *Family and Child Commission Act 2014*, the QFCC has the responsibility to maintain a register of all deaths of children and young people under the age of 18 years that are registered in Queensland. The information in the Register is required to be classified according to cause of death, demographic information and other relevant factors. The Queensland Child Death Register contains information in relation to all child deaths registered in Queensland from 1 January 2004. The *Family and Child Commission Act 2014* also outlines functions of the QFCC to help reduce the likelihood of child deaths, including to conduct research, make recommendations about laws, policies, practices and services and provide access to data contained in the Queensland Child Death Register to persons undertaking genuine research. Under the *Family and Child Commission Act 2014*, the Principal Commissioner must prepare an annual report in relation to child deaths in Queensland.

To support the establishment and maintenance of the Register, the Registry of Births, Deaths and Marriages and the Office of the State Coroner both advise the Principal Commissioner of a child's death and provide available relevant particulars.

Redesign of the Child Death Register

The QFCC launched its new Child Death Register, Coda, in March 2021. The replacement system has enhanced functionality and captures quality information in a more structured way. An important consideration in the system development was to migrate the child death data captured in the Register since 2004. Migration of field data was achieved on a one-to-one basis across most of the Register.

The QFCC considers key data items have for the most part been carried over with no changes detected as a result of the transition to the new system. Some changes from previously reported numbers are normal and expected as the Register is continually updated when new information is received.

Minor changes may have affected data in relation to Aboriginal and Torres Strait Islander status and indicators of geographic remoteness (ARIA+) and socio-economic status (SEIFA). Further details are provided in the relevant sections.

Data comparability and accuracy

The *Annual Report: Deaths of children and young people in Queensland, 2020–21* brings together information from a number of key sources and presents it in a way which facilitates consideration and interpretation of the risk factors associated with the deaths of children and young people in Queensland. The report also allows comparisons to be made between different population subgroups, such as Aboriginal and/or Torres Strait Islander children and children known to the child protection system.

Caution must be exercised; however, when making comparisons and interpreting rates due to the small number of deaths analysed. An increase or decrease of one or two deaths across the course of a year may have a significant impact on the rates when small numbers are involved.

As the Register relies on administrative data sources, a small margin of error is possible. There are no mechanisms available to formally verify the complete accuracy of the datasets provided to the QFCC.

Registry of Births, Deaths and Marriages

The information contained in the Queensland Child Death Register is based on death registration data from the Queensland Registry of Births, Deaths and Marriages (RBDM). The *Births, Deaths and Marriages Registration Act 2003* provides the registrar must give notice of the registration of all child deaths to the Principal Commissioner.[56] The data provided include:

- death registration number
- child's name
- child's date and place of birth
- child's usual place of residence
- child's age
- child's sex
- child's occupation, if any
- child's Aboriginal or Torres Strait Islander status
- duration of the last illness, if any, had by the child
- date and place of death
- cause of death, and
- mode of dying.[57]

The RBDM also provides the QFCC with birth registration data for linked birth/death records.

To the extent practicable, this information is provided within 30 days after the death is registered. Where the death is a natural death (due to diseases or morbid conditions), and a Cause of Death Certificate is issued by a medical practitioner, only death and birth registration data (as outlined above) are available for analysis. In coronial cases, additional information on the death is available.

Coroners Court of Queensland

In cases of reportable child deaths, coronial information is also available. Section 8 of the *Coroners Act 2003* defines a reportable death as a death where the:

- identity of the person is unknown
- death was violent or unnatural
- death occurred in suspicious circumstances
- death was health care-related
- Cause of Death Certificate was not issued, or is not likely to be issued
- death occurred in care
- death occurred in custody, or
- death occurred in the course of, or as a result of, police operations.

56 Section 48A (details of stillborn children are not included in the information given to the QFCC).

57 Section 48B of the *Births, Deaths and Marriages Act 2003* enables the registrar to enter into an arrangement with QFCC to provide additional data. Aboriginal and Torres Strait Islander status, date of birth and mode of dying are provided by administrative arrangement only.

A death in care occurs when the person who has died:

- had a disability (as defined under the *Disability Services Act 2006*) and was living in a residential service provided by a government or non-government service provider or hostel
- had a disability, such as an intellectual disability, or an acquired brain injury or a psychiatric disability; and lived in a private hostel (not an aged-care hostel)
- was being detained in, taken to or undergoing treatment in a mental health service, or
- was a child in foster care or under the guardianship of the Department of Children, Youth Justice and Multicultural Affairs.[58]

A death in custody is defined as a death of someone in custody (including someone in detention under the *Youth Justice Act 1992*), escaping from custody or trying to avoid custody.[59]

To help the QFCC fulfil its child death functions, the *Coroners Act 2003* imposed an obligation on the State Coroner to notify the Principal Commissioner of all reportable child deaths. The information provided by the State Coroner includes:

- the Police Report of Death to a Coroner (Form 1), which includes a narrative giving a summary of the circumstances surrounding the death
- autopsy and toxicology reports
- the coroner's findings and comments.[60]

For the major categories of reportable deaths, which include deaths from external causes and Sudden Unexpected Deaths in Infancy (SUDI), coronial information is reviewed with a view to identifying key risk factors.

Of the 398 deaths of children and young people registered in 2020–21, 36% were reportable under the *Coroners Act 2003* (145 deaths). At the time of reporting, coronial findings had been finalised for 27% (39 deaths) of reportable deaths. Autopsy and preliminary examination reports, where internal and/or external autopsies were performed, were provided in 35 of the 39 finalised cases and in 50 of the 106 cases where coronial findings were still outstanding.

Access to other data sources

The QFCC has information sharing arrangements with the following agencies:

- Registry of Births, Deaths and Marriages[61]
- Coroners Court of Queensland[62]
- Department of Children, Youth Justice and Multicultural Affairs (including records relating to child safety)
- Queensland Police Service
- Queensland Ambulance Service
- Department of Justice and Attorney-General (including records relating to Workplace Health and Safety Queensland)
- Australian Bureau of Statistics
- Queensland Health
- Department of Education
- National Coronial Information System.

58 Section 9 of the *Coroners Act 2003*.

59 Section 10 of the *Coroners Act 2003*.

60 Section 45 of the *Coroners Act 2003* provides the Coroner must give written copies of his/her findings relating to child deaths to the Principal Commissioner. Coroners' findings are the findings of coronial investigations and should confirm the identity of the person; how, when and where the person died; and what caused the death. Section 46 provides, in the case of a child death, the Coroner must give written copies of his/her comments to the Principal Commissioner. Coroners' comments may arise from an inquest that relates to public health or safety or relates to the administration of justice or ways to prevent future deaths.

61 The agreement between the Registry of Births, Deaths and Marriages and the QFCC was developed in accordance with the provisions of section 48B of the *Births, Deaths and Marriages Act 2003*.

62 The agreement between the Office of the State Coroner and the QFCC was developed in accordance with the provisions of section 54A of the *Coroners Act 2003*.

Confidentiality

Accompanying the QFCC's privileged access to information is a duty of confidentiality specified in the *Family and Child Commission Act 2014*. Section 36 (Confidentiality of Information) of the Act states:

> If a person gains confidential information through involvement in the administration of this Act, the person must not –
>
> (a) make a record of the information or intentionally disclose the information to anyone, other than under subsection (3),[63] or
>
> (b) recklessly disclose the information to anyone.

Coding cause of death

The QFCC used the *International statistical classification of diseases and related health problems, tenth revision* (ICD-10) to code underlying and multiple causes of death. ICD-10 was developed by the World Health Organization (WHO) and is designed to promote international comparability in the collection, processing, classification and presentation of morbidity and mortality statistics.

What is the underlying cause of death?

The concept of the underlying cause of death is central to mortality coding and comparable international mortality reporting. The WHO has defined the underlying cause of death as the:

- disease or injury which initiated the chain of morbid events leading directly to death, or
- circumstances of the incident or violence which produced the fatal injury.

Stated simply, the underlying cause of death is the condition, event or circumstances without the occurrence of which the person would not have died.

Qualified mortality coders

QFCC staff trained in ICD-10 mortality coding are responsible for the coding of all external cause deaths.

In addition, the QFCC has a formal arrangement with the Australian Bureau of Statistics (ABS) for the provision of mortality coding services. Qualified ABS mortality coders review all available information for natural cause deaths and code the underlying and multiple causes of death according to ICD-10 cause of death coding regulations. ABS also undertakes quality assurance of external cause deaths coded by the QFCC.

Classification of external cause deaths

The QFCC recognises that ICD-10 carries certain inherent limitations, particularly in regard to recognising contextual subtleties of cases, and in adequately capturing deaths due to:

- drowning in dams
- low-speed vehicle run-overs that occur in driveways
- four-wheel motorcycle (quad bike) incidents
- SUDI.

To help overcome the limitations of ICD-10, the QFCC primarily classifies deaths according to their circumstances. Based on the information contained in the Police Report of Death to a Coroner (Form 1), such classification enables the QFCC to discuss deaths occurring in similar circumstances, even where an official cause of death has not yet been established, or where the ICD-10 code does not accurately reflect the circumstances of death.[64]

All reportable deaths are classified as being caused by disease and morbid conditions, transport incidents, drowning, other non-intentional injury, suicide, fatal assault and neglect or unexplained. SUDI are also grouped together for the purpose of analysis.

63 Subsection 3 permitted a person to make a record of, or disclose, confidential information for this Act to discharge a function under another law, for a proceeding in a court or tribunal or if authorised under a regulation or another law.

64 Cases which have not received an official cause of death, as established at autopsy or coronial investigation, cannot be coded according to ICD-10.

As outlined above, discrepancies may exist between research categories and ICD-10 figures. The QFCC primarily reports by the broad external cause classifications described above. ICD-10 coding is still used to report on deaths from natural causes. Full details of ICD-10 coding for external cause deaths can be found in **Appendix D**.

Location geocoding

All locations related to child deaths (such as place of death, usual residence, incident location) are geocoded using the Queensland Government Property Location Service Plus. The geocoded locations are then linked to reference data for indicators of remoteness and socio-economic status.

Geographical remoteness (ARIA+)

The Accessibility/Remoteness Index of Australia Plus (ARIA+) is used to code geographical remoteness for locations recorded for child death data. ARIA+ is a standard distance-based measure of remoteness developed by the National Centre for the Social Applications of Geographic Information Systems (GISCA) and the former Australian Department of Health and Aged Care (now Department of Health). It interprets remoteness based on access to a range of services; the remoteness of a location is measured in terms of distance travelled by road to reach a centre that provides services.[65]

All child deaths are classified according to the ARIA+ index. The analysis of geographic distribution in the child death annual report refers to the child's usual place of residence, which may differ from the place of death or the incident location.

At the time of the implementation of the new Child Death Register in March 2021, the ARIA+ reference data for locations added after that date is from the Census 2016. Location data for all records entered into the Register from 2004 to February 2021 use reference data from Census 2011. Some locations needed to be revalidated after March 2021, and a small number may have shifted categories due to the updated reference data.

For the purposes of analysis in this report, the following general categories of remoteness are reported:

- **Metropolitan:** includes major cities of Queensland[66]
- **Regional:** includes inner and outer regional Queensland[67]
- **Remote:** includes remote and very remote Queensland.[68]

Socio-economic status (SEIFA)

Of the Socio-economic Indexes for Areas (SEIFA) developed by the ABS, the Index of Advantage/Disadvantage has been used in the child death report. This index aims to rank geographical areas to reflect both advantage and disadvantage at the same time, effectively measuring a net effect of social and economic conditions.

Variables associated with advantage include the proportion of families with high incomes, the proportion of people with a university degree or higher and the proportion of people with skilled occupations.

Variables associated with disadvantage include the proportion of families with low incomes, the proportion of persons with relatively low levels of education and the proportion of people in low-skilled occupations.

To determine the level of advantage and disadvantage, the child's usual place of residence was used for coding the geographic area. For this reason, measures of socio-economic status (SES) used in the Annual Report are measures of the status of the areas in which children and young people reside, not the SES of each individual child or their family.

The SEIFA reference data is based on Census 2011 for locations entered in the Register from 2004 to February 2021. All locations entered into the Register from March 2021 are based on Census 2016. Possible data changes arising from the transition to the new Register are similar to those noted above for remoteness indicators.

65 ARIA+ is a purely geographic measure of remoteness, which excludes any consideration of socio-economic status, rurality and population size factors (other than the use of natural breaks in the population distribution of urban centres to define the service centre categories).

66 Relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.

67 Significantly restricted accessibility of goods, services and opportunities for social interaction.

68 Very restricted accessibility of goods, services and opportunities for social interaction.

Aboriginal and Torres Strait Islander status

Historically, the identification of Indigenous status on death registration forms was often incomplete or inaccurate, leading to an undercount of the actual numbers of deaths of Aboriginal and Torres Strait Islander people. The identification of the deaths of Indigenous people has improved considerably in recent years; however, the extent of any continued under-reporting is not known and it is likely some undercount of the number of deaths registered as Aboriginal and Torres Strait Islander continues.

The Child Death Register records Aboriginal and Torres Strait Islander status as noted in the derived birth registration and death registration data, on the Form 1 and in other official records. There are instances of inconsistent reporting of Aboriginal and Torres Strait Islander status across official records. The QFCC uses a guideline to determine which status will be recorded within the Register.

The redesign of the Child Death Register has allowed additional source records on the Aboriginal and Torres Strait Islander status of deceased children to be included in the Register. The business rules have been reviewed to align with the best practice approaches described by the Australian Institute of Health and Wellbeing (AIHW) and more recent research findings.[69,70,71]

Following these processes, an audit was undertaken of the decisions in the Register resulting in changes in status for some children. As a result, there may be minor differences from previously reported mortality data by Indigenous status.

Children known to the child protection system

The deaths of children known to the child protection system have been analysed as a separate cohort, as the Queensland child protection system has legislative responsibilities in relation to these deaths. In accordance with Chapter 7A of the *Child Protection Act 1999*, the deaths of all children known to the Queensland child protection system are subject to an internal review by the Department of Children, Youth Justice and Multicultural Affairs (DCYJMA). These reviews are undertaken to facilitate learning, improve service delivery and promote accountability.[72]

A child is deemed to have been known to the Queensland child protection system, if within one year before the child's death:

- DCYJMA was notified of concerns of alleged harm or risk of harm, or
- DCYJMA was notified of concerns before the birth of a child and reasonably suspected the child might be in need of protection after their birth, or
- DCYJMA took action under the *Child Protection Act 1999*, or
- the child was in the custody or guardianship of DCYJMA.[73]

On 1 July 2020, a two-tier review process came into effect. Under the *Child Death Review Legislation Amendment Act 2020*, agencies are responsible for conducting internal system reviews following the death or serious physical injury of a child known to the child protection system. The independent Child Death Review Board has been established to conduct systemic reviews following the death of a child, connected to the child protection system, to identify opportunities to improve the child protection system and prevent future deaths.

69 AIHW, ABS (2012) ***National best practice guidelines for data linkage activities relating to Aboriginal and Torres Strait Islander people***, cat. no: IHW 74, AIHW, Australian Government.

70 Christensen D, Davis G, Draper G, Mitrou F, McKeown S, Lawrence D, McAullay D, Pearson G, Rikkers W, Zubrick SR (2014) 'Evidence for the use of an algorithm in resolving inconsistent and missing Indigenous status in administrative data collections', *Australian Journal of Social Issues*, 49:423–443, **https://doi.org/10.1002/j.1839-4655.2014.tb00322.x**.

71 Shipstone R, Young J, Thompson JMD (2019) 'The real divide: the use of algorithm-derived Indigenous status to measure disparities in sudden unexpected deaths in infancy in Queensland', *Australian and New Zealand Journal of Public Health*, 43:570–576, **https://doi.org/10.1111/1753-6405.12951**.

72 Section 245(3) of the *Child Protection Act 1999*.

73 Section 246A of the *Child Protection Act 1999*.

Analysis and reporting

Analysis period

The Queensland Child Death Register is analysed according to date of registration of the death (rather than date of death). This is in accordance with national datasets managed by the ABS and the AIHW, as well as child death datasets managed by other Australian states and territories.

Reporting period

This annual report examines the deaths of 398 children and young people aged from birth to 17 years, registered between 1 July 2020 and 30 June 2021.

Place of residence

The Queensland Child Death Register records the deaths of children which occur within Queensland, regardless of the child's usual place of residence. Deaths of interstate and international residents that occur within Queensland are therefore recorded (visitors, holidaymakers and children who die while accessing specialist and emergency medical care). Deaths of Queensland residents that occur within other jurisdictions are not recorded.

Differences from previously published data

Information on child deaths can be received at a much later date than the original registration data, following processes of child death reviews, autopsies and coronial investigations. A critical element of the Register's comprehensiveness and research value is the inclusion of new information relating to individual child deaths as it is received. However, it should be noted the information on deaths in previous periods may therefore differ from those presented in earlier published annual reports.

Copies of the **Appendix A** summary tables containing the timeseries data from 2004 are available online at **http://www.qfcc.qld.gov.au/kids/preventing-child-injury-death**.

Population data used in calculations of child death rates

Child death rates are calculated per 100,000 children (for each sex/age category/Indigenous status/child protection status/ARIA+ region/SEIFA region) in Queensland.

This annual report uses the estimated resident population (ERP) data to calculate rates, excepting for the age group under 1 year where the number of live births is used as the denominator. Infant mortality rates are calculated per 1,000 births; however, for comparative purposes rates are also presented as per 100,000 births. Rates are not calculated for numbers less than four deaths because of the unreliability of such calculations.

Rates and percentages presented in this report are calculated as multi-year averages to provide more reliable estimates of mortality data and smooth out year to year fluctuations that arise with reporting on small numbers. Three-year rolling averages are used for trends in all causes, major cause groups, by Aboriginal and Torres Strait Islander status, and SUDI. Five-year averages are used for data further disaggregated by cause, type and demographics.

In this report, mortality rates are calculated as the average number of deaths over the 3 (or 5) year period divided by the average population (or live births) over the 3 (or 5) year period.

The Queensland Government Statistician's Office provides updated ERPs each year. ERP by age, sex and Indigenous status for the latest year, 2020, were preliminary at the time of reporting. ERPs for SEIFA and ARIA+ were not available for 2020. In calculations, the 2019 values were used as proxies to replace the missing 2020 values.

Infant mortality rates

Chapters 1 and 2 present infant mortality rates, defined as the number of deaths of infants aged under one year per 1,000 live births. In the 2019 calendar year, there were 61,735 live births in Queensland, including 6,852 Indigenous live births.[74] Live births data was not available for 2020 at the time of reporting. In calculations, the 2019 values were used as proxies to replace the missing 2020 values.

Rates of death for children known to the child protection system

Rates of death for children known to Child Safety are calculated using, as the denominator, the number of distinct children known to the Queensland child protection system in the one-year period before the relevant financial year.

The denominator data, shown in Table B.1, represents the number of distinct children (aged 0—17 years) who had any of the following forms of contact with Child Safety in the preceding financial year:

- Child Concern Report
- Child Protection Notification
- Investigation and Assessment Order
- Ongoing intervention
- Child Protection Order
- Placement in care.

Table B.1: Children known to the Queensland child protection system

Reporting period	Number of distinct children known to the child protection system
2016–17	80,510
2017–18	84,597
2018–19	88,824
2019–20	92,040
2020–21	95,292

Data source: DCYJMA (2021)

74 ABS (2020) ***Births, Australia, 2019***, 'Births, summary, by state, Queensland – 2006 to 2019', ABS website, accessed 22 June 2021.

Appendix C — Abbreviations and definitions

ABS	Australian Bureau of Statistics.
Acquaintance homicide	A child killed by an adult (over 18 years) known to—but not intimately connected with or in a friendship with—the victim. Perpetrators may include neighbours, family friends, teachers or a person who had interacted with the child in an online context. This differs from domestic homicide, where there is an unambiguous familial association, and stranger homicide, where there is no prior association whatsoever between the perpetrator and victim.
AIHW	Australian Institute of Health and Welfare.
ANZCDR&PG	Australian and New Zealand Child Death Review and Prevention Group.
ARIA+	Accessibility/Remoteness Index of Australia Plus. An index of remoteness derived from measures of road distance between populated localities and service centres. These road distance measures are then used to generate a remoteness score for any location in Australia.
Autopsy	Also 'post-mortem'. A detailed physical examination of a person's body after death. An autopsy can be external only, external with full internal or external with partial internal.
Bathtub	A large open container for water in which a person may wash their body and includes a bathtub or baby bath.
Beach or ocean	Beach refers to the shoreline of an ocean (the land component) and ocean refers to the sea.
Bullying	Repeated hurtful behaviour which involves a power imbalance. It includes physical, verbal, social (often covert) and cyber bullying behaviours.
Bystander	Pedestrian incident in which a child who has not entered or attempted to enter a roadway or other area where vehicles are usually driven, is struck by a vehicle that has left the designated roadway or area. For example, a child playing in the front yard of a home is struck by a vehicle that has left the roadway after the driver has lost control.
Cause of death pending	Used to categorise deaths that do not have an immediately obvious cause (such as a transport incident), and where official cause of death information has not yet been received to enable classification.
CCYPCG	The Commission for Children and Young People and Child Guardian (Qld). The CCYPCG ceased operations on the 30 June 2014 following the repeal of the *Commission for Children and Young People and Child Guardian Act 2000*. Prior to the establishment of the QFCC on 1 July 2014, the CCYPCG was responsible for maintaining the Queensland Child Death Register.
CDRB	Child Death Review Board. The CDRB conducts systemic reviews following the death of a child connected to the child protection system under Part 3A of the *Family and Child Commission Act 2014*. These reviews identify opportunities to improve the child protection system and prevent future deaths. The CDRB uses agency information, research and data to make system-wide findings and recommendations for systemic improvements to help prevent deaths that may have been avoidable.
Child	A person aged from birth up to, but not including, 18 years.

Child known to Child Safety	A child is deemed to have been known to Child Safety if, within one year before the child's death: • Child Safety was notified of concerns of alleged harm or risk of harm, or if • Child Safety was notified of concerns before the birth of a child and reasonably suspected the child might be in need of protection after their birth, or if • Child Safety took action under the *Child Protection Act 1999*, or if • the child was in the custody or guardianship of Child Safety.[75]
Congenital anomalies	Congenital anomalies (ICD-10 Chapter XVII, Congenital malformations, deformations and chromosomal abnormalities) are mental and physical conditions present at birth that are either hereditary or caused by environmental factors.
CPR	Cardiopulmonary resuscitation.
DCYJMA	Department of Children, Youth Justice and Multicultural Affairs (Qld). Queensland government agency responsible for administering the *Child Protection Act 1999*.
Death in care	A death as defined under section 9 of the *Coroners Act 2003*. This occurs when a person who had died: • had a disability and was living in a residential service provided by a government or non-government service provider or hostel • had a disability and lived in a private hostel (not aged-care) • was being detained in, taken to, or undergoing treatment in a mental health service • was a child in foster care or placed at a residential facility under the guardianship of the DCYJMA.
Death in custody	A death as defined under section 10 of the *Coroners Act 2003*. This includes the death of someone in custody (including someone in detention under the *Youth Justice Act 1992*), escaping from custody or trying to avoid custody.
Death incident location	The address at which the set of circumstances leading to death occurred. This may be the same as, or different from, the place of death.
Diseases and morbid conditions	Also referred to as natural causes. A cause of death category used for those cases where the official cause of death has been given an ICD-10 Underlying Cause of Death which corresponds to Chapters 1–17 of the ICD Codebook (except deaths coded as R95 and R99 which are included in unexplained causes). Diseases and morbid conditions cannot be assigned as a category of death until an official cause of death has been received and coded. All reportable deaths suspected to be the result of a disease or morbid condition are assigned a category of death of 'Unknown—cause of death pending', until the official cause of death has been received and coded.
Domestic homicide	Homicide committed by someone in the child's familial network or foster carer where there is a clear intent to cause life threatening injury on the part of the perpetrator. Such events are usually characterised by evidence of a breakdown in the parental relationship and/or acute mental illness in one or both parents. It is characterised by an obvious critical event or angry impulse in which the perpetrator acts overtly (and usually suddenly) to end the life of one or more family members. Children of any age may be victims. It is common in cases of domestic homicide for a perpetrator to suicide subsequent to their killing of one or more family members. This subtype of domestic homicide is often referred to as murder-suicide. Parents, step-parents, foster parents and extended family members can be involved in these incidents.

75 Section 246A of the *Child Protection Act 1999*.

Drowning	Deaths that occur as a direct or indirect result of immersion in some form of liquid.
Dynamic waterway	A waterway with a flowing momentum, that is rivers and/or creeks.
ERP	Estimated resident population.
External causes of death	Pertaining to environmental events and circumstances that cause injury, poisoning and other adverse effects. Broadly, external cause deaths are generally more amenable to prevention than many deaths from disease and morbid conditions.
Fatal assault	Death of a child at the hands of another person who has inflicted harm to them through some means of force or physical aggression.
Fatal child abuse	Describes deaths from physical abuse perpetrated by a parent or caregiver against a child who is reliant upon them for care and protection where the intent was to harm the child (e.g. over-use of force or excessive disciplinary behaviours). It may be characterised by a history of chronic and escalating abuse or by an isolated incident. It also includes cases where the child is permanently injured from physical harm but dies at a later stage from medical issues initiated by the physical harm incident (late effects of abuse). Victims are predominantly infants, toddlers and preschool-aged children.
Fatal neglect	Defined as where a child, dependent on a caregiver for the basic necessities of life, dies owing to the failure of the caregiver to meet the child's ongoing basic needs. This may involve acts or omissions on the part of a caregiver that are either deliberate or extraordinarily irresponsible or reckless. It is most likely to involve younger children who are wholly reliant upon their primary caregivers.
Floodwater	A body of water that has escaped its usual boundaries (including overflows of drainage systems), water that exceeds the capacity of the structure normally holding it (including creeks and rivers), or water that temporarily covers land not normally covered by water (flash flooding).
ICD-10	International statistical classification of diseases and related health problems, tenth revision.
Indigenous	Refers to people who identify as being Aboriginal and/or Torres Strait Islander.
Intimate partner homicide	Homicide committed by intimate partners or former intimate partners. Intimate refers to a romantic or coupled relationship characterised by a level of mutual trust, dependence or commitment between the child and the perpetrator. It does not include friendship-only relationships. There is no age threshold for this category.
Known to be in or on water	When a child aged under 5 years is known by the carer to be actively swimming, paddling, wading, playing, bathing in water or on a watercraft.
Known to be around water	When the carer of a child aged under 5 years is aware of the existence of a nearby water hazard and a reasonable person could foresee that the child could quickly or easily gain access to it (i.e. no barrier or a defective barrier). Examples include where a carer leaves a child playing on the floor of the bathroom while the bath is filling up, or the carer leaves the child playing in the backyard but has propped open the pool gate.
Low-speed vehicle run-over	An incident where a pedestrian is injured or killed by a slow-moving vehicle travelling forwards or reversing. The incident can occur in a non-traffic area (e.g. residential driveway) or as a vehicle is merging into or out of a traffic area (e.g. school pick-up zone).
Neonatal death	A neonatal death is the death of an infant within 0–27 days of birth who, after delivery, breathed or showed any other evidence of life, such as a heartbeat.

Neonaticide	The killing of an infant within 24 hours of birth. It is to be differentiated from infanticide, which is commonly defined as the killing of an infant under the age of one year by a parent. Neonaticide is typically characterised by an attempt to conceal birth by disposing of the foetal remains but can also include intentional harm to the infant (regardless of the presence of mind of the offender at the time). This definition does not limit neonaticide to acts or omissions involving mothers, as fathers and stepfathers may also be involved.
Neoplasms (cancers and tumours)	The term 'neoplasm' (ICD-10 Chapter II) is often used interchangeably with words such as 'tumour' and 'cancer'. Cancer includes a range of diseases in which abnormal cells proliferate and spread out of control. Normally, cells grow and multiply in an orderly way to form organs that have a specific function in the body. Occasionally; however, cells multiply in an uncontrolled way after being affected by a carcinogen, or after developing a random genetic mutation. They may form a mass that is called a tumour or neoplasm. A 'benign neoplasm' refers to a non-cancerous tumour, whereas a 'malignant neoplasm' usually refers to a cancerous tumour (that is, cancer). Benign tumours do not invade other tissues or spread to other parts of the body, although they can expand to interfere with healthy structures.
Notifiable condition	A condition made notifiable to state health authorities if there is potential for its control. The Queensland Health list of notifiable conditions can be found at **https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/notifiable-conditions/list**.
Not known to be around water	When the carer of a child aged under 5 years is not aware the child is exposed to a water hazard (i.e. the carer thinks the water hazard is appropriately restricted and is not aware that the child has gained access to it) or the presence of the water hazard was not known. Examples include where a child is thought to be sleeping or playing safely in a restricted area but has gained access to a water hazard by climbing the fence to the pool or filling up the bathtub.
Object containing water	An object that acts as a vessel for water such as a mop bucket or laundry bucket.
Other non-intentional injury-related deaths	Other non-intentional injury-related deaths include those resulting from a fall, electrocution, poisoning, suffocation, strangulation and choking, fire, and other non-intentional injury-related deaths that are not discussed in **Chapter 3** (Transport) or **Chapter 4** (Drowning) of the Annual Report. The complete list is included in **Appendix E**.
Peer homicide	Lethal confrontations that occur between peers. Peers are classified as young people (under 18 years) who are of a similar age and/or developmental level, or 2 people of any age who are friends and therefore of the same social standing and peer network.
Peer passengers	Refers to the laws regarding restrictions on the number of passengers that a P1-type provisional licence holder under 25 years may carry in a vehicle. During the period between 11pm on a day and 5am on the next day, the P1-type provisional driver must not drive on a road in a vehicle carrying more than one passenger under the age of 21 years who is not an immediate family member.
Perinatal condition	Perinatal conditions (ICD-10 Chapter XVI, Certain conditions originating in the perinatal period) are diseases and conditions that originated during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. These include maternal conditions that affect the newborn, such as complications of labour and delivery, disorders relating to foetal growth, length of gestation and birth weight, as well as disorders specific to the perinatal period such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders.

Perinatal period	The perinatal period refers to infants of at least 20 weeks gestation or at least 400 grams birth weight, and all neonates (all live born babies up to 28 completed days of life after birth, regardless of gestational age or birth weight). This is based on the ABS definition of the perinatal period. The ABS has adopted the legal requirement for registration of a perinatal death as the statistical standard as it meets the requirements of major users in Australia. This definition differs from the World Health Organization's recommended definition of perinatal deaths, which includes infants and foetuses weighing at least 500 grams or having a gestational age of 22 weeks or a body length of 25 centimetres crown–heel.
Place of death	The address at which the child was officially declared deceased.
Place of usual residence	The address nominated by the child's family as the child's primary residential address upon registering the death with the Registry of Births, Deaths and Marriages.
Police Report of Death to a Coroner (Form 1)	A form completed by the police in accordance with section 7 of the *Coroners Act 2003*—Duty to Report Deaths.
Post-neonatal death	A post-neonatal death is the death of an infant 28 or more days, but less than 12 months, after birth.
Postvention	The provision of crisis intervention, support and assistance for those affected by a completed suicide.
Precipitating factor	An event that occurred in the months preceding a young person's suicide which may be considered to have contributed to the young person's decision to take their own life.
Principal Commissioner	Principal Commissioner of the Queensland Family and Child Commission.
Quad bike	Previously referred to as all-terrain vehicles (ATVs), these are four-wheeled motorcycles primarily used for agricultural purposes. Includes side-by-side vehicles and utility terrain vehicles (UTV).
QFCC	Queensland Family and Child Commission enacted by the *Family and Child Commission Act 2014* on 1 July 2014.
RBDM	Registry of Births, Deaths and Marriages (Qld).
Reportable death	A death as defined under sections 8, 9 and 10 of the *Coroners Act 2003*. This includes any death where the: • identity of the person is unknown • death was violent or unnatural • death occurred in suspicious circumstances • death was health care-related • Cause of Death Certificate was not issued and is not likely to be issued • death occurred in care • death occurred in custody, or • death occurred in the course of, or as a result of, police operations.
Rural water hazard	Sources of water used in agricultural activities, such as dams, irrigation channels, livestock dips and troughs.

SEIFA	Socio-Economic Indexes for Areas. Developed by the ABS using data from the Census of Population and Housing, SEIFA provides a range of measures to rank areas based on their relative social and economic wellbeing.
Self-harm	The non-socially or culturally sanctioned deliberate destruction of one's own body tissue and can be suicidal or non-suicidal in intent. Generally it does not include self-harm that is done for religious or cultural purpose, such as rites of passage.
Sex	The biological distinction between male and female, as separate and distinct from a person's gender or sexual identity. Indeterminate sex is recorded where medical practitioners are unable to ascertain an infant's sex due to extreme prematurity or non-viable gestation.
SIDS	Sudden Infant Death Syndrome.
Speeding/ excessive speed	May be a contributing factor when police have indicated that speed was definitely or likely a factor in the death incident or there is other evidence which can confirm the speed at which the vehicle was travelling to be above the speed limit for the place of incident.
Static inland waterway	A waterway without a flowing momentum such as dams and ponds.
Stillborn/ stillbirth	A stillborn child is a child who has shown no sign of respiration or heartbeat, or other sign of life, after completely leaving the child's mother and who has been gestated for 20 weeks or more, or weighs 400 grams or more.
Stranger homicide	A child death that occurs at the hands of an adult person (over 18 years) who is unknown to the child.
Stressful life event	An event that occurred over the course of the child's life, with the stressor first occurring more than six months before death. These types of events are often considered to be more chronic and longstanding in nature than a precipitating incident.
Sudden cardiac death	An unexplained or presumed arrhythmic sudden death, occurring in a short time period (generally within one hour of symptom onset), in a child or young person with no previously known cardiac disease.
SUDI	Sudden Unexpected Death in Infancy. This is a research classification and does not correspond with any single medical definition or categorisation. The aim of the grouping is to report on the deaths of apparently normal infants who would be expected to thrive yet, for reasons often not known or immediately apparent, do not survive. The QFCC adopted the following working criteria for the inclusion of cases in the SUDI grouping: the death was of an infant less than one year of age, the death was sudden in nature, the death was unexpected, the infant had no known condition likely to cause death, and the infant had no immediately obvious cause of death.
Suicidal act	Involves self-inflicted injury that is accompanied by the intention of the individual to die from the result of the action taken.
Suicidal contagion	The process by which a prior suicide or attempted suicide facilitates or influences suicidal behaviour in another person.
Suicidal ideation	The explicit communication of having thoughts of suicide.

Suicidal intent	Suicidal intent may be communicated directly or implied to a significant person in a child or young person's life such as a family member/carer, friend, health professional or educator. Notification of suicidal intent may occur in person, be verbalised via telephone or be written or expressed using online technology (SMS text messaging, online messenger and email, or through social media platforms).
Suicide	Death resulting from a voluntary and deliberate act against oneself, where death is a reasonably expected outcome of such act. This includes those cases where it can be established the person intended to die and those where intent is unclear, or the person may not have the capacity of reason to intend death, such as children under 15 years or persons with a serious mental illness.
Suicide attempt	A suicidal act causing injury but not leading to death.
Toxicology	The analysis of drugs, alcohol and poisons in the body fluids at autopsy.
Transport deaths	Death incidents involving a vehicle of some description. Vehicles include, but are not limited to: • motor vehicles and motorcycles • quad bikes, tractors and other rural plant • bicycles, skateboards, scooters and other small-wheel devices (excluding wheeled toys) • watercraft and aircraft • horses and other animals used for transportation.
Unexplained causes	Deaths where a cause of death could not be determined even after thorough investigation. It includes deaths from SIDS and Undetermined causes.
WHO	World Health Organization.

Appendix D — Cause of death by ICD-10 Mortality Coding Classification

Table D.1 provides a summary of the ICD-10 categories for child deaths from diseases and morbid conditions (or natural causes) registered during 2020–21. Table D.2 provides the ICD-10 categories for child deaths from external causes.

Table D.1: Deaths from diseases and morbid conditions and unexplained causes (number) 2020–21

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Diseases and morbid conditions	**200**	**18**	**12**	**13**	**23**	**266**
Certain infectious and parasitic diseases (A00–B99)	0	2	1	0	1	4
Neoplasms (C00–D48)	3	6	5	4	6	24
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50–D89)	2	1	1	0	1	5
Endocrine, nutritional and metabolic diseases (E00–E90)	3	1	0	0	0	4
Mental and behavioural disorders (F00–F99)	0	0	1	1	1	3
Diseases of the nervous system (G00–G99)	4	2	2	5	4	17
Diseases of the circulatory system (I00–I99)	0	0	0	0	3	3
Diseases of the respiratory system (J00–J99)	1	0	0	1	0	2
Diseases of the digestive system (K00–K93)	1	0	0	0	0	1
Diseases of the musculoskeletal system and connective tissue (M00–M99)	0	1	0	1	0	2
Certain conditions originating in the perinatal period (P00–P96)	124	0	1	0	1	126
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	61	5	1	1	5	73
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)	1	0	0	0	1	2
Unexplained causes	**15**	**1**	**0**	**1**	**0**	**17**
Sudden infant death syndrome (R95)	7	0	0	0	0	7
Other ill-defined and unspecified causes of mortality (R99)	8	1	0	0	0	9
Event of undetermined intent (Y10–Y34)	0	0	0	1	0	1
Total	215	19	12	14	23	283

Table D.2: Deaths from external causes (number) 2020–21

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Transport total	**1**	**5**	**4**	**5**	**16**	**31**
Pedestrian injured in transport accident (V01–V09)	0	4	0	0	0	4
Pedal cyclist injured in transport accident (V10–V19)	0	0	0	1	0	1
Motorcycle rider injured in transport accident (V20–V29)	0	0	2	0	3	5
Car occupant injured in transport accident (V40–V49)	1	1	2	3	12	19
Other land transport accidents (V80–V89)	0	0	0	1	1	2
Drowning total	**2**	**5**	**1**	**1**	**1**	**10**
Accidental drowning and submersion (W65–W74)	2	5	1	1	1	10
Other non-intentional injury-related death total	**3**	**4**	**1**	**1**	**3**	**12**
Exposure to inanimate mechanical forces (W20–W49)	0	1	0	0	0	1
Other accidental threats to breathing (W75–W84)	3	2	1	1	0	7
Exposure to electric current, radiation and extreme ambient air temperature and pressure (W85–W99)	0	0	0	0	1	1
Contact with venomous animals and plants (X20–X29)	0	0	0	0	1	1
Exposure to forces of nature (X30–X39)	0	1	0	0	0	1
Accidental poisoning by and exposure to noxious substances (X40–X49)	0	0	0	0	1	1
Suicide total	**0**	**0**	**0**	**6**	**24**	**30**
Intentional self-harm (X60–X84)	0	0	0	6	24	30
Fatal assault and neglect total	**0**	**2**	**0**	**0**	**1**	**3**
Assault (X85–Y09)	0	1	0	0	1	2
Sequelae of external causes of morbidity and mortality (Y85–Y89)	0	1	0	0	0	1
Total	6	16	6	13	45	86

Appendix E — Inclusions within the other non-intentional injury category

Causes of death included in other non-intentional injury-related death category:

- falls
- exposure to inanimate mechanical forces, examples include:
  - struck by object
  - caught or crushed between objects
  - contact with machinery
  - foreign body entering through eye, orifice or skin
- exposure to animate mechanical forces, examples include:
  - struck by other person
  - struck or bitten by mammal
  - contact with marine animal
- threats to breathing, examples include:
  - non-intentional suffocation or strangulation
  - threat to breathing due to cave-in, falling earth and other substances
  - inhalation of gastric contents
- exposure to electrical current, radiation and extreme ambient air temperature/pressure
- exposure to smoke, fire and flames
- exposure to heat and hot substances
- contact with venomous animals and plants
- exposure to forces of nature, examples include:
  - lightning
  - exposure to sunlight
  - excessive natural heat
  - excessive natural cold
- accidental poisoning by noxious substances, examples include:
  - inhalation of volatile substances
  - non-intentional overdose
  - unintended consumption
- complications of medical and surgical care.

Appendix F — Suicide classification model

The suicide classification model is used to classify all cases of suspected suicide into one of three levels of certainty. In classifying these deaths, the QFCC considers a number of factors, including whether intent was stated previously, the presence of a suicide note, witnesses to the event, previous suicide attempts and any significant precipitating factors or life stressors.

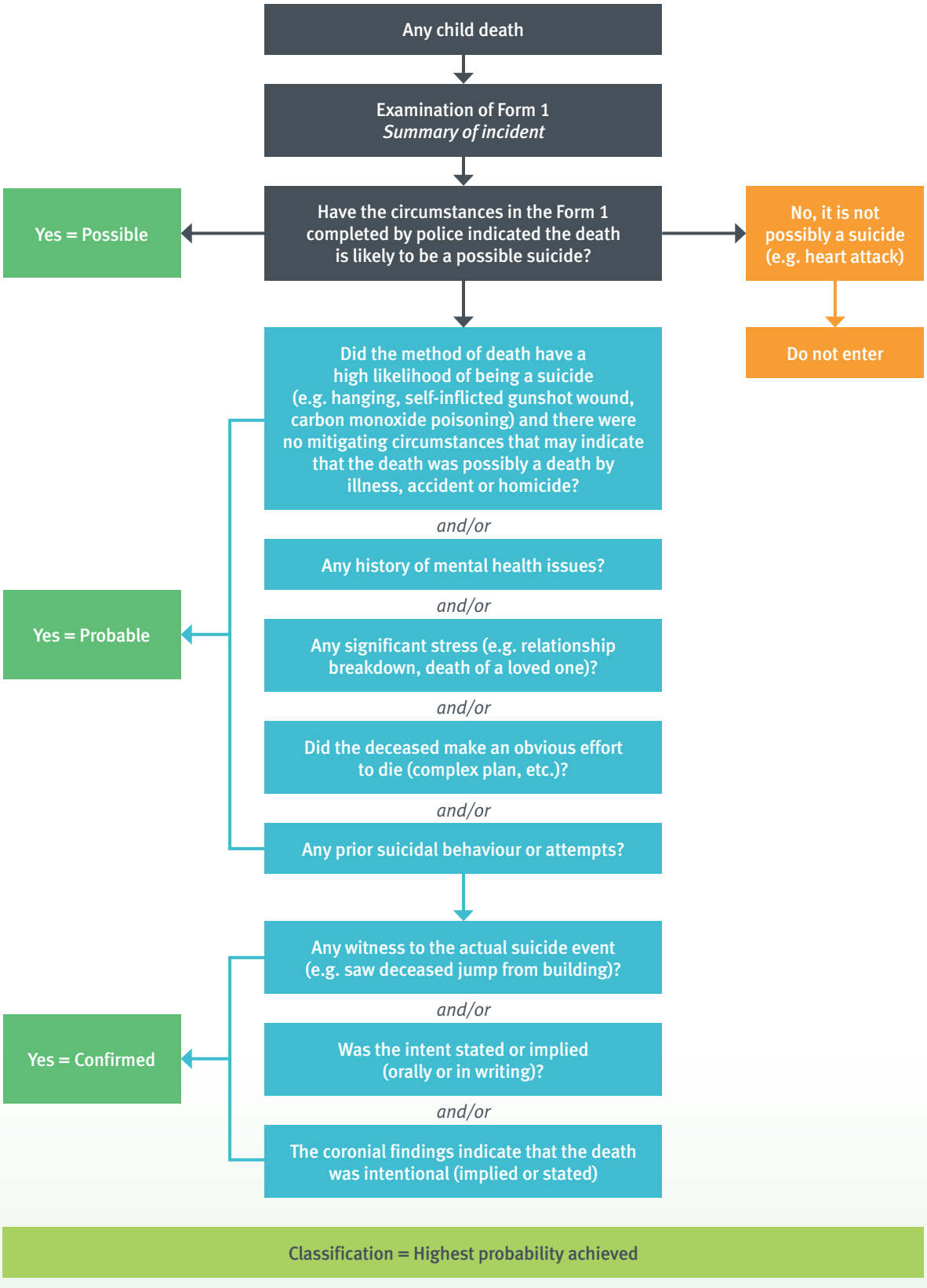
Information used to classify suicide certainty is based on data available to the QFCC at the time of reporting. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), additional information requested from police (including the contents of suicide notes), autopsy and toxicology report, child protection system records and coronial findings.

Levels of classification are as follows:

- **Confirmed:** The available information refers to at least one significant factor that constitutes a virtually certain level of suicide classification, or coronial investigations have found that the death was a suicide.
- **Probable:** The available information is not sufficient for a judgement of confirmed, but is consistent more with death by suicide than with death by any other means. Risk factors for suicide have been identified and/or the method and circumstances surrounding the death are such that intent may be inferred.
- **Possible/undetermined:** The police have indicated (on the Form 1) that the case is a suspected suicide or the QFCC identified the possibility of a suicide but, because of a lack of information on the circumstances of the death, there is a substantial possibility that the death may be the result of another cause, or is of undetermined intent.

Deaths are only reported as suicides in **Chapter 6** of this report if the classification is listed as probable or confirmed.

Figure F.1: Suicide classification model



Appendix G — Fatal assault and neglect screening criteria

The QFCC uses the fatal assault and neglect screening criteria to classify all cases of suspected fatal assault and neglect into one of three levels of certainty. In classifying these deaths, the QFCC considers a number of factors. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), autopsy and toxicology reports, child protection system records and coronial findings. Additional information from criminal proceedings and sentencing is also reviewed.

Information used to confirm fatal assault and neglect deaths is based on data available to the QFCC at the time of reporting.

Levels of confirmation are as follows:

Confirmed

- a perpetrator has been charged for a criminal offence relating to the death of the child and, regardless of the outcome, the facts establish the death was the result of inflicted harm or neglect, and/or
- coronial findings indicate (either expressly or impliedly) that the death was a result of inflicted harm or neglect, and/or
- a perpetrator has suicided in conjunction with the death of the child and has expressly or impliedly stated that they were responsible for the child's death.

Probable

- the evidence available to the QFCC indicated that there was a high likelihood that the death was a consequence of inflicted injury or neglect (i.e. but for the inflicted injury or neglect the child probably would not have died), and/or
- there is medical evidence to suggest the death was a consequence of inflicted injury or neglect, and/or
- a perpetrator has suicided in conjunction with the apparent non-accidental death of the child.

Possible

- the initial evidence available to the QFCC indicated that the child may have experienced inflicted harm or neglect which may have contributed to or caused the death (i.e. these deaths demonstrated the presence of risk factors at the time of the incident that could potentially have played some role in relation to the child's death, without establishing a probable likelihood of this having occurred).

Deaths are only reported as fatal assault and neglect if the classification is listed as probable or confirmed.

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