Queensland
Family & Child
Commission

SUPPLEMENTARY INFORMATION

ANNUAL REPORT

Deaths of children and young people Queensland

2015 — 16

Contents

1.1 Methodology

This supplementary information provides an overview of the methodology employed in the production of the *Annual Report: Deaths of children and young people, Queensland, 2015 — 16*. 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 research to help reduce the likelihood of child deaths. 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 Commissioner of a child's death and provide available relevant particulars.

Data comparability and accuracy

The *Annual Report: Deaths of children and young people in Queensland, 2015 — 16* brings together information from a number of key sources and presents it in a way that 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 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. The *Births, Deaths and Marriages Registration Act 2003* provides that the Registrar must give notice of the registration of all child deaths to the Commissioner.[1] The data provided includes:

- 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

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

- 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
- mode of dying.[2]

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

Office of the State Coroner

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.

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
- was a child in foster care or under the guardianship of the Department of Communities, Child Safety and Disability Services (DCCSDS).[3]

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.[4]

To help the QFCC fulfil its child death review 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.[5]

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[2] 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.

[3] Section 9 of the *Coroners Act 2003*.

[4] Section 10 of the *Coroners Act 2003*.

[5] Section 45 of the *Coroners Act 2003* provides that the Coroner must give written copies of his/her findings relating to child deaths to the Principal Commissioner. Coroner's 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 that, in the case of a child death, the Coroner must give written copies of his/her comments to the Commissioner. Coroner's 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.

For the major categories of reportable deaths, which include deaths from external causes and sudden unexpected death in infancy (SUDI), coronial information is reviewed with a view to identifying key risk factors.

Of the 390 deaths of children and young people registered in 2015 — 16, 34% were reportable under the *Coroners Act 2003* (132 deaths). At the time of reporting, coronial findings had been finalised for 33% (44 deaths) of reportable deaths. Autopsy reports, where performed, were provided in 30 of the 44 finalised cases and in 33 of the 88 cases where coronial findings are still outstanding.

Access to other data sources

The QFCC shares data with the following agencies:

- Registry of Births, Deaths and Marriages[6]
- Office of the State Coroner[7]
- DCCSDS (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)
- Department of Housing and Public Works
- Australian Bureau of Statistics
- Queensland Health
- Department of Education and Training.

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),[8] 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
- circumstances of the incident or violence which produced the fatal injury.

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[6] 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*.

[7] 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*.

[8] 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.

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 entered into 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 recognised that ICD-10 carries certain inherent limitations, particularly in regard to recognising contextual subtleties between 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 classified deaths according to their circumstances. Based on the information contained in the Police Report of Death to a Coroner (Form 1), such classification enabled 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.[9]

All reportable deaths are classified as transport, drowning, other non-intentional injury-related deaths, suicide or fatal assault and neglect. SUDI are also grouped together for the purpose of analysis.

As outlined above, discrepancies may exist between research categories and ICD-10 figures. The QFCC primarily report by the broad external cause classifications described above. ICD-10 coding is still used to report on deaths from diseases and morbid conditions. Full details of ICD-10 coding for external cause deaths can be found in section 1.3.

Geographical distribution (ARIA+)

The latest version of the Accessibility/Remoteness Index of Australia Plus (ARIA+) is used to code geographical remoteness.[10]

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 and Ageing).

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.[11]

All child deaths are classified according to the ARIA+ index. The analysis of geographic distribution in the Annual Report refers to the child's usual place of residence, which may differ from the place of death or the incident location. However, because of the importance of incident location in the prevention of transport-related deaths, the geographical distribution of all deaths falling within this category has also been reported according to the place of incident.

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[9] Where cases have not received an official cause of death as established at autopsy or coronial investigation, they cannot be coded according to ICD-10.

[10] Although base populations for all years are based on the latest version of ARIA+, deaths registered prior to 2012 — 13 were classified according to earlier ARIA+ boundaries.

[11] 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).

For the purposes of analysis in the Annual Report, the following general categories of remoteness are reported:

- Metropolitan: includes major cities of Queensland[12]
- Regional: includes inner and outer regional Queensland[13]
- Remote: includes remote and very remote Queensland.[14]

Socio-economic status (SEIFA)

The Socio-economic Indexes for Areas (SEIFA) developed by the ABS have been used in the Annual Report, specifically the SEIFA Index of Advantage/Disadvantage. 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.[15]

Variables associated with advantage include the proportion of families with high incomes, the proportion of people with a 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.

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 that 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 death registration data, on the Form 1 and from other official records. There are instances of inconsistent reporting of Aboriginal and Torres Strait Islander status across official records. For instance, several cases have been recorded where a child has been identified as Indigenous by the reporting police officer in completing the Form 1; but the death registration form, often completed by funeral directors on behalf of family members, did not identify the child as Indigenous. In cases where there has been inconsistent reporting of Aboriginal and Torres Strait Islander status across official records, a guideline is used by the QFCC to determine which status will be recorded within the register.

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 DCCSDS and an independent review by an external Child Death Case Review Panel. These reviews are undertaken to facilitate learning, improve service delivery and promote accountability.[16]

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

[13] Significantly restricted accessibility of goods, services and opportunities for social interaction.

[14] Very restricted accessibility of goods, services and opportunities for social interaction.

[15] Although base populations for all years are based on the latest version of SEIFA, deaths registered prior to 2012 — 13 were classified according to earlier SEIFA boundaries.

[16] Section 245(3) of the *Child Protection Act 1999*.

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

- the child was in the custody or guardianship of the DCCSDS, or
- DCCSDS was aware of alleged harm or alleged risk of harm, or
- DCCSDS took action under the *Child Protection Act 1999* in relation to the child, or
- DCCSDS was notified of concerns before the child's birth and reasonably suspected the child might be in need of protection after their birth.[17]

Prior to 1 July 2014, a review was required if the child was known to the department within the three years before their death. The timeframe was reduced to one year, following recommendations made in the *Queensland Child Protection Commission of Inquiry Final Report—Taking Responsibility: A Road Map for Queensland Child Protection*. This change was made to focus the reviews on recent service delivery (where relevant policies and procedures are likely to still be in place) and to enhance opportunities for in-depth exploration of the various decisions and issues.[18] The scope of these reviews was also expanded to include children who have suffered serious physical injuries.[19]

[17] Section 246A of the *Child Protection Act 1999*.

[18] Child Death Case Review Committee (2012) *Submission to the Child Protection Commission of Inquiry*; Department of Communities, Child Safety and Disability Services (2012) *Submission to the Child Protection Commission of Inquiry*.

[19] Section 246 of the *Child Protection Act 1999*.

Analysis and reporting

Analysis period

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

Reporting period

The Annual Report examines the deaths of 390 children and young people aged from birth to 17 years, registered between 1 July 2015 and 30 June 2016.

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 in the Queensland Child Death Register now comprises 12 years of data, and data from the last three years only is displayed in the first table for Chapters 1–8 of the Annual Report. Copies of the tables containing data since 2004 are available online at www.qfcc.qld.gov.au.

As indicated elsewhere, 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 coroners' reports. 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 that the information on deaths in previous periods may therefore differ from those presented in earlier published Annual Reports.

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/ARIA+ region/SEIFA region) in Queensland. The Annual Report uses the most up-to-date estimated resident population (ERP) data to calculate these rates. Rates are not calculated for numbers less than four deaths because of the unreliability of such calculations.

Rates for each reporting period use the ERP data as at the end of the previous financial year. For example, rates for the 2013 — 14 period use the ERP data as at 30 June 2013. However, the ERP data as at 2015 was not available to calculate rates for the current reporting period (2015 — 16). Therefore the ERP as at 30 June 2014 is used.

The ERP data for previous years is updated on an annual basis, which allows death rates for the previous reporting periods to be recalculated. Tables with counts and rates of child deaths for the 12 reporting periods from 2004 — 05 are available online at www.qfcc.qld.gov.au. The rates provided in the 12-year data tables may differ from rates provided in previous reporting periods, due to the use of updated ERP.

The ERP as at 30 June 2014 is provided in Table 1.

Table 1: Queensland and Aboriginal and Torres Strait Islander populations by age category as at 30 June 2014

Age group	Total number of children	Number of Aboriginal and Torres Strait Islander children
Under 1 year	62 146	5 361
1–4 years	254 834	20 345
5–9 years	316 923	24 579
10–14 years	300 959	23 050
15–17 years	183 001	13 349
Total 0–17 years	**1 117 863**	**86 684**

Data source: Queensland Treasury (2016)

Infant mortality rates

Chapters 2 and 8 present infant mortality rates, defined as the number of deaths of infants aged under 1 year per 1000 live births. In the 2014 calendar year, there were 63,066 live births in Queensland, including 5,345 Indigenous live births.[20]

Rates for ARIA+ and SEIFA classifications

Queensland Treasury provided Queensland population data for ARIA+ and SEIFA classifications (based on census populations at 30 June 2011),[21] to enable the calculation of child death rates by ARIA+ and SEIFA. Tables 2 and 3 provide ERP as at 30 June 2014, for the ARIA+ and SEIFA classifications used in the Annual Report.

Table 2: Queensland child population by ARIA+ as at 30 June 2014

ARIA+ classification	Total number of children
Remote	53 012
Regional	412 380
Metropolitan	652 471
Total	**1 117 863**

Data source: Queensland Treasury (2016)

Table 3: Queensland child population by SEIFA as at 30 June 2014

SEIFA classification	Total number of children
Low to very low SES	445 214
Moderate SES	216 613
High to very high SES	456 036
Total	**1 117 863**

Data source: Queensland Treasury (2016)

[20] Source: Australian Bureau of Statistics (2015), *Births, Australia, 2014,* 'Table 1.3: Births, Summary Statistics for Queensland – 2004 to 2014', time series spreadsheet, cat. no. 3301.0.

[21] Queensland Treasury (2016). *Population Estimates by Indigenous Status, 2014 edition* (Queensland Government Statistician's Office derived).

Rates of death for children known to the child protection system

Rates of death for children known to the child protection system 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 represents the number of distinct children (aged 0–17 years) who have had any of the following forms of contact with the DCCSDS in the preceding financial year:

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

This data was provided to the QFCC by the DCCSDS. Table 4 lists the denominator data provided by the department for the last five reporting periods.

Table 4: Children known to the Queensland child protection system

Reporting period	Number of distinct children known to the child protection system	Percentage change from previous year
2011 — 12	162 984	+8%
2012 — 13	165 572	+2%
2013 — 14	167 434	+1%
2014 — 15	96 788	. .
2015 — 16	84 262	-13%

Data source: DCCSDS (2016)

. . Percentage change has not been calculated due to the break in series (see note 1).

1. For 2013 — 14 and all earlier periods, denominator data is based on the distinct number of children known to the DCCSDS in the three-year period prior to their death. For 2014 — 15 onwards, this was changed to the distinct number of children known to the DCCSDS in the one-year period prior to their death.

Prior to the 2014 — 15 reporting period, a review was required if a deceased child was known to the Queensland child protection system within the three years before their death. The denominator used to calculate rates of death for children known to the child protection system was therefore the number of distinct children known to the Queensland child protection system in the three-year period before the relevant financial year. This change has reduced the number of children known to the child protection system and the number of child protection deaths.

It should be noted the number of distinct children known to the department increased considerably between 2005 — 06 and 2013 — 14, due to large increases in the numbers of child protection intakes received by the department. As the data are used as the denominator in rate calculations, there was a related reduction in the child protection death rates during this period, despite the number of child protection deaths remaining relatively stable.

1.2 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.
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 when the driver 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 Child Death Register.
Chaotic social circumstances	For the purpose of the Annual Report, a child is considered to have been living in chaotic social circumstances if their familial environment is characterised by persistent disruption, instability and exposure to risk relevant to one or more of the following: parental abuse or neglect, domestic violence, mental health problems, itinerancy, poverty.
Child	A person aged from birth up to, but not including, 18 years.
Child known to the child protection system	A child is deemed to have been known to the child protection system if, within one year before the child's death: • the child was in the custody or guardianship of the DCCSDS, or • DCCSDS was aware of alleged harm or alleged risk of harm, or • DCCSDS took action under the *Child Protection Act 1999* in relation to the child, or • DCCSDS was notified of concerns before the child's birth and reasonably suspected the child might be in need of protection after their birth. Prior to the 2014 — 15 reporting period, a three-year timeframe was used. The denominator used to calculate rates of death for children known to the child protection system for the 2015 — 16 reporting period is based on the distinct number

	of children and young people known to the department in the 2014 — 15 financial year who were subject to a child concern report, notification, investigation and assessment, ongoing intervention, child protection orders or placement in care.
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.
Death in care	A death as defined under section 9 of the Coroners Act. 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 DCCSDS.
Death in custody	A death as defined under section 10 of the Coroners Act. 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.
DCCSDS	Department of Communities, Child Safety and Disability Services (Qld). Government agency responsible for administering the *Child Protection Act 1999*.
Diseases and morbid conditions	A cause of death category used for those cases whose official cause of death has been given an ICD-10 Underlying Cause of Death that corresponds to Chapters 1–17 of the ICD Codebook. 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 (including SIDS or undetermined causes) 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 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 and extended family members can be involved in these incidents.
Drowning	Deaths that occur as a direct or indirect result of immersion in some form of liquid.
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	Defines where a child dies 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 which 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 Islanders.
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.
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. This is the definition used by the Australian Bureau of Statistics in all cause of death publications.
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.
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 section 5.1.
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 two people of any age who are friends and therefore of the same social standing and peer network.
Peer passengers	Refers to 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 gestation 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	This is 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. This is the definition used by the ABS in all cause of death publications.
Postvention	Defined by the American Association of Suicide Prevention as 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.
QFCC	Queensland Family and Child Commission enacted by the *Family and Child Commission Act 2014* on 1 July 2014.
The Registrar	Registrar of the Registry of Births, Deaths and Marriages (Qld).
Registry	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.
RSQ	Retrieval Services Queensland.
Rural water hazard	Sources of water used in agricultural activities, such as dams, irrigation channels, livestock dips and troughs.
SES	Socio-economic status.
SEIFA	Socio-Economic Indexes for Areas 2011. Developed by the ABS using data derived from the 2011 Census of Population and Housing, SEIFA 2011 provides a range of measures to rank areas based on their relative social and economic wellbeing.
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.
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.
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 of deaths of infants less than 1 year of age that—were sudden in nature, were unexpected, with no known condition likely to cause death, and have 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	Contagion refers to 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, written or expressed using online technology (SMS text messaging, online messenger and email, or through social media platforms).
Suicide	Deaths 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 that 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 • watercraft and aircraft • horses and other animals used for transportation.
UNCRC	United Nations Convention on the Rights of the Child.
WHO	World Health Organization.

1.3 Cause of death by ICD-10 mortality coding classification

Table 5 provides a summary of the ICD-10 categories for child deaths from diseases and morbid conditions, registered during 2015 — 16. Table 6 provides the ICD-10 categories for child deaths from external causes.

The numbers in Table 5 are equal to the numbers of deaths from diseases and morbid conditions presented in the Annual Report. Deaths are only categorised as such when an official cause of death has been assigned by Queensland Health or the Coroner, which provides the necessary information to determine the ICD-10 code.

The numbers in Table 6 will not necessarily equal the numbers of external-cause deaths presented in the Annual Report. In some cases, the general nature of the death can be identified (e.g. transport-related death), however there is insufficient information to determine the underlying cause of death. An ICD-10 code cannot be assigned for these cases until the Coroner has determined the official cause of death. As such, these cases have not been included in Table 6.

Table 5: Deaths from diseases and morbid conditions 2015 — 16

Cause of death	Under 1 year *n*	1–4 years *n*	5–9 years *n*	10–14 years *n*	15–17 years *n*	Total *n*
Explained diseases and morbid conditions total	**207**	**17**	**18**	**22**	**21**	**285**
Certain infectious and parasitic diseases (A00–B99)	2	0	2	1	0	**5**
Neoplasms (C00–D48)	3	6	6	10	6	**31**
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50–D89)	2	0	0	0	0	**2**
Endocrine, nutritional and metabolic diseases (E00–E90)	1	0	1	1	5	**8**
Diseases of the nervous system (G00–G99)	3	2	1	1	5	**12**
Diseases of the circulatory system (I00–I99)	4	1	0	1	3	**9**
Diseases of the respiratory system (J00–J99)	5	3	3	4	1	**16**
Diseases of the digestive system (K00–K93)	0	0	3	0	0	**3**
Certain conditions originating in the perinatal period (P00–P96)	118	2	0	0	0	**120**
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	69	3	2	4	1	**79**
SIDS and undetermined causes (infants) total	**5**	**0**	**0**	**0**	**0**	**5**
Sudden infant death syndrome (R95)	2	0	0	0	0	**2**
Other ill-defined and unspecified causes of mortality (R99)	3	0	0	0	0	**3**
Undetermined >1 year total	**0**	**0**	**0**	**1**	**0**	**1**
Other ill-defined and unspecified causes of mortality (R99)	0	0	0	1	0	**1**
Total	**212**	**17**	**18**	**23**	**21**	**291**

Table 6: Deaths from external causes 2015 — 16

Cause of death	Under 1 year *n*	1–4 years *n*	5–9 years *n*	10–14 years *n*	15–17 years *n*	Total *n*
Suicide total	**0**	**0**	**0**	**4**	**16**	**20**
Intentional self-harm (X60–X84)	0	0	0	3	16	**19**
Event of undetermined intent (Y10-Y34)	0	0	0	1	0	**1**
Transport total	**0**	**5**	**1**	**3**	**9**	**16**
Pedestrian injured in transport accident (V01–V09)	0	4	0	0	0	**4**
Motorcycle rider injured in transport accident (V20–V29)	0	0	0	1	0	**1**
Car occupant injured in transport accident (V40–V49)	0	1	0	0	6	**7**
Occupant of pick-up truck or van injured in transport accident (V50–V59)	0	0	0	0	1	**1**
Occupant of heavy transport vehicle injured in transport accident (V60–V69)	0	0	0	1	0	**1**
Other land transport accidents (V80–V89)	0	0	0	1	0	**1**
Exposure to inanimate mechanical forces (W20-W49)	0	0	0	0	1	**1**
Fatal assault and neglect total	**1**	**1**	**2**	**3**	**2**	**6**
Assault (X85–Y09)	1	1	1	1	2	**6**
Other non-intentional injury-related death total	**1**	**5**	**0**	**1**	**2**	**7**
Toxic effects of substances chiefly nonmedicinal as to source (T51-T65)	0	1	0	0	0	**1**
Exposure to inanimate mechanical forces (W20–W49)	0	2	0	0	0	**2**
Other accidental threats to breathing (W75–W84)	1	1	0	0	0	**2**
Exposure to smoke, fire and flames (X00–X09)	0	0	0	1	0	**1**
Accidental poisoning by and exposure to noxious substances (X40–X49)	0	0	0	0	1	**1**
Drowning total	**0**	**5**	**0**	**1**	**2**	**8**
Accidental drowning and submersion (W65–W74)	0	5	0	1	2	**8**
Total	**2**	**16**	**3**	**12**	**31**	**64**

2.1 Notifiable diseases

Table 7: Schedule of Notifiable Conditions (Public Health Regulation 2005)

Acquired immunodeficiency syndrome (AIDS)	Haemolytic uraemic syndrome (HUS)
Acute flaccid paralysis	*Haemophilus influenzae* type b infection (invasive)
Acute rheumatic fever	Hansen's disease (leprosy)
Acute viral hepatitis	Hepatitis A
Adverse event following immunisation	Hepatitis B (acute)
Anthrax	Hepatitis B (chronic)
Arbovirus (mosquito borne) infections • alphavirus infections including: – Barmah Forest – getah – Ross River – sindbis • bunyavirus infections including: – gan gan – mapputta – termeil – trubanaman • flavivirus infections including: – alfuy – Edge Hill – kokobera – kunjin – Stratford • Other unspecified arbovirus infections NB: dengue fever, yellow fever, Japanese encephalitis and Murray Valley encephalitis are listed separately	Hepatitis B (not otherwise specified)
	Hepatitis C
	Hepatitis D
	Hepatitis E
	Hepatitis (other)
	Human immunodeficiency virus infection (HIV)
	Influenza
	Invasive group A streptococcal infection
	Japanese encephalitis
	Lead exposure (notifiable) (blood level of 10 µg/dL (0.48 µmol/L) or more)
	Legionellosis
	Leptospirosis
	Listeriosis
	Lyssavirus (Australian bat lyssavirus)
	Lyssavirus (Australian bat lyssavirus), potential exposure
Avian influenza	Lyssavirus (rabies)
Botulism	Lyssavirus (unspecified)
Brucellosis	Malaria
Campylobacteriosis	Measles
Chancroid	Melioidosis
Chikungunya	Meningococcal infection (invasive)
Chlamydia trachomatis infection	Mumps
Cholera	Murray Valley encephalitis
Ciguatera intoxication	Non-tuberculous mycobacterial diseases
Cruetzfeldt-Jakob disease	Ornithosis (psittacosis)
Cryptosporidiosis	Paratyphoid
Dengue fever	Pertussis
Diphtheria	Plague
Donovanosis	Pneumococcal disease (invasive)
Equine morbillivirus (Hendra virus)	Poliomyelitis (wild type and vaccine associated)
Food-borne or waterborne illness in 2 or more cases	Q fever
Food-borne or waterborne illness in food handler	Rotavirus
Gonococcal infection	Rubella (including congenital rubella)

Salmonellosis	Tuberculosis
Severe acute respiratory syndrome (SARS)	Tularaemia
Shiga toxin and vero toxin producing *Escherichia coli* infection (SLTEC/VTEC)	Typhoid
Shigellosis	Varicella—zoster virus infection (chickenpox, shingles and unspecified)
Smallpox	Viral haemorrhagic fevers (Crimean-Congo, Ebola, Lassa fever and Marburg viruses)
Syphilis (including congenital syphilis)	Yellow fever
Tetanus	Yersiniosis

5.1 Inclusions within the other non-intentional injury-related death 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 cold
- accidental poisoning by noxious substances, examples include:
  - inhalation of volatile substances
  - non-intentional overdose
  - unintended consumption
- complications of medical and surgical care.

6.1 Suicide classification model

The suicide classification model is used to classify all cases of suspected suicide into one of three levels of certainty.[22] 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.

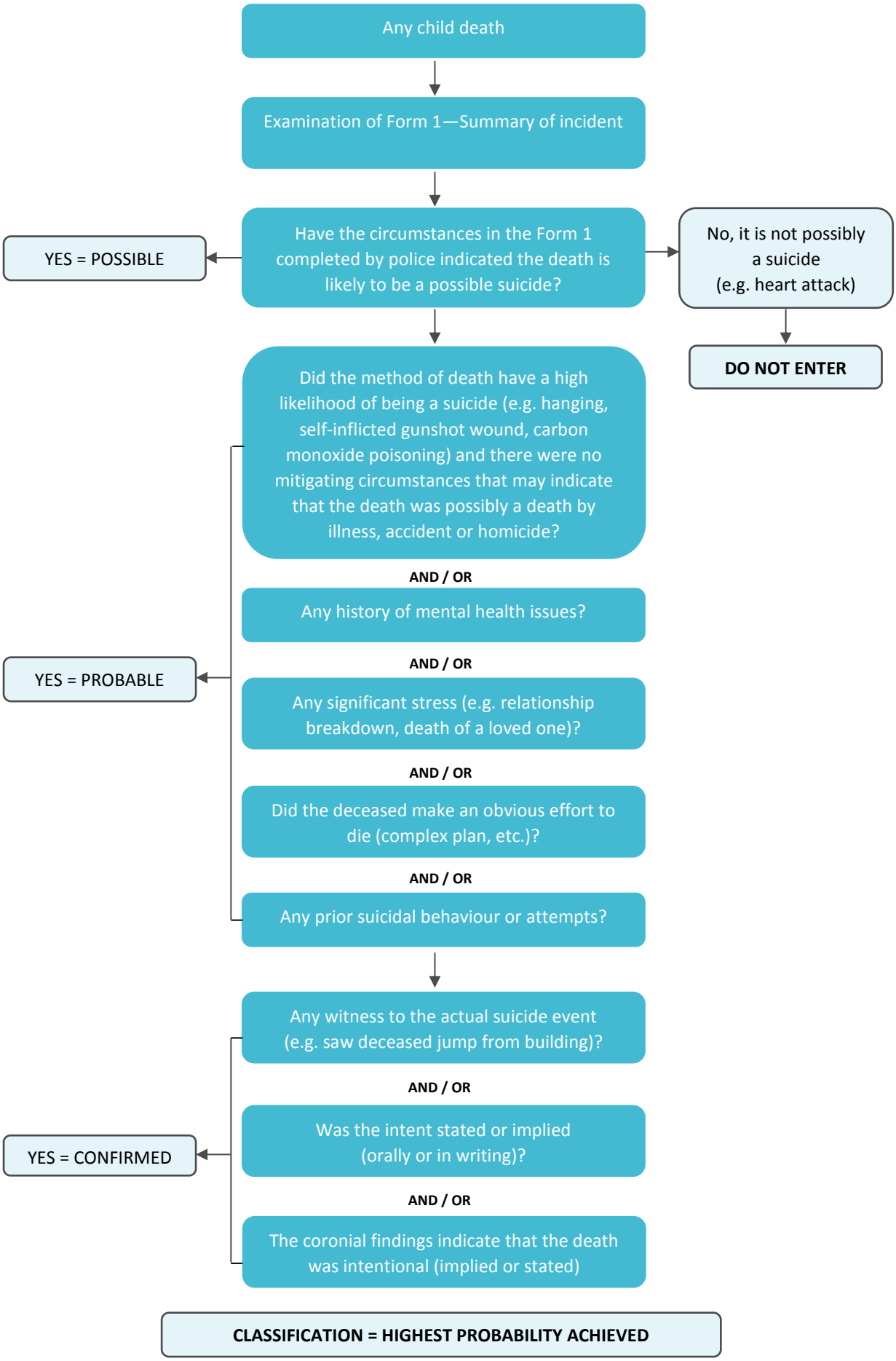
Information used to classify suicide certainty is based on data available to the QFCC at the time of reporting. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), autopsy and coronial findings, toxicology reports, child protection system records and, for finalised cases, police briefs of evidence to the coroner (which can include witness statements, supplementary Form 1s, additional police reports and suicide notes).

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 more consistent with death by suicide than 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.

[22] The QFCC classification model is an amended version of the Australian Institute of Suicide Research and Prevention's (AISRAP) suicide classification flow chart.

Figure 1. Suicide classification model



7.1 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, for finalised cases, police briefs of evidence to the coroner (which can include witness statements, supplementary Form 1s and additional police reports). 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).