SEPTEMBER 2025

Defining Fatal Assault and Neglect

Enabling Child Death Prevention

QUEENSLAND Family & Child Commission

Queensland Government

Acknowledgement

The Queensland Family and Child Commission (the Commission) and Lumenia acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work. We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the leadership that Aboriginal and Torres Strait Islander Peoples play in the child and family sector, enabling children and young people across Queensland to grow strong and safe in culture.

This report may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline on 13 11 14

Beyond Blue on 1300 22 4636

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Executive Summary

Redefining Fatal Assault and Neglect

This report provides a comprehensive, research-informed strategy for advancing the Queensland Family and Child Commission's (the Commission's) Child Death Prevention team's approach to the classification, review and prevention of fatal child assault and neglect.

In response to a desire to ensure consistency, accuracy and systemic learning from child death data, this project recommends adoption of new definitions which align to modern conceptualisations of child maltreatment, and a multi-layered framework drawing on literature, practice evidence, expert stakeholder consultation and analytical methods to enable more robust case classification, support high-impact prevention and drive continuous system improvement.

Project Purpose and Approach

Recognising the limitations of purely legal or episodic approaches to categorise child deaths coupled with the challenges of ensuring consistency in alternative processes, the Commission initiated this project to refine its child death classification and analytic processes.

The project was focused on:

- Ensuring **definitions and classification criteria and approaches for fatal assault and neglect are rigorous, evidence-based,** and fit for both system and advocacy purposes;
- **Embed prevention and learning** as core mandates, ensuring each analysis identifies opportunities for future harm reduction;
- **Address equity**, with focus on being mindful that any recommended strategies feature transparent anti-bias safeguards;
- **Strengthening analytic capacity** to enable more nuanced and actionable prevention insights into causes and patterns of child deaths.

To achieve these aims, the project's methodology integrated a literature review with a focus on risk factor validation and child assault and neglect classification models, expert consultation and multidisciplinary team workshops and benchmarking against inter-jurisdictional practice. Drawing on these inputs, Lumenia have developed a suite of recommendations and tools to support refinement of the Commission's practice, with implementation considerations highlighted.

Key Insights from Literature

- **There are a range of consistent indicators and associated risk factors in cases of fatal assault and neglect** which lend themselves to supporting classification of probable and possible incidents in a systematic fashion where definitive confirmation of abuse or neglect is absent.
- **The concept of neglect is differentially interpreted in literature** with alternative approaches focused on preventability put forward by some authors.
- **There is a role of structured, evidence-based decision tools coupled with multidisciplinary expert review** for accurate case classification and effective prevention, recognising that child death categorisation requires diverse expert-informed inputs.

Cross-Jurisdictional Lessons

Through workshops and small-group consultations with cross-jurisdictional teams in Australia and New Zealand, a range of key themes emerged:

- **There are consistent challenges defining cases across jurisdictions** noting that an element of clinical judgement is currently utilised in each jurisdiction, despite recognition of the benefit of more standardised approaches.
- **Neglect is inconsistently conceptualised and reported** with some jurisdictions preferring to focus on prevention opportunities rather than 'neglect' per se, which is considered to be laden with underpinning caregiver blame that may amplify classification biases.
- **Multidisciplinary review mechanisms which include diverse perspectives are utilised in numerous settings,** often integrating a blend of clinical/medical and forensic, child protection and legal expertise, with cultural inputs to address potential issues of systemic bias.
- **Audit and review cycles** are implemented in some jurisdictions to ensure reliability of categorisation.
- **There is an opportunity to drive system learning and prevention** through classification approaches, reporting and policy recommendations.

Analysis of Current Practice

The review of the Commission's statutory definitions, classification protocols, and review systems identified strengths, including its current three-tier (confirmed/probable/possible) system of classification and records of its complex cases, as well as opportunities for improvement.

These include the opportunity to strengthen practice through:

- Moving towards a **Maltreatment** lens that encompasses sub-categories of Assault and Other maltreatment, where 'other' maltreatment integrates *wilful and knowing* acts, more clearly differentiating from accidental lapses.
- Greater use of **structured, literature-informed assessment in screening** to reduce classification inconsistency risks
- **Enhanced multi-disciplinary expert input,** allowing for diverse expertise to inform classification in cases which are challenging to immediately classify
- **More systematic documentation of missed prevention opportunities related to modifiable care factors**, particularly where deaths implicate broader systemic prevention issues
- **Strengthened mandates and processes for culturally-centred review** and systems learning, especially for Aboriginal and Torres Strait Islander child deaths.

Strengthening Practice

The report makes a number of recommendations to refine the definitions utilised by the Commission's Child Death Prevention team, supporting capture of cases to best inform prevention. This includes moving towards a 'maltreatment' categorisation which encompasses child assault deaths alongside other forms of maltreatment (e.g. those previously captured as 'neglect').

The report further proposes the use of a literature-derived, structured classification decision tool for maltreatment, grounded in population research and forensic evidence, coupled with robust peer review and multidisciplinary review mechanisms.

The proposed decision tool integrates:

- Identifying **Confirmed Maltreatment** cases in a method generally aligned with the Commission's current practice.

- Screening **Probable Maltreatment** cases on the basis of indicative clinical presentations (e.g., sentinel and patterned injuries, multiple healing stages for trauma) followed by considering evidence-centred indicators.
- Automatic triggers for the Commission Peer review for **Probable Maltreatment** cases, with a subsection of Child Maltreatment Assault cases and all Other cases undergoing **the Commission Team Review** and, where uncertainty remains, **Multidisciplinary Expert Review.**

The proposed decision tool will enable consistency in consideration of the probability of maltreatment and be complemented by tailored recording processes to support consistency in implementation.

The report recommends processes of internal Commission Peer Review and the Commission Team Review to support robust categorisation. Where consensus cannot be achieved or uncertainty remains, a process of escalation to the Multidisciplinary Expert Review is recommended. This review is suggested to integrate a range of key practitioner voices including forensic, medical, legal, child protection and culturally-centred practitioners to enable strengthened classification and prevention learnings.

Processes to explore missed prevention opportunities to identify systems-level contributors to child death which can be addressed to enable prevention are additionally proposed to support the Commission's prevention learnings.

Implementation Considerations

Implementation considerations are discussed within the report, including ensuring sufficient:

- **Resourcing** including data infrastructure, multidisciplinary inputs and training
- **Continuous improvement** including annual audit processes
- **Culturally-informed delivery approaches** including direct mechanisms to be led by the expertise of Aboriginal and Torres Strait Islander leaders
- Mitigating actions to **manage impacts of changing counting approaches** and potential means of addressing these during implementation.

Recommendations:

It is recommended that the Commission's Child Death Prevention Team:

- Adopt a **child maltreatment lens** in its classification of child deaths where there is suspicion of inflicted harm or wilful deprivation
- Expand processes to review all non-natural and natural preventable child deaths for **Modifiable Care Factor related** prevention learnings
- Implement the **use of decision-making tools** to support initial child death classification
- Establish **tiered review mechanisms** including internal Commission Peer Review, Commission Team Review and external Multidisciplinary Expert Review to enable diverse expertise to shape classification and inform prevention.

The evidence-informed nature of the proposed process refinements will position the Commission as a national leader in rigorous, child-centred and learning-driven review and prevention.

Introduction

The imperative to accurately classify and investigate child deaths related to assault and neglect is central to meaningful prevention activities, child-rights focused advocacy, system accountability and research. Substantial literature and coronial investigations have highlighted persistent challenges in identification of assault and neglect, including inconsistent definitions, ambiguity in complex cases, systemic bias and fluctuating thresholds for review and action which impede child death classification and prevention activities (Scott, 2016; Sidebotham et al., 2016).

The Child Death Prevention Team within the Queensland Family and Child Commission (the Commission) performs a central role in improving systemic responses to, and understanding of, child mortality. Its mandate is grounded in legislation and aligned with public health best practices, with a specific focus on analysis and classification.

The Child Death Prevention team reviews the details of all child deaths for the purpose of classifying and coding deaths, identifying trends, risk factors and prevention strategies. This information is used to contribute to research, inform policy improvements and support community safety initiatives to help reduce the likelihood of future child deaths.

Through its classification, analysis and reporting process, the team identifies opportunities for primary prevention and earlier intervention, system responses and recurring risk profiles. The Child Death Prevention Team is focused on ensuring that data analysis and recommendations from these reviews inform broader system reform, policy development and community engagement initiatives.

We note that the Child Death Prevention team operates in a separate fashion from the Child Death Review Board (the Board) who conduct systemic reviews following the death of a child connected to the child protection system. The Board 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.

The current report was commissioned by the Commission and delivered by **Lumenia** to provide the Commission with a synthesis of the existing evidence base, undertake jurisdictional comparison and develop applied advice to support the Commission in its child assault and neglect death classification definitions and processes.

The recommendations contained within this report reflect published literature and practice evidence from jurisdictions across Australia to ensure robust, prevention-centred decision-making for the most complex and consequential child death cases.

Understanding Fatal Assault and Neglect

Conceptualising Fatal Assault and Neglect

Classifying fatal child assault and neglect is complex, posing practical challenges which have been documented in both the academic and operational literature and reinforced through consultations across jurisdictions undertaken during this project (Brandon et al., 2014). Multiple overlapping factors make this work challenging: differing definitions and understandings of assault and neglect, ambiguous injury presentations, inconsistent or incomplete histories and the interlocking roles of family, community and systemic contributors to child abuse and neglect (Finklehor & Ormrod, 2001).

It is well recognised that legal frameworks demand a high burden of evidence typically focusing on intent, direct perpetrator action and objective forensic evidence, whilst contemporary health promotion centred research recognises that far more children experience death related to assault and neglect than are ever categorised as such under criminal or coronial standards (Biron, et al., 2015; Sidebotham, 2013). Many fatal injuries in children, especially in infants, are either unexplained, poorly characterised, or occur without an identified perpetrator, resulting in undercounting and missed opportunities for prevention (Schnitzer et al, 2011).

Differential interpretations of what constitutes neglect further complicate its classification. Deaths from drowning, paediatric heat stress, or unsafe sleep as well as from unaddressed medical needs may present as accidents or

supervisory oversights, yet a deeper review often reveals elements of patterns of supervisory lapse, exposure to environmental risk, or engagement barriers that may be considered to cross the threshold into neglect (Damashek, et al., 2013; Sidebotham et al., 2016).

Medical neglect in particular poses these challenges in classification, where failure of care may be attributed to a range of factors, including caregivers genuinely believing they are acting in the child's best interest in line with alternative medicine belief systems, coupled with systemic failures to engage families (Friedman & Billick, 2015). Attributing risk exclusively to apparent parental or caregiver behaviour is known to present a limitation in assault and neglect classification (Lawrence, 2004; Scott, 2016).

Differentiating between accidents, acute lapses in care, medical neglect and neglect is nuanced, especially when compounded by social disadvantage and varied family and cultural norms which pose challenges in defining neglect in a consistent manner (Gardianos, 2010; Scott, 2016). Some classification methods consider both assault and neglect on a continuum from persistent caregiver behaviour to once-off acts, but there are no consistently agreed classification mechanisms to support identification (Damashek et al., 2013).

Alongside these challenges, the confluence of individual acts or omissions with system- and service- level failures such as inadequate follow-up, poor service cultural safety, resource constraints and organisational bias requires a classification approach that is generally accepted within the published literature to transcend singular culpability.

Longstanding evidence highlights that cultural bias and assumptions within protective and judicial systems can not only distort risk perception but may also compound the challenges faced by already marginalised children and families (Lawrence, 2004; Benbenishty, 2015). Evidence from multiple jurisdictions demonstrates that Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse families are over-represented in both substantiated child protection cases, in part as a result of the use of standardised decision making tools which have been shown to have cultural bias in risk consideration, alongside institutional discrimination, structural inequities and differential service responses (Harnett & Featherstone, 2020).

It is notable that numerous authors have highlighted inconsistencies in the analysis and reporting of fatal neglect in particular, suggested that classification of fatal neglect may be best positioned with a view to prevention possibility, rather than occurrence at a family level (e.g. Scott, 2016; LaPosata & Verhoek-Oftedahl, 2005).

Analytical Models for Classification

The literature identifies three key paradigms for child maltreatment classification, each with distinct strengths and limitations for prevention systems learnings:

Legal Model

The legal model of classification emphasises intent and criminal culpability, requiring clear forensic or legal evidence. This model is reflected in the Commission's current highest certainty (e.g. 'Confirmed') classifications, generally requiring criminal proceedings or explicit coronial findings to establish fatal assault or neglect. While this ensures procedural clarity, it is widely recognised that many child assault and neglect deaths never meet this threshold, and thus likely represents an undercount of the prevalence of assault related injuries (Kaltner et al., 2013; Sidebotham et al., 2014).

Ecological Model

Building on the work of Bronfenbrenner (1979), the ecological model of interpersonal violence which has been applied in the child death context (Krug et al., 2002; Scott, 2016) acknowledges that fatal assault and neglect arises from dynamic interactions at the child, family, community, and societal levels.

Ecological approaches recognise the influences of social determinants such as poverty, access to services, community violence, discrimination, and foregrounds the need to engage across systems such as child protection, health, education, justice, while respecting cultural and contextual diversity (Sidebotham et al., 2014). Ecological thinking inform classification approaches which integrate broad definitions (Bonner et al., 1999) and multidisciplinary panel processes drawn on in the classification of child death, alongside the greater inclusion of

cultural and systemic risk and protection factors in classification and prevention work which are being implemented in many jurisdictions.

Public Health Prevention Model

The public health approach focuses on examining all preventable deaths, whether or not intentional harm or neglect can be legally proven, with a focus on prevention (McCarroll, 2017).

This paradigm draws on pattern recognition, risk factor and system-level analysis to capture sentinel events, cumulative risk and cases that fall below legal thresholds but nevertheless reveal modifiable contributors to a child's death (Pierce, 2021; Lawrence, 2004). Such an approach allows for earlier identification of patterns and broader prevention focus, emphasising prevention opportunity over attribution. The Commission's current approach of capturing 'Probable' and 'Possible' incidents of child assault and neglect through analysis of diverse evidence reflects its prevention-oriented mandate aligned with a public health approach.

The current project builds on these models, developing approaches to child death classification which integrate elements of each paradigm with a focus on ensuring robust, equitable and reliable decision-making drawing on the span of ecological contextual factors to inform the Commission's ongoing prevention activities.

Project Method

Project Design

The current project employed a multi-phase, mixed-methods design to develop, benchmark and refine decision approaches for classifying fatal child assault and neglect in Queensland.

The project integrated targeted literature review, stakeholder engagement, cross-jurisdictional process analysis, expert consultation to inform the development of an applied suite of both processes and decision tools to refine the Commission's current child death classification approaches for assault and neglect.

The approach is situated within a public health, ecological and system-learning framework, integrating both academic rigor with a focus on practical applicability within the Commission's statutory and prevention setting. The following key activities were undertaken within the project:

Literature and Evidence Review

A targeted review of academic and grey literature was conducted to identify and synthesise evidence on risk factors, classification approaches, decision tools and review processes for fatal child assault and neglect. Searches were performed across major databases via Google Scholar.

Grey literature including national and international policy documents, reports and guidelines were additionally included via a snowballing methodology and where directly provided during jurisdictional consultation.

Stakeholder Consultation

Internal and external stakeholder engagement was undertaken to capture practice experience, expert insight and operational implementation considerations. Semi-structured interviews and consultation workshops were conducted with:

- The Commission's Child Death Prevention Team;
- Child protection, paediatric, social work, forensic experts and cultural representatives in the Queensland child and family context;
- Inter-jurisdictional agencies across Australia and New Zealand, with further one-on-one interviews with representatives from the New South Wales and Victorian contexts to further explore their current processes.

Thematic analysis of workshop and consultation notes was undertaken, with results triangulated against literature findings.

Jurisdictional Analysis

Engagement and analysis were undertaken to compare the Commission's system with other large Australian jurisdictions. This analysis included review of legislation, policy, and practice documents, assessment of current practice in definitions and classification thresholds and examination of multi-disciplinary review and documentation processes to inform process refinement recommendations.

Decision Tool Development

An evidence-informed, literature-validated decision tool for fatal child maltreatment was constructed through iterative synthesis of:

- Systematic review findings highlighting strong, evidence-informed indicators and risk factors for child assault and neglect;
- Existing decision tools and algorithms used in some settings;
- Consultation input on best practice approaches, operational feasibility and implementation considerations.

A pilot tool was created to this end alongside proposed process refinements and a range of implementation recommendations.

Strengthening Multidisciplinary Inputs

Aligned to best practice across jurisdictions, to complement the proposed evidence-based tools for classifying fatal child maltreatment, the project proposes establishment of multidisciplinary review processes to ensure that potential assault and neglect deaths are interpreted and contextualised using the full breadth of expertise across clinical, forensic, legal, social, and cultural domains.

The proposed review approach prioritises the review of complex or ambiguous cases by diverse panels, including paediatricians, forensic pathologists, child protection specialists, legal advisors, and Aboriginal and Torres Strait Islander cultural advisors.

Through engaged consultation with the Commission's Child Death Prevention team and cross-governmental stakeholders, proposed procedures were co-designed to ensure robust processes, ensuring that both individual case histories and contextual variables such as systemic barriers and cultural bias patterns are robustly considered in neglect and assault classification.

Processes were developed to both operationalise best practice, drawing on inter-jurisdictional models and learnings and reflect the operational realities of Queensland's service landscape.

Considerations and Limitations

The project methodology was informed by ethical principles centred in a child-rights lens, with a focus on enabling prevention of serious child injury and death and ensure equitable interpretations of risk which consider systemic bias.

The Lumenia project team consisted of a range of members, including with Doctor of Philosophy (PhD) level qualifications focused on the classification of intentional child injury, alongside cultural-centring through its Aboriginal team member with expertise in epidemiology, and members with extensive experience in process refinement in child and family settings. The Lumenia team's expertise was complemented by the Commission Child Death Prevention Team's experience.

Methodological limitations in the current project include a range of significantly varying inter-jurisdictional differences in process, with limited publicly available data on current process efficacy and effectiveness for

prevention to inform the project's work. These limitations were mitigated by triangulation of published evidence, multidisciplinary inputs and external validation where possible, alongside collaborative design of new processes with the Commission team to ensure ease of application to the Commission setting. Ongoing work to validate processes is proposed to ensure robustness of processes and definitions over time.

Literature and Evidence Review

Fatal Assault

Demographic and Developmental Risk and Indicators

Age, Developmental Stage, and Vulnerability

Published literature suggests that fatal assault in childhood shows a steep and well-defined age gradient, with the risk highest among infants and declining with age. Numerous epidemiological studies across Australia and internationally show that children under five, and especially under one, bear a disproportionate burden of fatalities from inflicted injury compared to all other age groups (Sheets et al., 2013; Jenny et al., 1999). For example, Jenny et al. (1999) found that nearly 80% of abusive head trauma cases in their United States cohort occurred in infants under 12 months. This was replicated in the Queensland context through the work of Kaltner et al. (2012), which highlighted higher rates of abusive head injuries in Queensland infants aged 0-12 months than in older cohorts.

The vulnerability of infants stems from their physical fragility, total dependence on adult caregivers and relative inability to communicate or defend themselves (Niederkrotenthaler et al., 2013). Pre-cruising infants are unable to roll, crawl, or walk, meaning that explanations of injuries such as accidental falls rarely align to their developmental abilities. This is consistently reflected in forensic and clinical reviews, where deaths attributed to accidental trauma in non-cruising infants are treated with higher suspicion (Hymel et al., 2021; Liley et al., 2012).

Crying peak periods have been well established to be associated with peaks in inflicted injuries in infants, with increased caregiver stress considered a potential contributor to these incidents (Reece, 2010; Liley et al., 2012). Sex-based and birth-order differences have been documented in some of the available literature but are less consistently observed. Some studies suggest a slight excess risk of fatal assault amongst boys, especially in the first year, whilst others note no sex difference after adjustment for household context (Sidebotham et al., 2016).

Clinical Forensics and Sentinel Injury

Sentinel Injuries: Predictive Value and Empirical Evidence

Sentinel injuries, including subtle or unexplained bruises, intra-oral injuries, or fractures in non-mobile infants, are powerful early markers of abuse. Prospective and case-control studies consistently show that such injuries often precede infant deaths. Sheets et al. (2013) demonstrated that 27.5% of abused infants had a documented sentinel injury at a prior clinical encounter, compared to zero among non-abused controls.

The clinical utility of these findings is strengthened by the validation of decision rules such as TEN-4-FACESp (Peirce et al., 2021) which flags bruises on the torso, ears, neck, frenulum, and other sites as highly indicative of inflicted harm, especially in non-cruising infants. In a large, multi-centre study, TEN-4-FACESp demonstrated a sensitivity of 95.6% and specificity of 87.1% for abuse in children under four. Such population-level studies confirm that, in the absence of plausible medical or accidental explanations, sentinel injuries demand robust multidisciplinary scrutiny, as they may represent opportunities to prevent escalation to fatal harm.

Patterned, Multiple, and Unexplained Injuries

Patterned injuries, e.g. those reflecting the shape of an implement or hand, such as grip marks or bites, are regarded as pathognomonic for inflicted trauma (Jenny et al., 1999; Garstang et al., 2021). Likewise, multiple injuries, particularly at different stages of healing, provide forensic evidence of repeated incidents rather than a single traumatic event. Serious case reviews in both the UK and Australia find that such indicators are commonly present upon retrospective investigation of fatal assault cases (Sidebotham et al., 2014).

Missed Opportunities for Early Identification and Prevention

Despite the predictive validity of sentinel injuries, numerous studies and inquiries highlight persistent under-recognition. In their analysis of missed cases of abusive head trauma, Jenny et al. (1999) documented repeated clinical visits where clear warning signs were not acted upon, usually due to attribution to plausible but unwitnessed accidents or a lack of familiarity with risk indicators among non-specialist clinicians. Such failures underscore the need for education, structured decision rules, and multidisciplinary escalation protocols.

Delay in Seeking Medical Care Inconsistent with Severity

A consistent red flag for inflicted injury or neglect-related fatality is an unexplained delay in seeking medical attention. Research highlights that in child maltreatment cases carers may postpone or avoid seeking care (Christian, 2015; Sidebotham et al., 2014). Studies show that such delays significantly increase the risk of serious harm or death, especially when the severity of an injury clearly warrants urgent care (Jacobi, 2010; Sheets et al., 2013). Clinical reviews identify delayed care-seeking as a recurring aspect in both fatal physical abuse and medical neglect cases (Stirling, 2019).

Household and Family Predictors

Unexplained Sibling or Prior Child Death in the Household

Familial clustering of unexplained child deaths, such as in sudden infant death syndrome (SIDS) and sudden unexpected death in infancy (SUDI) is well documented in epidemiological studies. Children in households with prior unexplained sibling death have been suggested to be at significantly heightened risk for subsequent child deaths, with rates reported of up to 10 times higher than the general population. Subsequent child deaths, including homicide related deaths, are more prevalent in this population, hypothesised to be in part due to modifiable parent or caregiver risk factors (Garstang et al., 2021).

Household Composition and Dynamics

The literature demonstrates a clear association between household instability and increased risk of both fatal and severe physical abuse. Children living with non-biological caregivers, particularly unrelated adult males, have a demonstrably higher risk of fatal assault (Stith et al., 2009). It is, however, important to interpret these findings with caution given social norms which may underpin some bias in the recognition of assault for cohorts who are seen to be non-nuclear families; this is particularly relevant given that subsequent studies have shown that biological fathers, rather than unrelated males, are the most common perpetrators of abusive injuries in infants (e.g. Starling & Holden., 2000).

Parental and Caregiver Risk Factors

Meta-analyses indicate that concurrent parental substance misuse (alcohol or drugs), mental illness, and domestic violence increase the probability of both non-fatal and fatal assault (Stith et al., 2009; Austin et al., 2020). The coexistence of these factors has been indicated to exert a synergistic effect on risk, meaning their combined presence is far more predictive than the sum of their independent effects. Systematic reviews have found that households with two or more of these characteristics are vastly overrepresented in fatal assault cases (Garstang et al., 2021).

Male caregivers have been demonstrated through numerous consistent studies across international and Australian settings to be more likely to perpetrate injury of infants and children than female caregivers (Sidebotham et al., 2014; Starling & Holden, 2000).

Socioeconomic Disadvantage and Community Context

Socio-economic disadvantage has been highlighted as a risk factor for assault injuries in a range of studies (Liley et al., 2012). It is notable that the confound of systemic bias is likely to influence these findings in a similar way to those which have suggested higher recognition of incidence in children of minority cultural status.

The relationship of socioeconomic disadvantage to fatal assault is best understood as a context that amplifies parental stress, diminishes protective factors and impedes timely access to support or intervention. Community-

level disadvantage, as measured by neighbourhood poverty, unemployment, and crime, further predicts heightened rates of maltreatment fatality (Sidebotham et al., 2014), likely linked to similar increased parental pressures.

Sibling status and large household size has been suggested to contribute additional complexity through its increased demands on caregivers, with children of twin status, infants with disability and infants residing in crowded homes or homes with frequent visitors noted in literature to be at heightened risk, possibly due to diminished individual caregiver attention due to competing demands on caregiver time (Stith et al., 2009; Kaltner et al., 2012).

Reviews emphasise that risk models that incorporate household, community and economic factors, rather than focusing exclusively on parental acts, are both more reliable and more just, reducing both under- and over-classification of inflicted injury among disadvantaged groups (Scott, 2016; Sidebotham et al., 2014).

System Involvement and Case Escalation

Prior Child Protection System Involvement

A recurring finding in the literature is the association between prior system engagement (e.g., child protection notifications, investigations, open cases) and risk of fatal assault (Schnitzer et al., 2013; Schnitzer et al., 2024).

Systematic missed prevention opportunities are commonly identified in reviews and literature: these include unassessed or poorly followed up earlier notifications, insufficient attempts to enable engagement in support services and communication breakdown between agencies (Garstang et al., 2021).

Patterns of Escalating Risk

Serious case reviews demonstrate that fatal events are rarely isolated; they are often the endpoint of escalating risk, where sentinel injuries, failure of services to engage with families, repeated child protection concerns and other indicators such as parental justice interactions accumulate without collaborative system action (Sidebotham et al., 2016). National and international child death reviews documents risk escalation over months or years prior to lethal outcome, establishing the imperative for child death classification processes that consider such patterns.

Service Engagement and Professional Response

Disengagement from health and social services, or a failure of services to enable engagement, often precedes fatal assault. Families may move frequently, miss appointments or present with escalating but unresolved concerns (Garstang et al., 2021).

Failures at the system level, e.g., lack of communication between agencies, no formal risk review and inadequate data sharing are repeatedly cited as missed preventative opportunities (Scott, 2016).

Fatal Neglect

Over time, conceptualisations of child maltreatment have significantly evolved, moving away from traditional frameworks that primarily attributed risk to individual parental or caregiver behaviour toward more nuanced, prevention-oriented approaches that recognise the complex interplay of systemic, cultural and socioeconomic factors.

Literature highlights critical limitations in traditional neglect classification systems, arguing that approaches focused exclusively on apparent parental omissions fail to capture the broader ecological context in which child deaths occur (Scott, 2016). Contemporary frameworks informed by this scholarship increasingly prioritise system learning over individual caregiver blame, integrating explicit assessment of cultural context, resource constraints and missed opportunities for professional intervention to support more equitable and effective prevention strategies.

The following literature explores circumstances traditionally classified as "neglect," noting the evolution toward maltreatment frameworks that distinguish between *wilful or knowing harm* and broader preventable circumstances requiring system-level intervention.

Environmental Hazard and Supervision

Fatal child neglect is one of the leading contributors to preventable childhood mortality in developed nations; the literature consistently identifies a suite of scenarios including drowning, fires, failure to engage in medical care, heat exposure, accidental poisoning and unsafe sleep environments where a lack of age-appropriate supervision or environmental safeguards are considered a primary contributor to child death (Scott, 2016; Garstang et al., 2021; Sidebotham et al., 2013). These deaths often occur in circumstances that depart markedly from community norms and expectations of care, for example in cases such as infants left alone near water or toddlers able to access dangerous substances (Sidebotham et al., 2016).

Large-scale epidemiologic reviews in Australia have highlighted that the majority of drowning deaths in young children under five years occur in private pools, bathtubs, or buckets, a context considered virtually always preventable through education, attentive supervision or reasonable physical barriers (Meddings, 2021).

Despite its suggested prevalence, the concept of neglect and its associated definitions are known to be subjective and centre on interpretation of behaviour relative to community norms. Key to contemporary classification of neglect is the distinction between a so-called “blameless accident” and “foreseeable hazard”: the literature argues that accidental explanations lose validity when there is evidence that prolonged or repeated absence of supervision, easily rectifiable hazards, or prior professional warnings were present but unheeded (Scott, 2016). Identifying fatal neglect relating to hazards through rigorous analysis of broad contextual factors is essential to informing prevention learnings.

Medical Neglect and Service Disengagement

Medical neglect is another well-documented, high-lethality pathway to fatal child maltreatment, capturing deaths that occur because a parent or caregiver fails to seek, provide, or adhere to essential medical care for a life-limiting or chronic condition (Garstang et al., 2021; Rimsza et al., 2002). Research from both hospital and coronial contexts suggests that repeated missed medical appointments, refusal of recommended therapy (such as insulin for diabetes or antibiotics for treatable infection) and disengagement from both primary and tertiary healthcare are considered core features of fatal medical neglect (Friedman, 2015; Ward, 2004).

A thematic analysis of English serious case reviews identified that deaths from medical neglect typically occur within settings of chronic family challenge, frequently integrating elements of poverty, substance misuse, domestic violence and untreated parental mental illness, which have been noted to be especially common in the families of children who die from treatable conditions. Notably, in the majority of cases, opportunities for professional intervention existed with a pattern of repeated failure to engage with families or missed appointments, or poor medication adherence (Stirling, 2019).

Jurisdictional benchmarking aligns with these findings, suggesting that medical neglect is rarely a single event but usually involves protracted disengagement from health systems, professionals’ inability to maintain effective engagement with the family, and sometimes failures in service provision or follow-up. Nevertheless, medical neglect can be challenging to differentiate, particularly where parents or caregivers have undertaken efforts to seek alternative medical treatments and genuinely believe that they are acting in their child’s best interests, including due to religious or cultural beliefs (Stirling, 2019).

The literature stresses careful discrimination between service non-engagement, as opposed to harmful non-adherence (e.g. neglect), highlighting that consideration must be given to health literacy, parental incapacity, and barriers related to service access including systemic inequality barriers such as the lack of cultural safe services available to families, wherein service system failures may be more salient than an attribution of parental responsibility (Scott, 2016; Brandon et al., 2009). Research suggests that determination of medical neglect must consider if the treatment for the dangerous condition was accessible to the caregivers, including its physical presence in the community, its affordability, and the family’s mobility and a caregiver’s ability to understand the medical recommendations and needs of their child (Stirling, 2019).

Chronicity and Single Severe Events

An enduring issue in classification is the tension between patterns of chronic endangerment and so-called "catastrophic one-off events."

Classic legal and social work models privileged pattern and chronicity, including a history of missed appointments, unsafe environments and previous child protection removal or notifications as markers that distinguish patterns of neglect from accidents (Lawrence, 2004; Scott, 2016). However, contemporary frameworks, especially those drawing from public health models and statutory review, recognise that there are challenges in applying these thresholds in practice, given other factors that may contribute to patterns of engagement such as inappropriate or culturally unsafe service provision. Single, egregious acts or omissions are often considered to meet the threshold for neglect if it is judged that a reasonably diligent caregiver would have foreseen and acted to avert the lethal risk, but agreement in defining these as 'neglect' is often challenging in practice.

Academic and best-practice reviews argue that "reasonable person" or appreciable risk thresholds, rooted in both case law and the literature, are essential when considering classification of neglect. Consideration of neglect requires careful balancing of chronicity, context and egregious departure from standard care, thereby capturing both sustained and acute forms of neglect (Scott, 2016).

The academic consensus suggests explicit recording of all evidence relating to patterns, prior warnings, and prior agency involvement, regardless of ultimate classification, to support transparency and continuous system improvement (Sidebotham et al., 2014; Garstang et al., 2021). These must be weighed alongside a caregiver's understanding of their child's needs, considering elements of parental capacity including mental health, disability and health literacy (Stirling, 2019).

Systemic, Cultural and Socioeconomic Determinants and Bias

There is overwhelming evidence that poverty, housing instability, food insecurity, social isolation and marginalisation combine to contribute to higher rates of both child maltreatment and fatality (Lawrence, 2004; Sidebotham et al., 2014). However, research warns strongly against the unwarranted conflation of social disadvantage with parental blame: criminalising poverty risks both over-counting among minoritised communities and failing to address broader system, agency, and resource failures which contribute to instances of child mortality.

There is a clear need for culturally competent review panels and the integration of Aboriginal and Torres Strait Islander community leadership in both case classification and subsequent systems change efforts. Over-representation of Aboriginal and Torres Strait Islander children in child neglect death data is recognised to be contributed to by system access failures, intergenerational trauma and ongoing systemic bias, demanding a health promotion lens in its response.

Bias is perpetuated not only in the initial labelling of cases, but also in the process of review: without structural inclusion of cultural expertise, review panels risk replicating and institutionalising stereotypes and blind spots. The practice literature recommends an explicit domain in review tools assessing the system, resource and cultural context, considering not only parental omission but also service failures, social barriers and the lived experience of disadvantage and discrimination (Scott, 2016; Harnett & Featherstone, 2020).

Prevention and Modifiable Care Factors

The imperative for prevention is central to classification of neglect. As mentioned previously, numerous authors suggest that neglect identification should be considered purely in relation to prevention activities (e.g. LaPosata & Verhoek-Oftedahl, 2005; Scott, 2016).

Prevention is considered in literature to encompass:

- Identification and mitigation of risk pathways and modifiable care factors: Integrating routine assessment of supervision, environmental safety, service engagement, and chronic health risk in all child/family encounters (Garstang et al., 2021).

- Reducing engagement barriers and empowering families and communities early in their journey: Prevention requires a focus on empowering families to engage in services, including culturally safe and culturally led services, integrating holistic service provision with a focus on refining services and policies through family and community voices (O'Dea et al., 2024; Benett et al., 2020).
- Cross-agency data integration and early warning: Child death review and prevention are most effective when systems for health, welfare, education and justice are linked, supporting both identification and cross-sector response. Missed systemic opportunities to prevent escalation of neglect prior to child death have noted to be common and important focus areas for child death reviews (Office for Standards in Education, Children's Services and Skills, 2009).
- Cultural and systemic competence: Prevention systems must be culturally safe, anti-discriminatory, and designed in true partnership with Aboriginal and Torres Strait Islander peoples and all communities subject to overrepresentation.
- Continuous learning and feedback: Narrative review, serious case review, and thematic reporting allow lessons to be rapidly disseminated and used to guide local and system changes, including policy, program design, and workforce training (Sidebotham et al., 2016).

The systematic application of modifiable care factor analysis across all child deaths represents a fundamental shift from individual blame toward system accountability and prevention opportunity identification. Research consistently demonstrates that most preventable child deaths result from complex interactions between individual circumstances and system failures, including inadequate service provision, cultural inappropriateness of interventions, resource gaps, and structural barriers to accessing support (Scott, 2016; Sidebotham et al., 2014).

In summary, the evolution from neglect-focused to maltreatment frameworks with modifiable care factor analysis represents a shift in child death classification and prevention. This approach captures broader prevention opportunities through systematic analysis of modifiable factors, supporting both accountability and comprehensive prevention strategies that address individual and family alongside community and system contributors to child deaths.

Comparing Practice Across Jurisdictions

There is significant variation in approaches to classification of child assault and neglect death across Australian jurisdictions. In order to explore the Commission's processes, consultations were undertaken with similar child death review practitioners from jurisdictions across Australia and New Zealand, followed by a series of targeted small-group consultations.

These qualitative workshops and small group discussions included members of the the Commission in addition to representation from South Australia, New South Wales, Northern Territory, Victoria and Australian Capital Territory, alongside New Zealand counterparts. These consultations explored current practice and process, key challenges and areas of opportunity across child death assault and neglect classification.

Key Findings Across Jurisdictions

Variability in Evidence Thresholds and Classification

'Reviewable' cases are not universally defined across jurisdictions. For example, New South Wales' legislative framework mandates review of deaths in statutory care, detention, or suspicious for child maltreatment, assault or neglect, while other jurisdictions cast a broader net, leaving more to the discretion of relevant agencies as which cases are subject to review. Some jurisdictions have an intensive focus on key subject areas, for instance in New Zealand, where specific classification of domestic and family violence deaths also occur.

Jurisdictions differ significantly in how causation and level of certainty required for classification are operationalised. For example, New South Wales applies a *"reasonable person "* threshold. Some jurisdictions, such as Northern Territory, are more heavily dependent on identification of a child's death via coroner's reports, whilst other jurisdictions such as Victoria and South Australia rely on multi-disciplinary expert review to determine their classification of assault and neglect.

These varying thresholds affect comparative reporting, prevention activities and policy decision making arising from child death reviews. Jurisdictions who draw on research or prevention focused approaches to classification generally were suggested to be more empowered to meaningfully shape prevention efforts in their jurisdiction than were those where classification was more exclusively tied to legal definitions.

Many jurisdictions noted a focus on clinical judgement being drawn upon to shape both the classification and consistency of classifications in their practice, with recognition of the benefit of more standardised decision-making approaches to complement clinical decision making.

System Versus Individual Accountability

Some jurisdictions articulated a shift toward their review processes being focused on system improvement and risk prevention, such as New South Wales, rather than individual caregiver or family blame. However, the degree to which this is currently viewed as successfully balanced was seen as variable, with opportunities to expand this focus to better inform systemic prevention efforts.

Integration of Intent

Intent is inconsistently considered across jurisdictions when classifying cases of child assault and neglect. The Commission's current definition of fatal child abuse includes intent to harm to be considered for its classification of fatal child abuse. In practice, however, acts such as shaking (e.g. in instances of shaken baby syndrome) without a clear intent to harm are included within the category. Other jurisdictions such as South Australia do not require intent for inclusion in child abuse, with a focus instead on acts and omissions alongside foreseeable consequences when examining carer behaviour leading to child death.

Navigating Ambiguity

Challenges in classification are highlighted by jurisdictions who undertake classification drawing on data beyond that recorded in coroner's findings. For example, jurisdictional representatives highlighted persistent difficulty in consistently distinguishing supervisory neglect from ordinary lapses in judgment and in determining what constitutes medical neglect as opposed to parental autonomy. This grey area was noted as a challenge in practice, particularly where child vulnerability or parental capacity is in flux due to factors that may be contributed to by systemic failure to meet their needs.

The transition point where inadequate supervision becomes actionable neglect remains both a definitional and practical challenge, as is differentiation between acts of caregiver neglect versus systemic failure.

Cross-System Data and Information Sharing

The ability to share relevant information cross-agency and cross-jurisdictionally with appropriate privacy safeguards was raised as a challenge, and participants discussed ongoing efforts to this end.

Audit and review cycles are implemented in some jurisdictions to ensure reliability of categorisation, for example in the New South Wales context, where audits support consistency of decision making.

Some jurisdictions are expanding the opportunities for external use of their de-identified data for research purposes, enabling analysis to inform prevention through agreed pathways for data accessibility. Increasing the accessibility of de-identified case data for research purposes enhances opportunities for independent research and the generation of new insights relevant to ongoing prevention. Some agencies, including the Commission, have ongoing programs to enable public data access to this end.

Standardising Classification via Decision Tools

Some jurisdictions have developed decision aids aligned to their processes and review structures, for example in New Zealand, where decision trees to support classification of cases of domestic and family violence related death are under development. Like the Commission, some jurisdictions also rely on published tools in the literature to consider specific injuries or SUDI deaths.

Whilst there was variability in the use of decision-making tools or algorithms, there was general consensus that such approaches are useful to support standardisation, particularly where there are changes in review team members or processes, so long as these are implemented with appropriate multi-disciplinary expertise.

Multidisciplinary Input Mechanisms

A common theme among jurisdictions is the establishment of multi-layered, independent review structures that integrate expert perspectives to inform classification and prevention recommendations. This approach enables a comprehensive, cross-sector perspective, drawing on diverse perspectives to triangulate findings and ensure decisions are grounded in robust, multidisciplinary evidence.

In some jurisdictions, there is comprehensive multidisciplinary review of all child deaths. For example, South Australia's Child Death Review Committee evaluates all known child deaths, using an inclusive definition that focuses on the acts or omissions that result in death, irrespective of intent. The committee draws on the totality of available evidence and classifies cases, and issues recommendations intended to inform both legislation and practice. It then refers cases to one or more of its 7 Special Interest Groups, which include a Child Protection group and an Aboriginal Child and Young Person group.

In New South Wales and Victoria, similar multidisciplinary expert advisory mechanisms operate to support review of cases, providing multidisciplinary input from a range of forensic, medical, nursing, allied health, child protection, legal and adjacent relevant practitioners such as education to inform considerations of child death classification and identify key prevention learnings.

Some jurisdictions noted that cultural inputs to support their multi-disciplinary review functions are currently minimal, with a recognition of their need and the importance of elevating voices of Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse individuals where reviewing children's deaths to address systemic bias and best identify prevention opportunities. South Australia provides a best practice example in this space, integrating Aboriginal leaders into both their Child Death Review Committee and holding a specific sub committee which reviews all Aboriginal children and young people's deaths in South Australia.

Analysis of the Commission's Current Practice

The Commission's current process integrates an iterative analysis of cases within the Child Death Prevention team, followed by classification of cases drawing on established existing definitions for child assault, abuse and neglect. The Commission team also draws on ICD-10 coding as previously overviewed to code each examined case.

Cases where there is suspicion of child assault or neglect are examined by the Commission Child Death Prevention team with a classification approach focusing on 3 tiers of certainty, whereby cases are classified as either confirmed, probable or possible assault or neglect.

Probable and Confirmed cases are subject to annual reporting processes. More information on current Commission processes is available in its *Annual Report: Deaths of children and young people, 2013-24* (Commission, 2025), with current definitions and potential refinements presented in the subsequent section of this report.

The current project undertook consultation with Commission team members to explore current practice, strengths and opportunities. Analysing this alongside the evidence examined within the literature review, jurisdictional consultations and benchmarking suggests a number of key strengths in the Commission's current practice, alongside refinement opportunities to support its future work.

Strengths

the Commission's current definitions and operational protocols enable prevention through tiered classification approaches which draw on diverse evidence.

At the core of the Commission's approach is the three-tier classification system, which distinguishes between *"Confirmed," "Probable,"* and *"Possible"* cases of child death due to assault or neglect. This framework is underpinned by detailed, multi-source evidence gathering, drawing on police, coronial, health, and child protection

records and is reflective of the Commission's commitment to robust decision-making in complex or contested cases to inform prevention activities.

The classification system provides transparency, with only **Confirmed** and **Probable** cases reported publicly. This helps to ensure a strong evidentiary basis with a focus on broad definitions alongside capture of lower-evidentiary level cases that may enable prevention activities.

The explicit delineation between **Confirmed** (e.g. legal, medical, coronial evidence, or an explicit confession) and **Probable** (e.g. where the available evidence suggests a high likelihood but may not reach the threshold of certainty) helps to manage ambiguity, which consultations and literature suggest is a consistent challenge in the review of child deaths across jurisdictions and within clinical practice.

The review identified several strengths in the Commission's current approach. Notably, the Child Death Prevention team's classification of cases does not depend solely on the outcome of criminal justice processes or evidence, and is able to responsively capture cases to enable prevention. Record keeping on complex cases supports development of precedent and reflection on previous classifications, although to date these peer reviews are undertaken in an ad-hoc, as-needs manner.

Refinement Opportunities

Despite these strengths, there are important opportunities for refinement of the Commission's processes which are highlighted by the evidence reviewed throughout this analysis.

The Commission's process currently centres in capture of deaths either as assault and neglect or in other primary categories. In practice, this means that assault or neglect deaths featuring other primary causes, for example drowning or transport, are not publicly reported in fatal assault and neglect reporting. There is an opportunity to expand prevention evidence through increasing the capture of systemic prevention opportunities that may be traditionally associated with neglect.

Another key opportunity lies in the adoption of more structured, literature-informed analysis mechanisms during the initial screening of cases. In practice, the Commission's team shared challenges in decision making for complex cases, where the team's limited medical or legal expertise posed a challenge to definitive classification, or where disagreement persisted despite peer discussion. Standardising such screening processes is likely to reduce subjective variation, thereby increasing consistency and accuracy in how deaths are classified across similar circumstances.

An additional enhancement would involve expanding and formalising multi-disciplinary input in challenging cases. While the Commission already engages with multiple data sources, the inclusion of diverse expertise across medical, child protection, legal, cultural, and forensic domains at the classification stage could further refine decision-making in cases that are not immediately clear-cut. This would align the Commission practice more closely with emerging best practice in other jurisdictions such as Victoria, South Australia and New South Wales who rely on the use of multidisciplinary expert reviews to support their classification approaches.

tThe Commission's current process offers the potential to systematically document broader system or service barriers that may have contributed to a child's death. By embedding more explicit documentation and analysis of missed prevention opportunities or systemic weaknesses, the Commission could more directly support the actioning of prevention-focused recommendations and systemic reform.

Finally, the review highlights the importance of strengthening the Commission's mandate and practice regarding culturally safe review and systems learning, particularly for Aboriginal and Torres Strait Islander children. Ensuring that processes, analytical frameworks and system improvements meaningfully incorporate cultural perspectives and expertise is fundamental to driving more equitable and effective prevention strategies across Queensland's diverse community.

Supporting Process Refinement

Strengthening Classification Decision Making

As previously highlighted, challenges exist in the child death classification process owing to a range of factors including difficulties defining deaths due to combinational complexity and subjective perceptions on indicators of maltreatment. The use of decision guides coupled with multidisciplinary input to enable more standardised approaches to classification of child death could support addressing these challenges.

Algorithmic decision tools are already used in various clinical and child death review settings to support classification and trigger further review of child deaths, as previously discussed. For example, in the current Commission context a decision tree is utilised to support identification of suicide, whilst inter-jurisdictional consultation during the current project highlighted tools which are currently being developed and refined in the New Zealand setting to support classification of domestic and family violence related deaths, and in the South Australian context to support child death categorisation.

Historically reliant on the expert judgment of clinicians, social workers and legal professionals operating within disparate statutory and organisational frameworks, child death reviews have been noted to be impacted by variability, subjective bias and challenges in recognition of preventable harm, particularly in ambiguous or complex circumstances (Scott, 2016; Sidebotham et al., 2016).

The move towards mixed-method approaches which integrate decision supports alongside multi-disciplinary expert review within the child death classification context arises from the recognition that child maltreatment fatalities frequently present subtle early signals, such as sentinel injuries, patterns of disengagement, or chronic environmental risk factors that can be missed or misclassified by ad-hoc or disciplinarily isolated assessment processes (Jenny et al., 1999; Pierce et al., 2021). Decision tools do not replace professional judgment; rather, they serve to structure it, promote explicit consideration of validated risk indicators and ensure a more consistent, transparent and defensible approach to these consequential determinations faced by review systems.

Considering Decision Tool Approaches to Support Child Death Classification

Enabling Prevention

A recurring finding in both academic and governmental analyses is the challenge of inter-reviewer variability in child injury classification, with differences in assessment and classification that arise not from underlying case facts but from reviewer background, local custom or institutional culture (e.g. Scott, 2016). Decision tools, particularly those constructed on a strong empirical foundation, can help standardise responses to common clinical, social or environmental signals. They do so by requiring that specific, literature-based risk factors (e.g., presence of unexplained injury in a non-mobile infant; pattern of missed health appointments) are evaluated in every potentially relevant case (Sheets et al., 2013; Garstang et al., 2021). Decision tools can support ensuring the sensitive capture of these evidence-centred indicators by embedding evidence-based thresholds and by mandating multidisciplinary review when combinations of risk are encountered, thus increasing the chances of timely and proportionate prevention responses.

Enhancing Consistency and Transparency

Applied appropriately, decision tools can facilitate documentation and audit. Precisely because their logic is explicit and built upon empirically validated risk factors, they provide both a standard of review and a clear record of the rationale underlying decisions. This can enhance opportunities for system learning, continuous quality improvement and research.

Moreover, decision tool enabled review can address the well-recognised concern of under- and over-classification in populations subject to social, economic, or cultural disadvantage. By requiring a minimum evidentiary and contextual basis for decision rather than intuition or culturally-centred indicator perception, well-designed and

culturally-informed tools may help protect against bias, noting that this effect depends on the tool's sensitivity to context and its integration with culturally safe and multidisciplinary processes, as further discussed below (Lawrence, 2004; Scott, 2016).

Bridging Disciplines and Supporting Multidisciplinary Review

Classification of child maltreatment deaths demand intersecting expertise across medicine, forensics, law, social services and education. No single discipline can capture their complexity in isolation, and evidence highlights that the absence of multi-disciplinary coordination can lead to 'siloed' decision-making and missed prevention opportunities (Garstang et al., 2021; Sidebotham et al., 2014). The utility of multidisciplinary inputs in examining complex cases, such as SUDI death cases, has been repeatedly highlighted in the literature to enable more robust identification of injury aetiology (Fitzgerald et al., 2022).

It is for this reason that existing clinical algorithmic tools which support recognition of injury indicative of assault are not applied in isolation, but are designed to be considered alongside comprehensive and multidisciplinary review, e.g. Pediatric Brain Injury Research Network (PediBIRN)'s abusive head trauma screening tool (Hymel et al., 2014), and the TEN-4-FACESp (Pierce et al., 2021) which screens patterns of bruising, represent two such examples which provide decision making guides that are designed to enable further multidisciplinary discussion and input.

Evidence Base and Validation

Recent years have seen the validation of several algorithmic or tool-based approaches to support escalation of suspected child maltreatment fatalities for multidisciplinary review. For example, the TEN-4-FACESp rule for bruising on non-mobile children has set an international standard for clinical screening, demonstrating high sensitivity and specificity for abusive injuries in large studies (Pierce et al., 2021). Similarly, registry and serious case review literature has identified core sets of risk indicators, such as chronic missed health appointments and prior system involvement which, when evaluated systematically, enable earlier and more reliable detection of individual and systems-level risk (Garstang et al., 2021).

Well-constructed injury identification tools are adaptable. As new evidence emerges they can be recalibrated, with weights and thresholds adjusted based on ongoing validation studies, audit outcomes, and frontline experience (Scott, 2016). It is for this reason that the current report recommends ongoing development, testing and refinement of decision tool proposed herein. This includes culturally-centred testing and ensuring multi-disciplinary and culturally varied input in the review process to reduce risk of bias.

Limitations and the Need for Context

While decision tools can support identification of cases of fatal child maltreatment, their strengths are best realised within a system that values diversity of perspective, context, professional expertise and continuous improvement. It is recognised that structured decision making tools can perpetuate bias, particularly where poorly developed, implemented without contextual adjustments and not subject to review; this has been well-documented in the domains of child protection and mental health, where rigid, context-insensitive decision tools have amplified systemic bias, particularly if they ignore the realities of family poverty, cultural difference or disability. It is thus vital that algorithmic thresholds are not interpreted as mechanical pass/fail criteria, but as structured prompts for multidisciplinary, narrative and culturally informed consideration.

A blended approach to child death categorisation which draws on decision tools to support consistency with close review and final decisions made by panels with access to the ecological and cultural context of every case would align with this evidence base to support consistency of decision making with diverse input in the Commission context.

Summary

The use of decision tools in the classification and review of child death from maltreatment is empirically supported where these tools are complemented by robust processes that enable multidisciplinary review. Structured, evidence-based tools may support greater consistency, earlier detection and improved accountability in child death

review where they are collaboratively designed and appropriately reviewed. Their strengths, however, are only realised when complemented by robust multidisciplinary review, centred in cultural safety and continuous system learning.

Proposed Definition Refinements

Currently the Commission definitions include specific definitions for Fatal Assault, Fatal Child Abuse and Fatal Neglect in their public annual report materials, alongside a range of working definitions contained in their data coding dictionary, noting some duplication and differing definitions feature in each respective document.

The reporting of this information in the Commission's annual report is further disaggregated by 'intra-familial' (domestic homicide, fatal child abuse, fatal neglect and other) and 'extra-familial' (intimate partner homicide, peer homicide, acquaintance homicide, stranger homicide).

Based on the review of inter-jurisdictional practice, practice literature and refinements proposed in process above, Lumenia make the following proposals to refine existing Commission definitions, with review processes further described in the audit section of this report.

Fatal Child Maltreatment

Lumenia proposes that the Commission adopt an overarching definition of Fatal Child Maltreatment, with sub-categorisation to capture the spectrum of harmful acts and omissions that contribute to child deaths. This approach aligns with contemporary understanding that recognises the interconnected nature of different forms of harm and supports more comprehensive prevention strategies including those with a systemic prevention lens.

Fatal Child Maltreatment is proposed to be defined as:

> *The death of a child resulting from wilful or knowing acts or omissions by parents, caregivers, or other persons that cause harm through deliberate action or reckless disregard for the child's safety and wellbeing. This includes deaths where maltreatment involving knowing harm or grossly negligent behaviour is a direct cause, a significant contributing factor, or occurs in combination with other causes.*
>
> *Fatal child maltreatment encompasses both immediate and delayed consequences of harmful acts or omissions where there is evidence of intent, knowledge of risk, or wilful disregard for the child's welfare.*

Sub-categorisation: Child Maltreatment (Assault)

Child Maltreatment (Assault) is proposed to be defined as:

> *Deaths resulting from deliberate acts of force, violence, or physical aggression that cause direct harm to the child. This includes cases where death is the outcome of inflicted injuries such as abusive head trauma, fractures, internal injuries, and other trauma inconsistent with accidental causation. Deaths classified under this sub-category involve clear evidence of intentional harmful physical acts, patterned injuries indicative of inflicted trauma, or injuries incompatible with the developmental stage or reported circumstances of the child.*

Sub-categorisation: Child Maltreatment (Other)

Child Maltreatment (Other) is proposed to be defined as:

> *Deaths arising from wilful or knowing failures to meet a child's essential safety, health, or wellbeing needs where there is evidence of deliberate disregard, knowledge of serious risk, or grossly negligent behaviour. This includes circumstances where caregivers knowingly exposed children to serious harm, wilfully refused essential medical care despite understanding consequences, or demonstrated reckless disregard for obvious and serious dangers to the child's welfare. Cases must demonstrate that caregivers knew or should reasonably have known their actions or omissions posed a clear risk of serious harm to the child, or where parents have been charged in relation to a death.*

Terms utilised within the above descriptions and their proposed definitions for implementation are contained in Appendix A.

Proposed Modifiable Care Factors Analysis

Reflecting on best practice opportunities to inform child death prevention, Lumenia propose introduction of a review process which considers Modifiable Care Factors where sufficient information is present in a child death case. To this end, each death would be reviewed on the basis of the data available to The Commission to consider the presence of one or more of:

- **Preventable harm in hazardous situations:** Deaths from parental acts that resulted in drowning, falls, poisoning, fires, or other environmental dangers where safety education, community programs, targeted resources or enhanced supervision support could have enabled prevention
- **Essential care and safety gaps:** Circumstances involving inadequate nutrition, shelter, hygiene, medical care or education, or safety measures where family support services, poverty alleviation, health system improvements, health literacy supports or resource provision may have ensured child wellbeing
- **Service system failures:** Deaths occurring where necessary services appear to have been inaccessible due to waitlists, geographic or language barriers, cultural inappropriateness or fragmentation, or where agencies had contact with the family but appear to have failed to coordinate effective support or recognise escalating risk.

Lumenia recognises that The Commission's Child Death Prevention team holds limited information, and that it may not be feasible to undertake review on all non-natural cause child deaths and preventable natural cause child deaths, thus would suggest that outcomes of this screening are recorded to note either evidence of one or more of the above, or 'insufficient evidence' as an outcome, with additional screening undertaken where future information suggests modifiable care factors existed.

Lumenia propose that such a review is undertaken to support research analysis and identification of prevention opportunities, where information available to The Commission enables this.

Rationale for Proposed Refinements:
Contemporary research and practice acknowledges that many preventable child deaths arise not only from intentional acts but also from a complex interplay of individual, community, and systemic contributors including service gaps, structural inequities and contextual barriers to care.

By adopting an overarching maltreatment definition with a narrower focus on wilful or knowing acts and complementing this with a systematic review of modifiable care factors in all accidental deaths, the proposed approach fosters a more nuanced, prevention-oriented and less stigmatising classification system. This ensures meaningful differentiation between egregious maltreatment and circumstantial or system-driven factors, supporting both robust accountability and the identification of actionable prevention opportunities across the system as a whole.

Coupled with consideration of Modifiable Care Factors across all non-natural cause child death cases, this approach aligns to best practice exemplars with a focus on identifying modifiable risk factors and missed opportunities that could inform comprehensive prevention strategies.

Confirmed, Probable and Possible Maltreatment Definition Refinements

Given the introduction of Maltreatment as a focus of the Commission's data capture, Lumenia propose the following revised definitions for the Commission categories of confirmed, probable and possible maltreatment:

Confirmed Maltreatment

Cases are classified as 'Confirmed Maltreatment' when there is clear, compelling, and corroborated evidence that wilful or knowing acts or omission maltreatment directly caused, or significantly contributed to, the child's death. This includes cases where legal processes, coronial findings, or explicit admissions (such as confessions or direct legal findings) unequivocally establish maltreatment as causal. Confirmation may result from formal judicial proceedings, coronial investigations, or documented admissions regardless of whether the fatal outcome was immediate or delayed.

Probable Maltreatment

'Probable Maltreatment' applies where there is strong evidence arising from medical, forensic, or multidisciplinary review that points to a high likelihood that maltreatment was a causal factor in the death. This includes cases flagged as probable maltreatment by structured screening criteria and those confirmed via peer or multidisciplinary review, where the convergent evidence supports maltreatment as highly likely to have contributed to the child's death.

Possible Maltreatment

'Possible Maltreatment' captures cases in which some credible evidence combined with risk factors point toward maltreatment contributing to or causing the child's death, but available information is insufficient to reach the "probable" threshold. This category is used for cases where concern remains but evidence is inconclusive, mixed, limited, or pending further findings (e.g., ongoing investigations, missing records, ambiguous injury mechanisms). While possible cases are not included in public annual reporting, they must be tracked internally and regularly revisited for possible reclassification as new evidence emerges, serving as a critical learning and prevention resource.

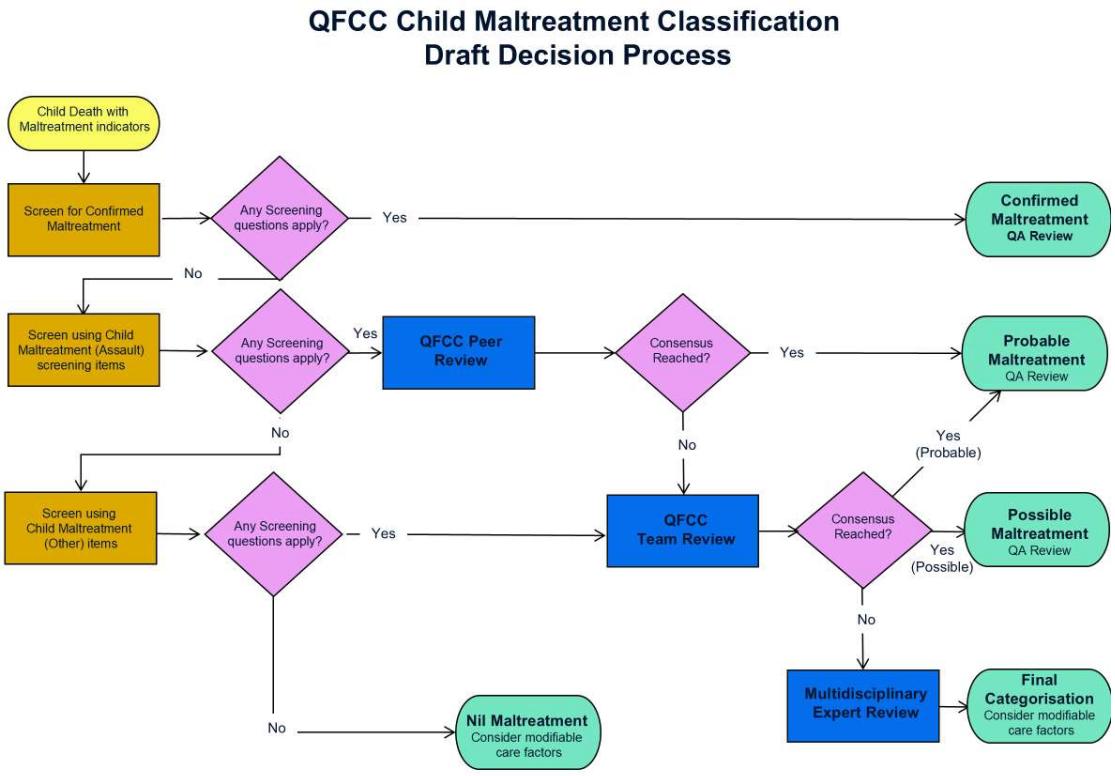
Strengthening Identification Processes for Fatal Child Maltreatment

As has been discussed herein, robust, criteria-driven identification of fatal child maltreatment can support child death prevention, system learning and accountability. The development and operationalisation of child maltreatment classification approaches requires integration of clinical, forensic, epidemiological, and social research, spanning multiple jurisdictions and systems.

This section overviews a proposed process and associated decision tools developed informed by literature and practice exemplars to identify key indicators and risk factors that may indicate confirmed, probable or possible child maltreatment aligned to the above-presented updated definitions and categories. Complementary review process to support tool application and implementation approaches are also presented herein to ensure robust implementation and ongoing classification accuracy and reliability.

A flowchart overviewing the proposed classification process is presented in full in Appendix B, and shown below (Figure 1).

Figure 1: Proposed Classification Flow Chart



Child Maltreatment Screening Application

The proposed decision tool is designed to be used by the Commission's Child Death Prevention team alongside their existing process of ICD-10 coding for deaths in children that meet specific screening criteria indicating potential maltreatment concerns. The tool should be applied to cases where maltreatment indicators exist such as any of:

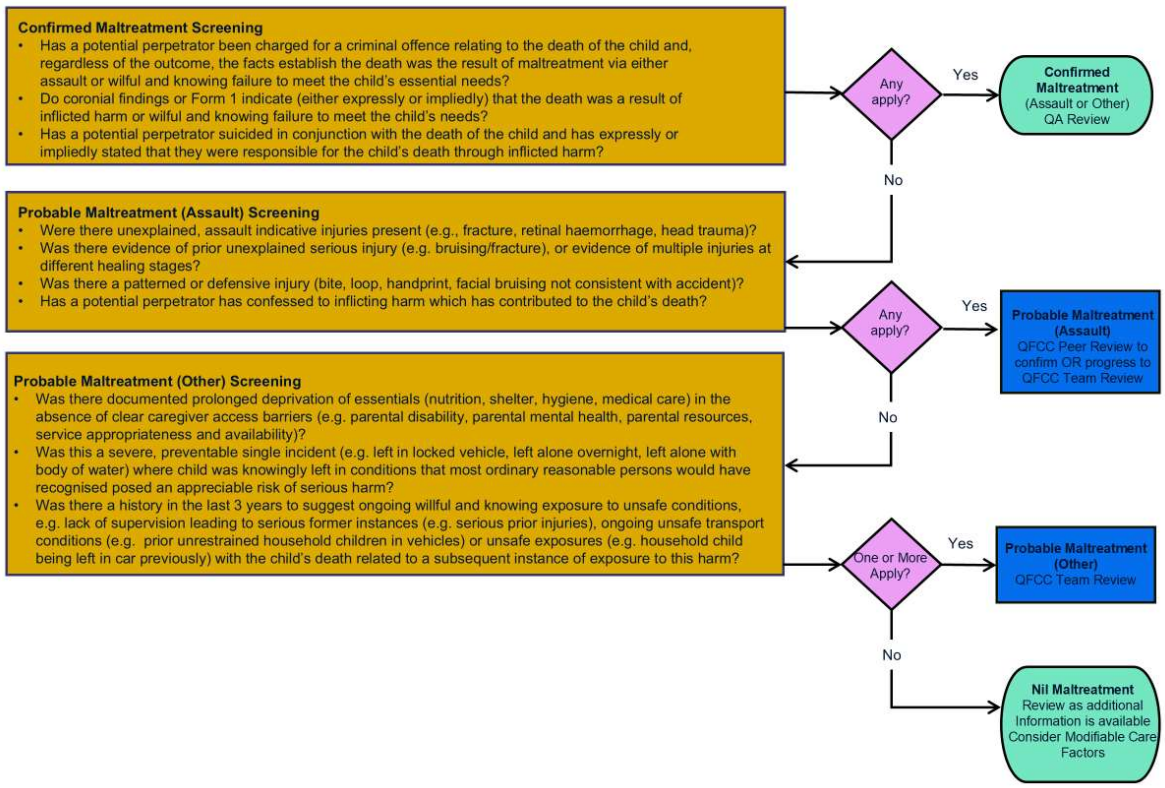
- The cause of death is unexplained, suspicious, or inconsistent with the reported history
- There are concerning injury patterns including unexplained fractures, head trauma, multiple injuries, or injuries inconsistent with developmental stage
- The child's household has prior child protection involvement or notifications in the last 3 years
- There has been unexplained delay in seeking medical care relative to injury severity
- Police, coroners, medical professionals, or other agencies have expressed maltreatment concerns
- SUDI cases present with scene inconsistencies or concerning circumstances
- Deaths from potentially preventable causes (drowning, heat exposure, medical conditions) occur in circumstances raising supervision or care adequacy questions e.g. inappropriate care
- Any other circumstances where professional judgment suggests maltreatment warrants consideration.

Cases meeting these screening criteria are allocated to a primary screener via standard allocation processes within the team, with the decision tool applied systematically to ensure consistent evaluation of maltreatment indicators and the classification considered ***Pending***. This screening approach ensures the tool is applied to cases where maltreatment review is warranted while maintaining efficiency in the team's broader case review processes.

Proposed Decision Tool

The Proposed Maltreatment Decision Making Tool is presented in full in Appendix C and described below (Figure 2).

Figure 2: Proposed Maltreatment Decision Making Tool



Confirmed Child Maltreatment Screening Items

As is evident through this tool, for all cases where there is potential maltreatment suspected, the decision tool initially prompts the responder to consider cases of ***Confirmed*** maltreatment aligned to current Commission definitions.

This includes a series of screening questions, being:

- Has a potential perpetrator 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 maltreatment via either assault or wilful and knowing failure to meet the child's essential needs?
- Do coronial findings or Form 1 indicate (either expressly or impliedly) that the death was a result of inflicted harm or wilful and knowing failure to meet the child's needs?
- Has a potential perpetrator suicided in conjunction with the death of the child **and** has expressly or impliedly stated that they were responsible for the child's death through wilful and knowing inflicted harm?

Where **any** of these questions are answered as yes, the case will be recorded as **Confirmed Maltreatment**, with a subcategory noted of either **Assault** or **Other** aligned to the definitions presented previously. The allocation of the sub-category for maltreatment is based on the reviewer's assessment of the information in line with the definitions presented previously. These cases are reviewed as part of QFCC Quality Assurance (QA) processes, including those undertaken during annual review. These cases are then reviewed for Modifiable Care Factors.

If none of the above apply, the Commission reviewers proceed to the decision tool, which features a range of questions to explore possible and probable maltreatment likelihood. Cases are considered ***Pending*** prior to finalisation of classification.

Probable Child Maltreatment Screening Items

The tool then covers a range of items which are suggested to be strongly associated with fatal child maltreatment on the basis of the literature evidence base:

- Were there unexplained, assault indicative injuries present (e.g., fracture, retinal haemorrhage, head trauma) not consistent with accident injury?
- Was there evidence of prior unexplained serious injury (e.g. bruising/fracture), or evidence of multiple injuries at different healing stages?
- Was there a patterned or defensive injury (bite, loop, handprint, facial bruising) not consistent with the explanation of the accident?

If yes to one or more, consider **Probable Maltreatment (Assault).** Undertake **the Commission Peer Review** process with two or more Commission Child Death Prevention team members to confirm classification as described below.

Possible Child Maltreatment Screening Items

If none of the above Probable factors are present, explore:

- Was there documented prolonged deprivation of essential needs (nutrition, shelter, hygiene, medical care) for the child in the absence of clear caregiver access barriers (e.g. parental disability, parental mental health, parental capacity, parental resources, service appropriateness and availability)?
- Was this a severe, preventable single incident (e.g. left in locked vehicle, left alone overnight, left alone with body of water) where child was *knowingly* left in conditions that most ordinary reasonable persons would have recognised posed a clear risk of serious harm?
- Was there a history in the last 3 years to suggest ongoing *wilful and knowing* exposure to unsafe conditions, e.g. lack of supervision leading to serious former instances (e.g. serious prior injuries), ongoing unsafe sleeping conditions (e.g. evidence of routinely sleeping with intoxicated carer), unsafe transport conditions (e.g. prior unrestrained household children in vehicles) or unsafe exposures (e.g. household child being left in car previously) with the child's death related to a subsequent instance of exposure to harm?

If yes to one or more indicator or if there is uncertainty in classification, consider **Probable Maltreatment (Other)** via **the Commission Team Review.**

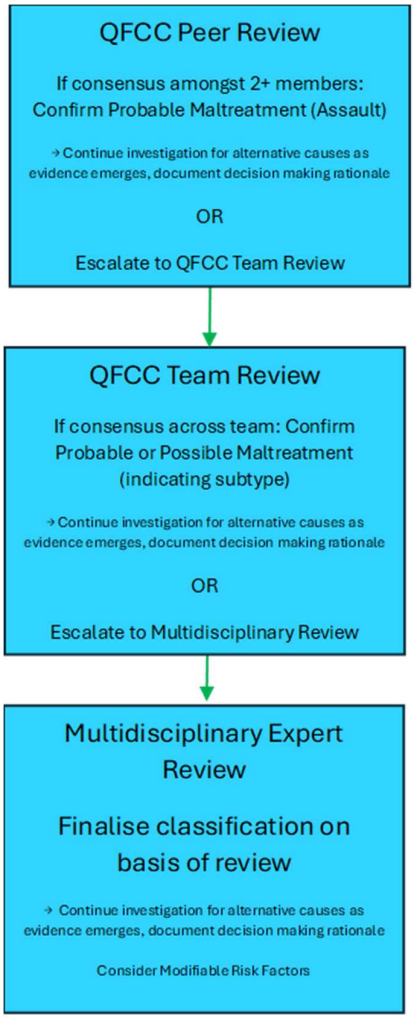
Where none of these factors are present, the case is **not recorded as maltreatment**, with continued investigation for alternative causes as any additional evidence emerges. These cases are screened for Modifiable Care Factors as described below.

In all screened cases, the Commission reviewers are to record their response to each item and note any rationale/evidence aligned to each response.

The Commission Peer, Team and Multidisciplinary Review Processes

This report suggests a tiered review process be implemented to support classification at the Commission Peer, Team and Multidisciplinary review levels, depicted in Figure 3 (below).

Figure 3: Review Processes for Cases of Probable and Possible Maltreatment



The Commission Child Death Prevention Peer Review

As highlighted, the proposed tools initially direct **the Commission Peer Review** in cases of probable assault-related maltreatment.

During the Commission Peer Review processes, **2 or more** Commission Child Death Prevention team members with experience in classification of cases cross-review those cases screened as probable assault-related maltreatment and confirm this classification.

This process entails the primary screener sharing information on the case, reviewing the decision tool process and discussing their rationale with their Commission internal team peer. Where the peer(s) agree in the classification, the case is recorded as **Probable Maltreatment (Assault)**.

Further escalation to **the Commission Team Review** is indicated where consensus cannot be reached through this peer review process.

The Commission Child Death Prevention Team Review

As per the decision tool, this review is triggered for:

- All cases are screened as **Probable Maltreatment (Other)**
- Cases of **Probable Maltreatment (Assault)** where a lack of consensus occurs in Peer Review.

The Team Review process is proposed to be co-chaired by the Commission's Child Death Prevention team alongside rotating other members of the Commission's broader team in a monthly cadence. Lumenia suggests a minimum of 4 QFCC staff participate in this review process.

During the Team Review meeting, the primary screener will present the case to the team, overviewing key points of consideration and uncertainty. The attendees will discuss the case, including reviewing decision tool outputs, documentation, and case files to explore the case classification.

When considering maltreatment risk factors in each case, it is suggested that the team consider evidence-centred risk factors present in the 3 years prior to the child's death within the child's immediate family including:

- Domestic Violence, including Coercive Control
- Parental Substance Misuse
- Serious Parental Mental Health
- Repeat family police or justice involvement
- Child protection notifications or any removal of child or their siblings
- Child disclosures of abuse prior to death.

In considering each case, the Commission's Child Death Prevention team will discuss if there are medical or clinical indicators where additional medical or legal expertise would be beneficial to ensure robust classification, and explore potential classification for each reviewed case.

Determining Probable vs Possible Maltreatment Classification

During the Commission Team Review, the team should apply the following guidance to distinguish between Probable and Possible maltreatment classifications:

Probable Maltreatment classification requires:

- Strong convergent evidence from multiple sources supporting maltreatment as a likely **direct** contributor to death, AND
- Professional consensus that, on the balance of available evidence, maltreatment more likely than not **directly** contributed to the child's death.

Possible Maltreatment classification applies when:

- Some concerning indicators or risk factors are present but evidence is insufficient to meet the "probable" threshold, OR
- Professional judgment suggests maltreatment warrants consideration but available evidence remains inconclusive.

No Evidence of Maltreatment applies when:

- Available evidence does not support maltreatment as a contributing factor, AND
- Alternative explanations adequately account for the death.

These cases are to be considered for Modifiable Care Factors.

Finalising Classifications and Referrals for Multidisciplinary Expert Panel Review

The Commission Team Review will operate in consensus to classify cases as either **Probable Maltreatment, Possible Maltreatment** or **No Evidence of Maltreatment**.

If consensus is achieved: Finalise classification. Document all elements of decision making and any key prevention learnings arising from the Commission's Child Death Prevention Team Review.

If insufficient information is noted: Seek additional information where possible. Await more information, e.g. Police, Autopsy or Coroner's findings to enable sufficient information to review the case at a subsequent meeting.

Cases are escalated to **Multidisciplinary Expert Review** for classification and review where:

- Consensus cannot be met during the Commission Team Review
- Additional depth of specialist knowledge is required to enable classification
- Case involves complex systemic/contextual factors
- High-profile/precedent-setting case.

Multidisciplinary Expert Panel Review

Where consensus cannot be reached the case is to be escalated to Multidisciplinary Expert Panel review to support decision making.

Recommended Multidisciplinary Expert Panel Composition:

- Clinical Health Specialist Representative (e.g. Paediatric), Forensic Pathologist, Child Protection Representative, Legal Representative, Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse Representatives, Disability Representative and others (e.g. Education) as required.

Recommended Multidisciplinary Expert Panel Recruitment Process:

To ensure the multidisciplinary expert panel comprises individuals with the appropriate expertise, cultural insight, and independence, it is proposed that recruitment be conducted through an open call for expressions of interest. A transparent, Commissioner-appointed process is suggested to be used to appoint panel members for fixed terms e.g. of two years, promoting both continuity and the regular infusion of new perspectives.

In recognition of the time and effort involved, it is recommended that participants who are not currently public servants be eligible for a modest stipend for work undertaken outside of their regular sessional commitments; public servants may participate on a non-reimbursed basis, consistent with standard public sector arrangements. This approach aligns with that used successfully in South Australia, where open recruitment and mixed remuneration have helped to attract a broad, skilled, and committed panel, and fostered robust and unbiased decision-making in child death reviews.

Recommended Multidisciplinary Expert Panel Cadence:

It is recommended that the Panel be convened at a quarterly cadence, pending review of demand, to enable regular review of emerging child deaths as they are screened for discussion.

Panel to receive in advance of meeting:

- Summary decision tool output with documented proposed decision making
- Points of consideration/uncertainty for Panel discussion.

Panel to Consider:

- Review decision tool outputs, documentation, and case file
- Determine final classification via majority agreement:
    - Probable Maltreatment (including subtype)
    - Possible Maltreatment (including subtype)
    - No Maltreatment (with documented rationale). This may include exclusion of suspected maltreatment due to alternative medical or other expert-informed hypothesis.
- Document rationales for recommendations

- Document any additionally identified prevention opportunities at individual and system levels.

Documentation & Reporting

- All steps, scores, professional judgements and decisions must be recorded
- Escalate lessons/system issues for prevention review
- Ensure cultural/contextual narrative and expert inputs are included.

Identifying Child Death Prevention Opportunities

For every case determined to be Confirmed, Probable, or Possible Maltreatment, as well as for all non-natural cause child deaths and preventable natural cause child deaths, Lumenia suggests the Commission's review process should systematically identify prevention opportunities through a Modifiable Care Factor lens.

In every case review of non-natural child death, the primary screener will draw on case notes, any multidisciplinary discussion alongside available evidence to assess both individual and systemic missed opportunities. Prompting questions include (but are not limited to):

- Was there a service or systemic failure leading to missed risk detection or response (e.g. referrals closed without follow-up, no response to repeated notifications, or agency inaction despite known risk)?
- Were adequate, culturally appropriate services offered, or did language, cultural, or access factors prevent effective family engagement and support?
- Were there missed opportunities at the caregiver or community level (e.g. where additional education, knowledge, resources, or supervision could have prevented harm)?
- Did social determinants, such as poverty, housing, or social isolation, contribute to gaps in protection or care?
- Did professional practice or agency coordination (within and between agencies) affect the outcome?

These prompts are considered in tandem with categorical recording of specific Modifiable Care Factors present in each case, such as:

- **Preventable harm in hazardous situations**: e.g. deaths from drowning, falls, poisoning, fire, or other environmental dangers where targeted prevention measures could have enabled protection;
- **Essential care gaps:** e.g. inadequate nutrition, shelter, medical care, education, hygiene that could have been addressed through services and family supports
- **Service system missed opportunities**: e.g. cases where potentially preventative services were inaccessible due to waitlists, geography, language or cultural barriers, or where lack of coordinated support contributed to risk escalation.

Regardless of whether these modifiable care factors are selected to be reported publicly against each primary death category, the Commission's Child Death Prevention team will ensure they are systematically reviewed and reflected upon for every relevant case. The goal is to inform actionable, prevention-focused recommendations at the individual, service, and system levels and to support continuous improvement in Queensland's child death prevention systems.

Proposed Audit Process

Overview

To ensure integrity, consistency, and continuous improvement in child death review and classification, it is recommended that the Commission should adopt a structured audit process. This process supports quality assurance, accountability, and system learning. The proposed audit system is designed to be transparent, cyclical, and inclusive of both internal and external oversight.

Objectives of the Audit Process

- Assess decision accuracy, consistency, and defensibility of the Commission Peer Review Process
- Identify and mitigate systemic or individual bias
- Monitor adherence to procedural standards and policy requirements
- Surface opportunities for prevention and system learning
- Facilitate feedback loops for continuous education and tool refinement.

Audit Process Structure

Case Selection and Audit Cycles

- Regularity: Audits should occur at least annually.

Sampling:

- Random Sample: e.g. 10% of all the Commission Team-reviewed cases in each period.
- Ensuring Culturally Significant Reviews: Ensuring representative rates of cases involving Aboriginal and Torres Strait Islander or culturally and linguistically diverse children are reviewed to assess cultural safety and equity.

Audit Panel Composition

- Audit Team: Includes at least two multidisciplinary members (clinical, forensic, child protection, legal) and an Aboriginal and Torres Strait Islander or cultural adviser.

Standard Audit Procedures

1. **Document Review**

- Evaluate the full case file: summaries, meeting minutes, tool outputs and decision rationale.

2. **Implementation Assessment**

- Review process implementation against procedural benchmarks: Was the decision tool and process guidance applied? Were relevant considerations reviewed and documented?

3. **Consistency Analysis**

- Compare similar cases for consistency of classification and rationale
- Consider blind rating of cases using the tool to determine inter-rater reliability for a random subset of reviewed cases (e.g. proportional alignment in ratings for audit vs. those ranked via the Commission Peer review).

4. **Feedback and Recommendations**

- Summarise findings and recommend changes to tools, procedures, definitions, or training. Feedback to original review teams is direct, constructive, and linked to ongoing professional development.

Continuous Improvement and Learning

- **Process and Tool Refinement**: Recurrent audit findings prompt revision of decision tools, update of checklists, or changes in panel protocols.
- **System Reporting**: Aggregated audit outcomes are summarised in the Commission Child Death annual reports, ensuring transparency.

Audit Trail and Data Security

- Maintain all audit results and related documentation in a secure, double-authenticated digital registry for future reference, research, and accountability.

- All audit materials are handled according to the Commission data governance standards and legislative requirements for privacy and confidentiality.

This audit process provides a robust framework for the Commission and its multidisciplinary panels to monitor, assure, and continually improve the quality and fairness of fatal maltreatment classification, ensuring the highest standards of system learning and child protection in Queensland.

Future Design and Implementation

Whilst the recommended tools are evidence-centred and informed, any new process requires iterative loops of testing and refinement to enable its implementation. Lumenia recommends that the Commission explore the following key actions to ensure implementation quality.

Establish Strong Expert Advisory Arrangements:

It is recommended that tool implementation be guided by robust expert input, such as that which may be garnered through the Multidisciplinary Review group, with whom the tools can be tested and refined as their use commences.

Allocate Adequate Resources and Infrastructure:

Sufficient infrastructure, workforce, and training resources should be finalised in advance of full rollout. This includes investing in the establishment of the proposed multidisciplinary panel, providing comprehensive training to all relevant staff, and developing secure and efficient data management and information-sharing systems to record information generated through the revised decision-making processes.

Pilot Test and Refine the Tool:

Continue to build and refine the tool through pilot testing with the Commission team, potentially with a subset of cases previously classified via existing approaches, identifying discrepancies in classification and opportunities for refinement which can be socialised with the multidisciplinary panel governance mechanisms highlighted above.

Embed Continuous Improvement Mechanisms:

Processes for ongoing quality assurance, such as regular audit cycles, annual system reviews, and structured feedback loops, should be established from the outset. Audit findings should drive iterative updates to policy and practice, ensuring that the system remains adaptive and evidence-informed.

Prioritise Culturally Informed Approaches:

The implementation plan should foreground cultural safety by ensuring the meaningful participation and leadership of Aboriginal and Torres Strait Islander experts.

Proactively Manage Impacts of New Counting and Classification Approaches:

Develop and communicate strategies to anticipate and address changes in data counting or classification that may arise with implementation on the basis of any pilot testing outcomes, noting that changes to the classification approaches and definitions are proposed by these recommendations.

Consider opportunities to re-classify previous child assault and neglect data to determine proportional impact to provide estimates of impact to support communication.

By adopting these recommendations, the implementation of new systems and processes will be positioned to support classification standardisation, uphold cultural safety and equity and drive sustained, system-wide improvement in the prevention of child deaths and harms.

Recommendations:

It is recommended that the Commission's Child Death Prevention Team:

- Adopt a **child maltreatment lens** in its classification of child deaths where there is suspicion of inflicted harm or wilful deprivation
    - Expand processes to review all non-natural child deaths and preventable natural cause child deaths for **Modifiable Care Factor related** prevention learnings

- Implement the **use of decision-making tools** to support initial child death screening for suspected child maltreatment

- Establish **tiered review mechanisms** including internal Commission Peer Review, Commission Team Review and external Multidisciplinary Expert Review to enable diverse expertise to shape classification and inform prevention.

By grounding the Commission child death prevention practice in the best available evidence including the inputs of diverse experts and creating structured pathways for system learning and continuous improvement, the proposed process refinements support future prevention activities, strengthening outcomes for children and support the Commission's aim of eliminating preventable child death in Queensland.

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Appendix A: Proposed Sub-Definitions

Terms utilised within the above descriptions and their proposed definitions for implementation are presented below, noting these can be further refined during implementation:

Wilful: Acting with conscious intent or purposeful decision-making, including deliberate choice to engage in harmful acts or omissions despite awareness of potential consequences to the child.

Knowing: Having awareness, understanding, or reasonable basis to understand that one's actions or omissions create risk to the child's safety or wellbeing. This includes situations where caregivers have been informed of risks by professionals, have previous experience of similar risks, or where the danger would be apparent to a reasonable person.

Reckless Disregard: Acting with conscious indifference to or deliberate disregard of a substantial and unjustifiable risk to the child's safety. This includes situations where the person is aware of the risk but proceeds anyway, or where the risk is so obvious that disregard of it constitutes gross deviation from reasonable care standards.

This encompasses acts such as shaking an infant, where the person may not intend to cause death or serious injury but acts with conscious disregard for the substantial risk of harm that such actions create.

Grossly Negligent Behaviour: Conduct that constitutes such a significant departure from reasonable care standards that it demonstrates conscious disregard for the child's welfare. This differs from ordinary negligence by requiring a higher threshold of departure from accepted care practices and awareness or obvious indifference to serious risk.

Deliberate Action: Conscious, purposeful acts undertaken with awareness of their nature and likely consequences, including both acts specifically intended to harm and acts undertaken despite knowledge of their harmful potential.

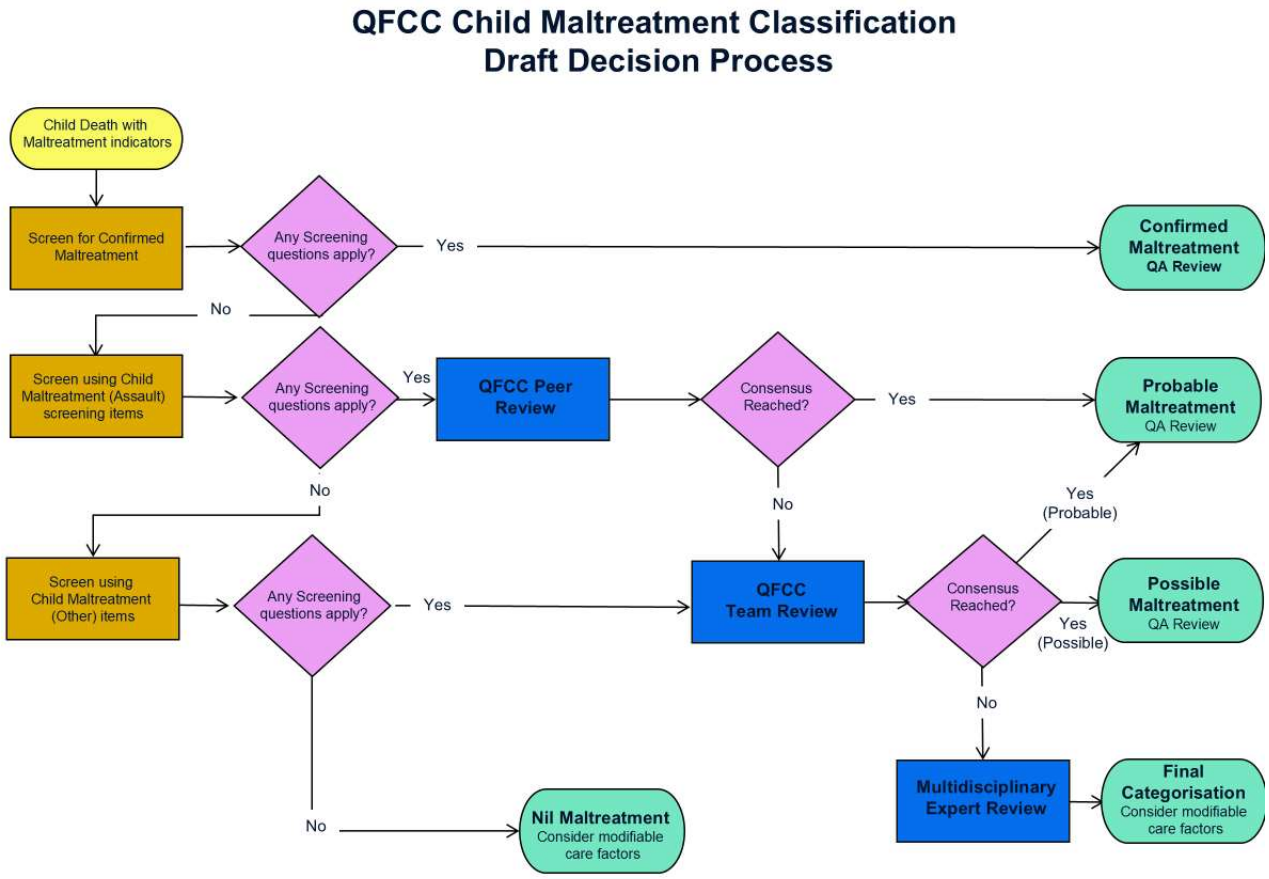
Essential Safety, Health, or Wellbeing Needs: Fundamental requirements for child survival and development, including but not limited to: adequate nutrition, shelter, medical care, supervision appropriate to age and circumstances, protection from known dangers and provision of basic hygiene and safety measures.

Clear Risk of Serious Harm: A likelihood of significant physical, psychological, or developmental injury that is apparent, substantial, and recognisable to a reasonable person in similar circumstances. This is synonymous with ‘appreciable risk’ and excludes theoretical, remote, or minimal possibilities of harm.

Should Reasonably Have Known: The standard applied when assessing whether a caregiver's failure to recognise risk constitutes maltreatment. This considers what a reasonable person with similar background, capacity, resources and circumstances would have understood about the risk, taking into account any relevant information provided by professionals, previous experience, or obviously dangerous conditions.

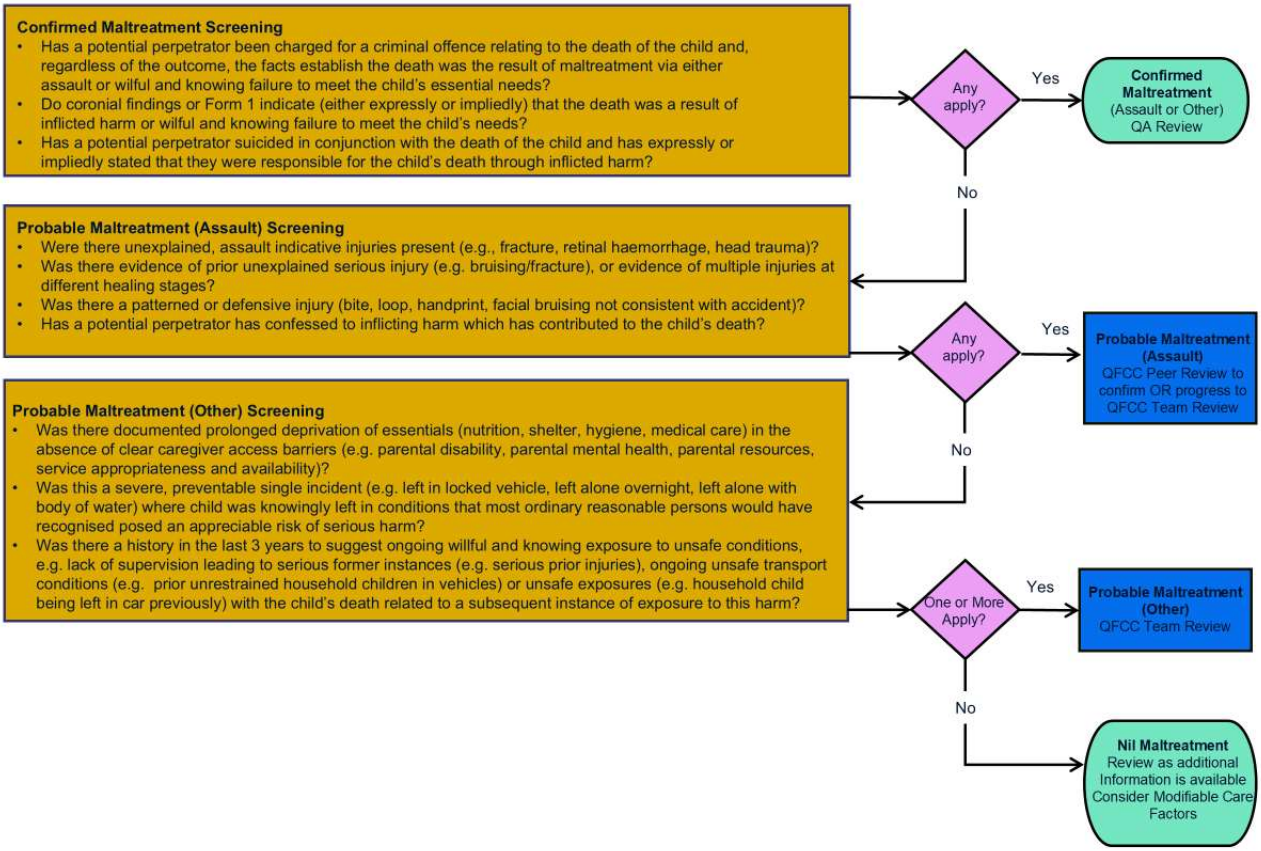
Appendix B: Process Flowchart

This document provides an overview of the process flow for considering suspected cases of child maltreatment to support their classification by the Commission Child Death Prevention Team.



Appendix C: Proposed Decision Making Tool

This decision tool is to be drawn on by the Commission Child Death Prevention team as they consider cases of suspected child maltreatment. It is to be accompanied by documentation aligned to its prompts, with rationales for decision making recorded as described previously.

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