

Appendices

Appendix 2.1: Unregistered deaths

| Year of death | Indigenous status | Coroner's findings finalised | Cause/category of death |
|---------------|-------------------|------------------------------|------------------------------------|
| 2004 | Indigenous | No | Drowning |
| 2004 | Indigenous | Yes | Undetermined* |
| 2005 | Indigenous | No | Drowning |
| 2005 | Indigenous | Yes | SIDS |
| 2006 | Indigenous | No | Natural |
| 2006 | Indigenous | No | Sudden unexpected death in infancy |
| 2006 | Indigenous | Yes | Suicide |
| 2006 | Non-Indigenous | No | Sudden unexpected death in infancy |
| 2006 | Non-Indigenous | No | Drowning |

* The Commission is liaising with Queensland Health in relation to this case as the cause of death was determined by the pathologist as sudden infant death syndrome. In accordance with the definition of SIDS, as this child was over the age of 12 months the cause of death cannot be certified as SIDS.

Appendix 3.1: Interstate residents, 2004–05

As mentioned in Chapter 3 of this report, a number of child deaths registered in the 2004–05 12-month period were unable to be classified according to geographical distribution and socio-economic status, as their usual place of residence was outside Queensland. These cases are detailed below.

Deaths of children whose usual place of residence was outside Queensland, 2004–05

| Case | Gender | Age group | Cause of death | Usual place of residence |
|------|--------|-------------------------|-------------------|--------------------------|
| 1 | Male | Under 28 days | Natural – neonate | Northern Territory |
| 2 | Male | 1–4 years | Natural | Western Australia |
| 3 | Female | Between 28 and 364 days | Transport | New South Wales |
| 4 | Female | 1–4 years | Transport | New South Wales |
| 5 | Male | 15–17 years | Transport | New South Wales |
| 6 | Female | 15–17 years | Natural | Fiji |
| 7 | Male | Under 28 days | Natural – neonate | New South Wales |
| 8 | Male | 15–17 years | Natural | Victoria |
| 9 | Male | 1–4 years | Natural | New South Wales |

Data source: Queensland Child Death Register (2004–05)

Appendix 4.1: Interstate residents, 2005–06

As mentioned in Chapter 4 of this report, a number of child deaths in the 2005–06 reporting period were unable to be classified according to geographical distribution and socio-economic status, as their usual place of residence was outside Queensland. These cases are detailed below.

Deaths of children whose usual place of residence was outside Queensland, 2005–06

| Case | Gender | Age group | Cause of death | Usual place of residence |
|------|--------|-------------------------|-------------------|--------------------------|
| 1 | Female | 10–14 years | Natural | New South Wales |
| 2 | Male | 1–4 years | Natural | New South Wales |
| 3 | Female | 15–17 years | Natural | New South Wales |
| 4 | Male | 15–17 years | Transport | New South Wales |
| 5 | Male | Between 28 and 364 days | Transport | New South Wales |
| 6 | Male | 1–4 years | Natural | New South Wales |
| 7 | Male | Between 28 and 364 days | Transport | New South Wales |
| 8 | Male | 15–17 years | Accidental | New South Wales |
| 9 | Male | 10–14 years | Natural | Victoria |
| 10 | Male | Under 28 days | Natural – neonate | New South Wales |
| 11 | Male | Under 28 days | Natural – neonate | New South Wales |

Data source: Queensland Child Death Register (2005–06)

Appendix 5.1: Notifiable diseases

Complete Notifiable Diseases Schedule (Public Health Act 2005)

| | |
|--|---|
| acquired immune deficiency syndrome (AIDS) | hepatitis B (acute) |
| acute flaccid paralysis | hepatitis B (chronic) |
| acute rheumatic fever | hepatitis B (not otherwise specified) |
| acute viral hepatitis | hepatitis C |
| adverse event following vaccination | hepatitis D |
| anthrax | hepatitis E |
| arbovirus infections: | hepatitis (other) |
| • alphavirus infections, including Barmah Forest, getah, Ross River and sindbis viruses | human immunodeficiency virus infection (HIV) |
| • bunyaviruses infections, including gan gan, mapputta, termeil and trubanaman viruses | influenza |
| • flavivirus infections, including alfuy, Edge Hill, Japanese encephalitis, kokobera, kunjin, Murray Valley encephalitis, Stratford and other unspecified flaviviruses (excluding dengue fever and yellow fever) | invasive Group A Streptococcal infection |
| • any other arbovirus infection (excluding dengue fever and yellow fever) | lead exposure |
| atypical mycobacterial infection | legionellosis |
| avian influenza | leptospirosis |
| botulism (food-borne) | listeriosis |
| botulism (intestinal – adult) | lyssavirus (Australian bat) |
| botulism (intestinal – infantile) | lyssavirus (Australian bat), potential exposure |
| botulism (wound) | lyssavirus (rabies) |
| brucellosis | lyssavirus (other) |
| campylobacteriosis | malaria |
| chancroid | measles |
| chlamydia trachomatis infection (anogenital) | melioidosis |
| chlamydia trachomatis infection (lymphogranuloma venereum) | meningococcal infection (invasive) |
| chlamydia trachomatis infection (non-anogenital) | mumps |
| cholera | ornithosis (psittacosis) |
| ciguatera intoxication | paratyphoid |
| Creutzfeldt-Jakob disease | pertussis |
| cryptococcosis | plague |
| cryptosporidiosis | pneumococcal disease (invasive) |
| diphtheria | poliomyelitis – wild type and vaccine associated |
| dengue fever | Q fever |
| diphtheria | rotavirus infection |
| donovanosis | rubella, including congenital rubella |
| echinococcosis (hydatid disease) | salmonellosis |
| equine morbillivirus (Hendra virus) infection | severe acute respiratory syndrome (SARS) |
| food-borne or waterborne illness in 2 or more cases | shiga toxin and vero toxin producing <i>escherichia coli</i> infection SLTEC/VTEC |
| food-borne or waterborne illness in food handler | shigellosis |
| gonococcal infection (anogenital) | smallpox |
| gonococcal infection (non-anogenital) | syphilis, including congenital syphilis |
| haemolytic uraemic syndrome (HUS) | tetanus |
| haemophilus influenzae type b (invasive) | tuberculosis |
| Hansen's disease (leprosy) | tularaemia |
| hepatitis A | typhoid |
| | varicella – zoster virus infection (chickenpox, shingles or unspecified) |
| | viral haemorrhagic fevers (Crimean-Congo, Ebola, Lassa fever and Marburg viruses) |
| | yellow fever |
| | yersiniosis |

Appendix 9.1: Inclusions within the ‘other’ non-intentional injury-related death category

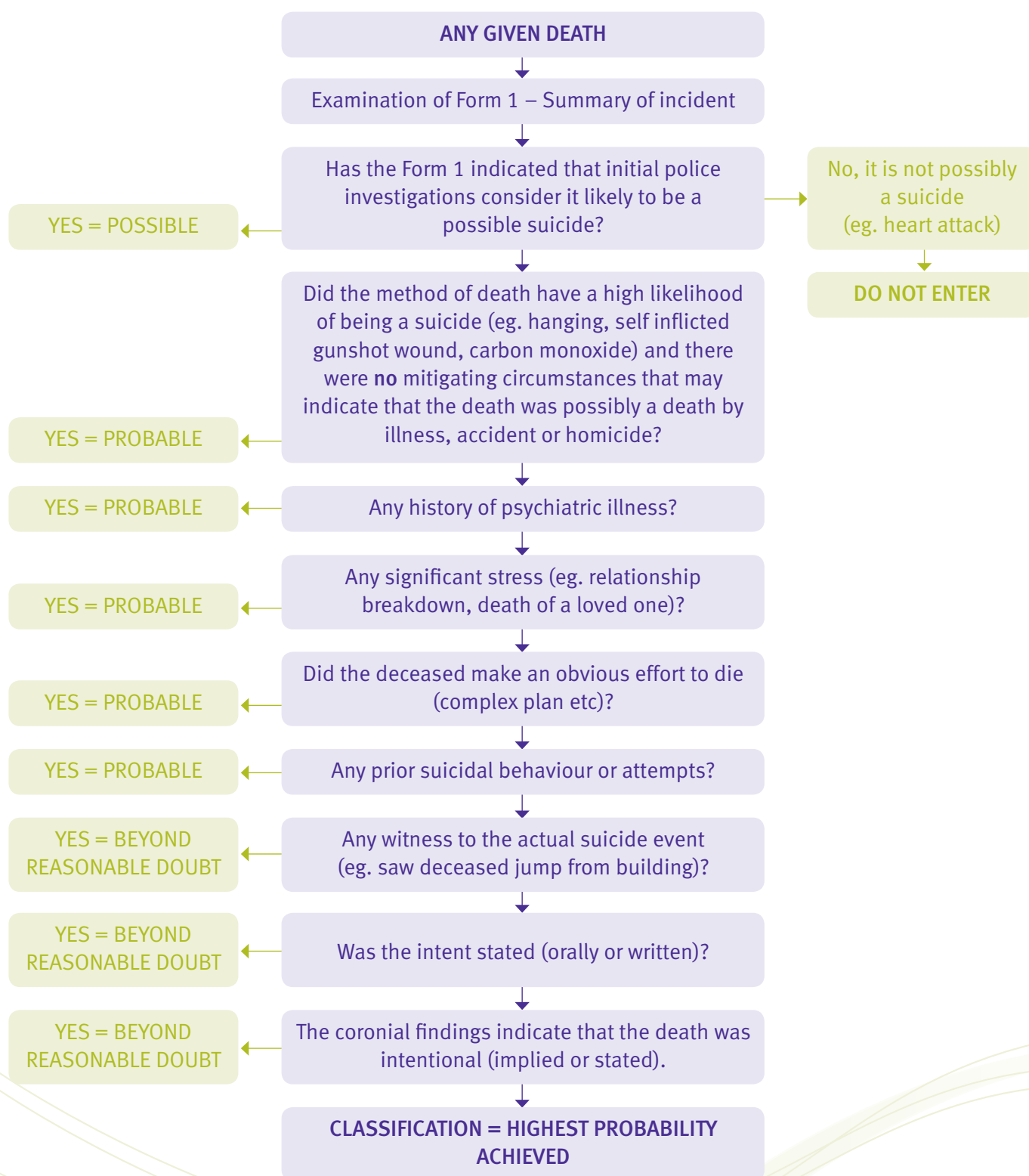
Causes of death included in other non-intentional injury related death category

- poisonings
- falls
- accidental threats to breathing, including accidental suffocation and strangulation in bed, other accidental hanging and strangulation, threats to breathing due to cave-in, falling earth and other substances, inhalation of gastric contents, food or other object causing obstruction of respiratory tract, and
- exposure to electrical current.

Other inclusions within this category

- misadventure to patients during medical or surgical care
- drugs, medicaments and biological substances causing adverse effects in therapeutic use
- surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
- injury caused by animals
- lightning
- cataclysmic storms and floods resulting from storms
- foreign body entering into or through eye, other orifice or skin
- struck by falling object or striking against or struck by other objects
- striking against or bumped into by another person (accidental)
- caught, crushed, jammed accidentally between objects
- accidents caused by firearms
- unspecified accidents
- late effects of accidental injury (excluding transport accidents)
- contact with heat and hot substances
- contact with venomous marine animals and plants
- exposure to forces of nature (for example, excessive natural heat), and
- sequelae with surgical and medical care as external.

Appendix 10.1: Suicide classification model



Modified from D. De Leo & R. Evans, *Suicide in Queensland 1996–1998: Mortality rates and related data* (Brisbane: Australian Institute for Suicide Research and Prevention, 2002).

Appendix 10.2: Suicide coding

The National Centre for Classification in Health provided the below information in relation to suicide coding.

According to the coding rules implicit in the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), for deaths due to injuries, the cause of the injury (known as the external cause) is recorded as the underlying cause of death for statistical tabulation purposes. An external cause of death is coded according to the intent behind the incident. There are certain blocks of codes which enable capture of various circumstances according to intent. These relate to external causes described as being an accident (codes V01–X59), intentional self-harm (X60–X84), assault (X85–Y09), event of undetermined intent (Y10–Y34), legal intervention and operation of war (Y35–Y36), and complications of medical and surgical care (Y40–Y84).

Of specific relevance to the capture of suicide is the requirement for specific documentation from a medical or legal authority regarding the self-inflicted nature of the incident in order to assign a code from the intentional self-harm block.²⁷² Unless the incident is specified by such an authority as self-inflicted with intent to suicide, the classification requires that the codes pertaining to accidents be used. Events of undetermined intent may be thought to be appropriate for cases in which the documentation does not support either the accident or self-inflicted code blocks, but the classification indicates:

Note: *This section covers events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. It includes self-inflicted injuries, but not poisoning, when not specified whether accidental or with intent to harm.*²⁷³

In the Australian context, a statement on the death certificate by the coroner following a coronial investigation is required before a death can be classified as suicide due to intentional self-harm. All external-cause deaths are referred to a coroner for investigation. Without such a statement, the default accident code block is used, as the classification requires. There has been concern raised that delays in coronial investigations, and a reluctance on the part of coroners to report suicides as such, mean that Australian suicide statistics are under-reported.

After representations from the Child Death Review Team, the issue of how to code cases which do not contain a formal statement of intent was investigated by the National Centre for Classification in Health (NCCH). The Causes of Death unit at the Australian Bureau of Statistics confirmed that it codes according to the ICD rules²⁷⁴ and requires a definitive statement of suicide or self-inflicted injury with intent to inflict fatal injury in order to assign a code from the intentional self-harm block. At a meeting of the Australasian Mortality Data Interest Group (AMDIG), the issue was also raised and concern was expressed at delays in the finalisation of coronial investigations, which mean that often a year's mortality data must be 'closed off' before the coroner reports on all cases. Thus the accidental code is likely to be used more frequently than may be the case if there is documentation of intent following coronial findings.

The Commission also developed a query to the World Health Organisation Mortality Forum, an email discussion list which focuses on difficult problems relating to the international use of ICD-10 for coding causes of death. Participants in the forum are mainly coders and statistics officers who work in national statistical organisations and research institutes

272 Coders should never make an assumption about intent. The default in the classification is to code the cause as an accident if not otherwise stated. In the Australian context this means that a statement by a medical or legal authority is required in order for the X60–X84 intentional self-harm code block to be used for coding mortality records.

273 Extracted from ICD-10 Second Edition, 2005, External causes of morbidity and mortality.

274 World Health Organisation, International Statistical Classification of Diseases and Related Health Problems, 2nd edition (2005), volume 2: 4.1–4.2.2, Mortality: guidelines for certification and rules for coding, pp. 33–73.

internationally. Although the response to the forum question was that the method of coding in Australia is consistent with both the ICD rules and the use of the ICD-10 in various countries, there was discussion about the appropriateness of the rules and whether it might be relevant to recommend changes to ICD-10.

This discussion was subsequently taken up at the Mortality Reference Group (MRG), a committee tasked with making recommendations for modification to the ICD specifically for coding deaths. The NCCH advised that the issue had been discussed by the MRG several years previously and that an addition to the ICD-10 note reported above was included for the coding of deaths from data year 2005 onwards under the accidental and undetermined intent code blocks. This additional note states: "Follow legal rulings when available." In discussions in 2006, the MRG decided that changing the coding rules now would create breaks in statistical series and that, although it agreed that the issue requires consideration, it would be preferable to place this on the work program for the 11th revision of the ICD. The issue has also been discussed informally with the Classification team at WHO Headquarters in Geneva, who have noted it for future ICD development.

In the interim, the NCCH has recommended that the Child Death Review Team assign an additional character at the end of the Y20 code. This character differentiates between cases of hanging of undetermined intent, but which are suspected suicides based on police and other reports, and those cases in which the coroner, after investigation, is unable to make a determination regarding intent. Cases meeting the former definition are designated:

Y20A Hanging, strangulation and suffocation, undetermined intent, suspected suicide

Use of this additional character means that cases can be analysed as undetermined as per the WHO definition, or as suicide as per the analytical requirements of the Commission. Importantly, consistency with other national and international mortality collections is maintained by rolling back the additional character to the standard ICD code.

Appendix 10.3: Australian Bureau of Statistics feedback on proposed recommendations (5 September 2006)

The Commission recommends that the Australian Bureau of Statistics works with training bodies such as the National Centre for Classification of Health (a body responsible for the training of mortality coders in Australia), mortality coders, child death review teams in Australia and relevant national representatives of the coronial system to develop a method of coding intentional self-harm, for research and policy development purposes in Australia, that more accurately reflects causes of death where coroners have not clearly stipulated intent or cause because of coronial practices and constraints.

The most recent ABS Cause of Death statistics released on 14 March 2005 highlighted a number of data quality issues in relation to external causes of death. Within external causes of death, deaths which relate to suicide or intentional self harm are of particular concern.

The ABS has been investigating a number of issues which may assist in increasing the quality and timeliness of cause of death statistics. These issues range from improvements in processing systems and methods, working with providers of source data and options for alternative methods of releasing cause of death statistics.

The Suicide Coding Review Working Group was established in August 2006 to assist in improving the quality of national cause of death data, with regard to deaths by suicide/intentional self harm. The outcomes sought by the Australian Bureau of Statistics (ABS) include:

- quality suicide data which meet the needs of users and ensures quality outputs and outcomes are delivered*

- suicide coding undertaken in accordance with the coding rules of the International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD-10)*
- consistent application of suicide coding rules and practices in Australia, and*
- best practice suicide coding practices are used by the ABS which are understood by providers and users of suicide data.*

The ABS has invited a number of key experts in the field of suicide data including representatives from the National Centre for Classification in Health, National Coronial Information System, Queensland Coroners Office, Victorian Coroners Office and the Queensland Child Death Review Team.

The Suicide Coding Review Working Group will undertake a review of current ABS and other Australian organisations' suicide coding practices. The review will include reviewing the following issues:

- data sources*
- ABS interpretation of ICD-10 suicide coding rules*
- coroner practices and constraints with regard to making a finding of suicide and how this relates to a statistical definition of suicide*
- level of 'evidence' required to code a death as suicide, and*
- revision of suicide coding practices.*

The Suicide Coding Review Group may make recommendations for ABS consideration with regard to the issues investigated. Final responsibility and accountability for practices and data quality will rest with the ABS.

The Commission recommends that the Australian Bureau of Statistics publicly report on suicides of children and young people under 15 years of age.

The Cause of Death collection is a long-standing ABS collection. The main outputs are a detailed initial publication and a unit record file, and there is a large demand for information consultancy services. The Australian Institute of Health and Welfare also publish detailed cause of death information in a product known as 'GRIM books'. While ABS has previously released detailed datacubes, they are no longer produced due to confidentiality requirements.

A review of Cause of Death products is currently occurring, to ensure that a suite of products is available which better meets user needs, takes advantage of the wealth of information available from the collection, is readily accessible, easy to produce, and provides additional analytical material. A proposal for a revised Cause of Death product suite will be circulated to key users for comment.

The ABS will consider the recommendation regarding publication of suicide data for children and young people under 15 years of age within the scope of the dissemination review outlined above.

Appendix 10.4: Incidence of self-harm – Education Queensland data

Incidence of self-harm: reports 1 January to 30 June 2006

From 1 January 2006 to 30 June 2006, Education Queensland received 204 reports of students engaging in self-harm. Of these reports, 126 (61.8%) detailed incidents of self-harm by female students while 78 (38.2%) detailed incidents of self-harm by male students.

Of the 204 reports of self-harm, 50 (24.5%) described incidents involving students in primary school (Years P–7). One hundred and forty (68.6%) of the reports received described incidents involving students in secondary school. The highest incidence of self-harm was among students in Years 9 and 10, with Education Queensland receiving 41 (20.1%) reports of self-harm pertaining to students in Year 9 and 36 (17.6%) reports pertaining to students in Year 10.

Some students who engaged in acts of self-harm received support and protection from their parents. In 73 (35.8%) cases, students' parents were judged by principals to be acting protectively and students were not referred to the Department of Child Safety. However, there were 131 (64.2%) cases in which parents were judged not to be acting protectively. In these cases, the incidents of self-harm were reported to the Department of Child Safety.

Education Queensland collects data on the incidence of self-harm and risks of self-harm within particular cultural groups. Of the 204 reports of self-harm

received, 38 (18.6%) described incidents involving students of Aboriginal or Torres Strait Islander heritage. Given that Indigenous students comprise only 7.3% of the total student population, these students appear to be at greater risk of self-harm than other students.

Education Queensland also received reports describing incidents in which students were judged to be at risk of self-harm. Of 189 reports received in relation to students at risk of self-harm, 110 (53.9%) described situations in which female students were deemed to be at risk of self-harm. Seventy-nine (38.7%) reports detailed situations in which male students were deemed to be at risk of self-harm. Thirty-four (18.0%) of the 189 reports received pertaining to students at risk of self-harm described incidents involving students of Aboriginal or Torres Strait Islander heritage.

Education Queensland emphasises that the data presented describes reports made in relation to self-harm and may not accurately reflect the true rate of self-harm among students. Caution must be exercised if using the data to draw conclusions about the incidence of self-harm among students from any particular cultural group. Another limitation that should be taken into account is that the data does not account for different degrees of severity but is inclusive of all incidents of self-harm or incidents where a student was deemed to be at risk of harm.

Appendix 12.1: Retrospective cause of death analysis, 2004–05

At the time of 2004–05 reporting, autopsy results were pending in 23 of the 63 cases of SUDI. Thus the cases of SUDI analysed in the *Annual Report: Deaths of children and young people, Queensland, 2004–05* included deaths which presented as a SUDI but the pathologist's or coroner's findings were pending.

The updated cause of death for the 23 cases of SUDI where cause of death was pending at the time of 2004–05 reporting is given below.

Updated cause of death for cases pending in 2004–05

| Cause of death | Total <i>n</i> |
|---|-------------------|
| SIDS and other ill-defined causes of mortality | |
| Sudden infant death syndrome | 16 |
| Undetermined | 3 |
| External causes of accidental injury | |
| Accidental suffocation and strangulation in bed | 1 |
| Diseases and morbid conditions | |
| Bronchopneumonia, unspecified | 1 |
| Pneumonia due to <i>Streptococcus pneumoniae</i> | 1 |
| Pending test results | 1 |
| Total | 23 |

Data source: Queensland Child Death Register (2004–05)

Table 12.6: Summary of SIDS risk factors for infants who died from SIDS and undetermined causes where cause of death was pending at time of 2004-05 reporting

| Cause of Death | Indigenous | Shared sleeping | Sleep surface | Prone/side sleeping | Low birth weight | Pre-term birth | Smoking | Drugs/ alcohol | Chaotic social circumstances* | Living in low socio-economic areas |
|-------------------------------|------------|-----------------|-------------------|---------------------|------------------|----------------|-----------|----------------|-------------------------------|------------------------------------|
| SIDS | | | cot | ✓ | | | ✓ | ✓ | ✓ | ✓ |
| SIDS | | | cradle | | | | ✓ | | | ✓ |
| SIDS | | | cot | | n/a | n/a | | | | ✓ |
| SIDS | | | cot | ✓ | ✓ | | ✓ | | | |
| SIDS | ✓ | ✓ | mattress on floor | | | n/a | ✓ | | | |
| SIDS | | ✓ | double bed | | | | ✓ | | | ✓ |
| SIDS | ✓ | ✓ | single bed | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| SIDS | | | cot | ✓ | | | | | | ✓ |
| SIDS | | | cot | ✓ | | | ✓ | | | |
| SIDS | | | double bed | | | | ✓ | | | |
| SIDS | | | mattress on floor | | | | ✓ | | | |
| SIDS | | | cot | ✓ | | | | | | |
| SIDS | ✓ | ✓ | mattress on floor | | n/a | n/a | ✓ | | | |
| SIDS | ✓ | ✓ | double bed | n/a | n/a | n/a | n/a | ✓ | ✓ | ✓ |
| SIDS | | | cradle | ✓ | ✓ | ✓ | | | | |
| SIDS | | ✓ | mattress on floor | | | | ✓ | ✓ | ✓ | |
| SIDS Total (16) | 4 | 6 | | 6 | 3 | 2 | 11 | 4 | 3 | 7 |
| Undetermined | | ✓ | mattress on floor | | | | ✓ | | | |
| Undetermined | | ✓ | couch | n/a | | n/a | ✓ | | ✓ | ✓ |
| Undetermined | | ✓ | double bed | n/a | | | ✓ | | ✓ | ✓ |
| Undetermined total (3) | 0 | 3 | | 0 | 0 | 0 | 3 | 0 | 2 | 2 |
| Total (19) | 4 | 9 | | 6 | 3 | 2 | 14 | 4 | 5 | 9 |

Data source: Queensland Child Death Register (2005–06)

* = known to DChS and/or Form 1 indicated that family are known to police for criminal activities, and/or domestic violence issues N/A = information not recorded or unknown to police

✓ SIDS risk factors present

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Notes

