

Chapter 2

Methodology

Key issues

- The Commission has identified an anomaly between the number of deaths reported by the Registry of Births, Deaths and Marriages and the reportable deaths identified by the State Coroner. As at 30 June 2006 the Commission is aware of 9 deaths that remain unregistered since 1 January 2004. Of these, 7 are Aboriginal or Torres Strait Islander children. The Commission has made a recommendation to the Registry of Births, Deaths and Marriages in relation to the registering of these deaths.
- Updated causes of death (from Autopsy Certificates and coronial findings) are provided to the Registry of Births, Deaths and Marriages in its capacity to maintain an updated register. The Commission has made recommendations that the Registry should forward this information on to the Commission and give consideration to forwarding this to other relevant agencies to provide the most accurate mortality datasets for public health records and research.

This chapter provides an overview of the methodology employed by the Commission in producing this report. As well, it explains the process of maintaining the Child Death Register and the methods used for the analysis of trends and patterns in the data.

Child Death Register

Under the *Commission for Children and Young People and Child Guardian Act*, the Commission has a statutory obligation to maintain a register of all deaths of children and young people under the age of 18 that occur in Queensland. The information in the register is required to be classified according to cause of death, demographic information and other relevant factors. The Commission is required to maintain the register of all child deaths from 1 January 2001. The Commission has responsibility for the centralised collection and coding of mortality information for both coronial and non-coronial child deaths.

The Commission analyses information in the Child Death Register to identify and report on patterns of child mortality and make recommendations about policies, practices and procedures aimed at reducing or preventing child deaths.

To support the establishment and maintenance of the register, the Registry of Births, Deaths and

Marriages and the Office of the State Coroner both advise the Commissioner of a child's death and provide available relevant particulars.

Registry of Births, Deaths and Marriages

The information contained in the Child Death Register is based on death registration data from the Queensland Registry of Births, Deaths and Marriages. To help the Commission fulfil its child death functions, the *Births, Deaths and Marriages Registration Act 2003* provides that the Registrar must give notice of the registration of all child deaths to the Commissioner.⁴⁴ The data provided include the following information:

- the registration number
- the child's name
- the child's date and place of birth
- the child's usual place of residence
- the child's age
- the child's sex
- the child's occupation, if any
- Aboriginal or Torres Strait Islander status
- the duration of the last illness, if any, had by the child
- the date and place of death
- the cause of death, and
- the mode of dying.⁴⁵

⁴⁴ Section 48A (details of stillborn children are not included in the information given to the Commission).

⁴⁵ Section 48B of the *Births, Deaths and Marriages Registration Act* enables the Registrar to enter into an arrangement with the Commissioner to provide additional data. Aboriginal and Torres Strait Islander status, date of birth and mode of dying are provided by administrative arrangement only.

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

Updated cause of death data

Section 48A of the *Births, Deaths and Marriages Registration Act* states that the Registrar must give notice of the registration of a child death to the Commission. The notice must include the child’s cause of death, to the extent it is known to the Registrar. In practice the Registrar usually provides this information to the Commission within 30 days after the death is registered.

The Registrar receives Autopsy Certificates under section 24A of the *Coroners Act 2003*. These are provided ‘as soon as is practicable’ after the completion of an autopsy. Section 41(8) of the *Births, Deaths and Marriages Registration Act* states that, if the Registrar receives a coroner’s notice in relation to the death of a person, the Registrar *may* enter the information contained in the notice or certificate in the relevant register. When updating the cause of death on receipt of Autopsy Certificates or coronial findings, the Registrar does not routinely update the death registration data provided to the Commission. Rather, the cause of death is provided as ‘Autopsy Notice given – cause of death not yet determined’ (that is, cause of death pending). It is understood that this updated data is also not sent on to other agencies such as the Australian Bureau of Statistics (ABS) or the Australian Institute of Health and Welfare (AIHW).

In February 2006 the Commission wrote to the Registry requesting updated causes of death for 217 deaths registered between 1 January 2001 and 30 January 2006 where cause of death was pending. The Commission met with staff from the Registry to discuss this issue again in June 2006. As Autopsy Certificates are provided to the Registry to maintain an updated register, the Commission considers that

there is scope for the Registry to be more active in forwarding this information to the Commission and give consideration to forwarding this information to other relevant agencies to provide the most accurate mortality datasets for public health records and research. For this reason:

Recommendation 1

The Commission recommends that by 31 December 2006 the Registry of Births, Deaths and Marriages complete a review of its current practice and identify options to provide updated cause-of-death data to the Commission resulting from its receipt of Autopsy Certificates under section 24A of the *Coroners Act 2003*.

As an interim measure the Registrar-General has agreed to fax updated cause-of-death information, in the form of the Autopsy Certificate, to the Commission. The Registry will give consideration to the resource implications of including updated cause-of-death information to the Commission. In the interests of providing consistent mortality data to statistical agencies, it is the Commission’s opinion that consideration should also be given to providing this updated data to other agencies.

Chapter 10, ‘Suicide’, gives an example of the practical implications of unreliable data on government program development and service response in the area of suicide.

Office of the State Coroner

In cases of ‘reportable’ child deaths, coronial information is also available.

Section 8 of the *Coroners Act 2003* defines a reportable death as a death where:

- the identity of the person is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- the death was not the reasonable expected outcome of a health procedure
- a Cause of Death Certificate was not issued or is not likely to be issued
- the death occurred in care, or
- the death occurred in custody.

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

- had a disability (as defined under the *Disability Services Act 1992*) and was living in a residential service provided by a government or non-government service provider or a hostel
- had a disability such as an intellectual disability or an acquired brain injury or a psychiatric disability and lived in a private hostel (not an aged-care hostel)
- was being detained, taken to or undergoing treatment in a mental health service, or
- was a child in foster care or under the guardianship of the Department of Child Safety (DChS).⁴⁶

A death in custody is defined as a death of someone in custody (including someone in detention under the *Juvenile Justice Act 1992*), escaping from custody or trying to avoid custody.⁴⁷

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

- the Police Report of Death to a Coroner (Form 1), which includes a narrative giving a summary of the circumstances surrounding the death
- autopsy and toxicology reports, and
- the coroner's findings and comments.⁴⁸

Coronial information is largely narrative and is not entered into the register.

For the major categories of reportable deaths, which include deaths from external causes, and sudden unexpected deaths in infancy (SUDI), coronial information is reviewed. The Commission has identified variables relevant to the major categories of reportable deaths and has developed additional databases to capture and analyse this information. For example, in cases of SUDI, coronial information was reviewed for each death in order to extrapolate and record additional information about the circumstances of death, such as infant

sleep position, shared sleeping arrangements, or evidence of smoking and drug or alcohol use in the household.

In comparing the Form 1s and the coroner's findings received since January 2004 against the Registry of Births, Deaths and Marriages data received on a monthly basis, the Commission has identified a number of deaths that have not been registered.

Unregistered child deaths

In accordance with sections 28 and 29 of the *Births, Deaths and Marriages Registration Act*, a death must be registered by a spouse or relative of the deceased by means of a 'death registration application'. This application must be completed within 14 days after the death. A death may also be registered by the person in charge of the place where a person has died, the person finding the body and the person arranging for the disposal of the deceased's body.

The Commission has identified inconsistencies between the number of deaths reported by the Registry and the reportable deaths identified by the Office of the State Coroner. The Commission noted that a number of deaths of children and young people were not being registered, particularly the deaths of Indigenous children and young people. As at 30 June 2006 the Commission is aware of 9 deaths that remain unregistered since 1 January 2004. Of these, 7 are Aboriginal or Torres Strait Islander deaths (see Table 2.1).

Table 2.1: Unregistered child deaths by year of death and Indigenous status

Indigenous status	2004	2005	2006	Total
Aboriginal	0	1	3	4
Torres Strait Islander	2	1	0	3
Non-Indigenous	0	0	2	2
Total	2	2	5	9

Data source: Queensland Child Death Register (2004–06)

46 Section 9 of the *Coroners Act 2003*.

47 Section 10 of the *Coroners Act 2003*.

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

The causes of death for the above 9 cases include 3 drownings, 4 sudden unexpected deaths in infancy (including 2 due to sudden infant death syndrome and 2 where cause of death is pending), 1 suspected suicide and 1 death due to diseases and morbid conditions.

The Commission receives a copy of the Police Report of Death to a Coroner (Form 1) within 48 hours of a reportable death and then checks these records against death registration data provided by the Registry. Effectively, the Commission has been acting as a conduit, providing details such as a child's name, usual place of residence, date of birth and date of death to the Registry, when it has been recognised that a death has not been registered. The Registry has subsequently endeavoured to seek an application for the death to be registered by the next of kin and/or the funeral director.

This process has been effective in registering 4 deaths to date, but the Commission has raised concerns about the ad hoc nature of this process. Further, this process has not been successful in registering all reportable deaths identified to the Registry to date.

To compound this problem, the Commission has been informed by the ABS that, if a death occurred more than 2 years before the ABS's processing year, it will not be captured in ABS statistics. The ABS estimates that the undercount due to late registrations and outstanding coronial findings is currently about 5%.

The issue of under-recording Indigenous deaths has long been recognised in Australia. Although the Commission has only been able to identify small numbers of unregistered child deaths, it is nonetheless evident that the current practice of not registering known reportable deaths compounds the problem of undercounting Indigenous mortality. Given the significant inequalities in health status between Indigenous and non-Indigenous people in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and

political context, there is a strong case for ensuring that known information on Indigenous status is captured and recorded when available from credible sources.

Sections 42 and 43 of the *Births, Deaths and Marriages Registration Act* allow the Registrar to correct the register on the order of a Queensland court or to reflect a finding made on an inquiry by the Registrar to find out whether a registerable event has happened. The Act details that the Registrar may correct the register by adding, cancelling, amending or deleting an entry in the register. The Commission has raised with the Registrar the use of these sections of the Act to register these deaths.

Under section 45 of the *Coroners Act 2003*, a coroner investigating a death or a suspected death has the statutory obligation to find whether or not the death in fact happened, who the deceased person is, how, when and where the person died and what caused the person to die. The coronial information should be sufficient to satisfy the information requirements under sections 42 and 43 of the *Births, Deaths and Marriages Registration Act*, with the effect that the Registrar could be more active in registering deaths reported by the State Coroner, in a timely manner.

Recommendation 2

The Commission recommends that by 31 December 2006 the Registry of Births, Deaths and Marriages complete a review of its current practice with a view to maximising the timely capture of deaths reported by the State Coroner. Further, that the Registry develop an organisational policy/procedure on the adopted practice.

Unregistered deaths that occurred in the 2005–06 financial year have been referred to in the relevant chapters but have not been included in the overall data count and analysis. The Registry has committed to registering these deaths upon receipt of coronial findings, as such these cases will be considered in the 2006–07 annual report.⁴⁹

49 It is expected that a number of these deaths will be registered early in the 2006/07 financial year.

Access to other data sources

Section 89ZG of the *Commission for Children and Young People and Child Guardian Act* enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably needed for the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions.

The Commission has developed agreements with the following agencies:

- Registry of Births, Deaths and Marriages⁵⁰
- Office of the State Coroner⁵¹
- Department of Child Safety and
- Department of Industrial Relations.

The Commission is currently in the process of enhancing existing information-sharing agreements with the following agencies for its research functions:

- Department of Child Safety
- Queensland Health
- Department of Education and the Arts
- Department of Housing, and
- Queensland Police Service.

Access to information held by these agencies will provide valuable insights into the lives of, and circumstances leading to the deaths of, some of Queensland's most vulnerable children.

Queensland Injury Surveillance Unit

The Queensland Injury Surveillance Unit (QISU) has provided injury data to the Commission. QISU collects and analyses injury data from emergency departments of participating hospitals throughout Queensland. Participating hospitals include Mater Children's, Mater Adult, Queen Elizabeth II Jubilee, Princess Alexandra, Redland, Logan, Royal

Children's, Mount Isa, Mackay Base, Mackay Mater, Proserpine, Sarina, Clermont, Dysart, Moranbah and Mareeba. As the data are taken from selected hospitals, they do not give a complete overview of all childhood injury in Queensland, but they do give an indication of injury trends in Queensland.⁵²

Confidentiality

Accompanying the Commission's privileged access to information is a duty of confidentiality that is specified in legislation. Section 153 (Confidentiality of Other Information) of the *Commission for Children and Young People and Child Guardian Act* states:

If a person gains confidential information through involvement in this Act's administration, the person must not –

- (a) *make a record of the information or intentionally disclose the information to anyone, other than under subsection (4),⁵³ or*
- (b) *recklessly disclose the information to anyone.*

Coding cause of death

The Commission uses the International Classification of Diseases and Related Health Problems, Revision 10 (ICD-10) to code underlying causes of death. ICD-10 was developed by the World Health Organisation and is designed to promote international comparability in the collection, processing, classification and presentation of morbidity and mortality statistics.

What is the underlying cause of death?

The concept of the underlying cause of death is central to mortality coding and comparable international mortality reporting.⁵⁴ The World Health Organisation has defined the underlying cause of death as:

50 The agreement between the Registry of Births, Deaths and Marriages and the Commission has been developed in accordance with the provisions of section 48B of the *Births, Deaths and Marriages Registration Act*.

51 The agreement between the Office of the State Coroner and the Commission has been developed in accordance with the provisions of section 54A of the *Coroners Act 2003*.

52 QISU estimated that in 1998–99 participating hospitals collected 20–25% of all injury emergency department presentations.

53 Subsection 4 permits a person to make a record of or disclose confidential information for this Act to discharge a function under another law, for a proceeding in a court or tribunal or if authorised under a regulation or another law.

54 In many cases, death certificates only record a single cause of death. These are relatively simple to deal with – the single cause reported is coded using the ICD-10. However, in other cases two or more conditions may have contributed to the death, and are all recorded on the death certificate. In such cases it is necessary to select one of the causes of death for classification purposes. This single cause is usually referred to as the underlying cause of death.

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

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

The National Centre for Classification in Health

The National Centre for Classification in Health (Brisbane) (NCCH) is the internationally recognised Australian centre of expertise in the classification of morbidity and mortality data.⁵⁵ The NCCH has developed collaborative relationships with several external organisations, including the ABS and the AIHW, to provide coding, data quality and education expertise.

The Commission has a formal secondment arrangement with the NCCH whereby the centre employs a qualified Health Information Manager who is subsequently seconded on a part-time basis to the Commission. The aim of this position is to provide the Commission with contemporary coding expertise.

For each death in the register, the Health Information Manager reviewed all available information and coded the death according to ICD-10 cause of death coding regulations.

Limitations of ICD-10

The Commission recognises that ICD-10 carries certain inherent limitations. A classification is used to group conditions, diseases, external causes and health-related problems into homogeneous groups to assist with statistical collection and analysis of health information. In the process of grouping and classifying using ICD-10, various specificities in cause or circumstances of death are missed. For example, a case in which a child dies in a car–pedestrian incident while being escorted across the road by an adult is qualitatively different from a case in which a chronically unsupervised child is struck by a car while crossing a busy street alone. For coding

purposes the manner and cause of death are the same, but the circumstances are distinctly different.

Additionally, some specific categories of death that are of interest to the Commission are not specified in ICD-10 coding. These are listed below:

- dam drowning
- driveway run-overs of toddlers
- four-wheel motorcycle (quad-bike) incidents.

Consequently, the Commission has developed databases based on research categories to assist with the capture and analysis of this information.

Research categories

To help overcome the limitations of ICD-10, the Commission also classifies deaths according to their circumstances – referred to as ‘research categories’ throughout this report. Based on the information contained in the Police Report of Death to a Coroner (Form 1), research categories enable the Commission to discuss deaths occurring in similar circumstances together, even where an official cause of death has not yet been established.⁵⁶ Research categories are also used when the ICD-10 code does not accurately reflect the circumstances of death. For example, as discussed in Chapter 10, ‘Suicide’, in Queensland a number of child and adolescent suicides are being coded as accidents. According to current coding practice, a high standard of proof is generally required for a suicide to be coded as such, and in the absence of a clear statement of intent before the child’s death (for example, a note or an oral statement) and in cases where coroners do not specify that the death was self-inflicted (for example, where the cause of death is listed as ‘hanging’), these deaths, which would ordinarily be categorised as suicides in clinical or research situations, are coded as accidents.

It is widely acknowledged that childhood suicides are under-reported in official statistics and a large proportion are mistakenly recorded as accidents. Therefore the Commission has endeavoured to reduce the likelihood of suicides being undercounted by classifying all cases where police

55 The NCCH is also the developer of the Australian modification of the ICD-10 (known as ICD-10-AM). ICD-10-AM is used for morbidity coding only.

56 Where cases have not received an official cause of death as established at autopsy, they are unable to be coded according to ICD-10.

have indicated that a death may be a suspected suicide in the research category ‘suicide’.

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

As outlined above, discrepancies may exist between research category and ICD-10 figures. In this report, while ICD-10 classifications have coded 93 child deaths as due to external causes, there are a total of 96 children included in the Commission’s research categories. Three cases have been included in the fatal assault research category based on the circumstances of their death, despite their cause of death being as yet unknown or undetermined. Any figures reporting the percentage of external cause deaths are calculated on a denominator of 93 (based on ICD-10 coding).

Geographical distribution (ARIA+)

The Commission uses the latest version of the Accessibility/Remoteness Index of Australia (ARIA), commonly referred to as ARIA+, to code geographical remoteness.

ARIA+ is a standard distance-based measure of remoteness developed by the National Centre for the Social Applications of Geographic Information Systems (GISCA) and the Commonwealth Department of Health and Aged Care.

It interprets remoteness on the basis of access to a range of services; the remoteness of a location is measured in terms of distance travelled by road to reach a centre that provides services.⁵⁷

ARIA+ defines five categories of remoteness:

- Major Cities of Australia:⁵⁸ relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction
- Inner Regional Australia: some restrictions to accessibility of some goods, services and opportunities for social interaction
- Outer Regional Australia: significantly restricted accessibility of goods, services and opportunities for social interaction

- Remote: very restricted accessibility of goods, services and opportunities for social interaction, and
- Very Remote: very little accessibility of goods, services and opportunities for social interaction.

All child deaths registered between 1 July 2005 and 30 June 2006 were classified according to the ARIA+ index. The analysis of geographic distribution in this report refers to the child’s usual place of residence, unless otherwise stated, which may differ from the place of death or the incident location. Transport incidents are an exception, however, as the geographical distribution of transport deaths has been reported according to the place of incident.

For the purposes of analysis in this report, ARIA+ categories have been combined into three more general categories:

- Metropolitan: includes major cities of Queensland
- Regional: includes inner and outer regional Queensland, and
- Remote: includes remote and very remote Queensland.

Socio-economic status (SEIFA)

The Socio-Economic Indexes for Areas (SEIFA) developed by the ABS have been used to code disadvantage. This index provides four measures of the social and economic conditions of geographic areas across Australia:

- Index of Advantage/Disadvantage
- Index of Disadvantage
- Index of Economic Resources, and
- Index of Education and Occupation.

The SEIFA Index of Advantage/Disadvantage is used in this report. This index aims to rank geographical areas to reflect both advantage and disadvantage at the same time, effectively measuring a net effect of social and economic conditions.

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

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

58 These are ABS-determined category names. GISCA ARIA+ uses the following category names: highly accessible, accessible, moderately accessible, remote, very remote.

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

The Index of Advantage/Disadvantage is used more frequently by the Queensland State Government than other SEIFA indexes.

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

Aboriginal and Torres Strait Islander status

The identification of Aboriginal and Torres Strait Islander people continues to be less than satisfactory in many administrative collections. While the identification of the deaths of Aboriginal and Torres Strait Islander people has improved considerably in recent years, it is not known how many Indigenous deaths are not identified. Therefore, the number of deaths registered as Aboriginal or Torres Strait Islander in a given year is expected to be an undercount of the actual number of deaths of Indigenous people.

Aboriginal and Torres Strait Islander status is recorded on both the Registry of Births, Deaths and Marriages death registration data and the Police Report of Death to a Coroner (Form 1). However, it is probable that these sources undercount the number of Aboriginal and Torres Strait Islander child deaths.

The Child Death Register captures Aboriginal and Torres Strait Islander status as recorded both in the death registration data and on the Form 1. Several cases have been identified where a child has been identified as Indigenous by the reporting officer in completing the Form 1, but family members did not identify as Indigenous when registering the death. These cases have been recognised, where applicable, throughout the report.

The Commission recognises that in Queensland Aboriginal and Torres Strait Islander children and young people aged 0–17 comprise approximately 46.5% of the Aboriginal and Torres Strait Islander populations (Commission for Children and Young People and Child Guardian 2005:7) and, as reported earlier in this chapter, the Commission is pursuing means to improve the undercounting of Aboriginal and Torres Strait Islander child deaths.⁵⁹

Child protection population

The deaths of children known to the Department of Child Safety have been analysed as a distinct cohort as the Commission has significant responsibilities in relation to these child deaths.

In addition to maintaining the Child Death Register and the research and analysis contained in this report, the Commission provides full secretariat support to the Child Death Case Review Committee (CDCRC), an independent committee established to increase accountability and improve effectiveness in decision-making in the child protection system.

Since 1 August 2004, the DChS has been required to conduct a review of its involvement in each case where a child dies who was known to the Department in the previous 3 years. The DChS has 6 months from the time it learns of the child's death to provide the CDCRC with a report. The CDCRC considers the DChS report and makes recommendations about:

- improving policies which impact on services to children in the child protection system
- improving relationships between the Department and other agencies involved with the children and their families, and
- whether disciplinary action should be taken against any departmental staff in relation to their involvement with a child.

The CDCRC is a multi-disciplinary committee composed of experts in paediatrics, child health and welfare and investigations. The Commissioner and Assistant Commissioner are standing members of the CDCRC, with the Commissioner permanently appointed as the chairperson.

59 In New South Wales, for example, when an Aboriginal member of the Child Death Review Team can identify the family as an Aboriginal family, the child is coded as Aboriginal (New South Wales Child Death Review Team 2001:23).

It should be noted that the rates of death of children known to the DChS due to all causes exceeded the rates in the general population, which may be explained by the complex contextual factors associated with children and young people known to DChS that place children at higher risk.

Disability status

There are difficulties in defining disability status because of the differing working definitions of disability. Disability Services Queensland, Education Queensland and Queensland Health define disability differently. The DChS does not systematically collect information in relation to disability, and the Queensland Police Service and the Registry of Births, Deaths and Marriages only note a disability on official records if the child's disability is seen to be relevant to the cause or mode of death.

Because of the paucity and inconsistency of information on the disability status of the children and young people who have died, it has not been possible for the Commission to code a child's disability status. Therefore the deaths of children and young people with disabilities have not been analysed in this report. (Refer to 'Improving data collection' later in this chapter.)

Analysis and reporting

Analysis period

The register was analysed according to date of death registration (rather than date of death). This is in accordance with national datasets managed by the ABS and the child deaths data managed by the New South Wales Child Death Review Team.

Reporting period

This report examines the deaths of 426 children and young people aged from birth to 17 years, registered between 1 July 2005 and 30 June 2006.

Incidence

With the exception of Chapter 3, 'Queensland Children and Young People, 2004–05', this

report uses age- and gender-specific death rates, calculated using ABS population projections for 2004–05. These rates show the number of deaths per 100,000 children in each age and/or gender group in the population. For infants under 1 year, rates per 1000 live births were also calculated. Rates allow comparisons over time, across states and internationally.

Population estimates for 2003–04 have been used in Chapter 3. These population figures have been revised and any comparisons with the rates reported in the *Annual Report: Deaths of children and young people, Queensland, 2004–05* will need to be interpreted with caution.

Indigenous child death rates

The ABS has published experimental estimates and projections of the Indigenous population. However, identifying children and young people under the age of 18 is problematic because of the age groupings used by the ABS. Rates for the Indigenous population of children and young people in this publication are based on high series projections for 30 June of the specified financial year. Estimated resident population by statistical local area, single year of age and sex was disaggregated into Indigenous status using Census 2001 Indigenous proportions by statistical local area. These Indigenous proportions were then benchmarked to the ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians figures, 30 June 1991 to 30 June 2009* (cat. no. 3238.0).

Rates for births by Indigenous status in this publication used total births from 2003–04 unpublished births data from the ABS and 2004–05 births data from the Queensland Government Population Projections. Indigenous births were calculated by applying the proportion of Indigenous births for the last 2 calendar years of published data to the 2003–04 and 2004–05 births figures.

Rates were not calculated where cases numbered less than 4 because of the unreliability of such calculations.

Rates in the child protection population

The Commission reports on the number of deaths where children have died within 3 years of coming to the attention of the DChS. Rates of death for children in the child protection population are calculated on the number of distinct children notified in the 3-year period from 2002–03 to 2004–05. These data, disaggregated by age category, sex and Indigenous status, were provided to the Commission by the DChS.

Table 2.1: Distinct children notified by sex, Indigenous status and age group, 1 July 2002 to 30 June 2005

Sex and Indigenous status		Unborn	Under 1	1–4 years	5–9 years	10–14 years	15–17 years	Unknown/not stated	All ages
Males	Indigenous	23	152	371	651	618	145	4	1,964
	Other*	96	2,542	7,234	8,835	7,451	1,555	31	27,744
	Total	119	2,694	7,605	9,486	8,069	1,700	35	29,708
Females	Indigenous	18	157	332	557	679	203	1	1,947
	Other*	85	2,315	6,913	8,231	8,306	2,531	44	28,425
	Total	103	2,472	7,245	8,788	8,985	2,734	45	30,372
Unknown (2)	Indigenous	5	–	–	–	–	–	–	5
	Other*	153	24	49	8	5	1	10	250
	Total	158	24	49	8	5	1	10	255
Total persons	Indigenous	46	309	703	1,208	1,297	348	5	3,916
	Other*	334	4,881	14,196	17,074	15,762	4,087	85	56,419
	Total	380	5,190	14,899	18,282	17,059	4,435	90	60,335

Data source: Department of Child Safety, Performance Monitoring and Evaluation Unit, 8 August 2006

* Including non-Indigenous and those whose Indigenous status is unknown or not stated.

- Notes:
1. The data for unborn children only apply from the 2004–05 financial year. Data were not available before this date.
 2. The 'unknown' entries relate to cases where the age or sex of the child was unknown – these can remain unknown if the notification was not investigated (e.g. protective advice) or the investigation was unable to proceed (e.g. the family went overseas the next day).
 3. Totals for children identified as Indigenous at notification stage are considered to be an under-representation because a notifier will not always be aware of a child's Indigenous status.

There is a growing body of research that shows that a higher proportion of children known to child protection agencies die than do children in the overall population. This was noted in Hansard on 14 July 2004 by the then Minister for the Department of Child Safety, the Honourable Mike Reynolds MP. The complexity of the issues faced by families of 'at risk' children may in part explain the disparity between outcomes for children known to child protective services and those for other Queensland children.

Quality of data

As the Queensland Child Death Register relies on administrative data sources, a small margin of error is possible. There are no mechanisms available to

formally verify the complete accuracy of the datasets provided to the Commission and the information contained in the Child Death Register.

Rates and percentages provided in this report have been quality assured by the Office of Economic and Statistical Research.

The *Annual Report: Deaths of Children and Young People 2005–06* brings together information from a number of key sources and presents it in a way that facilitates consideration and interpretation of the risk factors associated with the deaths of children and young people in Queensland. The report also allows comparisons to be made between different population subgroups such as Aboriginal and

Torres Strait Islander children and young people and children in the child protection population. However, as noted throughout the report, caution must be exercised when making comparisons and interpreting rates due to the small number of deaths analysed. An increase or decrease of one or two deaths across the course of a year may have a significant impact on findings when working with small numbers.

Recommendations

Under section 89ZE(c) of the *Commission for Children and Young People and Child Guardian Act*, the Commissioner is required to make recommendations about laws, policies and practices to help reduce the likelihood of child deaths.

Section 89ZF(e) further requires that the Commission for Children and Young People and Child Guardian Annual Report of all Queensland Child Deaths report on the extent to which previous recommendations have been implemented.

Updates on the progression of recommendations made to agencies in 2004–05 are given in Chapter 13 of this report.

In 2006–07 all agencies to which recommendations have been directed will be asked to provide progress reports on the extent to which the recommendations from the 2005–06 period have been implemented, and strategies and time frames for continued implementation, as well as reasons for any alternative action and/or non-implementation.

Improving data collection

Police Report of Death to a Coroner

One of the key data sources used in the Commission's child death research is the Police Report of Death to a Coroner (Form 1).

The Form 1 was developed by the Queensland Police Service and the Office of the State Coroner to improve the type and consistency of initial information provided to assist the pathologist

in determining the cause of death.⁶⁰ The Office of the State Coroner and the Queensland Police Service should be commended for the successful implementation of Form 1, which is a rich qualitative and quantitative data source used extensively by the Commission in analysing the deaths of children and young people in Queensland.

The Commission acknowledges that completion of these forms is an administrative task that police officers must undertake with sensitivity when interviewing a family grieving the loss of a child. However, as with all other administrative data collections used for research purposes, areas for improvement may be identified. For example, in relation to the investigation of infant deaths, the Form 1 identifies whether there was "any evidence of alcohol or drug use at [the] location of [the] event". However, it does not require officers to record the extent of alcohol or drug use; therefore, unless it is stated in the form's 'Summary of Circumstances', the extent is not clear. Improvements in such areas will help to clarify current ambiguities and thereby improve the utility of the data for research purposes.

The Office of the State Coroner undertook a review of the Form 1 in August 2006. The Commission provided extensive input into this review process and will continue to work collaboratively to identify areas that may improve the information captured on Form 1s in future years.

Indigenous status

As noted earlier in this chapter, during the 2004–05 reporting period the Commission received notification from the Office of the State Coroner of 6 Indigenous deaths which did not appear to have been registered with the Registry of Births, Deaths and Marriages. Two of these remain unregistered at the time of reporting. The deaths of a further 5 Indigenous and 2 non-Indigenous children during 2005–06 have not yet been registered.

The Registry employs a range of strategies to increase the registration of Indigenous births and

60 The former Report Concerning Death by a Member of the Police Service (Form 4) used by police officers to notify a coroner of a death did not contain a death scene examination. The Form 4 served only to identify the deceased and provide a brief summary of circumstances of the death. The Form 1 was introduced in conjunction with the new *Coroners Act 2003* in December 2003.

deaths in Queensland. More recently it has released a range of commemorative Aboriginal and Torres Strait Islander birth certificates that are intended to recognise the importance of Queensland's Indigenous heritage. It is hoped that these certificates will help to break down some of the cultural barriers surrounding birth registration, which may, in turn, assist with death registration.

The Registry has supplied birth and death registration forms and posters to Justice of the Peace Trainers to take into Indigenous communities and is currently working with Legal Aid Queensland outreach workers to have death registration packs issued with birth registration ones so that these may also be taken into the communities.

Development of strategies to improve Indigenous birth and death registration is included as part of the business plan for the Registry in the coming year.

The issue of registration of Indigenous deaths has been recognised for some time. To assist with notification of Indigenous deaths, a provision was inserted into the *Births, Deaths and Marriages Registration Act* (section 30(9)) which allows the doctor to forward the Cause of Death Certificate even if there has been a failure of the funeral director to do so. This notifies the Registry about a death and triggers follow-up work to get the death registered.

Disability status

The Commission will work with Disability Services Queensland, the Department of Child Safety, the Queensland Police Service and the Registry of Births, Deaths and Marriages to improve the systematic collection of this data in future years.